

SEXUAL AND REPRODUCTIVE BEHAVIOUR IN A CONTEXT OF EXTENDED ADOLESCENCE IN SRI LANKA

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Introduction

The changing demographic and socio-economic scenarios throughout the world have unfolded many important issues that demand the immediate focus of all relevant members of the world community. Among these, the sexual and reproductive health of the population is an important issue that needs to be addressed immediately throughout the countries in the developing world where the quality of health has a major impact on the development process.

The broad and comprehensive definition of reproductive health, adopted by the 1994 International Conference on Population and Development (ICPD) encompasses not merely women of childbearing age, but the reproductive health of all age groups of both sex. Nevertheless, more importantly, since the current generation of adolescents and youth constitutes the immediate next generation of parents, their preparation for reproduction and sexuality has tremendous implications for their individual as well as national reproductive health outcomes. Thus the Programme of Action (PoA) developed and adopted by the ICPD highlighted the importance of "addressing the adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, and HIV/AIDS, by promoting responsible and healthy reproductive and sexual practices, voluntary abstinence, and the provision of services and appropriate counseling specifically suitable for that age group" (United Nations, 1994).

The entry into the reproductive phase of the lifecycle is an important threshold in a person's life in which the choice and the behavioural patterns acquired during early adolescence will determine the subsequent life course (United Nations, 1989). Important steps in this transitional process are several critical life events such as puberty, initiation to sexuality, marriage and childbearing. The timing as well as the sequence and context in which these events take place have immediate and long-term repercussions on a particular individual's sexual and reproductive health. Generally, the commencement of adolescence is associate with a period of rapid physical growth, in which a gradual development of the reproductive organs occurs along with the appearance of gender specific secondary sex characteristics and menarche in girls.

In many countries of the developing region, due to the generally low level of mortality and morbidity among children and adolescents, the overall well-being of

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this segment of the population has not been on the agenda for discussion among policy makers. In this decade, their issues and problems received priority mainly because of the strong advocacy by governments, individuals, organizations, and international agencies in the region (De Silva, 1998).

In almost all the developing countries, two distinctive demographic trends with strong implications for the sexual and reproductive health of adolescents and youth are apparent. First is the decline of the average age of menarche, primarily related to a variety of environmental, genetic and socio-economic factors, such as improved nutrition and more importantly the change in cultural norms (Bongaarts and Cohen, 1998). Second, is the trend towards an increasing average age of marriage of both males and females causing the proportion of unmarried adolescents to increase (De Silva, 1997a). Due to the above trends the period of potential premarital sex, a phase of risk-taking behaviour among adolescents and youth, has lengthened (United Nations, 2001).

Defining Adolescents and Youth

The World Health Organization (WHO, 1975) defines adolescents as persons between 10-19 years of age, youth as those between 15-24 and young people as those between 10-24 years. Many studies throughout the world have adopted these age ranges, though they overlap, as appropriate to their cultures.

Defining adolescence and youth by a particular age range may defy standardization since different terms and age ranges are commonly encountered in the literature. Sociologically or biologically, there is no universally accepted beginning or end of adolescence. The experience of many countries also indicates that the definition of age could be culture-specific.

Therefore, in line with WHO definitions, the present study, unless otherwise stated, specifically will conform to the age range of 10-24 years when referring to adolescents and youth. The group is also subdivided into three categories, namely age 10-14, 15-17 and 18-24 years for analytical purposes. In fact, as noted by Elliott and Feldman (1990), the first period is particularly marked by profound physical and social changes that occur with puberty at which maturation begins. Middle period (age 15-17) is a period of increasing independence. The last category (age 18-24) is marked by educational goals or other social factors, delaying their entry into the adult role. In fact, in most countries these subdivisions have been incorporated into the educational structure: junior high or secondary school, senior high school, and college.

Defining Sexual and Reproductive Health

Along with 179 other countries, Sri Lanka was a signatory to the programme of action adopted at the International Conference on Population and Development (ICPD) held in Cairo in 1994, which "endorsed a new thinking that population growth

can be stabilized and development efforts enhanced by the advancement of women” (Ashford, 1995) and stressed the importance of reproductive rights and the provision of comprehensive reproductive health services to all. A crucial section of the Programme of Action included a definition of reproductive health (United Nations, 1994):

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide it, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant.... It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.”

In line with the above definition, reproductive health care is defined as the constellation of methods, techniques and services, which contribute to reproductive health and well-being through preventing and solving problems associated with reproductive health. It also includes personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases” (Hardee et al., 1998).

Adolescent and youth reproductive health, which comes under the above general definition, has been recognized by many researchers as a key development concern. While reproductive health information, counseling and service delivery have been identified as necessary programmes for adults for decades, availability of such programmes has been more recently endorsed for adolescents and youth. The ICPD and other subsequent international conferences endorsed the rights of adolescents and youth to reproductive health information and services.

Sexual Health

Even though the general definition of reproductive health adopted at the ICPD includes sexual health, at a more theoretical level, one could still examine the definitions used for sexual health.

“Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love. Three basic

elements include i) capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic, ii) freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships; iii) freedom from organic disorder, diseases and deficiencies that interfere with sexual and reproductive functions" (WHO, 1975).

In practical terms sexual health represents "healthy sexuality", which incorporates a sense of volition in sexual relations and control over one's body. When healthy sexuality is lacking it can result in higher risk of problems such as unintended pregnancies and sexually transmitted diseases (STDs), including HIV infection. Healthy sexuality affects people's ability to make use of reproductive health services as much as coercion and childhood sexual experience may affect adult sexual satisfaction and risk behaviours (Finkelhor, 1995).

Demographic and Socio-economic Context of Adolescents and Youth

In addition to demographic changes, adolescents and youth in almost all developing countries are also exposed to rapidly changing socio-economic and cultural environments, which have an overall negative impact on their well-being.

Adolescents and youth in Sri Lanka are a heterogeneous group, with a likelihood of heterogeneity in their needs, attitudes and behaviour related to sexual and reproductive health (Abeykoon & Wilson, 1998). Thus, there is an urgent need to study issues related to adolescent and youth sexual and reproductive health in the context of different socio-economic and cultural backgrounds that significantly influence their lives.

The Census of Population and Housing, 2001, which is the most recent in Sri Lanka, indicated the total enumerated population to be in the region of 18.7 million, establishing that the total population has multiplied by almost eight times, since the first National Census of 1871, which recorded a population of only 2.4 million persons. The current rate of population growth, which approximates 1.2 per cent per annum, is described as low. The declining pattern of population growth was initially observed during the 1963-1971 inter-census period. Nevertheless, due to the population momentum of the previous high fertility regime, Sri Lanka still adds more than 200,000 persons to its population annually and at the commencement of the third millennium, ranks as one of the most densely populated countries in the Asian region with more than 300 persons per square kilometre.

Magnitude of the population and structure

Table 1: Change in the size and percent of adolescent and youth population in Sri Lanka

Age	1953	1963	1971	1981	2001	2006	2011	2016	2021	2026
	(Census)	(Census)	(Census)	(Census)	(Census)	(Projected)	(Projected)	(Projected)	(Projected)	(Projected)
10-14	920.2	1,341.1	1,609.1	1,690.3	1,704.2	1,511.8	1,471.6	1,481.0	1,437.6	1,351.3
15-19	703.8	1,029.5	1,360.0	1,607.5	1,835.4	1,623.3	1,478.8	1,448.0	1,462.8	1,425.0
20-24	767.5	890.4	1,270.7	1,509.8	1,723.6	1,584.9	1,567.9	1,439.4	1,417.8	1,441.7
Sub Total	2,391.5	3,261.0	4,239.8	4,807.6	5,263.2	4,720.0	4,518.3	4,368.4	4,318.2	4,218.0
10-24 (%)	29.5%	30.8%	33.4%	32.4%	28.1%	24.3%	22.5%	21.2%	20.6%	20.0%
10-19 (%)	20.1%	22.4%	23.4%	22.2%	18.9%	16.1%	14.7%	14.2%	13.8%	13.2%
Total Pop.	8 097.9	10,590.1	12,689.9	14,848.4	18,734.0	19,462.7	20,110.6	20,629.7	20,948.2	21,087.7
Sex ratio Age10-24	106.7	102.9	102.8	102.4	102.2	101.0	101.4	102.2	102.5	102.5
Total Pop.	111.5	108.2	106.1	104.0	97.9	99.2	98.7	98.3	97.8	97.2

Source: Department of Census and Statistics, and De Silva (2007).

The size of the adolescent and youth population or the 10-24 age group, as a proportion of the total Sri Lankan population, has increased. Demographically the exclusive attention and focus towards this segment of the population is primarily due to the recognition of this phenomenon. The largest adolescent and youth cohort (age 10-24) in the history of the enumerated Sri Lankan population exists at present. In numerical terms the growth of this group, during a period approximating half a century, from 1953 to 2001, had increased from 2.4 million to a peak of 5.3 million in 2001 (Table 1). The current size and growth patterns of the adolescent and youth segment is in fact a lagged effect of the levels and trends in fertility and infant and childhood mortality of previous years.

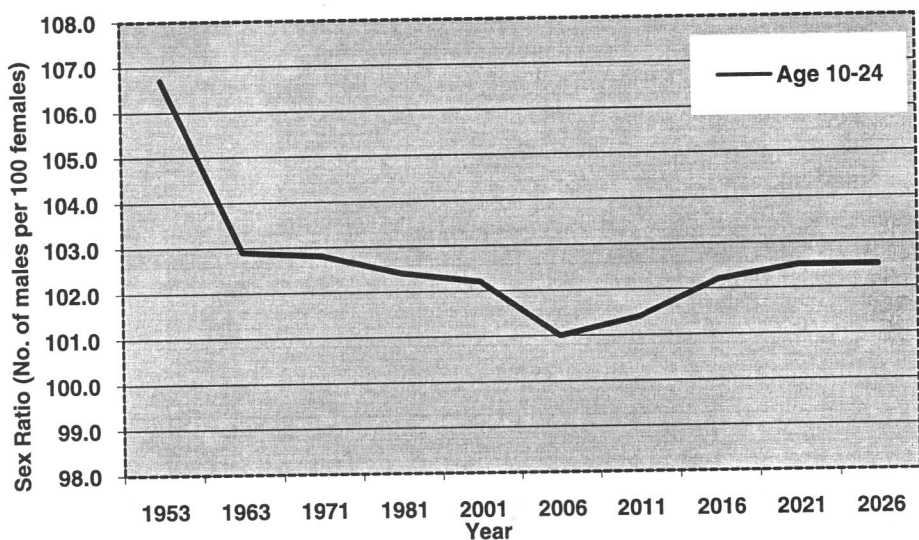
When the three separate age groups, 10-14, 15-19 and 20-24, of the population as at 2001 are considered, all three groups indicate the same changing trend. Nevertheless, the 15-19 age group was the largest with 1.8 million. It is worthy of note that prior to 1981, the size of the 10-14 group was higher than the 15-19 or 20-24 groups.

The peaking patterns of the 10-24 cohort when considered as a percentage of the total population show a difference. For example, in 1953 this age group was estimated to be 29 per cent of the total population, in 1971, 33 per cent and in 2001, 28 per cent, which establish that peaking time when considered as a proportion of the total population had occurred in 1971. The decline in the number of adolescents and youth of age 10-24 from 2001 is primarily attributed to the significant drop in fertility rates since the 1960s (De Silva, 1994).

In this context, issues such as prioritization of adolescent and youth consumerism, their consumption patterns, satisfaction of their demands, and changing behavioural patterns need to be addressed. The fact that the targeted age cohort is partly a subset of the 15-49 age group, the crucial ages of reproduction for females, cannot be overlooked. Hence addressing their needs will be critical in determining Sri Lanka's future population levels.

The projected outlook for growth of the adolescent and youth population based on population projections show that by the year 2006 the size of the 10-24 age segment will numerically decline to 4.7 million, and in another two decades, the number will further decline to 4.2 million.

Figure 1: Sex ratio of the adolescent and youth population



Source: Department of Census & Statistics, and De Silva (2007).

Sri Lanka, though located in the South Asian region, has not adhered to the common South Asian model. Except in the year 1953 the gender-wise breakdown of the adolescent and youth population does not indicate any significant disparity between the sexes (Figure 1). In 2001 for every 100 females there were about 102 males. Projection results also confirm this gender ratio pattern. Commencing from 1953 the sex ratio of adolescents and youth was more favourable to males. The adolescent and youth sex ratio stabilized around 102 in subsequent years. However, the sex ratio of the total population shows a significant disparity between the sexes. For instance, in 2001 for every 100 females in the total population there were only approximately 98 males, and in the coming decades, the ratio will be increasingly favourable to females, primarily due to greater improvement in female than male life expectancy (Table 1).

Education in Schools and Other Institutions

Education policies and programmes formulated and implemented, even before Independence, had clear objectives of reducing socio-economic disparities that had existed for many decades in Sri Lanka. Free education was introduced in 1945 along with the introduction of the local languages as the medium of instruction (Jayaweera, 2002). Thus, educational opportunities were generated, enabling participation of the general public and children of almost all socio-economic groups in education. The number of schools nearly doubled from 5,726 in 1945 to 9,550 in 1965, and to around 10,000 from the late 1970s onwards.

The improvement in school facilities in all parts of the country was an important forerunner to a significant increase in adolescent and youth participation in general school education. As shown in Table 2 the proportion of adolescents and youth in school increased significantly during the period 1981 to 2001. Even though education is compulsory for children aged fourteen and below in Sri Lanka, only 83 per cent males and 82 per cent females who were in the 10-14 age group were in school in 1981; however, in 2001 the corresponding proportions increased to 92 and 93 per cent respectively. Over the period 1981 to 2001 the proportion in school among the 15-19 age group also increased significantly. In fact, it is interesting to note that unlike in the rest of the South Asian countries, in Sri Lanka a higher proportion of female adolescents was in school in 2001 compared with male adolescents (Table 2). This shows that where formal education is concerned, gender disparities certainly do not exist in Sri Lanka.

Table 2: Percent of adolescents and youth in school

Age	Male		Female	
	1981	2001	1981	2001
10 - 14	83.0	92.1	82.0	93.4
15 - 19	40.0	51.2	41.9	54.8
20 - 24	5.9	3.6	6.3	3.6

Source: Department of Census & Statistics.

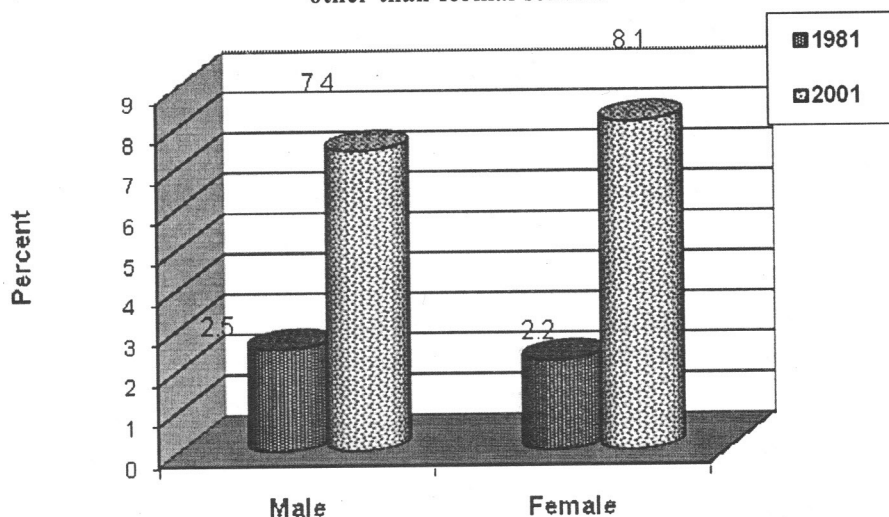
A negative association is observed in the participation of adolescents and youth in general education and age maturity; the proportion of them in school decreases as age increases. According to the Census of Population of 1981 and 2001, the general school participation of both genders in the 20-24 age group declined significantly. This declining trend commences when the adolescent is in the 15-19 age group and a precipitated decline is observed in the participation rate of the 20-24 group.

The explanation for the above declining trend in general education participation is that by age 17-18, a larger proportion have finished their G.C.E (Advanced Level) and joined the labour force, or as the age increases instead of participating in general education at least a lesser number are participating in tertiary or university

education. Admission to Sri Lankan state universities imparting formal education is extremely competitive. Only eight percent of the G.C.E (Advanced Level) output are able to enter the universities even though the number who qualify is much more.

The time series pattern of enrolment in university and other higher educational institutions indicates an increase. Among the males of age 20-24 only 2.5 per cent were at university or any other tertiary education institution in 1981. But by 2001, those who participated in university or other tertiary education increased to 7.4 per cent while among the females, the corresponding increase is even stronger (Figure 2). Clearly, there is an increasing adolescent and youth demand for higher or tertiary education. Consequent to this demand a large number of private tertiary educational institutions are mushrooming in all parts of Sri Lanka.

Figure 2: Percent of youth age 20-24 attending educational institutions other than formal schools



Labour Force Participation

Participation in general or further education have reduced the probability of labour force participation of 10-14 and 15-19 age groups. This trend follows the expansion of educational opportunities and compulsory education during the last couple of decades. The labour force participation rate (LFPR) of males in the 15-19 age group shows a decline from 41 to 30 per cent of the working age population during the 1981 and 2001 inter-census period (Table 3).

During the same period the labour force participation rate of females of age 15-19 declined only by 0.8 per cent from 19.7 to 18.9 per cent. Nevertheless, the female LFPR of the 20-24 age group increased from 37 to 43 per cent. During the last two decades, an increasing number of females of age 20-24 had entered the labour market. A substantial quantum of employment opportunities was available for them in

manufacturing (such as the garment industry) and service sectors of Sri Lanka. The direct foreign investment opportunities in these sectors enabled the opening of manufacturing industries and service sector industries with employment opportunities and better salaries and working environments.

There is a significant gender differential in Sri Lanka, in the adolescent and youth labour force participation patterns, particularly in the age groups 15-19 and 20-24 years (Table 3). In each of the three age groups, the proportion of females in the labour force was very much lower than that of males. In 2001 over 76 per cent of males in the age group of 20-24 were in the labour force when compared to 43 per cent of the same age group females.

Table 3: Percent of adolescents and youth in the labour force

Age	Male		Female	
	1981	2001	1981	2001
10 - 14	5.5	1.5	2.3	0.9
15 - 19	41.1	30.0	19.7	18.9
20 - 24	79.2	76.2	36.9	43.2

Source: Department of Census & Statistics.

An overall decline in the level of child labour in Sri Lanka is observed, with only 3.1 per cent of males of the 10-14 age cohort being reported as employed in 1981. This proportion had further declined to 1.1 per cent in 2001. Females of the parallel age groups show the same pattern. However, the 15-19 age group indicates a different trend. The proportion of employed males among ages 15-19 declined during the period 1981 to 2001, while among the females during the same period, there was a significant increase. Out of 100 females of age 20-24 in 1981 only 18 were employed but the figure had risen to 32 per cent in 2001. It is worthy of note that though the proportion of employed females had increased significantly after age 15, among the males the corresponding figures were much higher (Table 4).

Table 4: Percent of employed adolescents and youth

Age	Male		Female	
	1981	2001	1981	2001
10 - 14	3.1	1.1	1.4	0.7
15 - 19	24.4	19.1	9.2	12.9
20 - 24	57.0	59.2	18.3	31.7

Source: Department of Census & Statistics

Since the adolescents or the younger age cohorts are still in their formal schooling years, those of them who opted to be in the labour market or are already employed are likely to be having a lower level of education. Most of those male and female adolescents and youth who are already in the labour market are in unskilled jobs in the manufacturing, construction and service sectors.

Mortality and Morbidity

The period of adolescence characterized by relatively low mortality and morbidity and, as a consequence, their overall well-being have not been on the agenda for discussion until recently in countries of the developing world, including Sri Lanka. However, in this decade adolescent issues and problems received priority presumably because of strong advocacy by governments, individuals, organizations, and international agencies (Friedman, 1990).

In Sri Lanka usually among the adolescents and youth, in each sex, the lowest mortality is observed in the 10-14 age group. As shown in Table 5, except age-specific mortality of 5-9 males in 2000-02, in which the lowest mortality is observed, persons younger than and older than the 10-14 age group show a higher level of mortality. The highest level of mortality among the adolescents and youth is observed among the males of ages 20-24 in 2000-02 (2.7 per 1000 persons). The rate is more than double the figure reported for the aged 15-19 males. This trend cannot be observed among the females. The age-specific mortality rate among females in fact has slightly declined from 0.88 to 0.87 per 1000 persons in 2000-02.

Table 5: Age-specific mortality rate (per 1000 persons), 1980-1982 and 2000-2002

Age	Male			Female		
	1980-1982	2000-2002	Change (%)	1980-1982	2000-2002	Change (%)
Under 1	34.26	13.99	-59.2	28.56	11.13	-61.0
1-4	2.96	0.77	-74.0	3.03	0.68	-77.6
5-9	1.02	0.48	-52.9	0.94	0.41	-56.4
10-14	0.87	0.50	-42.5	0.65	0.37	-43.1
15-19	1.50	1.25	-16.7	1.36	0.88	-35.3
20-24	2.49	2.70	+8.4	1.66	0.87	-47.6

Source: Registrar General's Department

Except males aged 20-24, in all other age-sex groups reported in Table 5 there was a decline in the level of mortality over the period. It is important to investigate why only the mortality rate of males aged 20-24 has increased over the period 1980-82 to 2000-02. In fact, the decline in mortality reported for the males aged 15-19 is noted to be the lowest (16.7%), compared to all age-sex groups reported in Table 5. Interestingly, it is not only females who report the lowest mortality from infancy

to higher ages in 1980-82 and 2000-02, the percentage reduction in mortality over the period in all female age categories is higher than that for the corresponding age categories of males. As a whole, female adolescents and youth are observed to be experiencing a significantly higher level of mortality decline than their male counterparts.

Why do male adolescents and youth experience a higher level of mortality than their female counterparts? With the changes in Sri Lankan society a significantly larger number of males than females fall victim to homicides and injuries, which are inflicted by others. Also, suicides and accidents take a heavy toll of males more than that of females. On the other hand, an overwhelmingly large majority of female adolescents in Sri Lanka are not exposed to maternal complications primarily due to late marriage. However, in countries such as India, Pakistan and Bangladesh, female mortality during adolescence is significantly higher than male mortality as female adolescents begin to experience problems of early pregnancy, malnutrition, anaemia, and abortions (Hakim et al., 1998; International Institute for Population Sciences, 2000).

Although the incidence of suicide among both genders has declined, in Sri Lanka, presumably war casualties, homicides and injuries and accidents have increased disproportionately among the males aged 20-24 during the period 1980-82 to 2000-02. This trend demonstrates the emerging threats faced by the adolescents and youth in Sri Lanka. Apart from the civil war, the underworld groups are mushrooming in Sri Lanka through which significant numbers of male adolescents and youth in different parts of the country encounter the risk of death. This trend indicates the importance of development and maintenance of programmes for adolescents and youth, particularly for those involved in risky behaviour. The development of life skills among the school going population could be a specific activity of the mainstream educational programme.

Sexual and Reproductive Vulnerability

Postponement of Marriage

Sri Lanka, in contrast with other South Asian countries, demonstrated a significantly rapid transition in marriage patterns. The delays in marriage and their impact on the birth rate led Kirk (1969) to refer to Sri Lanka as "the Ireland of Asia". Other researchers identified Sri Lanka as the leader in the third world Asia's late marriage pattern; by the mid 1970s, Sri Lankan females were marrying not at puberty but a decade after puberty (Caldwell et al., 1989; De Silva, 1997a).

During a period approximating a century, from 1901 to 1993, the sex differentials of the mean age at marriage show that the female mean age increased more rapidly than that of males. During this period, the age at marriage of females increased by over seven years, from 18.3 in 1901 to 25.5 years in 1993, but males experienced an increase of only 3.5 years (Table 6). When the commonality of the incidence of marriage in Sri Lanka among adolescents and youth was examined, an interesting

revelation was that virtually all the males in the 15-19 age group were in the status of 'never married'. When the marital status of the females of the same age group was investigated, only just over 10 per cent of the cohort had entered into marriage (Table 7). The percentage of 'never married' in the three consecutive population Censuses, 1971, 1981 and 2001 shows that, among females of age group 15-19, the proportion of never married amounted to 89, 90 and 88 per cent respectively. Thus unlike in many other developing countries, in Sri Lanka a very large proportion of adolescents of the 15-19 age cohort are 'never married'. Nevertheless the marital status of the immediately next age group 20-24, indicates a more favourable tendency towards marriage with only slightly more than half of the female age cohort and more than four fifths of the male age cohort being in the 'never married' status.

Table 6: Mean age at marriage (SMAM)

Table 6: Mean age at marriage (SMAM)

Year	Male	Female	Age Difference
1901	24.6	18.3	6.3
1921	27.0	21.4	5.6
1953	27.2	20.9	6.3
1971	28.0	23.5	4.5
1981	27.9	24.4	3.5
1987	-	24.8	-
1993	-	25.5	-
1994	28.3	24.7	3.6
2000	-	24.6	-

Source: Department of Census & Statistics

Table 7: Percent never married among adolescents and youth

Age	Male			Female		
	1971	1981	2001	1971	1981	2001
10 - 14	-	-	-	-	-	-
15 - 19	99.4	99.0	98.3	89.4	90.1	87.7
20 - 24	86.6	83.0	81.9	53.2	55.3	55.5

Source: Department of Census & Statistics.

Today's Sri Lankan youth prefer love marriages compared to arranged marriages and this has been proven in many studies. Higher education, more opportunities for entry into the formal labour sector, along with less parental control, have all contributed to more freedom for adolescents and youth and consequently traditional marriage market practices have started to change. Thus, one of the most conspicuous single changes regarding marriage has been Asia's transformation from a society in which marriages were arranged by parents to one in which marriages are based

on the individual's own selection (Caldwell et al., 1989). In Sri Lanka, about a quarter of pre-war marriages were love marriages rather than arranged marriages. However, as observed in the 1985 Contraceptive Survey, love marriages made up 52% of all marriages (De Silva, 1997a). A study done by Basnayake (1996) shows that 49.9 per cent of the youth preferred love marriages compared to 18.4 per cent who said that they preferred arranged marriages. Love marriages give more freedom for the couple which may lead to pre marital sexual contact.

Sexual Behaviour

Simultaneously with a clear trend among young men and women in many countries in the world including Sri Lanka to marry later in life, sexual relations prior to marriage are on the rise. Social and economic changes, including urbanization, industrialization and extension of education, have eliminated many of the traditional restraints on early sexual activity outside marriage and have exposed many adolescents and young people to the risk of unwanted pregnancy and abortion, which in turn, increase the risks to their reproductive health and well-being (Dixon-Mueller, 1993).

There is relatively little information available regarding the sexual behaviour of unmarried adolescents and youth in Sri Lanka. Such information could be directly obtained by asking about sexual contacts from them. Alternatively, sexual behaviour among the unmarried adolescents and youth could also be estimated indirectly by examining the incidence of induced abortions and sexually transmitted infections (STIs), evaluation of fertility behaviour and subsequent events related to their lives. Such behavioural events could include suicide, infanticide and also adoption of babies born to these Sri Lankan adolescents and youth by local and foreign infertile couples through formal and informal channels.

Indicating the incline towards premarital sexual relations in Sri Lanka a study done by Basnayake (1996) on reproductive health knowledge, attitudes and practices among unmarried Sri Lankan youth within the age range of 16–29 shows that 9.9 per cent of the sample approves of premarital sex under any circumstances. This included 17.1 % of the males and 2.2% of the females. In the same study, the respondents were questioned as to whether they had ever had sexual contact (not sexual intercourse) with someone of the opposite sex. About 42% answered positively. When looking at the male female differences 57% and 26% unmarried males and females respectively reported having sexual contacts. About 18% of the sample answered in the affirmative when asked whether they had had sexual intercourse with someone of the opposite sex. Gender-wise 31.4% of the males and 4.4% of the females responded that they had had intercourse with the opposite sex (Table 8). When asked about homosexual relations 14.1% of the sample reported in the affirmative.

Table 8: Sexual behaviour of the adolescents and youth

Engaged in sexual intercourse?	1996 (Basnayake)			1997 (Silva & others)		
	Male %	Female %	Total %	Male %	Female %	Total %
Yes	31.4	4.4	17.9	28.2	2.3	15.4
No	67.4	94.4	80.9	71.8*	97.7*	84.6*
No answer	1.3	1.3	1.3			
Total %	100.0	100.0	100.0	100.0	100.0	100.0
N	1262	1262	2524	309	301	610

Note: * - Includes persons answering as 'No' as well as the ones who did not answer.

Sources: Basnayake (1996); Silva & others (1997)

Another survey collecting information on sexual knowledge, attitudes and practices of unmarried youth found that the intensity and intimacy of peer activities were greater among young men than among young women (Silva et al., 1997). The study comprised a sample of unmarried youth within the age group of 17–28 years in the community and among university students. About half of both males and females reported having love affairs; community males reported the highest level of love affairs (62.9%), followed by community females (50.7%). University females (49%) came next and university males (39.3%) last. Undoubtedly, love affairs among adolescents and youth, a common primary source of sexual experience, is identified to be significantly higher in each sector of the Sri Lankan community. Silva and others (1997) also found that 8.9% of the youth had engaged in full vaginal penetration/withdrawal and 7.2% in full vaginal penetration/ejaculation. In this case also the incidence is more prevalent among the males compared to females. As noted by respondents in the survey the first sexual encounter is often experimental and most do not use contraceptives even if they know where to get them. However, they have found that most young people in Sri Lanka preferred behaviour perceived to protect female virginity, such as inter-femoral and other forms of non-penetrative sex.

In a study done by Attanayake (1999) on levels of knowledge, attitudes and practices of secondary school pupils (Year 9) on reproductive health education and reproductive health issues, the statement “intercourse is permitted only between married couples” was presented to the students and their views were obtained. About 38 % of the sample firmly disagreed or did not respond; and this shows an attitudinal change among the youth with regard to sexual behaviour in Sri Lanka.

A study done by Hettiarachchi and Schensul (2001) on a sample of 775 female FTZ workers, aged 18 – 30 investigated the risky sexual behaviour of adolescents and youth. The results indicated that some young women thrive in the relative freedom of the Free Trade Zone (FTZ) communities, avoiding the constraints and dictatorial demands of parents, and many develop lasting relationships. Approximately 29.5% of the sampled women reported having female friends, who often have been in the

FTZ longer, and are involved in risky behaviour, such as alcohol use, living with a man, having sex, etc. while those friendships provide the young women with the knowledge, motivation and initial feeling of security they need, in order to begin involving themselves in the FTZ communities outside their residence. About 16 per cent of the respondents were involved in risky sexual behaviour. They investigated the factors and processes that can result in the occurrence of risky sex and the consequences of unwanted pregnancies. The youth from the rural community, especially the females who work in the FTZ, were targeted because they are another category who undergo reproductive health risks.

Rajapakse and De Silva's study (2000) on women seeking abortions show that 6.3% of the total sample (Number = 983) can be identified as either unmarried (5.9%) or living together (0.4%). The mean age of the entire group was 22.4 years. This is an indication that premarital sex is prevalent among adolescents and youth in Sri Lanka. The same study shows that 28.8 % of the total sample has had their first intercourse before age 19. Although the study does not indicate whether this was within or outside marriage it can be assumed that a certain percent of this was pre-marital.

Another indirect way of investigation of sexual behaviour and resulting fertility is to retrieve the numbers of adopted children from unmarried adolescents and youth. The adoption of children born to these mothers is not an uncommon phenomenon in Sri Lanka. Apart from adoption of children a significant number of induced abortions, infanticide and abandoned children is reported from many parts of the country, which tends to support the occurrence of pre marital sexual intercourse among Sri Lankan adolescents and youth (De Silva, 1998).

Induced Abortion

Given the limited information on sexual health, it may not be surprising that unwanted pregnancy and induced abortion can possibly be a feature among vulnerable adolescents and youth in Sri Lanka. Even though the incidence of conception among unmarried young women in Asian countries is less known, available information suggests that a substantial minority of sexually active unmarried young women have experienced pregnancy (Gao, 1998). An overwhelmingly large proportion of these pregnancies is unwanted and terminated by safe or unsafe induced abortion procedures. In the study done by Basnayake (1996), the unmarried youth were asked whether a woman should have the right to have an abortion if she wants? 33.9% answered "yes" to this question showing that liberal ideas with regard to abortions are emerging.

Despite the difficulty in obtaining data on abortions in Sri Lanka, primarily due to its illegal status, a number of studies have attempted to collect such information. Among these, the 1993 and 2000 Demographic and Health Surveys (DHS) have unsuccessfully attempted to collect information on induced abortions from women who fall into the ever-married group. Only 152 and 76 of those ever-married reported having induced abortion at these national surveys conducted in 1993 (N= 7,078)

and 2000 (N= 10,382) respectively. Naturally, women may wish to conceal their having had one, either because abortion is illegal or due to the social stigma associated with the procedure (De Silva et al, 2006).

Another approach is to base the study on the reports of patients who were admitted to hospitals for post-abortion complications. However, this represents a selected group of abortion seekers who had developed serious complications, while others are not represented (Kodagoda and Senanayake, 1982). The others include those who developed complications but received treatment from a private hospital/doctor, and those who did not develop any serious complications. Thus, obtaining information from clients at abortion clinics seemed to be the best way to represent vulnerable abortion seekers, including adolescents, youths and unmarried groups.

A number of studies has collected data from abortion seekers before the procedure with the permission of service providers. It should be emphasized here that it is the clinics' policy to provide abortion for all women who request it and not to intimidate single women by asking more than routine family questions. According to the most recent study (De Silva et al., 2006), of 306 abortion seekers interviewed, only about 3% and 11% were identified to be in the 15-19 and 20-24 age groups respectively (Table 9). Previous studies also noted more-or-less the same level of concentration of women of adolescent and youth age categories (Ban et al., 2003; Rajapakse and De Silva, 2000).

Table 9: Distribution of abortion seekers by demographic variables

Age group	2006 (De Silva & others)		2000 (Rajapaksa & De Silva)		Percentage distribution of women from DHS 2000	
	%	N	%	N	%	N**
<i>Age group</i>						
15 – 19	2.9	9	3.0	24	18.5	1,921
20 – 24	11.4	35	15.6	123	16.3	1,692
25 – 29	25.5	78	26.6	209	14.3	1,483
30 – 34	22.5	69	26.1	205	13.5	1,407
35 – 39	26.8	82	20.1	158	12.2	1,369
40 – 49	10.9	33	8.5	67	24.2	2,510
<i>Marital status</i>						
Never married	8.8	27	6.3*	49		
Married	90.2	276	93.7	736		
Divorced/separated	1.0	3	0.1	1		
Total	100.0	306	100.0	786	100.0	10,382

Notes: * - In this category, 0.4% are living together.

** - Total female household population (age 15-49) of the Demographic & Health Survey 2000

Sources: De Silva & others (2006); Rajapaksa & De Silva (2000); Department of Census & Statistics (2002)

According to Table 9 in the age groups 25–29, 30–34 and 35–39 the percentage of women in the above two abortion samples selected are significantly higher than the population distribution of women observed in these age groups in the DHS 2000 sample. However, age groups 15–19 and 40–49 are under represented in the two abortion samples compared with the DHS samples. Compared to the adolescent population in the DHS sample, representation of abortion seekers in the two samples is very low.

Even though only a small proportion of the samples interviewed was reported to be single in this study, the actual percentage of single women may be slightly higher, as some women may have misreported their marital status to protect themselves from the socio-cultural taboos of premarital pregnancy. For instance, De Silva and others (2006) and Rajapakse and De Silva (2000) found that of the total abortion clients 9% and 6% were never married respectively. As noted by researchers the practice of induced abortion among the unmarried could be higher in some particular locations such as the Free Trade Zones, in which an overwhelmingly large percentage of female workers are unmarried and tend to have love affairs with multiple partners (Hettiarachchy and Schensul, 2001). However, it is the opinion of the enumerators, the researchers and the service providers that the overwhelmingly large majority, about 85%-90% of the abortion clients, were married (De Silva et. al, 2006).

According to the above study, among the unmarried clients the majority were terminating their first pregnancy. This was due to the influence of their parents or male partner, or as a result of a partner's desertion or refusal to accept paternity. Among the married only a small proportion were terminating their first pregnancy.

Adolescents have considerably less decision-making authority compared to older abortion seekers and are thus more likely to have been pushed into an abortion. On the other hand, some of the adolescents might have faced opposition from their family members and/or partner on termination. As found in many studies from India, unmarried adolescents are considerably more likely than older women to delay seeking abortion and hence undergo more hazardous second trimester abortions (Chabra, 1992). Thus, it may be possible that some of the pregnant adolescents in Sri Lanka who demanded terminations were rejected by most of the service providers where the services are available only up to 12 weeks of gestation (menstrual regulation procedure). The majority of these rejected cases and those who did not approach the service providers due to possible rejection might have used traditional methods or self-induced procedures for termination. Alternatively, the unmarried adolescents and youth who were unable to terminate their unwanted pregnancy kept the pregnancy for the full term. The majority of babies who were born to these adolescents and youth were given for adoption, while the balance would have faced desertion or infanticide (De Silva, 1996).

Contraceptive use and knowledge

Contraceptives have recently been made available to young men and women in many developing countries including Sri Lanka, but legal or social restrictions and

limited access still make their use difficult (Tusi, 1985). As a result, the level of contraceptive use in most of the countries is higher among older women (aged 25-39) and typically lower among adolescents and youth. Adolescents and youth are also less likely than adults to use contraceptives, either within or outside marriage. Data on contraceptive use is mainly available for married persons. Unmarried adolescents and youth have rarely been interviewed on this theme.

In Sri Lanka the 1993 and 2000 Demographic and Health Surveys along with many other variables gathered information on contraception from 15-49 ever-married women. As highlighted in Table 10, in general the use of contraception among married adolescents of age 15-19 was significantly lower than the youth in the 20-24 age category. Even though there was a significant difference in the use of contraceptives between these two groups of married women in 1993 the difference had narrowed by 2000. The trend indicates that in 2000 just over one-half of the 15-19 married adolescents used contraception, while the corresponding estimate for the 20-24 group was 61%. The increase in the use of contraception among the 15-19 group over the period of 1993-2000 took place due to a significantly heavy acceptance of modern temporary methods of contraception. The significantly large increase in the use of modern temporary contraception should be related to the desire for postponement of fertility. The reliance on traditional methods by these married women has not changed over the period: 12% in age 15-19 and 17% in age 20-24 used less reliable methods such as safe period or withdrawal for avoidance of contraception.

Table 10: Contraceptive practice (current use) among married adolescents, 1993 and 2000

Type of methods	1993 DHS		2000 DHS	
	15-19	20-24	15-19	20-24
Traditional	12.7	17.8	11.8	16.8
Modern temporary	17.6	31.7	41.0	43.6
Modern permanent	0.0	4.0	0.0	0.8
Any method	30.3	53.6	52.8	61.2

Source: Department of Census and Statistics (2002).

Even though unmarried adolescents and youth have rarely been interviewed about their contraceptive behaviour, the available studies in a number of countries in Asia indicate a significant low reliance on contraception. For example, a study in Thailand found that about 48% of sexually active unmarried adolescent females had never used contraceptives (Suporn, 1990). Studies done on unmarried males in India indicated that less than half have [ever?] used condoms or any other form of contraception and fewer did so regularly (Abraham & Kumar, 1999).

A few studies done in Sri Lanka too indicate the same trend, where a significantly small proportion of unmarried people rely on contraception to ward off their sexual vulnerability. A study done by Silva and others (1997) indicates that the use of contraceptives is very low among the youth. For example, 16.7% of the youth (96

out of 574) reported using condoms. Almost all of them were males and only 7.3% were females. According to the study, even among the group having potentially high risk sex (80) only 15.1% of the males and 14% females always or almost always use condoms (Table 11).

Table 11: Use of contraception (condom) among high risk group

Do you always use a condom?	Male		Female		Total	
	%	N	%	N	%	N
Yes	16.4	12	14.3	1	16.3	13
No	83.6	61	85.7	6	83.7	67
Total	100.0	73	100.0	7	100.0	80

Source: Silva & others (1997).

A more recent study by UNICEF (2004) found that only a small proportion of out-of-school adolescents aged 15-19 had ever used any form of contraception, the emergency contraceptive pill (postino) being the most commonly used method (3.7%). However, when sexually active out-of-school adolescents are taken separately, about 39% of them reported the use of condoms. In terms of contraceptive dynamics, sexually active males (46%) had used condoms more than females (26%).

In a study done by Rajapakse and De Silva (2000) on women seeking abortions a question was asked regarding the use of contraceptives. It is observed from this study that among the abortion seekers, non use is highest among the youth (72.8%) and very much so among the females below 20 years of age (91.7%).

Why have most of the sexually active adolescents and youth never used contraception? Possibly because there is little concern or worry about pregnancy, or poor knowledge about contraception, or because of the partner's unwillingness to use contraceptives.

Contraceptive knowledge

Almost all married adolescents and youth in Sri Lanka are familiar with some contraceptive method (Dept. of Census and Statistics, 2002). What could be the level of knowledge with regard to unmarried adolescents and youth? According to the study done by Basnayake (1996), knowledge of contraceptives varies in terms of method. The highest awareness is of oral contraceptives where 93% and 92.2% of the males and females respectively knew of the method. A high percentage had heard of condoms (87%) but the knowledge level showed a difference between males (95.2%) and females (78.8%). Injectable (Depo provera) contraceptives came third with males and females having similar knowledge (males 80.3 % and females 87.1%).

It is interesting to note that the preferred source of information on contraceptives varies according to sex (Basnayake, 1996). Among males, the highest number preferred doctors (29.6%) while it was very low among females (9.4%). Most of the females preferred a nurse or a midwife (31.4%). Preference for relatives and

teachers was very low in both groups, which indicates that including RH knowledge dissemination in the school curriculum may not be successful.

Pregnancy and Fertility

Childbearing and pregnancy during early adolescence are clearly unwelcome in many Asian societies because these will usually reduce the mothers' social position and contribution to society. Relatively little information is known about pregnancy among unmarried female adolescents and youth in Asian countries. The available research on the theme suggests that a substantial minority of sexually active unmarried young women have experienced pregnancy, which is typically unwanted (Gao, 1998).

Given its adverse health, social and economic outcomes, adolescent pregnancy has been identified as an important indicator of sexual and reproductive health of adolescent girls. Comparative data from many countries has shown that at the global level females aged 15-19 are twice as likely to die from childbirth as are women in their twenties, while girls younger than age 15 face a risk that is five times as great (UNICEF, 2001).

Unfortunately, however, a large number of adolescents in many South Asian countries continue to have children, even though many governments and institutions have attempted to minimize the incidence of adolescent childbearing. For example, the 1996-1997 Bangladesh Demographic and Health Survey found that 14% of 15-year-old girls were either already mothers or were pregnant with their first child.

In Sri Lanka, adolescent and youth fertility among the married women has shown a significant decline over many decades: 52 live births were reported for 1000 females of 15-19 age group in 1963, while the corresponding figure has declined to 27 by 1995-2000 (Table 12). Youth fertility (20-24 age group) has in fact declined even at a higher rate than the adolescents' rate during the same period.

Table 12: Adolescent and youth fertility and their contribution to total fertility

Year	TFR (per woman)	ASFR (per 1000 women)		Relative Contribution for TFR by 15-19 (%)
		15-19	20-24	
1963	5.0	52	228	5.1
1974	3.4	31	146	4.6
1981	3.7	34	172	4.6
1982-1987	2.8	38	147	6.7
1988-1993	2.3	35	110	7.7
1995-2000	1.9	27	83	7.2

Source: Dept. of Census and Statistics, (2002).

Along with the decline in fertility among adolescents and youth, women in the older reproductive ages also have contributed to the overall decline in fertility. Thus, TFR has declined from 5.0 children per woman in 1963 to 1.9 children in 1995-2000, which is well below the replacement level fertility.

Although fertility among adolescents and youth has shown a steady decline in Sri Lanka it is necessary to elucidate their relative contribution to overall fertility. In other words, "How frequently do adolescents and youth bear children compared to all women of the reproductive age group (age 15-49)?" Countries with high overall fertility usually have high adolescent and youth fertility. For instance, adolescent fertility (ASFR of 15-19) in India had contributed 17% of TFR in 1992-93, while the corresponding estimate for the Republic of Korea was only 0.8%.

In Sri Lanka, adolescents have contributed only about 5.1% of the TFR in 1963, while the corresponding estimate had increased to 7.7% by 1988-1993 (Table 12). What demographic factors can explain this trend? As fertility desires began to decrease and the use of contraception to increase significantly among women in the older reproductive ages, fertility tends increasingly to be concentrated among the adolescent group. In other words, when fertility decreases higher parity births are curtailed but an overwhelmingly large proportion of women still obtain low parity births.

In many instances, an adolescent mother, irrespective of her marital status and with a low level of education and with no employment prospects, is not only unable to contribute to the development of the community, but she and her family may become a burden to it. Such a situation may force adolescent mothers to enter the commercial sex industry or to perform hard physical labour, which are both hazardous to their reproductive and overall health.

Health Risk

Female adolescents under 18 years of age in the reproductive age group are considered as facing a high risk of pregnancy-related illness and death. Although their bodies may be mature enough to become pregnant, some adolescents are not sufficiently developed physically to have a safe pregnancy and delivery. The dynamic period of growth associated with poor intake of all nutrients and vitamins due to improper dietary habits put adolescent girls at high risk of anaemia and nutritional deficiency. The added burden of pregnancy may not only be psychologically traumatic, but also deprive her of nutrition.

Adolescents often report their pregnancies later than adult women. These behaviours are associated with less psychological maturity and fewer coping mechanisms. Furthermore, these high-risk adolescents' behaviours have resulted in delayed maternal health services until the very last stage of pregnancy. In some instances, attitude and behaviour of the service providers may discourage adolescent girls from seeking antenatal and postnatal care, which is vital to their reproductive health and the health of the new born (De Silva, 1997b).

Maternal morbidity rates have also been especially high among the younger adolescents (De Silva, 1997b). Pregnant adolescents are more likely to suffer from eclampsia and obstructed labour than women who become pregnant in their early twenties (Senanayake, 1990). Babies born to young adolescent mothers also face more health risks, including premature delivery, low birth weight and perinatal mortality, than the babies of older women (IIPS, 1995).

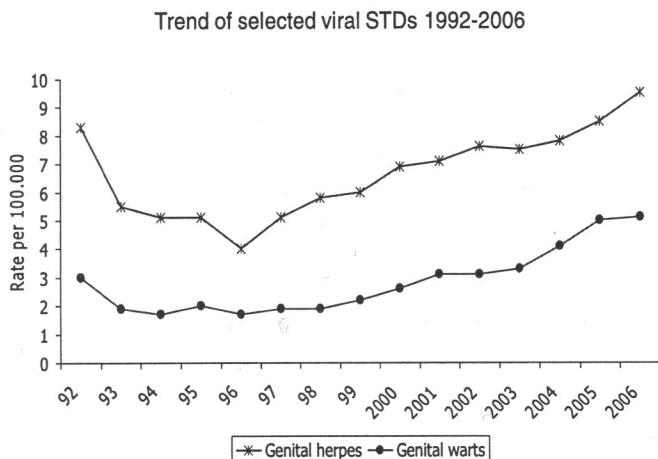
STIs and HIV/AIDS

Even though premarital sex among young women in Asian cultures including Sri Lanka is low, young men show an opposite trend. An increasingly large proportion of unmarried young men in Asian countries are engaged in sex with commercial sex workers and unknown persons. At the same time, their use of protective mechanisms is also reported as low. Thus, increased sexual behaviour and lower use of contraception has resulted in more adolescents being exposed to sexually transmitted infections (STIs) and HIV/AIDS (Singh, 2000). Increased commercial sexual activities have begun to fuel STI and HIV transition in Asia. As far as STIs and women's health are concerned, a common misconception until recently has been that STIs affect only a small proportion of extremely sexually active women, primarily commercial sex workers (Dixon Muller & Wasserheit, 1991). Recent studies, prompted in part by the efforts to understand and control the spread of HIV infection, make it clear that the problem of STI for women extends well beyond commercial sex workers (Winikoff, 1998). Where data on STI levels are available, the highest rates occur in adolescents and youth. The World Health Organization data indicates that half of all the people infected with HIV are in the 15-24 age category and live in developing countries (Senanayake & Ladjali, 1994).

Since Sri Lanka demonstrates an increasing trend of STIs, it implies a strong possibility of extensive HIV spread (Figure 3). Naturally, the future HIV trend would largely depend on the sexual behaviour of adolescents and youth. In fact, it has been the experience with the HIV/AIDS pandemic that change, whether behavioural or attitudinal, is difficult to achieve and occurs only in small steps. The sexual behaviour of those who are sexually active, including young people, will heavily depend on their attitudes, knowledge, skills, and also the quality of the sexual and reproductive health services available for them.

The cumulative number of HIV infections reported in Sri Lanka from 1987 to the end of 2001 was 405; of this, 132 persons were diagnosed as having AIDS and 99 were already deceased. However, the National Working Group on HIV Estimates indicates that 4,700 to 7,200 persons were living with HIV/AIDS at the end of 2001. Of the 405 cases identified, the age was known for 369. Concerning the age distribution of the infected, 82% were in the 15-49 age category with the highest percentage in the 30-34 age category. Once we consider the duration of the incubation period, a significantly large majority of those in the 30-34 age category would have contracted the illness during their adolescence and youth.

Fig 3: Trend of sexually transmitted diseases



Source: National STD/AIDS Control Programme

While adolescents are receiving international focus in STI efforts, knowledge about the epidemiology of STI in Asian populations remains limited (Hannum, 1997). In the case of Sri Lanka also a number of researchers have noted that knowledge of HIV/AIDS seems to be low among adolescents. For example, in the study done by Attanayake (1999) of secondary school pupils, 63% out of 2214 students could not state even one method of contracting AIDS. However, Basnayake (1996) shows a contradictory picture where 98%, 94% and 87.8% respectively knew that HIV could be transmitted by sex, blood and contaminated injections. Also 79.4% of the urban and 70% of the rural youth were aware that the use of condoms is a preventive measure for STIs and HIV. However, in the same sample nearly half thought that HIV is transmitted also through mosquitoes. The study done by Silva and others (1997) also indicates that knowledge of HIV/AIDS is high among the study sample. However, they point out that knowledge of certain risks and preventive behaviour is poor.

Summary and Conclusions

The sexual and reproductive health of adolescents and youth is currently considered an important issue throughout the developing world. This is mainly because the quality of their health is considered to have a major impact on the development process of a country. This focus on adolescent and youth issues is enhanced also because a rapid transformation of the socio economic scenario is observed in almost all of these countries, which increases the vulnerability of the present adolescent and youth. Therefore, any resulting adverse consequences will have a negative impact on their mental, physical and social wellbeing.

The adolescent and youth population throughout the developing countries is showing profound demographic changes. Sri Lanka is no different. During the past half a century the adolescent and youth population of Sri Lanka increased from 2.4 million (1953) to 5.3 million (2001). The adolescent and youth population reported in 2001 is the largest enumerated in the history of Sri Lankan population Censuses and constitute 28% of the total population. Although the number of adolescents and youth shows a decline from year 2001, numerically they will continue to be a considerable proportion of the total population in the coming few decades.

Compared to other South Asian countries the Sri Lankan adolescents and youth are in a much more advantageous position. The introduction of free education in 1945 created a demand for education from a wide range of the population. School participation among adolescents and youth is high and gender disparities are non-existent in Sri Lanka compared to other south Asian countries. In fact, by 2001, a higher proportion of female adolescents were in school compared to males. The proportion of both 10–14 and 15–19 age groups in school shows a significant increase from 1981 to 2001. Although only a small proportion of the youth are able to enter university or other tertiary educational institutes the percentage in these institutions also shows a remarkable increase from 1981 to 2001. Opportunities for education together with all the accompanying plus points will expose the young population to more freedom, less parental control, independent thinking and change of attitudes which will result in an increase in their risk taking behaviour

Consequent to the expansion of educational opportunities and compulsory education the labour force participation of the adolescents and youth has declined. It is more among the males compared to the females particularly in the 15 to 19 age group. However, unlike in education a significant gender difference is observed in the adolescent and youth labour force participation patterns where the proportion of females in the labour force was very much lower than the males in all three age groups of 10-14, 15–19 and 20- 24. However, the labour force participation rate of the females aged 20 – 24 shows a 6 per cent increase from 1981 to 2001 while it has declined among the males during the same period. This is mainly due to the expansion of numerous employment opportunities such as the FTZs for the females in this age group. However, it must be noted that especially the adolescents in the labour market are very likely to have low education levels since this is the period generally involving formal schooling. Therefore, this group is very likely to be engaged in unskilled manual employment. Factors such as being less educated, having less opportunities for career enhancement and low incomes may all increase the vulnerability of this group.

Since adolescents and youth have relatively low mortality and morbidity levels compared to other groups even in developing countries including Sri Lanka their health needs have been neglected until recently. In Sri Lanka, age specific mortality rates for both male and female adolescents and youth have declined from 1980-82 to 2000-02. However, a contrast to this pattern is observed among the males in the 20-24 age group, where an increase in mortality is observed. The same cannot be observed among the females in the same age group. The Sri Lankan female

adolescents and youth are not exposed to maternal complications due to the high age at marriage which gives them a distinct advantage compared to their counterparts in the region, which more or less explains female mortality. However, the pattern among young males in the 20 – 24 age group needs further careful investigation. Although the incidence of suicide has declined among both sexes in Sri Lanka, the young males' lives have been at risk due to on going war and the civil disturbances which occurred in the 1980s. Furthermore, homicide, injuries and accidents are increasing among this group. Therefore, it is time that programmes were conducted for youths, especially the ones involved in risky behaviour, to combat their mortality and disability levels. Thus, males not only have a higher level of sexual exposure and vulnerability than females, their general mortality is also significantly poor during the period of adolescence and youth.

When considering the reproductive health of adolescents and youth in Sri Lanka compared to their South Asian counterparts, the most prominent feature is the change in marriage patterns where age at marriage has increased significantly. This has resulted in the increase of the never married proportion among the adolescents of 15 – 19 years. The resultant increase in the sexual risk-taking period promotes premarital sexual relations, which is becoming a common phenomenon even in Asian cultures. This situation is complemented by the higher education opportunities, entry into the labour force, less parental control and the consequences thereof.

Premarital sexual relations among youth in all developing countries are on the rise, which is very likely to result in unwanted pregnancies, abortions, STIs, HIV and AIDS. There is relatively little information with regard to the sexual behaviour of adolescents and youth in Sri Lanka. The few studies done indicate that an attitudinal change towards premarital sex is occurring. In addition, these studies indicate that 7 to 18 per cent of the adolescents have engaged in pre marital sex and the incidence of premarital sex is more prevalent among males than among females. However, in certain subsections of the population such as the FTZs, premarital sexual behaviour among females is also high. Although sexual behaviour is on the rise, contraceptive use among the unmarried adolescents appears low. According to the Demographic and Health Surveys carried out in Sri Lanka, contraceptive use even among the married adolescents in the 15-19 age group is low compared to other age groups. This is in a context where contraceptives are available in all parts of the country through government, non-government and private sector institutions for all sections of the population. However, due to the cultural barriers that exist in Sri Lanka as well as most other South Asian countries adolescents and youth are overlooked when providing these services. Therefore, it is not surprising that the use of contraceptives among the unmarried adolescents and youth should be even less compared to the married in these age groups. As reported by Silva and others (1997) even among the adolescents and youth who are engaged in high-risk sex, only 15 and 14 percent of the males and females respectively use condoms always or almost always.

The lesser use of protective mechanisms when sexual activity increases exposes the adolescents and youth to STIs, unwanted pregnancies and resultant abortions.

In contrast to other Asian countries, a small percentage of abortion seekers in Sri Lanka are unmarried. The risk involved here is that due to the illegal status of induced abortion in Sri Lanka, a significantly large proportion of these unmarried abortion seekers have to rely on unsafe procedures to obtain abortions resulting in health complications and even death. This needs immediate attention as a reproductive issue.

Sri Lanka demonstrates an increasing trend of STIs and this implies a strong possibility of the spread of HIV/AIDS. The data shows that of the cases of which the age was identified, 82 per cent were in the 15–49 age category with the highest percentage in the 30–34 age group. When the incubation period is considered, it can be concluded that a significantly large proportion of this group would have contracted the illness during their adolescence and youth. A main concern here is that researchers identify poor knowledge levels or misconceptions with regard to the transmission of STIs and HIV. Educating the youth with regard to this issue should therefore be a priority. Since the spread of HIV is largely related to attitudes and practices, equipping the young population who are at the beginning of their sexual lives is all the more appropriate for it is easier for them to adopt and continue safe practices.

All these indicate that the Sri Lankan adolescents and youth should be a primary target group among the population in the present context. The Sri Lankan Population and Reproductive Health Policy enacted in 1998 shows that our policy makers are influenced by the international goals with regard to population and development adopted at the 1994 International Conference on Population and Development. The vulnerability of the young population is confirmed by giving special provision to this group in goal 4 which recognizes the importance of promoting responsible adolescent and youth behaviour. Therefore strengthening and supplementing the goals adopted in the Population and Reproductive Health policy of 1998 should be a priority of the policy makers.

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