Health and well-being are crucial for youth, both now and later as they establish a foundation for adulthood. While Sri Lanka is on track to achieve most of the health-related MDGs by 2015, youth face specific challenges, as explored in this chapter. It examines socio-economic, educational and other factors, focusing on particular concerns for young people; these include sexual and reproductive health, alcohol and tobacco usage, and mental health. A discussion of new health threats considers changing lifestyles and persistent behavioural risks. The chapter also looks at the consequences of limited health-related knowledge, awareness and education.

Growing challenges in the health care economy

For decades, Sri Lanka, owing to its remarkable commitment to financing and regulating universal health care, has had an impressive record of health care provision, especially compared to similar developing countries. It has ratified many international conventions, and passed a variety of national laws and policies relevant to the health of children and young people, including its Constitution, the Ten Year Health Master Plan (2007-2016), the National Child Protection Act (1998), the National Authority on Tobacco and Alcohol Act (2006), the National Policy on Maternal and Child Health (2011), the National Nutrition Policy (2010), the Population and Reproductive Health Policy (1998), the National HIV/AIDS Policy (2011), the National Policy on Health Promotion (2009), the National Policy and Strategy on the Health of Young Persons (2011), and the National Policy and Strategic Framework for Prevention and Control of Chronic Non-Communicable Diseases (2009).

New challenges have come, however, from recent demographic, epidemiological and socio-economic shifts. Rapid declines in fertility and increased life expectancy have resulted in a growing number of people over the age of 60. The over 60 population is expected to double to 24.4 percent of the total by 2040, from 12.2 percent in 2012. This transition hints at drastic changes in disease patterns, especially with regard to non-communicable illnesses, which now account for almost 90 percent of Sri Lanka’s disease burden.4

Currently, nearly 60 percent of Sri Lankans turn to public services for health care. State spending on health accounts for 45.8 percent of the total as of 2009; the rest comes from private sources. Around 85 percent of private financing is borne by patients, about 51 percent of the total.5 With growing health care needs, and hobbled by insufficient health care investments, the public system is increasingly unable to meet demands.6 Overall public expenditure remained below 5 percent of GDP between 1995 and 2008, which is low compared to the global average of 8 percent.7

Given increases in non-communicable illnesses such as heart disease and cancer, and an ageing population, chances are high that public funds for youth could decline if public health care spending remains within current limits. Human vulnerability to non-communicable diseases starts at a young age, however, through factors such as poor nutrition patterns and unhealthy lifestyles, mental stress and substance abuse. Young people are also vulnerable to other modern threats such as road casualties, which are currently a leading cause of death and injury. Twenty-six percent of drivers were between 16 and 30 years old in 2011.8

Changing lifestyles

The increase in non-communicable diseases is in part linked to lifestyle shifts, such as changing eating habits and decreased physical activity. The National Youth Survey 2013 found that among respondents, only about a quarter were actively involved in sports. Twenty-two percent claimed that they are heavily engaged in religious activities, 20 percent ranked reading very high, and 23 percent said they often watched television and movies—all fairly sedentary pursuits. As this is the age with the greatest opportunities for high levels of physical activity, the lack of it indicates a problem that will likely only increase with age, with potentially negative impacts on health, productivity and psychological well-being. Survey respondents also commented on eating patterns where consuming fast food and skipping meals appeared to be common.
Several youth and young health care workers expressed their fear of youth trying to experiment and live up to ideologies perpetuated through the media, mentioning the vulnerability of youth in the face of negative social influences. Increasing access to different types of media was perceived as affecting norms and values that in turn have an impact on lifestyle.

Youth are increasingly exposed to busy and stressful lifestyles. From school days and throughout their life there is not enough time even to eat properly. There are many youth in Colombo who are coming from other areas of the country. Some travel daily to work from places like Nittambuwa, Padukka and Awissawella. They travel in crowded buses from as early as 4 in the morning without anything to eat or drink. My colleague who is a girl and travels from Awissawella told me how she used to get harassed in the bus; on top of hunger due to missing breakfast, and sleep deprivation, she has to put up with men harassing her in the bus. And by the time she comes to work she’s exhausted, angry and frustrated. This certainly must be affecting her work productivity as well. She wanted to start a diploma course over the weekend, but she couldn’t since she’s always burnt out by the end of the week, and the weekend is the only time she has left to regain her energy. Some of my friends who are boarded here in Colombo are skipping meals on purpose to save money. Already the rent in Colombo is too high, and the starting salary of a 23-year-old cannot facilitate all these needs.

Today media (are) making (creating) people through marketing. They create (mawanawa) things. Rural people think that it is the reality because media is displaying that. Earlier some positive messages were given through tele-dramas (TV soap operas) but that is not there now. It doesn’t deliver positive messages to people anymore, even about lifestyles.

Youth appear to be spending a lot of time on Facebook, this can be both a positive and a negative thing. The danger of the type of information received by youth can make them vulnerable to poor health and well-being. At the same time these are good avenues that as health care workers we can use to provide health-related information to youth.

Knowledge of health is poor in some areas

In the National Youth Survey 2013, around 80 percent of respondents had a fair knowledge of general health care services provided in nearby areas. But 15 percent stated that they were unaware of such services. Knowledge of the availability of sexual and reproductive health, and mental health services was poor: 55 percent and 59 percent of respondents, respectively, said that they did not know about services close to where they live.

When asked whom they would most likely ask for advice on health-related issues, 49 percent stated that they would turn to parents, 19 percent mentioned health care workers, and 11 percent and 10 percent, respectively, named spouses and friends. The fairly significant proportion of youth who said that they would go to a health care worker is a positive sign. Socio-cultural and religious norms hold particular influence over sexual and reproductive health and mental health issues. The tendency to rely on parents, spouses and friends for advice can therefore indicate a good chance that youth will receive misleading information.

Further strengthening the knowledge and skills of health care workers to engage with youth and
setting up systems of qualified peer educators could do much to ensure that health care information and services are more attractive, confidential and youth friendly.

**Barriers to accessing care**

The National Youth Survey 2013 found that 38 percent of respondents considered cost the biggest barrier to accessing general health care. Youth spending on health care despite free public services could indicate that services have not kept up with demand, due to insufficient investment, and are not catering to youth-specific needs.

Fifty three percent of respondents said that parents covered their health care expenditure. Youth referred to financial dependency on parents and obligations to support their family as among the reasons for minimizing their health care spending.

During focus group discussions, youth health care workers expressed their concerns about the lack of active youth organizations that could advocate for the concerns of young people, including to reduce barriers to care. Youth in the discussions repeatedly expressed their discontent with the lack of space to express themselves.

**Lack of education, unemployment, poverty and financial difficulties appear to be determining the ways in which an individual practices good health and enjoys well-being. With the current busy lifestyles and societal transformations youth are moving away from healthy nutrition habits, sports and recreation, and their affiliations with religious activities. Thus, the physical, mental and spiritual well-being of today’s generation appear to be frighteningly deteriorating. Drug usage (and) risky sexual behaviour are serious causes of concern with regard to young people’s health and well-being.**

*Youth health care worker, Focus Group Discussion, Sabaragamuwa Province*

Village level youth organizations should be revived and platforms should be provided for youth to discuss their concerns. It can reduce stress and develop their leadership skills. But in our villages we don’t have any active youth to take those organizations forward. They are more focused on education, tuition classes, social media and income generating activities.

*Youth health care worker, Focus Group Discussion, Sabaragamuwa Province*

Little does the society listen to the young; there is very little room for them to express themselves and issues that affect their lives.

*Young Woman, Focus Group Discussion, Western Province*

**Exposure to malnutrition during early childhood**

One way of assessing the well-being of today’s youth, born between 1985 and 1999, is to assess their nutritional status in the first five years of life. This affects health at all subsequent stages of the human life cycle. Malnutrition, for instance, impedes educational attainments by causing school drop-outs, and stalling progress in primary and secondary schooling. Poor nutrition also hinders opportunities for employment once children become adults, and increases health risks, including from non-communicable diseases, and mortality.

The Demographic and Health Surveys of 1987, 1993 and 2000 cover children who are now youth. According to their data, the prevalence of severe stunting, caused by long-term insufficient nutrient intake, dropped by approximately 75 percent between 1993 and 2000 in Sri Lanka, moving the country from ‘high’ to ‘low’ prevalence, based on a World Health Organization classification.

Wasting, or low weight to height, which usually results from significant food shortage, remained unchanged, however. Wasting is a strong predictor of mortality among children under five. As of 2000, prevalence of mortality in this age group was 14 percent, considered high by the World Health Organization. And even though underweight rates dropped between 1987 and 2000, prevalence as of 2000 was 29.4 percent for the same age group, also high according to the World Health Organization.

In the estate sector, stunting rates declined by 37 percent between 1993 and 2000, but remained much higher than in the urban and rural sectors. Underweight prevalence fell much more slowly in the estate sector, compared to the other sectors, and wasting rates increased slightly. The Demographic and Health Survey for 2000 reported that child malnutrition was considerably higher in the
conflict-affected Northern and Eastern provinces, with an underweight prevalence rate of 46 percent, compared to the rest of the country.

Given growing inequalities in income, the extent to which undernutrition disproportionately affected poor children increased. In 1993, a child from the poorest household was 2.8 times more likely to be underweight than a child from the richest household. By 2000, this ratio had increased to 4.1. In 1993, a child from the poorest household was 3.7 times more likely to be stunted. By 2000, this ratio had more than doubled to 7.7.12

Intergenerational effects, such as those linked to maternal nutrition and education, are important determinants of the good nutritional status of children. Maternal undernutrition is one of the major causes of low birth weight and undernutrition among children (box 4.1). By the end of 2000, more than 33 percent of all Sri Lankan women suffered from chronic energy deficiency, disproportionately so in the estate sector. Demographic and Health Survey data show that women’s mean body mass index increased between the early 1990s and 2000, but inequalities in the mean index also increased.

In 2000, children whose mothers had no schooling were twice as likely to be underweight or stunted compared to children whose mothers had secondary schooling or more. Across the surveys in 1987, 1993 and 2000, the link between a mother’s lack of schooling and child stunting became stronger.

**Gaps in sexual and reproductive health services**

The Demographic and Health Survey 2006-2007 reported that 68 percent and 58 percent of ever-married women in the age groups 15 to 19 and 20 to 24, respectively, were not visited by family health workers responsible for providing information on family health planning. Among respondents to the National Youth Survey 2013, 55 percent were not aware of reproductive health services in their regions. Shame and legal barriers were among the major obstacles preventing them from accessing services (figure 4.1).

**BOX 4.1: YOUNG WOMEN OFTEN SUFFER FROM POOR NUTRITION**

Adequate nutrition is a fundamental cornerstone of women’s health, especially because of the intergenerational impacts, and also because poor nutrition undermines women’s productivity, capacity to generate income and ability to care for their families. Children of malnourished women are more likely to face cognitive impairments, short stature, lower resistance to infections, and a higher risk of disease and mortality.

Sri Lanka’s Demographic and Health Survey 2006-2007 found that one in six women of reproductive age (15 to 49 years) were malnourished. Women aged 15 to 19 years comprised 40 percent of the total, making them most likely to suffer from malnutrition, followed by women aged 20 to 29 years at 22 percent. Among women on estates, malnutrition was 33 percent, twice as high as for urban women at 16 percent. Nearly 39 percent of women between the ages of 15 and 49 were anaemic. The highest rates of moderate and severe anaemia were on estates, at 10.4 percent and 2.3 percent, respectively.

Source: Department of Census and Statistics 2009.

The issue of legal barriers needs careful attention. It points to dominant cultural norms and values that consider sexual relations only for married people, leading youth to assume that there are legal barriers to services if they are unmarried. It also suggests that service providers or those who are in a position to provide information, such as teachers or health professionals, do not encourage youth to use sexual and reproductive health services unless they are married. It raises questions about the impact of the lack of support for youth in terms of unwanted pregnancies and abortion-related issues, and for those who are homosexual; both abortions...
and homosexuality are illegal. In general, obstacles to reproductive health care reflect stigma and negative social connotations.

**Sexual behaviour despite limited knowledge**

Sexuality and reproductive health matters are not spoken of in public due to stigma. Youth are reluctant to go to public health providers owing to the same reason, and financial constraints may prevent them from receiving care from private practitioners. Ultimately health issues are left untreated.

Young Woman, Focus Group Discussion, Western Province

A significant portion of youth and adolescents seem to be sexually active. One United Nations Children’s Fund survey found that 6 percent of 14 to 19 year old children and adolescents have experienced heterosexual intercourse, while 10 percent reported having had homosexual relations. Among females between the ages of 14 and 19 years, the average age of first sexual intercourse was 15 years, whereas for males it was 14 years. According to the Demographic and Health Survey 2006-2007, 11.7 percent of young women aged 15 to 24 have their first experience of sexual intercourse around age 18.

The United Nations Children’s Fund survey found that a major proportion of sexual debuts took place between lovers, but a significant number of adolescents reported that they had their first sexual encounter with individuals with whom they were not romantically involved. Twelve percent of males claimed that they had their first sexual experience with a commercial sex worker. Only about 24 percent of adolescents used condoms during sex, a concern reported elsewhere. According to a study by De Silva, young people were not fully aware of the outcomes of having sex or how to have safe sex. This absence of knowledge exposes them to relatively high reproductive health risks.

The United Nations Children’s Fund survey noted that less than 50 percent of school-going adolescents had an overall knowledge of matters related to reproductive health. Less than 25 percent had comprehensive understanding of menstruation, the risk of conception among teenagers and signs of pregnancy. Knowledge of risks from induced abortions and frequent child bearing was also limited. Only 57 percent of adolescents had some awareness of sexually transmitted infections.

There are disparities in awareness of sexual and reproductive health issues among different groups of youth. Only 18 percent of young people on estates have some knowledge of sexually transmitted infections and HIV/AIDS. Young women in Batticaloa, Ampara, Badulla, Kandy and Matale know less about sexually transmitted infections than young women in other districts.

Poor knowledge of contraception was reflected in the National Youth Survey 2013, where 56.7 percent of respondents indicated that they were unaware of contraceptive methods (figure 4.2). Of those who were aware, 73 percent said that they knew about condoms and 71.2 percent about oral contraception (figure 4.3). The United Nations Children’s Fund survey found, across all its respondents, that condoms were the most frequently known contraceptive method at 29 percent, followed by birth control pills at 24 percent.

In the National Youth Survey 2013, only around 59 percent of respondents had received education on reproductive health at school (figure 4.4). The study conducted by De Silva found that more than 60 percent of a sample of adolescents and youth reported discussing sexual and reproductive health in school. According to the National Youth Survey 2013, 13 percent of respondents reported learning about reproductive health through friends. While around 30 percent considered health professionals the best source of information on reproductive health care overall, only about 5 percent have received information from them.
Among survey respondents, 31 percent had learned about sexually transmitted infections from school and 20 percent through awareness programmes. For information on contraception, 19 percent had turned to their family, 14 percent to awareness programmes and 13 percent to health officers (figure 4.5).
Teenage pregnancies pose special risks

The incidence of teenage pregnancies appears low by international standards. The fertility rate among women aged 15 to 19 years declined from 35 per 1,000 live births in 1993 to 27 per 1,000 in 2000, although from 2006 to 2007 it marginally increased to 28 per 1,000. The adolescent fertility rate on estates from 2006 to 2007 was 37 per 1,000.21

Teenage pregnancies in any number are a special concern, in part owing to the risk of complications due to the young age of mothers. The Demographic and Health Survey 2006-2007 reported that 6 percent of adolescent women aged 15 to 19 years were already mothers or were pregnant with their first child. The estate sector recorded the highest number of teenage pregnancies at 10 percent compared to other sectors.21 According to the district-wise distribution of teenage pregnancies, Ampara in the Eastern Province recorded the highest portion at 16 percent. Trincomalee, Hambantota, Monaragala and Kalutara had more than 10 percent of the total reported number of teenage pregnancies.21 Among respondents to the National Youth Survey 2013, 6 percent of those aged 15 to 19 years were married, mostly women. Their chances of pregnancy and childbirth were quite high.

Abortions are illegal and unsafe

Abortion is a criminal offence under section 303 of Sri Lanka’s 1883 Penal Code. Doctors can advise therapeutic abortions under certain circumstances to safeguard the life of the mother. But the majority of women lack access to safe abortion care.26 This has opened up a market for unregulated private providers and unqualified personnel, thereby leading to unsafe abortions and related economic burdens for households.27

The study by De Silva found that 12.5 percent of a sample of 18 to 24 year olds had induced abortions. About 32 percent of them had sought skilled persons to perform abortions, while 68 percent resorted to various other remedies.26 Approximately 19 percent of abortion seekers interviewed in two separate studies were between the ages of 15 and 24 years.24

Socio-cultural pressures and a lack of options appear to push unmarried teenagers with unwanted pregnancies to have abortions.20 On estates, 16 percent of teenagers have reported unwanted pregnancies; septic abortions are relatively common there compared to urban and rural areas.21

HIV cases among youth have sharply increased

Sri Lanka has low HIV prevalence, but the most recent National HIV Strategic Plan 2013-2017 notes that the number of infections has gradually increased, particularly among high-risk groups.
Youth are vulnerable, with 20 percent of the HIV cases reported in 2013 occurring in people between the ages of 15 and 25, a very sharp increase in that age group. In 2009, the same group accounted for less than 6 percent of infections. Low levels of knowledge and awareness, and limited accessibility to youth friendly health care services foster risky behaviours. Other issues include a tourism boom and return migration. In combination, these factors have stirred fears of a future epidemic.

![reported HIV cases by age as of end 2013](image)


Gender-based violence and sexual abuse take many forms, with some reports of increases in cases. Violence adds to youth vulnerability, on top of poverty, poor quality educational attainment, unemployment and risky sexual behaviour.

![HIV is transmitted in many ways, but not all groups have access to equal care](image)

Source: Department of Health Services 2002.

A national United Nations Children’s Fund study indicated that 10 percent of children aged 10 to 13 years admitted to being sexually abused at some point in their lives; 8 percent were girls. In the 14 to 19 age group, 14 percent said they had been sexually abused, a portion divided almost evenly among boys and girls. A second, cross-sectional study in the Southern Province surveyed 2,389 students, with 22 percent of male students and 16 percent of female students reporting they had
suffered physical abuse. Thirty one percent of male students and 25 percent of female students experienced emotional abuse at least a few times during the three months preceding the study.

In the United Nations Children’s Fund study, perpetrators of abuse in early adolescence seemed to be mainly family members, with 38 percent from the immediate family and 27 percent being more distant relatives. Among older adolescents, the portion of perpetrators who were close family members was the same, but outsiders rose to 35 percent.

The National Youth Survey 2013 showed little awareness of gender-based violence, with 92 percent of respondents saying that they did not know any young person who had experienced it. Stigma associated with talking about gender issues and low awareness may explain this tendency, since other studies show that gender-based violence is present among youth.

**Risks to mental health**

Homicides, other purposely inflicted injuries and suicides are major causes of death among youth. In the National Youth Survey 2013, 21 percent of respondents claimed that they personally knew a young person who had attempted suicide. Police records for 2011 show 3,770 deaths due to suicide, which is most prevalent among men. Among people aged 17 to 30 years, there were 683 reported cases of male suicide, about 18 percent of the total. Among female suicide victims, about 44 percent involved women aged 17 to 30 years.

The United Nations Children’s Fund explored the perceptions, aspirations, expectations and frustrations affecting the mental well-being of Sri Lankan adolescents. Almost half of those in school and 75 percent of those out of school had some key worry. About 3 percent were concerned that their academic performance was poor compared to others, while nearly 60 percent rated their academic performance as average. Among school-going adolescents, fear of failing exams was the most common problem. Financial constraints, parental disharmony, absence of a mother from home and fear of not finding a job were other sources of stress. Worries increased with age, but with no gender differences, and declined with better socio-economic status. Marginalized groups carry particularly heavy burdens (box 4.2).
**BOX 4.2: YOUTH IN PRISONS SUFFER DIRE CONDITIONS**

Prison inmates are subjected to severe marginalization and exclusion. Despite the crimes they have committed, they are part of society and their well-being matters. In 2011, according to police records, around 45,520 people aged 16 to 30 years were admitted to prison. Narcotic drug offences, homicides and sexual abuse were the main reasons for imprisonment.

Prisons are overcrowded, with poor ventilation. Severe anxiety and other health issues prevail among prisoners, who often lack a resident doctor to provide care. Dire living conditions and inadequate nutrition have caused a high prevalence of tuberculosis. Beyond solving these problems, prisoners need education, rehabilitation and spaces to express their concerns.

In a focus group discussion, a male inmate noted: “Here, people are depressed about their situation, so they automatically get addicted to drugs. It is hard to stop. You see, if you want to stop selling rice in a shop, first you have to stop people eating rice. Then the selling will automatically stop. If they want to prevent prisoners using drugs in the prison, first they have to address the reasons for people using drugs. People do not care about their lives. They think that they are going to die anyway. When the army soldiers were shooting from everywhere, these prisoners tried to run away in the middle of that fight. They didn’t care whether they will get shot or not, they said that they are going to die anyway, so it is better to try. They have lost their hopes.”

Another inmate said: “My whole life has been destroyed because of one mistake. They are telling us that we are given rehabilitation but no one knows the reality. When we go to the society how can I tell them the reality? How would people treat me? They will not care about what I have to say.”

Source: Youth in prisons, Focus Group Discussion

**Significant use of tobacco and alcohol**

Smoking and alcohol use among youth are significant.\(^{43}\) While substance abuse could be due to peer pressure, other factors include conflict, high stress owing to uncertainties about the future, unemployment, and lack of education and opportunities. A 2013 survey by the Alcohol and Drug Information Centre found that 26.9 percent of respondents aged 15 to 24 years were current users of tobacco, while 26.7 percent drank alcohol. Use of tobacco and alcohol was highest in the under 40 category, and particularly among people aged 25 to 39 years, where 35.9 percent used tobacco and 43 percent alcohol.\(^{41}\)

A 2004 United Nations Children’s Fund survey estimated that among adolescent boys who attend school, 18 percent had smoked at some point and 6 percent were current smokers; the corresponding rates among adolescent girls were 6 percent and 1 percent, respectively. Among out-of-school adolescents, 42 percent had smoked and 23 percent did so currently.\(^{43}\)

Current users of alcohol and tobacco aged 15 to 24 years have reported that the main reasons were to be with friends and enjoy themselves.\(^{46}\) Attitudes towards smoking and alcohol use appear to be favourable among the majority of adolescents,\(^{49}\) so a recent decision by authorities to have health warnings cover at least 60 percent of tobacco packets is a positive measure.

**Policy perspectives: new demands, distinct needs**

National interest in the health of adolescents and youth has manifested in many commitments to their personal, spiritual, social, mental and physical development. Despite socio-economic transitions and certain policy improvements, however, lifestyles, persistent behavioural risks, lack of knowledge, mental stress, and new health situations and threats challenge the health of young persons.

Certain urgent challenges require action, preferably through an intersectoral approach, since factors influencing the health of young people are numerous and interrelated. The economy, socio-cultural norms and values, the media and education all shape how young people understand health and access care accordingly. Further, mental stress due to marginalization, unemployment, inadequate education, lack of socio-economic mobility and other issues can determine the rapidly changing nature of youth vulnerability to poor health and well-being. Successful health policies and practices must take all aspects of the lives of youth into account.
Sri Lanka’s impressive health outcomes in maternal and child health, low levels of communicable diseases and long life expectancy result from a fundamentally sound health system. But growing health care needs and reduced health care investments now endanger these achievements.

With the transformation of the economy to a lower middle-income level, and social, demographic and epidemiological changes, the health care system needs stronger state support to meet new and growing demands. Any shifts should ensure that no young person slips through the cracks, and recognize the different life situations of youth. For instance, while some youth are vulnerable to non-communicable diseases due to sedentary lifestyles and the fast food culture, others suffer poor nutrition associated with poverty. The fact that stunting and wasting continue to be problems in certain parts of the country shows that despite vast improvements in health care, some marginalized groups suffer problems generally associated with countries at lower levels of human development.

Information reinforced by positive attitudes and useful skills will largely contribute to making youth less vulnerable to health risks. Even though many policies and action plans have recognized the importance of learning, health care knowledge among young people is still often low. Health care providers, educational institutions and youth workers could consider peer-based models to share information, and provide counselling and services. Institutions that work with youth can provide additional support to health promotion by emphasizing supportive social values and norms, including through peer engagement, and making information, counselling and services available.

While the competence of health care providers denotes quality in services, their attitudes and practices often stand out in the minds of adolescent clients, and can be strong indicators of whether or not a follow-up visit will be made. It is imperative that health care professionals build trust and confidence when working with young people.

Since young people need to be involved in decisions affecting them, Sri Lanka could also look for health solutions that include and are friendly to youth. Youth themselves must be actively empowered to resolve issues hindering their development. Their rightful participation should be respected and positive environments created to encourage it. As the Cairo Declaration, part of the International Conference on Population and Development Beyond 2014 review process, affirms, policy makers and implementing bodies must recognize the need of young people “to be involved in the decisions that affect their lives.”

Educational mechanisms in particular can equip youth with adequate health-related knowledge, self-esteem and life skills, with an emphasis on gender equality, and special encouragement for people with disabilities and youth with different sexual orientations.

A particular area of concern for youth is sexual and reproductive health. Dominant cultural norms and values of chastity and abstinence outside a heterosexual marital union are not reflected in actual practices. Teenage pregnancies and pregnancies outside marriage, early marriage or cohabitation, and homosexual relations all take place among young people. They need comprehensive sexual and reproductive health knowledge to make informed decisions. While some youth get this in school, such initiatives need to be part of non-formal education and vocational training programmes. Out-of-school youth also should have ready access to sexual and reproductive health information and services. The particular needs of vulnerable groups, including street children, internally displaced people, prisoners and people on estates should be factored into future policies and programmes. Further, there is an urgent need to sensitize parents, religious groups, teachers and the society at large on the reality of the sexual activity of youth, and the importance of access to family planning services.

Other issues relate to the rise in illegal abortion clinics run by unqualified practitioners, which put many pregnant teenage mothers at risk. Even though the Health Master Plan 2007-2016 identifies unwanted pregnancies and abortions as a challenge for the health and well-being of young persons, the scope of intervention is still limited to knowledge
provision, such as through school health programmes and mentoring. There is no proper mechanism to safeguard the right to attend school for adolescents who get pregnant.

The implementation of the Domestic Violence Act 2005 is a major milestone; however, steps must be taken to ensure that its limitations with regard to sexual and other forms of gender-based violence are addressed. Given the prevalence of gender-based violence and sexual abuse, more could be done to meet the physical, psychological and legal needs of survivors. One priority is to develop and implement a national strategy to eliminate all forms of gender-based violence. Another is to ensure the competency of law enforcement officers and practitioners at medical and legal institutions offering care to survivors of sexual abuse. In general, continuous training, counselling and gender sensitization are imperative to change discriminatory perceptions of gender-based violence and to assist survivors. Care providers should be well trained in recognizing, counselling and providing appropriate referrals to survivors.

The role of both curative and preventive health care could be integrated in a violence identification system, and medical practitioners sensitized to identification, especially when there are inconsistencies between injuries and patient explanations. Other measures could encourage all institutions, including schools, government agencies, the police and private sector organizations, to examine whether or not they foster gender stereotyping that can lead to violence, and be a barrier to survivors seeking assistance and justice, and act on the findings accordingly.

Sri Lanka has progressively ratified all major international human rights treaties, but its Constitution does not explicitly recognize health as a socio-economic right. Nonetheless, the judiciary has affirmed a child’s right to survival and health care through articles on the right of access to education and the right to freedom from torture. The constitutional right to freedom of speech and expression, as well as to equality and non-discrimination, confers the right to access reproductive health information. The Domestic Violence Act 2005 bans coercion in family planning methods, and protection of young persons from different forms of abuse, while the Health Act of 1952 highlights the “duty of the state to disseminate health information.” Legal concepts such as age of discretion, evolving capacity and the right to information should be embedded in legal and policy documents, however, as these are imperative to ensuring the right of young persons to sexual and reproductive health information and services.

Current legislation does not clearly state the concept of the ‘best interest of the child’, opening the door to varying definitions among medical personnel that may not be well informed and may affect the quality of care. There is no clear right to privacy, and young people often find privacy and confidentiality are violated by law enforcement authorities and others, including on sensitive issues such as sexual orientation. All youth need to be treated by all actors and service providers with sensitivity, and as a group with distinct needs.