

Population Situation

Analysis: Sri Lanka

Introduction

The main objective of this report is to review existing data and discover emerging issues of population in Sri Lanka in order to propose appropriate policy interventions which will facilitate the promotion of overall development in the country. Addressing such population issues and investigating and linking its association with socio-economic development of the country will be done within the overarching context of International Conference on Population and Development (ICPD) in 1994, 2005 World Summit, Millennium Declaration (MD) and the Millennium Development Goals (MDGs), other important internationally agreed treaty obligations as well as most importantly Sri Lanka's development agenda which is popularly known as '*Mahinda Chinthana Idiri Dekma*'.

It is quite important to note that ICPD in 1994 worked as a turning point for the world to move away from the conventional family planning perspective to the reproductive health theme as most of the developing countries were already underway in their respective fertility transitions. Therefore, there was a necessity to address broader issues of human reproduction related matters than just regulating unwanted fertility. As Sri Lanka was well ahead of most of the developing countries in terms of its fertility transition, the Government of Sri Lanka wisely adopted ICPD Programme of Action with the full support of UNFPA, the United Nations Population Fund. UNFPA has been a major contributory factor in the promotion of

various national population programmes in Sri Lanka. The latest is the 7th Country Programme of UNFPA (2008-2012) was aimed at national capacity building, with the expectation of delivering high quality, equitable, inclusive and sustainable services. The reproductive health (RH) interventions proposed at this programme direct attention towards not only enhancing capacity of the national health system to improve the quality of and demand for comprehensive RH services but also towards increasing availability of and access to high quality RH services in conflict affected and underserved districts, increasing efforts to prevent sexually transmitted infections and HIV/AIDS among women and young people and increasing coverage and utilization of youth friendly RH services. Additionally, gender issues have been addressed to strengthen capacities of government, non-governmental organizations (NGOs) and community organizations. The outcomes are a continuous advancement aimed at providing these institutions the ability to prevent and respond to gender-based violence, to reinforce national capacity and institutional mechanisms for increased state accountability to fulfill and protect the rights of women and girls within the communities they serve.

In addition to the dimensions of reproductive health and gender, the component of population and development also plays a critical role in the 2011 census as it can provide a wealth of data which enable us to examine existing relationships between population and development indicators. This key factor is vital in increasing the availability and utilization of data disaggregated by sex and age as well as supporting the development of new data bases, and capacity building among relevant personnel in planning and analytical skills.

It must be duly noted that in addition to the national level focus, UNFPA has also focused interventions based on maternal mortality and other RH related indicators in critical locations in Anuradhapura, Batticaloa, Kalmunai (RDHS Division) of the Ampara

district, Nuwara Eliya, and Vavuniya. In this context, it is also very important to evaluate whether these districts have improved their RH indicators over time and which districts are currently underserved.

The present analysis provides a unique opportunity for UNFPA to not only strengthening its on-going activities further but also to add some more significant actions on the basis of newly emerging issues.

Reproductive Health

Policy and Implementation

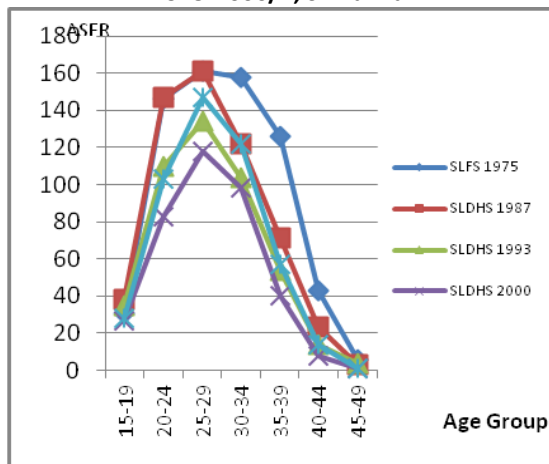
Following ICPD in 1994, the Government of Sri Lanka devised a Population and Reproductive Health Policy which intended at accomplishing a better quality of life for its population by providing quality reproductive health information and services, achieving gender equality, providing healthcare and social support for the elderly, promoting economic benefits of migration and urbanization while controlling their social and health ill effects and reaching a stable population size in the long run (Ministry of Health and Indigenous Medicine, 1998). Although specific strategies were implemented, it was pointed out that the action plan was incompetent in addressing those issues adequately, mostly RH services for adolescents within the public health system and thereby restricted the role of public health service personal to provide RH services to the adolescents (UNFPA, 2007). **Although it is apparent that appropriate mechanisms have been introduced to link RH and gender equity and the role of public health personnel in preventing or eliminating gender based violence, its efficient continuation could produce the expected outcomes in the long-run.** Another important aspect which needed priority but had less attention was reproductive health issues affecting women in the conflict-affected areas in Sri Lanka. A study conducted by Kottegoda and others (2008) during 2004-5 period in six conflict-areas in the north and east of Sri Lanka found higher levels of poverty, higher rates of school dropout, low pay, and precarious access to work particularly in the

informal sector, higher rates of early marriage, pregnancy and births delivered at home, higher level of maternal mortality and lower levels of contraceptive use all affect reproductive health in these regions. They also claimed that physically and psychologically, women were at high risk of sexual and physical violence, mainly from their partners/spouses but also from family members often related to dowry. **These circumstances surely call for appropriate interventions in order to eliminate structural barriers that impede their right to healthcare services and establish a right environment for them to make informed decisions about their lives and to live free of violence.**

Age-specific fertility rates (ASFRs)

Sri Lanka's fertility transition began in the 1960s but the country is still cruising through the third stage of the demographic transition even after 50 years from its onset as fertility is still on the decline while mortality remains at low stationary stage. Although Sri Lanka achieved this status well ahead of other countries in the region, not to mention many other developing nations in the world, the island nation has still not been able to speed up its fertility decline to arrive at a low stationary stage to produce a stable population. The most recent data from the SLDHS 2006/7 (Department of Census and Statistics, 2009) suggests that fertility started to fluctuate on the high side rather than having a constant decline. Furthermore, the data demonstrates that age-specific fertility rates have gone up in all the age groups compared to the values obtained in the SLDHS 2000 (Figure 1).

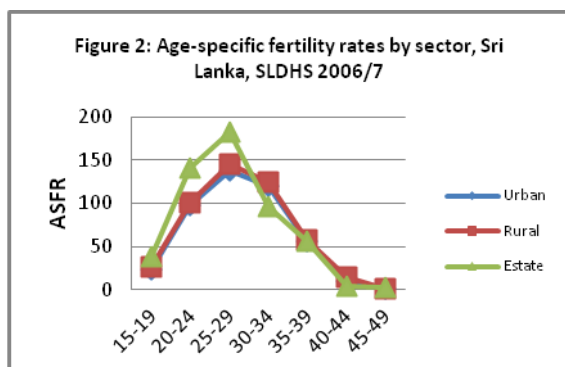
Figure 1: Age-specific fertility rates, various years, 1975-2006/7, Sri Lanka



Source: Department of Census & Statistics, 2009

It is also quite interesting to note that ASFRs of the Sri Lanka Demographic and Health Survey (SLDHS) 2006/7 in the age range of 25 to 39 were even higher than that of the SLDHS 1993 values and ASFR in the age group of 30-34 has levelled with the SLDHS 1987 value. **Amazingly, most fecund women have shown higher fertility in the latter survey, indicating an unexpected outcome despite the prevalence of government and non-governmental fertility control programmes. Therefore, it is essential to explore the reason for the change of women’s fertility behaviour in comparison to the previous years as well as to scrutinize newly emerging reproductive health issues.**

Age-specific fertility rates derived for urban, rural and estate sectors show that urban and rural sectors have converged into similar levels while the estate sector still illustrates significantly higher levels of fertility during the first half of childbearing period (Figure 2).

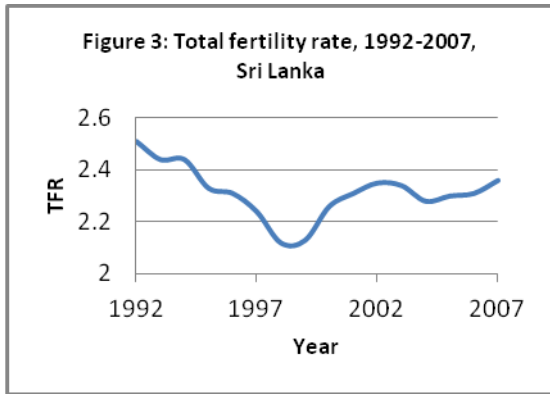


Source: Department of Census & Statistics, 2009

However, most interestingly the estate sector fertility curve shows concavity during the second half of the childbearing period which is a usual symptom observed during early period of fertility transition with the onset of termination of childbearing at an earlier age. Most strikingly, the fertility rate in 30-34 year old women has reached a level that is significantly below the levels of urban and rural sectors. **This suggests that the onset of the fertility transition has been underway for sometime in the estate sector and currently childbearing is heavily concentrated on the early part of the reproductive age span.** When women start restricting their fertility for the early part of their childbearing period, they will desire adequate information about reproductive and health issues including sexual intercourse, contraception, sexually transmitted infections, pregnancy and childbirth.

Total Fertility Rate (TFR)

Although some claimed that fertility reached the below replacement level (De Silva, 1994; 2007) by the mid 1990s, SLDHS 2006/7 data shows that the Total Fertility Rate (TFR) increased to 2.4 from its previous figure of 1.96 observed in SLDHS 2000. Actual TFR values released by the country’s vital statistics system (Registrar General’s Department, 2011) show a steady increase from the year 2004 and most importantly the actual complete data proves that TFR never fell below replacement level (Figure 3). **This implies that the country will not reach its stable population size by the middle of this century as predicted on the basis of misinterpreted TFR values. If Sri Lanka desires to attain stable population size and obtain its consequent benefits, the country still needs to carry out its fertility-related policies further until TFR shows a steady decline.**



Source: Registrar General's Department, 2011

Reproductive health issues affecting women in the context of displacement, return and resettlement

Although Sri Lanka has almost resettled its war-affected internally displaced persons (IDPs), reproductive health issues emerged during the war as well as in IDP camps can still have greater impact on the lives of current and former IDP women. Hence, their reproductive health issues need to be addressed in the three contextual areas of displacement, return and resettlement. However, there seems to be little acknowledgement of the fact that usually during most conflict situations and in IDP camps sexual and gender-based violence escalates and women continue to have babies. Yet, it is a generally accepted fact that the unmet need for reproductive healthcare for displaced persons still remains enormous. Therefore, it appears essential to recognize the rights of resettled communities for a comprehensive reproductive healthcare plan while highlighting areas which need more concerted work.

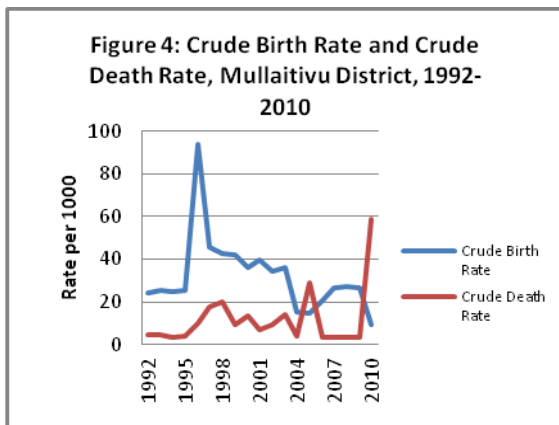
It was claimed that the fear of sexual violence against women presiding in communities and among conflict-affected families, led these families to arrange the marriages for their teenage daughters. However, the reasons for early marriage can also be seen as the results of teenage love affairs and subsequent pregnancies and these marriages seem unstable in most of the cases (South Asians for Human Rights, 2007). **Therefore, it is vital to carryout RH interventions in the conflict-affected areas, taking into consideration the understandings of the behavioural patterns**

which existed during the war and in IDP camps. Therefore, providing necessary assistance to Ministry of Health to develop an appropriate contingency plan on RH and Gender under the national preparedness plan of MOH can be very useful. Moreover, it is reasonable to hypothesize that absence of war can create a healthier environment for women to attend to their reproductive health matters without substantial constraints because their right to enjoy reproductive health would not be controlled by outside forces such as militant groups during the war. They would attempt to enjoy the benefits of peace by having healthy children, intimate relationships and happy families.

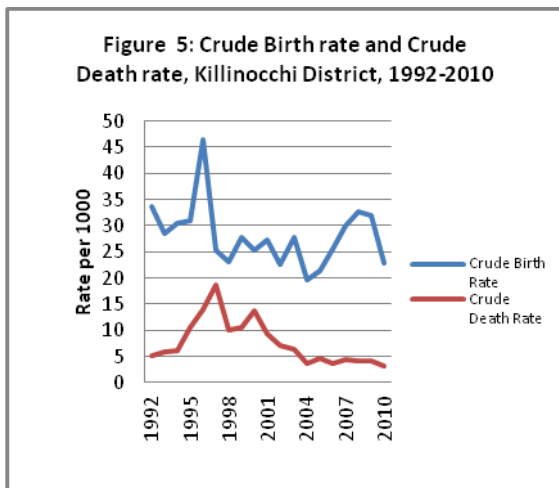
Recently released vital statistics (Registrar General's Department, 2011) provide important insight into very important reproductive health matters in the conflict-affected areas as they evidently show a strong association of fertility levels and war (Figures 4 & 5). It demonstrates that absence of war has undoubtedly provided benefits for the families to improve their fertility levels. According to the latest information available on the crude birth rates, all the conflict affected districts prove higher fertility immediately during the post-war period (Registrar General's Department, 2011). Most importantly, these districts have responded to deaths due to war by replacing them with additional births. **However, Mullaitivu and Killinochchi call for special concentration because they demonstrate extremely high fertility levels during the mid 1990s.** In addition, there was a positive response on fertility from tsunami-affected districts of the north such as Jaffna, and Mullaitivu immediately after the tsunami disaster. This is true even in the Ampara, Batticaloa districts in the East. Therefore, **these eastern districts also need special attention as they still continue to show higher birth rates than the average Sri Lankan level.** Another reason for prevailing high fertility in those districts could be the unmet needs of family planning due to unavailability of family planning services during the initial stage of resettlement. It was also evident from the SLDHS 2006/7 data that

eastern districts of Batticaloa, Trincomalee and Ampara showed substantially high percentages of unmet need for family planning as the figures were 22.9, 15.4 and 18.7 whereas average Sri Lankan value was 7.3¹.

In this regard, it is worthwhile to support Family Health Bureau to review and update the existing Family Planning guidelines in order to accommodate these new trends in fertility.



Source: Registrar General's Department, 2011



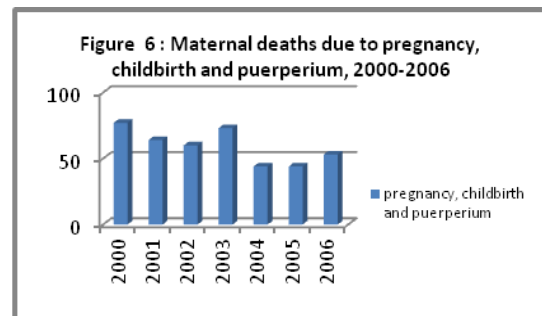
Source: Registrar General's Department, 2011

Family Health Bureau played a leading role in delivering emergency reproductive health services to the internally displaced population in the conflict-affected areas. This was mainly done by strengthening Maternal and Child Health, Emergency Obstetric Care facilities

(EmOc) and Family Planning services while drawing special attention to other reproductive health issues. FHB activities were strengthened by its relationship with also with the UNICEF, UNFPA and professional organization such as College of Obstetricians and Gynecologists and Pediatricians.

Maternal Mortality Rate

Overall level of deaths due to pregnancy, childbirth and the puerperium have not shown any significant decline during the recent years (Figure 6).

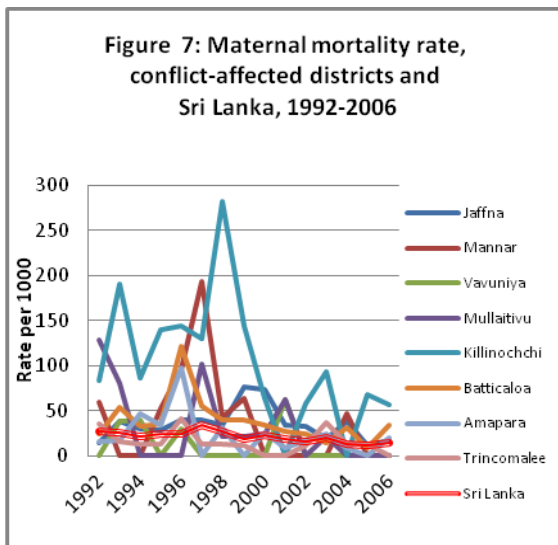


Source: Registrar General's Department, 2011

Furthermore, recent data suggests that maternal mortality rates have been unusually high among mothers in Killinocchi, Mannar and Batticaloa (Figure 7). Fernando and others (2003) also claimed that despite continuing improvements, maternal morbidity and equity in access to services across the country, especially in conflict-affected and plantation areas, need more attention. It appears that continuing provision of free health care and improvement of coverage and quality of maternal health services remain a challenge for Sri Lanka. Therefore, a strong obligation crops up to devise special programmes of RH interventions in these war-torn districts as well as in the plantation sector to help families to enjoy healthier lives. This is also very important in the context of Millennium Development Goals as improving maternal health and thereby reducing maternal mortality is one of the MDGs adopted by the international community at the United Nations Millennium Summit in 2000.

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[http://www.statistics.gov.lk/social/dhs_final_report/CHAPTER %207%20-%20FERTILITY%20PREFERENCES.pdf](http://www.statistics.gov.lk/social/dhs_final_report/CHAPTER%207%20-%20FERTILITY%20PREFERENCES.pdf)



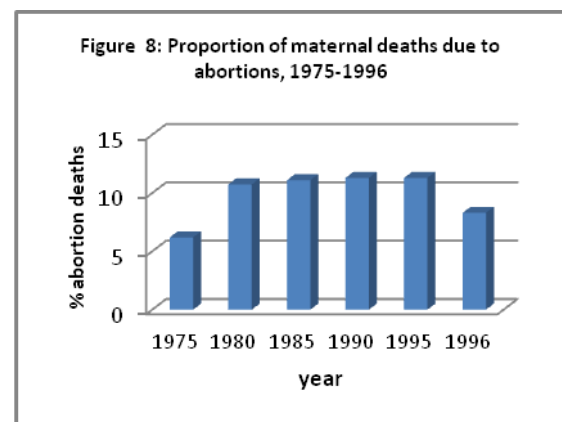
Source: Registrar General's Department, 2011

The high incidence of maternal death is one of the signs of major inequity among different population groups. Women in the above mentioned districts have had more pregnancies on average. Their lifetime risk more accurately reflects the overall burden of these women. Firstly, maternal deaths can be avoided by ensuring that women in these vulnerable districts have access to family planning. This will reduce unwanted pregnancies and unsafe abortions. The women who continue pregnancies need care during the gestation period for their health and for the health of the babies they are bearing. Most maternal deaths are avoidable, as the health care solutions to prevent or manage the complications are well known. Since pregnancy complications are not predictable, all women need care from skilled health professionals, especially at birth, when rapid treatment can make the difference between life and death. **In this regard, mobile health clinics in these conflict-affected areas can be strengthened further as these districts appear to be relatively high risk areas of pregnancy related complications. Therefore, Killinochchi, Mannar and Batticaloa districts need RH interventions which are particularly aimed at reducing unusually high maternal mortality. However, the Annual Report 2008-09 of the Family Health Bureau indicates that domiciliary care in districts of Northern and Eastern provinces will increase as the situation has improved at present. It is also**

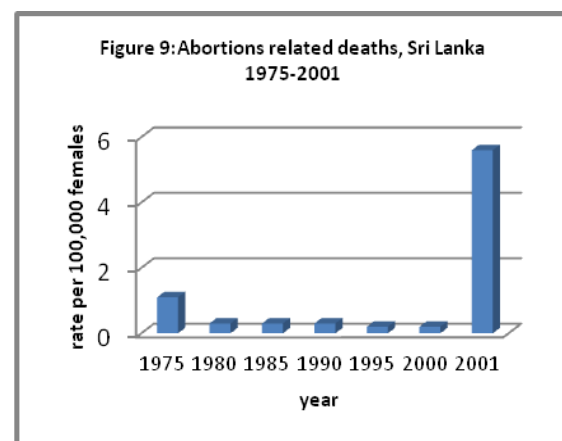
important to mention that postpartum care is essential for prevention of maternal mortality and morbidity. The leading causes of maternal deaths have been post partum haemorrhage (PPH), cardiovascular diseases, pregnancy induced hypertension (PIH) and embolism (Family Health Bureau, 2010). **Since PPH remains the main cause, an appropriate attention is needed and this calls for quality emergency obstetric facilities and the improvement of expertise of healthcare providers.**

Unsafe Abortions

Unsafe abortions are another contributing factor to maternal mortality (Figures 8 & 9). Maternal deaths due to abortions ranked fourth leading cause accounting 12.33 and 10.64 percent of all maternal deaths in 2006 and 2007, respectively (Family Health Bureau, 2010). Relatively high maternal deaths reported due to unsafe abortions in recent years indicate a high prevalence of unmet need for family planning.



Source: Rodrigo and others, 1996



Source: Annual Health Bulletin, 2001

In Sri Lanka, where abortion is illegal, except to save a woman's life, the majority of women lack access to safe abortion care and control of their reproduction (Abeyesekera 1997; Hirve 2004). This has opened up a market for unregulated private providers and unqualified personnel thereby leading to unsafe abortions and economic burdens for households (Duggal 2004; Hettiarachchy and Schensul 2001). Rajapaksha (1998) estimated that the abortion ratio would be 741 per 1000 live births. Furthermore, the same study showed that the **problem of induced abortion is seen predominantly among married women ranging from 25-39 years having two or more children and hence reproductive health programmes need to concentrate more on this group in order to help them to meet their family planning needs.** By applying Bongaarts Model (Bongaarts, 1978), Abeykoon (2010) indirectly estimated that total abortion rate² to be .087 in 2006/7. It has increased from a relatively low level in the early 1990s to more than four times its level by the year 2000 and has thereafter declined by about 40 percent from its level during 2000 to 2006/07. In this regard, one can also reasonably claim that the clamp down on Marie Stopes clinics in 2007 which provided abortion services at relatively low cost for more than 20 years may be reason why abortion rate decline after 2007. Kumar (2011) is of the opinion that there is a necessity to advocate abortion law reform and the registration of abortion medicines now as a substitute of reinforcing the silence by pretending that abortion does not take place in Sri Lanka. In practice, women or couples will access abortion services if they require them whether it is legally prohibited or not. Therefore, decriminalization and registration may make existing services cheaper and safer, thereby preventing maternal deaths and disabilities.

In addition, It has been claimed that high rate of deaths due to unsafe abortions in both

² The Total Induced Abortion Rate is defined as the average number of abortions a woman would have during her reproductive life span.

2006 and 2007 suggests a high prevalence of unmet need for family planning (Family Health Bureau, 2010). This is important because 50 percent of abortion seekers have given the reasons as; needs for spacing a pregnancy or completion of the desired family size; 15 percent as economic difficulties; 11 percent as opportunities for employment abroad; and 4 percent as because they were unmarried.

Reproductive health issues among the disabled population

Disability can be regarded as a cause as well as a consequence of poor reproductive health. It has been estimated that 10 percent of the world population or 650 million people live with a disability³. Therefore, it is important to address the sexuality and reproductive health (SRH) issues of the persons with disabilities because they also have the same sexual and reproductive health needs and most importantly rights as other people. In terms of reproductive freedoms within the international human rights framework, there are four conditions: the right to equality and non-discrimination; right to marry and found a family; right to reproductive health including family planning and maternal health services, information and education; and the right to physical integrity. These reproductive health rights are equally applicable to the disabled people as well⁴. However, Sri Lankan situation does not provide enough information on current RH issues that the disabled people are facing with and whether they do not have adequate access to available RH services. Therefore, it seems essential to carry out a well-designed survey on these lines to capture such information. It is imperative to deal with the SRH issues of disabled persons in Sri Lanka as the country already has a significant disabled population resulting from both the tsunami and the war.

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http://www.who.int/mediacentre/events/annual/day_disabilities/en/index.html

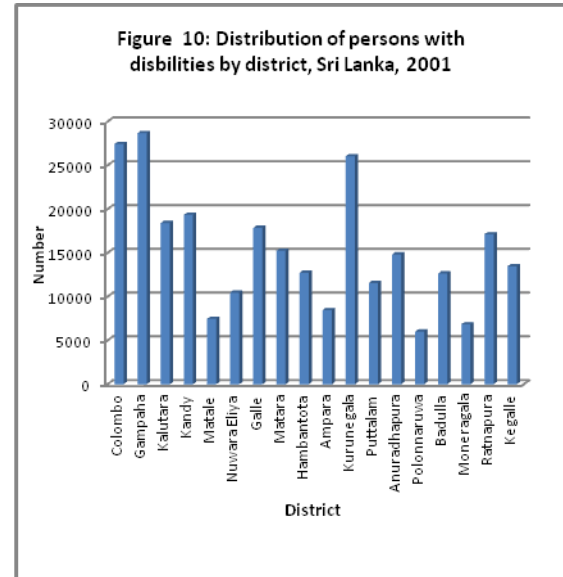
⁴ http://www.handicap-international.fr/bibliographie-handicap/4PolitiqueHandicap/groupes_particuliers/Femmes_Genre/reproductive_rights.pdf

Although exact figures will not be available on both these occurrences until the 2011 census data is available. One can reasonably hypothesize that numbers can be more than what was observed in 2001 census, which showed that there were 274,711 disabled people. District-wise distribution of disabled population shows a relatively large number of disabled-people in Colombo, Gampaha and Kurunegala districts (Figure 10), and hence, they need priority in the SRH programmes but war-torn districts also need special attention as there can be a significant number of disabled persons amongst the population. In fact, 2001 census did not cover those districts due to lack of accessibility. It is also essential to gather information about disabled-people among the armed forces as well as ex-militant groups and address their SRH issues since there can be a considerable number of people who became disabled during the war.

In general, disabled people encounter special problems in acquiring a positive sexual identity and in accessing mainstream sexual and reproductive health services. In particular, parents of the disabled youth may find that their disabled young children are sexual beings. Therefore, they would have poor access to information and perhaps, some services can be physically inaccessible. Therefore, it is highly likely that disabled women rarely get information about sexuality, birth control, sexually transmitted diseases or pregnancy and motherhood from mainstream health care facilities. Another major problem could be the lack of medical services available for women with disabilities who have been sexually abused or assaulted.

Existing SRH services available can be tailored to accommodate the sexual and reproductive needs of persons with disabilities. In order to improve the efficacy of such programmes, persons with disabilities can be involved in programme design and monitoring. Persons with disability are widely distributed among all the districts by each having more than a 5000 disabled population (Figure 10), **broad-based SRH programmes for all the districts**

also can be very useful, especially to increase the awareness among mothers that preventable disability arising from complications of labour and pregnancy can be averted.



Source: Department of Census and Statistics, 2001

Problems in accessing health care

Information on factors that can prevent women obtaining health care services is very important to address the barriers women face in seeking care during pregnancy and at the time of delivery. According to the SLDHS 2006/7, almost half of the women interviewed reported that they encountered at least one such problem. District-wise distribution of problems in accessing health care (Figure 11) **demonstrates that Batticaloa and Nuwara Eliya districts were leading among those districts which have indicated access to healthcare as a major problem.** As the war-torn northern districts were not covered by the SLDHS 2006/7, it is quite obvious those districts also need improvements in the access to health care. SLDHS also reports that estate women have reasonable difficulty in getting care compared to other sectors. These evidences suggest that it is essential to **monitor and evaluate access to RH services available within the broader healthcare system.**

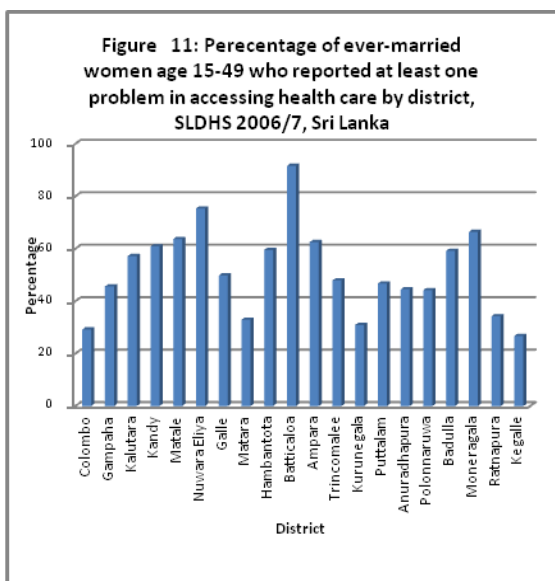
Contraceptive prevalence

It is apparent that contraceptive use among currently married women aged 15-49 in

Batticaloa, Trincomalee and Ampara districts significantly deviate from other districts as they show the lowest contraceptive prevalence rates among all the districts in Sri Lanka. However, northern districts also could show lower level of contraceptive prevalence due to conflict situations during the past but they were not captured in SLDHS 2006/7. It is quite interesting to note that the estate sector recorded the highest prevalence rate as a result of relatively high level of female sterilization (Department of Statistics, 2009). This was also proven by their fertility rates after the age of 35 indicating a larger number of women terminated childbearing compared to other sectors. However, most importantly, **estate fertility has started to concentrate more in the early childbearing years** (Figure 2) and thus their fertility at those ages turned out to be higher than that of the other sectors. **Contraceptive prevalence in Batticaloa, Ampara and Trincomalee districts can be improved by strengthening family planning programmes in those districts. This can be attributed to the northern war-torn districts as well, as they were not captured by the SLDHS in relation to contraceptive prevalence. It is quite certain these districts will exhibit high level of unmet need for family planning as Batticaloa, Ampara and Trincomalee already showed extremely high levels as reported in the SLDHS 2006/7.**

Antenatal Care

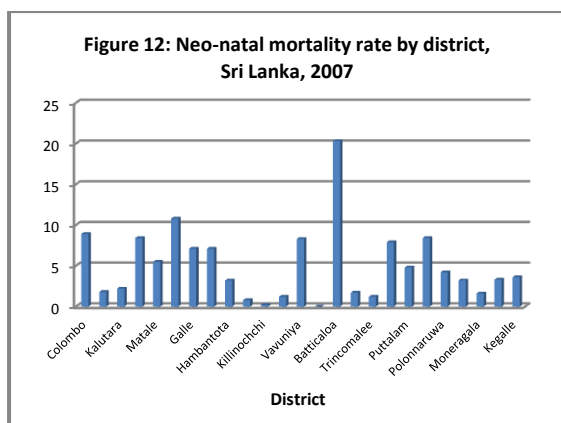
Antenatal care is extremely helpful in preventing adverse pregnancy outcomes when it is sought early in pregnancy and continued through to delivery. It is expected that the first antenatal visit should happen during the first three months of gestation and becomes regular on a monthly basis until the 28th week of gestation and every two weeks up to birth of the child. District wise variation in antenatal visits shows that there is no significant difference. In addition, SLDHS 2006/7 data further indicates that antenatal care clients who received services have remained at the highest possible levels since 2000. This suggests that **quality of antenatal care services in Sri Lanka is at the acceptable level. However, when the district-wise variation in terms of percentage ever-married women aged 15-49 who saw specialist doctor/doctor, is examined, Batticaloa showed the lowest (60.6 percent) whereas more than 79 percent of women in all other districts have seen such medical personnel** (Department of Census and Statistics, 2009). This situation calls for special attention with regard to Batticaloa district, and possibly the northern conflict-affected districts as they also could show similar or lower level due to deteriorated health infrastructure in those districts.



Source: Department of Census and Statistics, 2011

Assistance during delivery

Birth outcome and subsequent health of mother and the infant greatly depend on the quality of assistance during pregnancy. In this regard, skills of the birth attendants decide whether they properly manage complications and observe hygienic practices. **According to SLDHS 2006/7 data, on average, percentage of providing assistance during delivery by a skilled person was 98.6 percent, but Nuwara Eliya, Amapara, and Trincomalee districts still can be improved further as they show lower percentages than other districts.**



Source: Registrar General's Department, 2011

However district differences in neo-natal mortality calls for a special attention to Batticaloa district because of its curiously high neo-natal mortality rate (Figure 12). It was 9.6 in 1992 and then fluctuated until 2002 but increased to high levels thereafter. This may be due to a higher proportion of women (22.1%) compared to all other districts, not attending postnatal care (Department of Census & Statistics, 2009). Therefore, **persuading mothers to visit postnatal care clinics in Batticaloa district becomes a major requirement of the existing health service. However, a detailed analysis on factors influencing neonatal mortality in Batticaloa district could be very valuable to find real answers to this unusual situation.**

Prevalence of low birth weight

Birth weight is an exceedingly important determinant of newborn infant's survival as well as an indicator of a child's vulnerability to the risk of childhood illnesses. If birth weight is less than 2.5kg, such children are considered to have a higher risk of having an early childhood death. **In the SLDHS 2006/7 sample, Nuwara Eliya district, where majority of plantations are concentrated, showed the highest percentage of low birth weight children (33.8%).** It was also reported that low birth weight in the estate sector has increased rapidly from 21 to 31 percent between the SLDHS 2000 and SLDHS 2006/7. **Therefore, there is a great necessity to enhance the health and nutrition of pregnant mothers as well as to provide extra attention and care during infancy.**

Prevalence of Anaemia

Anaemia causes women to be at high risk for poor pregnancy outcomes including increased risk of maternal mortality, perinatal mortality, premature births, spontaneous abortions and low birth weight. It was observed that anaemia among non-pregnant women was **highest in Galle district (52 percent)**⁵. However, **Colombo, Kalutara, Ampara, Kurunegala, Puttalam, Moneragala and Rathnapura districts also need equal attention to reduce anaemic conditions of women which in turn prevent vulnerability to poor reproductive health situations.**

Well Woman Clinic Services

This concept was introduced in 1996 to provide services for reproductive organ malignancies as a part of the reproductive health concept promoted by the ICPD. UNFPA supports Well Women's Clinics to cater to the specific reproductive health needs of the older women. It was reported that 582 clinics provided pap smear examinations facilities and from 2008, cervical smear screening started targeting for those women reaching 35 years age (Family Health Bureau, 2010). It is quite important to point out that the number of clinics as well as the number attended these clinics has increased significantly over the years as the dire commitment of the service providers. The current trend suggests that more and more women would seek services from these centers for routine screening against non-communicable diseases in the future. **However, the number of clinics operated in Kalmunai, Mannar, Batticaloa, Vavuniya, Jaffna, and Colombo Municipal Council area seem inadequate and hence it is essential that programme managers to take action to establish more clinics to accommodate more women for the screening services** (Family Health Bureau, 2010).

Sexually Transmitted Infections (STI)

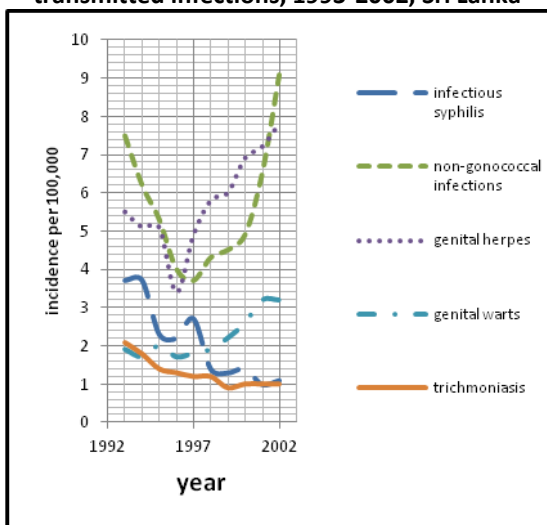
Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) and other Sexually Transmitted Infections (STIs) can be regarded as emerging

⁵ <http://www.statistics.gov.lk/social/Anemia.pdf>

public health problems in Sri Lanka. Annually the estimates of identified new STI cases fluctuate from about 60,000 to 200,000 of which only 10 to 15 percent are reported by the Government clinics (World Bank, 2005). The epidemiological patterns of STIs could be inferred from data reported by the clinics providing services for sexually transmitted diseases (STD) of the National STD/AIDS Control Programme (Figure 13).

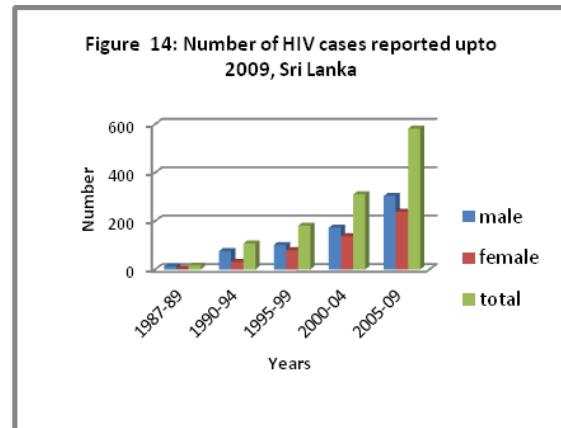
The incidence of infectious syphilis, gonorrhoea has shown a declining trend. Incidence of non-gonococcal infections diminished sharply from 1993 to 1997 but increased in the next five years in an exponential manner. Genital Herpes incidence also indicates a similar trend. According to the recent data available from the National STD/AIDS Control Programme, genital herpes, non-gonococcal infections, candidiasis and genital warts accounts about 75 percent of all the diagnosis from all the STD clinics by the end of 2010. The apparent rise of genital herpes and non-gonococcal infections may be due to a number of factors including increased awareness, better facilities for diagnosis, better reportage and/or genuine increases in incidence (http://www.searo.who.int/LinkFiles/Reproductive_Health_Profile_sexually.pdf).

Figure 13: Incidence rate of selected sexually transmitted infections, 1993-2002, Sri Lanka



Source: National STD/AIDS Control Programme (NSACP), Sri Lanka

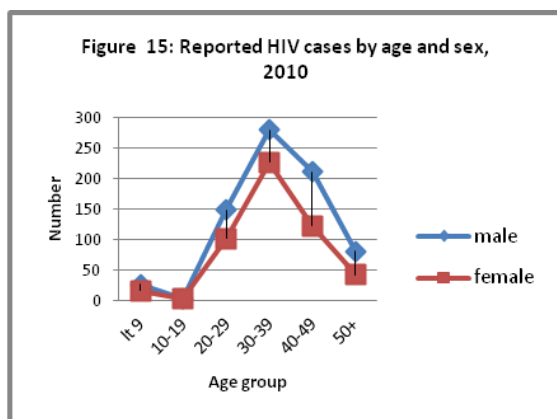
The first HIV case in Sri Lanka was reported in 1987. There has been constant rise of the HIV and AIDS cases since then and hence HIV/AIDS can be regarded as a new epidemic emerging in Sri Lanka. Number of HIV cases has increased an exponential manner during the last two decades (Figure 14).



Source: National STD/AIDS Control Programme (NSACP), Sri Lanka

It has been shown in some countries that unprotected paid sex, the sharing of contaminated needles and syringes by injecting drug users and unprotected sex between men seem to be the commonalities observed in Asia in relation to HIV transmission (UNAIDS, 2008). According to the recent available information by end of 2010, National STD/AIDS Control Programme suggests that probable modes of HIV transmission in Sri Lanka was heterosexual (55.7 percent) and homosexual (7.6 percent) but unknown category consists of 32.6 percent. Therefore, it appears that prevention efforts are highly associated with dire reduction of HIV transmission among and between these three categories of most-at-risk populations. In addition however, some infected women might transmit HIV to their new born or unborn infants. Such a possibility can arise in Sri Lanka due to infected overseas migrant men and women. It was quite interesting to note that 48 percent of the reported HIV infected women were employed overseas. These cases were being recorded as a result of compulsory testing required by the receiving countries, largely Middle-eastern, for the migrants. Therefore, it is highly likely that these data overstate the importance of

the pattern of transmission and over-represented in HIV testing data (The Joint Team on AIDS in Sri Lanka, 2006). Annually about 200,000 Sri Lankans migrate for overseas employment, mainly to the Middle-eastern countries and of which 70 percent are women. It was reported that 40 percent of HIV infected women have acquired the infection most likely outside the country and almost 22 percent of the infections in each year were associated with external migration. It seems that HIV is being introduced to the country to a considerable extent by external migrants⁶. They are however, based on anecdotal reports and hence, the extent of the pattern of transmission cannot be adequately documented. Nevertheless, it can be important to examine how they contracted HIV as information on such evidence is not available at present to draw a firm conclusion. Age pattern of HIV infected cases reported up to 2010 shows some signals towards this phenomenon since there is a noticeable minority of children having this disease although the number is not so great (Figure 15).



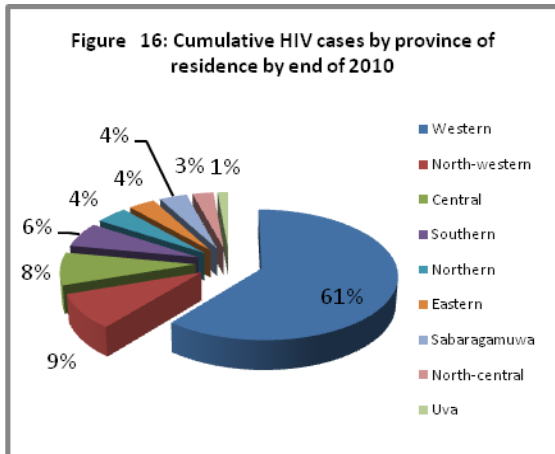
Source: National STD/AIDS Control Programme (NSACP), Sri Lanka

Furthermore, age distribution of HIV is similar for both sexes but the number of female infections appears to be rising slowly. **Age group of 30-39 is the most vulnerable group** and hence, any HIV/AIDS prevention

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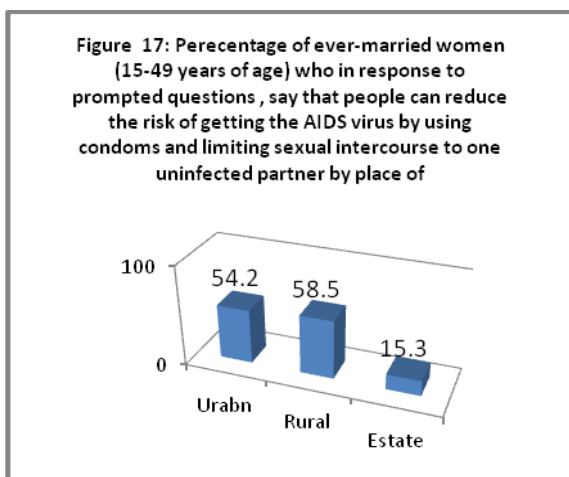
http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/srilanka_2010_country_progress_report_en.pdf

programmes in **Sri Lanka need to focus more on both men and women in this age category**. Cumulative HIV cases by province of residence suggests that **priority should be given to the western province** as 61 percent of cases were reported from that province but **North-western, Central and Southern provinces** also need attention as they represent more than 5 percent of the cases reported (Figure 16). An important way of tackling HIV transmission is to reduce HIV transmission among men who buy sex, initially in the districts where there is high prevalence, as illustrated in figure 16. In this regard, any effective interventions need to aim at clients of sex workers through strong mass media campaigns, which possess the ability to encourage a virtual and lasting norm of condom use during paid sex (UNAIDS, 2008). Such campaigns have proved successful in both Cambodia and Thailand but they were direct and focused upon marketing and acceptance of condoms. Hence, there is a great necessity to identify places where there is demand for sex work in order to effectively reach the clients of sex workers and provide them with HIV education and services. In this regard, Round 9 of the HIV/AIDS component of the Global Fund which is carried out in collaboration with the National STD/AIDS Control Programme, the Sri Lanka Sarvodaya Sangamaya and some other NGOs which work at grass root level seem very important as its primary objectives are to increase the scale and quality of comprehensive interventions for most at risk populations; to provide care, treatment and support for people living with HIV and AIDS; and to generate and use strategic information and planning and administration of project.

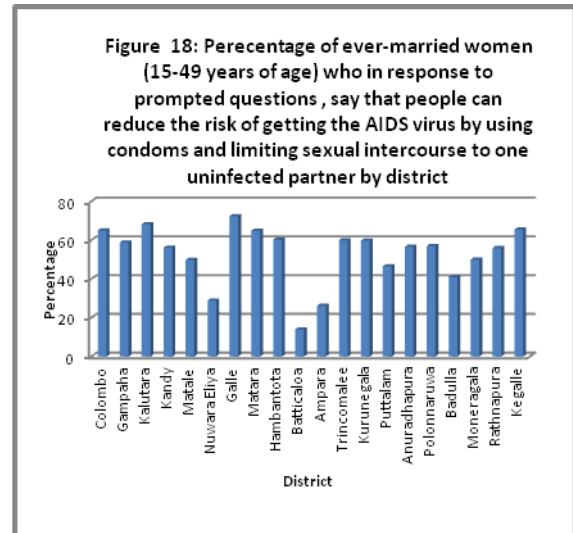


Source: National STD/AIDS Control Programme (NSACP), Sri Lanka

Generally, HIV/AIDS prevention programmes promote monogamy and the use of condoms as primary sources of preventing infection. In this regard, women in the estate sector have the lowest knowledge of HIV prevention (Figure 17). Only 20 percent of women who have ever been married and eligible for childbearing have reported to being aware of the risk of exposure to HIV infection can be minimized by using condoms and having sexual intercourse with only one partner (Figure 18). Batticaloa, Ampara and Nuwara Eliya districts show the lowest figures in this regard. **These findings suggest that Batticaloa and Ampara districts also need special attention for HIV/AIDS awareness programmes in addition to the estate sector.**



Source: Department of Census & Statistics, 2006/7



Source: Department of Census & Statistics, 2006/7

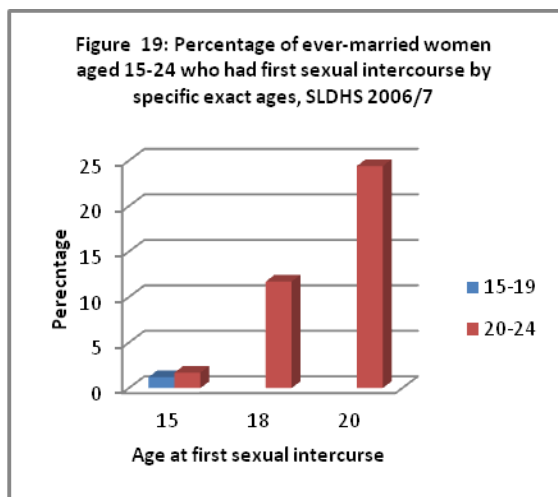
Adolescent and Youth Reproductive Health

According to the 2001 census, there were 5.3 million adolescents and youth in Sri Lanka in 2001. It comprises 28 percent of the total population. Adolescent sexual and reproductive behaviour has serious implications for their own lives as well as for reproductive health outcomes of Sri Lanka. These outcomes will be mainly fertility, safe motherhood and STIs and HIV/AIDS. The ICPD emphasized a holistic concept of reproductive health that incorporated adolescent and youth reproductive health as an integral component. In addition, the MDGs included young people's need for gender equity, education, safe pregnancy and reduction in the spread of STIs and HIV/AIDS. Presently, Sri Lanka implements adolescent and youth reproductive health programmes through the Ministry of Health, Ministry of Education, National Youth Services Council and NGOs which, jointly, have commenced important initiatives.

Knowledge on sexual and reproductive health

A study conducted by UNICEF (2004) reported that a fair proportion of school-going aged adolescents seem to be sexually active because 6 percent of 14-19 year old children have had heterosexual sexual intercourse

while 10 percent experienced homosexual relations. More recent data coming from the SLDHS 2006/7 survey reported that 11.7 percent of young women aged 15-24 have had first sexual intercourse around the age of 18 (Figure 19).



Source: Department of Census & Statistics, 2009

Another study in 2007 (De Silva, 2007) showed that more than 60 percent of their sample of 3,322 adolescents and youth, have indicated that sexual and reproductive health was discussed at school level as a subject. **However, it appears that a substantial proportion of unmarried males and females including those who do not have any formal education still do not have enough knowledge on sexual and reproductive health. Therefore, there is a great necessity to devise effective programmes geared towards illiterate or less-educated youth on comprehensive life skills based, gender sensitive ASRH education.**

Intimate relationships

Among those adolescents who were reported as sexually active in the UNICEF study (2004), it was estimated that the average age at first sexual intercourse was 15.3 years for males and 14.4 years for females. About 43 percent sexual debuts had occurred among lovers but a significant proportion of sexual debuts were between friends who were not in love. Most strikingly, 11 percent (boys) had their sexual debut with a commercial sex worker. Behavioural Surveillance Survey (BSS) which was conducted from October 2006 through

March 2007 estimated that most likely number of female sex workers in Sri Lanka is around 30,000 (World Bank)⁷. It was also reported in the UNICEF study that about 24 percent used condoms during sex. De Silva's (2007) study also noted that lengthier duration of love affairs was observed as age advanced. It was further observed that individuals were not aware of the outcomes of having sex during that age or how to have safe sex. Altogether, the majority of both males and females viewed that they should have the freedom to choose their partner. This shows that **lack of awareness on sexuality and reproductive health matters have exposed youth to relatively high reproductive health risks.**

Teenage pregnancies

Teenage mothers are a special concern as they are more likely to suffer from pregnancy related complications in addition to socio-cultural pressures and lost opportunities. The incidence of unwanted pregnancies among adolescents in Sri Lanka seems to be quite low by international standards, mainly due to socio-cultural reasons and unwanted pregnancies that do occur among unmarried adolescents appear to end in abortions (De Silva, 2003). De Silva and others (2000) found that approximately 19 percent of abortion seekers interviewed in two separate studies were identified as adolescents ages 15–24, the majority of whom were married. The SLDHS 2006/7 reported that 6 percent of adolescent women aged 15 to 19 years were already mothers or were pregnant with their first child. District-wise distribution of teenage pregnancies demonstrate that **Ampara recorded the highest percentage (15.8%) but Trincomalee also showed around 14 percent** (Figure 20). It is also quite important to examine the situation in the war-torn northern districts since the SLDHS 2006/7 did not capture it due to lack of accessibility. An important contributory factor could be unmet

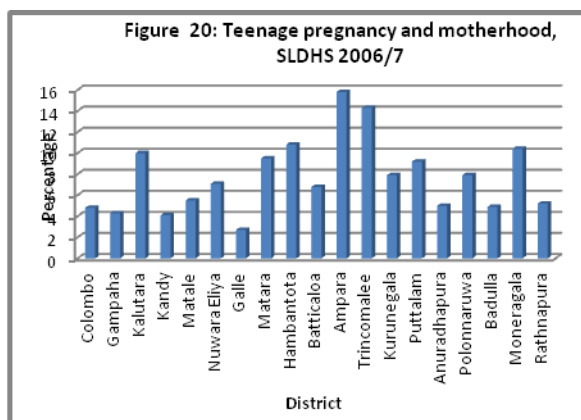
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<http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1192413140459/4281804-1231540815570/5730961-1235157256443/HIVAIDSbriefLK.pdf>

need for family planning among the teenagers.

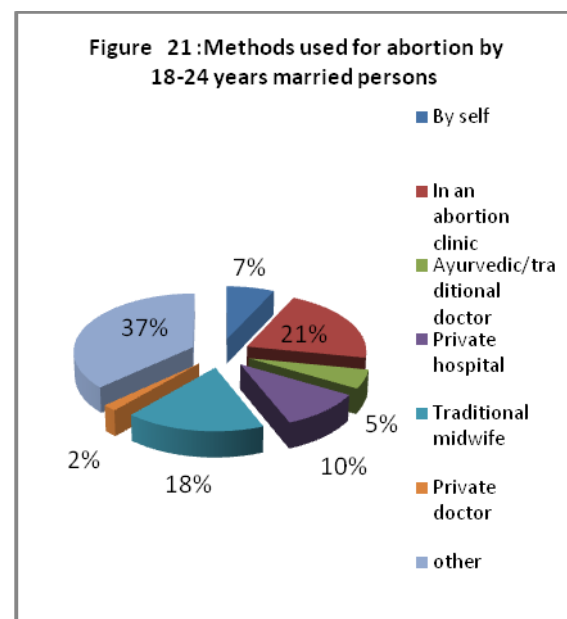
Adolescent population in the plantation sector is about 20 percent of the total estate population. Age at marriage is relatively low compared to other sectors as estate women marry before the age of 24 years. De Silva (2007) reported that there were 16 percent of unwanted pregnancies among teenagers and thus septic abortions are relatively high compared to urban and rural sectors.

The most prominent feature observed in the early childbearing period is relatively high incidence of teenage fertility in the 15-19 age group. A study carried out in the estate sector which drew a sample of 401 from Ratnapura, Kandy, Hatton, Badulla, Nuwara Eliya, Kegalle and Galle in 2008 showed that age at first intercourse range between the ages of 13 and 18 and the mean age at marriage was 18.3 years (Dissanayake,2008). This study further claimed that 23.6 percent teenagers have had pre-marital sex and substantial minority of them terminated their pregnancies with induced abortion. It was also reported that 5.4 percent of pregnancies were a direct result of rape and 57.1 percent of teenage mothers had unwanted sexual experiences preceding their pregnancy. **As serious health risks are associated with both teenage mothers and their babies, a special effort has to be devoted to address reproductive health concerns of estate teenagers.**



Induced abortion

Abortions are illegal in Sri Lanka but therapeutic abortions are allowed under certain circumstances in order to safeguard the life of the mother by a trained doctor. Septic abortions⁸ are illegal and evidence suggests that they are being conducted by unskilled person under unhygienic environment. Most of the deaths occurring due to such abortions were caused by ruptured uterus, tetanus or severe systematic infection developed after such abortions. De Silva (2007) indicated that 12.5 percent in their sample of 18 to 24 year olds had induced abortions. About 32 percent had sought skilled persons to perform abortions while 68 percent resorted to various other remedies (Figure 21). Again, **there is clear evidence that lack of awareness on reproductive health matters, especially on service delivery, leads the youth for higher reproductive health risks.**



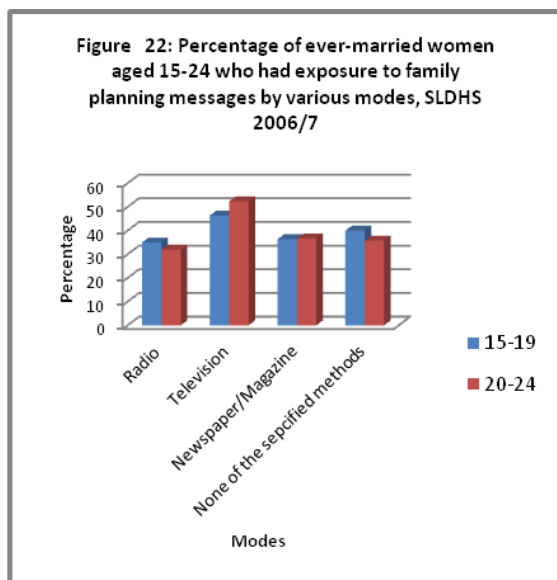
De Silva, 2007

Utilization of sexual and reproductive health services

Available evidence suggests that both adolescents and youth irrespective of their

⁸ Abortion complicated by fever, endometritis, and parametritis, often leading to sepsis (The American Heritage® Medical Dictionary Copyright © 2007, 2004 by Houghton Mifflin Company. Published by Houghton Mifflin Company. All rights reserved).

place of residence prefer state sector services over private or NGOs (De Silva, 2007). SLDHS 2006/7 reported that 68.3 and 57.9 percent of ever-married women in the age groups 15-19 and 20-24 were not visited by family planning providers. Exposure to family planning messages through various modes illustrates that **there is a necessity to provide such messages to the youth through other group awareness programmes and most importantly with personal contact by family planning field workers (Figure 22)**. It was also observed that the use of family planning services was relatively low among this group not only due to lack of awareness of such services but also because of stigma attached to use of such services. Therefore, there is a great need to educate and sensitize the adolescents and youth in order to encourage them to seek counselling on sexuality and reproductive health matters before marriage. It was reported that most preferred person to talk about personal matters across all socio-economic categories appears to be mother followed by friends (UNICEF, 2004). However, a more clear understanding on this topic is essential in order to devise any appropriate programme of preventing teenage pregnancies.



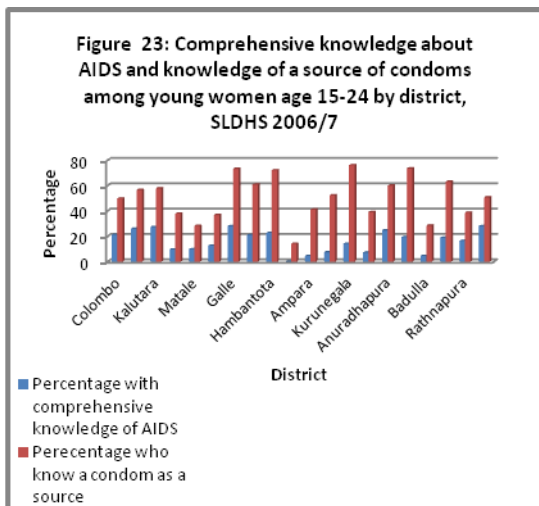
Source: Department of Census and Statistics, 2009

Awareness and knowledge on sexually transmitted infections

In the UNICEF study (2004), it was reported that 57 percent of the adolescents in their sample was aware of STIs. About 59 percent knew about HIV/AIDs while 38 and 22 percent knew about gonorrhoea and syphilis, respectively. It is quite important to note that awareness of these diseases increases with age and socio-economic status. Tamils reported the lowest awareness. De Silva (2007) showed that most common STIs heard by the respondents were gonorrhoea (51.82 %), syphilis (36.14), and pubic warts (40.50). In general, males knew more about STIs than females. It was also reported by this latter study that 73 and 82 percent of unmarried and married in the 15-17 age group knew about HIV. In relation to HIV/AIDs, about 30 and 23 percent of males and females were unaware of the disease.

A substantial proportion of youth are at risk of acquiring HIV infection unless they are conscious of ways to evade unsafe behaviour. The key route of transmission was found to be heterosexual. The prevalence of HIV/AIDs is low in the country but STI prevalence is on the increase among young people. **The lack of information about the causes and risks of STIs and the association between STIs and HIV/AIDs can create a considerable risk of acquiring HIV infection to a large number of young people** (World Health Organization, 2005). However, it was also reported that young people are not most at high risk population in Sri Lanka (National STD/AIDs Control Programme, 2010). The Demographic and Health Survey of 2002 established that 70 percent and 80 percent of ever married females in the age groups 15-19 and 20-24 years respectively were aware of AIDs and other STIs and knew at least one method of prevention (Ministry of Health, 2002). However, SLDHS 2006/7 still showed that knowledge of using condom to prevent HIV infection was 47.4 and 61.1 percent in the age groups of 15-19 and 20-24, respectively. **Young women in Batticaloa, Ampara, Badulla, Kandy and Matale need special attention as they still show lesser knowledge**

than those in other districts (Figure 23). Nonetheless, one may reasonably hypothesize that northern war-torn districts also need attention as they were not included in the above survey which can jeopardize their situation. It is very important to concentrate on these age categories as they will be moving into the most vulnerable 30-39 age group very soon.



Source: Department of Census and Statistics, 2009

The most recent report on Mapping of most-at-risk populations in Sri Lanka, a precursor to effective prevention interventions, which was conducted by the National STI/AIDS Control Programme, Ministry of Healthcare and Nutrition, showed that it is essential to prevent the establishment and potential expansion of HIV epidemic by reducing the potential transmission in important networks of vulnerable key populations (National STI/AIDS Control Programme, 2010). Furthermore, it was suggested that the HIV surveillance system needs to be strengthened in order to better track the state of the epidemic and the delivery of prevention programmes as well as their effectiveness.

Although there have been various programmes directed towards reproductive health matters of adolescents and youth through the National Youth Services Council, peer-education, school-based health education, and various non-Governmental sector organizations, the above evidence suggests that a substantial gap exists among the adolescents and youth in the knowledge

on sexuality and reproductive health issues including service delivery. Since this gap cuts across all the socio-economic groupings in the country, there is a requirement to devise an island-wide programme which can accommodate the sexual desires of this group. Another important strategy would be to involve mothers (as the most trusted person to talk personal matters), through a properly designed programme which has the capacity for educating mothers on ASRH.

Gender

Various UN conferences have campaigned that women's empowerment is fundamental to development. The United Nations Conference on Environment and Development (UNCED) Agenda 21 mentions women's advancement and empowerment in decision-making, including women's participation in ecosystem management and control of environment degradation as a key area needed for sustainable development. The International Conference on Population and Development (ICPD) in Cairo, stressed the fact that the population issue is not just a technical, demographic problem, but a choice that women should be empowered to take within the context of their health and reproductive rights. The Copenhagen Declaration of the World Summit on Social Development (WSSD), called for the recognition that empowering people, particularly women, to strengthen their own capacities is a main objective of development, and that empowerment requires the full participation of people in the formulation, implementation and evaluation of decisions determining the functioning and well-being of societies. The Beijing Declaration and Platform for Action at the UN Fourth World Conference on Women Beijing, 1995 emphasized that the principle of shared power and responsibility should be established between women and men at home, in the workplace and in the wider national and international communities. All these world forums reiterated that women's participation is central to the success of any

development programme, whether at national or local level. Most importantly, the Development Policy Framework of the Government of Sri Lanka recognizes 'women as a pioneer of development' and endorsed that 'all policy direction will emphasize the creation of a conducive environment for where they can utilize their knowledge in emerging opportunities' (Department of National Planning, 2011: 186). It was specifically mentioned that special attention will be given to those who are unemployed, pregnant, widowed, destitute and to female headed households. Therefore, accommodating gender issues in appropriate policy framework can facilitate to minimize or evade inadvertent negative impacts of development programmes. In this regard, strategic actions, both gender-focused and gender-mainstreamed, can maximize positive gender impacts such as improving the status of women and thereby balancing opportunities for men and women.

During the past few decades, Gender-Based Violence (GBV) has been accepted as a global problem, which cuts across cultural, geographic, religious, social and economic boundaries. United Nations Population Fund has a long history of supporting GBV programmes and the 2001 publication, *A Practical Approach to Gender Based Violence: A Manual for Health Care Providers* can be regarded as a major step forward by UNFPA in initiating the prevention and assessment of GBV. UNFPA has mainstreamed the prevention and management of GBV into its policies and programming comprehensively and is supporting many more countries including Sri Lanka to strengthen the health sector response to GBV. Accordingly, GBV has been identified as a main concern in UNFPA's overall Strategic Plan 2008-2011.

National Machinery

Successive Sri Lankan governments have accepted the importance of the norm of non-discrimination against women developed National Plans of Action to realize gender equality, even incorporating CEDAW (UN Convention on the Elimination of All Forms of

Discrimination Against Women) in a policy document, the Women's Charter 1993 and various initiatives of law in order to achieve gender equality. The Women's Bureau was established in 1978 to be the national machinery which develop, implement, monitor, evaluate and coordinate the policies and programmes for the recognition of women's rights within socio-cultural foundation of Sri Lanka in order ensure their total development, protection and participation. Women's Bureau is the oldest national institution with a mandate to advance the status of women in Sri Lanka. It has gradually become a project based institution focusing mainly on income generation and improving awareness on gender issues. National Committee on Women (NCW) was setup in 1993 with the objectives of achieving 'women's convention' that symbolizes the government policies on women. The NCW was an outcome of the 1995 Beijing conference and its Platform for Action and was created to implement the Women's Charter adopted by Cabinet in 1993. It has a mandate to both develop policies related to women's issues and investigate areas of gender inequality. Members of the Committee are drawn from NGO practitioners, academics and government officials. From its inception, the expectation was that the Committee will be elevated to a fully fledged Commission with greater powers but this is yet to happen.

The current Ministry of Child Development and Women's Affairs⁹ was established in 1993 in order to cover wide areas of child development as well as women empowerment. NCW has been very active in drafting the Women's Rights Bill, engagement with NGOs to lobby for the Prevention of Domestic Violence Act. However, the Ministry itself seems to be taking the lead at present and can be regarded as the key player within the state machinery which promote and protect the rights of women in Sri Lanka. **As the Ministry is the key player in promoting**

⁹ The original name was Ministry of Health and Women's Affairs . the state ministry was established in 1985

women rights, it is essential to strengthen its activities. A Gender Complaints Centre was established in 1999 to offer free legal assistance to those women whose rights have been violated. Current political leadership has accepted the norm of non-discrimination against women. Some of the current initiatives for women implemented by the present government include national food package for expectant mothers, thripasha programme, diriya kantha programme, kantha saviya programme, gender-based violence programme, economic empowerment of rural/urban women, revolving fund for self employment, entrepreneurship training programme, skills development programme, trade fair and marketing programme and home gardening and livestock development programme.

Women's status in Sri Lanka

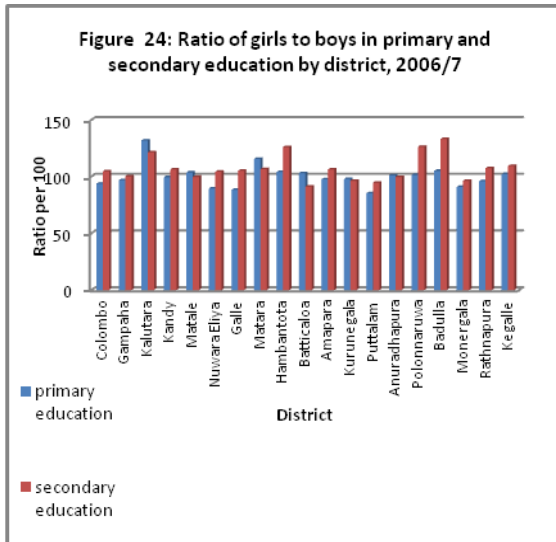
Sri Lanka's report to the CEDAW's 48th Session in January 2011 highlighted several issues of special concern to the Government: low participation of women in politics, abuse of female migrant workers, women's high unemployment rates, and the need for economic empowerment of rural women. The different forms of violence against women in Sri Lanka is another prioritized issue in which the delegation expressed its awareness of the urgent need to strengthen Sri Lanka's legal framework and improve implementation to facilitate women's access to justice. A recent emerging political concern is discrimination against female-headed households, to which the Government has initiated assistance programmes. According to the report submitted to 48th Session of CEDAW, the Government seems to be satisfied with the achieved progress so far but is still deeply aware of the remaining work. **Therefore, there is a necessity for the UNFPA to have continuous dialogue with the Ministry of Child Development and Women Affairs as well as with the Women's Bureau in order to monitor the progress on the above mentioned gaps and support them in order to overcome any limitations.**

Participation of women in politics

It is obvious that the social customs in a developing country's set-up limit women's activities outside the home although there is no legal barrier to the participation of women in politics. The proportion of women in Government does not correspond to their percentage of the population. Although the proportion of women in the total population outnumber men, only less than 6 percent of women candidates were nominated by the major political parties at the 2010 parliamentary elections. The '*Mahinda Chinthana*', the present Government's policy document, indicates that the aim is to promote the number of nominations of women to a minimum of 25 percent of the total number of candidates with respect to Provincial Councils and Local Government Authorities. The Development Policy Framework of the Government of Sri Lanka states that necessary steps will be taken to ensure sufficient representation of women through community consultation. In this regard, the government seems to be committed to promote increased women nominations to contest local elections.

Education

According to the 2001 census, total adult literacy rates for male and females were 92 and 89 percent, respectively. This shows that there is still a gender gap in adult literacy rate. In addition, regional disparities can be seen in primary and secondary educational levels by gender (Figure 24). For primary education, **Puttlam, Moneragala, Nuwara Eliya** and even Galle districts were the most affected. At secondary level, girls in the districts of **Puttlam, Batticaloa and Moneragala** were more disadvantaged.



Source: Department of Census and Statistics, 2009

At the tertiary level women still tend to be concentrated in service sector related programmes. The only change has been in the expanding field of Information Technology but here too women tend to move towards lower skill level courses. Although Sri Lanka has made an excellent effort to achieve a universal education standing, the 30 year-long war worked as a major barrier towards achieving such a status. **The above factors suggest that women need to be encouraged to engage in educational activities which will generate an equal chance to obtain employment in non-service sector related professions as well.** This recommendation endorses the commitment of the government as its policy framework recognizes that systems and mechanisms to be developed to attract women to the technical and vocational educational field.

Female Headed Households

The Household Income and Expenditure Survey 2009/10 estimates that out of 5 million households, in Sri Lanka, 1.1 million households or 23 % of the households were female headed households. The majority of female heads of the households are in the age group of 40-59 years. Among the total female heads of the households, more than 50% are widows while a small percentage (4.5%) has been reported as never married again. It is also important to note that this survey did not include **Mannar, Mullaitivu and Killinochchi**

districts as there was a massive programme on the clearance of landmines in those three districts at the time. As the latter two districts were heavily affected by the war, it is quite reasonable to accept that there will be significant proportion of female headed households although actual numbers cannot be determined at present. It is also reasonable to accept that most of these women are poor and rural. **Their specific needs should be identified and addressed.** One of the major limitations often discussed is that the current projects identify female headed households as target beneficiaries but do not address women farmers needs or those of other rural sector producers. **Various categories of women should be included in beneficiary lists where their needs are mainstreamed into policies, programmes and projects. Many internally displaced persons and refugees have been resettled or relocated; most of their livelihoods were land resource based. Therefore, they need assistance to recommence their original livelihood activities or to start new ones.** Women should be recognised as producers contributing to their household economies to ensure that they too receive resources and inputs for income generation. In this regard, the government's effort to recognize women as the head of the household in instances where she shoulders the responsibility of the family through legal provisions needs to be supported. In addition, equal right of access to productive resources such as land can further create supporting institutional framework.

Labour Force Participation

First quarter of 2011 Labour Force Survey data shows that male labour force participation was 66.2 percent while it was 33.2 for females. It suggest that **there is a huge gender gap in labour force participation by gender** as male participation was almost twice as that of females. The total number of employed persons was estimated to be 7.8 million in first quarter of 2011. Among them, 42.7 percent engaged in the services sector, 32.3 percent in the agricultural sector, and 25.1 percent in the industrial sector. Although

higher percentage of employees engaged in non-agricultural sector, majority of women were employed in agricultural sector which indicates that they may be contributing family workers. Although unemployment rate has reached a low value of 4.3 percent, female unemployment still remained high as 6.7 percent while it was 3.0 percent for males. The highest female unemployment rates were reported during the age limits of 15 to 24 years. These evidences suggest that women are expected to comply with both roles as wives and mothers that deter them from either seeking regular wage employment and/or discourage employers from enlisting women of childbearing age into the workforce. **Therefore, gender-empowerment programmes at grass-root levels need to be integrated with other employment generation programmes which will enable women to find suitable employment activities.** Such an attempt will supplement the government's effort to develop entrepreneurship culture for women in order to find new business. This will be further enhanced by expanding credit facilities, marketing and high technology to produce quality goods for commercial and export purposes.

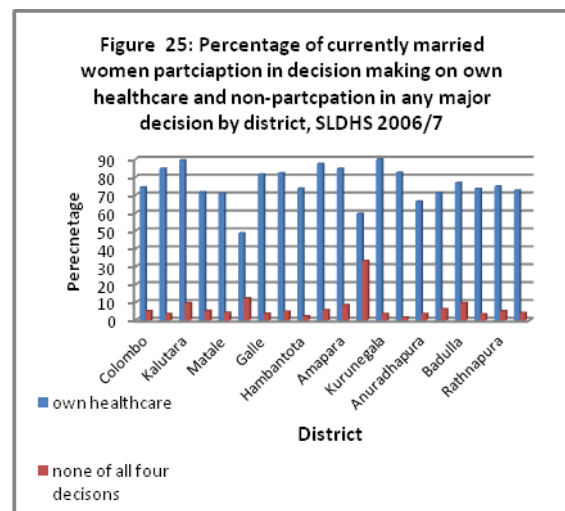
Migrant women workers

The female participation for foreign employment was 51.73 percent out of total departures of 247,119 in 2009. Most of females who departed in 2009 were housemaids and it was 89 percent of the total women migrant workers. Most strikingly, 42 percent of women who migrated as housemaids were between 30 and 44 years. This indicates that women of childbearing ages tend to utilize higher income avenues available through overseas employment. There appears to be growing evidence that the Government is unable to cope with the range and extent of rights violations of their women migrant workers. **Hence, viable programmes need to be created to support those who seek legal aid overseas while engaged in income generation activities in order to protect their rights.** Bilateral agreements with labour receiving countries

can protect the female migrant workers from economic and sexual exploitation. Furthermore, support access for child and dependent care by providing services, resources and information for working mothers can ensure proper working conditions and services for women.

Women's participation in household decision making

SLDHS 2006/7 demonstrates that 44 percent of women make joint decisions with their husbands on their own healthcare while corresponding percentages for major household purchases and visits to her family or next of kin were 58 and 65, respectively.



Source: Department of Census and Statistics, 2009

More than 20 percent of women have indicated that they have a self-autonomy to decide about their healthcare, purchasing household goods and visits to family or relatives. However, the major concern here is that one fifth of women reported that husbands alone decide about the wife's healthcare. Spatial variation is more striking, because a relatively high percentage of women in Nuwara Eliya and Trincomalee do not participate in making any of the decisions mentioned above (Figure 25). Furthermore, the percentages of women making their own healthcare decisions also vary substantially between the districts. Amongst them, the **most disadvantaged districts were again Nuwara Eliya and Trincomalee. Therefore, women empowerment programmes in these**

districts need to be strengthened in order to enhance agency and autonomy of women which includes individual empowerment like confidence, Self-esteem, Sense of agency, sense of “self”, Self-organization and management, Dignity and Collective empowerment.

Violence against women

The Gender Based Violence (GBV) Forum was established in 2005 following a consultation with selected agencies working on gender-based violence (GBV) issues, in order to facilitate greater coordination, understanding & sharing of information and resources and strengthen multi-sectoral responses to GBV. The Forum against GBV is a collective national voice facilitated by individuals, the government, United Nations agencies, national and international non-governmental organizations and community-based organizations. The primary objective is to create awareness on the issues of GBV and reduce its prevalence by engaging people from all walks of life to collectively lobby, advocate and build and strengthening networks. The media campaigns organized by the GBV forum seem very effective and the aim behind this was to convey that combating violence against women cannot be done solely by women and also to acknowledge the role men and boys have to play to ensure a safe place for women and girls.

Evidence suggests that GBV is a public health dilemma to a considerable extent in Sri Lanka as it causes a wide range of physical and mental health problems which include death and disability (Women’s Health Committee, 2007). It is a violation of human rights which put constraints on women’s opportunities in all aspects of life and hence it is costly to victims, to the family and ultimately to the society. However, GBV is not an issue just restricted to health sector alone and thus it is essential to ensure an integrated approach by linking related sectors and non-governmental organizations. In this context, strengthening health care institutions in order to identify and support the victims seems imperative. In addition, mobilizing community to understand

the health effects of GBV can make a difference because such awareness can lessen the tolerance for GBV among the community members.

Women and adolescent girls are at high risk of GBV and suffer exacerbated consequences as compared with what men undergo. They also suffer SRH consequences, including forced and unwanted pregnancies, unsafe abortions which result in deaths, traumatic fistula, and higher risks of sexually transmitted infections (STIs) and HIV. These issues are at the center of the UNFPA programming mandate.

By enacting Domestic Violence Act in 2005, the Sri Lankan government showed its commitment to eliminate gender based violence and hence, honoured the obligations under the UN convention on the Elimination of All Forms Discrimination Against Women (CEDAW). However, it has been claimed that law alone cannot achieve the expected results unless relevant implementing partners such as judiciary, the police, counsellors, medical profession, and support groups are actively involved in eliminating GBV (Wijayatilake, 2009).

It appears that 30-40 per cent of women in Sri Lanka suffer from some form of violence and domestic violence (Anderson, 2008). This is relatively high while the global population figures too reveal that every third woman is a victim of violence and approximately 40 per cent of women suffer from violence and domestic violence. However, it has been reported that ‘Sri Lankan women battered by their spouses have been seeking refuge in a law enacted... to tackle domestic violence, but activists say they need far closer protection’ (Samath, 2007). Domestic violence assistance centres can help women open out their feelings and improve relationships. The UNFPA's effort in addressing gender-based violence through its support to 14 women centres run by local NGOs in Sri Lanka is very valuable in this regard as they provide safe and accessible spaces for women and serve multiple needs through the provision of

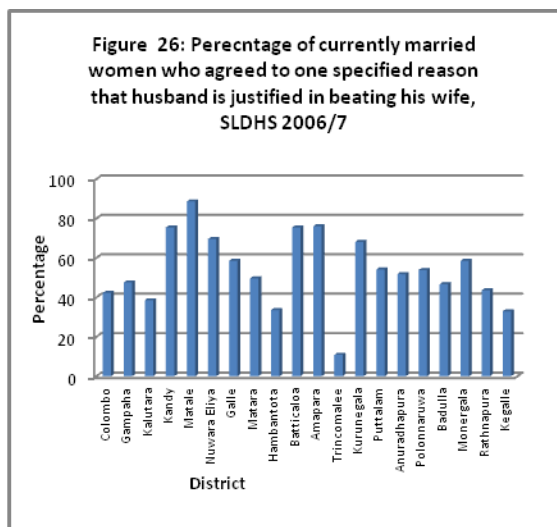
services such as counselling, legal aid, referrals to health and other services, livelihood training; information and awareness raising on women's rights, gender and gender-based violence issues and by mobilizing communities to respond to violence against women through community-based self help groups and various other community development activities.

The reasons for domestic violence vary and the immediate causes range from the trivial to machinations of in-laws, infidelity of both partners, jealousy, loss of self worth (of the aggressor), alcoholism, low or lack of education, unemployment, employment of women outside the home, financial difficulties, disputes, most commonly regarding land and congested living conditions. Whether one cause is more widespread than another is difficult to ascertain, as even the much-cited cause of domestic violence being precipitated by alcoholism does not bear out in all the studies (Deraniyagala 1992). The underlying causes for such widespread violence and abuse within the family are attributed to patriarchy and the unequal power relations that exist between women and men. The subordinate status of women and the discriminations they face, the perception of men being superior to women and socialisation, which make men and women internalise such attitudes and the gender role expectations that follow are considered to be the root causes of the violence that women have to endure. Thus, men control women's sexuality and reproductive choices, their labour and also the rewards for their labour. Women are expected to uphold cultural and family values, and act in a manner that does not bring shame on the family, especially on the spouse, father or brother. For these reasons their mobility may be restricted thus limiting their access to life's choices. The patriarchal attitudes of law enforcement agencies impact negatively on women. The authorities when confronted with even life threatening acts of violence against women in a domestic setting refuse to address them as anything other than a "private matter." Health personnel provide

medical assistance but do not probe the causes of injury. Family courts and conciliation boards exhort women to be patient and behave properly placing the onus for family harmony on the woman.

Kottegoda and Jayasundera (2004) suggest that reproductive rights and health care programmes need to accommodate more male participants, especially young men and boys in order to make a better environment to facilitate more gender equal social relationships. A pilot study conducted in Anuradhapura district in 2003 showed that 68 percent of women were subjected to some form of GBV in the form of 45 percent being verbal threats while 36 percent encountering physical beating (Senanayake, 2003). The 2006/7 SLDHS used wives being beaten as an indicator of violence against women by holding the view that husbands regarding it justifiable to be physically abusive to their wives reflects a low status of women. This accepts the fact that women who believe that a husband is justified in hitting or beating his wife for any of the specific reasons may believe themselves to having low status both absolutely and relative to men. It is believed that such a perception could function as a barrier to accessing health care for women and their children affecting their attitudes towards use of contraception and impact their general wellbeing. In the SLDHS 2006/7, women were asked whether they thought that a husband is justified in beating his wife in each five reasons: if she burns food, argues with him, goes out without telling him, neglects the children, and refuses sexual intercourse with him. It was found that 42 percent of women indicated neglect of children as the major reason followed by arguing with husband (41 percent). It is also important to note that 21 percent have agreed that a husband is justified to beat his wife when she refuses to have sexual intercourse with him. One of the most interesting evidences unearthed from this survey was that a significant number of women who have attained higher educational qualifications (42.7 percent) accepted to being victim to any form of violence against

women raised in this survey. It was observed that there is a significant variation in attitude towards wife beating but six districts namely **Matale, Kandy, Nuwara Eliya, Batticaloa, Ampara and Kurunegala** show a relatively high acceptance to wife beating (Figure 26). **This suggests that these districts need to be concentrated more in implementing gender empowerment programmes**, prevention of GBV programmes as well as engagement of men and boys to prevent GBV.



Source: Department of Census and Statistics, 2009

At present, **there is no systematic mechanism for data collection in relation to the occurrence, causes and consequences of violence against women and there are no disaggregated statistics available concerning intimate partner violence.** Research into these aspects of gender based violence is very rare in Sri Lanka. It is imperative that in addition to other efforts to eliminate gender-based violence, a national database on violence against women is developed and research undertaken to show that without the elimination of violence against women it is not possible to achieve equality, development and peace.

Incest refers to sexual activity between persons closely related by blood or marriage as defined by law or social norms. Relationships that are considered incest are defined by the Penal Code (Amendment) Act, No. 22 of 1995 or marriage regulations in Sri

Lanka. Incest carries a punishment of rigorous imprisonment for a period not less than seven years and not more than twenty years. In addition, an attempt to commit incest carries a prison sentence of up to two years. National Committee on Social Development (undated) indicates that one out of four females and one out of five males are sexually abused before reaching the age of 18 with around 75 percent of the perpetrators being family members. Since it is a growing problem, measures need to be taken to protect and assist the incest victims to overcome their psychosocial situation while bringing perpetrators before the law.

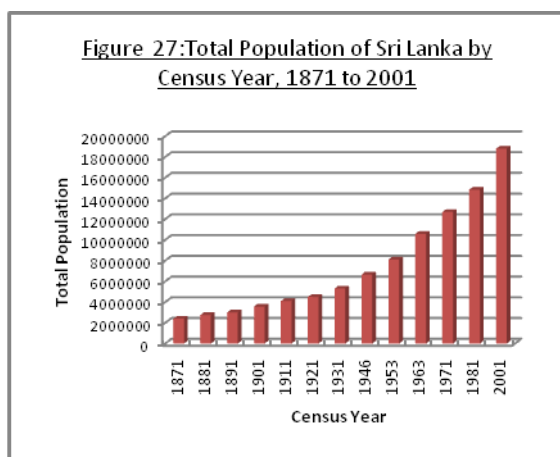
The above analysis suggests that there is a great need to strengthen institutional mechanisms and empower communities to protect the rights of women. It has been pointed out that gender has to be mainstreamed in all national and provincial projects and programmes (Jayaweera et al., 2007). In addition, senior officials of the Ministry of Child Development and Women Affairs need to be trained with appropriate skills in gender analysis and be sensitized in order to ensure equitable outcomes of the development programmes. Design and implementation of rehabilitation programmes in conflict affected areas require a multi-stakeholder approach incorporating consultative and participatory processes. References to gender equality non-discrimination and women's triple roles (productive, reproductive and community management role) must be enacted with specific policies, adequate finance and ground level action. NGOs at the grassroots level better understand women's needs that are incorporated in the projects' designs. Gender considerations must be included in the overall policy framework of rehabilitation. Collection of sex disaggregated data need to be mandatory in all projects. Periodic reviews should assess whether project objectives are being achieved and whether women are being marginalised. Follow up corrective action should be taken in consultation with beneficiaries. Senior officials and project managers should incorporate and prioritize

gender concerns at all institutions engaged in post-conflict rehabilitation. An extensive capacity building programme needs to be undertaken from the national to local level to build capacity for gender analysis. The capacity of local women’s NGOs that partner with the Government and international and national NGOs should be enhanced, and gender incorporated into their management. At the community level, gender needs to be integrated in social mobilization in which women and men become agents of change so the current gap between social and economic empowerment will be eliminated. In addition, Ministries should develop their gender action plans; strengthen gender focal points systems in order to mainstream gender into the public sector agencies.

Population and Development

Population growth trends

The growth of the total population has been declining from the 1960s coinciding with the onset of the fertility transition. However, the size of the total population of Sri Lanka has been growing at an exponential manner without showing any stabilization (Figure 27).

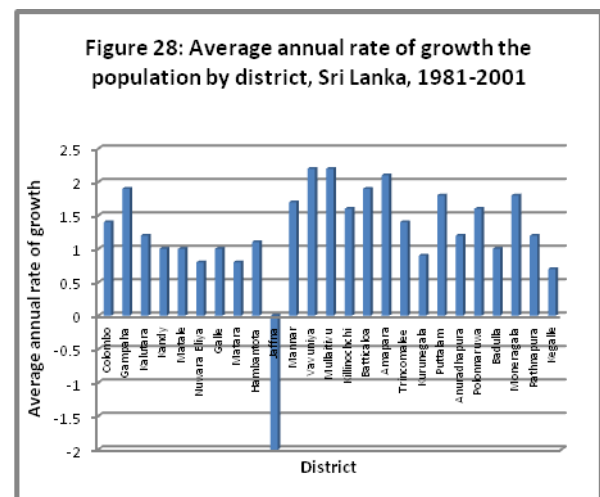


Source: Department of Census and Statistics, various census years

According to the standard projection estimates made for Sri Lanka, it appears that near zero population growth rate would be attained after the year 2021 (De Silva, 2007).

Consequently, total population size would be expected to stabilize around 21 million until the middle of the 21st century and a gradual decline thereafter. However, one has to consider a large proportion of women entering the reproductive age and the consequent in-built growth of the population in addition to factors such as the effects of the tsunami and war which may sustain such a growth pattern. **Therefore, one cannot be absolutely certain that Sri Lanka’s population would be stabilizing in 10 years time unless detailed studies are carried out on impact of tsunami and war disasters on the demography of Sri Lanka.**

Although the 2001 census did not fully cover the districts of the Northern and Eastern provincesⁱ, district-wise growth rates during the intercensal period of 1981 to 2001 demonstrates that there was a substantial spatial variation (Figure 28). **It is reasonable to expect that spatial variation in growth rates to continue at least for the next decade because of a new trend of internal migration towards the northern and eastern parts of the country stemming few years after the war and resulting increase of fertility levels.**



Source: Department of Census and Statistics

Age-sex composition

Sri Lankan population is currently ageing because the standard projection estimates made for Sri Lanka illustrates that the median age has begun to increase from 27.9 years in 2001 and to reach 37.8 years by 2026. Elderly population (60+ years) is expected to grow

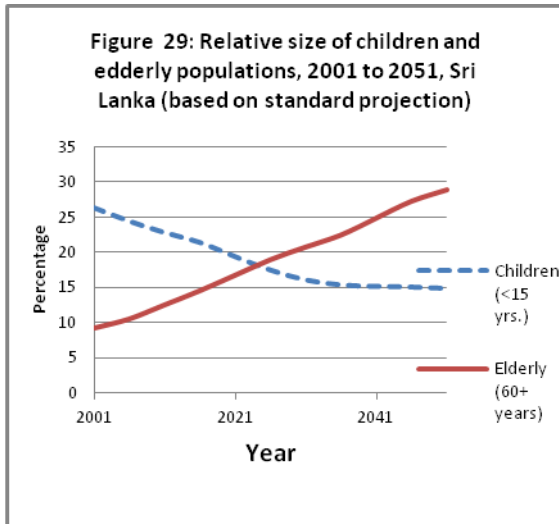
from 1.7 million in 2001 to 4.1 million in 2026, which is 141 percent increase during a 25 year time period (De Silva, 2007). On the other hand, child population is expected to decrease from 4.9 million in 2001 to 3.8 million in 2026, which is a 28 percent decline. However, the numbers of women in the childbearing ages still tend to increase slightly from 5,525,900 in 2011 to 5,584,500 in 2021 although most fecund ages (20-34) show a slight decrease during the next 10 year period. **This suggests that continuation of the programmes geared for reproductive health issues becomes still imperative during the next decade.**

Feminization of elderly and feminization of poverty: a major gender issue

Since the age structure is moving upward through time, reproductive health issues related to older women such as pre and post menopausal health issues will also turn out to be exceptionally important. Another important age-sex characteristic of the Sri Lankan population is feminization of the elderly population. With the ever increasing life expectancy for females after the 1960s, women tend to live longer than men and as a result, a larger number of women accrue at older ages. Standard population projection figures indicate that female population at the ages 60 and above will likely grow from 1,408,800 in 2011 to 2,001,200 in 2021, which is a 42 percent increase during the next 10 year time period. A woman in 2001 is expected to live, on average an additional 21.6 years, compared to 17.7 years for men (Gunasekera, 2008). This suggests that elderly women have a greater chance of exhausting their resources of income, thus making it difficult for them to bear age related expenses. Hence, elderly women will be more impoverished in their advanced ages. Although studies on population ageing in Sri Lanka have addressed issues of health and care of the elderly, other issues such as economic challenges faced by elderly women have not been examined. **A study on economic challenges faced by elderly women in the context of feminization of poverty by addressing women's longevity, marital status and employment histories on their financial**

security will provide a unique opportunity for the Government as well as non-governmental organizations working for women's welfare to devise appropriate programmes and strategies to provide appropriate elderly care.

Changes in age categories of children, labour force and elderly can have major implications for Sri Lanka's socio-economic development. Furthermore, percentages of children and elderly would approach equilibrium by the end of the first quarter of this century (Figure 29). This so-called 'window of opportunity' or 'demographic bonus'/'demographic dividend' would be available for Sri Lanka for the next decade or so, in which the proportion of the working age population becomes prominent. There are three important mechanisms that produce the demographic dividend: (1) Labour supply, the volume, age-distribution and spatial spread which, are demographic phenomenon and the quality and skills which, are owing to education and other factors; (2) savings; and (3) human capital, the quantum of which is a demographic factor and the exploitation of which is a function of social and cultural norms in which public and private sector enterprises, and small/family businesses/farms are organized (Bloom *et al* ,2003: 39-42). Asian economies strongly support the links between age-structural changes, and savings and investment, and thus fiscal capacity (Higgins and Williamson 1997). Therefore, age-structural changes are not just important for those sectors that deal with social policy, including employment and other human capital issues but also with those that deal with more financial and fiscal aspects of planning and policy (Pool, 2004).



Source: De Silva, 2007

It is also vital to use 2011 census data to investigate whether both tsunami and war have produced any unsmoothed population waves and cohort flows because such disruption can have some adverse effects on short and medium term planning. In this regard, examination of regional age-sex structures appears imperative as tsunami and war effects were mostly region-specific. Therefore, understanding and incorporation of age-structural effects into development planning in Sri Lanka seems vital in order to obtain full benefits produced by the peace dividend which can accelerate socio-economic development in the country.

Forced migration, residential mobility and increased circulation

Another forced migration stream was witnessed in Sri Lanka during the initial stage of the ethnic conflict from the Tamil dominated north and east of the country because of forced eviction of Sinhalese and Muslim population from those areas by the militant group called Liberation Tigers of Tamil Elam (LTTE) during the late 1970s and early 1980s. In addition, large numbers of Tamils also fled to Sinhalese-dominated southern districts in order to avoid the effects of war. Therefore, it is apparent that sporadic civil unrest in a country also could generate an unexpected migration stream irrespective of the decrease or increase in population numbers. Resettlement of forced migrants due to civil conflict can be considered as an

integral part of the country's social reconciliation which can protect and safeguard social harmony among the affected communities.

In Sri Lanka, a high level of residential mobility is discernible mainly in urban areas. This mainly occurred due to the frequent change of residence by employed people, married couples or families, and those who were engaged in higher education within urban areas, especially around the capital city of Colombo. Introduction of the Free-Trade Zone concept to Sri Lanka in the 1980s contributed to extend the urban periphery beyond city limits of Colombo. Towns such as *Kiribathgoda*, *Ja-ela*, *Maharagama* and *Moratuwa* began to expand due to the influx of people into these areas, inclusive of newly employed youth finding cheaper residence and lands from areas a slight distance away from the Colombo city. This situation has now extended to other urban areas in the country as well because of individuals moving from rural to urban areas starting to look for better settlement places in the outskirts of urban centers due to convenience, availability of houses and lands at reasonable prices.

It was observed that the urban to rural migration still continues and the direction has been mainly towards the Western Province where the majority of the growth is centered. During the 1996-97 and 2003-04 period the internal migration had doubled. This was mainly due to rural to urban migration and also migration stemming from the conflict affected northern and eastern parts of the country to the Western Province. Although it is not vigorous movements, a significant level of mobility is currently observed city to city and within urban agglomerations. The opening up of opportunities for business ventures due to open economic policies promoted city to city mobility among those who are involved in the business sector. The growth in the cities within the Colombo district as well as in other districts has been noticeable during the recent period. The growth in the tourism industry also substantially contributes to open up new

businesses in many cities around the country but, especially along the south-western coast. Introduction of regional universities in many locations such as, Jaffna, Batticaloa, Trincomalee, Amapara, Passara and Kuliyaipitiya also substantially increased the mobility of students and other university communities into cities around the country.

At national level, a significant movement of unskilled and semi-skilled workers from underdeveloped land to more developed land is observed due to the opening up of various types of employment opportunities including informal sector activities. It has been found that the non-farm employment has begun to increase in the country because of various reasons such as lack of productivity of farm employment and rejection of farm employment by the literate youth.

Infrastructure development taking place in larger towns also provided opportunities for the rural youth to obtain employment such as helpers to masons and carpenters etc. At the international level, unskilled and semi-skilled labour migration began after 1977 due to opening up of opportunities in the gulf regions. Huge infrastructure development projects took place in that region during the mid 1970s and 80s attracted a large number of Sri Lankan unskilled or semi-skilled men while women were recruited as housemaids. At the initial phase, the labour recruitments were facilitated by private agencies without any policy guideline of the Government but when the volume of migration became significant, the Government even set up its own Foreign Employment Bureau to manage and help the labour migrants. Gradually, South-east Asian countries also have started recruiting labour migrants from Sri Lanka.

During the recent decades, Sri Lanka started witnessing **a significant immigration or circulation of skilled professional persons from the developed countries in order to engage in various socio-economic development projects.** Either they come as a part of the development package or as recruitments by the respective donor agencies

or the Government. Massive projects such as the Hambantota Port Development, Hambantota Airport Development, construction of Norochcholai Coal Power Plant, oil exploration in the Mannar basin employ many foreign professionals who have specific skills for such projects. This trend has been increasing during later years as Sri Lanka has embarked into an accelerated developmental stage with the termination of civil war which existed for about 30 years. The country also witnessed an increase of mobility of foreign nationals because of the development activities taking place but due to catastrophes such as the civil war and tsunami disaster. The former being a man-made while the latter being natural disaster and both demanded international assistance paved the way for foreign professional to engage in various intervention programmes.

It is quite explicable that all the places in the country will not have equity in development because of its respective standing during various earlier stages of development. Therefore, some places will still remain underdeveloped. In Sri Lanka, the Western Province will develop faster than others because of its historical standing. Therefore, Sri Lanka could still expect some migration flows to the Western Province from other areas throughout the 21st century. If one hypothesizes that there can be disparity of development between areas within Sri Lanka even during the 21st century, **one may expect the current pattern of circulation also to continue further and new types of circulation to emerge.** The current transport development between India and Sri Lanka via *Thalaimannar* and *Dhanuskodi* suggests that there can be a new circulatory pattern established between Sri Lanka and southern India. This can be supported and strengthened with the signing of the Closer Economic Partnership Agreement (CEPA) between Sri Lanka and India. In addition, improved air transportation between Sri Lanka and Maldives may provide opportunities especially for the people who are engaged in the higher education and tourism sectors to involve in a new circulatory

pattern as traditionally there has been a strong association between the two countries in the higher education and tourism sectors.

Political control over international movements

It is quite logical to anticipate that some strict political control of internal as well as international movements to be imposed in Sri Lanka during the second half of this century by judging the economic growth predictions of the Government of Sri Lanka.

The Central Bank of Sri Lanka's predictions shows that the country's economy expects to grow at 7 percent per annum during the next few years¹⁰. At the same time foreign investment is encouraged to come to Sri Lanka in order to initiate more business opportunities. News paper reports at present highlight that there are 30,000 Chinese personnel are already working in Sri Lanka in various such projects¹¹. India is very much concerned about Chinese involvement in Sri Lankan projects and hence, there can be some political commitment to monitor and control immigration from the part of the Government due to continuous external political pressure. This type of action can be anticipated because there will be some involvement and a flow of migration into the country due to the oil exploration in the Mannar Basin and various other projects in the context of reconstruction activities in the previously war-torn East and North parts of Sri Lanka. It is also quite probable that Sinhalese and Muslims may look for various opportunities in the North and East parts of Sri Lanka due to the emergence of a growing economy after 30 years of civil war.

Conclusion

The present analysis will help the Government of Sri Lanka to identify emerging issues of population within the Development Policy

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http://article.wn.com/view/2010/06/07/Sri_Lanka_Forecasts_Stronger_GDP_Growth/

¹¹

<http://www.srilankaguardian.org/2010/06/violence-kyrgyzstan-concern-in-beijing.html>

Framework (Mahinda Chinthana-Vision for the Future). This is due to the fact that it correctly expects to ensure the well-being of the families through a group of specific interventions to uplift the living standards of vulnerable groups such as children, disadvantaged women, elders and the disabled, and to mainstream them into the society. Therefore, it is expected that interventions proposed in this report will help to overcome population constraints that will hinder the socio-economic development of Sri Lanka both in the short and long-term.

As overall fertility levels increase, there is a great necessity to re-visit and strengthen fertility-related policies. Estate fertility which has been lagging behind until recently has shown a clear transition, but, higher concentration on the early part of the childbearing ages, calls for RH interventions. When the estate women who have the highest fertility group in the country, are showing a steady decline of fertility, both theoretically and practically fertility of all the sub-groups of the population will converge into a similar pattern during this century. Nonetheless, there can be minor fluctuations due to natural disasters like tsunami and man-made ones such as war. These minor fluctuations are part of the adjustment processes to those specific events and are a temporary phenomenon. However, as mentioned before, specific RH needs of these groups need to be attended properly in order to assist them to bounce back towards a normal situation once more.

The government's concerted effort in strengthening women's roles in sustaining conflict affected families and communities needs to be highly recognized because, most of the population issues in the North and East are centered on displacement and resettlement. In this regard, maternal mortality, neo-natal mortality, STIs, contraceptive knowledge and use, and adolescents' sexual and reproductive health components need special attention. Programmes geared towards these areas, need to be supported and strengthened in

order to create supportive institutional framework to protect and secure the rights of women in the conflict-affected areas.

It has been pointed out in the government's policy framework that one of the main challenges in the health sector is addressing health needs of vulnerable groups. The present analysis identifies adolescents and youth, the disabled population, married women aged 25-39 with two or more children, women with anemic conditions, migrant women, and elderly women as the most vulnerable groups who need special attention in relation to their reproductive health needs and elderly health care. Therefore, it is essential to strengthen the existing health services in order to provide quality care and thus reintegrate these disadvantaged groups into the society.

Although Sri Lanka excels much better in most of its gender indicators compared to its south Asian counterparts, women's status is still constrained by low levels of participation of women in politics, the gender gap prevails in education, increasing number of female headed households, low level labour force participation, increasing incidents of rights violations of women migrant workers, gender based violence against women. Strengthening the role of women by placing them as pioneers of development by Mahinda Chinthana: Vision for the Future, and implementation of proposed activities will help to eliminate the barriers that exist for women's development.

It is imperative to understand the magnitude of the relationships between population variables and various development indicators in order to maintain the former and speed up the latter. However, there is no disaggregated data available especially in relation to gender-based violence, disabled population, and elderly care. Therefore, it is essential to support the Department of Census and Statistics and/or other agencies in relevant ministries to collect such information, develop databases and feed them into the planning process of the country.

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ⁱ In the 2001 Census out of the 5 Districts in the Northern Province, Jaffna, Kilinochchi, Mullaitivu were not covered during Preliminary and Final Census. Vavuniya and Mannar were covered partially. In the Eastern Province, Ampara was covered completely and Trincomalee and Batticaloa were covered partially. As such, estimates for the Districts and which were not covered or partially covered, are based on the information collected during the Listing and Numbering operation of the Census 2001, wherever possible, wherever the Listing and Numbering operation was also not complete the Registrar General's Estimates based on the registration of Births and Deaths, have been used.