

# Reproductive Futures in Transition: Adolescent Agency, Reproductive Choice and Resilient Sexual and Reproductive Health Systems

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## Editorial

Sexual and reproductive health (SRH) is often encountered through separate doors: a school lesson, a contraceptive consultation, an antenatal visit, an infertility clinic, a legal debate, or a public-health response after a disaster. Yet these are not separate concerns. They are connected moments in a reproductive life course, shaped by knowledge, autonomy, relationships, social conditions, and the capacity of institutions to respond. The papers in Volume 2, Issue 1 bring these links into focus. Taken together, they suggest a central theme for contemporary SRH: reproductive futures are being reshaped by rapid demographic, technological, environmental and social change, and health systems must remain both clinically safe and firmly anchored in dignity and choice. This direction is consistent with the ethical framework advanced in the previous issue of ReproSex, in which autonomy,

justice, beneficence and non-maleficence were presented as practical foundations for reproductive healthcare [1].

This issue opens with Professor Iqbal H. Shah's leading article, published in his memory and developed from his keynote contribution to ReproSex 2024. Its central argument is straightforward but far-reaching: adolescence should be treated not only as a period of vulnerability, but also as a strategic period of opportunity. Shah draws attention to the formative importance of early adolescence, the double-edged role of digital media, and the need to invest before preventable harms become established. He proposes five linked priorities: earlier engagement, stronger age-appropriate SRH education, purposeful use of digital platforms, explicit inclusion of boys and young men, and adolescent-responsive services that protect privacy and dignity [2].

The contribution is especially fitting for this issue because it reminds us that the reproductive future of a population begins long before pregnancy enters the consulting room. It begins with what young people know, what they are allowed to ask, whom they trust, and whether services are designed to meet them without judgement.

Three further papers extend this adolescent agenda from education into institutions and rights. Sana and Dissanayake review evidence from Pakistan and Sri Lanka and identify recurring weaknesses in teacher preparation, community acceptance and curriculum coherence. Their proposed five-pillar framework combines developmentally structured content, teacher training, community and parental engagement, safe-school guidance on violence and digital risks, and mechanisms for monitoring and accountability [3]. De Silva approaches the same problem from a legal perspective, arguing that comprehensive sexuality education (CSE) may be strengthened in Sri Lanka through broader judicial interpretation of the rights to life and education, supported by the Directive Principles of State Policy and international human-rights instruments, while maintaining objective and pluralistic teaching [4]. Palihawatta and colleagues then carry the discussion into higher education, where they describe persistent knowledge gaps, stigma and misconceptions among undergraduates and call for universities to provide structured orientation, credible information, counselling and stronger links to SRH services [5]. Together, these contributions position accurate, age-responsive sexuality education as a practical bridge between knowledge, rights and access to care.

The consequences of missed opportunities during adolescence are illustrated from a

regional perspective by Radhakrishnan's analysis of adolescent mothers in India using National Family Health Survey data. The study reports associations between child marriage, consanguineous marriage and adverse first-delivery outcomes, including child loss, and shows better child-survival odds among women who married at 18 years or later than among those who experienced child marriage [6]. The study should be interpreted within the limits of its cross-sectional design, but its message is important: early reproductive transitions do not occur in isolation. They are embedded in education, marriage practices, poverty, social norms and access to information. Prevention therefore requires more than clinical management after a complication has occurred; it requires action on the conditions that shape when and how young women enter marriage and motherhood.

Maternal health itself is examined through a different but equally important lens in the qualitative study by Suranga and colleagues. ReproSex previously synthesised Asian evidence showing that intimate partner violence (IPV) during pregnancy is associated with important maternal and pregnancy risks and remains insufficiently detected in many settings [7]. The new study from Nuwara Eliya moves from prevalence and association to lived experience. Through case-study interviews, the authors describe perinatal IPV as a spectrum extending beyond episodic physical assault to sexual, emotional and economic abuse and sustained coercive control. Women described restrictions affecting antenatal care, strategic and selective disclosure, reliance on trusted Public Health Midwives, crisis-driven contact with formal services, and substantial psychological and functional consequences [8]. For obstetricians and gynaecologists, the clinical implication is

difficult to ignore: an antenatal or postnatal contact is not only a biomedical encounter. When privacy, continuity, safe enquiry and referral pathways are present, it can also become an entry point to protection and support.

Fernando broadens this safety agenda from routine maternity care to disaster settings. His post-Cyclone Ditwah commentary reviews Sri Lanka's policy and institutional response to sexual and gender-based violence (SGBV) during emergencies, acknowledging recent policy advances while identifying continuing gaps in legislation, protection standards in evacuation centres, referral procedures, data systems, institutional accountability and women's participation in disaster-related decision-making [9]. The paper makes a persuasive case that SGBV prevention and survivor-centred response cannot be treated as optional additions to disaster management. Disruption of shelter, privacy, transport and health services can magnify pre-existing vulnerabilities; therefore, preparedness must include clear responsibilities, safe referral pathways and sustained resources for protection and SRH care [9].

Reproductive autonomy also includes the ability to pursue a wanted pregnancy. Athauda and colleagues explore the experiences of women who underwent subfertility treatment and subsequently achieved pregnancy at Teaching Hospital, Kurunegala. Their qualitative findings describe treatment-related discomfort, repeated attempts, financial and access burdens, anxiety and emotional strain, together with social expectations, gender roles and family dynamics that shape the treatment journey [10]. These findings resonate with the qualitative study of

couples attending infertility services in Jaffna published in the previous issue, which documented effects on marital relationships, social interaction and psychological well-being [11]. Together, these studies reinforce a clinical principle that deserves greater attention: fertility care should not be reduced to investigations, medications and procedures. Good care must also recognise the emotional, relational and financial realities through which patients experience infertility and its treatment.

The issue then turns to contraception and the changing tools available to support contraceptive choice. Karunaratne's analysis of the 2016 Sri Lanka Demographic and Health Survey examines factors associated with traditional family-planning use among ever-married women. The study identifies a combination of age, parity, education, knowledge, decision-making and contact with health services as important correlates, and notably shows that greater family-planning knowledge does not automatically translate into use of a modern method [12]. This is a useful reminder that contraceptive behaviour is not determined by information alone; preferences, perceived side effects, relationships, social context and trust in services also matter. Chamikara and colleagues look forward technologically, proposing a hybrid artificial-intelligence model that combines deterministic UK Medical Eligibility Criteria safety rules with probabilistic decision support for complex contraceptive consultations [13]. Their proposal is appropriately cautious: artificial intelligence should support, not replace, clinical judgement, and any system must be transparent, validated, protected against bias and designed around patient safety and informed choice [13].

These individual reproductive decisions ultimately contribute to population-level change, but the relationship between demography and reproductive rights requires careful handling. In Volume 1, Issue 1, de Silva and De Silva used an indirect total-birth-number method to signal that Sri Lanka was approaching an ultra-low fertility level before complete census-based fertility estimates were available [14]. In the present issue, Silva and Suranga compare that estimate with the 2024 Census age-specific fertility rates. The indirect total fertility rate (TFR) of 1.340 and the census-derived TFR of 1.325 differ by only 0.015, or approximately 1.1%, suggesting that the indirect method provided a useful early signal while not establishing equivalence across every year, district or population group [15]. More importantly, their policy discussion avoids a simplistic pronatalist response. It calls for reproductive autonomy to be protected while strengthening the conditions that allow people to realise their reproductive preferences, including infertility services, childcare, counselling, health and maternity protection, and broader social and economic support [15].

Deegodage places this national discussion within a wider global debate by describing a 'demographic squeeze' at the intersection of population ageing and the climate crisis. The commentary warns that demographic anxiety can encourage policy approaches that treat fertility as a macroeconomic instrument rather than a personal reproductive decision. In response, it argues for reproductive justice and demographic resilience: stronger care economies, dignified migration, supportive family policies, access to assisted reproduction, climate-resilient health systems and technological adaptation without reproductive coercion [16]. Whether every

proposed policy mechanism is appropriate in every country will require further evidence and context-specific evaluation, but the underlying ethical point is compelling. Low fertility, ageing and climate instability are legitimate policy concerns; they do not weaken the obligation to protect bodily autonomy.

Read together, the papers in this issue move from the classroom and university to the household, antenatal clinic, infertility service, disaster shelter, courtroom and national population debate. They also move across the life course: from the formation of knowledge and relationships in adolescence, through contraception and pregnancy, to fertility treatment and the demographic consequences of millions of individual reproductive decisions. Across these settings, a common principle emerges. Better SRH cannot be achieved through clinical technology alone, through information alone, or through population policy alone. It requires systems that connect reliable knowledge with respectful care; protect people from violence and coercion; support both the prevention and achievement of pregnancy according to individual preference; and use law, policy and emerging technologies to strengthen rather than displace human judgement and reproductive choice [1-16].

For clinical practice, this means listening as carefully to the context of a reproductive decision as to the clinical history. For public-health programmes, it means building services that remain accessible across adolescence, adulthood, pregnancy, infertility and crisis. For policymakers, it means resisting the temptation to turn demographic targets into individual obligations. And for researchers, it means

continuing to generate evidence that is locally grounded while remaining relevant to regional and global debates. As *ReproSex* enters its second volume, this issue offers a timely reminder that the future of sexual and reproductive health will depend not simply on whether systems become more advanced, but on whether they become more responsive, more resilient and more respectful of the people they are intended to serve.

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