

NATIONAL YOUTH HEALTH SURVEY 2012/2013 SRI LANKA

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National Youth Health Survey 2012/2013 Sri Lanka



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Message from the Director General of Health Services



During the past years, there has been mounting attention towards adolescents and youth globally as well as nationally. The Ministry of Health has taken several steps to enhance health of our young persons. These efforts includes, formulating Youth Health Policy, National Strategic plan on Adolescent Health and Communication strategy on Adolescent Sexual & reproductive Health; establishing Youth friendly Health centers at health institutions; facilitating multi-stakeholder involvement in decision making in the form of Technical Advisory Committee on young persons Health; Developing websites to deliver technically accurate and updated health information to youth; Developing communication materials targeting specific youth groups and enhancing capacity of health, education and youth sector officers on adolescent and youth health, etc.,

It is a very favorable time for us as the Ministry of Health to conduct a National Survey and produce a report that synthesizes information on health of young persons in Sri Lanka including young people's knowledge, life skills and behaviours related to their physical activity, substance abuse, violence, diet and sexual reproductive health. I appreciate the support rendered by the UNICEF and UNFPA in this national endeavor. I take this opportunity to thank Family Health Bureau, the technical focal point for Adolescent & Youth Health for their continuous and dedicated effort to improve health of young persons in Sri Lanka. We do hope that this report will further strengthen and support youth health initiatives, and provide a support to evaluate interventions on improving health of young persons in Sri Lanka.

Dr. P G Mahipala

Director General of Health Services

Ministry of Health, Nutrition and Indigenous Medicine

Message from the Director /Family Health Bureau



Young persons are an important client group and their health is a valuable investment for the future development of the country.

The Family Health Bureau, as the focal point for Adolescent and Youth Health in the Ministry of Health, has undertaken numerous steps to improve health of these young persons which includes capacity building of health officers, formulating a website for youth, production of series of communication materials, etc.

The National Youth Health Survey was carried out with the aim of providing an updated understanding for policy and programme planners about health issues of our young persons in Sri Lanka. All persons and organizations with a responsibility towards lives and health of young persons are requested to make use of these information to upgrade their interventions.

I really appreciate the support of UNICEF and UNFPA for their valuable technical and financial support and all the Consultants, Medical and other officers in the School & Adolescent Health Unit and Research & Development Unit in the Family Health Bureau for taking an extra effort to conduct this survey.

Dr. Hemantha Benaragama

*Director, Maternal and Child Health
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National Youth Health Survey Research Team

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EXECUTIVE SUMMARY

The overall aim of this survey was to gather information about the behaviours and needs of youth in Sri Lanka aged 15-24 years. The survey attempted to explore their general health conditions, knowledge in relation to physical, psychosocial wellbeing and behaviours and socio-economic and lifestyle factors which promotes substance use, early sexual initiation and experimentation, violence, injuries, food habits, which influence their life and that of families and the country at large.

Health and social indicators of youth in Sri Lanka has achieved a remarkable status when compared with some countries in the region. However, globalization, mechanization and commercialization will continue to mould youth lifestyles. The health authorities face an unprecedented challenge in shaping up today's youth towards healthier choices which will facilitate their optimum physical and psychosocial development. The information of the present survey is expected to help in evidence based planning targeting youth of Sri Lanka.

The survey was conducted as a stratified multistage cluster with a sample representing four strata namely Urban, Rural, Estate and North- East (N-E). Data were available for 92% of the estimated sample size (n=8118). Since the sample sizes of different strata were disproportionate to the national distribution of youth population, it was accounted by using appropriate weights in the analysis.

KEY FINDINGS

Education and productive engagement at present

The majority of the sample were Sinhalese (78.5%), Buddhists (75.4%) in keeping with the national distribution and belonged to the unmarried group (84.5%). One third of the sample were in school education while another one third were staying at home without productive involvement. The proportion of youth pursuing higher studies in the estate stratum was significantly low. In general, poor educational performance, financial difficulties and necessity to find employment were the main reasons for leaving school earlier than expected. Financial constraints and poor academic performance had contributed to the estate youth leaving school early while in addition to these conditions early marriage made North and East (N-E) youth leave school education. Nearly one third have followed a vocational training course with higher proportions in urban and rural strata. The fact that only a third of the sample were benefited by continuum of care from

school education to vocational training highlights the absence of policies and strategies to help youth, follow a pathway which would help them to be self-reliant and also contribute to the development of the country.

Family

In Sri Lanka, family plays a key role in shaping up an individual's life and evidence shows greater advantages in conducive family environment and parental supervision in reducing adolescent risk behaviours. The survey gathered information which reflect the state of youth –parent relationship and other family characteristics. Majority of youth (83%) live with their parents and one third with their grandparents. Only a minority had issues of parental separation, single parent families and high paternal deprivation which was noted among the youth from North East (N-E) areas. It was heartwarming to notice that the majority (nearly 88%) of youth perceived their families as “sweet and warm” or “good”. Of the sample, 52.4% of youth perceived that their family income was adequate, however 4.7% reported it was inadequate and had to take loans while another 1.2% revealed greater financial constraints. The survey has observed that risk taking behaviors, negative attitudes were less among youth who reported of having a caring family environment. The survey reiterates the importance of strengthening family and parental supervision in improving health and wellbeing of the youth.

Physical Health

The present survey revealed that, nearly 20-25% of youth irrespective of their sex or age, experienced acute illnesses preventing them from attending productive work during the preceding month. School absenteeism due to acute illnesses were higher among females of all strata and male estate youth. The commonest cause of acute illness was fever with or without a cough and cold (17.9%). Young males experienced injuries /accidents as one of the leading causes for absenteeism. Asthma has been the commonest chronic illness reported with 6.0% prevalence for the total sample. Significantly higher percentage of the urban (8.0%) and rural (5.9%) youth reported of asthma. Of the sample, 5.1% reported of visual and 4.0% hearing difficulties and 1.4% of walking disabilities needing some form of aids /correction. Of the present sample, 6.2% reported injuries during the preceding 12 months which needed medical attention with significant male and estate youth predominance. Commonest types of injuries were road traffic injuries (RTI) (41.5%), falls (25.1%) and sports related injuries (12.2%). Motor cycle accidents has been the major cause for RTI where half of the youth (51.4%) were reported to be either riding or travelling as a pillion rider when they had their last injury. The survey stresses the

importance of introducing routine health checks, youth specific injury prevention strategies and the health promotional programmes targeting youth.

Life styles

Adolescence and youth is considered as the most important stages of life in the prevention of non-communicable diseases. The survey revealed unhealthy nature of today's youth life styles. Nearly half of the males and three fourths of females had not engaged in manual work in the preceding week. Females in all strata were having very sedentary lifestyles. Approximately 44% of total youth were spending five or more days in the preceding week as "screen time" with a higher female preponderance. Male youth were prominently engaged in formal exercise (16%-17%) compared to 4.5% of females. These findings warrant extra efforts to inculcate active life style among youth using multifaceted approach.

Information and media

It was noted that youth do not read newspapers on a daily basis and weekend newspapers were the most popular among them, irrespective of their sex or age or strata. Nearly 30% (23.5% of males and 36.1% of females) lacked the knowledge on internet use while 17.8% of the total revealed that they did not have access to internet facilities. Although the government policy is to promote Information Technology (IT) knowledge and its use, a well-planned strategy is necessary with a special attention focusing towards estate and N-E sectors.

Nearly 80% of males and 60% of females had their own mobile phone while 16.1% reported "not using mobile phones regularly". This very same facility is becoming a social evil as shown in the survey where around 10% of youth tried to develop relationships with unknown people via mobile calls.

Knowledge and skills on Sexual and Reproductive health (SRH)

SRH related knowledge among youth was not satisfactory as nearly 50% were unaware about most aspects of basic physiology and common SRH issues. Knowledge on the SRH system of the opposite sex was poor among both males and females. With regard to knowledge on sexually transmitted infections (STI), more than half of the youth correctly identified the risk of STI even after a single sexual intercourse and 48% knew that genital ulcers can be a symptom of STI. Although the knowledge on unprotected sex and

contaminated blood as modes of transmission was good, knowledge on mother to child transmission was poor.

It was contented to see that the youth were aware on the legal age of marriage (72.6%) and the fact that having sex with an under-aged person is an offence (74.2%). However less than 5% knew about the minimum legal age a person can give consent for sexual intercourse. The reported proportions were significantly low among the estate and N-E youth highlighting the need to have specific and targeted messages on SRH Laws and policies.

Sources of SRH information differed according to sex of the youth and subject area. For puberty related issues, male youth turned to friends (46.2%) while females accessed parents (75.2%). For sexual problems, males accessed friends while females used newspapers, highlighting the necessity to use different methods in a complementary manner in programme communication, to reach wider and effective population coverage.

The police (46.5%), Public Health Midwife (22.2%) and General Practitioner (18.7%) were identified as sources of help in the case of rape. Although the recommended policy and practice is to contact the National Child Protection Authority (NCPA) hot line 1929 when such an incident takes place it appears that nearly 80% of youth were unaware of it.

The analysis of responses to scenarios given, revealed that still a considerable proportion of youth lacked essential life skills specifically in dealing with youth–parent disagreements, negotiating with intimate partners, risk taking behaviours with regard to SRH and in making important decisions in their life. Nearly 37% possessed consensus generating skills in parent-youth disagreement situations while 39.8% of youth were just obedient. Approximately half of youth had assertive skills in negotiating with their partner, 20% just obeyed and another 4.2% agreed with the partner just to sustain their relationship. Only 34.9% takes precautionary steps of informing parents about an invitation for a date, that were received from an unknown person communicated via a missed call. Around one third declared that important decisions are made after discussions with their parents and other adults, indicating superior decision making skills while another one third were over confident which was common among males and among non-schooling youth.

Interventions are much needed on empowering parents to develop their parenting and communicating skills with adolescents and youth. Each and every occasion where these

young person's come in to contact with the health services should be used to enhance their knowledge and life skills.

Diet and Nutrition

A considerable proportion of youth consumed carbonated /cola drinks, pre-cooked food and food with high salt while 5.6% of youth were taking energy formulas. In general, more boys and more urban youth were taking energy drinks and vitamins without medical advice. Only half of the youth, have heard about the BMI concept. It is important that they should be given a proper insight on the importance of having a balanced diet.

Psychosocial Health

Selected aspects of psychosocial health were explored which revealed a positive picture with regard to mood where 83.1% of youth reported a happy mood during the preceding two weeks. Reasons for worry, differed depending on the sex where boys were worried about finding a job, current job, relationship issues while girls were worried about exams, parental conflicts /family disputes. Significantly more females were having the feeling that their life is not worth living. Nearly one fifth of youth were feeling sad or helplessness and had stopped their routine work for a while, 6.4% felt like the above for two weeks or more in a row while 6.4% seriously thought about committing suicide during the preceding 12 months, 4.0% had made plans and only 3.0% sought some help. Nearly 2.3% of the total, had fights which required them to seek medical treatment during the preceding 12 months. Life skill development in youth is much needed specially in conflict management, communication and coping with stress.

Family appears to have a strong influence towards mental well-being of these 15-24 years old youth. Significantly higher proportion of youth who perceived their families as “not good or intolerable” had more suicidal feelings compared to youth who declared their family as “sweet and warm” irrespective of their family socioeconomic status. It was appealing to see that 80% declared having a social capital irrespective of their sex or age group. Males have selected friends, while females selected both friends and siblings as their social capital. It is necessary to strengthen sibling bond-ships and have useful lessons from young age onwards. Of the sample 8.1% reported of having felt discriminated at least once during their life regardless of their age or sex. The most commonly cited reason for discrimination was “income level”.

Substance abuse

The survey explored ever use and use during the preceding week (current use) with regard to smoking, betel chewing and alcohol use. In general, the current use of tobacco and alcohol remain more or less static, compared to the figures reported in the UNICEF survey in 2004.

According to the present survey, ever and current smoking was 30.5% and 17.6% for males and 1.6% and 0.7% for females respectively. Significantly more non-schooling males (23.9%) had smoked during the preceding week compared to schooling males (4.3%). Significantly higher portion of non-schooling youth were currently smoking. A caring family was significantly associated with lower current smoking. Betel chewing during the preceding week was 6.3% with a male and rural strata predominance.

Significantly more non-schooling males reported of alcohol ever use (43.4%) as well as current use (13.8%) compared to schooling males (17.0% and 2.6%). UNICEF (2004) survey reported comparable figures for non-schooling males with regard to ever and preceding week alcohol intake. A significantly higher fraction of rural youth reported of ever use and current use of alcohol, in the present survey.

Commonly cited reasons for refusal of substance by the youth were “disbelief about the effect of such substances as claimed”, “parental disapproval” and “religious norms”, irrespective of sex or schooling status. With regard to other additive substances, Babul was the most commonly tried substance among the male youth in general.

Violence in relationships: Rape, gender based violence and intimate partner violence

The reported past experience of rape among youth was 3.0%. Neighbors, relatives and strangers were abusing youth irrespective of their strata or schooling status. With regard to gender based violence, significantly more females reported unpleasant experiences with gender based harassment in public places predominantly among the urban, rural strata and among the non-schooling group. Setting barriers on relationships; blaming /scolding and physical violence by the partner were reported as experiences of intimate partner violence. All above evidence warrants the necessity of sensitizing young persons about sexual abuse and gender issues as components of SRH education.

Sexual behavior

The survey explored sexual activities among the youth which revealed, that although the majority of the youth refrained from risk behaviours related to Sexual and Reproductive Health, a considerable proportion of youth had engaged in such risky behaviours. One third of the total sample and one fifth of the unmarried youth reported in engaging in some sexual activities during the preceding year with higher proportions among the urban and rural youth. Youth had their first sexual intercourse with their regular partner or spouse (64%), girl /boyfriend (20%), relative /friend (5%), casual partner (2.7%) and with a commercial sex worker (2.3%). Of the total, 14.7% were sexually active (engaged in sexual intercourse during the preceding year) with higher proportions reported among the non-schooling youth, urban and rural youth. It was noted that 1.3% of school going youth admitted to having sexual intercourse during the preceding year. About 85% of sexually active youth, were having one sexual partner, 7.2% had two while 3.2% had three or more sexual partners. Having multiple partners and having same sex partners were significantly higher among males.

The survey assessed the assertive skills of the youth in relation to SRH using the question whether the youth had ever said “no” to sexual intercourse in their life. Of those who had the invitation to have sex, 63.2% had reported of such refusal, mainly due to “societal disapproval on pre-marital sex”, “the need to pursue higher studies”, “the risk of STI/HIV and pregnancy” while one third of the female youth highlighted “fear of losing virginity”. These positive factors should be reinforced in SRH programmes targeting adolescents and youth.

Contraceptive use and Pregnancy details

With regard to the use of condoms, 4.5% of the total youth and 30.4% of the sexually active youth, reported using condoms during the preceding year mostly with their spouse /regular partner, boy/girlfriend and commercial sex partners. The common reasons for non-use of condoms by the sexually active youth were, practicing another contraceptive method (20.8%), expecting a child (16.3%), other reasons (13.7%), non-availability of condoms (3.8%) and unawareness (3.1%). Unavailability was cited as the main reason for non-use, by the unmarried sexually active youth which reiterates the importance of making comprehensive SRH services available for unmarried youth. The use of modern contraceptive was explored. Only 40.7% of married and sexually active youth were practicing a family planning method highlighting significantly low use of contraceptives. Popular methods of contraceptives were oral contraceptives followed by Depo provera

injections. Of the sexually active youth, 9.0% had taken emergency contraceptive pills during the preceding month. Of the sample 14.6% had past pregnancies and 4.2% were pregnant at the time of survey.

Youth friendly Health Services

Nearly half of the youth (51.0%) reported the need of youth specialized health services and preferred opening times of Sunday morning and Sunday evening highlighting the importance of reorientation of health services to meet the needs of youth.



1 INTRODUCTION

BACKGROUND

Sri Lanka has invested heavily and has been successful in establishing an organized healthcare system which is delivered free of charge through a network of strong community based preventive health services which is linked to curative institutions. Free education and social protection policies have supported the health system to reap positive dividends and today the country is able to boast of excellent health and social indices; a low maternal mortality ratio considered as the best in the Asian region, low infant mortality rate, universal coverage of childhood immunization, universal coverage antenatal care, high primary school enrollment rate, high male and female literacy rate and high life expectancy. At present, Sri Lanka is facing the challenge of maintaining the hard earned achievements and focusing on several public health issues such as universal coverage of sexual and reproductive health services and increasing prevalence of non - communicable diseases which determines the well- being of youth.

The World Health Organization defines a youth as an individual between 15-24 years of age. The census conducted in 2012 reports that nearly 15.6 % of Sri Lankan population¹ comprise of approximately 3.2 million youth; for every 100 persons there are nearly 16 young people. To youth, this is a critical period of life which is characterized by a profound physical and psychological transformation and often includes sexual initiation, leaving school and entering the labour market, forming partnerships and having children. It is also a period of curiosity coupled with risk-taking behaviors which may include first-time experimentation with sex, drugs and alcohol which endangers their development, health and future lives.

It should be acknowledged that there are other factors such as school education with close bonding with teachers and friends, parental closeness and guidance, peer influences, societal norms, religious values, attitudes, financial resources, media influence, establishing connectivity through modern technology such as internet and mobile phones

¹Department of Census and Statistics (2015), Census of Population and Housing –2012 Sri Lanka : Available at : <http://www.statistics.gov.lk/PopHouSat/CPH2011/>

and accessibility and availability of health and social services have a bearing on health of these young persons.

To the government, this is a unique opportunity to reap the best out of this large youth population which has potential to contribute significantly towards the much envisioned social and economic development plans after ending the 30 year long civil unrest in the country.

The policy makers and political leaders together with the civil society have to now pay attention to maintain the hard gained health and social achievements and face the health issues of youth such as teenage pregnancies, unintended pregnancies, early sexual activity associated with low condom use, sexual violence including rape, gender base violence. Rising rates of road traffic accidents, use of drugs and alcohol, substance use, under nutrition, inequality in accessing quality healthcare, and limited access to comprehensive sexual and reproductive health information adds a wider dimension to youth related health issues.

Proper insight into the above mentioned youth health issues, which have emerged makes it a mandatory requirement to formulate strategies to suit the current situation to promote health and wellbeing of the youth. Although there is statistical data on these issues gathered from surveys and surveillance systems except for the National survey on 10-19 year old adolescents carried out by UNICEF Sri Lanka in 2004, context specific national level data on youth pertaining to the 15-24 year age group is scarce in Sri Lanka². The necessity has been raised for a national survey including Northern and Eastern Provinces that will look in to important matters related to the wellbeing of youth in all corners of the country.

In response to this need, the Family Health Bureau (FHB) decided to embark on this National Survey which could also be considered as an assessment of application of existing policies, laws and strategies and reassessing some of the indicators in the UNICEF survey (2004).

²UNICEF (2004) [National Survey on Emerging Issues among Adolescents in Sri Lanka](http://www.unicef.org/srilanka/Full_Report.pdf); available at www.unicef.org/srilanka/Full_Report.pdf

OBJECTIVES

General Objective

To obtain a profile of Sri Lankan youth in terms of selected aspects of their health, personal situations, home and environmental factors affecting their health.

Specific Objectives

1. To describe knowledge and practices/ behaviors relevant to substance use, violence, deliberate self-harm, injury, physical activity, diet and Sexual Reproductive Health, including HIV/AIDS among youth.
2. To assess the level of selected life skills among youth in relation to risk behaviors namely substance use, violence, deliberate self-harm, injury, physical activity, diet and Sexual Reproductive Health, including HIV/AIDS among youth.
3. To describe family, social and environmental factors affecting the health of youth in substance use, violence, deliberate self-harm, injury, physical activity, diet and Sexual Reproductive Health, including HIV/AIDS among youth.

METHODOLOGY

Study design -

A descriptive cross sectional study was conducted to achieve the above mentioned general and specific objectives.

Study setting -

The study was conducted island-wide, in order to elicit information which represent the following four geographical strata:

1. Urban Stratum – excluding the Northern and Eastern Provinces
2. Rural Stratum – excluding the Northern and Eastern Provinces
3. Northern and Eastern Stratum (N-E) (traditionally national surveys such as the Census and Statistics or the DHS have urban, rural and estate sectors as population strata. This survey included the N-E provinces together as a separate strata as these were the geographical localities which faced the conflict situation which lasted for almost

three decades and faced many socio-economic hardships and restricted services including education, social protection and health services)

4. Estate stratum – the six districts Nuwara Eliya, Kandy, Kegalle, Ratnapura, Badulla and Galle, where over 85% of all estate stratum youth live in, were covered in this strata.

Study population and sample:

Males and females in the age group of 15-24 years were the study population. The study sample was divided into four distinct strata. Taking into consideration the findings of previous studies, Northern and Eastern Provinces were considered together as one stratum.

Sample size:

The total sample size was 8820. Based on the distinct characteristics related to age of youth, the two age categories 15-19 and 20-24 year were studied separately.

Sample size calculation was carried out as follows:

The strata were sampled based on expected proportion of 50% to get the maximum sample size, with alpha risk of 5%, precision of estimate of 5%, non-response rate of 10%, and cluster size of 10. Sample sizes calculated for stratum 1 and 2, 3 and 4 were as follows:

Stratum 1 and 2 (Urban and rural strata): With an intra-cluster correlation of 0.2 and design effect of 2.8, the sample size for each age group of each stratum was 1200. Thus there were a total of 2400 youth for each urban and rural strata.

Stratum 3 (Northern and Eastern Provinces): With an intra-cluster correlation of 0.2 and design effect of 2.8, the sample for each age group of the stratum was 1200 youth. Therefore the total sample size was 2400.

Stratum 4 (Estate stratum): With an intra-cluster correlation of 0.1 and design effect of 1.9, 810 youth were selected for each age group. Therefore the total sample size was 1620.

A preliminary enumeration survey was carried out with the support of area Public Health Midwife (PHM) and the data collectors. All youth aged between 15 to 20 years were

identified, lists were prepared by census blocks and used as sample frameworks to select the clusters of youth randomly.

Sampling:

Youth were selected for each stratum using stratified multistage cluster sampling method, in the following manner:

Stratum 1 and 2 (Urban and Rural strata):

1. The primary sampling unit was the Divisional Secretary (DS) area, and 40 DS areas each for urban and rural strata were selected using probability proportional to size (PPS) technique. After excluding estate areas, those coming under Municipal and Urban councils were considered as the urban strata, and rest as the rural strata. For the DS areas consisting of both urban and rural areas, the urban section was categorized under the urban stratum, and the rural section under the rural stratum.
2. The secondary sampling units were the Census blocks (as used in the Census of Population and Housing 2012). For each of the urban and rural strata, 120 census blocks were selected using PPS sampling technique, from the DS divisions selected above.
3. Ten youths for each age group were selected randomly from the eligible youth list prepared for the census block selected, based on the initial enumeration survey.

Stratum 3 (Northern and Eastern Provinces):

1. The primary sampling unit was the DS area, and 40 DS areas were selected using PPS technique.
2. The secondary sampling units were the Census blocks, and 120 census blocks were selected using PPS sampling technique, from the DS divisions selected above.
3. Ten youths for each age group were selected randomly from the eligible youth list prepared for the census block selected, based on the initial enumeration survey.

Stratum 4 (Estate stratum):

1. The primary sampling units were the DS areas having estate areas in the six districts described above and 27 DS areas were selected using PPS technique.
2. The secondary sampling units were the Census blocks. 81 census blocks were selected using PPS sampling technique from the DS divisions selected above.
3. Ten youths for each age group were selected randomly from the eligible youth list prepared for the census block selected, based on the initial enumeration survey.

Stratum	Comments
Stratum- 1 – Urban Youth from 17 districts: 1-Colombo, 2-Gampaha, 3- Kalutara, 4-Galle, 5-Matara, 6-Habantota, 7-Kandy, 8-N’Eliya, 9-Matale, 10-Kegalle, 11-Rathnapura, 12-Monaragala, 13-Badulla, 14-Kurunegala, 15-Puttalam, 16-Anuradhapura,17-Polonnaruwa,	This stratum was designed to capture the general population of youth in the urban areas of the country.
Stratum- 2 – Rural Youth from 17 districts: 1-Colombo, 2-Gampaha, 3- Kalutara, 4-Galle, 5-Matara, 6-Hambantota, 7-Kandy, 8-N’Eliya, 9-Matale, 10-Kegalle, 11-Ratnapura, 12-Monaragala, 13-Badulla, 14-Kurunegala, 15-Puttalam, 16-Anuradhapura,17-Polonnaruwa,	This stratum was designed to capture the general population of youth in the rural areas of the country.
Stratum- 3 – Northern and Eastern Provinces Youth from 8 districts: 1-Jaffna, 2-Vauniya, 3-Kilinochchi, 4-Mannar, 5-Mullaitivu, 6-Batticaloa, 7-Ampara, 8-Trincomalee	This stratum was designed to capture the youth in the Northern and Eastern Provinces. Although these areas are fast catching up with the rest of the country, an understanding of their health needs is important from a programmatic point of view.
Stratum- 4 – Estate sector 1-Nuwara Eliya, 2-Kandy, 3-Kegalle, 4-Ratnapura, 5-Badulla, 6-Galle	Due to historical reasons, the health needs of the estate sector are still considered as different from the rest of the country. This stratum is designed to capture the health needs of the youth in the estate sector. Over 85% of all Estate youth live in these 6 districts.

Selection of study units from the selected Census blocks

Ten youths per each age group from each Census block selected in Step 2 were selected using the following method.

- Fifty households belonging to each Census block were first selected randomly. In the few Census blocks comprising less than 50 households, all the households were selected.
- A preliminary population enumeration within these households was carried out under the supervision of field Public Health Midwives (PHMs) by the youth volunteers selected for the data collection.
- All the youth belonging to the two age groups in the selected households were identified and two separate lists were prepared for the two age groups of 15-19 years and 20-24 year age group
- From the lists prepared, 10 each were selected randomly from each of the two age groups, using a random number table by the MOH or PHI.

Study instruments:

A questionnaire was developed by a panel of experts after conducting a literature review, to gather information relevant to the objectives outlined above. It consisted of two Parts:

- Part I- Interviewer Administered Questionnaire (IAQ) that contained sections on personal information, family history, physical health, injuries, lifestyle, sources of sexual and reproductive health (SRH) information, exposure to media, knowledge on SRH and knowledge on STI and HIV/AIDS.
- Part II- Self-administered Questionnaire (SAQ) that contained sections on income status, food habits and diet, violence, mood, family connectedness, social assets, substance use, life skills, sexual abuse and gender based violence, relationships, sexual behavior and access to health services.

Sensitive questions and confidential in nature were included in Part II. The questionnaire was pretested and necessary modifications were made before commencing the study. The approximate time taken to fill parts I and II of the questionnaire were 20 and 30 minutes respectively.

Data collection:

Selection of data collectors: Data collectors were selected from among youth in the same district with General Certificate of Education (Advanced Level) qualification. At recruitment they were explained of the nature of the survey, objectives and confidentiality of information. On average two data collectors, one male and one female were selected per each DS division. A higher number were selected for DS divisions with a larger population and/or terrain.

Training: The selected trainers were trained by the research investigators. The training included explanations and discussions on variables, role plays and mock interviews. The training focused on obtaining consent from youth and parents, communicating with youth, ways of ensuring privacy and confidentiality during completion of questionnaire, standard administration of the questionnaire and detailed review of Part I (IAQ) and part II (SAQ).

Data collection technique: The data collectors visited the households of youth selected for the survey. After introducing themselves the aim of the survey was explained to the target youth and household members present. The strict measures taken to ensure confidentiality of data including anonymity of the respondent and privacy were explained to the participants. The participants were made to understand that the questionnaire once filled and given over to the data collector cannot be traced back to the respondents as it bears no name or address of the respondent. Thereafter a suitable place was selected to conduct the interview in private where others are not able to listen or intervene in the interview. Only the selected youth and data collector of the same sex were present during administration of Questionnaire Part I. A setting was selected where only the youth was present when completing Part II, however the youth could contact the data collector for any clarification. At the end of data collection the filled questionnaires were sealed by the youth himself/herself and handed over to the data collector. Data collection was completed within two months in each DS division and supervised by trained Medical Officers of Health (MOOH), Public Health Inspectors (PHI) from the same area, Medical Officers of Maternal and Child Health (MOO-MCH) at district level as well as by members of the national team.

Analysis:

Weighted analysis was carried out to account for differential selection probabilities. Prevalence estimates were summarized as percentages along with 95% confidence intervals. EPIDATA software was used for the data base compilation. The analysis was carried out using STATA10 software.

Ethical issues:

Ethical clearance was obtained from the Ethics Review Committee of the Faculty of Medical Sciences of University of Sri Jayawardanapura. Administrative clearance was obtained from respective Provincial, Regional and Divisional health authorities. The sensitive questions in the questionnaire were designed in such a way to avoid any psychological impact on the interviewee. Informed consent of the youth was taken before the interview. In addition, the consent of the guardian was also obtained before interviewing youth less than 18 years. The voluntary nature of the data collection process was explained to the interviewee which gave the opportunity to withdraw as a respondent and extreme care was taken to maintain the identified methodological process during data collection.



2 RESULTS

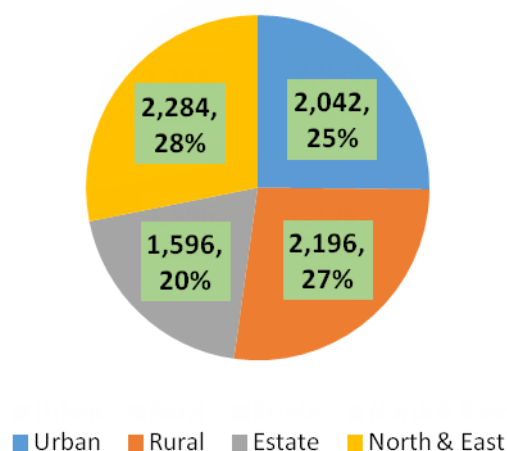
PROFILE OF THE SAMPLE

Youth, defined as the age between 15-24 years, is a critical phase of life. During this period, young persons complete their school education, start working, establish relationships and begin to pursue life with their ambitions to form a productive adult life. Unfortunately some youth have difficulties accomplishing this transition which is further complicated by modern life and complex societies. This National level survey aimed to explore different facets of youth health and associated determinants of youth aged 15 - 24 years in Sri Lanka.

SAMPLE CHARACTERISTICS

A stratified multistage cluster sample of 8118 youths were enumerated in the study. Sri Lanka was stratified into four strata considering the socio cultural characteristics of youth and geographical distribution of youth groups namely Urban, Rural, Estate and North-East (N-E).

Figure 2.1: Profile of Youth Respondents by strata (n=8118)



This was 92.0% of the estimated sample of 8820 from the 4 strata. (8.0% rejection rate). Sample sizes of different strata were not equal and disproportionate to the national distribution of youth population. This disproportion was accounted for by using appropriate weights in the analysis.

The statistics presented in the tables and figures represent these weighted figures.

The following table depict the actual numbers of youths in the country according to the national census 2012.

Table 2.1: Description of 15-24 year old population of the country, represented by the sampled subjects in different strata

Strata	Male		Female		Total
	15- 19 y	20 - 24 y	15- 19 y	20 - 24 y	
Urban	132164	131928	132074	128124	524290
Rural	548260	506082	566773	527030	2148145
Estate	32369	27340	34564	30638	124911
North and East	95789	78450	98864	84800	357903
Total	808582	743800	832275	770592	3155249

The following table presents the approximate numbers of youths represented by the sampled youths in different strata.

Table 2.2: Distribution of the sample by strata

Strata	Male		Female		Total
	15- 19 y	20 - 24 y	15- 19 y	20 - 24 y	
Urban	482	450	544	566	2,042
Rural	490	493	606	607	2,196
Estate	410	332	478	376	1,596
North and East	580	470	690	544	2,284
Total	1,962	1,745	2,318	2,093	8,118

ETHNICITY, RELIGION AND MARITAL STATUS

Sinhala ethnic group contributed for nearly three fourths of the youth population, a similar proportion was reported in 2012 census with regard to total population with 11.2% of Tamils and 9.3% of Moors.

Table 2.3: Distribution of youth by ethnicity by strata

Strata	Urban% (95%CI)	Rural% (95%CI)	Estate% (95%CI)	N-E% (95%CI)	Total% (95%CI)
Sinhala	76.0 (74.1-77.9)	93.9 (92.8-94.9)	4.3 (3.5-5.3)	15.6 (14.1-17.1)	78.5 (77.6-79.4)
Tamil	8.3 (7.1-9.5)	2.9 (2.2-3.7)	95.2 (94.1-96.2)	60.3 (58.2-62.3)	13.9 (13.2-14.7)
Muslim	15.4 (13.9-17.1)	3.1 (2.4-3.9)	0.4 (0.2-0.9)	24.2 (22.5-26.0)	7.4 (6.8-8.1)
Other	0.3 (0.1-0.6)	0.1 (0.0-0.4)	0.0	0.0	0.1 (0.1-0.3)
Total	100.0	100.0	100.0	100.0	100.0

The youth proportions representing various religious corresponded with the 2012 census, which showed a Buddhist majority, 12.6% Hindu, and 6.2% Roman Catholic.

Table 2.4: Distribution of youth by religion by strata

Strata	Urban% (95%CI)	Rural% (95%CI)	Estate% (95%CI)	N-E% (95%CI)	Total% (95%CI)
Buddhist	66.1 (64.0-68.2)	91.9 (90.6-93.0)	4.3 (3.4-5.4)	15.3 (13.9-16.8)	75.4 (74.4-76.5)
Hindu	6.5 (5.5-7.7)	2.6 (2.0-3.3)	85.8 (84.0-87.4)	50.6 (48.5-52.6)	12.0 (11.3-12.6)
Catholic/Christian	11.8 (10.5-13.3)	2.4 (1.8-3.1)	9.5 (8.1-11.0)	9.8 (8.7-11.1)	5.1 (4.6-5.6)
Islam	15.5 (14.0-17.1)	3.2 (2.5-4.0)	0.4 (0.2-0.9)	24.3 (22.6-26.1)	7.5 (6.9-8.1)
Total	100.0	100.0	100.0	100.0	100.0

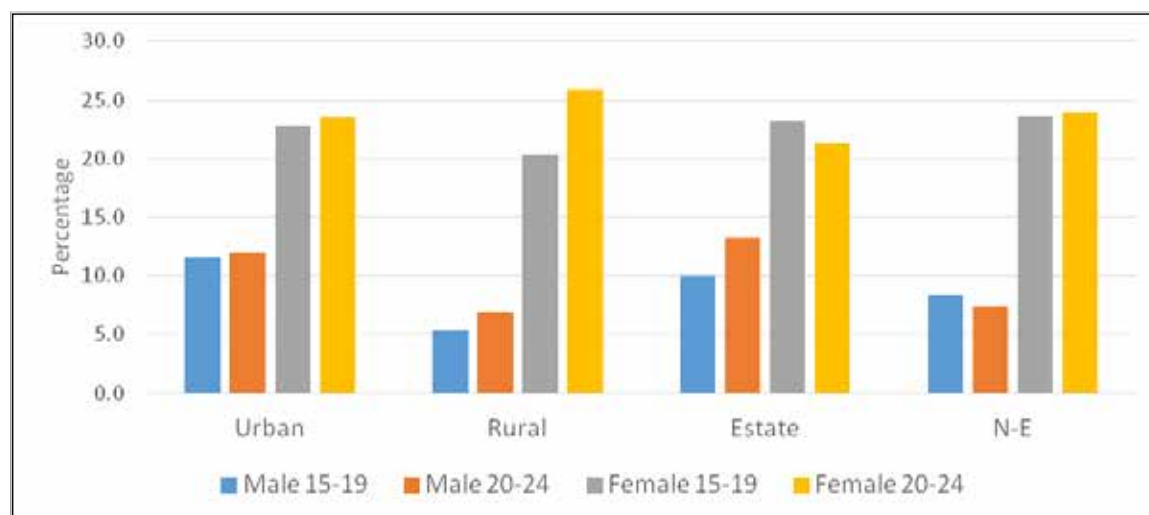
MARITAL STATUS

Table 2.5: Marital status of youths by sex and age

	Male % (95%CI)		Female% (95%CI)		Total % (95%CI)
	15-19 y	20 -24 y	15-19 y	20 -24 y	
Unmarried	93.1 (91.5-94.4)	91.9 (90.1-93.3)	78.4 (76.0-80.6)	74.8 (72.2-77.2)	84.5 (83.4-85.4)
Married	6.7 (5.6-8.5)	8.1 (6.6-9.9)	21.2 (19.0-23.6)	25.1 (22.6-27.6)	15.4 (14.4-16.4)
Divorced	0.2 (0.0-1.2)	0.2 (0.0-1.5)	0.4 (0.1-1.3)	0.0 (0.0-0.0)	0.2 (0.1-0.5)
Widowed	0.0 (0.0-0.0)	0.2 (0.0-1.5)	0.4 (0.1-1.3)	0.0 (0.0-0.0)	0.2 (0.1-0.4)
Total	100.0	100.0	100.0	100.0	100.0

Approximately 6.7% (95%CI: 5.6-8.5) 15-19 year old males have reported as married while 21% (95%CI: 19.0-23.6) for females in the same age group are married. This female sex preponderance was seen in almost all strata specifically in rural and N-E strata which was highlighted in the Census 2012 report also³.

Figure 2.2: Profile of Married youth by strata



³ Census of Population and Housing 2012 Key Findings, Department of Census and Statistics, Available at: www.statistics.gov.lk

PRODUCTIVE INVOLVEMENT OF YOUTH AT PRESENT

Table 2.6: Distribution of youth by their productive involvement in education /employment

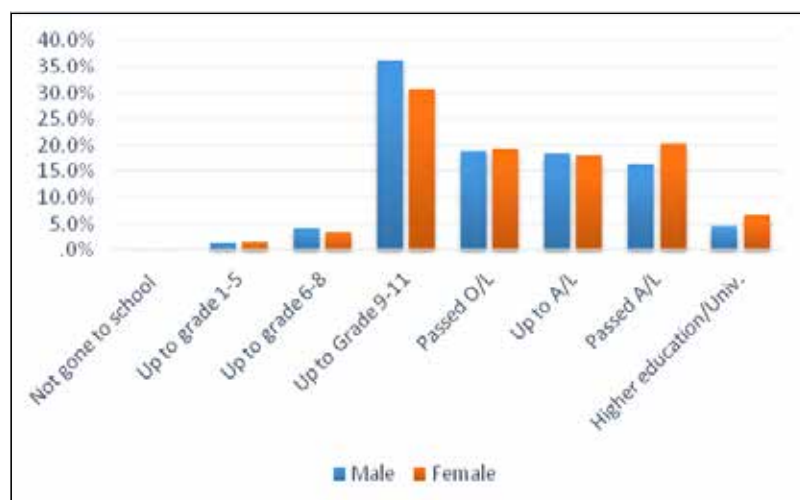
	Schooling (95%CI)	Non schooling (95%CI)						
		Higher studies	Vocat. training	Follow course	Full time job	Part time job	Stay at home	Other
Urban	28.5 (26.3-0.5)	8.2 (7.1-9.5)	4.4 (3.6-5.4)	4.6 (3.7-5.6)	15.2 (13.7-16.8)	8.6 (7.4-9.9)	29.6 (27.7-31.6)	0.9 (0.5-1.4)
Rural	31.6 (29.7-33.6)	8.1 (7.0-9.4)	3.0 (2.4-3.8)	4.4 (3.6-5.3)	9.7 (8.5-10.9)	8.4 (7.3-9.6)	33.6 (31.7-35.6)	1.1 (0.8-1.7)
Estate	25.4 (23.3-33.6)	3.5 (2.7-4.5)	3.3 (2.5-4.3)	4.3 (3.4-5.4)	20.6 (18.7-22.6)	7.8 (6.6-9.2)	34.1 (31.7-35.6)	1.1 (0.7-1.7)
N_E	26.7 (24.9-28.6)	8.1 (7.0-9.2)	5.2 (4.3-6.1)	3.2 (2.5-3.9)	10.6 (9.4-11.9)	7.2 (6.2-8.3)	37.3 (35.4-39.2)	1.8 (1.4-2.5)
Total	30.3 (28.9-31.7)	8.0 (7.2-8.8)	3.5 (3.1-4.1)	4.3 (3.7-4.9)	11.1 (10.2-12.1)	8.3 (7.5-9.1)	33.4 (32.0-34.8)	1.2 (0.9-1.5)

Among the respondents, 30.3% were still schooling. A higher percentage of rural youth were still at school whilst the lowest was in the estate sector. Only 11.1 % were engaged in full time jobs and the estate youth were the highest proportion to do so. There were also 8.3% involved in part time jobs and urban and rural youth were more than the estate and N-E youth in doing so. A third of the total sample was staying at home and the highest percentage was from the N-E sector followed by the estate sector. There were 8.0% pursuing higher studies and youth in urban, rural and N-E sectors have availed of this opportunity whilst only 3.3% of the estate youth have entered higher studies. (data not shown)

EDUCATIONAL ACHIEVEMENTS OF YOUTHS

Sri Lanka introduced free education policies from the 1940s at all levels. This has accounted for the successes in high rates of school enrollment without gender bias. The school going young persons were studying in grade 10 (22.8%), 11 (38.0%), 12 (21.6%) and 13 (17.7%). The survey questioned non-school going young persons at present about the highest educational level achieved. Nearly one third had studied up to grades 9 to11 (33.3%) while 42.2% had progressed beyond GCE O/L.

Figure 2.3: Highest Educational status achieved by non-schooling youths by sex

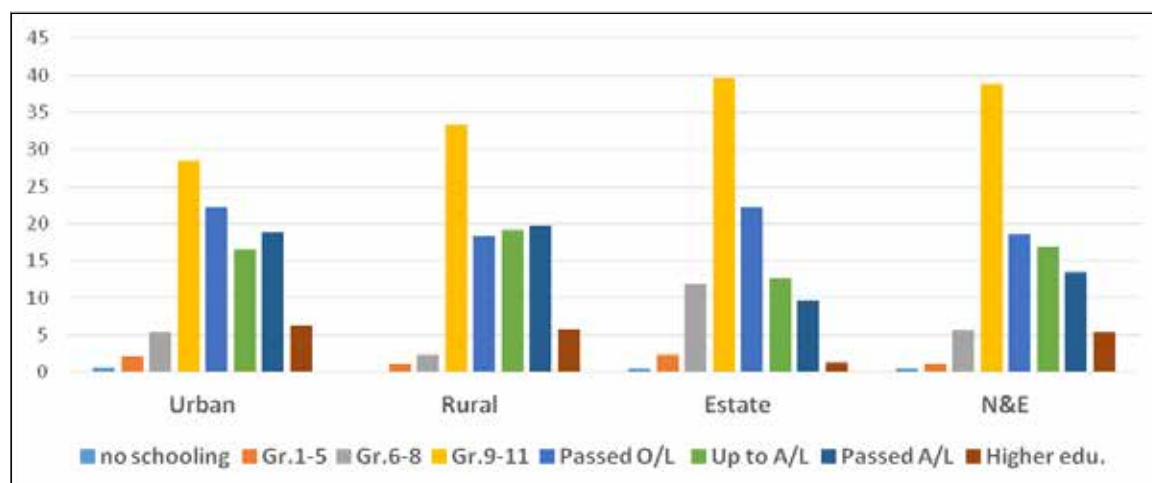


More females had pursued higher education beyond GCE A/L in urban and rural strata.

Proportion of youth pursuing higher education, was lowest in the estate stratum

The proportion pursuing higher education was significantly low in the estate stratum with 45.1% of males discontinuing their education before GCE O/L. More females tend to continue higher education beyond GCE A/L in urban and rural strata. This difference was markedly seen in the rural stratum where only 3.9 % (95%CI: 2.6-5.8) of boys entered higher education compared to 7.5% (95%CI: 5.9-9.5) of girls doing so.

Figure 2.4: Highest Educational status achieved by non-schooling youth by strata



The highest educational status achieved was assessed among the currently non-schooling youth. Most had studied up to grades 9-11 irrespective of strata. In the estate stratum those who pursued higher education was lower than the rest of the sample with equal proportions of males and females (1.3%; 95%CI: 0.7-2.7) continuing to higher education.

It was noted that in the North-East stratum more males (6.3%; 95%CI: 4.8-8.4) pursued higher education compared to females (4.3%; 95%CI: 3.1-5.8).

Reasons for pre mature school leaving

About 55.5% (95% of CI: 53.6-57.4) of currently non-schooling youths claimed that they had completed their schooling as planned. The perceived reasons for the rest of the sample to leave school early were explored. Poor educational performance has been cited as the commonest reason for early school drop -out among the total sample, followed by financial difficulties and necessity to find an employment.

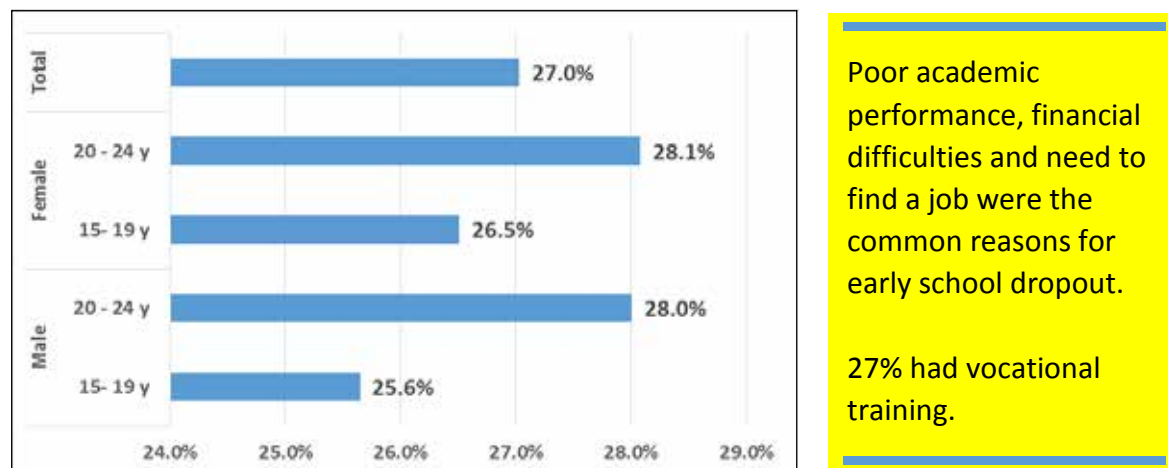
Table 2.7: Reasons for early school dropouts by strata

	Urban % (95% CI)	Rural % (95% CI)	Estate % (95% CI)	N and E% (95% CI)	Total % (95% CI)
Could not afford	6.2 (5.0-7.8)	4.8 (3.7-6.1)	18.4 (16.0-21.0)	13.3 (11.6-15.3)	6.6 (5.7-7.5)
Wanted to do a job	9.5 (8.0-11.4)	6.6 (5.3-8.2)	12.6 (10.6-14.9)	6.8 (5.6-8.3)	7.4 (6.4-8.4)
Could not do well in studies	10.2 (8.6-12.1)	9.0 (7.5-10.7)	17.9 (15.5-20.5)	24.1 (21.9-26.5)	11.3 (10.2-12.5)
Not sure	10.2 (8.6-12.0)	9.6 (8.1-11.4)	18.8 (16.3-21.4)	11.6 (10.0-13.5)	10.3 (9.2-11.5)
Suspended from school	0.2 (0.0-0.7)	0.3 (0.1-0.9)	1.0 (0.5-2.0)	0.5 (0.2-1.1)	0.3 (0.2-0.6)
Due to illness	1.6 (1.0-2.5)	1.0 (0.5-1.7)	4.0 (2.9-5.5)	1.2 (0.7-1.9)	1.2 (0.9-1.7)
Due to disability	0.5 (0.2-1.1)	0.2 (0.0-0.7)	0.2 (0.1-0.9)	0.2 (0.1-0.7)	0.2 (0.1-0.5)
Parents stopped schooling due to a love affair	0.3 (0.1-0.9)	0.3 (0.1-0.9)	1.0 (0.5-1.9)	0.9 (0.5-1.5)	0.4 (0.2-0.7)
Due to early marriage	3.4 (2.6-4.6)	2.9 (2.1-4.0)	1.5 (0.9-2.5)	6.4 (5.3-7.9)	3.3 (2.8-4.1)
Due to bullying	0.2 (0.1-0.7)	0.7 (0.4-1.4)	1.7 (1.0-2.7)	0.8 (0.5-1.5)	0.7 (0.4-1.1)
Other	2.1 (1.4-3.1)	2.9 (2.1-4.0)	2.3 (1.5-3.5)	2.9 (2.1-4.0)	2.7 (2.2-3.5)
Not relevant	55.6 (52.7-58.4)	61.9 (59.1-64.6)	20.7 (18.2-23.5)	31.1 (28.7-33.7)	55.5 (53.6-57.5)
Total	100.0	100.0	100.0	100.0	100.0

Financial constraints and poor academic performance have significantly contributed for the estate youth to leave school early. Poor academic performance and early marriage had been the major determinants for the N-E youth to leave school prematurely.

Of the sample 27.0% (95%CI: 25.7-28.4) have had a vocational training for a period of 4 months or more.

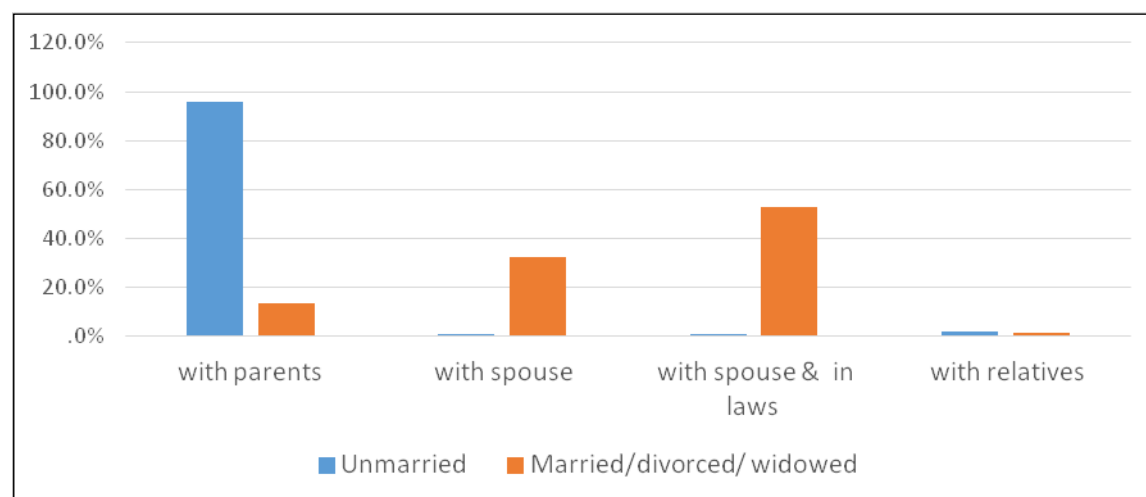
Figure 2.5: Vocational training for 4 months or more



Significant higher proportions of urban and rural youth were engaged in vocational training compared to other strata, indicating lack of opportunities or lack of awareness among youth groups in the estate and N-E strata.

FAMILY DETAILS

Figure 2.6: Living arrangements of youth

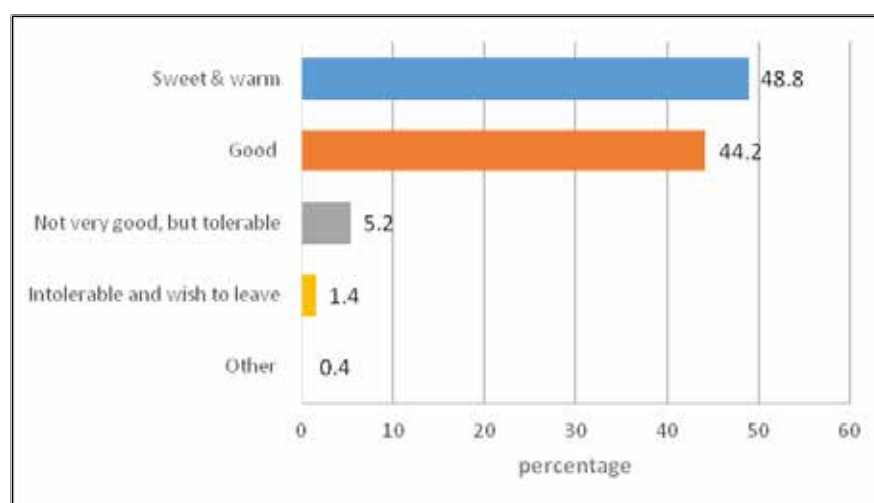


Approximately 83.1% (95%CI: 82.0-84.2) of total, 95.9% (95%CI: 95.1-96.5) of unmarried and 13.4% (95%CI: 11.1-16.1) of married youth lived with their parents. Of the married youth, 32.1% (95%CI: 28.8-35.6) lived separately with their partner /spouse while 52.8% (95%CI: 49.2-56.5) lived with their in laws. Of the total youth, 1.8% (95%CI: 1.5-2.3) were living with their relatives and nearly 30% declared, that their grandparents were living with them.

It was noteworthy that 91.7% (95%CI: 90.8-92.5) of the youth declared that their parents live in the same house and 3.0% (95%CI: 2.5-3.6) of youth reported of parental divorce /separation. Mother was in a foreign employment among 2.3% (95%CI: 1.9-2.8) of the youth while the respective figure for father was 1.1% (95%CI: 0.9-1.5).

GENERAL PERCEPTION ON FAMILY

Figure 2.7: Family characteristics as perceived by youth



49% thought that their families were “sweet and warm” while 44% as “good”.

The family plays a major role in determining health and wellbeing of young persons and a better connected family increase protective factors and reduce negative factors for youth risk behaviors. The survey evaluated youth perception about their families in general. The responses given as “sweet and warm” to denote a “caring and loving family” while “intolerable and wish to leave” was referred to the other extreme of the scale to denote the “uncaring or cold family”. It was heartfelt to notice that still majority of youth perceived their families as “sweet and warm” (49.1%) or

A significantly higher paternal loss (8.7%) compared to maternal loss (1.6%) was observed across both sexes and age groups.

0.5% of youth had lost both parents.

“good” (44.0%) regardless of their sex or age. Significantly higher proportion of the estate (60.1%) and N-E youth (58.9%) thought that their families were “sweet and warm” compared to urban (48.1%) and rural (46.5%) youth.

PARENTAL DEPRIVATION (DUE TO DEATH)

Parental death has deleterious effects on adolescent emotional wellbeing and their holistic development. Significantly more paternal deprivation was observed compared to maternal loss. Of the sample 8.7% had lost their fathers while 1.6% had lost their mothers. Of the sample 0.5% had lost both their parents.

Table 2.8: Parental deprivation due to death by strata

Status of Parental deprivation	Urban	Rural	Estate	N and E	Total
Father died	8.0 (6.9-9.3)	8.5 (7.4-9.7)	8.5 (7.2-10.0)	11.4 (10.2-12.8)	8.7 (7.9-9.6)
Mother died	1.7 (1.2-2.4)	1.5 (1.1-2.1)	2.3 (1.6-3.2)	1.8 (1.3-2.4)	1.6 (1.3-2.0)
Both mother and father died	0.7 (0.4-1.2)	0.4 (0.2-0.7)	1.3 (0.8-2.0)	0.9 (0.6-1.4)	0.5 (0.4-0.7)
Both parents alive	89.6 (88.2-90.8)	89.7 (88.3-90.9)	88.0 (86.2-89.5)	85.9 (84.4-87.2)	89.2 (88.2-90.0)
Total	100.0	100.0	100.0	100.0	100.0

Significantly high paternal deprivation was noted among the N-E youth. However the estate youth experienced more loss of mothers and loss of both parents. However the observed differences were not statistically significant.

ORPHANED YOUTH

Traumatic experiences during childhood or adolescence are associated with psycho-social ill health and behavioral disorders in later life. Living in an orphanage is considered as a traumatic experience which will have long lasting impact. The survey investigated on instances where the youth had to stay in an orphanage for more than 2 years ever in their life.

Table 2.9: Youth having lived in orphanages by strata

	Urban	Rural	Estate	N and E	Total
Having lived in an orphanage	0.9 (0.6-1.4)	0.8 (0.5-1.2)	1.8 (1.2-2.6)	1.9 (1.4-2.6)	1.0 (0.7-1.3)

There was a noticeable difference among the estate and N-E youth groups compared to other strata where they had a higher chance to live in an orphanage in their life.

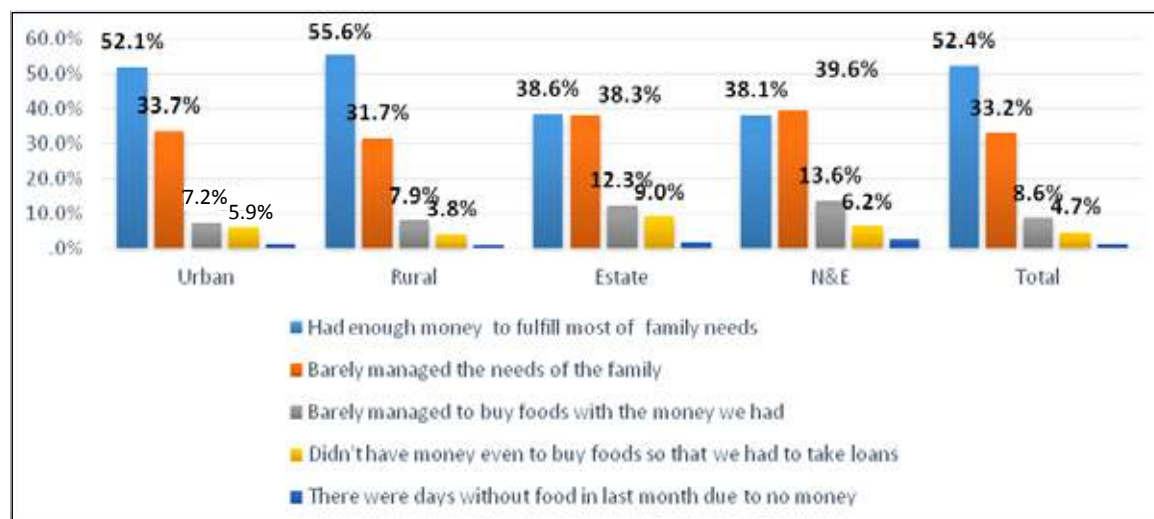
INCOME LEVEL

Evidence shows that socio-economic status is significantly associated with health outcomes of young persons. The family socioeconomic status during the preceding month was assessed as perceived by the youth.

Of the total, 52.4% of youth perceived that the “income was adequate to satisfy most of their family needs” while 33.2% revealed that “family income barely managed the needs of the family” and 8.6% reported that they could “barely manage to buy food with the money they had”. Nearly 4.7% perceived that they “did not have money to buy food, so that they had to take loans” and 1.2% as “there were days without food in the last month due to financial constraints”. Significantly lower proportions of the estate and N-E youth provided the answer as “had enough money to fulfill most family needs” compared to urban and rural youth.

A significantly lower proportions of Estate and N-E youth perceived that their family income was adequate to fulfill most of their family needs during the preceding month compared to urban and rural youth.

Figure 2.8: Family Socio-economic status during the preceding month



PHYSICAL HEALTH ISSUES

Adolescence and youth can be considered as periods of growth and development and often treated as relatively healthy stages of life. However puberty and the changes it brings, can both positively or negatively affect the health of an adolescent.

Nearly 25% of youth, despite their sex or age, have experienced acute illnesses which in turn prevented them from attending school or education or employment for one to three days during the preceding month. Females reported significantly more health related absenteeism compared to males in the respective age groups.

Table 2.10: Health related absenteeism by strata

Strata	Urban	Rural	Estate	N and E	Total
0 days	57.2 (54.9-59.3)	65.4 (63.3-67.4)	41.5 (39.1-43.9)	49.5 (47.4-51.6)	61.3 (59.8-62.7)
1-3 days	27.1 (25.14-29.1)	23.5 (21.7-25.4)	31.9 (29.6-34.3)	25.7 (23.8-27.5)	24.7 (23.4-26.0)
More than 3 days	1.6 (1.1-2.2)	2.4 (1.8-3.1)	2.0 (1.4-2.)	1.2 (0.8-1.8)	2.1 (1.7-2.6)
Cannot remember	14.2 (12.7-15.9)	8.7 (7.6-10.0)	24.6 (22.5-26.8)	23.6 (21.9-25.5)	11.9 (11.1-12.9)
Total	100.0	100.0	100.0	100.0	100.0

Health related absenteeism for 1-3 days was markedly high in the estate stratum with 31.9% (95% CI: 29.6-34.3) comparing to 27.1% (95% CI: 25.1-29.1) in urban and 23.5% (95% CI: 21.7-25.4) in rural stratum.

School going youth were having significant higher proportion of health related absenteeism for 1-3 days compared to non-schooling youth (34.8% Vs 20.1%).

Acute physical health problems during the preceding month

The survey examined the specific causes for health related absenteeism among the youth.

Table 2.11: Acute physical health problems experienced by youth during the preceding month

Health problem	Male % (95%CI)		Female% (95%CI)		Total % (95%CI)
	15-19 y	20 -24 y	15-19 y	20 -24 y	
Fever with or without cough and cold	20.9 (18.4-23.7)	17.2 (15.0-19.7)	17.5 (15.4-19.9)	16.0 (13.9-18.1)	17.9 (16.8-19.2)
Headache	4.3 (3.2-5.8)	3.4 (2.5-4.7)	5.3 (4.1-6.7)	5.2 (4.1-6.6)	4.6 (3.99-5.2)
Joint pain	0.9 (0.5-1.7)	0.6 (0.3-1.2)	1.1 (0.2-1.95)	1.0 (0.5-1.8)	0.9 (0.7-1.2)
Asthma / wheezing attacks	1.4 (0.8-2.4)	0.8 (0.4-1.6)	1.0 (0.5-1.7)	1.5 (0.9-2.4)	1.2 (0.9-1.5)
Dengue fever	0.46 (0.2-0.9)	0.68 (0.3-1.4)	0.33 (0.1-0.8)	0.54 (0.3-0.9)	0.50 (0.3-0.7)
Fits/ Epilepsy	0.19 (0.0-0.8)	0.09 (0.03-0.3)	0.06 (0.02-0.25)	0.05 (0.02-0.17)	0.10 (0.04-0.23)

(Multiple options were allowed)

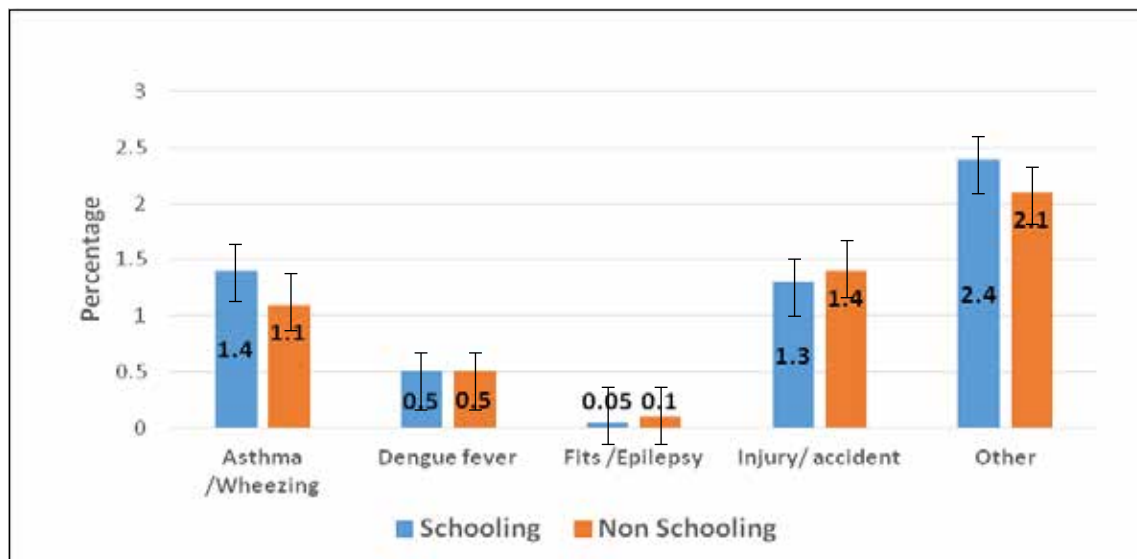
Among those who had reported as having acute illnesses which incapacitated them from engaging in productive work during the preceding month, the commonest illness associated was, fever with or without cough and cold followed by headache without sex or age difference. It was noted that the young males experienced injuries /accidents as the third leading cause for absenteeism from productive work due to illness.

Young females complained of headaches followed by joint pains and asthma /wheezing as causes for such absenteeism.

Commonest cause for health related absenteeism was, fever followed by headaches. Injuries and asthma were also causing health related absenteeism.

It was noted that injuries /accidents (1.3%), asthma /wheezing (1.3%) and dengue fever (0.5%) contributed for absenteeism in both school going and non-school going young persons in more or less equal proportions.

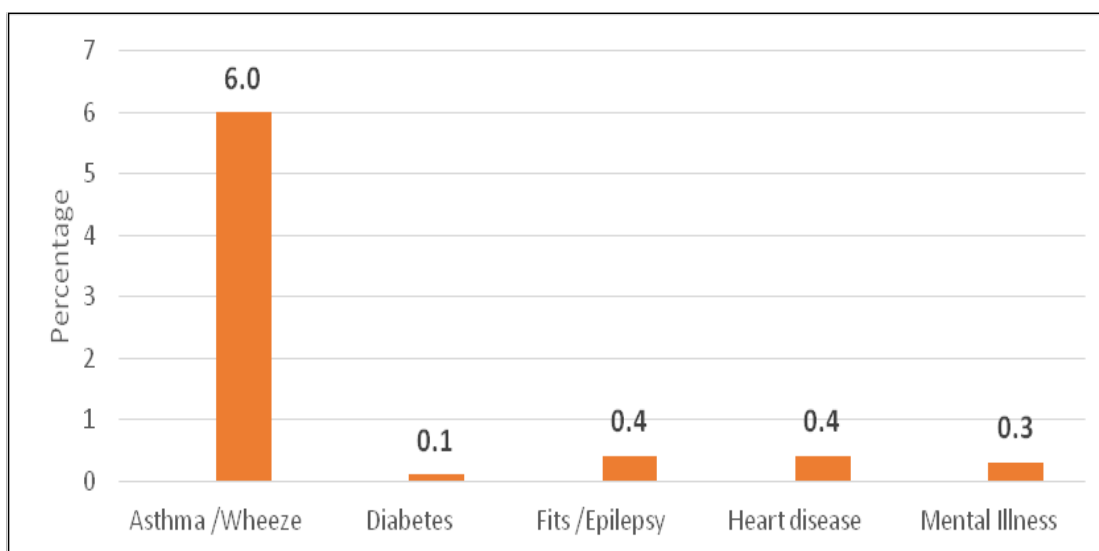
Figure 2.9: Acute Physical health Problems among youth during the preceding month by schooling status



Chronic Physical health problems

Young persons living with chronic illness have significantly more obstacles to overcome, and those health problems interfere with their day today lives and optimum development. These illnesses can exclude them from certain activities, reduce the social acceptance, give a sense of being different from peers and feelings of dependency at a time when autonomy is being developed, and cause increased absence from education or employment. The survey assessed about the presence of chronic illnesses diagnosed by an allopathic or Ayurveda doctor needing long term medication and /or clinic follow up for more than six months duration preceding the survey.

Figure 2.10: Reported prevalence of chronic diseases among youth



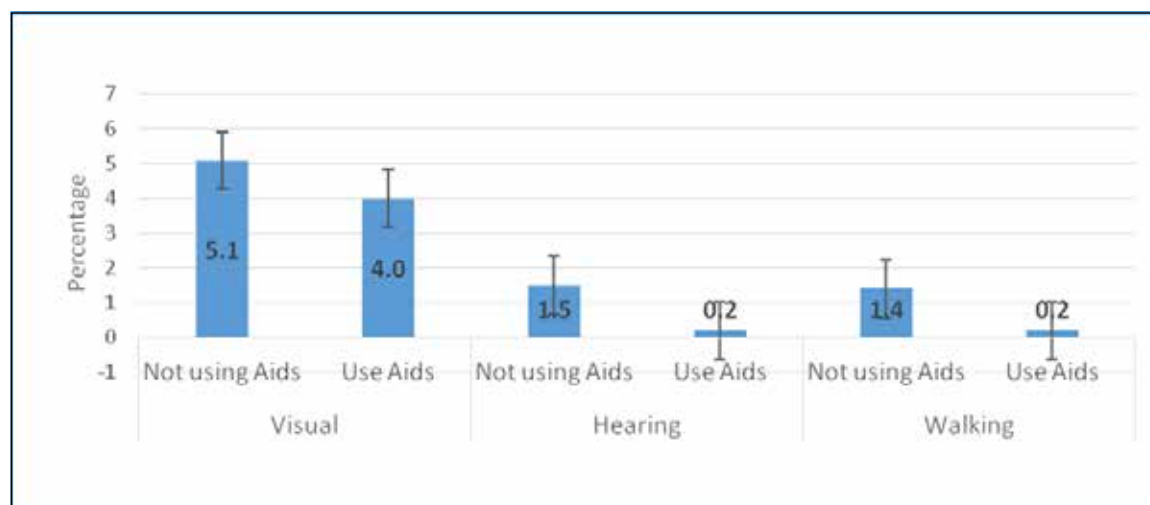
Asthma was the commonest reported chronic illness among the youth irrespective of sex or age groups. Reported Asthma prevalence for the total sample was 6.0% (95%CI: 5.3-6.7). The reported prevalence of asthma among 15-19year aged males was 7.8 % (95%CI: 6.2-9.6) while that for females was 5.2% (95%CI: 4.0-6.6). The Prevalence rate for 20-24 year old males was 4.7% (95%CI: 3.5-6.1) while for the same aged females, 6.2% (95%CI: 4.9-7.7). Urban (8.0%; 95% CI: 6.9-9.3) and rural (5.9%; 95%CI: 5.0-7.0) youth reported significantly higher proportions of asthma compared to the estate youth (2.4%; 95%CI: 1.7-3.3). The reported prevalence rates for diabetes, epilepsy, heart diseases and mental illness were 0.1% (95%CI: 0.1-0.3); 0.3% (95%CI: 0.2-0.5); 0.4% (95%CI: 0.3-0.6) and 0.3% (95%CI: 0.1-0.5) respectively.

DISABILITIES

The presence of a disability limits access to education, entertainment, employment, health care and social services. The present challenging environment with physical and psychosocial barriers prevent the youth with disabilities from living an optimal life. The survey assessed the youth for any difficulties in vision, hearing and walking and if any aids were used presently such as spectacles, hearing aids and walking aids.

Asthma was the commonest chronic illness reported by the youth

Figure 2.11: Reported disabilities among youth



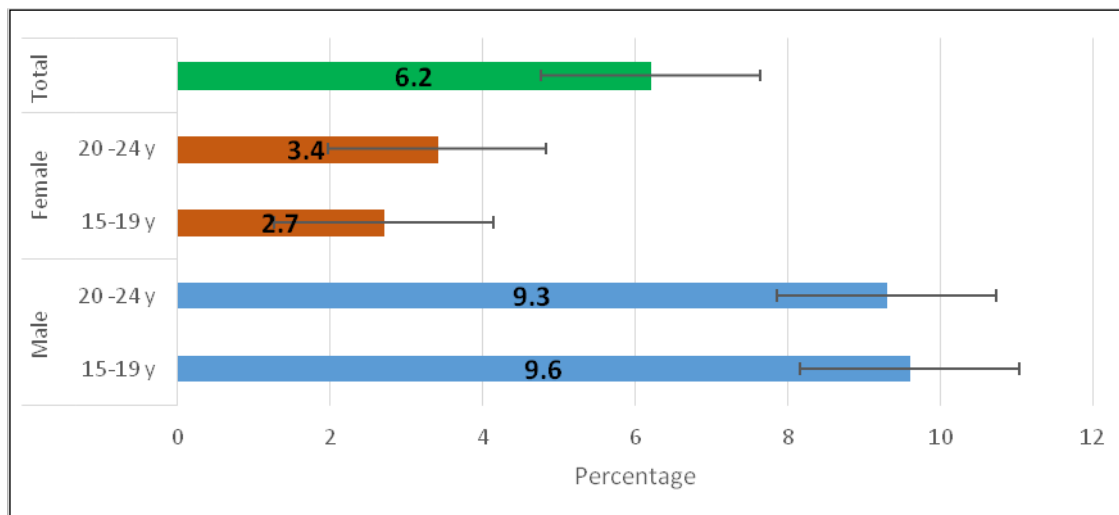
Of the sample, 5.1% reported as having visual disabilities but not using spectacles with significantly higher proportions among the rural and estate youth. Another 4.0% used spectacles for their vision problems with significantly higher proportions among the urban youth compared to other strata. Hearing difficulties were reported by 1.5% and another 0.2% used some aids for their hearing problem. Walking disabilities restricting movements was reported by 1.4%. It was noticeable that a considerable fraction of youth experienced disabilities that needed correction or aids.

The survey explored whether the participant had any difficulties in reading or writing in general. Of the sample, 2.5% declared as having a reading problem while 1.8% reported of having writing difficulties without strata difference.

INJURIES

Injuries have been rated as a leading cause of morbidity, mortality as well as disability of youth all over the world.

Figure 2.12: Prevalence of injuries requiring medical attention during past 12 months



Of the total sample, 6.2% (95%CI: 5.5-6.9) reported of injuries during the preceding 12 months which needed medical attention with a statistically significant male predominance.

There was a statistically significant difference between males and females with regard to incidence of injuries which required medical attention during the preceding 12 months.

The rate for male sex was 9.4% (95%CI: 8.2-10.8) while the rate for females was 3.0% (95%CI: 2.4-3.7). Estate youth were reporting significantly higher rate of injuries with 10.5% (95%CI: 9.0-12.1) and the lowest rate of injuries was among the rural youth with 5.8% (95%CI: 4.8-6.9). The incidence of injuries was highest among the lowest socioeconomic group, however did not gain a statistical significance.

6.2% of the youth reported of injuries during preceding 12 months. Commonest types of injuries were RTI, falls and sports related injuries. Males reported a significantly higher incidence of injuries.

Figure 2.13: Incidence of injuries requiring medical attention during past 12 months by strata

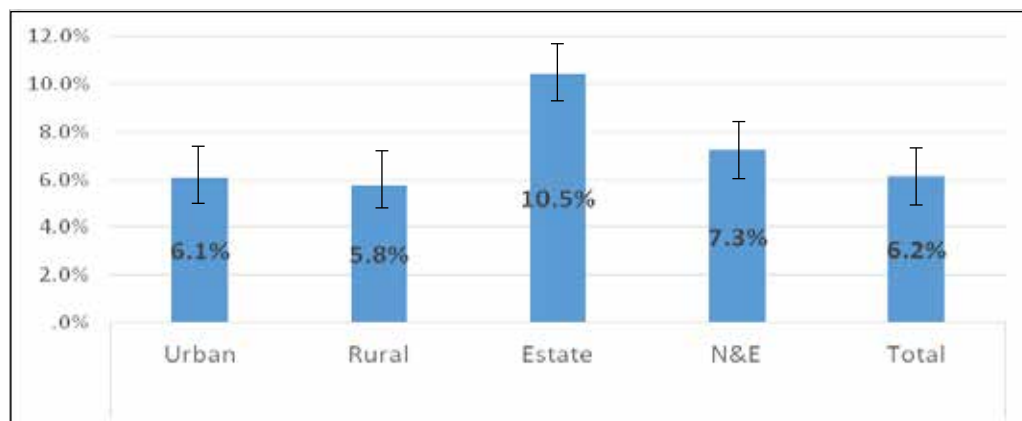
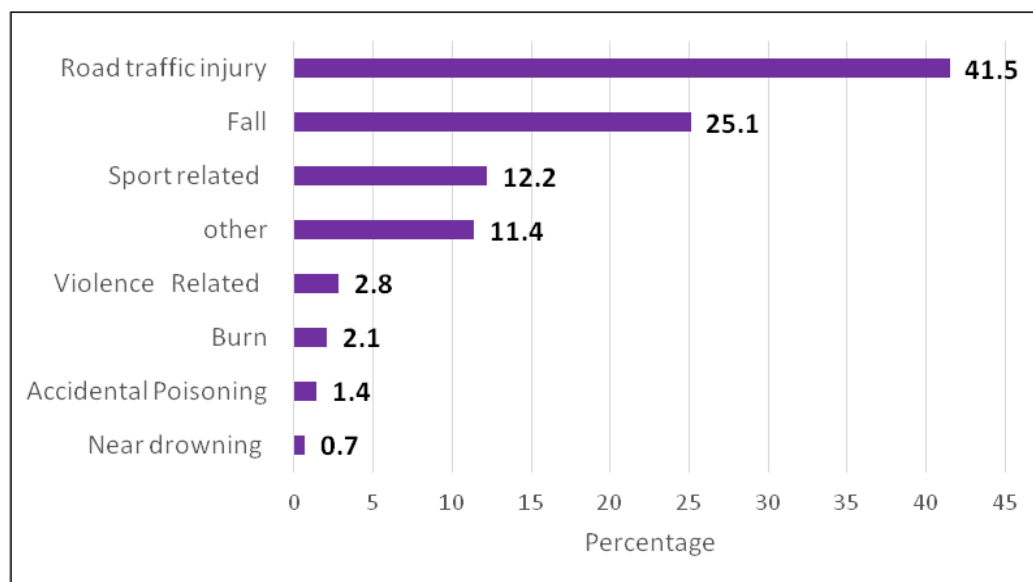


Figure 2.14: Most recent injury experienced by youth



Of those who reported as having had injuries during the preceding 12 months, the survey requested the details of the most recent injury. Forty one percent (95%CI: 35.1-47.2) reported that they had road traffic injuries (RTI), 25.1% (95%CI: 20.2-30.7) complained of accidental falls while 12.2% (95%CI: 9.1-16.3) had sport related injuries.

The RTI were significantly common among urban (37.6%) and rural (46.5%) strata compared to the estate youth (14.5%). There was no difference in experiencing RTI during the preceding 12 months according to youth's socio economic status (data not shown).

Since there was a difference in types and occurrence of injuries according to sex, a detailed analysis was carried out.

Table 2.12 : Type of most recent injury among youth

Most recent injury	Male % (95%CI)		Female% (95%CI)	
	15-19 y	20 -24 y	15-19 y	20 -24 y
Road traffic injury	42.9 (33.1-53.3)	47.3 (37.1-57.9)	39.2 (24.6-56.0)	18.3 (8.7-34.6)
Fall	26.5 (18.3-36.7)	20.5 (13.7-29.6)	18.9 (10.6-31.3)	39.9 (25.2-56.6)
Sports related	13.6 (8.4-21.1)	13.6 (8.4-21.5)	6.1 (3.0-12.3)	9.6 (3.8-22.0)
Near drowning	0.0 (0.0-0.0)	0.4 (0.1-3.1)	0.7 (0.1-4.7)	0.0 (0.0-0.0)
Burn	1.9 (0.4-9.1)	0.4 (0.1-1.8)	0.0 (0)	2.1 (0.7-6.1)
Accidental poisoning	0.1 (0.01-0.08)	0.6 (0.1-2.7)	3.3 (1.1-9.1)	6.2 (1.6-20.7)
Violence related	2.5 (0.7-8.6)	3.8 (1.2-11.4)	1.8 (0.4-7.4)	2.0 (0.6-6.7)
other	10.1 (5.2-18.6)	8.7 (4.1-17.7)	21.5 (10.7-38.3)	14.0 (5.6-30.6)
Missing	2.5 (1.3-4.9)	4.7 (1.8-11.6)	8.6 (3.0-22.4)	7.9 (2.8-20.4)
Total	100.0	100.0	100.0	100.0

It was noted that 2.8% of total sample had experienced accidental poisoning with females reporting a slightly higher proportion (4.8% of the total females).

Nearly two thirds (63.7%; 95%CI: 57.6-69.3) of those who succumbed to injuries had to refrain from their routine work for more than 3 days indicating the severity of injuries.

The survey explored from those who had RTI whether the youth was a passenger or a driver at the time of RTI. If there were more than one episode, then the question referred to the latest injury.

Table 2.13 : Type of victim when youth experienced the latest Road traffic injury (of those who had RTI)

The party of involvement in the RTI	% experiencing RTI				
	Male % (95%CI)		Female% (95%CI)		Total % (95%CI)
	15-19 y	20 -24 y	15-19 y	20 -24 y	
Pedestrian	5.3 (2.4-11.2)	11.0 (4.0-26.9)	20.0 (5.8-50.4)	33.9 (9.4-71.8)	10.9 (6.2-18.3)
Cyclist	18.1 (9.1-32.9)	12.8 (5.8-25.9)	24.2 (6.8-58.2)	2.0 (0.2-14.4)	15.7 (9.8-24.2)
Motor cyclist /passenger	56.7 (40.9-71.2)	50.5 (34.7-66.3)	29.7 (10.2-61.0)	62.2 (26.1-88.4)	51.4 (41.2-61.6)
Motor vehicle driver	7.4 (2.6-19.3)	3.8 (0.7-18.7)	0.0	2.0 (0.2-14.4)	4.8 (2.0-11.1)
Other	11.4 (4.0-28.3)	18.5 (8.7-35.3)	26.2 (8.0-59.2)	0.0	15.4 (9.0-25.0)
Missing	25.6 (16.5-37.4)	34.8 (24.2-47.1)	37.8 (22.2-56.5)	64.3 (45.3-79.7)	35.2 (28.5-42.5)
Total	100.0	100.0	100.0	100.0	100.0

Motor cycle seems to be the major cause for the youth to succumb road traffic injuries (RTI) where half of the youth reported to be either riding or travelling as a pillion rider in a motor cycle when they were last injured during the preceeding 12 months. This was followed by being a cyclist with 15.7% (95%CI: 9.8-24.2).

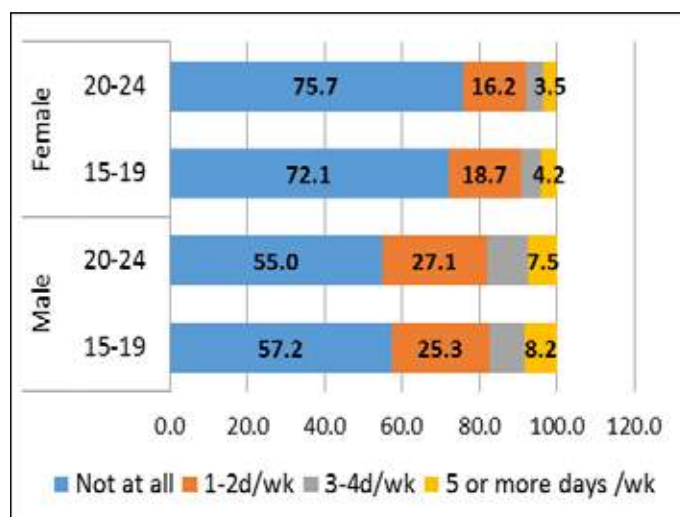
LIFE STYLES

Adolescence and youth provide a window of opportunity to inculcate healthy life style behaviors in order to prevent non-communicable disease morbidity and mortality of future adults. Active Life style and regular physical activity in adolescence are associated with number of health benefits.

Engaging in manual work

The survey examined the extent of youth involvement in manual work in their backyard or garden during the preceding week.

Figure 2.15 : Frequency of engaging in manual work during the preceding week



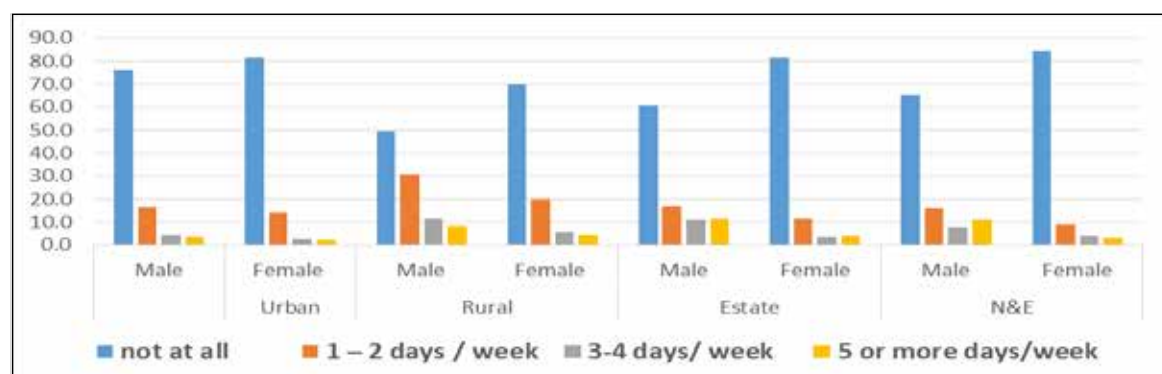
Nearly half of the males and three fourths of females had not done manual work in the preceding week.

43.8% had “screen time” for 5 or more days with higher proportions in urban and rural strata.

16-17% males were involved in formal physical exercise compared to 4.5% of females

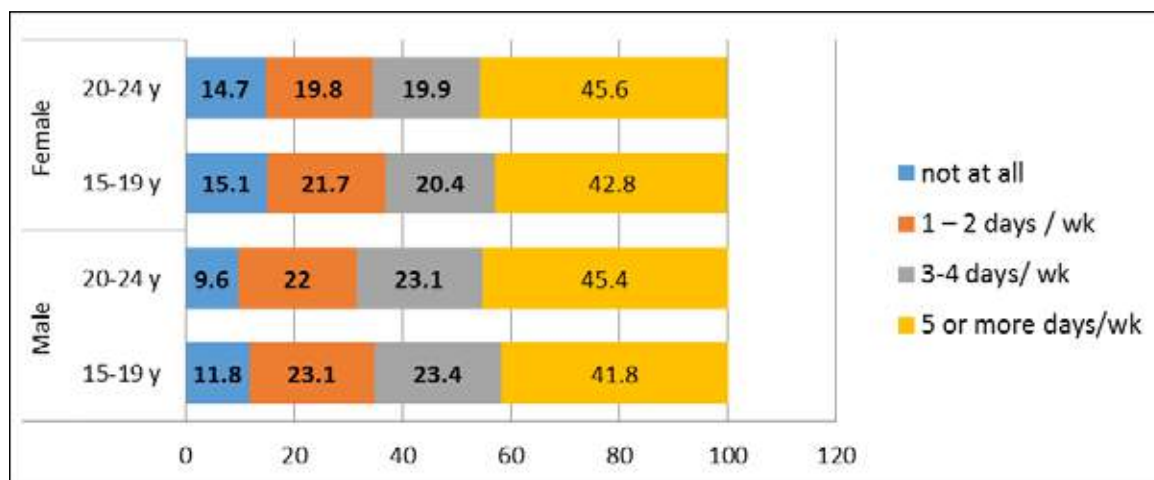
Present day youth seem to be having a more sedentary lifestyle with significantly higher female proportions in both age groups. Of the males, 57.2 % of 15-19 year olds and 55% of 20-24 year olds were not engaged in any manual work in their backyard or field during the preceding week. The respective values for females were 72.1% and 75.7%.

Figure 2.16: Frequency of engaging in manual work by youth by strata



The youth proportions engaged in manual work in the preceding week were varied significantly between strata. A significantly higher proportion of the urban males (75%) never engaged in manual work during the preceding week. The respective figures for the males in rural, estate and N-E strata were 49.5% and 60.8% and 65.4%. A similar pattern was observed with the females as well. Approximately 70% of females in the rural stratum, 80% in estate and urban strata and 84% in the N-E stratum had not engaged in manual work at all during the preceding week.

Figure 2.17: Frequency of television viewing /computer / internet use by youth



The survey assessed the “youth screen time” based on the frequency of watching television, video films, video games or internet. Of the total, 43.8% claimed that they had been involved in above activities in five or more days in the preceding week. Of the males, 41.8%-45.4% reported to have been engaged in such sedentary activities for five days or more in the preceding week. The respective proportions for females were 42.8% for 15-19 year old females and 45.6% for 20-24 year old females with low proportions among the estate youth.

Figure 2.18: Frequency of watching television /video/computer use by strata

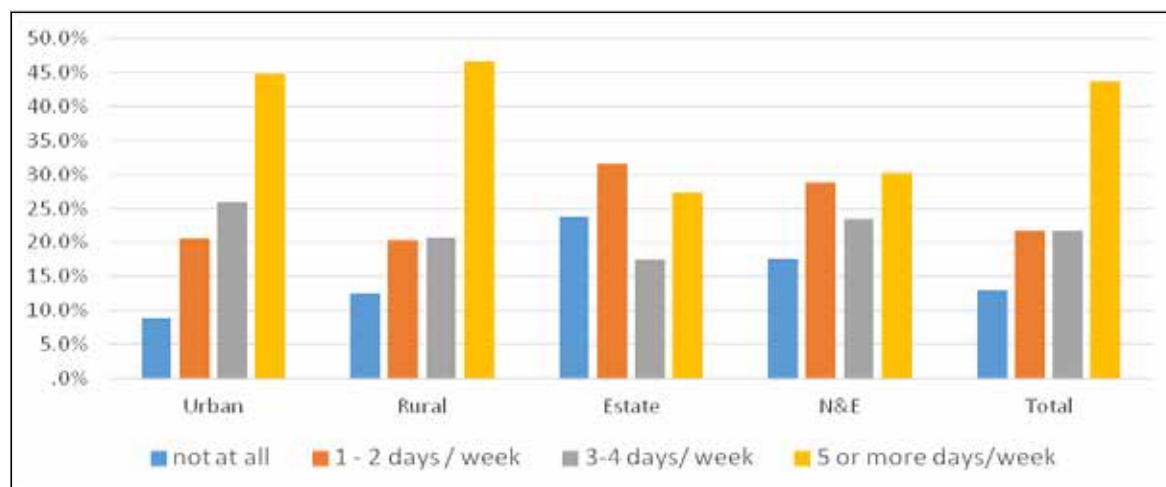
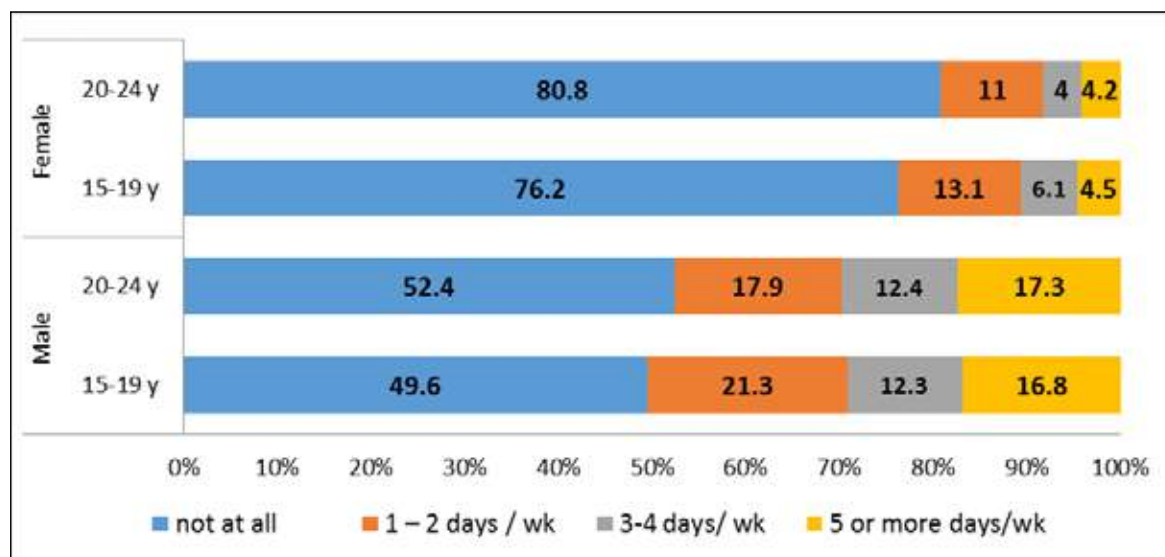


Figure 2.19: Frequency of engaging in physical exercise /sports activities by youth

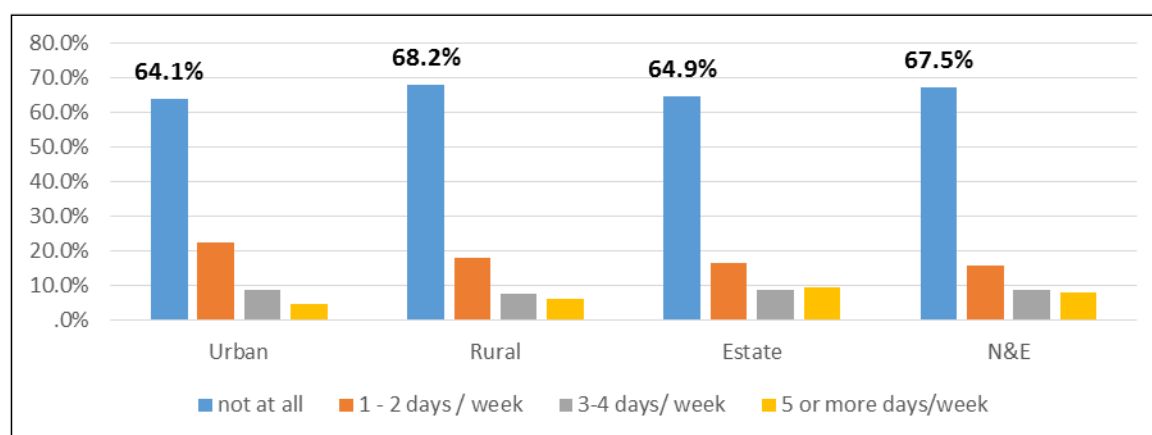


World Health Organization recommends at least 60 minutes of moderate- to vigorous-intensity physical activity daily for adolescents and at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week for adults above 18 years of age.

However, it was regret to note that present day youth do not practice recommended levels.

Male youth were prominently engaged in moderate to severe exercise including running, cycling, swimming and body building exercise (16%-17%) compared to 4.5 % of females.

Figure 2.20: Youth engagement in group sports by strata



It was disheartening to note that the majority of youth had not engaged in group sports during the preceding week, abandoning the opportunities for physical health improvement as well as for life skill development.

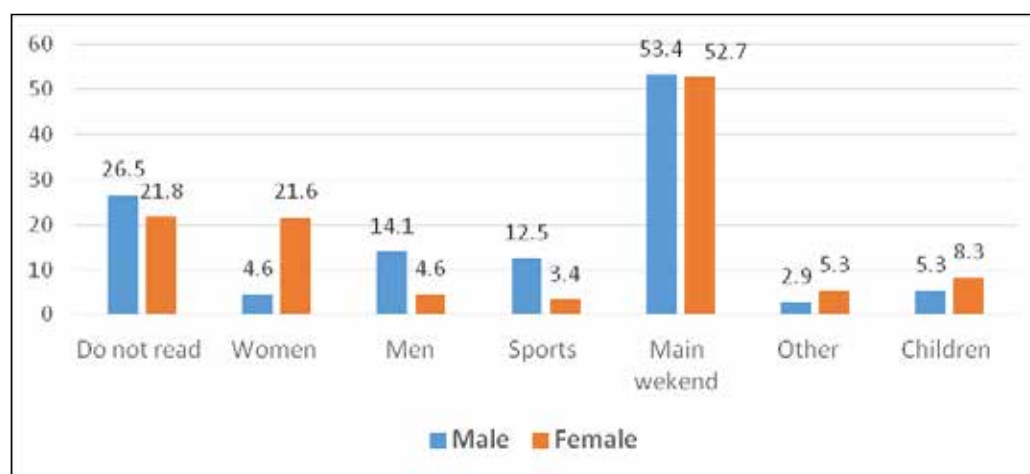
Only 10% of males and 2% of girls reported of being engaged in such group events for five days or more during the preceding week. Half of the male youth and 84.0% of female youth had never engaged in such activities during the preceding week irrespective of the strata (data not shown).

50% male and 84% female youth had not engaged in group sports in the preceding week

EXPOSURE TO INFORMATION AND MEDIA

NEWSPAPER READING

Figure 2.21: Newspaper reading among youth by sex



Nearly half of the sample read the weekend newspapers, but 26.5% male and 21.8% female youth did not read newspapers regularly. Approximately one fifth of females read women's newspapers and 14% of boys read men's newspapers without much sector difference. Weekend major newspapers were popular among nearly 50% of both sexes irrespective of strata.

26.5% male and 22% female youth were not reading newspapers regularly. Weekend popular newspapers were read by among 50% of both sexes in all strata.

INTERNET USE

Table 2.14: Internet use by youth

	Male % (95%CI)	Female % (95%CI)	Total % (95%CI)
Everyday	12.3 (11.0-13.8)	6.5 (5.6-7.6)	9.4 (8.6-10.3)
Few days a week	28.1 (26.1-30.2)	14.7 (13.3-16.2)	21.3 (20.1-22.6)
Once a week or less	20.7 (18.9-22.7)	16.8 (15.3-18.4)	18.7 (17.5-20.0)
No knowledge on internet use	23.5 (21.6-25.6)	36.1 (34.1-38.2)	29.9 (28.5-31.4)
other	2.7 (2.0-3.5)	3.0 (2.3-3.8)	2.8 (2.4-3.4)
No internet facilities	12.6 (11.5-13.9)	22.9 (21.4-24.4)	17.8 (16.8-18.8)

(Multiple options were allowed)

Information technology (IT) has become an essential requirement in everyday life of young persons. Over the last few years in keeping with globalization, the government of Sri Lanka has invested in communication networks and nearly 10% use internet daily with more males in the urban sector doing so. It was disappointing to notice that 23.5% of males and 36.1% of females still lacked the capacity to use internet. Comparatively low internet use was observed in the N-E stratum (54.2%).

Nearly 10% used internet everyday with.
23.5% of males and 36.1% of females lacked the capacity to use internet.
Nearly 80% of males and 60% of females had their own mobile phones.

MOBILE PHONE USE

The Mobile phone has become an essential device among the youth today. Nearly 80% of males and 60% of females have their own phone with little or no difference between strata or age groups. Of the sample, 14.1% declared as not having their own phone but used a family member's phone while 16.1% reported that they were not using a mobile regularly.

There was a marked difference between males and females with regard to phone ownership with higher proportions reported among males and youth in the urban strata.

The Estate youth had the highest proportion (23.6%) of “not using mobile phones regularly” followed by rural (16.4%) and N-E (16.1%) youth while urban youth reports the lowest as 13.2%.

Table 2.15: Mobile phone use by youth by strata

	Urban%	Rural%	Estate%	N-E %	Total %
“Has a own mobile phone”	73.4 (71.5-75.3)	69.1 (67.2-70.9)	60.4 (58.1-62.7)	59.2 (57.3-61.1)	68.4 (67.0-69.7)
“Uses a family members phone”	12.6 (11.2-14.1)	13.1 (11.8-14.6)	13.3 (11.7-14.9)	22.7 (21.1-24.4)	14.1 (13.0-14.9)
“Got a sim-card , use friends phone”	0.5 (0.2-0.8)	0.7 (0.4-1.1)	1.3 (0.8-1.9)	0.9 (0.5-1.3)	0.7 (0.5-0.9)
Not using a mobile regularly	13.2 (11.9-14.8)	16.4 (14.9-18.0)	23.7 (21.7-25.7)	16.0 (14.6-17.6)	16.1 (15.1-17.3)
Other	0.3 (0.1-0.6)	0.7 (0.4-1.1)	1.4 (0.9-2.1)	1.2 (0.8-1.7)	0.7 (0.5-0.9)
Total	100.0	100.0	100.0	100.0	100.0

The youth population seem to be using different mobile networks more or less in similar proportions and also more than one network. Most popular networks were Dialog (28.5%), Mobitel (27.4%), Etisalat (20.1%) and Airtel (18.1%) among total sample without a significant sex difference.

KNOWLEDGE ON SEXUAL AND REPRODUCTIVE HEALTH (SRH)

Youth need to know the basic anatomy and physiology, related to sexual and reproductive systems, to facilitate informed decision making in order to protect their health and wellbeing. Many adolescents and youth obtain necessary SRH information from poorly informed sources. Inaccurate beliefs and poor knowledge and skills can prevent young persons from accurately perceiving the potential consequences of their behavior. With the objective of assessing SRH knowledge, few questions were included, with the expected mark as “correct”, “incorrect” or “don’t know”.

Table 2.16: Youth having correct Knowledge on Reproductive biology

Knowledge item	% Having correct knowledge (95% CI)					% Don't know (of total sample)
	Male		Female		Total	
	15-19 y	20 -24 y	15-19 y	20 -24 y		
Menstruation is a process where the lining of the womb is shed periodically in every month	46.7 (43.3-50.0)	46.1 (42.8-49.5)	69.7 (67.0-72.3)	69.4 (66.7-72.1)	58.7 (57.2-60.2)	31.5 (30.0-32.9)
It is normal that menstrual process be irregular at its beginning	27.6 (24.7-30.7)	27.5 (24.6-30.6)	66.8 (64.1-69.5)	64.3 (61.5-67.1)	47.9 (46.3-49.5)	33.8 (32.3-35.3)
A girl should seek medical advice if she does not attain menarche by age 16 years	46.3 (43.0-49.7)	46.5 (43.1-49.9)	82.7 (80.4-84.8)	81.3 (78.9-83.5)	65.5 (64.0-67.0)	27.4 (26.0-28.9)
A girl should seek medical advice if her bleeding is heavy with clots and severe pain	39.3 (36.1-42.6)	41.7 (38.3-45.0)	72.2 (69.5-74.8)	71.1 (68.3-73.7)	57.2 (55.6-58.7)	32.2 (30.8-33.7)
A girl is capable of getting pregnant after she attains her puberty (first menses)	68.2 (65.1-71.2)	68.4 (65.3-71.4)	82.3 (80.3-84.2)	82.5 (80.4-84.4)	75.9 (74.6-77.1)	18.6 (17.5-19.8)
If a women / girl who used to have regular cycles, misses her menstruation it can be a sign of pregnancy	39.9 (36.7-43.3)	39.4 (36.2-42.8)	65.2 (62.5-67.9)	65.0 (62.2-67.7)	53.3 (51.7-54.9)	32.7 (31.3-34.2)
The sizes of two testicles can be different among boys and it is normal	55.8 (52.6-59.0)	58.7 (55.5-61.9)	31.4 (28.7-34.2)	32.6 (29.8-35.5)	44.8 (43.2-46.4)	43.8 (42.3-45.4)
It is common and normal for adolescent males to have nocturnal emissions (“wet dreams”)	69.8 (66.7-72.6)	72.8 (69.8-75.5)	56.9 (53.9-59.8)	57.4 (54.4-60.3)	64.3 (62.8-65.8)	29.0 (27.7-30.5)
Nocturnal emissions can weaken the body	22.3 (19.9-24.9)	20.0 (17.8-22.5)	12.1 (10.5-14.0)	11.8 (10.2-13.7)	16.5 (15.5-17.6)	52.1 (50.6-53.6)
A woman can get pregnant even at first time of sexual intercourse	47.0 (43.8-50.2)	46.2 (43.0-49.5)	45.5 (42.5-48.5)	45.7 (42.7-48.7)	46.1 (44.5-47.7)	37.9 (36.4-39.5)
Masturbation can make the body weak	30.2 (27.5-33.1)	30.0 (27.2-32.9)	18.2 (16.2-20.5)	19.1 (17.0-21.5)	24.3 (23.0-25.6)	52.8 (51.3-54.3)

The survey probed few questions on basic physiology and functions related to male and female reproductive systems expecting at least 75% of these 15-24 year olds would provide accurate responses. It was disheartening to note that overall knowledge was inadequate and the expected results were noticed with regard to only one item, “a girl is capable of getting pregnant after she attains her puberty (first menses)”.

It was noted that youth were aware of their own reproductive system, however have a limited or significantly low knowledge on reproductive system of the opposite sex. Nearly 50% of male youth reported “don’t know” for items on menstrual cycle while approximately 60-65% of girls reported “don’t know” for items on anatomy and physiology of male reproductive system.

Overall knowledge on basic SRH knowledge was not satisfactory.

Youth knew about their own system but were unaware about the systems of opposite sex.

45% of girls knew that pregnancy can occur even at the first sexual intercourse.

Half of the youth were unaware about nocturnal emission and masturbation.

Only 45.6% of girls had correctly identified that pregnancy can occur even at the first sexual intercourse. Only 53.3% of the total sample knew that missing menstruation could be a sign of pregnancy and 50% were unaware of nocturnal emissions and masturbation. Certain myths were common among both males and females in both age groups. Significantly higher fraction of married youth had reported accurate responses with regard to most of the items compared to the unmarried youth except for items on nocturnal emissions and masturbation. When analyzed according to strata, significantly lower proportion of the estate and N-E youth provided correct answers compared to others.

STI AND HIV/AIDS KNOWLEDGE

Globally, sexually transmitted infections including HIV/AIDS are becoming a major public health challenge. Sri Lanka still remains a country with a low level epidemic, around 15-24 new cases of HIV are being reported annually to the National STD/AIDS Control Program. Yet there are several socio-economic and behavioral risk factors which are present among youth, which have to be addressed to prevent the entry of the virus into the youth population. It is useful to assess the knowledge of youth regarding basic facts of STI/HIV/AIDS to strengthen the on-going prevention efforts.

It was interesting to note that 54.8% (95% CI, 53.3-56.3) of youth correctly understood that there was a risk of sexually transmitted infection even after a single sexual intercourse. However only 48.7% knew that genital ulcers can be a symptom of STI.

Table 2.17: Youth having the correct knowledge on STI, HIV/AIDS

Knowledge item	% having correct knowledge				
	Male % (95%CI)		Female% (95%CI)		Total % (95%CI)
	15-19 y	20 -24 y	15-19 y	20 -24 y	
STI					
There is a risk of acquiring STIs even after single sexual intercourse	56.0 (52.9-59.0)	57.1 (53.9-60.2)	53.4 (50.6-56.2)	52.8 (49.9-55.6)	54.8 (53.3-56.3)
Genital ulcers can be a symptom of STIs	45.8 (42.7-48.9)	49.5 (46.4-52.7)	47.8 (44.9-50.6)	52.2 (49.4-55.1)	48.8 (47.3-50.3)
HIV/AIDS					
HIV/AIDS is transmitted by unprotected sexual intercourse (sexual intercourse without using a condom)with an HIV/AIDS infected person	68.4 (65.4-71.2)	72.3 (69.4-75.0)	66.9 (64.3-69.5)	67.7 (65.0-70.3)	68.7 (67.4-70.1)
HIV/AIDS can be transmitted from infected pregnant mother to her child.	54.9 (51.8-58.0)	58.3 (55.1-61.4)	62.4 (59.7-65.1)	62.7 (59.9-65.4)	59.6 (58.1-61.0)
HIV/AIDS is transmitted by HIV infected blood	66.3 (63.3-69.2)	68.3 (65.3-71.2)	68.3 (65.7-70.9)	69.5 (66.8-72.0)	68.1 (66.7-69.5)
HIV/AIDS cannot be transmitted from infected mother to child through breast feeding	29.2 (26.4-32.1)	29.0 (26.2-32.0)	34.7 (32.0-37.5)	33.4 (30.7-36.1)	31.6 (30.2-33.0)
A healthy looking person can be infected with HIV, the virus that cause AIDS	57.4 (54.3-60.4)	57.5 (54.4-60.6)	61.7 (59.0-64.3)	60.5 (57.8-63.2)	59.3 (57.9-60.8)
HIV/AIDS is not transmitted by sharing unsterilized needles and syringes	65.2 (62.3-68.1)	64.9 (61.9-67.7)	66.8 (64.2-69.3)	67.9 (65.2-70.4)	66.2 (64.8-67.6)

HIV/AIDS is not transmitted by sharing cups and plates with HIV infected person.	62.7 (59.7-65.7)	61.8 (58.7-64.7)	64.0 (61.3-66.6)	64.8 (62.1-67.4)	63.3 (61.9-64.7)
HIV/AIDS is transmitted by mosquito bites	57.1 (53.9-60.1)	56.4 (53.2-59.5)	55.2 (52.4-58.0)	54.6 (51.8-57.4)	55.8 (54.3-57.3)
People can protect themselves from HIV/AIDS by using condoms correctly every time they have sex	53.5 (50.4-56.6)	55.6 (52.4-58.7)	42.4 (39.6-45.2)	44.1 (41.1-46.9)	48.8 (47.3-50.3)
Drugs are available to prevent HIV/AIDS transmission from infected mother to child	19.9 (17.5-22.4)	19.8 (17.6-22.3)	19.8 (17.6-22.1)	21.7 (19.4-24.1)	20.3 (19.1-21.5)
Transmission of HIV/AIDS can be prevented by having sexual intercourse with only one mutually faithful partner	60.0 (56.9-63.0)	64.6 (61.5-67.5)	63.1 (60.3-65.7)	63.6 (60.9-66.3)	62.8 (61.3-64.2)
HIV/AIDS can be diagnosed accurately by a specific blood test	66.7 (63.7-69.5)	68.3 (65.3-71.1)	70.2 (67.6-72.6)	70.4 (67.7-72.8)	68.9 (67.5-70.2)

With regard to knowledge on transmission of HIV, 68.7% and 68.1% knew that, unprotected intercourse with an HIV infected person and infected blood were modes of HIV transmission. Nearly 60% knew that, an infected mother is able to transmit the virus to the baby, females in both age groups had a better knowledge than males. Only 31.6% of the total knew that breast feeding is a source of infection and there was no difference between males and females in both age groups. Almost 60% were aware that a healthy looking person could be infected with HIV.

Misconceptions about HIV/AIDS still remains among youth, despite accurate facts on HIV/AIDS have been disseminated via several modes of communication to general public.

Almost half of the respondents (55.8%) had incorrect knowledge that HIV is transmitted by mosquito bites. Only 63.3% were aware that HIV is not transmitted by sharing cups and plates with an infected person.

Regarding methods of prevention, 62.8% knew that mutual monogamy is a method of prevention of HIV. Only 48.8% knew that consistent condom use is a method to prevent HIV and males in both age groups had a better knowledge than female counterparts. Although use of anti-retroviral drugs during pregnancy is able to reduce HIV transmission

from mother to child, only 20.3% knew about the availability of such drugs to prevent mother to child transmission. Nearly 69% knew that there is a specific blood test to diagnose HIV infection. Overall assessment showed that estate and N-E strata youth were having lower knowledge.

GARP score was constituted to assess the percentage of young women and men aged 15-24 who correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission. “Don’t know” answers were categorized as incorrect answers in the analysis.

The score was calculated using five items namely; a healthy looking person can be infected with HIV, the virus that cause AIDS; HIV/AIDS is transmitted by sharing cups and plates with HIV infected person; HIV/AIDS is transmitted by mosquito bites; HIV/AIDS is not transmitted by sharing unsterilized needles and syringes, People can protect themselves from HIV/AIDS by using condoms correctly every time they have sex. The overall score was 8.3% for the total sample. The scores for urban, rural, estate and N-E youth were 9.5%, 8.1%, 8.5% and 8.0% respectively. The younger age group males and females performed poorly. The scores for males and females in the 20-24 years were higher than the respective counterparts.

Table 2.18: GARP score by age and by sex

	Male (95%CI)		Female (95%CI)		Total (95%CI)
	15-19Y	20-24Y	15-19Y	20-24Y	
GARPR score	7.4 (6.0-9.1)	9.2 (7.5-11.1)	7.9 (6.5-9.6)	9.0 (7.5-10.8)	8.3 (7.6-9.2)

AWARENESS ON SEXUAL AND REPRODUCTIVE HEALTH LAWS

The State should ensure that youth have access to correct updated information on health as envisaged in the National Youth Policy of Sri Lanka and as the country has ratified all the major human rights instruments that deals with rights of children and adolescents. Youth should be aware about the existing laws pertaining to sexual and reproductive health in Sri Lanka. The survey explored the level of awareness about the minimum ages on marriage and consent for sex. In Sri Lanka, the minimum age at marriage is 18 years for both sexes and minimum age for consent to sex is 16 years. It was striking to see that 72.6% (95 % CI, 71.3-73.8) knew about the minimum age of marriage without much sex, age or schooling status difference. Nearly 75% knew that having sex with a minor is an offence.

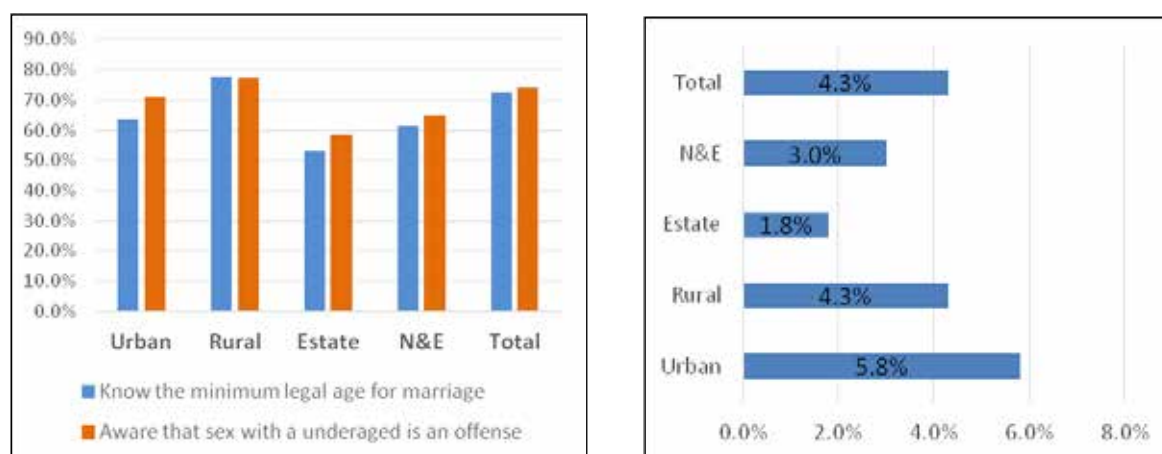
Table 2.19: Youth Knowledge on sexual and reproductive health laws

Having correct knowledge	Male % (95%CI)		Female% (95%CI)		Total % (95%CI)
	15-19 y	20 -24 y	15-19 y	20 -24 y	
Know the minimum legal age for marriage in Sri Lanka as 18 years	70.2 (67.4-72.8)	69.1 (66.3-71.8)	73.7 (71.3-76.0)	77.3 (74.9-79.4)	72.6 (71.3-73.8)
Aware that having a sex with an under-aged person is an offence	73.2 (70.4-75.8)	72.2 (69.4-74.8)	74.2 (71.8-76.5)	77.2 (74.8-79.4)	74.2 (72.9-75.4)
Aware about the minimum age for giving consent for sex as 16 years	4.7 (3.5-6.4)	5.4 (4.2-6.9)	4.2 (3.2-5.5)	2.8 (2.0-3.9)	4.3 (3.7-4.9)

Significantly higher portion of the married youth reported accurate responses for above variables compared to others while significantly lower proportion of the estate youth gave correct answers. With regard to the question on the minimum legal age that a young person can give consent for sex, only 4.3% of total (95%CI: 3.7-4.9) had answered correctly and with a significant difference between strata. Since the question was an open ended one, the majority were of the opinion that the legal age for consent to sex was 18 years.

A Significant proportion of youth were aware of country laws on marriage

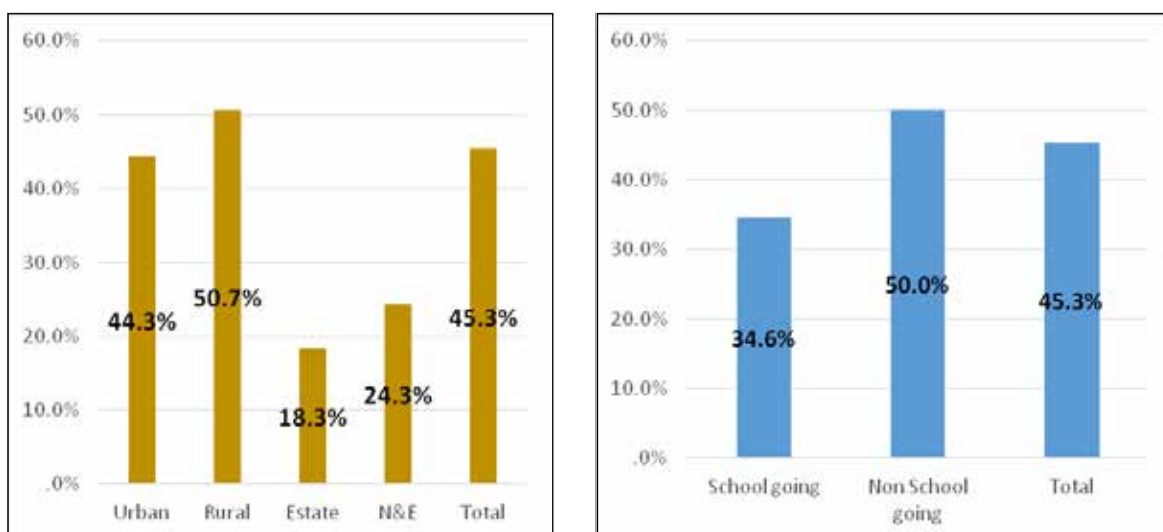
Figure 2.22: Awareness on adolescent sexual laws by strata



Awareness on Emergency contraceptive pills

The survey explored the youth awareness on emergency contraceptive pills (ECP) and their awareness on the time interval that ECP should be taken following a sexual intercourse. SRH guidelines says that that ECP should be initiated within the first 48 hours after a risky sexual exposure to avoid a conception. Married youth had a significantly higher knowledge of the time interval that ECP should be taken after sex.

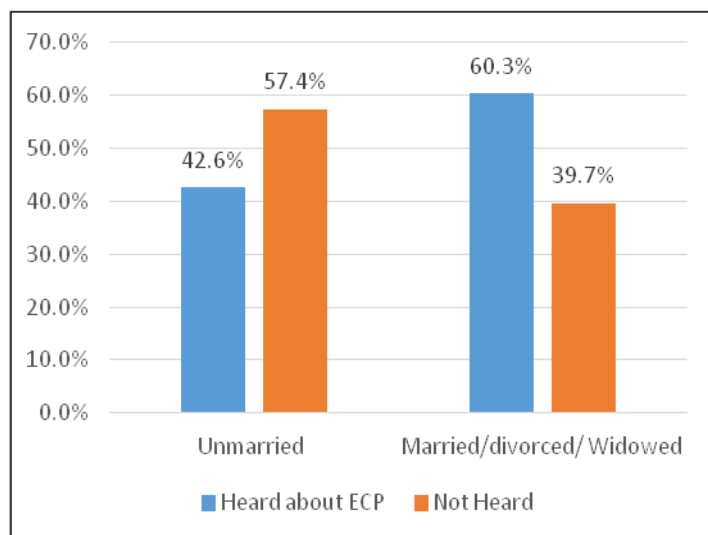
Figure 2.23: Awareness on emergency contraceptive pills



Little less than a half (45.3%, 95%CI: 43.8-46.8) had heard of emergency contraceptive pills (ECP) regardless of age or sex. However a significant variance was observed between strata where the estate and N-E youth reporting significantly lower awareness compared to other strata. Similar low level of awareness was noted among schooling group as well.

Of the school going youth, 34.6% have heard about ECP (95%CI: 31.9-37.3) while the reported proportion for non-school going youth was 50.0% (95%CI: 48.2-51.8).

Figure 2.24: Awareness on ECP by marital status



Nearly 45% of the youth had heard about ECP. Significantly higher urban and rural youth, non-school going youth and married youth had heard of ECP. Majority were unaware on the time interval that ECP should be taken after a sexual act.

Low awareness on ECP was also noted among the unmarried youth, however the differences were not statistically significant.

The majority (71.5%; 95%CI: 70.1-72.9) were unaware of the time interval that ECP should be taken after a sexual act. Married youth had a significantly higher knowledge of the time interval that ECP should be taken after sex.

Figure 2.25: Awareness on the time interval that ECP should be taken after a sexual act by marital status

