

# 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*

*Family Health Bureau*

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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

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## 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 population<sup>1</sup> 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

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<sup>1</sup>Department 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 Lanka<sup>2</sup>. 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).

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<sup>2</sup>UNICEF (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](http://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  |
|--|---|
| <p><b>Stratum- 1 – Urban</b></p> <p>Youth from 17 districts:<br/>           1-Colombo, 2-Gampaha, 3- Kalutara, 4-Galle,<br/>           5-Matara, 6-Habantota, 7-Kandy, 8-N’Eliya,<br/>           9-Matale, 10-Kegalle, 11-Rathnapura,<br/>           12-Monaragala, 13-Badulla, 14-Kurunegala,<br/>           15-Puttalam, 16-Anuradhapura,17-Polonnaruwa,</p> | <p>This stratum was designed to capture the general population of youth in the urban areas of the country.</p>  |
| <p><b>Stratum- 2 – Rural</b></p> <p>Youth from 17 districts:<br/>           1-Colombo, 2-Gampaha, 3- Kalutara, 4-Galle,<br/>           5-Matara, 6-Hambantota, 7-Kandy, 8-N’Eliya,<br/>           9-Matale, 10-Kegalle, 11-Ratnapura,<br/>           12-Monaragala, 13-Badulla, 14-Kurunegala,<br/>           15-Puttalam, 16-Anuradhapura,17-Polonnaruwa,</p> | <p>This stratum was designed to capture the general population of youth in the rural areas of the country.</p>  |
| <p><b>Stratum- 3 – Northern and Eastern Provinces</b></p> <p>Youth from 8 districts:<br/>           1-Jaffna, 2-Vauniya, 3-Kilinochchi,<br/>           4-Mannar, 5-Mullaitivu, 6-Batticaloa,<br/>           7-Ampara, 8-Trincomalee</p>  | <p>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.</p>                             |
| <p><b>Stratum- 4 – Estate sector</b></p> <p>1-Nuwara Eliya, 2-Kandy, 3-Kegalle,<br/>           4-Ratnapura, 5-Badulla, 6-Galle</p>   | <p>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.</p> |

## 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

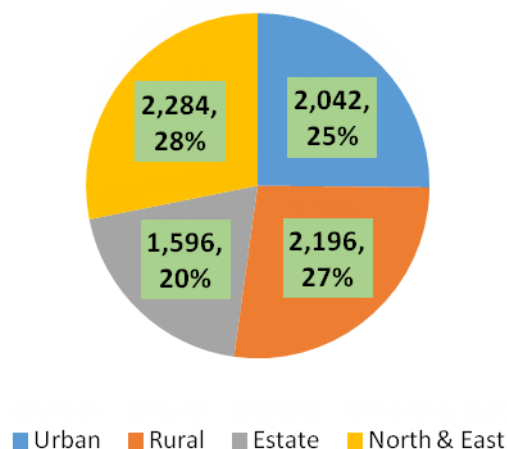
### PROFILE OF THE SAMPLE

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 depicts 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         |
| <b>Total</b>   | <b>808582</b> | <b>743800</b> | <b>832275</b> | <b>770592</b> | <b>3155249</b> |

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        |
| <b>Total</b>   | <b>1,962</b> | <b>1,745</b> | <b>2,318</b> | <b>2,093</b> | <b>8,118</b> |

## 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**

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

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

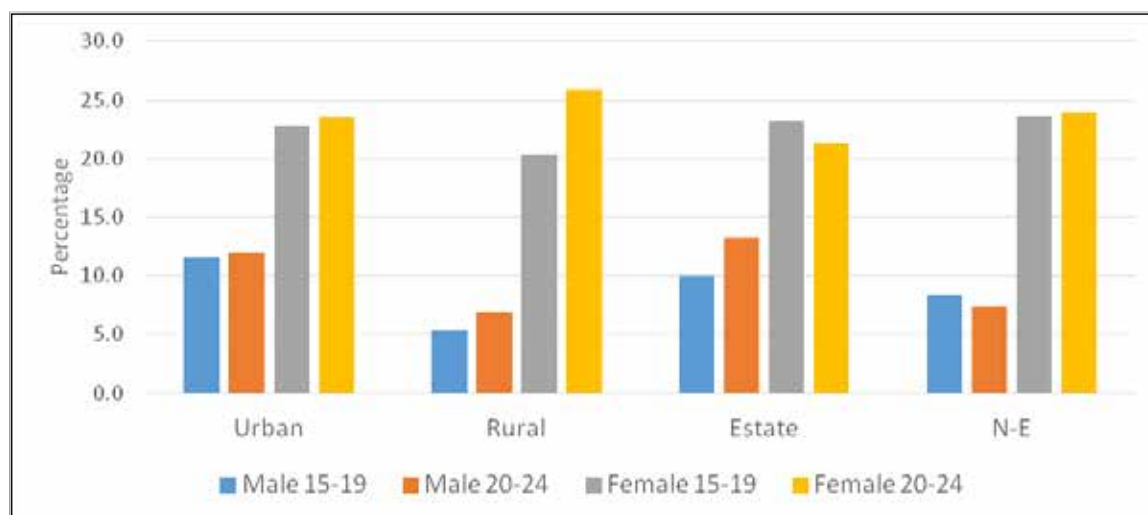
## MARITAL STATUS

**Table 2.5: Marital status of youths by sex and age**

|              | Male %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     | Total %<br>(95%CI)  |
|--------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|              | 15-19 y             | 20 -24 y            | 15-19 y             | 20 -24 y            |                     |
| Unmarried    | 93.1<br>(91.5-94.4) | 91.9<br>(90.1-93.3) | 78.4<br>(76.0-80.6) | 74.8<br>(72.2-77.2) | 84.5<br>(83.4-85.4) |
| Married      | 6.7<br>(5.6-8.5)    | 8.1<br>(6.6-9.9)    | 21.2<br>(19.0-23.6) | 25.1<br>(22.6-27.6) | 15.4<br>(14.4-16.4) |
| Divorced     | 0.2<br>(0.0-1.2)    | 0.2<br>(0.0-1.5)    | 0.4<br>(0.1-1.3)    | 0.0<br>(0.0-0.0)    | 0.2<br>(0.1-0.5)    |
| Widowed      | 0.0<br>(0.0-0.0)    | 0.2<br>(0.0-1.5)    | 0.4<br>(0.1-1.3)    | 0.0<br>(0.0-0.0)    | 0.2<br>(0.1-0.4)    |
| <b>Total</b> | 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 also<sup>3</sup>.

**Figure 2.2: Profile of Married youth by strata**



<sup>3</sup> Census of Population and Housing 2012 Key Findings, Department of Census and Statistics, Available at: [www.statistics.gov.lk](http://www.statistics.gov.lk)

## PRODUCTIVE INVOLVEMENT OF YOUTH AT PRESENT

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

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

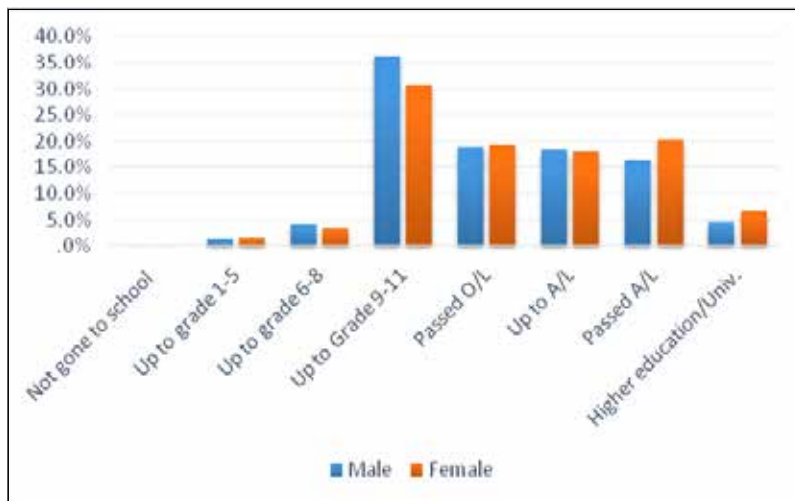
Among the respondents, 30.3% were still schooling. A higher percentage of rural youth were still at school whilst the lowest was in the estate sector. Only 11.1 % were engaged in full time jobs and the estate youth were the highest proportion to do so. There were also 8.3% involved in part time jobs 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**

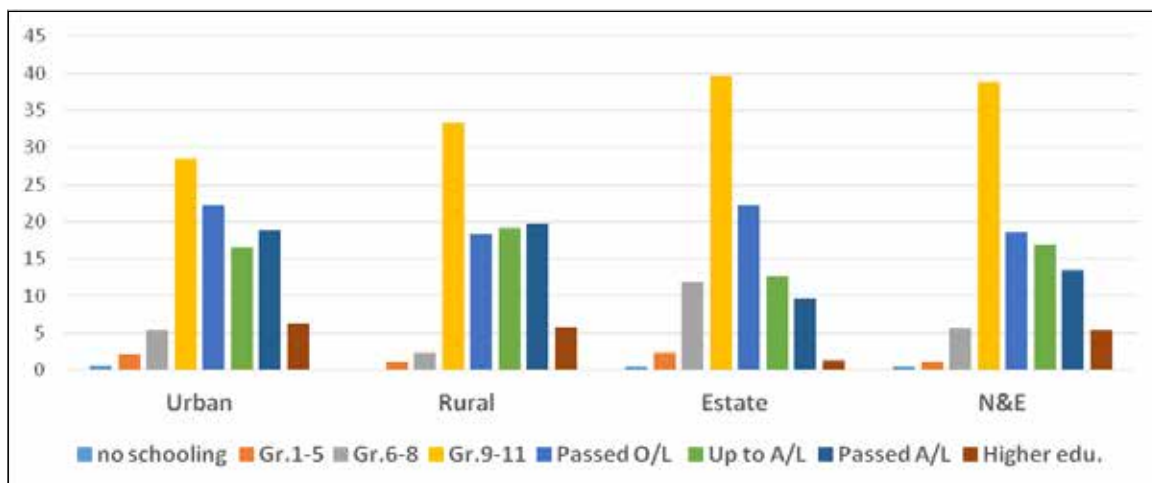


More females had pursued higher education beyond GCE A/L in urban and rural strata.

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.

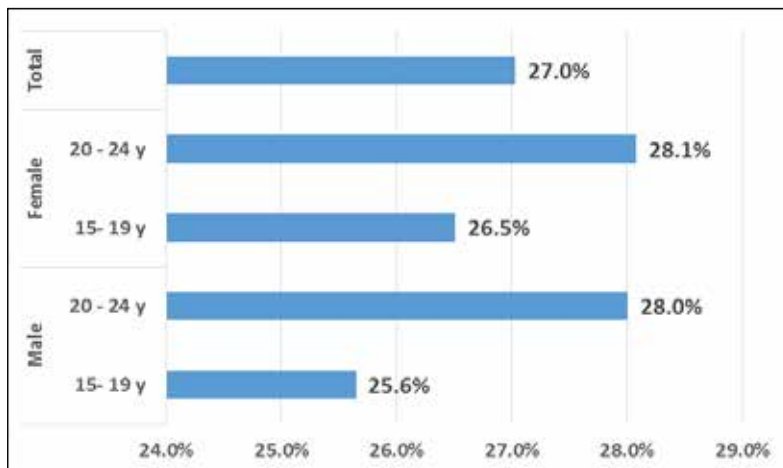
**Table 2.7: Reasons for early school dropouts by strata**

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



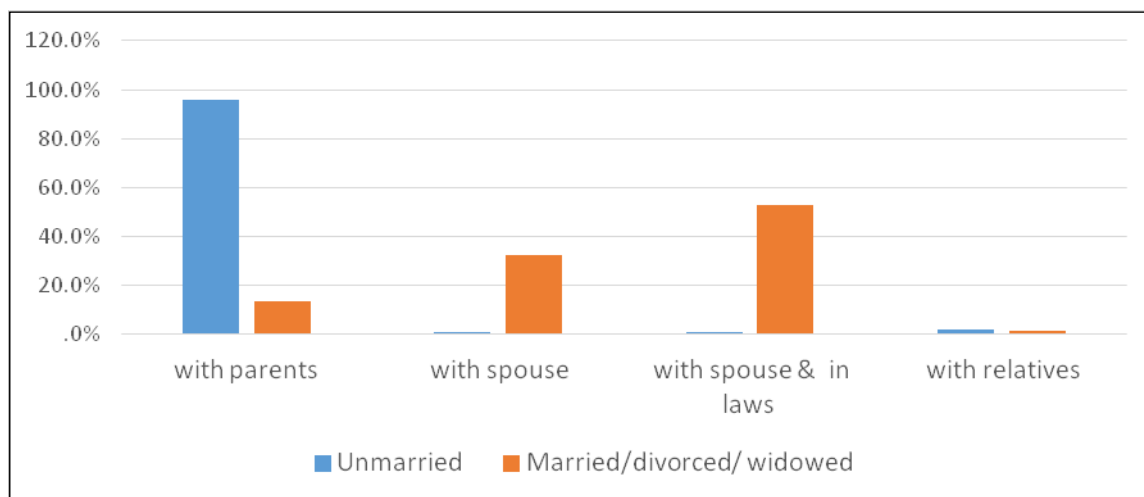
Poor academic performance, financial difficulties and need to find a job were the common reasons for early school dropout.

27% had vocational training.

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**

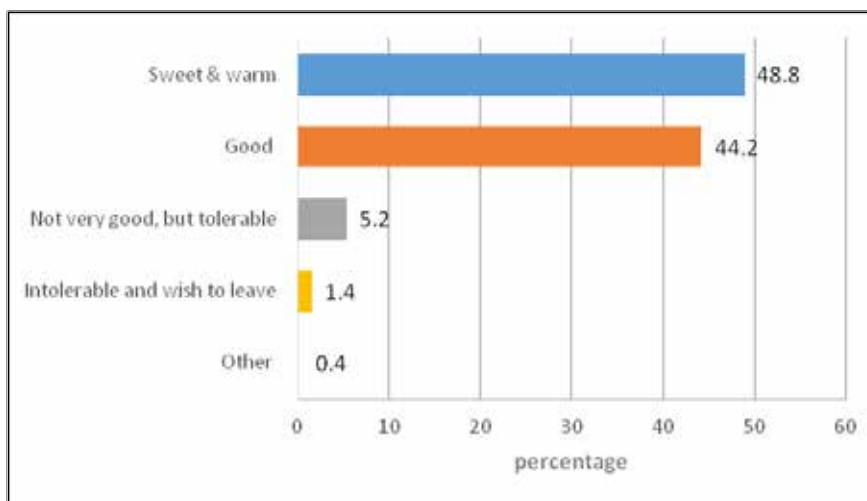


Approximately 83.1% (95%CI: 82.0-84.2) of total, 95.9% (95%CI: 95.1-96.5) of unmarried and 13.4% (95%CI: 11.1-16.1) of married youth lived with their parents. Of the married youth, 32.1% (95%CI: 28.8-35.6) lived separately with their partner /spouse while 52.8% (95%CI: 49.2-56.5) lived with their in 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<br>(6.9-9.3)    | 8.5<br>(7.4-9.7)    | 8.5<br>(7.2-10.0)   | 11.4<br>(10.2-12.8) | 8.7<br>(7.9-9.6)    |
| Mother died                    | 1.7<br>(1.2-2.4)    | 1.5<br>(1.1-2.1)    | 2.3<br>(1.6-3.2)    | 1.8<br>(1.3-2.4)    | 1.6<br>(1.3-2.0)    |
| Both mother and father died    | 0.7<br>(0.4-1.2)    | 0.4<br>(0.2-0.7)    | 1.3<br>(0.8-2.0)    | 0.9<br>(0.6-1.4)    | 0.5<br>(0.4-0.7)    |
| Both parents alive             | 89.6<br>(88.2-90.8) | 89.7<br>(88.3-90.9) | 88.0<br>(86.2-89.5) | 85.9<br>(84.4-87.2) | 89.2<br>(88.2-90.0) |
| <b>Total</b>                   | 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<br>(0.6-1.4) | 0.8<br>(0.5-1.2) | 1.8<br>(1.2-2.6) | 1.9<br>(1.4-2.6) | 1.0<br>(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.

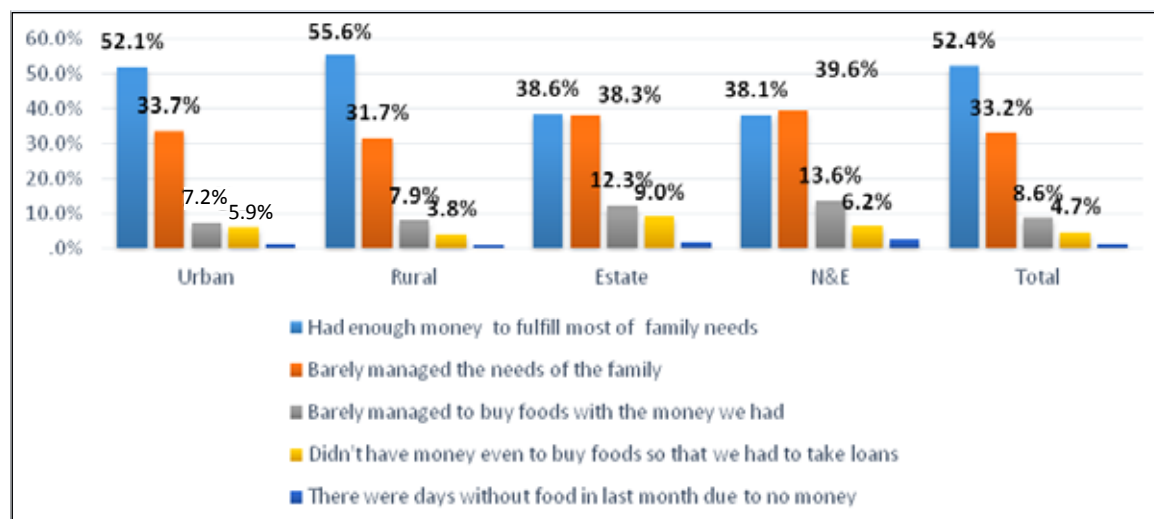
## INCOME LEVEL

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<br>(54.9-59.3)  | 65.4<br>(63.3-67.4) | 41.5<br>(39.1-43.9) | 49.5<br>(47.4-51.6) | 61.3<br>(59.8-62.7) |
| 1-3 days         | 27.1<br>(25.14-29.1) | 23.5<br>(21.7-25.4) | 31.9<br>(29.6-34.3) | 25.7<br>(23.8-27.5) | 24.7<br>(23.4-26.0) |
| More than 3 days | 1.6<br>(1.1-2.2)     | 2.4<br>(1.8-3.1)    | 2.0<br>(1.4-2.)     | 1.2<br>(0.8-1.8)    | 2.1<br>(1.7-2.6)    |
| Cannot remember  | 14.2<br>(12.7-15.9)  | 8.7<br>(7.6-10.0)   | 24.6<br>(22.5-26.8) | 23.6<br>(21.9-25.5) | 11.9<br>(11.1-12.9) |
| <b>Total</b>     | 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 %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     | Total %<br>(95%CI)  |
|--------------------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|                                      | 15-19 y             | 20 -24 y            | 15-19 y             | 20 -24 y            |                     |
| Fever with or without cough and cold | 20.9<br>(18.4-23.7) | 17.2<br>(15.0-19.7) | 17.5<br>(15.4-19.9) | 16.0<br>(13.9-18.1) | 17.9<br>(16.8-19.2) |
| Headache                             | 4.3<br>(3.2-5.8)    | 3.4<br>(2.5-4.7)    | 5.3<br>(4.1-6.7)    | 5.2<br>(4.1-6.6)    | 4.6<br>(3.99-5.2)   |
| Joint pain                           | 0.9<br>(0.5-1.7)    | 0.6<br>(0.3-1.2)    | 1.1<br>(0.2-1.95)   | 1.0<br>(0.5-1.8)    | 0.9<br>(0.7-1.2)    |
| Asthma / wheezing attacks            | 1.4<br>(0.8-2.4)    | 0.8<br>(0.4-1.6)    | 1.0<br>(0.5-1.7)    | 1.5<br>(0.9-2.4)    | 1.2<br>(0.9-1.5)    |
| Dengue fever                         | 0.46<br>(0.2-0.9)   | 0.68<br>(0.3-1.4)   | 0.33<br>(0.1-0.8)   | 0.54<br>(0.3-0.9)   | 0.50<br>(0.3-0.7)   |
| Fits/ Epilepsy                       | 0.19<br>(0.0-0.8)   | 0.09<br>(0.03-0.3)  | 0.06<br>(0.02-0.25) | 0.05<br>(0.02-0.17) | 0.10<br>(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.

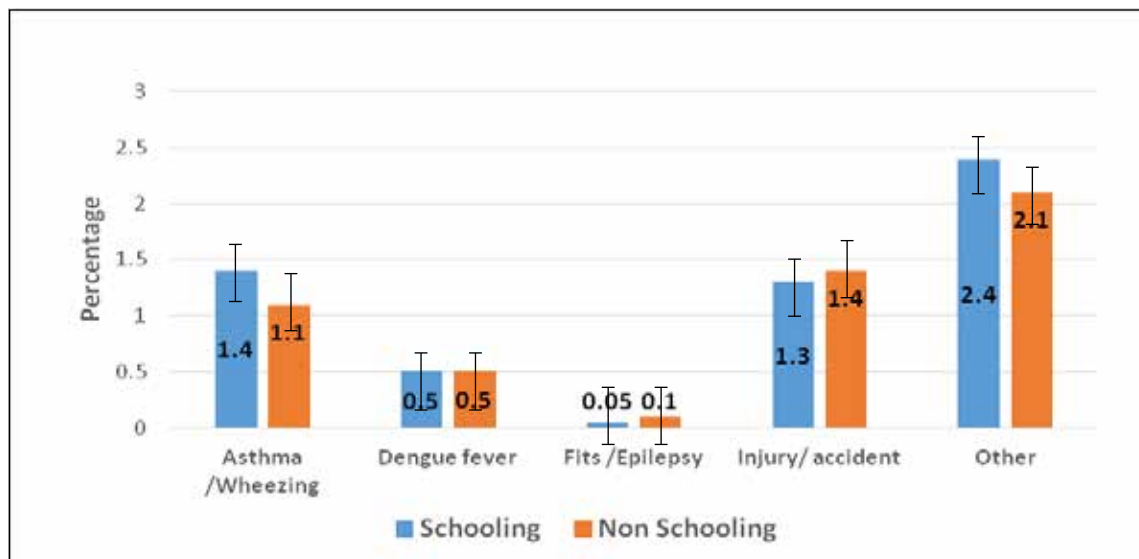
Young females complained of headaches followed by joint pains and asthma /wheezing as causes for such absenteeism.

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.

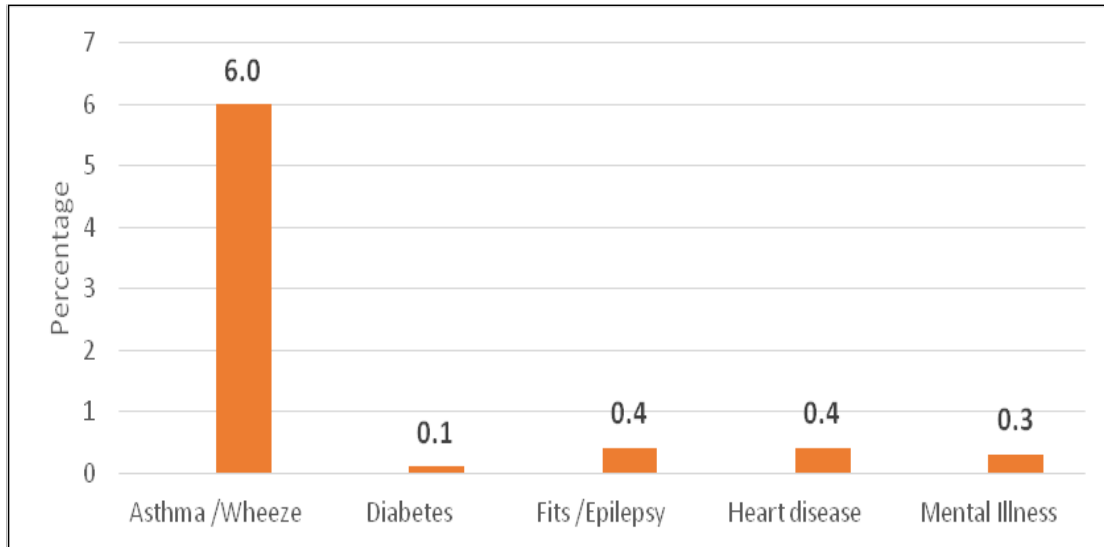
**Figure 2.9: Acute Physical health Problems among youth during the preceding month by schooling status**



### 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**



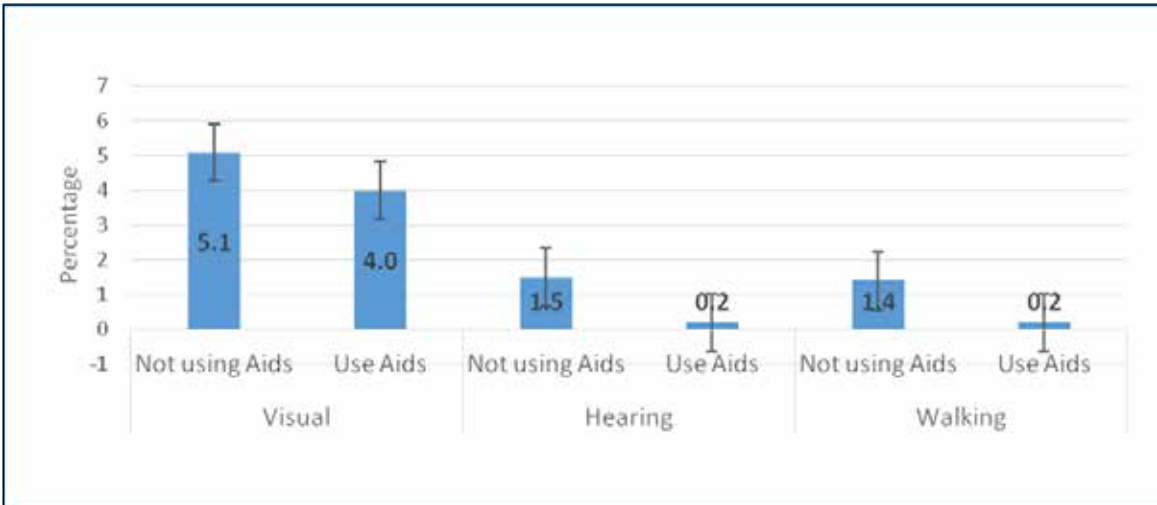
Asthma was the commonest reported chronic illness among the youth irrespective of sex or age groups. Reported Asthma prevalence for the total sample was 6.0% (95%CI: 5.3-6.7). The reported prevalence of asthma among 15-19year aged males was 7.8 % (95%CI: 6.2-9.6) while that for females was 5.2% (95%CI: 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**



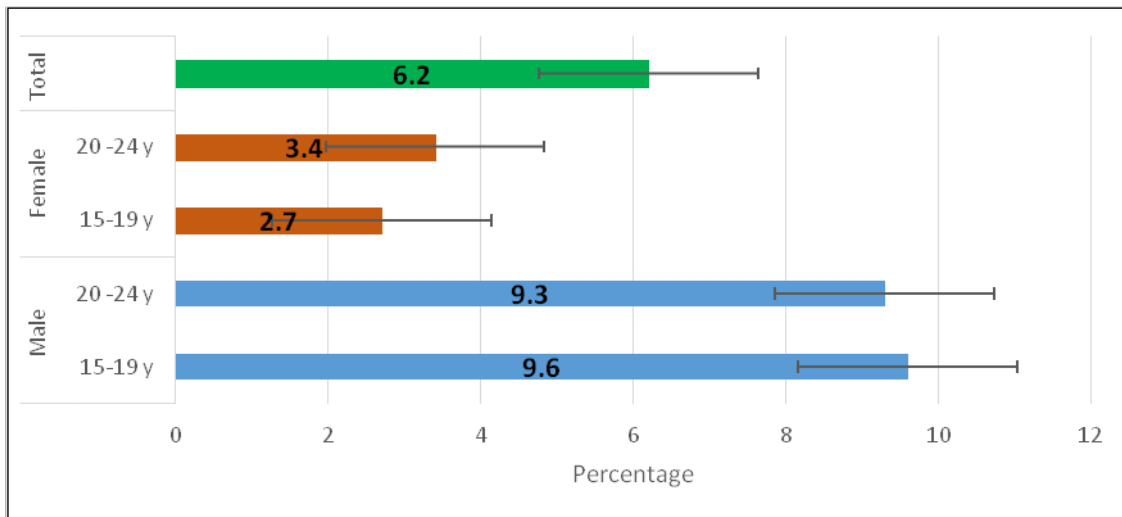
Of the sample, 5.1% reported as having visual disabilities but not using spectacles with significantly higher proportions among the rural and estate youth. Another 4.0% used spectacles for their vision problems with significantly higher proportions among the urban youth compared to other strata. Hearing 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**



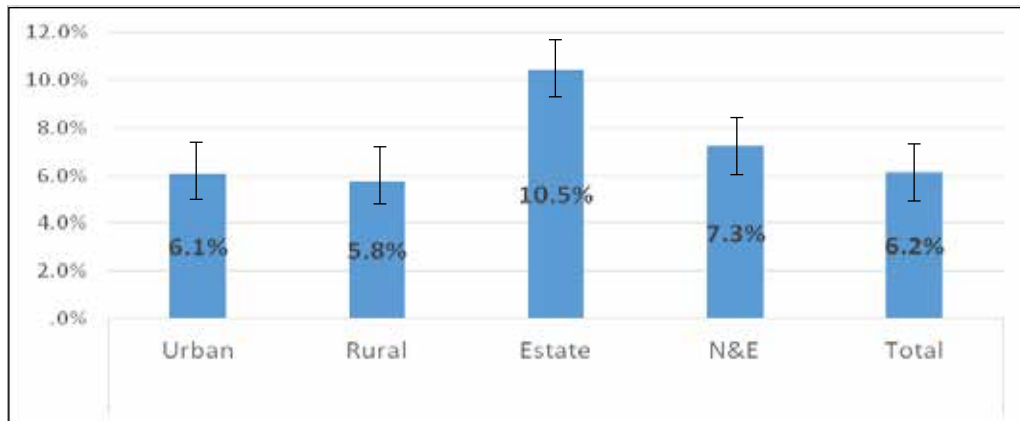
Of the total sample, 6.2% (95%CI: 5.5-6.9) reported of injuries during the preceding 12 months which needed medical attention with a statistically significant male predominance.

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.

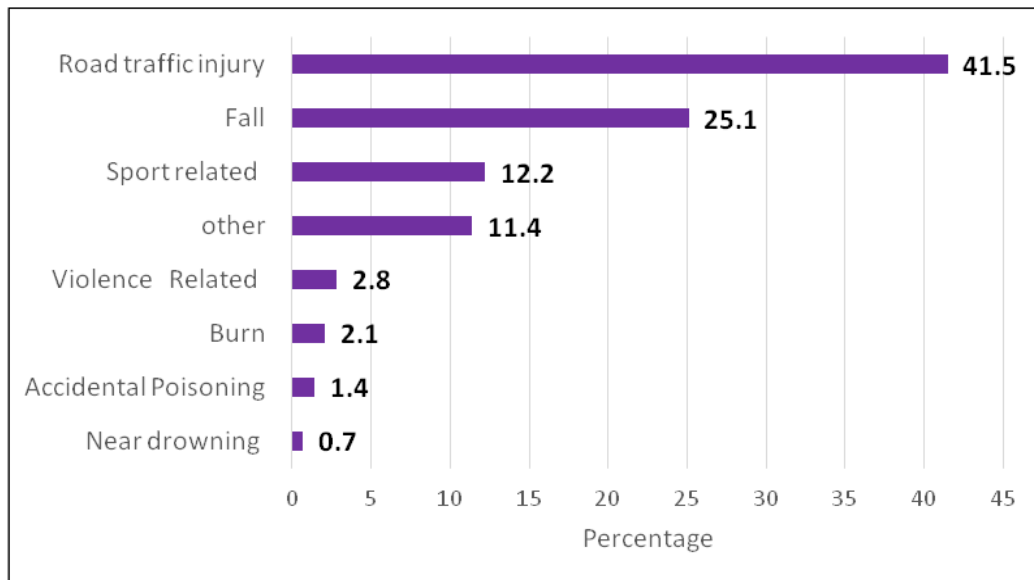
The rate for male sex was 9.4% (95%CI: 8.2-10.8) while the rate for females was 3.0% (95%CI: 2.4-3.7). Estate youth were reporting significantly higher rate of injuries with 10.5% (95%CI: 9.0-12.1) and the lowest rate of injuries was among the rural youth with 5.8% (95%CI: 4.8-6.9). The incidence of 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 %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     |
|----------------------|---------------------|---------------------|---------------------|---------------------|
|                      | 15-19 y             | 20 -24 y            | 15-19 y             | 20 -24 y            |
| Road traffic injury  | 42.9<br>(33.1-53.3) | 47.3<br>(37.1-57.9) | 39.2<br>(24.6-56.0) | 18.3<br>(8.7-34.6)  |
| Fall                 | 26.5<br>(18.3-36.7) | 20.5<br>(13.7-29.6) | 18.9<br>(10.6-31.3) | 39.9<br>(25.2-56.6) |
| Sports related       | 13.6<br>(8.4-21.1)  | 13.6<br>(8.4-21.5)  | 6.1<br>(3.0-12.3)   | 9.6<br>(3.8-22.0)   |
| Near drowning        | 0.0<br>(0.0-0.0)    | 0.4<br>(0.1-3.1)    | 0.7<br>(0.1-4.7)    | 0.0<br>(0.0-0.0)    |
| Burn                 | 1.9<br>(0.4-9.1)    | 0.4<br>(0.1-1.8)    | 0.0<br>(0)          | 2.1<br>(0.7-6.1)    |
| Accidental poisoning | 0.1<br>(0.01-0.08)  | 0.6<br>(0.1-2.7)    | 3.3<br>(1.1-9.1)    | 6.2<br>(1.6-20.7)   |
| Violence related     | 2.5<br>(0.7-8.6)    | 3.8<br>(1.2-11.4)   | 1.8<br>(0.4-7.4)    | 2.0<br>(0.6-6.7)    |
| other                | 10.1<br>(5.2-18.6)  | 8.7<br>(4.1-17.7)   | 21.5<br>(10.7-38.3) | 14.0<br>(5.6-30.6)  |
| Missing              | 2.5<br>(1.3-4.9)    | 4.7<br>(1.8-11.6)   | 8.6<br>(3.0-22.4)   | 7.9<br>(2.8-20.4)   |
| <b>Total</b>         | 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<br>(2.4-11.2)   | 11.0<br>(4.0-26.9)  | 20.0<br>(5.8-50.4)  | 33.9<br>(9.4-71.8)  | 10.9<br>(6.2-18.3)  |
| Cyclist                             | 18.1<br>(9.1-32.9)  | 12.8<br>(5.8-25.9)  | 24.2<br>(6.8-58.2)  | 2.0<br>(0.2-14.4)   | 15.7<br>(9.8-24.2)  |
| Motor cyclist /passenger            | 56.7<br>(40.9-71.2) | 50.5<br>(34.7-66.3) | 29.7<br>(10.2-61.0) | 62.2<br>(26.1-88.4) | 51.4<br>(41.2-61.6) |
| Motor vehicle driver                | 7.4<br>(2.6-19.3)   | 3.8<br>(0.7-18.7)   | 0.0                 | 2.0<br>(0.2-14.4)   | 4.8<br>(2.0-11.1)   |
| Other                               | 11.4<br>(4.0-28.3)  | 18.5<br>(8.7-35.3)  | 26.2<br>(8.0-59.2)  | 0.0                 | 15.4<br>(9.0-25.0)  |
| Missing                             | 25.6<br>(16.5-37.4) | 34.8<br>(24.2-47.1) | 37.8<br>(22.2-56.5) | 64.3<br>(45.3-79.7) | 35.2<br>(28.5-42.5) |
| <b>Total</b>                        | 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 preceding 12 months. This was followed by being a cyclist with 15.7% (95%CI: 9.8-24.2).

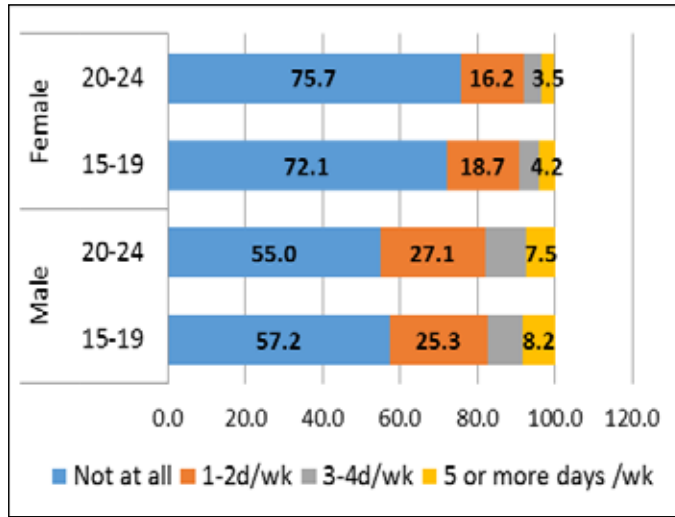
## LIFE STYLES

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**



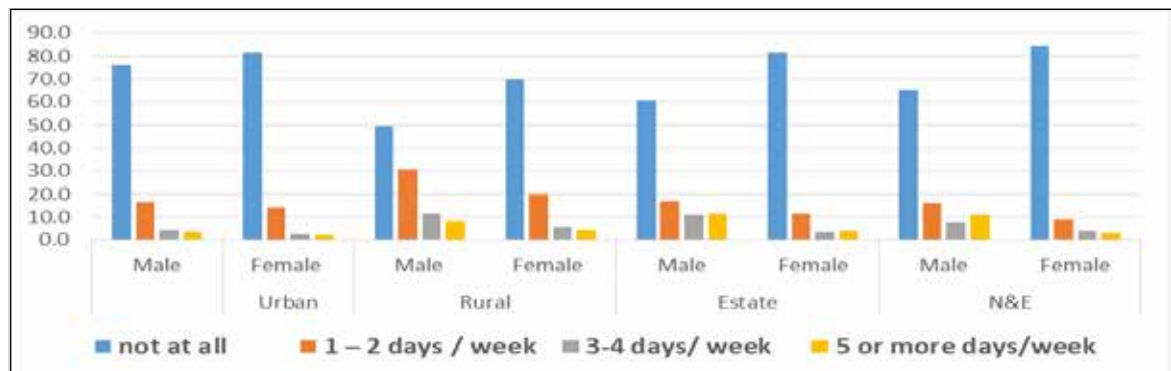
Nearly half of the males and three fourths of females had not done manual work in the preceding week.

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%.

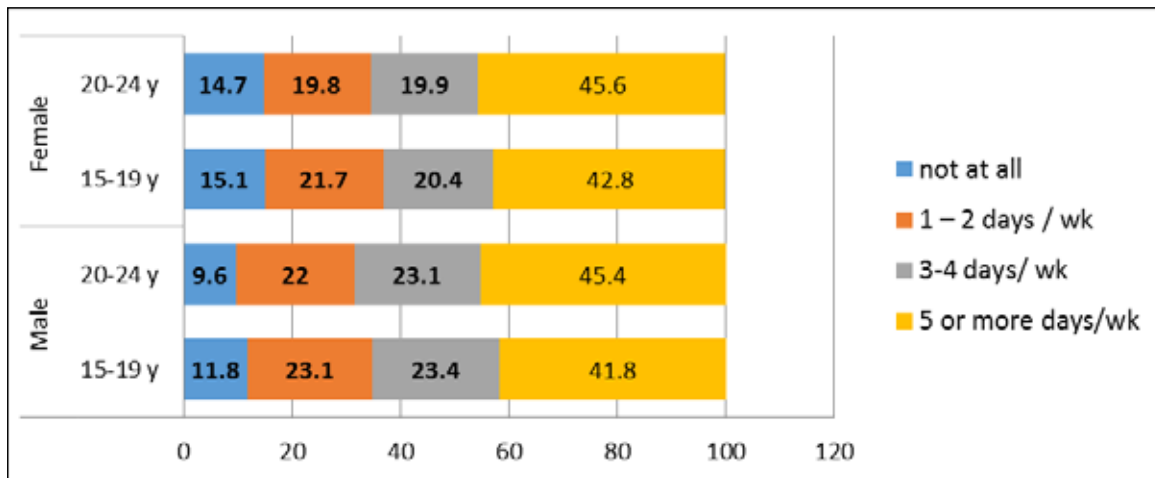
**Figure 2.16: Frequency of engaging in manual work by youth by strata**



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**

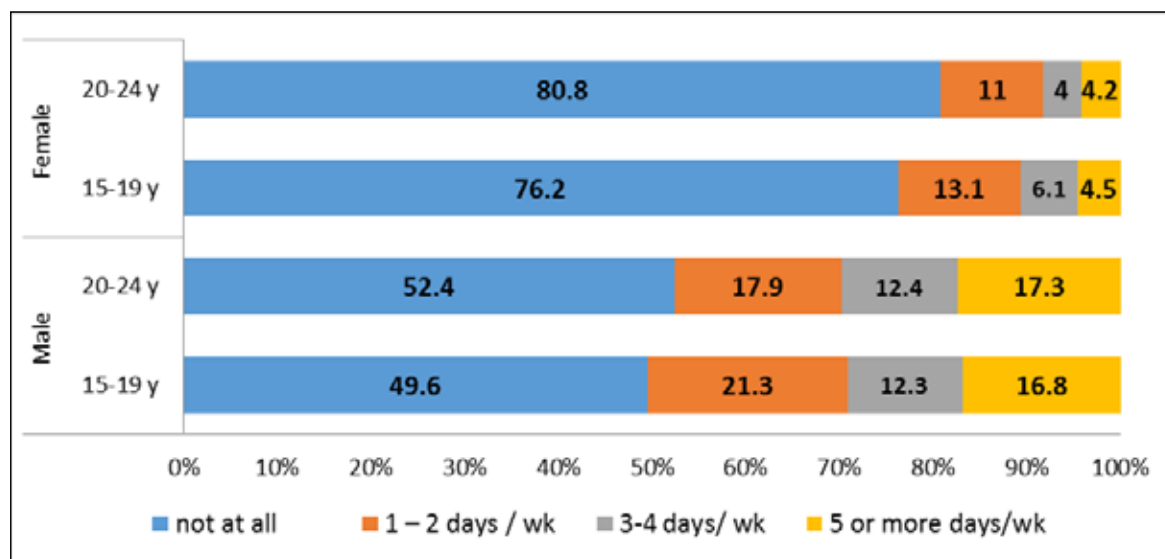


The survey assessed the “youth screen time” based on the frequency of watching television, video films, video games or internet. Of the total, 43.8% claimed that they had been involved in above activities in five or more days in the preceding week. Of the males, 41.8%-45.4% reported to have been engaged 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 48% 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**

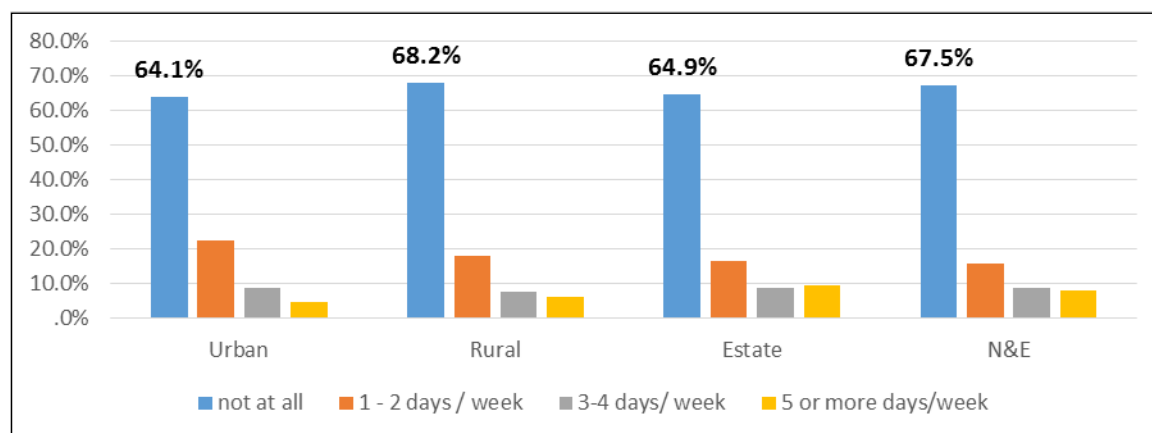


World Health Organization recommends at least 60 minutes of moderate- to vigorous-intensity physical activity daily for adolescents and at least 150 minutes of moderate-intensity aerobic physical activity throughout the week or at least 75 minutes of vigorous-intensity aerobic physical activity throughout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

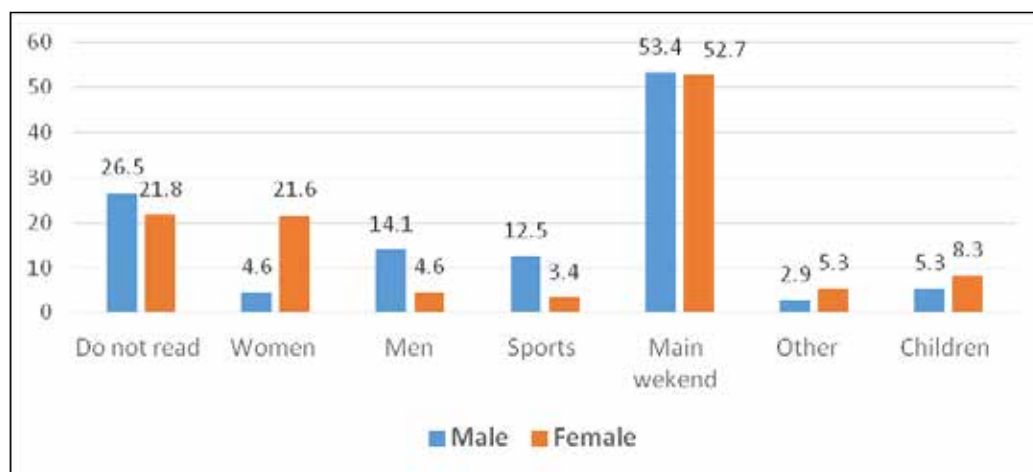
50% male and 84% female youth had not engaged in group sports in the preceding week

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).

## 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**

|                              | <b>Male %<br/>(95%CI)</b> | <b>Female %<br/>(95%CI)</b> | <b>Total %<br/>(95%CI)</b> |
|------------------------------|---------------------------|-----------------------------|----------------------------|
| Everyday                     | 12.3<br>(11.0-13.8)       | 6.5<br>(5.6-7.6)            | 9.4<br>(8.6-10.3)          |
| Few days a week              | 28.1<br>(26.1-30.2)       | 14.7<br>(13.3-16.2)         | 21.3<br>(20.1-22.6)        |
| Once a week or less          | 20.7<br>(18.9-22.7)       | 16.8<br>(15.3-18.4)         | 18.7<br>(17.5-20.0)        |
| No knowledge on internet use | 23.5<br>(21.6-25.6)       | 36.1<br>(34.1-38.2)         | 29.9<br>(28.5-31.4)        |
| other                        | 2.7<br>(2.0-3.5)          | 3.0<br>(2.3-3.8)            | 2.8<br>(2.4-3.4)           |
| No internet facilities       | 12.6<br>(11.5-13.9)       | 22.9<br>(21.4-24.4)         | 17.8<br>(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<br>(71.5-75.3) | 69.1<br>(67.2-70.9) | 60.4<br>(58.1-62.7) | 59.2<br>(57.3-61.1) | 68.4<br>(67.0-69.7) |
| “Uses a family members phone”        | 12.6<br>(11.2-14.1) | 13.1<br>(11.8-14.6) | 13.3<br>(11.7-14.9) | 22.7<br>(21.1-24.4) | 14.1<br>(13.0-14.9) |
| “Got a sim-card , use friends phone” | 0.5<br>(0.2-0.8)    | 0.7<br>(0.4-1.1)    | 1.3<br>(0.8-1.9)    | 0.9<br>(0.5-1.3)    | 0.7<br>(0.5-0.9)    |
| Not using a mobile regularly         | 13.2<br>(11.9-14.8) | 16.4<br>(14.9-18.0) | 23.7<br>(21.7-25.7) | 16.0<br>(14.6-17.6) | 16.1<br>(15.1-17.3) |
| Other                                | 0.3<br>(0.1-0.6)    | 0.7<br>(0.4-1.1)    | 1.4<br>(0.9-2.1)    | 1.2<br>(0.8-1.7)    | 0.7<br>(0.5-0.9)    |
| <b>Total</b>                         | 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) |                     |                     |                     | Total               | % Don't know (of total sample) |
|--|-------------------------------------|---------------------|---------------------|---------------------|---------------------|--------------------------------|
|  | Male                                |                     | Female              |                     |                     |                                |
|  | 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<br>(43.3-50.0)                 | 46.1<br>(42.8-49.5) | 69.7<br>(67.0-72.3) | 69.4<br>(66.7-72.1) | 58.7<br>(57.2-60.2) | 31.5<br>(30.0-32.9)            |
| It is normal that menstrual process be irregular at its beginning  | 27.6<br>(24.7-30.7)                 | 27.5<br>(24.6-30.6) | 66.8<br>(64.1-69.5) | 64.3<br>(61.5-67.1) | 47.9<br>(46.3-49.5) | 33.8<br>(32.3-35.3)            |
| A girl should seek medical advice if she does not attain menarche by age 16 years                        | 46.3<br>(43.0-49.7)                 | 46.5<br>(43.1-49.9) | 82.7<br>(80.4-84.8) | 81.3<br>(78.9-83.5) | 65.5<br>(64.0-67.0) | 27.4<br>(26.0-28.9)            |
| A girl should seek medical advice if her bleeding is heavy with clots and severe pain                    | 39.3<br>(36.1-42.6)                 | 41.7<br>(38.3-45.0) | 72.2<br>(69.5-74.8) | 71.1<br>(68.3-73.7) | 57.2<br>(55.6-58.7) | 32.2<br>(30.8-33.7)            |
| A girl is capable of getting pregnant after she attains her puberty (first menses)                       | 68.2<br>(65.1-71.2)                 | 68.4<br>(65.3-71.4) | 82.3<br>(80.3-84.2) | 82.5<br>(80.4-84.4) | 75.9<br>(74.6-77.1) | 18.6<br>(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<br>(36.7-43.3)                 | 39.4<br>(36.2-42.8) | 65.2<br>(62.5-67.9) | 65.0<br>(62.2-67.7) | 53.3<br>(51.7-54.9) | 32.7<br>(31.3-34.2)            |
| The sizes of two testicles can be different among boys and it is normal                                  | 55.8<br>(52.6-59.0)                 | 58.7<br>(55.5-61.9) | 31.4<br>(28.7-34.2) | 32.6<br>(29.8-35.5) | 44.8<br>(43.2-46.4) | 43.8<br>(42.3-45.4)            |
| It is common and normal for adolescent males to have nocturnal emissions ("wet dreams")                  | 69.8<br>(66.7-72.6)                 | 72.8<br>(69.8-75.5) | 56.9<br>(53.9-59.8) | 57.4<br>(54.4-60.3) | 64.3<br>(62.8-65.8) | 29.0<br>(27.7-30.5)            |
| Nocturnal emissions can weaken the body  | 22.3<br>(19.9-24.9)                 | 20.0<br>(17.8-22.5) | 12.1<br>(10.5-14.0) | 11.8<br>(10.2-13.7) | 16.5<br>(15.5-17.6) | 52.1<br>(50.6-53.6)            |
| A woman can get pregnant even at first time of sexual intercourse  | 47.0<br>(43.8-50.2)                 | 46.2<br>(43.0-49.5) | 45.5<br>(42.5-48.5) | 45.7<br>(42.7-48.7) | 46.1<br>(44.5-47.7) | 37.9<br>(36.4-39.5)            |
| Masturbation can make the body weak  | 30.2<br>(27.5-33.1)                 | 30.0<br>(27.2-32.9) | 18.2<br>(16.2-20.5) | 19.1<br>(17.0-21.5) | 24.3<br>(23.0-25.6) | 52.8<br>(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 %<br>(95%CI)          |                     | Female%<br>(95%CI)  |                     | Total %<br>(95%CI)  |
|   | 15-19 y                    | 20 -24 y            | 15-19 y             | 20 -24 y            |                     |
| <b>STI</b>  |                            |                     |                     |                     |                     |
| There is a risk of acquiring STIs even after single sexual intercourse  | 56.0<br>(52.9-59.0)        | 57.1<br>(53.9-60.2) | 53.4<br>(50.6-56.2) | 52.8<br>(49.9-55.6) | 54.8<br>(53.3-56.3) |
| Genital ulcers can be a symptom of STIs   | 45.8<br>(42.7-48.9)        | 49.5<br>(46.4-52.7) | 47.8<br>(44.9-50.6) | 52.2<br>(49.4-55.1) | 48.8<br>(47.3-50.3) |
| <b>HIV/AIDS</b>   |                            |                     |                     |                     |                     |
| HIV/AIDS is transmitted by unprotected sexual intercourse (sexual intercourse without using a condom)with an HIV/AIDS infected person | 68.4<br>(65.4-71.2)        | 72.3<br>(69.4-75.0) | 66.9<br>(64.3-69.5) | 67.7<br>(65.0-70.3) | 68.7<br>(67.4-70.1) |
| HIV/AIDS can be transmitted from infected pregnant mother to her child.   | 54.9<br>(51.8-58.0)        | 58.3<br>(55.1-61.4) | 62.4<br>(59.7-65.1) | 62.7<br>(59.9-65.4) | 59.6<br>(58.1-61.0) |
| HIV/AIDS is transmitted by HIV infected blood   | 66.3<br>(63.3-69.2)        | 68.3<br>(65.3-71.2) | 68.3<br>(65.7-70.9) | 69.5<br>(66.8-72.0) | 68.1<br>(66.7-69.5) |
| HIV/AIDS cannot be transmitted from infected mother to child through breast feeding   | 29.2<br>(26.4-32.1)        | 29.0<br>(26.2-32.0) | 34.7<br>(32.0-37.5) | 33.4<br>(30.7-36.1) | 31.6<br>(30.2-33.0) |
| A healthy looking person can be infected with HIV, the virus that cause AIDS  | 57.4<br>(54.3-60.4)        | 57.5<br>(54.4-60.6) | 61.7<br>(59.0-64.3) | 60.5<br>(57.8-63.2) | 59.3<br>(57.9-60.8) |
| HIV/AIDS is not transmitted by sharing unsterilized needles and syringes  | 65.2<br>(62.3-68.1)        | 64.9<br>(61.9-67.7) | 66.8<br>(64.2-69.3) | 67.9<br>(65.2-70.4) | 66.2<br>(64.8-67.6) |



|  |                     |                     |                     |                     |                     |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
| HIV/AIDS is not transmitted by sharing cups and plates with HIV infected person.                               | 62.7<br>(59.7-65.7) | 61.8<br>(58.7-64.7) | 64.0<br>(61.3-66.6) | 64.8<br>(62.1-67.4) | 63.3<br>(61.9-64.7) |
| HIV/AIDS is transmitted by mosquito bites  | 57.1<br>(53.9-60.1) | 56.4<br>(53.2-59.5) | 55.2<br>(52.4-58.0) | 54.6<br>(51.8-57.4) | 55.8<br>(54.3-57.3) |
| People can protect themselves from HIV/AIDS by using condoms correctly every time they have sex                | 53.5<br>(50.4-56.6) | 55.6<br>(52.4-58.7) | 42.4<br>(39.6-45.2) | 44.1<br>(41.1-46.9) | 48.8<br>(47.3-50.3) |
| Drugs are available to prevent HIV/AIDS transmission from infected mother to child                             | 19.9<br>(17.5-22.4) | 19.8<br>(17.6-22.3) | 19.8<br>(17.6-22.1) | 21.7<br>(19.4-24.1) | 20.3<br>(19.1-21.5) |
| Transmission of HIV/AIDS can be prevented by having sexual intercourse with only one mutually faithful partner | 60.0<br>(56.9-63.0) | 64.6<br>(61.5-67.5) | 63.1<br>(60.3-65.7) | 63.6<br>(60.9-66.3) | 62.8<br>(61.3-64.2) |
| HIV/AIDS can be diagnosed accurately by a specific blood test  | 66.7<br>(63.7-69.5) | 68.3<br>(65.3-71.1) | 70.2<br>(67.6-72.6) | 70.4<br>(67.7-72.8) | 68.9<br>(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<br>(95%CI)  |                   | Female<br>(95%CI) |                   | Total<br>(95%CI) |
|-------------|------------------|-------------------|-------------------|-------------------|------------------|
|             | 15-19Y           | 20-24Y            | 15-19Y            | 20-24Y            |                  |
| GARPR score | 7.4<br>(6.0-9.1) | 9.2<br>(7.5-11.1) | 7.9<br>(6.5-9.6)  | 9.0<br>(7.5-10.8) | 8.3<br>(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.

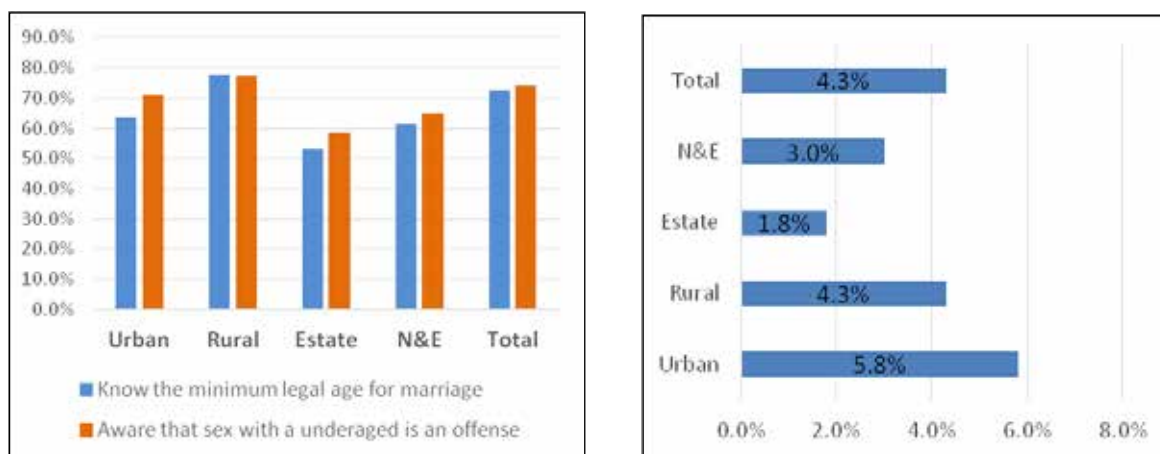
**Table 2.19: Youth Knowledge on sexual and reproductive health laws**

| Having correct knowledge   | Male %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     | Total %<br>(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<br>(67.4-72.8) | 69.1<br>(66.3-71.8) | 73.7<br>(71.3-76.0) | 77.3<br>(74.9-79.4) | 72.6<br>(71.3-73.8) |
| Aware that having a sex with an under-aged person is an offence    | 73.2<br>(70.4-75.8) | 72.2<br>(69.4-74.8) | 74.2<br>(71.8-76.5) | 77.2<br>(74.8-79.4) | 74.2<br>(72.9-75.4) |
| Aware about the minimum age for giving consent for sex as 16 years | 4.7<br>(3.5-6.4)    | 5.4<br>(4.2-6.9)    | 4.2<br>(3.2-5.5)    | 2.8<br>(2.0-3.9)    | 4.3<br>(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*

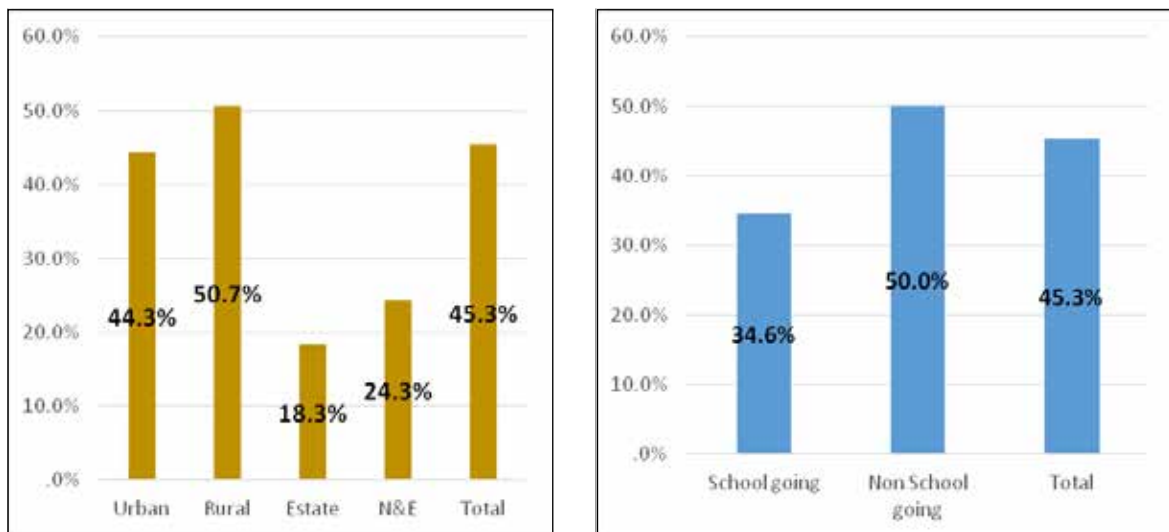
**Figure 2.22: Awareness on adolescent sexual laws by strata**



## 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.

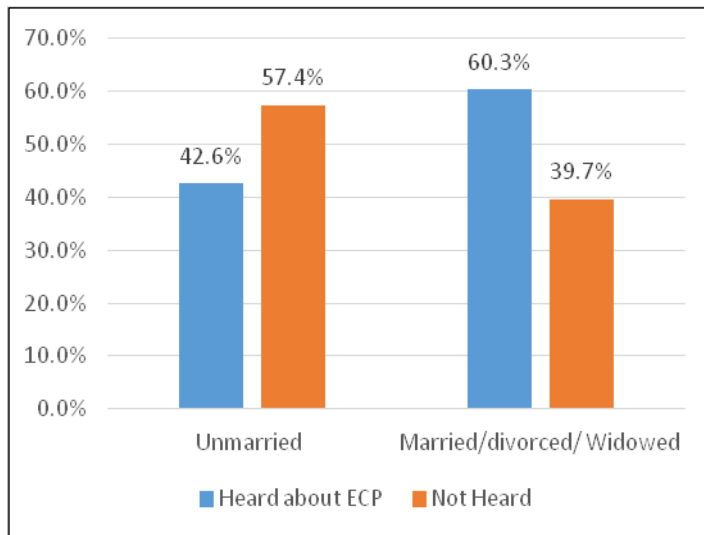
**Figure 2.23: Awareness on emergency contraceptive pills**



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**

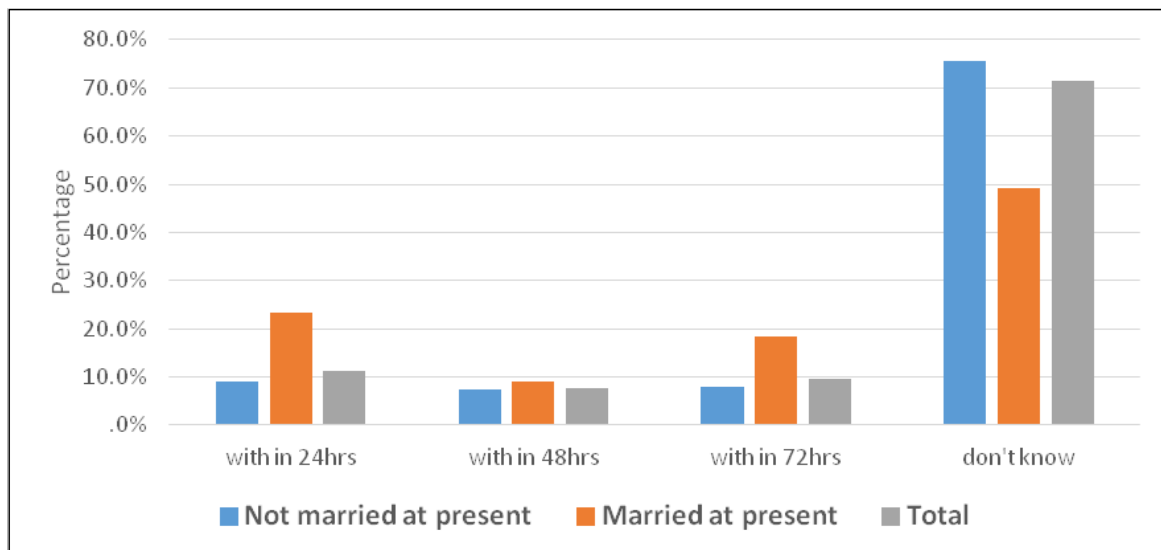


Nearly 45% of the youth had heard about ECP. Significantly higher urban and rural youth, non-school going youth and married youth had heard of ECP. Majority were unaware on the time interval that ECP should be taken after a sexual act.

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**



## AWARENESS ON CONSEQUENCES OF RAPE AND SOURCES OF HELP

Sexual abuse is defined as an abuse of power over a person and can be physical, visual and verbal. Sexual abuse can have many short and long term effects on a victim or survivor. Many adolescents who experience sexual abuse suffer negative developmental outcomes including depression, low self-esteem, substance abuse, promiscuity, anger, hostility, inappropriate sexual behavior, internalizing and externalizing problems.

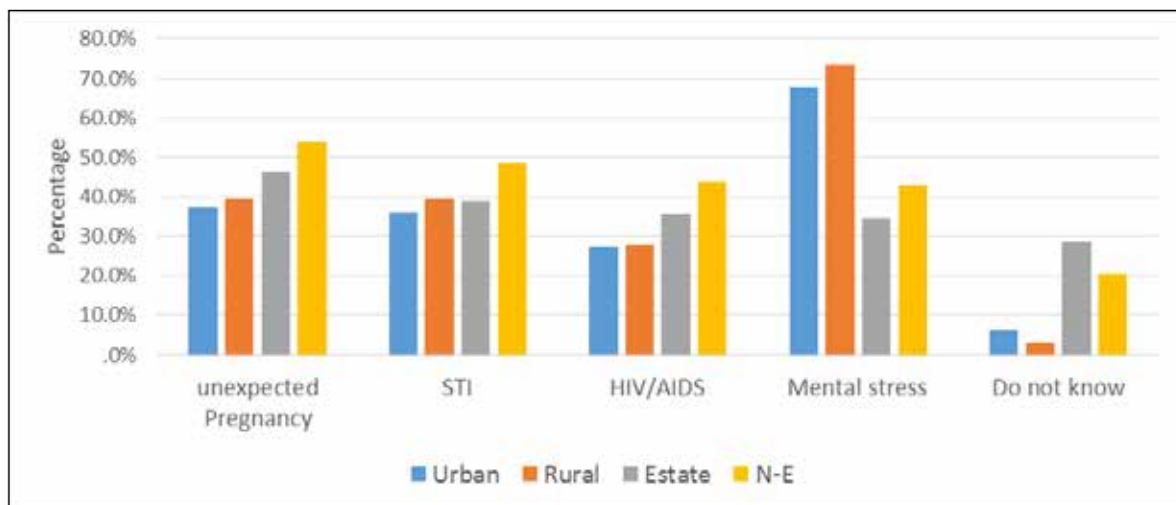
The survey assessed the knowledge on consequences of rape. The majority has highlighted about mental stress, unexpected pregnancy and possible sexually transmitted diseases. It was striking to see the significantly higher fraction of male youth being unaware of the possibility of unexpected pregnancy as a consequence of rape.

**Table 2.20: Youth Awareness on consequences of rape**

| Consequences of rape | Male %              |                     | Female%             |                     | Total%<br>(95%CI)   |
|----------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|                      | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) |                     |
| Unexpected Pregnancy | 19.4<br>(17.2-21.7) | 22.4<br>(20.0-24.9) | 60.3<br>(57.5-63.0) | 61.0<br>(58.2-63.7) | 41.0<br>(39.8-42.3) |
| STI                  | 37.8<br>(34.8-40.8) | 37.7<br>(34.7-40.8) | 41.3<br>(38.6-44.1) | 42.9<br>(40.1-45.7) | 39.9<br>(38.5-41.4) |
| HIV/AIDS             | 30.4<br>(27.7-33.3) | 27.2<br>(24.6-30.0) | 30.5<br>(28.0-33.2) | 31.9<br>(29.4-34.6) | 30.1<br>(28.7-31.4) |
| Mental stress        | 63.0<br>(60.1-65.9) | 63.5<br>(60.5-66.4) | 70.8<br>(68.4-73.1) | 72.4<br>(70.0-74.7) | 67.5<br>(66.2-68.8) |
| Other                | 1.9<br>(1.2-3.0)    | 2.4<br>(1.6-3.7)    | 2.1<br>(1.4-3.2)    | 2.0<br>(1.3-3.1)    | 2.1<br>(1.7-2.6)    |
| Do not know          | 8.7<br>(7.3-10.3)   | 6.6<br>(5.5-7.9)    | 5.7<br>(4.9-6.7)    | 5.1<br>(4.3-6.1)    | 6.6<br>(6.0-7.1)    |

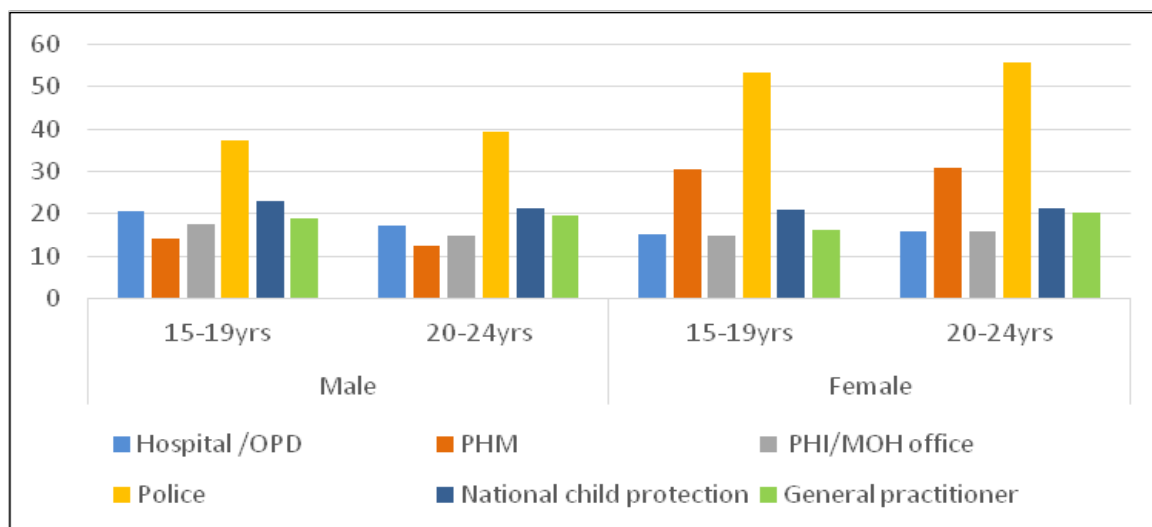
*(Multiple options were allowed)*

**Figure 2.26: Youth Awareness on consequences of rape by strata**



Significantly higher proportions of the N- E youth rated, unexpected pregnancy, STI and HIV/AIDS as consequences while significantly higher proportions of urban and rural youth had marked mental stress. There were no significant differences on awareness on consequences of rape between married youth and others.

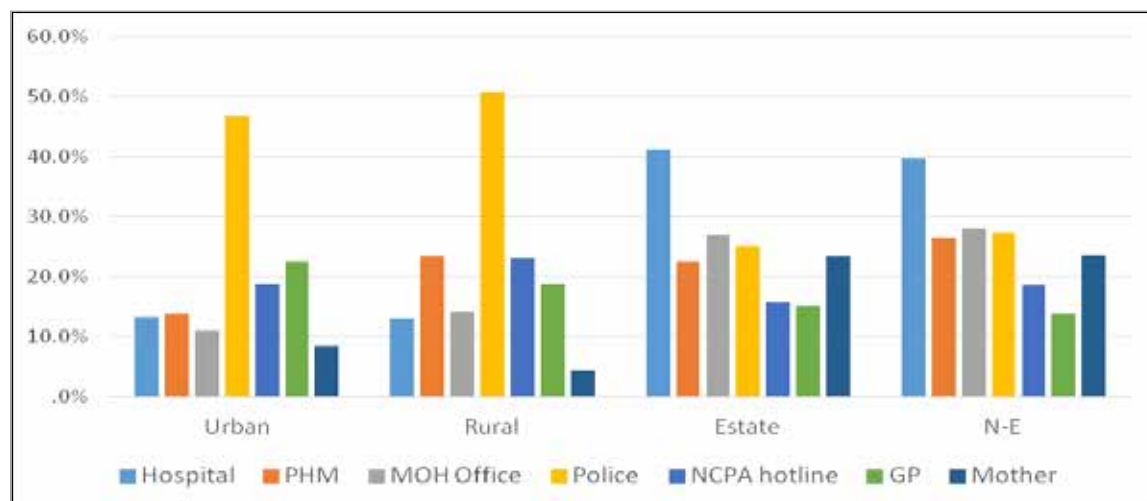
**Figure 2.27: Youth Awareness on where to seek help following a rape**



The youth were asked to select places where they can seek help following a rape. Nearly half (46.5%) reported police while other places /persons mentioned were Public health midwife (PHM) (22.2%) National Child Protection Authority (NCPA) hot line 1929 (21.6%), General Practitioner (18.7%), Hospital (17.2%) and MOH office (15.7%).

It was noteworthy that significant sex preponderance with regard to PHM was observed, where 30% females in contrast to 12%-14% males named PHM as a possible person to seek help following a rape.

**Figure 2.28: Youth Awareness on sources of help following rape by strata**



It was noted that youth awareness on sources of help following rape differed by strata. The Police has been highlighted by most (nearly 50%) urban and rural youth while hospital by the estate and N-E youth. Nearly one fourth of youth in all strata highlighted the PHM except in urban stratum with just 13.7% (95%CI: 12.3-15.3). Only 15.7% (95%CI: 14.0-17.6) of the estate youth knew about NCPA hotline 1929 while 23.1% (95%CI: 21.4-24.9) of the rural (the highest of all strata) knew about it. It was encouraging to note that the mother has been rated by nearly 23% of the Estate and N-E youth as a source of help following a rape.

## INFORMATION SOURCES ON SRH

It was interesting to note that sexual reproductive health information sources varied according to sex of the youth and the subject. Males relied on friends (46.2%) for puberty related information while girls accessed parents for the same (75.2%). For sexual problems nearly 40% males accessed friends while another 33.8% reached for newspapers.

Males relied on friends for puberty related information while girls accessed parents. For sexual problems males accessed friends and newspapers while females, used newspapers, teachers and parents.



Among females, the majority (43.2%) turned to newspapers for information on sexual health information including teenage pregnancy while teacher (37.2%) and parents (29.3%) were also cited as sources highlighting the need to build capacity of those groups on ASRH. It was striking that both sexes used friends (57.6%-63.9%) as the main information source on relationships while teacher and newspapers were approached to obtain knowledge on STI, HIV /AIDS.

**Table 2.21: Sources used by the youth to obtain information**

|                                 | Sex | Parent              | sibling             | Friends             | Teacher             | WWW                 | News papers         | Other               |
|---------------------------------|-----|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| Puberty                         | M   | 10.9<br>(9.6-12.4)  | 4.5<br>(3.7-5.6)    | 46.2<br>(44.0-48.4) | 31.6<br>(29.5-33.7) | 8.3<br>(7.2-9.6)    | 20.6<br>(18.8-22.5) | 6.8<br>(5.7-8.1)    |
|                                 | F   | 75.2<br>(73.5-76.8) | 16.5<br>(15.1-18.1) | 33.5<br>(31.6-35.4) | 33.3<br>(31.4-35.2) | 2.0<br>(1.5-2.6)    | 22.1<br>(20.4-23.9) | 5.5<br>(4.5-6.5)    |
| Family Plannin g                | M   | 20.2<br>(18.4-22.1) | 5.2<br>(4.3-6.3)    | 25.4<br>(23.5-27.4) | 24.2<br>(22.3-26.2) | 7.2<br>(6.1-8.3)    | 23.1<br>(21.2-25.0) | 7.4<br>(6.3-8.7)    |
|                                 | F   | 29.4<br>(27.6-31.4) | 9.3<br>(8.1-10.6)   | 17.7<br>(16.2-19.3) | 27.6<br>(25.8-29.5) | 3.8<br>(3.1-4.6)    | 27.9<br>(26.1-29.8) | 14.4<br>(13.0-15.9) |
| Sexual problems / teen pregn.   | M   | 6.7<br>(5.6-7.9)    | 3.7<br>(3.0-4.6)    | 39.9<br>(37.7-42.1) | 28.7<br>(26.7-30.8) | 11.1<br>(9.8-12.5)  | 33.8<br>(31.7-35.9) | 9.8<br>(8.5-11.3)   |
|                                 | F   | 29.3<br>(27.5-31.2) | 8.0<br>(6.9-9.2)    | 27.4<br>(25.6-29.2) | 37.2<br>(35.2-39.2) | 5.6<br>(4.7-6.5)    | 43.2<br>(41.2-45.2) | 12.4<br>(11.7-13.9) |
| Love / relationships / Marriage | M   | 20.2<br>(18.4-22.1) | 12.7<br>(11.2-14.3) | 63.9<br>(61.7-66.0) | 17.5<br>(15.9-19.4) | 6.2<br>(5.3-7.3)    | 24.6<br>(22.7-26.6) | 8.8<br>(7.5-10.2)   |
|                                 | F   | 37.3<br>(35.3-39.3) | 18.6<br>(17.0-20.3) | 57.6<br>(55.7-59.6) | 22.3<br>(20.6-24.1) | 5.0<br>(4.2-5.9)    | 30.7<br>(28.8-32.6) | 7.9<br>(6.8-9.1)    |
| STI/ HIV/AIDS                   | M   | 7.3<br>(6.2-8.6)    | 4.7<br>(3.8-5.8)    | 29.1<br>(27.1-31.2) | 43.8 (41.6-46.0)    | 15.6<br>(14.1-17.3) | 42.0<br>(39.8-44.2) | 10.6<br>(9.2-12.1)  |
|                                 | F   | 15.5<br>(14.0-17.1) | 5.4<br>(4.6-6.5)    | 18.1<br>(16.6-19.7) | 49.6<br>(47.6-51.6) | 10.5<br>(9.4-11.8)  | 50.1<br>(48.0-52.0) | 14.0<br>(12.6-15.6) |

(M: Male; F: Female) (Multiple options were allowed)

## FOOD AND DIET

Proper nutrition is essential for adolescent growth and development. Nutrition is determined by several factors including knowledge, skills, behavior and availability of a conducive environment.

### KNOWLEDGE ON DIET AND NUTRITION

For the question which tested their knowledge on iron rich food, the majority of both males and females had answered correctly without much sex or age group difference. Of them, 82.6% (95%CI: 81.5-83.7) had correctly identified dark green leaves as source of iron. However, eggs have been identified as an iron rich food by approximately one fifth (19.5%, 95%CI: 18.4-20.7) while fish /meat by only 38.5% (95%CI: 37.1-40.0). It was disappointing to note that youth were unaware of the advantages of fruit and vegetable intake, where only 34.1% (95%CI: 32.7-35.5) answered correctly.

34% youth knew the advantages of fruit and vegetable intake.

Significantly lower proportion of schooling youth have had breakfast regularly.

The majority (91.5%) of the sample claimed having breakfast regularly without a sex or age group difference. However, it was noted that significantly lower portion of school going young persons declared having breakfast regularly (11.0%, 95%CI, 9.5-12.9) compared to non-school going young persons (5.5%, 95% CI, 4.8-6.2).

### FAST /PRE-COOKED FOOD INTAKE BY YOUTH

High consumption of fast and pre-cooked food by adolescents and youth has become a common practice throughout the world. Excessive consumption of junk food leads to a multitude of health problems at present as well as in future adult life.

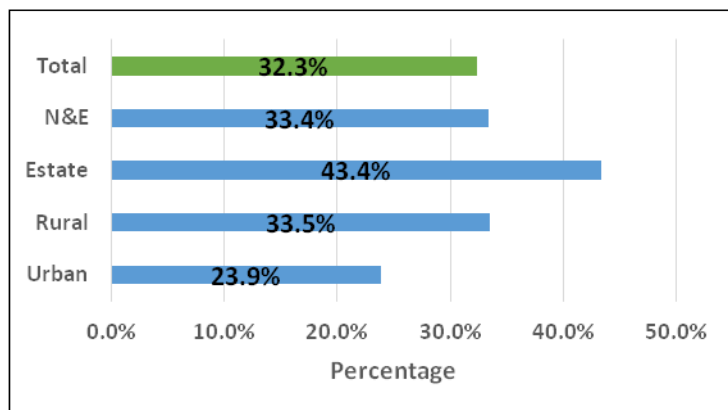
**Table 2.22: Intake of Fast /pre-cooked food /carbonated drinks by youth**

|   | Male %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     | Total %<br>(95%CI)  |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | 15-19 y             | 20 -24 y            | 15-19 y             | 20 -24 y            |                     |
| Cola drinks/<br>carbonated /<br>aerated soft drinks | 53.8<br>(51.7-56.0) | 54.4<br>(52.0-56.7) | 36.5<br>(34.6-38.4) | 35.9<br>(33.9-38.0) | 44.4<br>(43.4-45.5) |
| Sausages,<br>Meatballs/other<br>precooked food      | 20.9<br>(19.3-22.7) | 21.5<br>(19.7-23.5) | 17.5<br>(16.1-19.1) | 19.6<br>(18.0-21.3) | 19.8<br>(18.9-20.6) |
| Food Items with<br>high salty taste                 | 22.4<br>(20.6-24.3) | 22.0<br>(20.1-24.0) | 26.6<br>(24.8-28.4) | 26.4<br>(24.6-28.3) | 24.5<br>(23.6-25.5) |
| I have not taken<br>any of the above                | 28.3<br>(26.4-30.3) | 26.5<br>(24.5-28.6) | 39.2<br>(37.3-41.2) | 37.4<br>(35.3-39.4) | 33.4<br>(32.4-34.4) |

*(Multiple options were allowed)*

Nearly half of the boys in both age groups had consumed carbonated /cola drinks during the preceding week compared to 35-36% of females. One fifth of the sample had consumed pre- cooked food like sausages while one fourth had taken food with high salt. Significantly higher percentage of the urban youth revealed consumption of carbonated drinks and pre-cooked food compared to youth from other strata. It was noteworthy that 26%-28% of boys and 37%-39% of girls claimed that they never had unhealthy food mentioned during the preceding week and the difference was statistically significant.

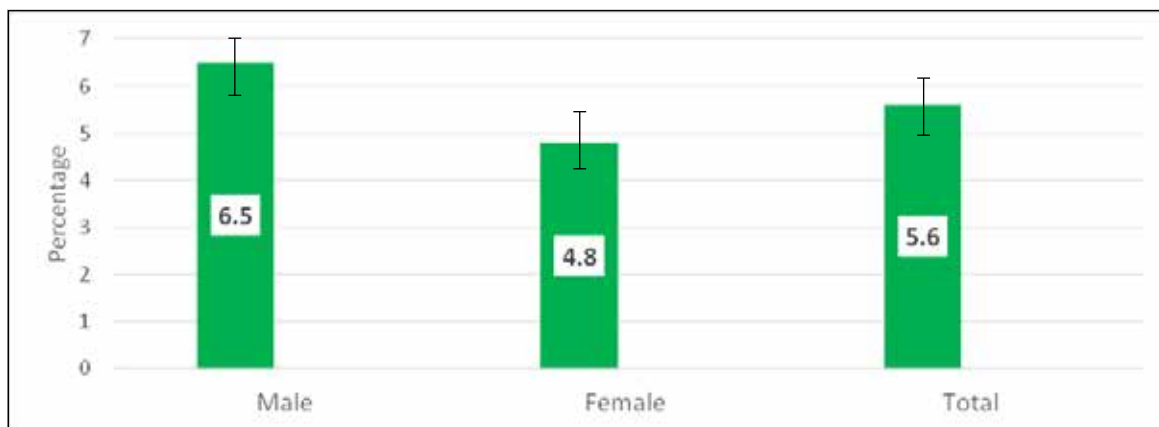
**Figure 2.29: Not consuming fast food /carbonated drink in the preceding week by strata**



Significantly higher portion of males and urban youth had consumed carbonated drinks and pre-cooked food

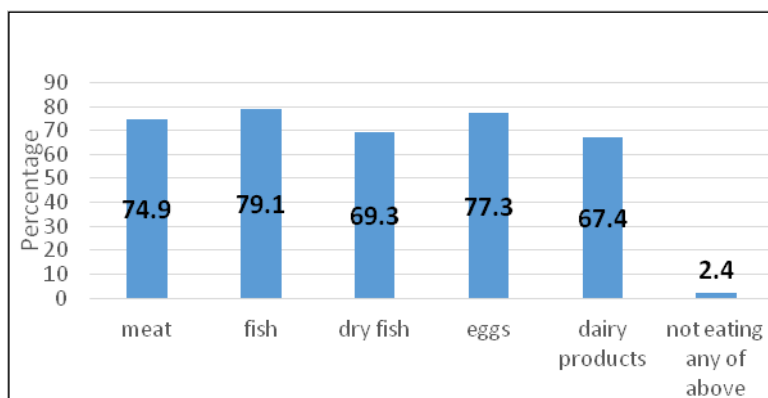
The survey explored the intake of any pills /powders to gain weight or energy without doctor’s advice during the preceding 30 days.

**Figure 2.30: Youth taking energy pills /powders without medical advice**



About 5.6% of the total youth reported of taking energy formulas with a male predominance. It was noteworthy that significantly more males had consumed red bull (2.5%) compared to females (0.3 %) and about 1.8% were taking some kind of vitamin without sex or age group difference during the stipulated period. The urban youth had the highest intake of such products (9.9%) followed by the estate (6.3%), N-E (6.3%) and rural youth (4.3%).

**Figure 2.31: Dietary patterns among youth**



- 5.6% youth had taken energy formulas /vitamins without prescriptions with
- 2.7% were vegans.
- 50.4% had heard about BMI

Nearly 70% of youth consumed animal sources of food regardless of their sex or age group. Only 67.4% claimed of consuming dairy products while 2.7% (2.4-3.1) have reported as being vegans. The concept of Body Mass Index (BMI) has been incorporated into school curriculum and was supposed to be measured at school medical inspection as an indicator of their nutritional status.

**Table 2.23: Awareness on the concept of Body Mass Index among youth**

| Question                              | Male %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     | Total %<br>(95%CI)  |
|---------------------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
|                                       | 15-19 y             | 20 -24 y            | 15-19 y             | 20 -24 y            |                     |
| % heard of Concept of Body Mass Index | 45.7<br>(43.6-47.6) | 46.9<br>(44.6-49.2) | 53.2<br>(51.2-55.1) | 54.8<br>(52.7-56.8) | 50.4<br>(49.4-51.5) |

The survey inquired whether they have heard about BMI with regard to their height and weight. Only half of the youth sample, reported that they have heard of it with a significant female and schooling youth predominance.

## VIOLENCE

Violent behavior among adolescents and youth can range from physical aggression to intentional destruction of property and homicides. The young person can be a victim, an offender, or a witness to the violence.

## VIOLENCE AMONG YOUTH

The survey asked about exposure to fights which required them to seek medical treatment during the preceding 12 months. Of the sample 3.7% of 15 -19 years and 2.9% of 20-24 year old males had answered positively. Significantly more male youth reported as having engaged in such violent acts.

**Table 2.24: Involvement in physical fights and consequences during preceding 12 months**

| Question   | Male %<br>(95%CI) |                  | Female%<br>(95%CI) |                  |
|--|-------------------|------------------|--------------------|------------------|
|  | 15-19 y           | 20 -24 y         | 15-19 y            | 20 -24 y         |
| Involved with a fight during past 12 months which needed medical treatment | 3.7<br>(2.7-4.9)  | 2.9<br>(2.0-4.0) | 1.5<br>(0.9-2.3)   | 1.1<br>(0.7-2.0) |
| Not able to engage in routine work due to the last incidence of violence   | 1.3<br>(0.8-2.1)  | 1.7<br>(1.0-2.7) | 0.6<br>(0.3-1.2)   | 0.3<br>(0.1-0.9) |

There was no significant differences among the youth groups classified based on their religion or strata or schooling status with respect to involvement with fights during previous 12 months. However significantly higher urban (3.6%) and estate (3.2%) youth reported about fights compared to the rural (2.0%) and N-E (1.7%).

## MOOD

Adolescence and youth can be considered as a period of frequent mood swings, due to biological factors related to puberty and also due to psychosocial factors associated with transition from childhood to adulthood. With regard to mood disorders in this age group, the symptoms are atypical and difficult to diagnose. Youth’s insight on general happiness, main worries, feeling life is not worth living and suicidal feelings were explored as indicators of mental health.

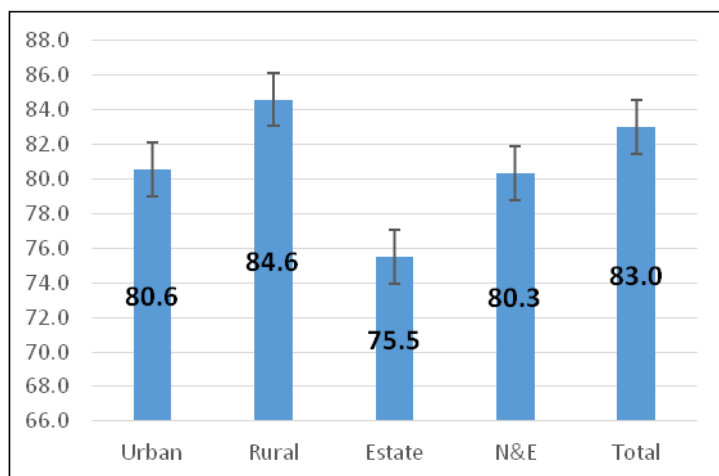
## HAPPY MOOD

Evidence shows that those who experienced happiness were successful in various aspects of life and development including relationships, income and education. It was interesting to note that 83.1% of our youth reported having a happy mood during the preceding two weeks irrespective of their sex. It was noted that significantly lower proportion of the estate youth reported having a happy mood (75.5%; 95%CI: 73.3-76.6) while significantly higher proportion of the rural youth revealed of having a happy mood (84.6%; 95%CI: 83.0-86.1) compared to others.

**Table 2.25: Presence of Happy mood during preceding 2 weeks**

|   | Male %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     | Total %<br>(95%CI)  |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | 15-19 y             | 20 -24 y            | 15-19 y             | 20 -24 y            |                     |
| % were in a happy mood for most of the time during past 2 weeks | 84.6<br>(82.3-86.6) | 84.1<br>(81.7-86.2) | 82.7<br>(80.5-84.7) | 80.9<br>(78.7-83.1) | 83.1<br>(81.9-84.2) |

**Figure 2.32: Presence of happy mood by strata**



- 83% of the total youth reported of having a happy mood during the preceding two weeks.
- Exams, Finding a job and finding money were the major reasons for youth worries.

The presence of a happy mood during the preceding two weeks did not vary much based on schooling status or marital status. However youth belonging to higher socio-economic group reported significantly higher proportions of having a happy mood compared to the youth in the lowest socio-economic category.

On analyzing of factors which might have worried them, 26.6% of boys reported “finding a job”. Nearly a third of 15-19 year old girls were worried about exams. It was noteworthy that boys were more worried about relationships compared to girls. Statistically significant higher proportion of boys were worried about the current job.

Parental conflicts /family disputes had affected more females while body size was a worrying factor for males. Interestingly 28.7% declared that nothing worries them at present.

The reported figures were comparable with the figures reported in the 2004 UNICEF survey with reference to out of school adolescents of 15-19 years old where 25% reported nothing worries them, 25% worried about finding a job while 5% was anxious on adolescent-parent relationships.

**Table 2.26: Reported reasons for worry**

| Things that worry them at present         | Male %               |                     | Female%              |                     | Total % (95%CI)     |
|---|----------------------|---------------------|----------------------|---------------------|---------------------|
|   | 15-19 y (95%CI)      | 20 -24 y (95%CI)    | 15-19 y (95%CI)      | 20 -24 y (95%CI)    |                     |
| Exams                                     | 28.2<br>(25.4 -31.2) | 25.4<br>(22.7-28.3) | 29.3<br>(26.7 -31.9) | 26.8<br>(24.3-29.5) | 27.5<br>(26.2-28.9) |
| Finding a job                             | 26.7<br>(24.0-29.5 ) | 26.6<br>(23.9-29.4) | 22.7<br>(20.4-25.2)  | 23.3<br>(20.9-25.8) | 24.8<br>(23.5-26.1) |
| Finding money for day to day expenditures | 16.5<br>(14.3-18.9)  | 17.2<br>(14.7-19.5) | 12.6<br>(10.8 -14.6) | 11.7<br>(9.9 -13.6) | 14.4<br>(13.4-15.5) |
| My Romantic relationships                 | 11.7<br>(9.8-13.9)   | 11.4<br>(9.5-13.8)  | 7.7<br>(6.3 -9.5)    | 7.8<br>(6.3 -9.5 )  | 9.6<br>(8.7 -10.6)  |
| Body size                                 | 7.5<br>(5.8-9.2)     | 7.4<br>(5.8-9.3)    | 6.7<br>(5.4-8.4)     | 6.8<br>(5.4-8.4)    | 7.1<br>(6.3-7.9)    |
| Illness/Phobias                           | 4.6<br>(3.4-6.1)     | 4.8<br>(3.6-6.45)   | 5.5<br>(4.3-6.9)     | 5.4<br>(4.2-6.9)    | 5.1<br>(4.4-5.8)    |
| Current job                               | 6.5<br>(5.1 -8.3)    | 7.3<br>(5.8-9.1 )   | 2.9<br>(2.1-3.9)     | 3.3<br>(2.4-4.4)    | 4.9<br>(4.3-5.6)    |
| Arguments with parents                    | 3.5<br>(2.6-4.9)     | 3.9<br>(2.9-5.5)    | 3.6<br>(2.7-4.8)     | 4.7<br>(3.6-6.0)    | 3.9<br>(3.4-4.56)   |
| Parental conflicts / family disputes      | 2.4<br>(1.6-3.6)     | 2.9<br>(2.0-4.3)    | 3.2<br>(2.3-4.5)     | 3.3<br>(2.4-4.6)    | 2.9<br>(2.5-3.5)    |
| Finding a boy /girlfriend                 | 4.2<br>(3.1-5.7)     | 3.6<br>(2.5-5.0)    | 0.6<br>(0.3-1.2)     | 0.5<br>(0.3-1.1)    | 2.2<br>(1.8-2.7)    |
| Finding a suitable person for marriage    | 2.9<br>(2.0-4.3)     | 1.7<br>(1.0-2.8)    | 0.8<br>(0.5-1.5)     | 1.4<br>(0.89-2.12)  | 1.7<br>(1.4-2.2)    |

*(Multiple options were allowed)*

## SUICIDAL IDEATION

Suicide was considered as one of the leading cause of death in adolescence and youth. Significantly more females have had the feeling that their life was not worth living. Nearly one fifth of youth complained of feeling sad or helplessness and had stopped their routine work; 6.4% felt like above for two weeks or more in a row while similar proportion seriously thought about committing suicide during the preceding 12 months, 4.0% made plans and 2.9% sought some help.

19.1% ever felt their life is not worth living  
6.4% had depressive feelings  
6.4% seriously attempted suicides and 4.0 made plans and 2.9% sought help.



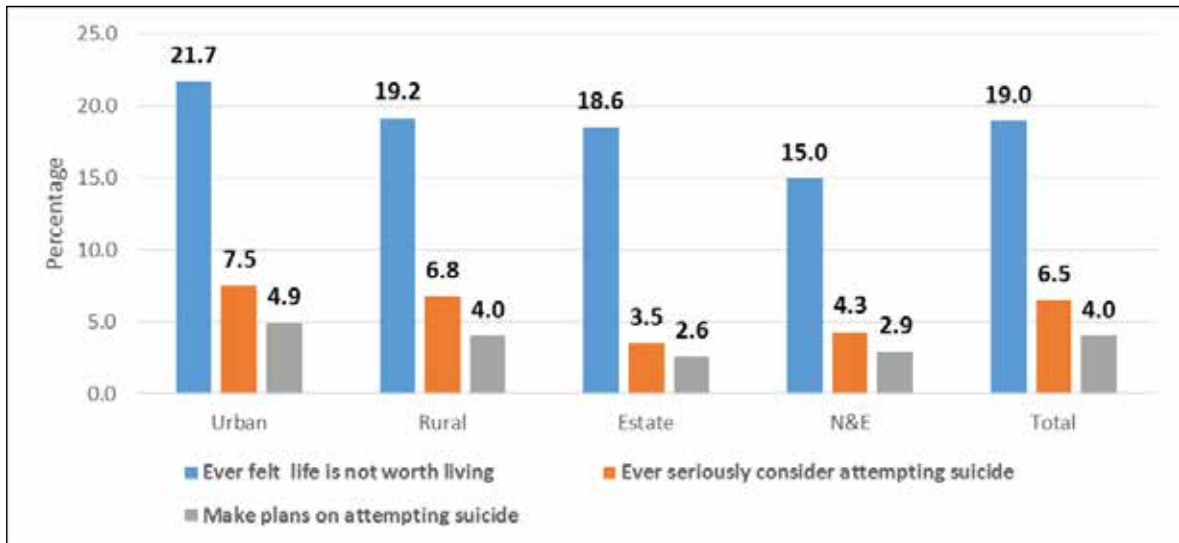
**Table 2.27: Suicidal feelings and actions taken during past 12 months (of total youth sample)**

|   | Male %              |                     | Female%             |                     | Total %<br>(95%CI)  |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) |                     |
| Ever felt that their life is not worth living   | 17.1<br>(14.7-19.5) | 15.9<br>(13.7-18.3) | 21.6<br>(19.3-24.0) | 21.7<br>(19.5-24.2) | 19.1<br>(17.9-20.3) |
| Ever felt so hopeless and had to stop some usual activities during the past 12 months | 18.5<br>(16.2-21.0) | 21.6<br>(19.1-24.3) | 19.9<br>(17.8-22.3) | 21.8<br>(19.5-24.2) | 20.4<br>(19.2-21.6) |
| Felt like above almost every day for two weeks or more in a row                       | 5.9<br>(4.6-7.4)    | 7.7<br>(6.2-9.6)    | 5.1<br>(4.1-6.5)    | 6.7<br>(5.5-8.3)    | 6.4<br>(5.7-7.1)    |
| Seriously considered attempting suicide in the past 12 months                         | 5.5<br>(4.3-7.2)    | 5.1<br>(3.9-6.7)    | 8.3<br>(6.8-10.1)   | 6.9<br>(5.6-8.5)    | 6.4<br>(5.8-7.3)    |
| Made plans about how they would attempt suicide                                       | 3.2<br>(2.2-4.4)    | 2.8<br>(1.9-4.0)    | 5.6<br>(4.4-7.1)    | 4.4<br>(3.3-5.6)    | 4.0<br>(3.5-4.6)    |
| Sought help to relive their suicidal feelings   | 2.2<br>(1.5-3.4)    | 2.4<br>(1.6-3.6)    | 4.2<br>(3.1-5.6)    | 3.0<br>(2.2-4.2)    | 2.9<br>(2.5-3.6)    |

Higher proportions in older age group (20-24 years) complained of feeling sad or helpless and stopped their usual acts for two weeks or more in both sex groups. However when it comes for seriously thinking of committing suicide, the younger age group (15-19years) was slightly predominant, which could have been attribute to a lack of capacity in controlling emotions due to their developing brain.

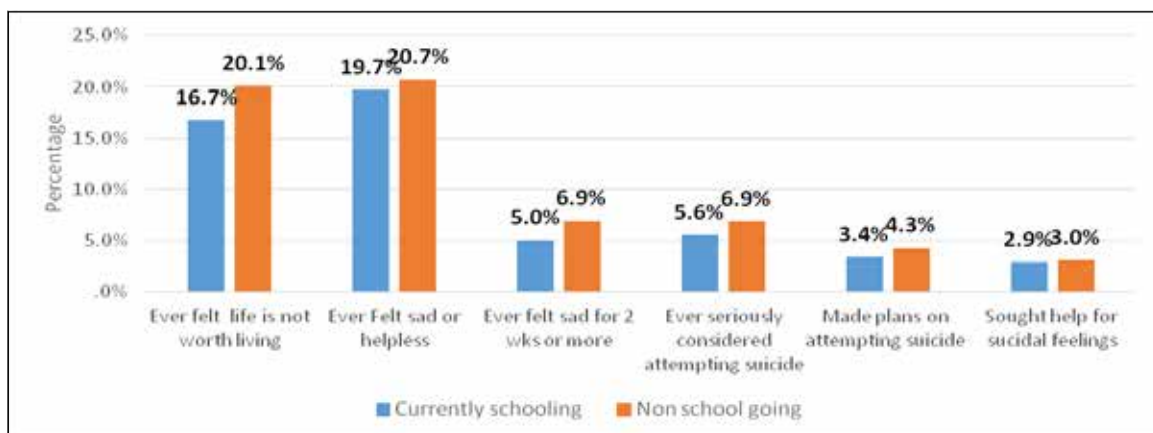
Out of those who felt hopeless and stopped some of their usual activities for almost every day for two weeks or more in a row, 35.0% (95% CI: 29.7-40.8) had seriously considered of attempting suicide. Out of those who seriously considered of attempting suicide, 61.7% (95%CI: 55.6-67.3) made plans. There were no statistical significance sex wise or age wise differences with regard to attempting suicide or making plans to suicide although younger age groups and female youth were having slightly higher proportions in both indices.

**Figure 2.33: Suicidal feelings among youth by strata (of the total sample)**



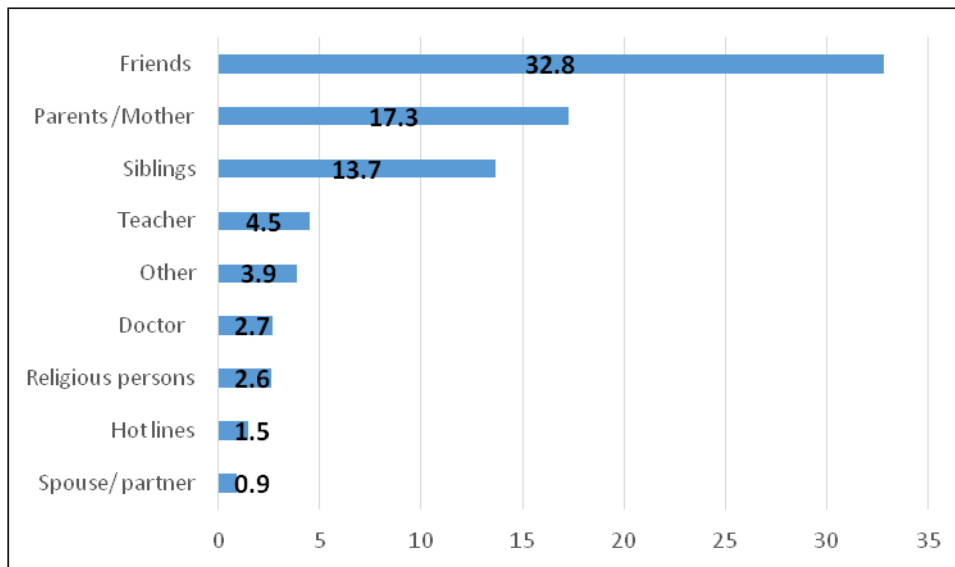
The urban youth were having higher proportion of depressive feelings, higher risk for attempting suicide and making plans to do so. However the observed differences were not statistically significant. In depth assessment is needed to find out reasons for these suicidal ideations. Data were analysed according to schooling status to facilitate, upgrading of existing health programmes.

**Figure 2.34: Suicidal feelings and actions by schooling status**



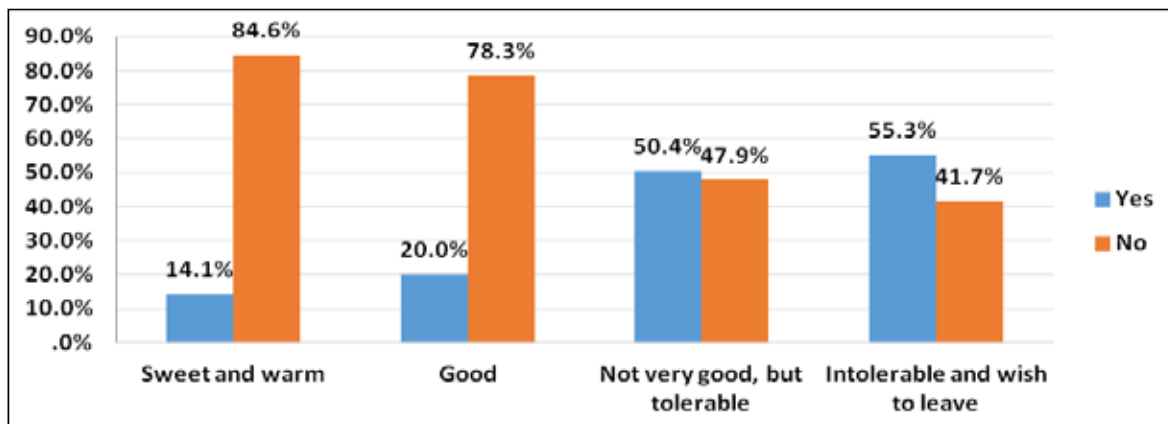
Non-school going youth reported an increase in depressive and suicidal feelings and for making plans to commit suicide. However the observed difference was statistically not significant. All six indicators related to occurrence of suicidal feelings had a significant negative correlation with socio-economic status of youth. (data not shown)

**Figure 2.35: Persons contacted for help by the youth for suicidal feelings**



Friends have been highlighted as the most approached group where 32.8% of those who seriously considered of attempting suicide had sought help from friends irrespective their sex and age followed by parents (17.3%).

**Figure 2.36: Association between Youth feelings as life is worthless and family connectedness**



The above graph denotes there was a significant association between depressive feeling and their family connectedness.

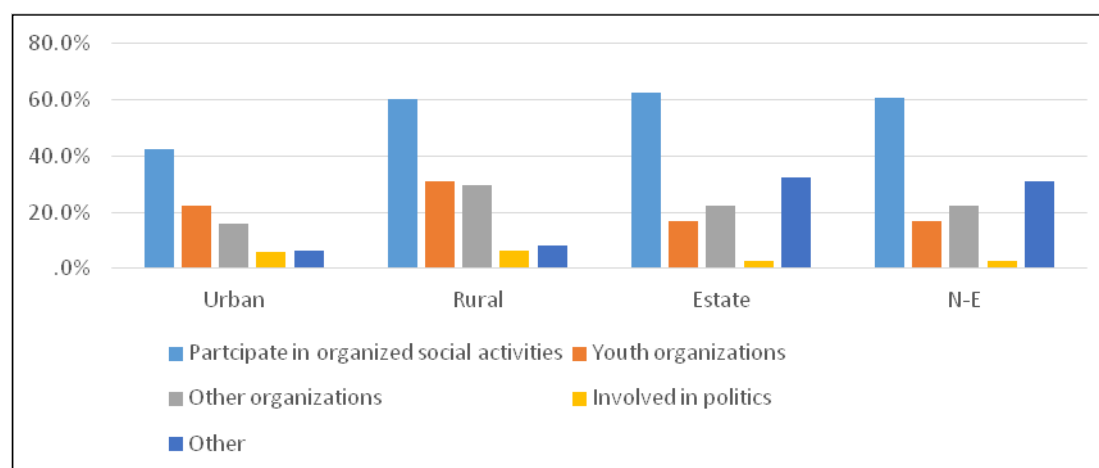
Nearly 50%-55% of youth whose family was “not good or intolerable” had more suicidal feelings reported as “ever felt that life was not worth living” compared to 14.1% who declared their family was “sweet and warm”.

## SOCIAL HEALTH

### SOCIAL ACTIVITIES

Youth social participation is vital in acquiring skills and experience for a successful transition to adulthood. Youth need to be empowered for their own development and also development of their communities. The survey explored the extent of youth participation in organized social activities in their communities. Nearly half (57.4%) of the sample, 66.2% of males and 49.3% of females answered positively. Significantly more males were engaged in such activities.

**Figure 2.37: Participation of youth in organized social activities by strata**



The survey explored the types of social activities the youth routinely engaged, 27.5% participate in youth clubs, 26.1% in other clubs, 11.3% highlighted about other work like Shramadana while a few (5.6% of total) were involved in politics. Significantly higher proportion of the rural youth were engaged in youth based organizations. A striking feature to note was the low proportions of N-E (2.7%) and estate (2.8%) youth engaged in politics compared to urban (5.7%) and rural (6.2%) youth.

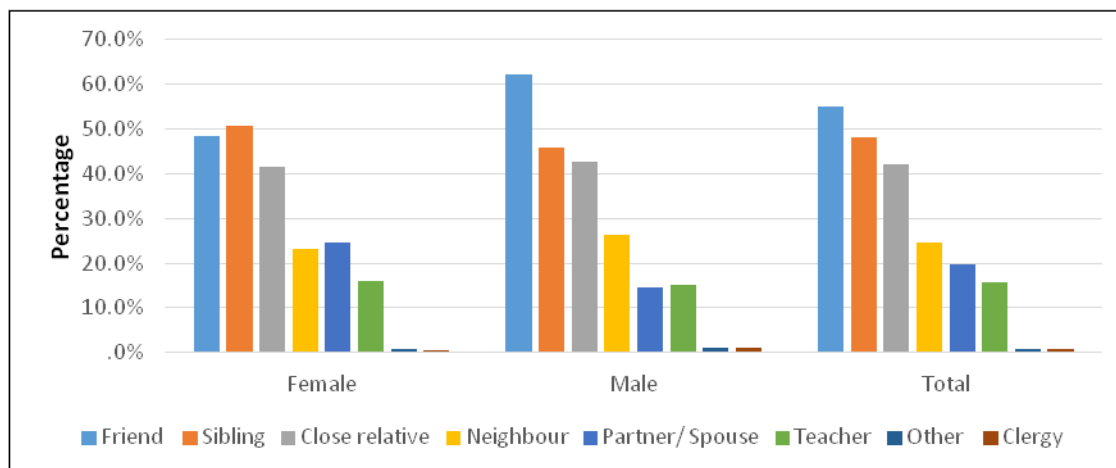
27.5% participated in youth clubs, 26.1% in other clubs, 11.3% engaged in public work and 5.6% in politics. Higher portion of rural youth engaged in social activities

## SOCIAL CAPITAL

"Social capital" refers to what extent that one's family, friends, and associates constitute an important asset, one that can be called upon in a crisis. Social capital plays a significant role in youth development as they facilitate optimum psychosocial development. It was appealing to see that Sri Lankan youth were blessed with social capital as 80.6% have reported that there would be someone (other than their parents) who would offer help if they were in trouble irrespective of their sex or age. Nearly half of the youth (55.2%) have identified friends as the social asset with a significant sex difference. Males have selected friends (60.5%-63.9%), while females selected both friends and siblings.

80.6% reported that they have someone to help them if they are in trouble. For males it was friends and for females it was siblings and friends.

**Figure 2.38: Social assets identified by youth by sex**



The survey asked "whom they would talk about a personal/private matter to?" Of the weighted sample, 46.1% reported, it would be their "mother" with a significant difference between males and females. When 57.8%-59% female youth approached their mother for private matters, only 32.5%-34% male youth reported so. Males relied on "friends" mostly.

46.1% identified "mother" as the person to talk about a private matter

Next preferred person was the "friend" and again with a sex difference. It was noted that fathers were less approached by both young males and females for personal problems.

**Table 2.28: Persons to contact for personnel matters**

| Persons to talk about a personnel and private matter | Male %              |                     | Female%             |                     | Total % (95%CI)     |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
|  | 15-19 y (95%CI)     | 20 -24 y (95%CI)    | 15-19 y (95%CI)     | 20 -24 y (95%CI)    |                     |
| Mother   | 34.0<br>(31.1-37.0) | 32.5<br>(29.6-35.5) | 59.0<br>(56.3-61.8) | 57.8<br>(55.0-60.6) | 46.1<br>(44.6-47.5) |
| A friend   | 52.2<br>(49.0-55.3) | 50.2<br>(47.0-53.3) | 31.4<br>(28.9-34.1) | 33.9<br>(31.2-36.6) | 41.8<br>(40.3-43.2) |
| Spouse/partner                                       | 18.9<br>(16.5-21.5) | 19.2<br>(16.8-21.9) | 27.3<br>(24.9-30.0) | 30.0<br>(27.4-32.8) | 23.9<br>(22.7-25.2) |
| Sibling  | 17.6<br>(15.4-20.0) | 17.7<br>(15.4-20.2) | 23.9<br>(21.6-26.5) | 24.1<br>(21.7-26.6) | 20.8<br>(19.7-22.1) |
| Father   | 15.4<br>(13.2-17.9) | 17.4<br>(15.1-20.0) | 11.6<br>(9.9-13.6)  | 11.6<br>(9.8-13.5)  | 13.9<br>(12.9-15.0) |
| Teacher  | 9.3<br>(7.7-11.3)   | 8.2<br>(6.7-10.2)   | 7.0<br>(5.6-8.6)    | 7.6<br>(6.2-9.3)    | 8.0<br>(7.2-8.9)    |
| A close relative                                     | 4.5<br>(3.5-5.8)    | 6.7<br>(5.3-8.4)    | 5.4<br>(4.2-6.8)    | 5.5<br>(4.3-6.9)    | 5.5<br>(4.9-6.2)    |

*(Multiple options were allowed)*

## PERCEPTION OF BEING DISCRIMINATED

Discrimination symbolizes a significant social problem throughout the world with negative impact on developmental aspects of youth especially on their self-esteem and identity development. Young people can be discriminated due to their sex, cast, race or religion. The survey examined the perceptions about feelings of ever been discriminated in education or seeking employment opportunities.

*8.1% youth had felt being discriminated ever with higher proportion among the estate youth. The commonest reason for such discrimination was “their income level”.*

Of the sample 8.1% (95%CI, 7.4%-8.9%) reported that they felt discriminated without much sex or age group difference and 7.5% males and 8.8% females answered positively. It was noted that the most commonly cited perceived reason was their income level followed by their sex.

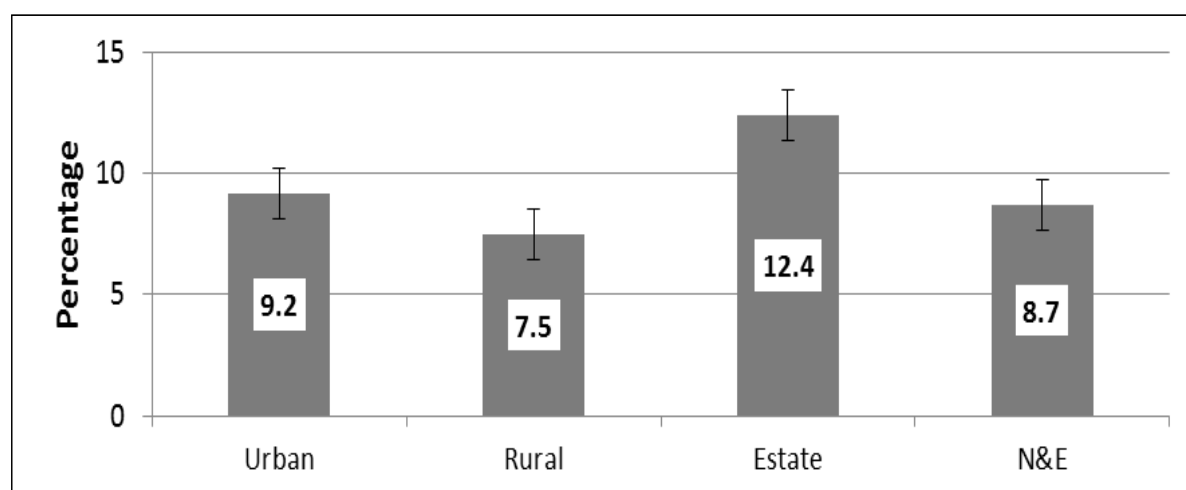
**Table 2.29: Perceived reasons for being discriminated (of those who had discriminated feeling ever)**

| Perceived reasons | Male%<br>(95%CI)    | Female %<br>(95%CI) | Total%<br>(95%CI)   |
|-------------------|---------------------|---------------------|---------------------|
| Income status     | 43.2<br>(35.7-51.0) | 45.9<br>(39.3-52.6) | 44.7<br>(39.7-49.8) |
| Sex               | 23.9<br>(17.8-31.5) | 44.0<br>(37.4-50.8) | 35.0<br>(30.2-40.0) |
| Cast              | 17.9<br>(12.6-24.8) | 15.0<br>(10.6-20.7) | 16.3<br>(12.8-20.6) |
| Religion          | 16.7<br>(11.8-23.0) | 9.6<br>(7.1-12.8)   | 12.8<br>(10.1-16.1) |
| Race              | 12.6<br>(8.9-17.5)  | 4.6<br>(2.8-7.3)    | 8.2<br>(6.2-10.7)   |
| Other             | 4.3<br>(2.0-8.9)    | 5.7<br>(3.2-10.0)   | 5.1<br>(3.2-7.9)    |

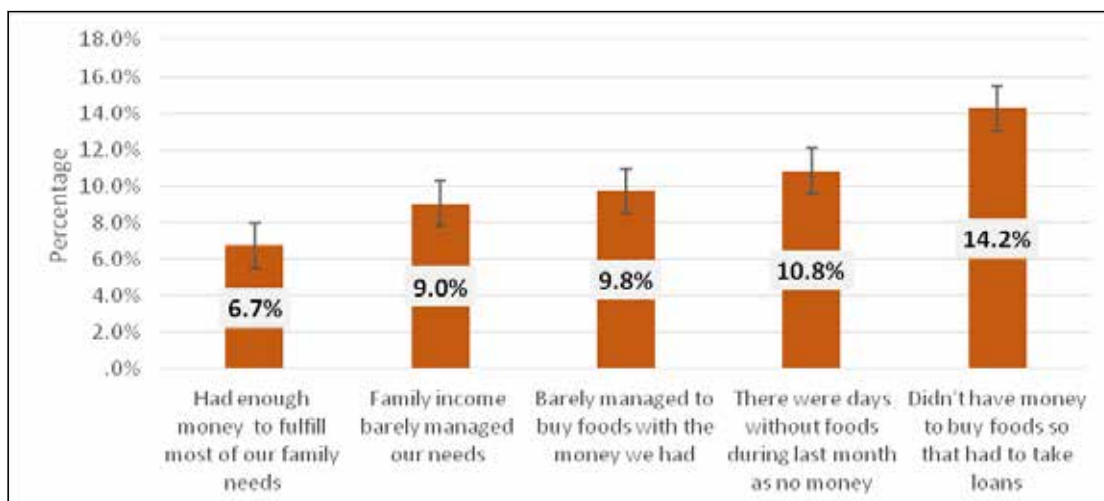
(Multiple options were allowed)

The perceived status of ever being discriminated was significantly higher among the estate youth. Youth belong to poor socioeconomic status measured as “not having money to buy food” were having increased experiences of ever being discriminated.

**Figure 2.39: Youth ever felt discriminated by strata**



**Figure 2.40: Youth ever felt discriminated by family socio economic status**



## SUBSTANCE ABUSE

Tobacco, alcohol and other drug use among youth is a major public health problem in Sri Lanka. Substance use increases the risk for injuries, violence, STI/HIV infection, and other diseases including non-communicable diseases in later life. The typical risk taking behavior during the adolescence facilitates the first puff of a cigarette, and first sip of alcohol to be tried out. Young people who abuse substances experience various problems, including academic difficulties, health-related problems, poor peer relationships, and involvement with the juvenile justice system in addition to consequences for family members, the community, and the wider society.

The substance use was analyzed according to sex, strata and schooling status, to facilitate targeted interventions in preventing substance use among youth groups.

## SMOKING

One third (30.5%; 95%CI: 28.4-32.6) of the total male group and 1.6% (95%CI: 1.2-2.2) of the total female group have tried a cigarette even once.

On questioning the current use, the survey asked about tobacco use during the week preceding the survey. Significant higher proportion of males (17.6%; 95% CI: 15.9-19.4) reported current use (smoking in the preceding week) compared to females (0.7%; 95%CI: 0.4-1.1).

Current use of smoking among male youth was 17.6%.

Significantly lower fraction of schooling youth, N-E youth, youth belonged to caring families were currently smoking.

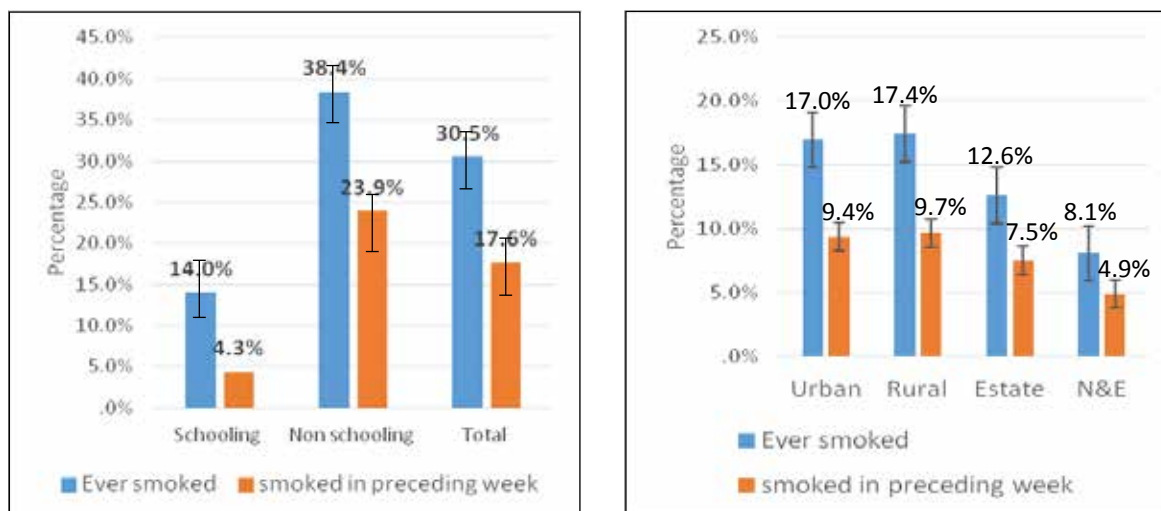


**Table 2.30: Prevalence of ever smoke and current smoke by sex and age groups**

|                                | Male %              |                     | Female%            |                     | Total %<br>(95%CI)  |
|--------------------------------|---------------------|---------------------|--------------------|---------------------|---------------------|
|                                | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) | 15-19 y<br>(95%CI) | 20 -24 y<br>(95%CI) |                     |
| % Ever smoked                  | 28.9<br>(26.0-31.8) | 31.7<br>(28.8-34.8) | 1.8<br>(1.2-2.8)   | 1.3<br>(0.8-2.1)    | 15.7<br>(14.6-16.7) |
| % smoked in the preceding week | 18.0<br>(15.6-20.6) | 17.1<br>(14.9-19.7) | 0.8<br>(0.4-1.5)   | 0.6<br>(0.2-1.2)    | 9.0<br>(8.2-9.9)    |

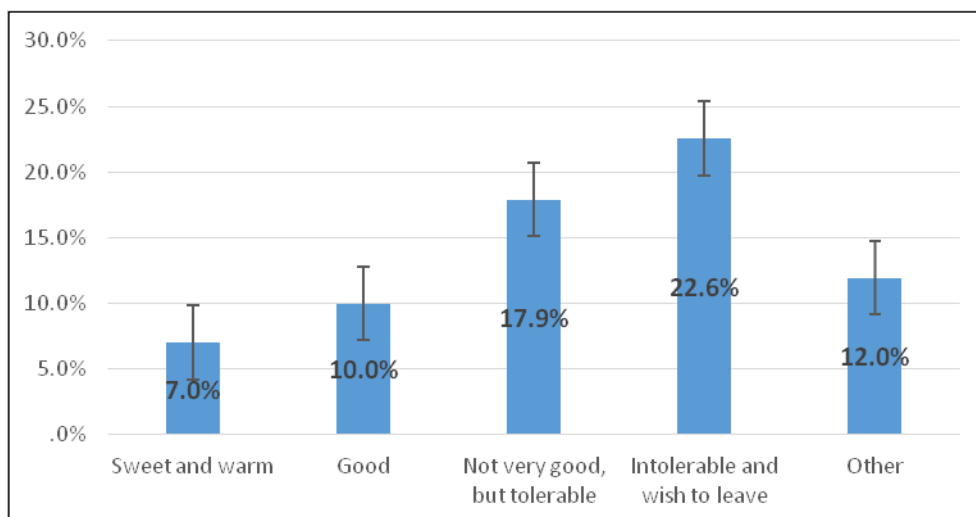
The sub analysis was conducted only for male youth to see any variances depending on strata or schooling status.

**Figure 2.41: Smoking among males by schooling status and by strata**



Significantly more non schooling male youth (23.9%; 95%CI: 21.7-26.4) reported smoking during the preceding week compared to the schooling youth (4.3%; 95%CI: 2.9-6.3). The N-E youth were having markedly lower current smoking prevalence. Results were analyzed according to the family characteristics which revealed that the presence of a caring family was significantly associated with lower current use of tobacco among the youth sample. However the present sample failed to show any association between current smoking and family socioeconomic status.

**Figure 2.42: Current smoking by family characteristics**



Exposure to tobacco with betel chewing among these youth groups during the preceding week was explored. It was noted that 6.3% had answered positively with a significant male predominance.

**Table 2.31: Current use of betel chewing with tobacco**

|  | Male %              |                     | Female%            |                     | Total %<br>(95%CI) |
|--|---------------------|---------------------|--------------------|---------------------|--------------------|
|  | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) | 15-19 y<br>(95%CI) | 20 -24 y<br>(95%CI) |                    |
| % consumed tobacco with beetle during the preceding week | 13.0<br>(10.9-15.4) | 11.3<br>(9.4-13.6)  | 0.8<br>(0.4-1.5)   | 0.6<br>(0.3-1.2)    | 6.3<br>(5.6-7.2)   |

The proportion was significantly higher among the rural strata with 7.5% (95%CI: 6.4-8.7). Significantly more non-school going youth reported chewing tobacco with betel during the preceding week of 7.6% as compared to 3.3% of school going youth (data not shown).

## ALCOHOL USE

As per alcohol use, the ever use, current use (use during the preceding week) and the findings were similar to smoking.

Nearly one third of boys (34.9% of total male youth) have tried alcohol even once compared to 3.8-5.0% of girls. A significantly lower proportion of N-E youth had ever used alcohol compared to others.

Ever use and current use of alcohol among males were 35% and 10%. Significantly higher fraction of males, non-Schooling youth, rural youth, youth belonged to “intolerable” families, youth from lower socio economic families were engaged in current alcohol consumption.

**Table 2.32: Prevalence of Alcohol use among youth**

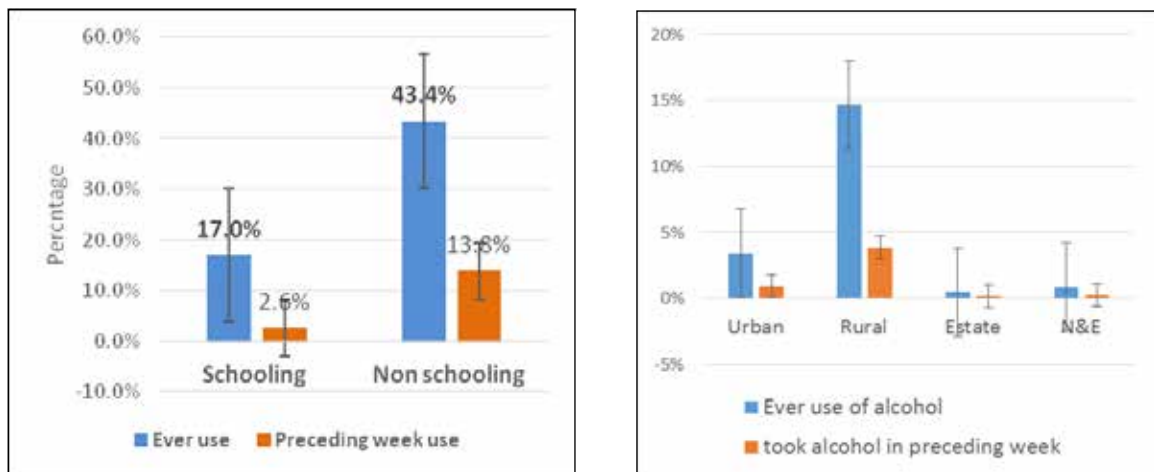
| Question  | Male %               |                     | Female%            |                     | Total %<br>(95%CI)  |
|---|----------------------|---------------------|--------------------|---------------------|---------------------|
|   | 15-19 y<br>(95%CI)   | 20 -24 y<br>(95%CI) | 15-19 y<br>(95%CI) | 20 -24 y<br>(95%CI) |                     |
| % Ever use alcohol<br>(including beer, wine,<br>illicit liquor) | 32.7<br>(29.7 -35.7) | 37.3<br>(34.3-40.5) | 4.9<br>(3.8-6.4)   | 3.8<br>(2.9-5.1)    | 19.4<br>(18.3-20.6) |
| % Had alcohol in<br>preceding week                              | 10.4<br>(8.6-12.5)   | 10.0<br>(8.3-12.1)  | 0.6<br>(0.3-1.3)   | 0.6<br>(0.3-1.3)    | 5.3<br>(4.7-6.0)    |

The survey inquired about alcohol use during the week prior to the survey as an indicator for current use of alcohol. Nearly 10.2% (95%CI: 8.9-11.7) of male youth and 0.6% (95%CI: 0.3-1.0) of female youth have consumed alcohol during the preceding week.

There was an increase in current use of alcohol with age. Significantly more non-schooling youth had ever used alcohol (16.3% 95% CI: 15.1-17.5) and during the preceding week (4.9% 95%CI: 4.2-5.6) compared to schooling youth. The respective figures for schooling youth were 3.1% (95%CI: 2.6-3.8) and 0.5 (95%CI: 0.3-0.7). Similarly both ever use (14.7%; 95%CI: 13.5-15.9) and current use (3.9%; 95%CI: 3.2-4.6) were significantly higher among rural youth.

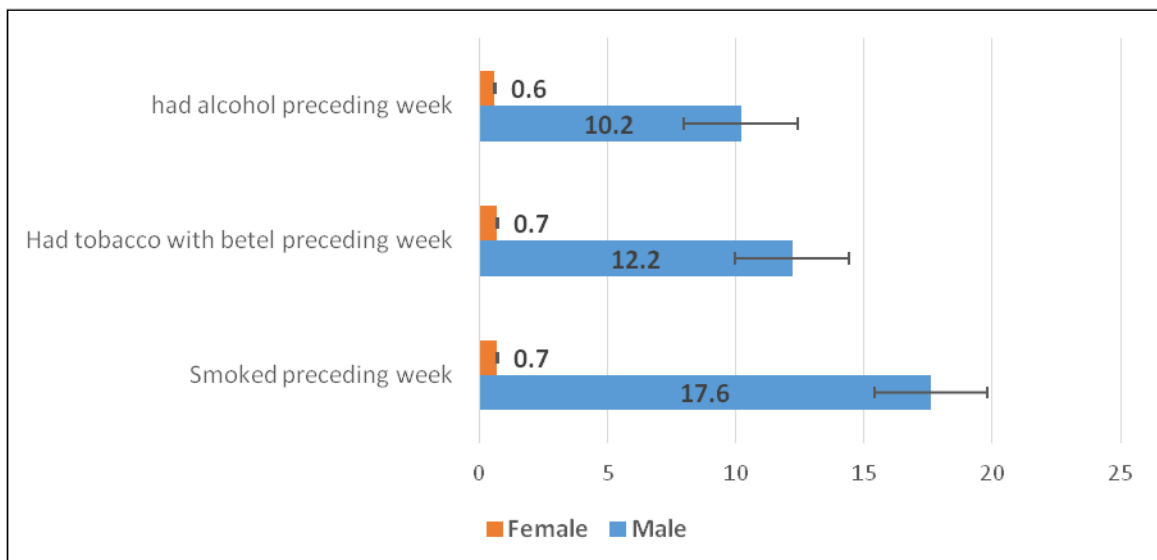
Current use of alcohol was higher among youth with families categorized as “intolerable” (13.1%) compared to “sweet and warm” families (4.2%). This association was observed with socioeconomic status of the family as well, where youth belonging to families with better socioeconomic background were having a lower current alcohol consumption (5%) compared to poor families (10%) identified by the label “there were days without food due to lack of money”.

**Figure 2.43: Prevalence of alcohol use by schooling status and strata (among male youth)**



In general, it seems that male youth were having significantly higher current use of all substances as per the figure below.

**Figure 2.44: Current substance use by youth by sex**



It was also evident that one risk behavior (smoking) was significantly associated with another risk behavior (alcohol use) where the youth who were smoking during the preceding week were more likely to take alcohol. Of the youth who had consumed alcohol during the preceding week, 69.3% had practiced smoking.

## REASONS FOR NON-USE OF ADDITIVE SUBSTANCE

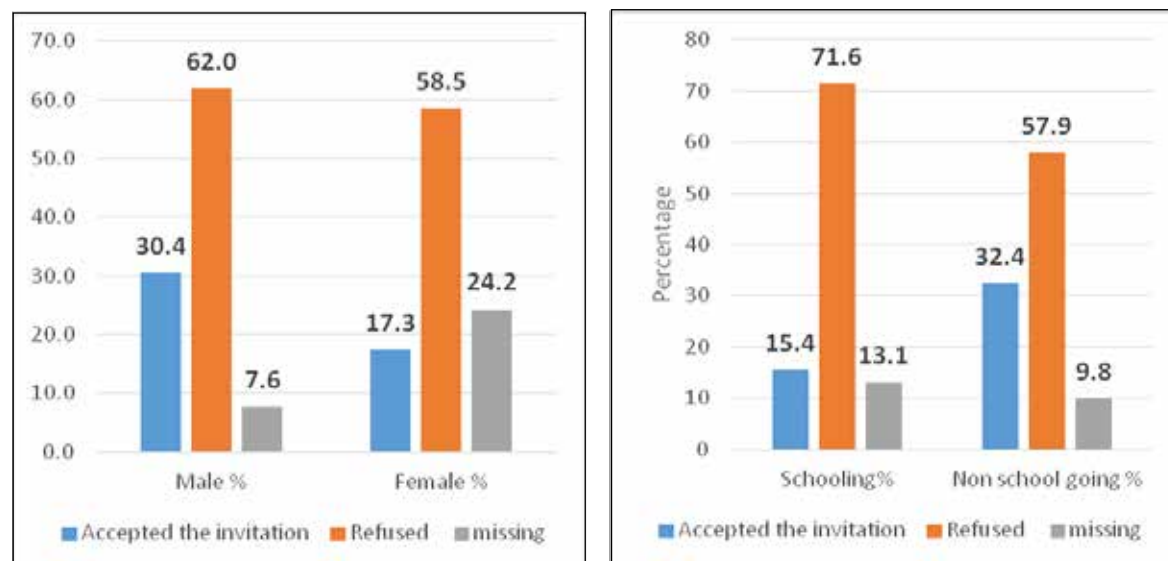
The survey explored the youth skills on refusing substance, by inquiring about invitations for such substance use in the past. Nearly 17% (95%CI: 15.9-18.2) answered affirmatively with 28.3% of males (95%CI: 26.3-30.4) and 6.0% of females (95% CI: 5.1-7.1).

The survey explored the youth response for invitation to use substance from those who had such opportunity. About 61% had refused it while another 28% accepted and tried it. A significantly higher proportion of males and non-school going youth have accepted the invitation.

61% of youth who received invitations for substance use, had refused such invitations due to

“As they do not give such a kick as claimed”, “parental disapproval”, “and “religious norms”.

**Figure 2.45: Youth response for invitation to try additive substances (out of those who had such opportunity)**



The reasons for refusal of such invitation were further explored, with the objective of finding out factors which enabled youth on saying “No”. Common reasons cited were “I don’t feel like using those as they do not give such kick as claimed”, “parental disapproval”, and “disapproval by religious norms”.

There were no significant differences among the above mentioned reasons cited by the youth based on their sex or schooling status.

**Table 2.33: Commonly cited reasons for refusal (% out of those who had refused)**

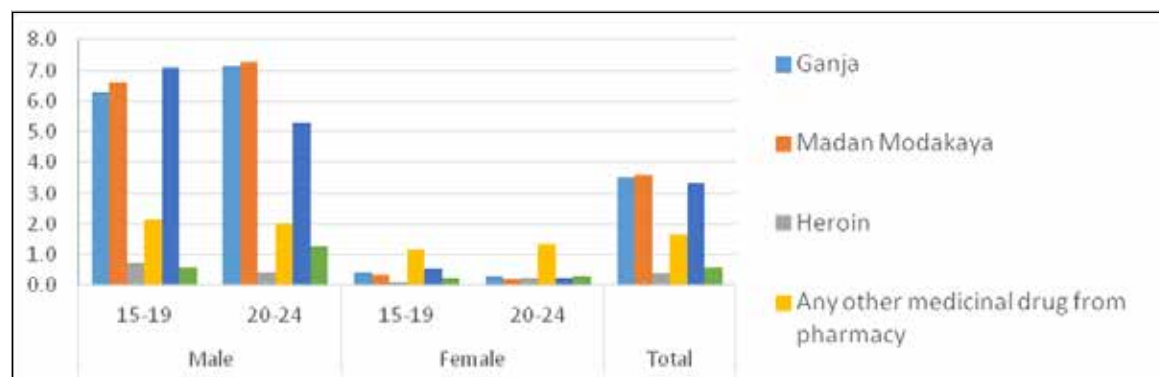
| Reasons  | Male %<br>(95%CI)   | Female %<br>(95%CI) | Total%<br>(95%CI)   |
|--|---------------------|---------------------|---------------------|
| I don't think they give any pleasure /kick as they claimed to be | 50.5<br>(45.1-55.9) | 43.0<br>(32.6-54.0) | 49.2<br>(44.3-54.0) |
| Parents do not approve taking those                              | 39.6<br>(34.4-45.0) | 26.9<br>(18.5-37.5) | 37.4<br>(32.8-42.2) |
| My religious beliefs do not approve                              | 19.1<br>(15.2-23.7) | 27.8<br>(19.1-38.7) | 20.6<br>(17.0-24.8) |
| My school /teachers do not approve                               | 15.6<br>(11.9-20.1) | 17.8<br>(10.7-28.1) | 16.0<br>(12.6-20.0) |
| My friends do not use those                                      | 7.6<br>(5.1-11.1)   | 9.2<br>(4.6-17.5)   | 7.9<br>(5.6-11.0)   |
| Other  | 7.9<br>(5.3-11.6)   | 5.0<br>(2.0-11.9)   | 7.4<br>(5.1-10.5)   |

*(Multiple options were allowed)*

## EVER USE OF OTHER ADDITIVE SUBSTANCE

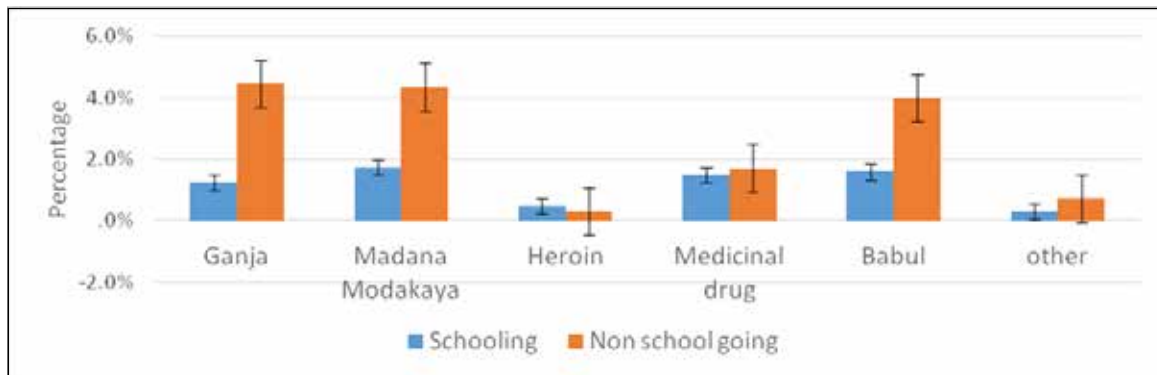
Previous experiences in using selected addictive substances were explored. Significantly more male youth have tried those substances compared to females. Babul was the most commonly tried substance among the males. It was noteworthy to note that nearly 84.3% of the total youth with 80.2% males and 88.6% females declaring that they have not tried any additive substance previously. When the drug use by strata was analyzed, it was noted that urban and rural youth have used Ganja (cannabis) and Madana Modaka (Cannabis based product) and Babul (areca nut from India) in significantly higher proportions compared to youth in other strata.

**Figure 2.46: Ever use of additive substances**



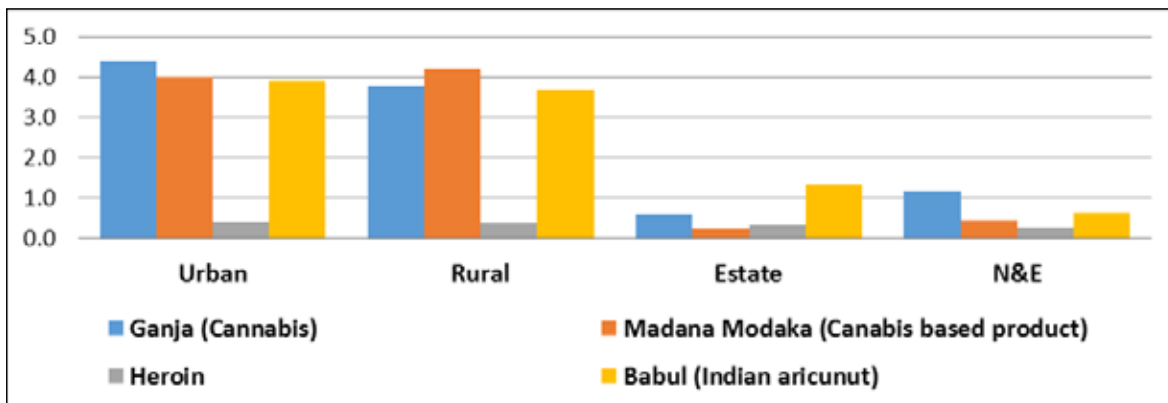
The ever use of addictive substances was analyzed according to schooling status. Statistically significant differences were observed with ever use of ganja, madana modakaya and babul where non schooling youth were having higher proportions. There were no significant differences with regard to ever use of heroin and medicinal drugs by schooling status.

**Figure 2.47: Ever use of addictive substances by status of schooling**



Urban and rural youth have used Ganja, Madana Modaka and Babul in significantly higher proportions compared to other strata youth.

**Figure 2.48: Ever use of addictive substances by strata**



## LIFE SKILLS

Life skills are required for youth to succeed in education, employment and future adult life. The questionnaire consisted of few case scenarios and requested youth to mark the appropriate response with the objective of assessing their skills with regard to selected areas in life skills.

One such case scenario was exploring youth reactions to their parent’s advice regarding his/ her risk behavior, going out with friends in the night.

**Table 2.34: Youth Reaction to disagreement with parents**

| Youth Reaction to parents advice regarding his/her risk behavior            | Male %              |                     | Female%             |                     | Total% (95%CI)      |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | 15-19 y (95%CI)     | 20 -24 y (95%CI)    | 15-19 y (95%CI)     | 20 -24 y (95%CI)    |                     |
| “Might get angry because I think I should have a freedom to do what I like” | 14.4<br>(12.3-16.7) | 15.6<br>(13.5-18.1) | 4.5<br>(3.5-5.9)    | 5.3<br>(4.1-6.7)    | 9.8<br>(9.0-10.8)   |
| “Will do as I am confident about my instincts”                              | 12.7<br>(10.8-14.9) | 12.6<br>(10.7-14.7) | 4.6<br>(3.6-5.9)    | 3.9<br>(3.0-5)      | 8.4<br>(7.6-9.2)    |
| “Will not do because I know my parents worry about me”                      | 29.4<br>(26.6-32.3) | 28.5<br>(25.8-31.5) | 51.6<br>(48.8-54.5) | 48.7<br>(45.8-51.5) | 39.8<br>(38.4-41.2) |
| “Will discuss with my parents and come to a consensus”                      | 39.8<br>(36.7-42.9) | 38.5<br>(35.4-41.6) | 33.5<br>(30.8-36.2) | 36.6<br>(33.9-39.4) | 37.0<br>(35.6-38.5) |
| Other   | 0.3<br>(0.1-0.8)    | 0.6<br>(0.3-1.2)    | 0.8<br>(0.5-1.3)    | 1.2<br>(0.8-1.9)    | 0.7<br>(0.6-1.0)    |
| Missing   | 3.4<br>(2.5-4.6)    | 4.2<br>(3.2-5.6)    | 4.9<br>(3.8-6.2)    | 4.3<br>(3.3-5.6)    | 4.2<br>(3.7-4.8)    |
| <b>Total</b>  | 100.0               | 100.0               | 100.0               | 100.0               | 100.0               |

Nearly 40%, stated that they will not do things like “going out in the night” as parents worry about their safety. This encouraging figure corresponds with 40% reported by UNICEF survey in 2004.

There was no significant difference between strata with regard to this attitude. However significantly higher proportion of females and schooling youth were having this obedient attitude compared to others. Another 37.2% of the total sample reported that they will discuss with parents and come to a consensus irrespective of

37.2% had negotiation skills in youth –parent disagreements. Half of the sample displayed negotiation skills when a partner invites to go to a private place.



their sex or age group or schooling status. Higher proportions of urban and rural youth had this negotiation concept compared to other strata.

Nearly 10% reported that they will be angry if restricted as they think that they must have the freedom to decide and act according to their own decision. This attitude was apparent without much differences with sex, strata or schooling status. Another 8.4% of the total sample had an overconfident attitude which was more among males in significantly higher proportions in both age groups and among non- schooling youth.

The next case scenario was to assess their reaction to their partner’s suggestion to visit a private place to discuss something personal. Approximately one fifth of the sample reported that they believe in their partner and accept the invitation. However this proportion was markedly low among females and school going youth. Half of the sample declared that they would explain the negative consequences of such activity and propose alternatives. The reported proportion was significantly higher among schooling youth, rural and urban youth. The negotiation skill was significantly lower among the estate youth with 27.3% (95%CI; 25.2-29.5) as compared in comparison to rural youth (62.3%, 95%CI; 60.2-64.3).

Four percent of the total, reported that they would go despite their reluctance to sustain the relationship which highlights the lack of assertive skills and negotiation skills irrespective of their strata and schooling status (data not shown).

**Table 2.35: Reaction to a partner invitation to visit a private place**

| Reaction to partner invitation to visit a private place alone                            | Male %              |                     | Female%             |                     | Total % (95%CI)     |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
|  | 15-19 y (95%CI)     | 20 -24 y (95%CI)    | 15-19 y (95%CI)     | 20 -24 y (95%CI)    |                     |
| “Will tell my partner about the negative side of such action and suggest an alternative” | 45.3<br>(42.2-48.4) | 45.8<br>(42.7-49.1) | 65.5<br>(62.9-68.0) | 68.2<br>(65.7-70.6) | 56.3<br>(54.9-57.7) |
| “I trust my partner, so I will go”   | 33.4<br>(30.4-36.3) | 35.3<br>(32.4-38.4) | 9.1<br>(7.7-10.9)   | 9.7<br>(8.27-11.5)  | 21.7<br>(20.5-22.9) |
| “Although I don’t like to go, I may go if it makes my partner angry or upset”            | 5.6<br>(4.4-7.1)    | 5.2<br>(4.1-6.6)    | 3.3<br>(2.4-4.4)    | 2.9<br>(2.1-3.9)    | 4.2<br>(3.7-4.8)    |
| “Won’t go”   | 5.3<br>(4.5-6.4)    | 4.4<br>(3.5-5.3)    | 11.1<br>(9.9-12.3)  | 9.7<br>(8.7-10.9)   | 7.7<br>(7.2-8.2)    |
| Other  | 2.4<br>(1.7-3.6)    | 1.7<br>(1.0-2.6)    | 5.1<br>(4.0-6.5)    | 4.2<br>(3.2-5.5)    | 3.4<br>(2.9-4.0)    |
| Missing  | 8.0<br>(6.4-10.0)   | 7.5<br>(6.0-9.3)    | 5.9<br>(4.7-7.4)    | 5.3<br>(4.1-6.7)    | 6.7<br>(5.9-7.5)    |

The survey assessed their reaction to an invitation from an unknown person who made contact through a missed call, which is a common associated factor for most youth risk behaviors in the present context. Approximately 10% reported that they would go and meet that person with or without a friend which highlights the typical lower level of risk perception by adolescents and youth regardless of their strata or schooling status. The reported proportion was higher among males in both age groups.

Of the total, 6.7% declared that they would not meet the person, but will continue to talk via phone which was again higher among males. This option was highlighted by estate and N-E strata with increased proportions compared to other strata.

Response to a missed call revealed that 10% take the risk and comply with request of an unknown person to go to a private place.

Of the total, 41.8% reported that they would neither meet nor talk with a significant predominance observed among females, N-E youth and among non-school going youth. Approximately 35% wanted to tell their parents. The reported proportions were significantly higher with female sex, and schooling youth.

**Table 2.36: Reaction for an invitation for a date by an unknown person**

| Reaction for an invitation for a date by a person got to know via a missed call | Male %              |                     | Female%             |                     | Total % (95%CI)     |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | 15-19 y (95%CI)     | 20 -24 y (95%CI)    | 15-19 y (95%CI)     | 20 -24 y (95%CI)    |                     |
| Will go alone or go with a friend   | 17.4<br>(15.1-20.0) | 17.5<br>(15.2-20.1) | 2.6<br>(1.8-3.7)    | 1.5<br>(1.0-2.3)    | 9.6<br>(8.8-10.6)   |
| Will not go but continue to talk as it will not do any harm                     | 11.3<br>(9.6-13.2)  | 10.31<br>(8.6-12.2) | 2.5<br>(1.8-3.5)    | 3.0<br>(2.1-4.0)    | 6.7<br>(6.0-7.4)    |
| Will neither go nor talk with him   | 32.3<br>(29.4-35.3) | 34.4<br>(31.4-37.4) | 50.4<br>(47.5-53.2) | 49.8<br>(47.0-52.7) | 41.8<br>(40.4-43.3) |
| Will tell my parents / guardians and get an advice                              | 31.4<br>(28.5-34.4) | 30.0<br>(27.1-33.0) | 38.3<br>(35.6-41.1) | 39.8<br>(37.1-42.7) | 34.9<br>(33.5-36.4) |
| Other   | 2.1<br>(1.3-3.2)    | 2.4<br>(1.6-3.7)    | 1.7<br>(1.1-2.6)    | 1.8<br>(1.2-2.8)    | 2.0<br>(1.6-2.5)    |
| Missing   | 5.6<br>(4.3-7.2)    | 5.3<br>(4.1-6.9)    | 4.5<br>(3.5-5.8)    | 4.1<br>(3.1-5.4)    | 4.9<br>(4.3-5.6)    |
| <b>Total</b>  | 100.0               | 100.0               | 100.0               | 100.0               | 100.0               |

Decision making is an important life skill which determines the future of youth. The survey assessed the way they make important decisions in their lives. Nearly one third (29.4%, 95%CI: 28.1-30.8) declared without strata difference that they take important decisions on their own as they are confident in doing so. The reported proportion was higher among males and among non-schooling youth.

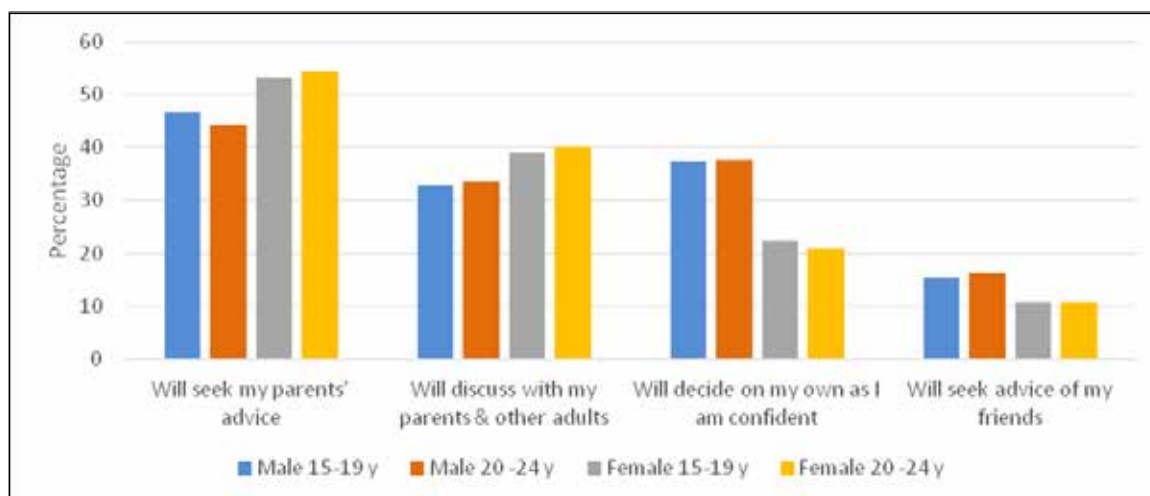
49.7% seek parental advice in taking important decisions. 36.3% reported to have better communication skills and negotiation skills in decision making.

Approximately half of the youth (49.7%, 95%CI: 48.2-51.2) seek parental advice and statistically significant higher proportions were observed with female sex and school going youth. It was interesting to note that the reported proportion was higher among the rural youth (52.6%, 95%CI: 50.5-54.7) and lowest among estate youth (37.2%, 95%CI: 34.9-39.6).

Of the youth sample, 36.3% (95%CI: 35.0-37.8) reported that they will discuss the situation with their parents and other adults to reach a consensus indicating better skills in communication, negotiation and decision making irrespective of their age groups or sex or strata or schooling status of youth.

Although higher proportion of males tend to seek friend's support in such decision making compared to females, it was noted that only 13.3% (95% CI: 12.3-14.4) of the total sample practice such a method which was predominantly seen among school going youth.

**Figure 2.49: How Youth are making important decisions in life**



## Youth Ability to say “No” for sex

The survey explored the assertive skills of the youth by questioning whether they were proposed to have sex and refused ever in their life. The results were analyzed for the unmarried youth component. Of those who had such invitation, 72.4% had refused at least once. The reported proportions was higher among females (89.8%) compared to males (64.7%), however without significant differences between sex, age groups or strata.

The survey explored from whom the unmarried youth received invitation to have sex and rejected by the youth. Unmarried females highlighted “Boyfriends” as the commonest person, to whom they have reported “No”, while male youth reported of “a known person”. The reasons for such refusal were explored to have a better understanding on factors that contribute for assertive skills of the young unmarried persons.

**Table 2.37 Reasons for saying “No” for sex by the unmarried youth**

| Reasons to say “No” for sex               | Male %<br>(95%CI)   | Female %<br>(95%CI) | Total %<br>(95%CI)  |
|---|---------------------|---------------------|---------------------|
| Want to pursue with higher studies        | 22.7<br>(15.8-31.5) | 45.0<br>(34.5-55.9) | 31.3<br>(25.0-38.2) |
| Societal disapproval on pre-marital sex   | 24.7<br>(17.7-33.4) | 64.2<br>(53.2-74.0) | 40.0<br>(33.2-47.0) |
| Parental disapproval on such behavior     | 9.9<br>(5.8-16.3)   | 23.5<br>(15.5-33.9) | 15.1<br>(10.9-20.6) |
| Fear of Risk for STI/HIV /pregnancy       | 27.6<br>(20.2-36.5) | 34.7<br>(25.1-45.7) | 30.3<br>(24.3-37.2) |
| Possibility of jeopardizing freedom /life | 20.1<br>(13.7-28.5) | 31.1<br>(21.8-42.1) | 24.3<br>(18.7-30.9) |
| Fear of losing virginity                  | 7.3<br>(3.7-13.9)   | 41.4<br>(31.2-52.4) | 20.4<br>(15.3-26.5) |
| Fear of performance during the sexual act | 8.6<br>(4.6-15.5)   | 9.0<br>(4.3-18.0)   | 8.8<br>(5.4-13.8)   |

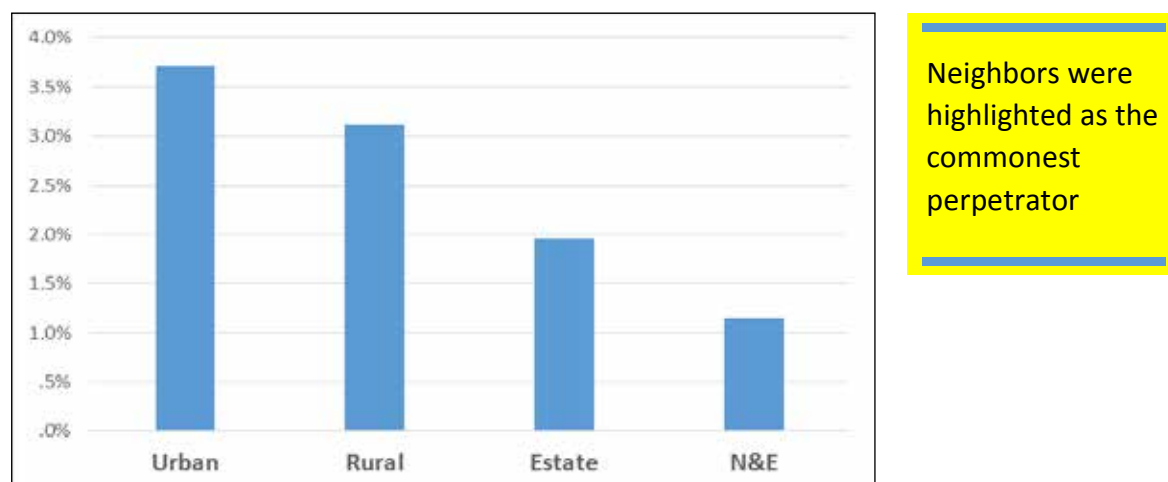
*(Multiple options were allowed)*

“Societal disapproval on pre-marital sex” has been highlighted as the commonest reason for youth to say “No” for sex, followed by the “need to pursue with higher studies” and the “risk for STI/HIV and pregnancy”. Female youth highlighted “fear of losing virginity “as the second common reason after “societal disapproval”.

## SEXUAL ABUSE

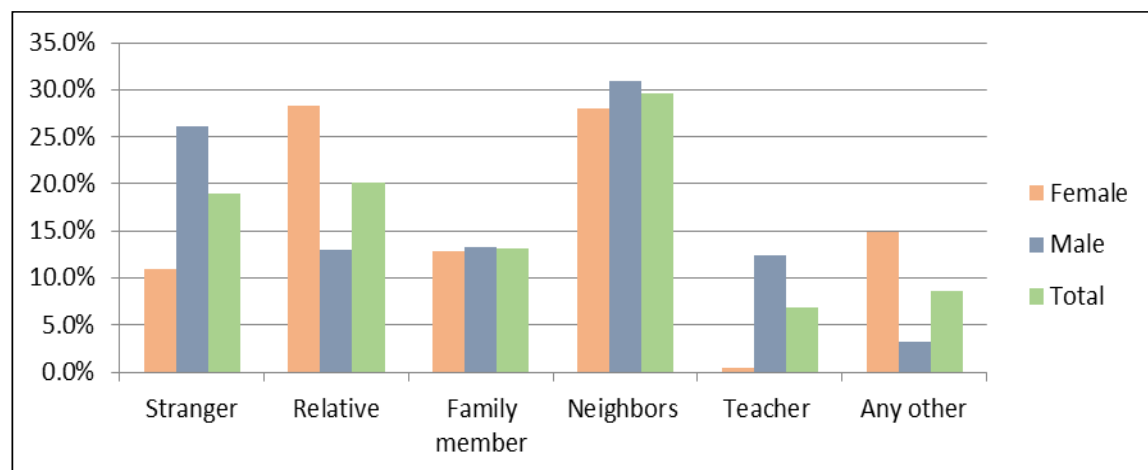
The survey explored selected facets of sexual abuse among the youth including being abused sexually ever and the details of perpetrators of sexual abuse.

**Figure 2.50: Prevalence of sexual abuse ever among youth by strata**



Of the total, 2.9% (95%CI: 2.5-3.5) reported “being sexually abused” irrespective of their sex and age or schooling status or being married or otherwise. However, higher proportions of victims of sexual abuse were noted in urban and rural strata and among the married. Of those who were subjected to abuse were asked to name the perpetrators.

**Figure 2.51: Perpetrators of sexual abuse of youth (of those who had been sexually abused ever)**



Neighbors (29.6%, 95%CI: 21.9-38.6) have been highlighted as the main perpetrator for sexual abuse by both sexes. Relatives were commonly reported by females (28.3%; 95%CI: 18.4-40.8) compared to males (13.0%; 95%CI: 6.7-23.7).

Strangers were the second common perpetrator highlighted by the male youth (26.2%, 95%CI: 16.6-38.7). Significant higher proportions of males (12.4%; 95%CI: 5.8-24.6) were being abused by teachers compared to females (0.5%; 95%CI: 0.1-2.2). There were no significant differences between strata or schooling status with regard to perpetrator types.

## GENDER BASED VIOLENCE

Gender-based violence (GBV) often stems from unequal power relationships and includes physical, sexual, psychological harm and exists in many forms. The nature and extent of specific types of GBV can vary across cultures, countries, and regions. The survey explored about youth experiences on selected common types of violence.

**Table 2.38: Past experiences of gender based violence**

| Experiences of gender based violence   | Male %<br>(95%CI)   |                     | Female%<br>(95%CI)  |                     |
|--|---------------------|---------------------|---------------------|---------------------|
|  | 15-19 y             | 20 -24 y            | 15-19 y             | 20 -24 y            |
| Someone makes you feel uncomfortable touching your body in a public place  | 3.8<br>(2.8-5.2)    | 3.5<br>(2.6-4.9)    | 14.0<br>(12.1-16.2) | 14.4<br>(12.4-16.5) |
| Someone make you feel uncomfortable by inappropriate actions of sexual nature in your school / institution or work place | 1.1<br>(0.7-1.9)    | 1.5<br>(0.9-2.5)    | 0.8<br>(0.4-1.3)    | 1.6<br>(1.0-2.5)    |
| You had to oblige someone by indulging in sexual activity to get something done  | 0.5<br>(0.2-0.9)    | 1.1<br>(0.6-2.0)    | 0.6<br>(0.3-1.1)    | 0.4<br>(0.1-1.1)    |
| Other  | 0.4<br>(0.2-0.9)    | 0.2<br>(0.1-0.4)    | 0.9<br>(0.5-1.7)    | 1.2<br>(0.7-2.2)    |
| I did not had any such experience ever   | 85.0<br>(82.6-87.1) | 84.8<br>(82.5-86.9) | 77.2<br>(74.7-79.6) | 77.4<br>(74.9-79.7) |

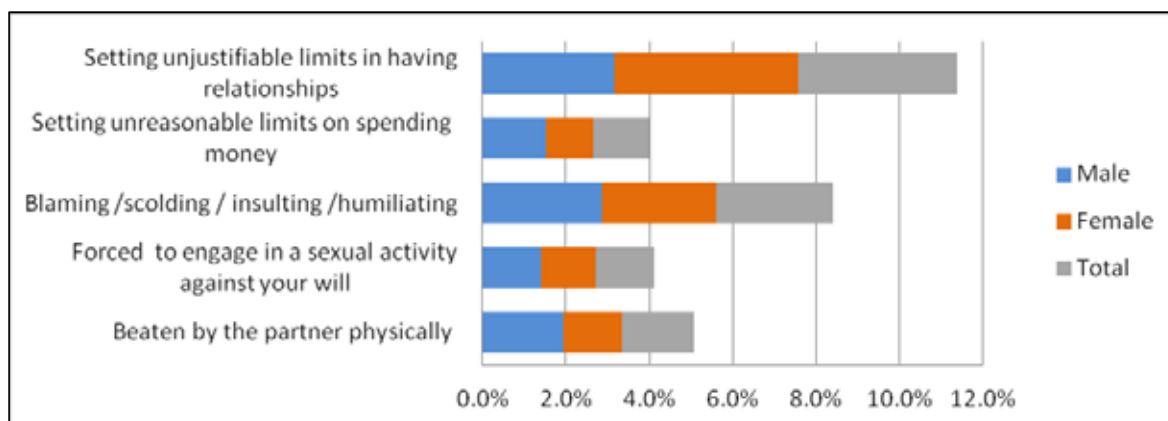
*(Multiple options were allowed)*

It was of note that significantly more females have had unpleasant experiences in gender based harassment in public places including public transport systems predominantly in urban and rural strata and among non-school going group compared to others. Both male and female groups complained of inappropriate actions of sexual nature in school /work place and about instances where they had to oblige someone in sexual activities to get something done. Of the total 81.1% declared that they have never experienced gender based harassments irrespective of strata or schooling status.

## INTIMATE PARTNER VIOLENCE

Global research has identified that teenage /youth partner violence is associated with a range of adverse outcomes for young people, such as mental health, depression and suicide in fact some studies indicate that adolescent partner violence is strongly associated with experiencing domestic violence in adulthood. The survey explored the past experiences of intimate partner violence ever.

**Figure 2.52: Description of experience of intimate partner violence ever**



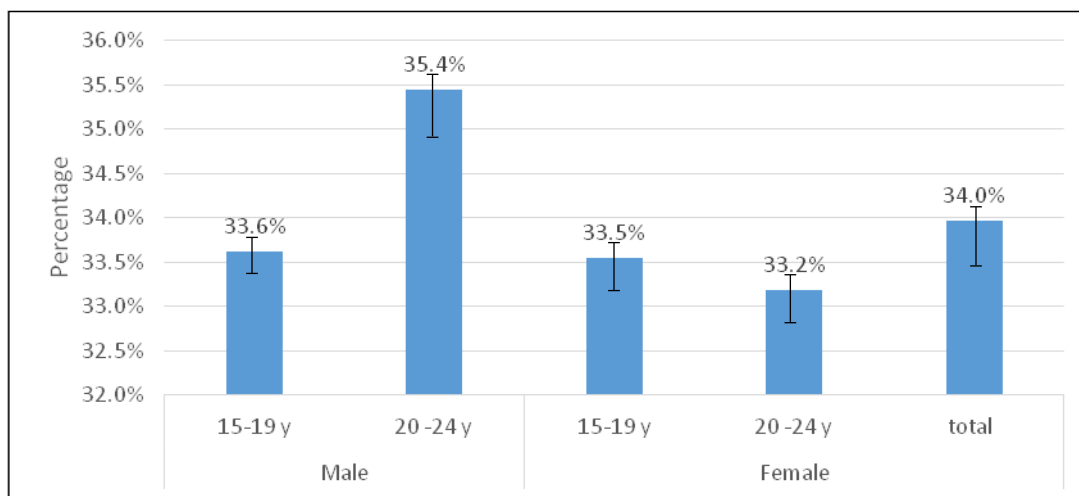
Setting barriers to have relationships has been noted by 3.8%, blaming /scolding /insulting has been highlighted by 2.8% while physical violence by the partner was reported by 1.7% of the total. There were no significant differences between age groups or sex in past experiences related to partner violence.

## RELATIONSHIPS

Healthy relationships, caring adults and family connectedness have been identified as protective factors which influence risk behaviors of young persons. Intimate relationships also play a vital role in determining health and wellbeing of youth. Youth experiences on

intimate relationships at present were explored. The analysis was carried out among unmarried youth. Nearly one third claimed to have a girl /boyfriend at present while another 20% who lack intimate relationship at present reported that they had similar relationships in the past. There were no significant differences with regard to sex or age groups in both current and past experiences in intimate relationships.

**Figure 2.53: Prevalence of an intimate relationship at present (among unmarried youth)**



The mean age reported for starting a love affair was 17.0 years (95%CI: 16.8-17.1) for boys and 17.3 years (95%CI: 17.2-17.5) for girls without much strata variance.

## SEXUAL BEHAVIOR

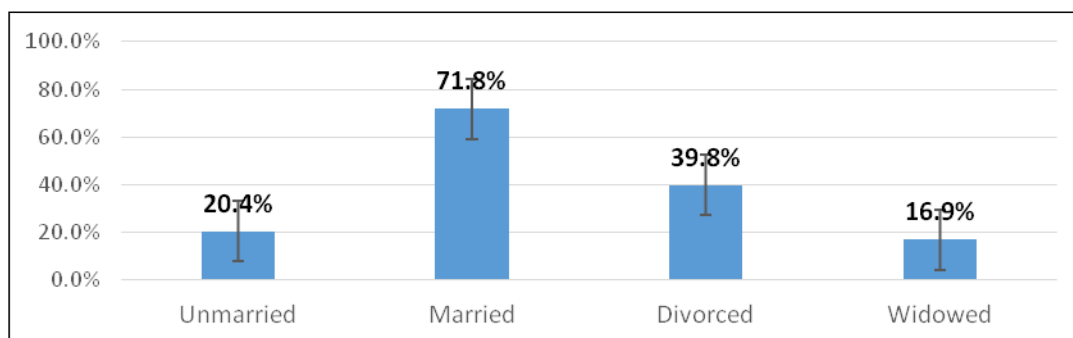
The survey explored about youth sexual activities during the preceding year. Of the total, only 28.3% answered affirmatively with higher proportions among males in both age groups, non-schooling youth and among married youth. About one fifth (20.4%, 95%CI: 19.0-21.9) of unmarried youth reported of having engaged in such activities. Higher proportions of urban and rural youth reported of having had in any sexual activity in the preceding year.

**Table 2.39: Prevalence of any sexual activity during the preceding year**

| Question   | Male %           |                  | Female%          |                  | Total% (95%CI)   |
|--|------------------|------------------|------------------|------------------|------------------|
|  | 15-19 y (95%CI)  | 20-24 y (95%CI)  | 15-19 y (95%CI)  | 20-24 y (95%CI)  |                  |
| Engaged in any sexual activity during the preceding year | 34.3 (31.3-37.3) | 39.8 (36.7-42.9) | 18.1 (15.9-20.5) | 22.1 (19.8-24.6) | 28.3 (27.0-29.7) |

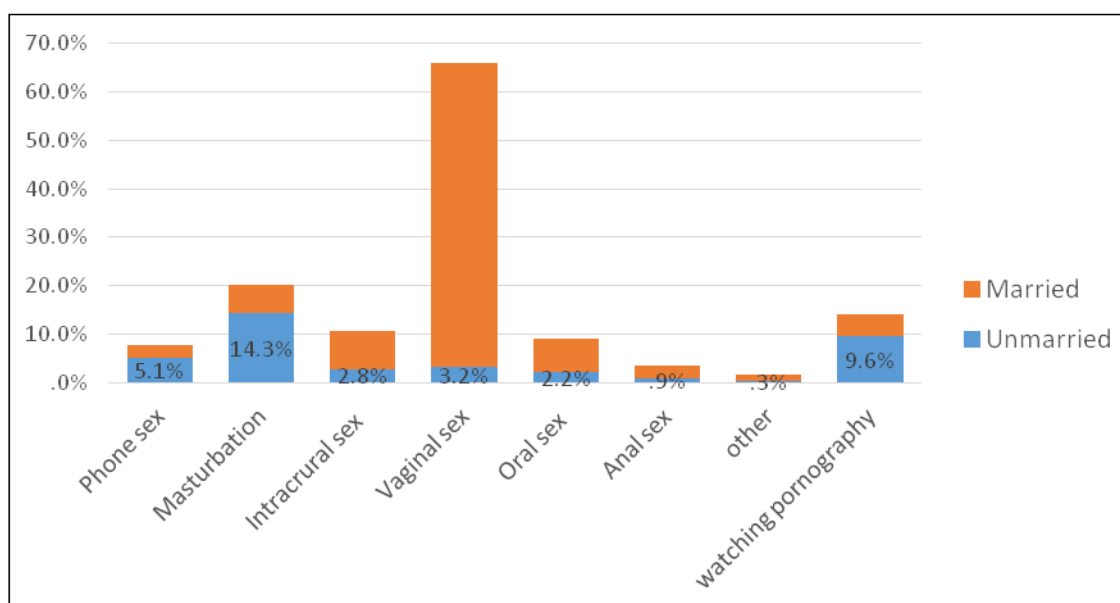


**Figure 2.54: Prevalence of any sexual act during the preceding year by marital status**



Furthermore the survey assessed details about sexual activities during the preceding year. The analysis was confined to unmarried youth.

**Figure 2.55: Types of sexual activities practiced by youth during the preceding year\***



\*"Divorced" & "widowed" groups were excluded in the analysis

Masturbation, vaginal intercourse and watching blue films (pornographic films) were highlighted as most common sexual activities engaged. Nearly 10% of unmarried youth engaged with watching pornography and 2.8% in intra-crual sex.

Watching pornographic films, phone sex /internet sex and masturbation were reported by males in significantly higher percentages. Higher percentages of urban and rural youth reported of engaging in above activities compared to other strata.

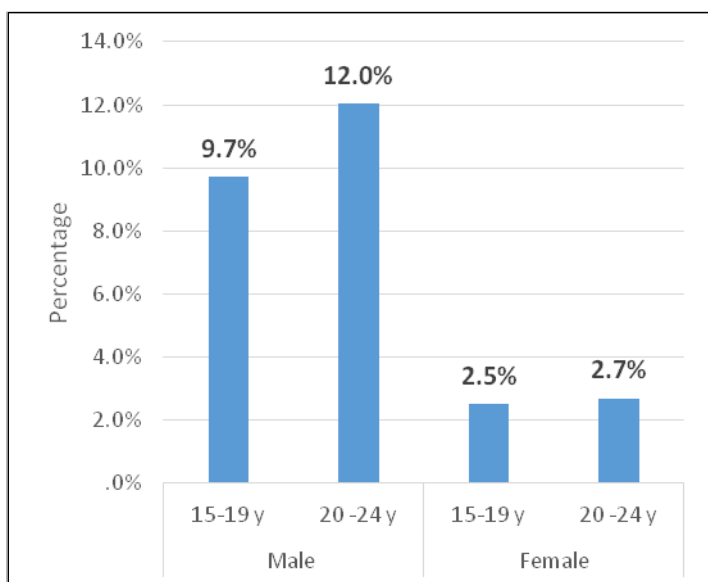
Significant differences were not observed between schooling and non-schooling youth with regard to masturbation, phone /internet sex, watching blue films. However anal, oral, vaginal and intra-crural sex activities were significantly more prevalent among non-school going group compared to schooling youth.

The survey asked questions on penetrative and other types of sexual intercourse further explaining the definitions of vaginal, oral and anal intercourse highlighting the penetrative nature of such activities. Of the total youth, 20.2% (males 16.7% and females 23.6%) answered affirmatively for having sex ever while 78.2% gave negative answers.

Around 14.8% declared of having sexual intercourse during the preceding year. Of them, 5.3% of unmarried, 34.7% of divorced and 17.2% of widowed youth reported that they were engaged in such activities during the preceding 12 months.

When the sub analysis was conducted among unmarried youth, 7.0% reported that they had sexual intercourse ever in their life regardless of strata.

**Figure 2.56: Had sexual intercourse ever by unmarried youth**



Masturbation, vaginal intercourse and watching pornographic films were the common sexual activities among youth with significant differences in sex and strata.

7.0% of unmarried youth had sexual intercourse ever without strata difference.

## First Sexual encounter

The details of sexual debut were explored among those who reported of ever having engaged in sexual intercourse. Majority (64.4%) reported of having the first sexual experience, with their regular partner or spouse (84% females and 35% males) without much strata difference.

Married youth reported to have their first sex with spouse /regular partner (80.7%), girl /boyfriend (3.7%), commercial sex worker (0.6%) while unmarried youth had it with boy/girlfriend (3.7%), a friend (1.1%) and casual partner met accidentally (0.7%). Significant higher proportions were reported by male youth with regard to having sexual intercourse compared to females regardless of age or strata or schooling status.

Of those who ever had sexual intercourse, 87.4 % declared that their sexual debut occurred with their consent and there were no significant differences with regard to sex or age group or strata or schooling status.

## Current sexual practices of youth

The survey assessed youth experience of engaging in sexual intercourse during the preceding year and about their partners among the unmarried youth.

Analysis was carried out based on schooling status and strata to facilitate fine tuning of the existing interventions or programmes.

Among the unmarried, 5.3% had sex during the preceding year with significantly higher proportions observed among males, non-school going youth, urban and rural youth compared to others. It was noted that 1.3% of school going youth admitted of having sexual practices during the preceding year.

5.3% of unmarried youth engaged in sexual intercourse during the preceding year. Male youth were more likely to have multiple sex partners.

Of the currently sexually active unmarried youth (who had sexual intercourse during the preceding year), 85.5% declared of engaging with one sexual partner. Small proportion (7.2%) had two sexual partners while 3.2% of sexually active youth declared of having three or more sexual partners during the stipulated period.

Having multiple partners was significantly higher among males compared to age matched females. Non-schooling youth and non N-E strata youth were having a higher preponderance towards having multiple sex partners.

The survey examined about same sex relationships and found that among total youth group, 1.6% of 15-19 year old males and 2.1% of 20-24 year old males and approximately 1.2% of 15-19 year old girls and 0.4% of girls in 20-24 age group, had such same sex activities during the preceding year.

Partners of unmarried youth who claimed to have sexual intercourse during the preceding year (Sexually active) the details were explored.

**Table 2.40: Sex Partner characteristics of sexually active unmarried youth**

| <b>Partner characteristics</b>  | <b>Male %<br/>(95%CI)</b> | <b>Female%<br/>(95%CI)</b> |
|---------------------------------|---------------------------|----------------------------|
| Cohabiting partner              | 0.4<br>(0.2-0.9)          | 0.5<br>(0.3-1.1)           |
| Boyfriend /Girl friend          | 5.4<br>(4.4-6.6)          | 0.8<br>(0.5-1.3)           |
| Relative / friend               | 0.9<br>(0.5-1.5)          | 0.2<br>(0.1-0.5)           |
| Casual partner met accidentally | 0.5<br>(0.2-0.9)          | 0.1<br>(0.0-0.4)           |
| Commercial sex partner          | 0.7<br>(0.4-1.2)          | 0.0                        |

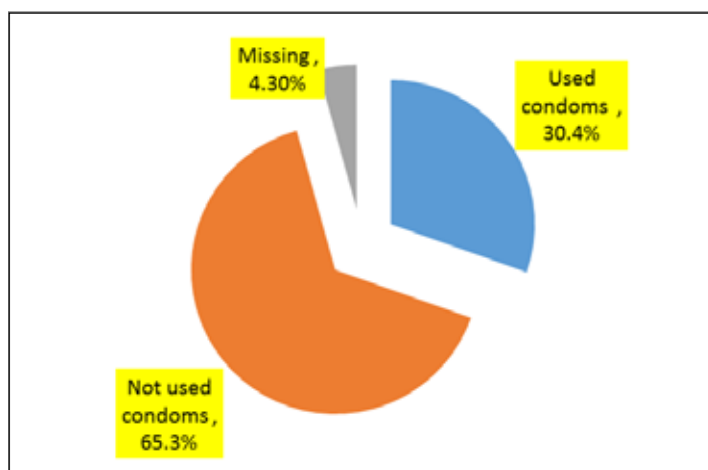
Out of unmarried youth who claimed to be engaged in sexual intercourse during the preceding year, the majority had it with their girl /boyfriend. The reported proportion was significantly higher among males and among non-schooling youth.

The survey explored whether the youth or his partner had any problem of unexpected pregnancies and actions followed. Of the total 1.4%, (2% of females and 1% of males) had such issues and 1.1% reported they continued with the pregnancy while 0.1% of total sample had aborted.

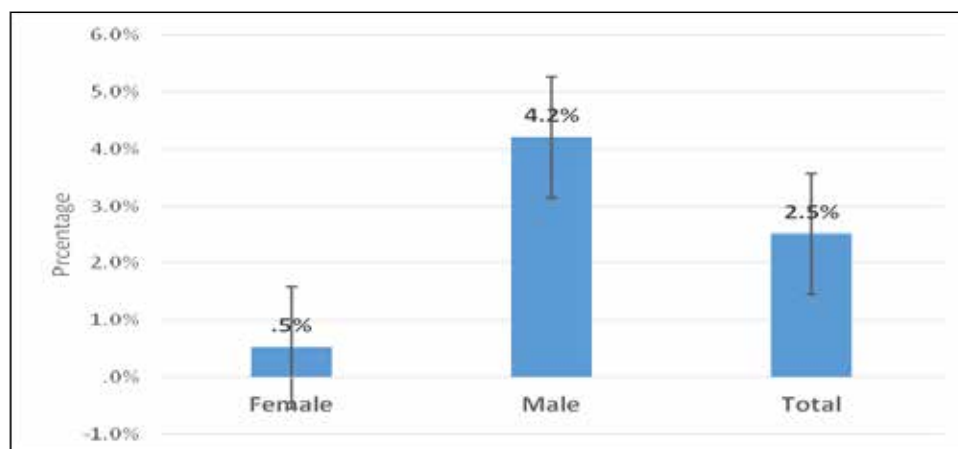
## Condom usage among youth

The survey assessed the use of condoms during sexual intercourse. Of the total youth sample, 4.5% (95%CI: 3.9-5.2) had used condoms during sexual intercourse during the preceding one year. The respective figures for 20 -24 year old males (6.5%) were higher compared to age matched females (4.1%). Similarly more males in 15-19 year age group (4.7%) had used condoms compared to females (2.7%). However observed differences were not statistically significant. There was an increasing trend in condom use with age among youth. The usage of condoms was further analyzed in relation to currently sexually active youth, who answered affirmatively to question on having sexual intercourse during the preceding year.

**Figure 2.57: Condom usage by youth who engaged in sex (currently sexually active) during the preceding year**



**Figure 2.58: Condom usage by unmarried youth during the preceding year**



Among unmarried youth, a significantly higher percentage of non-schooling youth, urban and rural youth had used condoms in the preceding year.

The survey further inquired about the sex partners with whom the total youth had used condoms.

**Table 2.41: Description of sexual partners with whom currently sexually active youth had used condoms, during the preceding year (of the total sexually active youth)**

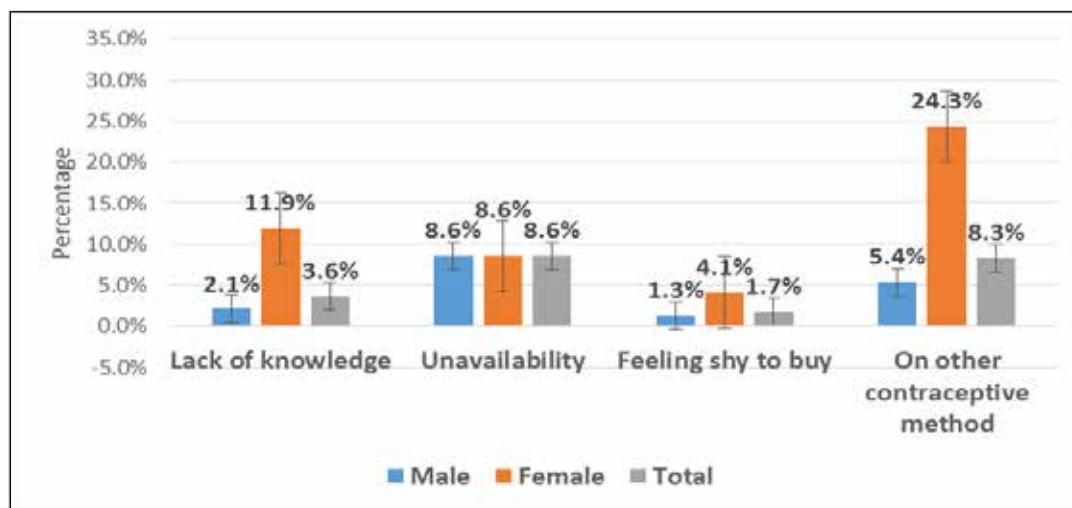
| Of those who have used condoms, with whom have they used it | Male %              |                     | Female%             |                     | Total % (95%CI)     |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | 15-19 y (95%CI)     | 20 -24 y (95%CI)    | 15-19y (95%CI)      | 20 -24 y (95%CI)    |                     |
| Spouse/ regular partner                                     | 23.5<br>(13.5-37.7) | 28.4<br>(18.6-40.7) | 91.0<br>(77.8-96.7) | 83.0<br>(70.9-90.7) | 49.4<br>(42.0-56.7) |
| Boyfriend /Girl friend                                      | 49.9<br>(35.5-64.2) | 44.2<br>(31.8-57.3) | 6.7<br>(1.9-21.1)   | 10.1<br>(5.0-19.3)  | 32.1<br>(25.5-39.4) |
| Relative / friend   | 8.9<br>(3.4-21.3)   | 10.2<br>(4.5-21.6)  | 0.6<br>(0.1-4.5)    | 3.9<br>(0.9-15.0)   | 6.9<br>(3.9-11.9)   |
| Casual partner met accidentally                             | 4.9<br>(1.4-15.6)   | 9.4<br>(3.9-20.9)   | 1.7<br>(0.4-7.1)    | 0.7<br>(0.1-5.0)    | 5.0<br>(2.6-9.6)    |
| Commercial sex partner                                      | 23.3<br>(12.6-38.9) | 21.1<br>(12.3-33.8) | 0.0                 | 0.0                 | 13.7<br>(9.1-20.1)  |

*(Multiple options were allowed)*

Of the total sexually active youth who had used condoms in the preceding year, the majority (49.4%) had used it with their spouse /regular partners followed by their girl/ boyfriends (32.1%) and commercial sex workers (13.7%). Commonest use of condoms among males during the preceding year was when having sex with their girlfriends /boyfriends. When the analysis was conducted among unmarried youth, who were sexually active in the preceding year, the same pattern was observed.

The reasons for not using condoms when the youth were having sexual intercourse during the preceding year were also explored. The common reasons were, practicing another contraceptive method (20.8%), expecting a child (16.3%) and other reasons (13.7%). Non availability of condoms was emphasized by 3.8% while 3.1% youth reported that they did not know that condoms should be used on such occasions. These findings did not differ significantly between strata.

**Figure 2.59: Reasons for not using condoms during sex in preceding year (of unmarried and currently sexually active youth)**

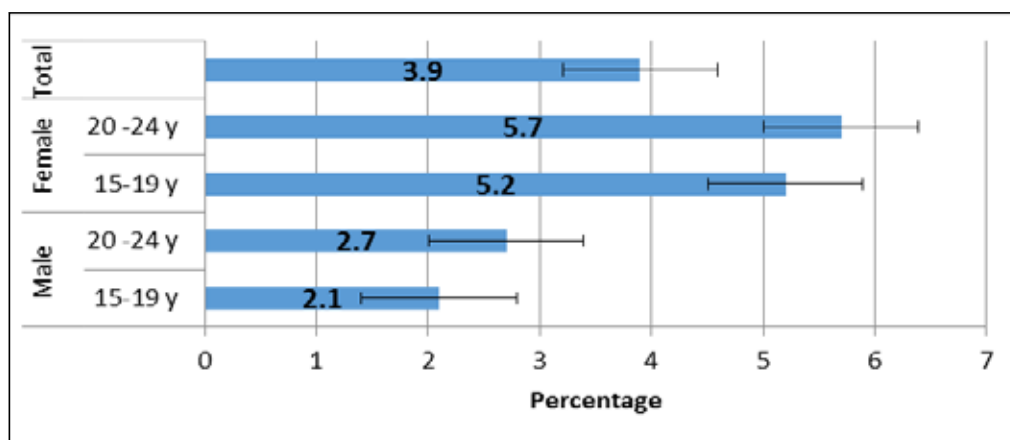


The analysis was conducted among the unmarried sexually active youth, to explore the reasons for not taking protective measures when they engage in risky sexual behaviours. The results highlighted that unavailability (8.6%) was a main barrier for use of condoms during sex in the preceding year (among total youth). For females, reported reasons were, on another contraceptive, lack of knowledge followed by unavailability.

## CONTRACEPTIVE USE

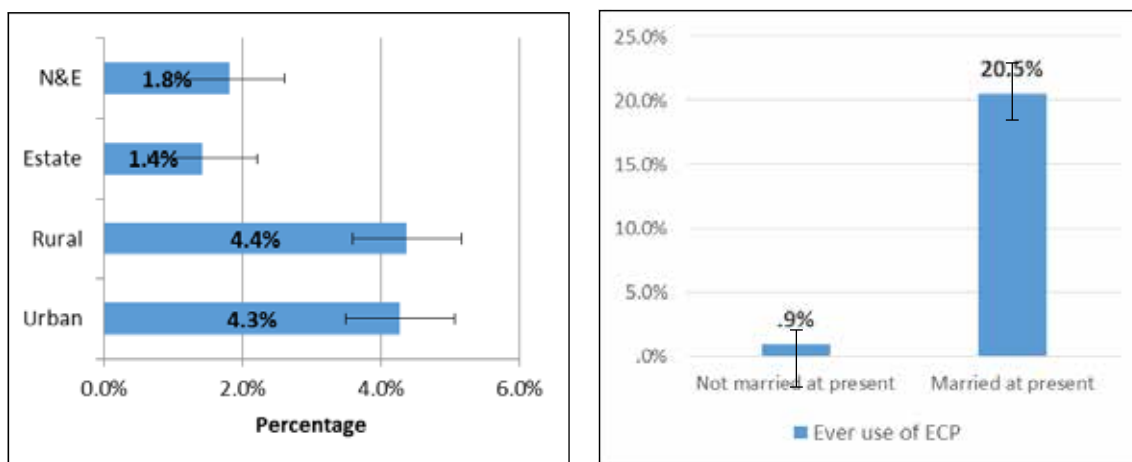
The survey explored the ever use of emergency contraceptive pills (ECP) in the form of Postinor™ or oral contraceptive pills by the youth /partners.

**Figure 2.60: Ever use of ECP by youth**



Nearly 4% (95%CI: 3.4-4.6) of the total youth, reported using ECP ever with 5.2% among 15-19 year olds and 5.7% among 20-24 year olds. Significantly higher proportions of urban, rural youth and married youth had used of ECP.

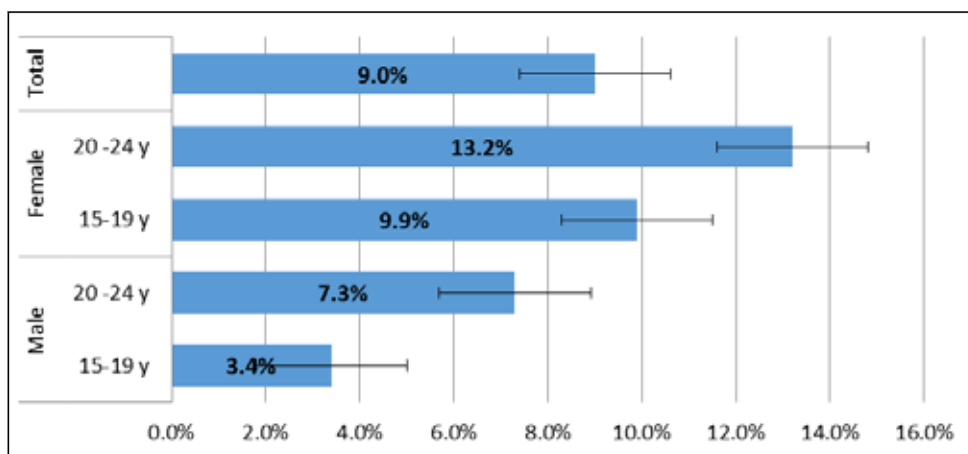
**Figure 2.61: Ever use of ECP by strata and by marital status**



The frequency of using ECP during the preceding 6 months was assessed in relation to sexually active youth sample (those who had sexual intercourse during the preceding year) which revealed that, 8.5% had taken ECP 1-2 times while another 4.4% had taken it 5 times or more (data not shown). It was interesting to note that there was no difference between unmarried youth and married youth with regard to the frequency of ECP use during the preceding six months.

The use of ECP by the sexually active youth during the preceding month was sought to find out the current ECP usage patterns.

**Figure 2.62: ECP use by sexually active youth during the preceding month**





Of the sexually active youth, 9.0% (95%CI: 7.0-11.5) of youth or their partners had taken ECP during the preceding month with higher proportion among 20-24 year old females (13.2%, 95%CI: 9.0-18.8). Although the estate and N-E youth were having lower proportions of ECP use during the preceding month, the observed differences were not significant. The ECP use during the preceding month among divorced youth, married youth and unmarried youth were 22.1%, 10.4% and 5.7% respectively.

### Use of modern methods of Contraceptive

An inevitable consequence of early sexual debut in women is unintended and teenage pregnancies. Early childbearing is often associated with adverse outcomes to the mother during pregnancy, childbirth and to the newborn. SRH programs should have interventions to prevent early sexual initiation such as postponing marriage, postponing sexual debut and postponing early childbearing. Contraceptive use becomes the most important secondary prevention strategy for preventing a teen pregnancy.

The use of modern contraceptive was explored as a proxy indicator on knowledge, attitude and practices on contraception among youth. Of the total youth sample, 5.2% (95%CI: 4.6-5.8) reported of using a contraceptive method at present. The figures for males were 2.2 (95%CI: 1.7-2.9) and for females 8.0% (95%CI: 7.0-9.2). Contraceptive prevalence among married youth, unmarried and divorced youth were 31.8%, 0.3% and 7.6% respectively.

The contraceptive use among sexually active youth (among those who had sexual intercourse during the preceding year) was separately analyzed to obtain more detailed information.

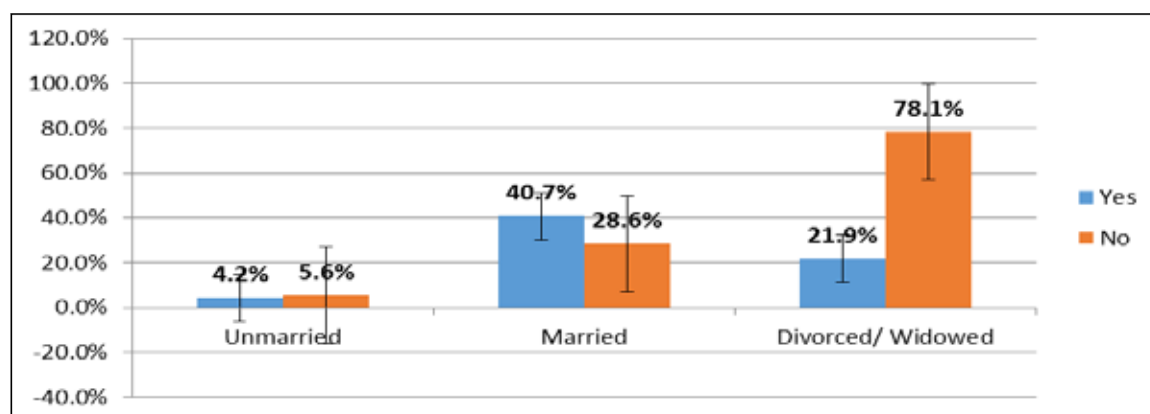
**Table 2.42: Current use of contraceptives by sexually active youth**

|   | Male %              |                     | Female%             |                     | Total %<br>(95%CI)  |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
|   | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) | 15-19 y<br>(95%CI)  | 20 -24 y<br>(95%CI) |                     |
| Use a family planning method at present | 11.3<br>(7.1-17.6)  | 14.1<br>(9.6-20.3)  | 43.0<br>(35.8-50.5) | 41.1<br>(34.4-48.0) | 29.5<br>(26.1-33.1) |
| Not using                               | 14.9<br>(9.6-22.5)  | 17.1<br>(11.4-24.8) | 25.5<br>(19.6-32.4) | 26.3<br>(20.6-32.8) | 21.7<br>(18.6-25.1) |
| Missing                                 | 73.8<br>(65.3-80.8) | 68.8<br>(60.5-76.0) | 31.5<br>(25.2-38.7) | 32.7<br>(26.5-39.4) | 48.9<br>(44.9-52.8) |
| <b>Total</b>                            | 100.0               | 100.0               | 100.0               | 100.0               | 100.0               |

The proportion of using contraceptives among youth having live-in partner was 44.2% (95%CI: 39.9-48.6) while 36.7% (95%CI: 32.5-41.1) declared as not using a contraceptive method. Nearly one third of sexually active youth were using a contraceptive method at present with significantly higher proportions among females without much strata variance.

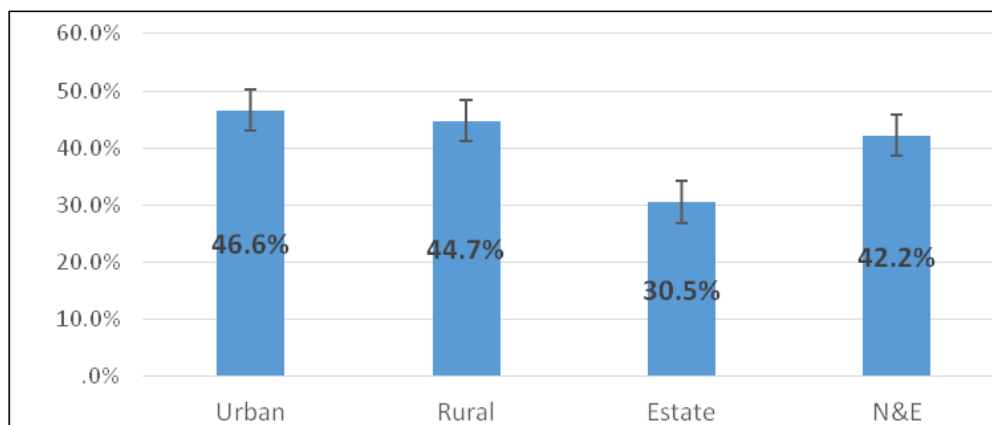
Use of contraception by sexually active youth was examined based on their marital status.

**Figure 2.63: Use of contraceptives among sexually active youth**



Nearly 40.7% (95%CI: 36.3-45.3) of currently sexually active and married youth were practicing a contraceptive method at present. Popular methods of contraceptives used were oral contraceptives (OCP) (2.0%) and DMPA injections (1.3%) among the total sample and OCP (17.0%) among the married. The sexually active unmarried youth reported of low contraceptive prevalence of 4.2% (95%CI:2.2-8.1). Contraceptive use among the married youth was markedly low among the estate stratum with 30.5% (95%CI: 24.3-37.5).

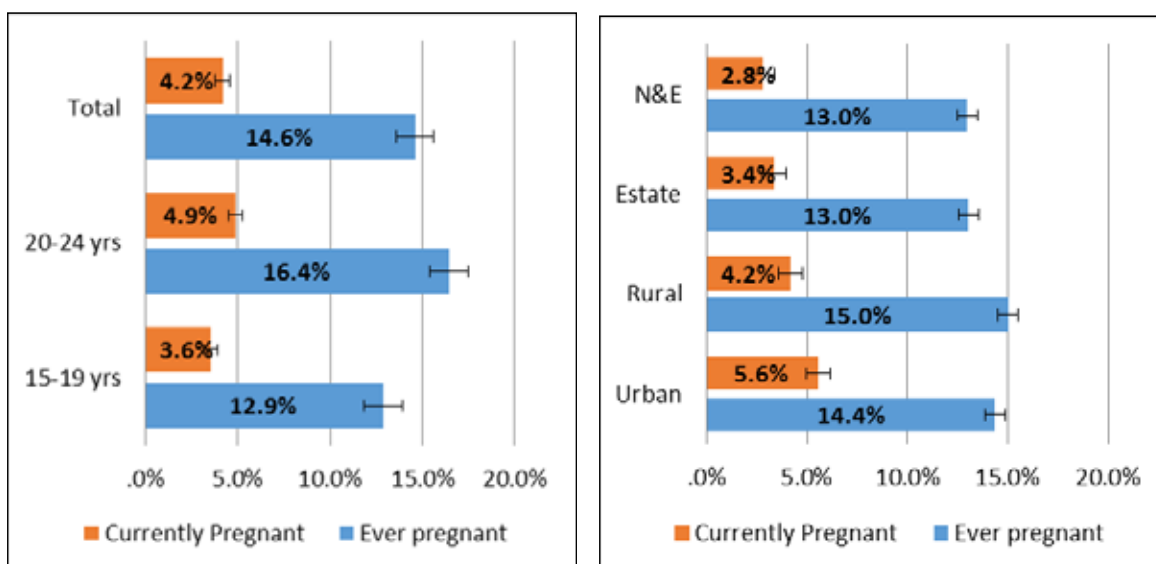
**Figure 2.64: Use of contraceptive methods among married youth by strata**



### EVER AND CURRENT PREGNANCIES

Information on past and present pregnancies was explored from female youth participants.

**Figure 2.65: Ever and current pregnancies among female youth by age groups and by strata**



Of the female youth sample, 14.6% (95%CI: 13.2-16.1) reported of past pregnancies. It is important to note that, among 15-19 year age group, 3.6% were currently pregnant.

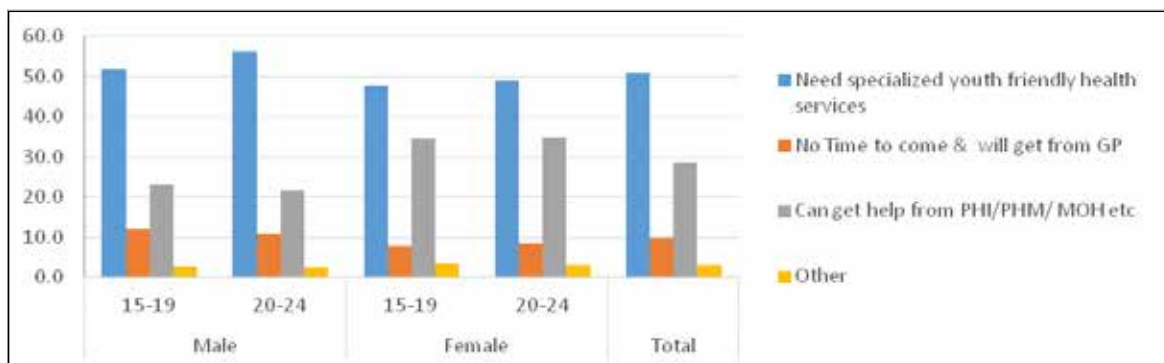
Of the total females, 4.2% were pregnant at the time of survey. The data shows no statistical differences between strata on child bearing ever and current pregnancies.

## HEALTH SERVICES

The health system in Sri Lanka is broad based and at community level it is the Public Health Midwife who provides information, services and referrals. The point of contact with the health services begins with the registration as an eligible family. Families either legally married or living together where the woman is between 15 to 49 years of age and /or having a child less than 5 years of age is referred to as an eligible family. A family with a pregnant or cohabiting woman irrespective of marital status and age and also women who are widowed, divorced or separated are also recognized as eligible persons for SRH services. Provision of adolescent health services has been identified as a component of PHM duties. However, young persons especially those who are unmarried, often do not access these services due to issues such as confidentiality and social stigma. During the last few years youth friendly health services (YFHS) were established at institutional and community level. Such services were established with a view to empower youth to resolve issues that hinder their development and be able to contribute to the socio-economic development of the country.

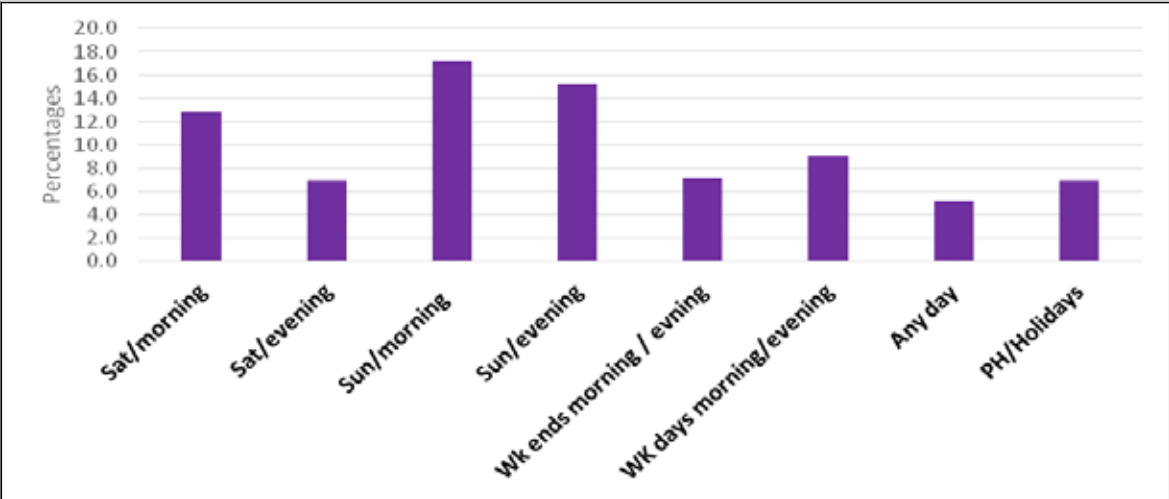
The survey assessed the concerns of youth on their preferred ways of health services.

**Figure 2.66: Youth preferences on health services**



Nearly half of the youth (51.3%,95%CI: 49.6-52.5) reported the use of specialized youth health services while 28.6% reported that they are able to obtain healthcare services from the Medical Officer of Health and his field health staff; this was predominant among female youth as opposed to males, who preferred specialized services. Only 10% identified the General Practitioners as the possible person to obtain health services with a significant male predominance.

**Figure 2.67: Youth preferences on health service opening hours**



The survey explored their views on preferred dates and times for such services. Among who preferred specialized health care services, the preferred days and times of access were Sunday morning or evening. However in reality, the health clinic system does not function on Sundays in the Government health structure.





### 3 CONCLUSIONS AND RECOMMENDATIONS

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The National Youth Health Survey was conducted using a stratified multistage cluster sampling methodology with a sample of 8820 youths in the age range of 15 -24 years, representing four strata namely Urban, Rural, Estate and North-East (N-E). Data were available for 92% of initial recruits (n=8118). Weighted analysis was conducted to account the disproportionate sample sizes in relation to the national distribution of youth population.

#### EDUCATION AND PRODUCTIVE ENGAGEMENT AT PRESENT

The majority of the sample were Buddhists, belonging to Sinhala ethnic group and rural stratum. Nearly one third of the sample were staying at home without a productive work. The proportion of youth pursuing higher studies in the estate stratum was significantly low, which could have been due to limited opportunities and necessity for early engagement in employment due to the socio economic constraints.

Poor educational performance, financial difficulties and necessity to find an employment have made young people to drop out from formal education earlier than they expected. Financial constraints and poor academic performance have significantly contributed for estate youth to leave school early, while poor academic performance and early marriage for the N-E youth.

Nearly one third reported having a vocational training (VT) for 4 months or more, which is in line with the UNDP survey (2014) which highlighted that youth do not consider VT as an attractive option. Proportions of youth engaged in VT were lower in the estate and N-E strata.

#### ***Recommendations***

- Policy makers and political leaders of the central and provincial education sector together with parents, students and representatives of the civil society should discuss



the reasons for school drop outs and find practical solutions to curtail this situation and strengthen resources to promote continuation of formal education

- Parents and adolescents should be made aware of academic as well as non-academic advantages of formal school education.
- Vocational training facilities to be improved and more awareness campaigns targeting school children are to be conducted. A collaborative mechanism between Ministries of Education and Vocational Training, is needed to facilitate school going children enrolling in vocational training.

## FAMILY

Living with parents and grandparents can have a significant impact on the health and development of a young person. Although, the family itself or family functioning in a wider context, affect either positively or negatively on one's health, available evidence shows greater advantages of family environment and parental supervision in reducing adolescent risk behaviours. Majority of the married as well as unmarried youth were living with their parents and one third with their grandparents.

The quality of parenting is important in determining its impact on young person's life. It is interesting to notice that the majority (nearly 88%) of youth perceived their families as "sweet and warm" or "good". UNICEF (2004) survey disclosed a similar portrait where majority of the adolescents perceived their families positively. Family socioeconomic status during the preceding month revealed that, 52.4% of youth perceived that their income was adequate while a minor proportion reported of taking loans due to their financial difficulties and 1.2% reported of extreme economic hardships.

### ***Recommendations***

- Health services should attempt to introduce parenting programmes targeting parents to emphasize the youth- parent bonding. As most of the youth perceive their families were caring, it is important to reinforce these norms and habits.

## PHYSICAL HEALTH

Results of the present survey revealed that nearly 20-25% of youth, experienced acute illnesses preventing them from attending productive work for one to three days during the preceding month. A higher portion of the estate youth reported of health related

absenteeism, which could have been due to lower socio economic conditions and relatively inaccessible /inadequate health services. The commonest cause of acute illness was, fever with or without cough and cold, followed by headache. It is noted that young males experienced injuries /accidents as the third leading cause for absenteeism.

Asthma has been the commonest reported chronic illness among the youth with 6.0% of reported Asthma prevalence for the total sample. Other commonly reported diseases were diabetes, epilepsy, heart diseases and mental illnesses.

Of the sample, 5.1% reported of visual disabilities, while 4.0% complained of hearing difficulties and 1.4% of walking disabilities needing some form of aids /correction. Of the present sample, 6.2% reported of injuries during the preceding 12 months which needed medical attention. Common types of injuries among youth were road traffic injuries (RTI) falls and sports related injuries and these findings were comparable with the results of Global School Health Survey (GSHS) in 2008. Motor cycle was found to be the main associated factor for RTIs where half of the youth reported to be either riding or travelling as a pillion rider.

### ***Recommendations***

- Health services should be more sensitive and youth friendly to support youth to overcome health issues and achieve full potential of their health and development.
- Causes for visual and hearing disabilities should be determined and corrected. Strengthening the school medical inspection should be considered and mobile medical camps for young persons should be encouraged.
- Introduction of an annual youth health checkup via healthy lifestyle centres will be a feasible model in addressing acute and chronic health problems among youth. For working youth, this can be incorporated as an annual health check -up at work settings.
- Youth specific strategies on Injury prevention need to be identified, introduced or incorporated in to existing packages of services. Nature of adolescence and youth need to be entertained by the programme planners in designing such preventive programmes on the foundation of 3 Es' (Education, Engineering and Enforcement) in order to have the youths' full compliance in injury prevention.

## LIFE STYLES

Adolescence and youth are considered as important stages of life in the prevention of non-communicable diseases as most of unhealthy or risky behaviours either start or are reinforced during this stage of life.

The survey results revealed unhealthy trend of life style among present day youth confirming previous research. Nearly half of males and three fourths of females had not engaged in any manual work and 44% were engaged in sedentary activities for most of the days of the week.

### ***Recommendations***

- Need to explore the possibilities of designing, youth specific NCD prevention strategies taking in to consideration the distinct characteristics of each group and the socio cultural background. Adolescents and youth should be considered as one important target group in combating the impending NCD epidemic in Sri Lanka. Multiple service delivery models should be used to deliver services and key messages.
- Policy makers and programme planners should pay more attention in providing an environment which facilitate adaptation of a healthy lifestyle by youth.
- Information package on health and nutrition should be developed and delivered among out of school young persons to refresh their knowledge gained in school.

## INFORMATION AND MEDIA

With regard to print media use, it was noted that weekend newspapers were popular among youth, irrespective of sex, age groups and strata. This could have been due to high availability of weekend newspapers at household level, or may be due to the presence of employment advertisements. Nearly one fourth of youth did not read newspapers regularly. It could be due to the increased use of electronic devices like smart phones and computers for obtaining information. The survey further revealed that one third of the sample lacked the knowledge on internet use while 17% (estate 70.2%) lacked facilities, warranting further efforts to increase IT knowledge and facilities. Nearly 80% of males and 60% of females were having their own mobile phone. Popular mobile networks among youth were Dialog, Mobitel, Airtel and Etisalat.

### ***Recommendations:***

- The possibility of using weekend newspapers as potential modes of disseminating information to youth should be explored.
- Major proportion of youth claimed to have access to mobile phones, which again can be used as a mode of communication.
- IT Knowledge among youth and necessary facilities need to be further strengthened via schools, vocational training courses and higher educational authorities.
- Mapping of schools with facilities for teaching IT should be carried out especially in the estate sector to enable identification of resource deficient areas to advocate relevant authorities.

## **KNOWLEDGE AND SKILLS ON SEXUAL AND REPRODUCTIVE HEALTH**

In order to ensure sexual and reproductive health and well-being of youth, they should be equipped with necessary knowledge, skills and services. With the objective of assessing the ASRH knowledge, few basic questions were included in the questionnaire.

It was noted that knowledge with regard to basic physiology and common SRH issues related to adolescence and youth was not satisfactory, as nearly 50% were unaware about most of the basic aspects of SRH systems. They had adequate knowledge on their own SRH system, however had a very limited knowledge on SRH 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. UNICEF (2004) survey reported of extremely poor knowledge on risk of conception and signs of pregnancy with less than 25% giving the correct answers. Although there were improvements with regard to percentage of correct answers, the present survey expected a greater majority to provide with accurate responses as they were older (15-24 years) compared to UNICEF survey sample (10-19 years), and 15.4% are married.

Significantly higher proportions of the estate youth, unmarried youth were providing incorrect or don’t know answers. It was interesting to note the myths and misconceptions were continued to occur among both married and unmarried youth. Significantly lower

portion of the estate and N-E youth provided correct answers on the myths, misconceptions and on emergency contraceptive pills.

With regard to life skills in SRH, a considerable proportion (39.8%) of the youth had favorable skills towards dealing with parental control and another 37.0% possess consensus generating skills with regard to parent-youth disagreements. It was also important to note that nearly 10% think that they should have the freedom to do what they want and another 8.4% had overconfident instincts which can drive themselves in to risk behaviours.

Nearly 56% of the youth seemed to be employing their assertive skills in negotiating with their partner. Nearly one fifth lacked the negotiation skills and obeyed their partner disregarding the negative consequences of such actions, and another 4.2% agreed with the partner just to sustain their relationship which again showed the abusive or unhealthy nature of the relationship. Only 34.9% took precautionary steps of informing parents about invitation for a date by an unknown person, got to know via a missed call which happens to be a predisposing incident for youth risk behaviours in today's context.

Decision Making is an important life skill which can immensely influence the future of youth. Nearly one third declared of taking important decisions on their own, as they were confident in doing so while half of the youth sought parental advice. Another 36.3% reported of discussing the situation with their parents and other adults to make a decision, indicating better skills in communication, negotiation and decision making.

With regard to knowledge on sexually transmitted infections (STI), more than half of the youth correctly understood the risk of STI even after a single sexual intercourse, however only 48.7% knew that genital ulcers could be a symptom of STI.

Present youth sample had a substandard level of awareness on HIV/AIDS, as 50%-60% youth provided accurate answers for most of the items. These items contained basic messages, hence a greater proportion of correct answers was expected. Youth were unaware about risk of HIV transmission from mother to child via breast milk (31.6% correct answers), and the availability of drugs to prevent mother to child HIV transmission (20.3% correct answers). GARP score was constituted to assess percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV, and who reject major misconceptions about HIV transmission.

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 the minimum legal age that a person can give consent for sex. The reported proportions were significantly low among estate and N-E youth.

Sources of SRH information varied according to sex and subject, for eg. for puberty related information, males relied on friends while girls accessed parents. For sexual problems, males accessed friends and newspapers, and girls used newspapers. The communication experts need to be sensitive of this situation in designing IEC packages.

Majority had highlighted about mental stress, unexpected pregnancy and sexually transmitted diseases as possible consequences of rape. The police (46.5%), Public Health Midwife (22.2%), National Child Protection Authority (NCPA) hot line 1929 (21.6%) and General Practitioner (18.7%) were identified as sources of help in a case of rape. Although the government policy wants the public to access NCPA, it was highlighted by one fifth of the youth.

***Recommendations:***

- The results again highlight the need to improve SRH knowledge among adolescents and youth as a priority issue as suggested by the UNICEF survey (2004). Different teaching techniques to be introduced to teach the SRH as an important subject rather than another theory lesson targeting exams. Both males and females should be made aware of both systems.
- Innovative methodologies need to be identified, pilot tested and scaled up in providing key SRH information to different youth groups with a special attention towards the estate and N-E strata. As recommended by the UNICEF (2004) survey, skills on teaching SRH need to be strengthened.
- A selected age cohort of the school can be used to provide a session on comprehensive SRH information package by the primary health staff headed by the MOH. The delivery of the package can be monitored via routing information system with regard to coverage. In addition, public health staff should pay more attention to improve SRH knowledge with life skill development among marginalized and vulnerable youth.

- SRH information should always be delivered coupled with relevant life skills education. Family life education, healthy relationships and gender should be intricately woven into the SRH awareness programmes for better results.
- Parenting programmes need to be introduced specifically targeting communicating with adolescents, negotiating with adolescents and youth and enhancing life skill development of young persons.
- Comprehensive HIV/AIDS awareness programmes to be conducted achieving wider population coverage. This should be done as specific programmes as well as integrated subject with other health awareness programmes.
- Specific attention need to be focused to incorporate Prevention of Mother to child Transmission (PMTCT) key messages in the HIV/AIDS Communication Package.
- Following Key points need to be incorporated in the SRH communication package to fill the existing knowledge gaps. Minimum legal age for consent for sex, indications and time frame of using emergency contraceptive pills, identification and management of close relationships of abusive nature, healthy use of mobile phones, symptoms and signs of conception, consequences of risky sexual practices, and more importantly how to say “No”. Adverse consequences and sources of help following a rape, (including NCPA hot line -1929) should also be given publicity.
- Special effort should be taken by the health authorities in disseminating the SRH messages for youth in schools and in the estate and N-E sector.
- SRH communication package should use multiple methodologies to provide the SRH information as youth reach different information sources depending on the sex and subject.
- Since the school curriculum at present have inputs on SRH. A quick assessment of the current status should be carried out to identify the gaps to upgrade the curriculum.
- A comprehensive, high quality, age appropriate curriculum based sexuality education program should be planned with participation of school going children, parents and teachers. All components of SRH (maternal health, teenage pregnancy, GBV, HIV/AIDS) should be included.

## DIET AND NUTRITION

Many individual, social and environmental factors have negatively influenced the physical activity and eating behaviors of youth. Individual factors like knowledge, attitude and skills play a major role in determining youth dietary behavior.

Majority were unaware about sources of iron and reasons for vegetable and fruit intake. Since the adolescents and youth should be given a proper insight to as why they should have a balanced diet and the importance of certain food groups. A considerable proportion of youth consumed carbonated /cola drinks, pre-cooked food like and food with high salt. About 5.6% of youth were taking energy formulas. More boys and more urban youth were taking energy drinks and vitamins without medical advice. Of the sample 2.7% are vegans. Only 50% of the youth, have heard about BMI concept with a significant female predominance.

### ***Recommendations:***

- Present school curriculum contains considerable amount of information on nutrition including body mass index. These information should be delivered in a more practical and interesting manner.
- Nutrition communication package targeting youth should include messages on importance of a balanced diet, proper /healthy use of energy supplements, vitamins etc.

## PSYCHOSOCIAL HEALTH

Youth violence is a problem that can impose permanent harmful effects on youth themselves and their family and communities. The survey asked about exposure to fights which required them to seek medical treatment during the preceding 12 months for which 2.3% answered positively with male and urban youth predominance, but no significant differences between religious groups or strata or schooling status.

It is of note that 83.1% of youth reported of having a happy mood during past two weeks. However significantly lower proportion of the estate youth reported of a happy mood. Reasons for worry differed according to sex, where boys were worried about finding a job, current job, relationship issues, while girls were worried about exams, parental conflicts /family disputes. The reported figures were comparable with that of 2004



UNICEF survey. Of the out of school adolescents of 15-19 of age, 25% mentioned nothing worried them at present whilst 25% worried about finding a job and 5% was anxious on youth-parent relationships.

Significantly more females had the feeling that their life is not worth living. Nearly one fifth of youth complained of feeling sad or helplessness and had stopped their routine work for a while. Of the total, 6.4% had felt like above for two weeks or more in a row, while 6.4% had seriously thought about committing suicide during the preceding 12 months, 4.0% had made plans and 2.9% sought some help. Significantly more youth who perceived that “family is not good or intolerable” had more suicidal feelings compared to youth who declared their family as “sweet and warm”.

The Global School Health Survey (GSHS, 2008) conducted among students aged 13-15 years, revealed that nearly 10% of school going adolescents aged 13-15 years had seriously thought about suicide during the preceding 12 months. The lower proportion of suicidal thoughts among youth reported in the present study (6.4%) could be due to older age, compared to GSHS.<sup>4</sup>

Social capital plays a significant role in youth psychosocial health and development. It was appealing to see that 80.6% have reported that there was someone who would offer help (other than their parents) if they are in trouble irrespective of sex or age group. Males had rated friends, while females selected both friends and siblings as their social capital. Friends have been rated as the social capital after “parents” by the 10-19 year old out of school adolescents in UNICEF (2004) survey as well. Majority of female youth highlighted “Mother” while males mentioned “Friends” as the preferred person to talk about a personnel /private matter replicating the UNICEF (2004) survey findings.

Of the sample 8.1% reported that they had experienced feelings of being discriminated regardless of their age or sex. The reported proportion was significantly higher among the estate youth and among lower socio economic group. The commonly cited perceived reason was their income level followed by sex.

### ***Recommendations:***

- Empowering parents about the influence of families towards youth mental wellbeing is important and should be incorporated in to communication packages on parenting

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<sup>4</sup> Global School Health Survey (2008): Available at <http://www.cdc.gov/gshs/countries/seasian/index.htm>

- Since friends and parents were commonly accessed by the youth for help with suicidal feelings, youth health / mental health programme planners need to look for innovative approaches in strengthening peer support and parent support as youth suicide prevention strategies
- Need to reinforce the positive determinants of psychosocial wellbeing of the youth such as family connectedness, youth-parent relationships, social capital, engage in social /community activities
- Youth specific, evidence based mental health care services should be made available for young persons.

## SUBSTANCE ABUSE

The survey explored ever use and use during the preceding week (current use) of smoking, betel chewing and alcohol use. Ever and current smoking in the present sample were 30.5% and 17.6% for male youth and 1.6% and 0.7% for female youth respectively. Significantly more non-schooling male youth (23.9%) were reported smoking during the preceding week. It is noted that 4.3% of schooling youth reported on smoking during the preceding week.

The respective figures for ever and current smoking for schooling boys were 18% and 6% while for out of school boys 42% and 23% in the UNICEF (2004) survey. The present current smoking rates were comparable to the previous 2004 UNICEF survey data. Chewing betel with tobacco during the preceding week was 6.3%. Caring family was significantly associated with lower current use of tobacco.

Significantly more non-schooling males had used alcohol ever (43.4%) and during the preceding week (13.8%) compared to schooling males (17.0% and 2.6%). UNICEF (2004) survey figures for ever and preceding week alcohol intake among non-schooling males were 48.9% and 12.7% respectively. Both ever use (14.7%) and current use (3.9%) of alcohol were significantly higher among the rural youth.

In summary, it was evident that the current use of tobacco and alcohol had remained unchanged during last 10 years.

Reasons such as “don’t feel like using those as they do not give such kick as they claimed to be”, “parental disapproval”, “and “disapproval by religious norms” were cited as factors for refusal of invitations for substance use by the present sample (among those who had refused them) irrespective of sex or schooling status. With regard to other additive substances, Babul was the most commonly tried substance among the males while urban and rural youth had used Ganja (cannabis) and Madana Modaka (Cannabis based product) and Babul (areca nut from India) in significantly higher proportions.

### ***Recommendations:***

- Innovative methodologies are needed to prevent adaptation of youth risk behaviours with regard to substance use since the current smoking prevalence as well as alcohol use remained unchanged at 23% since 2004.
- Parenting programmes focusing on the importance of parental supervision and caring family atmosphere in the prevention of youth risk behaviours related to substance use should be promoted.
- Substance use prevention programmes should not only be delivering the facts and figures but focus in life skill development with special emphasis on improving assertive skills “How to say No”.

## **VIOLENCE IN RELATIONSHIPS: RAPE, GENDER BASED VIOLENCE AND INTIMATE PARTNER VIOLENCE**

The survey explored about the past experience on rape among youth, for which 2.9% answered affirmatively with significantly higher proportions in the urban and rural strata. Neighbors, relatives, strangers were abusing youth irrespective of their strata or schooling status. The reported figures were lower compared to UNICEF survey in 2004 which revealed a rate of 10% among out of school adolescents.

With regard to gender based violence, significantly more females reported of unpleasant experiences of gender based harassment in public places predominantly among the urban and rural strata and among non-school going group. Youth complained about setting barriers on having relationships with others, and blaming /scolding /insulting and physical violence by the partner as evidence for intimate partner violence.

### ***Recommendations:***

- Importance of Life skill development is again to be re-emphasized on identification the perpetrator early, as most of them are either neighbours or relatives.
- Gender sensitization and healthy relationships need to be integrated to adolescent sexual and reproductive health programs.

### **SEXUAL BEHAVIOR**

The survey asked about sexual activities during the preceding year. One third of total sample answered affirmatively with one fifth of the unmarried youth. Significantly higher proportions of the urban and rural youth reported of such activities. Masturbation, vaginal intercourse and watching pornographic films were the common activities cited, while anal, oral, vaginal and intra-crural sex activities were significantly prevalent among non-school going group.

Majority, had their first sex with their regular partner or spouse. Other partners were girl/boyfriend, relative /friend, casual partner or commercial sex worker. Significantly higher proportions of males were engaged in all above irrespective of age or strata or schooling status. Majority (78%) of the youth reported of never engaging in sexual intercourse in their life and only 20.2% declared as having sex ever. This norm, "abstinence till marriage" should be further reiterated and promoted.

Of the total, 14.7% have had sex during the preceding year (being sexually active) with significantly higher proportions among the non-school going youth, urban and rural youth. It was noted that 1.3% of school going youth admitted of having sexual practices during the preceding year. About 85% of the sexually active youth were having one sexual partner, 7.2% had two while 3.2% had three or more sexual partners. Having multiple partners was significantly higher among the males, non-schooling youth and non N-E strata youth. More male youth reported of having sex with same sex partners.

The UNICEF survey (2004) reported of heterosexual relationship among 14% boys and 2% girls and 10% having homosexual relationships. The difference could have been due to the differences in age group and presence of married youth in the present sample. Of the unmarried youth, 7.0% were sexually active regardless of strata, while majority have had

sex with their boy /girlfriend. This figure correspond with 2004 UNICEF survey, where 6% of in-school adolescents reported of ever having sex.

The survey explored about the assertive skills of the youth. Nearly 10.3% divulged as having being invited for sex. Of those who had such invitations, 63.2% revealed refusal ever in their life. The reported proportions were higher among females compared to males, regardless of age groups or strata.

The reasons for such refusal were explored to have a better understanding on factors contributing to assertive skills among young persons. Reported reasons were societal disapproval on pre-marital sex, need to pursue higher studies, and the risk for STI/HIV and pregnancy. Female youth highlighted fear of losing virginity after societal disapproval.

### **Recommendations:**

- Primary, secondary and tertiary prevention strategies in delaying sexual relationships among youth should be strengthened. Communication messages should re-iterate the importance of abstinence till marriage as the “gold standard”. For the minorities who adopt risk behaviours despite SRH education, should be targeted with secondary preventive measures like life skill development and contraceptive services, diverting attention to education, employment or other methods of entertainment.

## **CONTRACEPTIVES AND PREGNANCY DETAILS**

With regard to use of condoms, 4.5% of total youth and 30.4% of currently sexually active youth, had reported of using condoms during the preceding year during sexual intercourse with spouse /regular partner, boy /girlfriend and commercial sex partner. Nearly one fifth of the boys who had used condoms during the previous year, had used them when having sex with commercial sex partners. The common reasons were for non-use of condoms by sexually active youth were practicing another contraceptive method (20.8%), expecting a child (16.3%) and other reasons (13.7%), non-availability of condoms (3.8%) and unawareness (3.1%) irrespective of their strata. Of the sexually active youth, 9.0% of youth had taken emergency contraceptive pills during the preceding month.

The use of contraceptives was explored as a proxy indicator on knowledge, attitudes and practices on contraception among youth. Of the total youth, 5.2% were using a contraceptive method at present. The said proportion among those who have a live-in/cohabiting partner was 44.2 % while that for sexually active (have had sexual intercourse during the preceding year) youth, was approximately one third with

significantly higher proportions among females. Nearly 40.7% of sexually active and married youth were practicing a contraceptive method at present which highlights a low prevalence compared to DHS (2006/7). Popular methods of contraceptives were oral contraceptives followed by DMPA injections.

Of the sample, 14.6% had past pregnancies while 4.2% were pregnant at the time of survey irrespective of strata. This was in contrast to the Demographic Health Survey (DHS) conducted in 2006/2007 findings which revealed 6 %of girls of 15-19 years have given birth or currently pregnant<sup>5</sup>. The observed differences could be due to exclusion of the Northern Province and the sample consists of ever married women in the DHS. The DHS (2006/7) revealed of 10% estate adolescent girls have begun child bearing, compared to 14.2% in the present sample.

***Recommendation:***

- The findings highlights the necessity of enhancing the awareness and services on contraceptive including emergency contraceptive pills among youth
- Health authorities need to adopt target group specific messages and methodologies in enhancing contraceptive use among youth groups.

## HEALTH SERVICES

The survey assessed the concerns of youth on their preferred ways of health services. Nearly half of the youth (51.3%) reported they need specialized health services while 28.6% reported that they can get their health services from the Medical Officer of Health and his field health staff. The most preferred opening times were Sunday mornings and evenings.

***Recommendation:***

- Youth requests specialized health services opened during weekends. It is high time that health authorities should pay attention and make adolescent / youth health services function at youth friendly opening hours.
- It is important to use multiple methodologies of service delivery in complimentary manner, as one model will not be able to reach all target groups.

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<sup>5</sup>Demographic and Health Survey(2006/7) , Department of Census and Statistics ,Colombo, Sri Lanka. Available at <http://www.statistics.gov.lk/social/DHS%20200607%20FinalReport.pdf>



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