

中国青少年生殖健康可及性调查基础数据报告*

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摘要:目的是了解中国未婚青少年性与生殖健康的知识、态度和行为现状,评价青少年性与生殖健康服务的可得性与可及性,为改善青少年的性与生殖健康可及性提供政策支持。利用分层和概率比例规模抽样相结合的四阶段混合的抽样方法,用结构化问卷对15-24岁未婚青少年的三类子总体进行匿名一对一面访式调查。青少年整体缺乏全面正确的生殖健康知识,22.4%的青少年具有性经历。首次和最近一次性行为中,未采取任何避孕措施的比例分别为51.2%和21.4%。在有性经历的女性青少年中,怀孕率为21.3%,多次怀孕率为4.9%。书/杂志、同学/朋友、学校老师、网络以及电影/电视是青少年生殖健康知识的五大来源。学校课程对青少年的性与生殖健康知识具有积极作用,但青少年参加相关课程/讲座的比例不足40%。50%以上的咨询和治疗需求未实现。分析了原因,提出了对策和建议。

关键词:未婚青少年;性与生殖健康;知识;态度;行为;可及性;知识来源;咨询;治疗

中图分类号:C913.14

文献标识码:A

文章编号:1674-1668(2010)03-0002-15

1 背景

1994年,ICPD指出“生殖健康”是青少年应当享有的一项基本权益(联合国,1994)。同时,MDCs也进一步明确,到2015年要实现普遍享有生殖健康(联合国,2000)。根据2005年全国1%人口抽样调查数据推算,中国当时有15-24岁未婚青少年1.61亿,占总人口的12.6%(国家统计局,2005)。但迄今为止,中国尚无专门针对这一群体的性与生殖健康的具体政策。

早在上世纪50年代,中国政府就已开始倡导促进青少年的性与生殖健康。1979年底,卫生部 and 教育部联合印发《中小学生卫生工作的暂行规定》,第一次以政府的形式提出,“要加强青春期卫生教育”(许洁霜,2007)。但是,小范围调查显示受快速变化的社会环境影响,当前我国的未婚青少年生殖健康形式依然严峻,且暴露出许多新的问题(钱序,黄迎,蒋泓等,2007)。不安全性行为、未婚少女意外妊娠、艾滋病及性病蔓延等问题严重威胁着青少年的生殖健康。如何使我国青少年掌握正确和全面的性与生殖健康知识、形成正确的性与生殖健康观念,做出知情的性与生殖健康行为选择,是当前亟待解决的社会问题之一。

保障未婚青少年这一庞大人口群体的性与生殖健康权利,需要进一步结合青少年生殖健康服务需求与供给现状,明确生殖健康发展策略,发展适合中国文化背景和青少年发展状况的政策。正确地评估青少年生殖健康的需求是提供相应政策建议或政策开发的重要基础。当前关于青少年性与生殖健康的研究缺乏系统的、具有全国代表性的调查数据。

收稿日期:2010-05-29

* 本研究受国务院妇女儿童工作委员会办公室支持,受联合国人口基金资助。调查报告主要工作人员:郑晓瑛、陈功、韩优莉、陈鹤、林婷、邱月、杨蓉蓉、胡玉坤、乔晓春、王旭光、张蕾、穆光宗、宋新明、庞丽华、武继磊、林艳、刘岚、裴丽君、李宁、魏继红。

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本研究的主要目的是了解中国青少年性与生殖健康的知识、态度和行为现状,评价青少年性与生殖健康服务的可得性与可及性,以及青少年对服务的满意度和所期望的服务提供方式。

本研究包括定量与定性研究两部分。此报告仅基于定量调查数据。定性调查数据以及进一步的分析结果将会在 2010-2011 年间发布。

2 方法

本次调查在 2009 年 10 月 20 日至 11 月 30 日展开。

2.1 抽样方法

调查对象是在中国大陆 30^①个省(自治区/直辖市)居住、年龄在 15-24 岁之间的未婚青少年。针对青少年群体本身的多样性,我们将其划分为学校青少年、家庭户青少年和集体户青少年三个子总体^②。本次调查采用分层和概率比例规模抽样(PPS)相结合的四阶段混合的抽样方法,共涉及 25 个省(自治区/直辖市)、40 个县(市、区)的学校、家庭户和集体户。

2.2 访问技术

调查利用结构化问卷进行面访,共有访问员 579 名,督导员 155 名。全国共发放问卷 22535 份,收回有效问卷 22288 份,有效问卷率为 98.9%。

在调查中,为了获得高质量的数据,我们针对访问员采用了督导员和第三方监察的双重方式;针对被访青少年,采用了营造独立环境、匿名、敏感部分自填、投票箱方式回收问卷等多种方式,尤其注重性别视角。

2.3 数据加权

利用 2005 年全国 1% 人口抽样调查数据,对此次调查调查结果进行加权。经推断,2009 年全国共有 15-24 岁未婚青少年 164,719,905 人(除特别声明,本报告均基于该数据)。其中,男性青少年占 50.8%,年龄均值为 19.2 岁。

2.4 专家参与

我们在研究过程中,多方征求专家意见和建议,尽可能获得有效、可信的数据。总体上本次调查样本分布比较科学合理,调查严格按照研究设计要求进行,执行过程监控力度强,调查结果真实可靠。

3 初步结果

3.1 性与生殖健康的知识和态度现状

3.1.1 知识

对青少年性与生殖健康知识知晓情况的分析包括以下三个方面:(1)性与生殖健康知识知晓情况;(2)无保护性行为应对措施知晓情况;(3)艾滋病相关知识知晓情况。

总体来说,青少年比较缺乏性与生殖健康知识;各青少年群体的知识掌握情况存在差异。对于问卷中提



图1 调查样本分布图

①未包括西藏自治区。

②“学校青少年”是指目前正在学校读书的青少年,不区分住校还是走读;“家庭户青少年”是指在家居住,有工作或者目前正在待业的青少年;“集体户青少年”是指具有集体居住性质且有工作的青少年。

出的三道生殖健康知识问题,只有4.4%的被访青少年能够将三道题^①完全答对。安全套/避孕套、避孕药/丸以及紧急避孕药是青少年中知晓率最高的前三种避孕方法;只有不足1/2的青少年知道如何正确应对无保护性行为。尽管超过95%的青少年都表示听说过艾滋病,但是青少年对艾滋病知识,尤其是艾滋病的传播途径方面掌握情况并不乐观,不同的青少年群体的掌握情况存在较大差异。面对着问卷中提出的五道^②有关艾滋病的问题,只有14.4%的人能够正确回答五道题。

分性别分析结果显示,男女青少年对性与生殖健康知识的掌握情况具有差异。女性青少年在以上三项生殖健康知识掌握情况低于男性青少年,处于弱势地位。

分析以上三项性与生殖健康知识的掌握情况发现,具有以下特征的青少年,知识的掌握情况较差:15-19岁、高中/中专及以下受教育程度、西部/中部地区的青少年。

3.1.2 态度

多数青少年对婚前性行为持接受态度。除了不到1/3的青少年明确表示不接受外,其他人在不同程度上接受婚前性行为或持有模糊态度。大部分被访者对女性青少年婚前保持贞洁的要求更为严格,而男性青少年的婚前性行为则更容易被接受(见图2)。

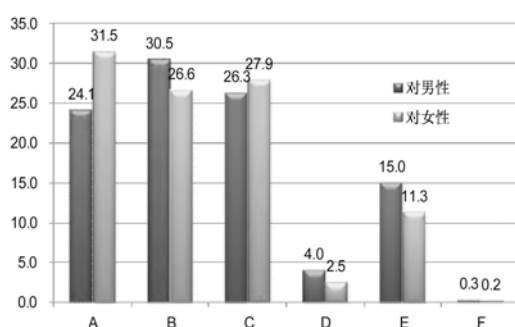


图2 对男/女性青少年的婚前性行为的态度(%)

注: A 代表应保持贞洁, 任何情况下都不应该有婚前性行为; B 代表如果与对方有感情, 可以有婚前性行为; C 代表如果准备和对方结婚, 可以有婚前性行为; D 代表有无感情都可以有婚前性行为; E 代表不确定。

分性别分析结果显示,男女青少年对待婚前性行为的态度具有差异,男性青少年对婚前性行为更易接受。两性均更能接受男性青少年婚前性行为。

具有以下特征的青少年,对婚前性行为更易接受:20-24岁、校外、收入偏高的青少年。父母婚姻状况也与青少年对婚前性行为的态度之间存在一定的联系。在与亲生母亲和继父生活在一起的青少年中,对婚前性行为持接受态度的比例最高,达到65%以上。

3.2 性行为

3.2.1 性行为^③

22.4%的青少年具有性经历;分性别分析显示,男性青少年性行为比例高于女性。有以下特征的青少年,具有较高的性行为比例:20-24岁、城镇、父母均不在身边、独生子女、流动、校外以及西部地区的青少年。在校外青少年中,收入越高,性行为比例越高。对待婚前性行为的态度与性行为的发生之间具有一定相关性。

在被访青少年中,首次性行为的最小年龄为12岁,中位年龄为20岁。同时,男性青少年首次性行为发生的

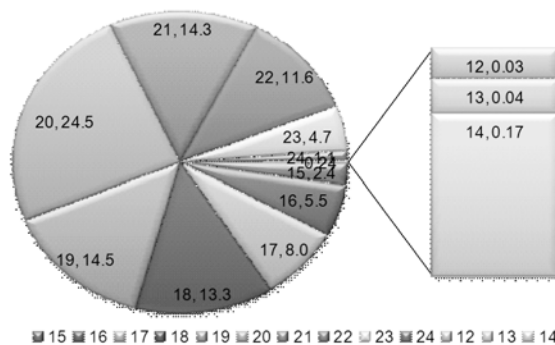


图3 首次性行为的年龄分布(%)

①三道问题分别是:“女性一次性交就有可能怀孕”;“手淫导致严重的健康问题”;“人工流产对女性以后的妊娠不会产生影响”。

②五道问题分别是:“只与一个没有其他性伴,且没有感染艾滋病的人发生性关系可以减少艾滋病感染的风险吗?”;“每次性交都使用避孕套可减少感染艾滋病的风险吗?”;“一个看起来健康的人会携带艾滋病病毒吗?”;“蚊子叮咬会传播艾滋病吗?”;“与艾滋病感染者共餐会感染艾滋病吗?”。

③“性行为”指插入性行为,即指一方把阴茎、手指或假阳具插入到另一方的阴道或肛门内。

年龄略早于女性青少年。

3.2.2 多个性伴侣

在有性行为的青少年中,20.3%的人过去12个月内有不止一个性伴侣。男性青少年中多个性伴侣的比例高于女性,15-19岁的青少年中多个性伴侣比例高于20-24岁的青少年。

3.3 避孕

青少年中的避孕情况不容乐观。在首次性行为中,超过1/2的青少年未采取任何避孕措施。在最近一次性行为中,尽管未避孕比例降至21.4%,但仍意味着每五次青少年性行为中,就有一次没有采用任何避孕措施,面临着STIs/HIV感染、非意愿妊娠和可能流产的风险。未避孕比例较高也反映出,绝大多数青少年缺乏性行为中自我保护意识。

从避孕措施的构成来看,“避孕套/安全套”在避孕措施中所占的比例,从首次性行为的60.5%

上升到最近一次性行为的71.4%。首次性行为使用紧急避孕药的比例低于最近一次性行为。但是,在最近一次性行为中,利用“体外射精”与“安全期避孕”这两种传统避孕方式的比例仍占到15%左右。

3.4 怀孕经历和妊娠结局

在有性行为的女性中,21.3%有过怀孕经历,4.9%人有过多次怀孕经历。20-24岁、农村、校外、无父无母、独生子女、流动、西部青少年的怀孕比例更高;对多次怀孕的分析发现,除了15-19岁青少年的多次怀孕率高于20-24岁之外,其他的分布特征与有怀孕经历的青少年的分析结果类似。需要注意的是,分年龄和在校与否进行分析发现,校外青少年的怀孕率与多次怀孕率高于在校青少年。

在未婚妊娠的女性青少年中,90.9%有过人工流产的经历。有19%的怀孕的女性青少年有过多次流产经历。被访者中,人工流产最多为四次,占1.2%,三次占1.5%,二次占16.3%,一次占72%。此外,2%的女性青少年有过引产经历,0.2%的女性青少年有过活产经历。

表1 未婚妊娠女性青少年的人工流产经历次数的分布情况(%)

次数	比例
0	9.1
1	72.0
2	16.3
3	1.5
4	1.2
人工流产率	90.9
多次流产率	19.0

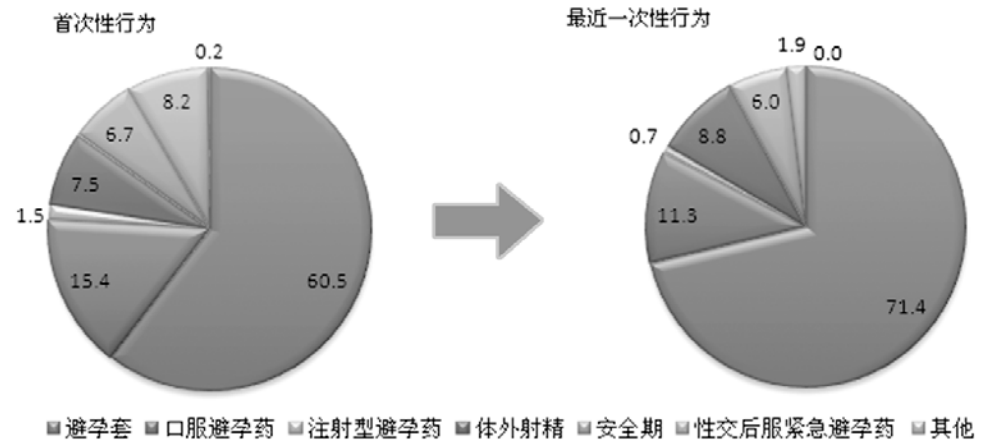


图4 青少年首次与最近一次性行为中的避孕措施构成(%)

3.5 生殖健康知识来源

无论是青春期知识、生殖系统知识,还是如何与异性相处方面,书/杂志、同学/朋友、学校老师、网络以及电影/电视都是青少年生殖健康知识的五大重要来源。从知识的获取方式来看,青少年在获取性与生殖健康知识时,更多地处于一种“自学”的状态。非正规及非规范化的信息来源成为青少年获取生殖健康知识主要途径。

从青少年较低的生殖健康知识知晓率可以反映出,目前这些非规范化的途径获得的生殖健康知识是不可靠的。

3.6 学校课程对性与生殖健康知识的影响

学校教育对提高青少年的生殖健康知识具有积极作用,但青少年参加相关课程/讲座的比例较低,需要进一步提高。参加过青春期教育或相关课程、预防性病、艾滋病讲座以及避孕节育知识讲座的青少年的生殖

健康知识满分率都不同程度地高于未参加者。

尽管课程具有积极的作用,但是自报参加过三类课程的青少年的比例都不足40%。避孕知识讲座的参与率更低至4.3%,但是参加该课程的青少年的性与生殖健康的知识最好。分层分析发现,农村青少年、15-19岁的流动青少年、以及中部地区青少年接受相关教育的情况尤其值得关注。

通过分层分析发现,具有以下特征的青少年参加3种课程/讲座的比例较低,15-19岁,农村,中部地区的青少年,特别是15-19岁的流动青少年。

3.7 性与生殖健康服务的需要、利用与可及性

医疗机构的面访和热线电话是青少年中知晓最高的咨询方式(60%)。粗略累计,只有将近两成的青少年利用过各种机构提供的咨询服务。例如,学校与非医疗机构提供的服务。

表2 各种咨询需要未实现的原因

咨询需要类别	1	2	3
生殖系统卫生保健问题	A	C	B
性心理	C	B	A
避孕的知识与技能	C	A	B
性病预防和治疗	C	A	D
怀孕/流产	C	A	B
性伦理/性道德	C	B	A
获取避孕药具	C	B	A
性侵犯	C	A	B

注:A 问题不严重;B 不知道跟谁咨询;C 不好意思;D 怕碰到熟人。1,2,3 表示前三位最主要的因素。

“不好意思”、“问题不严重”以及“不知道跟谁咨询”是青少年未能获取咨询服务的三项最重要原因。青少年咨询需求,主要问题为生殖系统卫生保健、性心理以及避孕知识与技能等。但是,约60%的需求最终没有得到满足。分性别与年龄分析结果显示,20-24岁,男性青少年咨询需要率和咨询实现率均低于女性青少年。15-19岁,两性间差异不大。西部农村地区青少年的处于最弱势的位置,他们是性与生殖健康咨询需求率最高和实现率最低的青少年群体。青少年的生殖健康治疗需要的实现情况也有待提高,自我感知的“问题不严重”为需要未实现的首要原因。青少年具有治疗需要的主要问题是,月经问题、生殖系统感染以及生殖器官异常等。但是,一半以上的需要最终没有实现。分性别分析结果显示,女性青少年治疗需要率和实现率均高于男性青少年。15-19岁、农村、西部地区青少年的治疗需要与实现情况处于弱势地位,尤其需要关注。他们往往是性与生殖健康治疗需要率较高和实现率较低的青少年群体。“问题不严重”、“害怕被嘲笑”以及“不知道哪里看”是青少年有治疗需要但没有的三项最重要因素。青少年在选择服务提供者时所考虑的主要因素,医疗技术水平(20.2%),注意保护隐私(14.5%),服务价格(10.8%),服务态度不好(10.4%),就诊环境不好(9.5%),就诊程序方便(9.3%),离家近(8.7%),远离熟悉的人群(6.1%),就诊时间灵活(5.8%),工作人员的性别(4.6%),其他(0.1%)。

4 结论与初步建议

此次调查结果显示,目前青少年的性与生殖健康状况令人担忧。信息与服务供给不足需要得到政府与社会的关注。健康权利包括以下四个方面:信息与服务的可得性、可及性、可接受性与高质量。(1)信息与服务的可得性。可得性意味着有足够数量的公共卫生设施满足人们的基本健康需求。此次调查没有从供给的角度进行探究,但是从被访青少年调查的数据中我们看出,青少年性与生殖健康知识是不足的,咨询和治疗的需要多没有得到实现。学校教育对青少年性与生殖健康知识具有积极作用。但是,只有不到40%的青少年参加过学校组织的三种类型的生殖健康课程。“不知道向谁咨询或向哪些机构获取治疗服务”是青少年无法实现咨询与治疗需求的三个主要原因之一。(2)信息与服务的可及性。可及性指健康服务信息和服务要从生理和经济

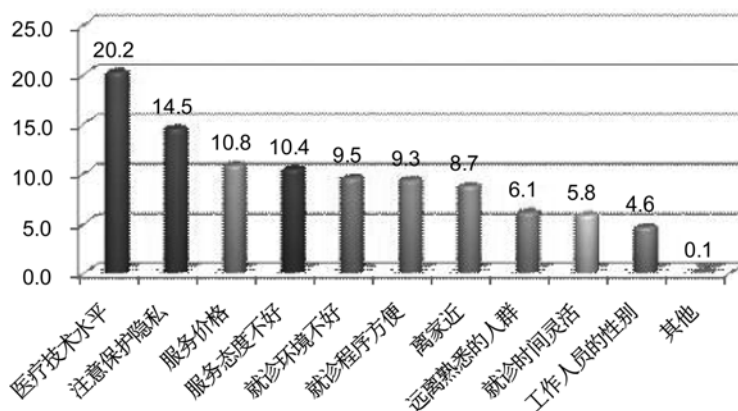


图5 青少年选择治疗机构的标准 (%)

两方面均可承受,必须是一种面向所有人的无偏见的供给,可以自由获取的。调查结果显示,青少年生殖健康服务可及性不高。医疗技术水平、隐私保护、服务价格和服务态度是青少年在获取治疗服务时首要考虑的四个主要因素。(3)信息与服务的可接受性。可接受性指所有卫生服务要遵从医学伦理、文化背景,并且要被青少年所接受。调查结果显示,“不好意思”,“怕碰到熟人”是青少年获取咨询和治疗服务的主要障碍。(4)信息与服务的高质量。高质量主要指卫生设施、物资和信息与服务必须要遵从科学与医学的规律,保证高质量的服务。青少年缺乏全面正确的性与生殖健康知识反映出目前我国信息与服务质量有待提高。另外,避孕套和避孕措施的低使用率,非计划怀孕与多次怀孕,高流产率与多次流产等都说明目前我国青少年性与生殖健康权利未得到充分实现。

世界上只有少数国家在 2008 年千年发展目标进展报告中展示了“2015 年前普遍的生殖健康”的实现情况,中国是其中之一。此次调查将推动中国政府和社会对青少年性与生殖健康促进的进一步关注。

4.1 社会多部门联合促进青少年性与生殖健康

初步调查结果显示,如同其他国家一样,中国社会各界需要共同协作以促进青少年的性与生殖健康。青少年性与生殖健康的信息有多种来源,信息和服务的提供涉及多个部门,多部门的协调配合是保障青少年性与生殖健康权益的重要基础。政府中与该领域相关的包括卫生部、教育部、人口与计划生育委员会、中国共青团、公安部、文化部、全国妇联、财政部等。私人部门中的媒体,私立医院和药房等也具有重要作用。调查发现,大部分的青少年性与生殖健康知识是通过各种各样的传播渠道,这些传播渠道需要有效利用。同时,国际与国内的非政府组织同样也是中国当前促进青少年性与生殖健康的重要力量,有大量的青少年工作经验可供学习。中国青少年和世界其他国家青少年一样,他们的需求在不断变化,并且信息与服务的获取途径与成人不同。各部门需合作,统一信息,互帮互助。

4.2 建立性别政策视角

调查结果显示,任何干预与政策规划都需要建立性别视角,以此来促进男性青少年与女性青少年的共同成长。其中,要尤其关注女性青少年群体。这一群体承担着无法避免的生殖健康风险。同时,也要强调男性青少年在女性生殖健康中应当承担的责任。

性与生殖健康的方方面面中都体现出性别差异的特点。尤其,以下事实需要社会的关注:女性青少年的性与生殖健康知识,包括整体知识、紧急避孕知识和艾滋病知识掌握的全面性和正确性都差于男性青少年;女性青少年的婚前性行为承受更多的社会压力;女性承担着无保护性行为的直接后果,流产与反复流产对女性青少年的生殖健康产生长远的负面影响;女性青少年比男性青少年的性与生殖健康的治疗需求更高。

由于社会、经济尤其是文化的影响,男性与女性青少年在性与生殖健康问题上的社会期望以及所处的地位都是不同的。因此,在看待青少年性与生殖健康问题以及构建政策体系时应当充分体现性别视角。

4.3 关注弱势群体

在中国社会、经济、文化不断变化的背景下,青少年的性与生殖健康问题也处于日益凸显和多元化的境况之中。在人力、物力与时间有限的情况下,抓住重点、着力解决弱势青少年群体的具体问题是成本-效益高的政策和干预选择。通过调查数据分析发现:(1)在性与生殖健康知识方面,15-19 岁青少年,高中/中专教育水平及以下,中部/西部地区青少年是较或最弱势的群体,需要重点关注;(2)在怀孕与多次怀孕方面,需要重点关注的人群为,农村,校外,家中无父母,独生子女,流动和西部地区青少年。另外,15-19 岁女性青少年多次怀孕率较高;(3)在青少年接受性与生殖健康学校教育的情况中:农村,15-19 岁流动青少年,中部青少年是学校教育可及性较差和最差的群体;(4)在咨询及治疗的需求和实现情况中,西部农村青少年均是需求率最高和实现率最低的群体,处于弱势地位。

4.4 推广青少年友好服务

建立广泛的青少年友好信息与服务,提高青少年性与生殖健康的可及性。数据分析显示,“不好意思”是青少年性与生殖健康咨询和治疗服务需求未实现的关键原因,同时,青少年在选择治疗机构时,医疗技术

水平、注意保护隐私、服务价格、工作人员的服务态度、就诊环境和就诊程序的便利性等是其考虑的主要因素。这些都反映出青少年对友好服务的渴望。通过政府、非政府组织、服务机构等来满足青少年的需求。要有措施来确保他们的青少年友好服务是有青少年参与设计和确保服务的提供。

本报告仅包含青少年性与生殖健康可及性调查的初步结果,项目组还将结合定量和定性的研究结果,通过与政府部门和专家的讨论,进行更深入的分析。在此基础上会形成更加具体和详细的政策建议随后发布。

致谢:本研究得到了国务院妇女儿童工作委员会办公室的指导支持,受到联合国人口基金的资助。得到了国内外著名专家、各部委和专业机构的帮助和支持。非常感谢我国著名的生殖健康和流行病学专家高尔生教授、詹绍康教授等专家多次来京与项目组共同讨论研究内容和报告形成。感谢卫生部、国家人口计生委、教育部、公安部、文化部、全国妇联、共青团中央等多部委对调研工作的支持。感谢中国人口宣教中心/青苹果之家、玛丽斯特普中国代表处及其一些地方的“你我青少年健康服务中心”等生殖健康研究机构对我们访谈提供的支持。国务院妇女儿童工作委员会苏凤杰副主任、宋文珍处长、胡道华副处长,蒋曦宁等;联合国人口基金 Mariam Khan、贾国平、金华、高翠玲、王岩等对报告的修改和完善提出了很多宝贵的意见和建议。特此致谢。

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Survey of Youth Access to Reproductive Health in China^{*}

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Abstract: This survey aims to determine the sexual and reproductive health (SRH) knowledge, attitudes and practices of youth, assess the availability and accessibility of SRH services, and provide support for policy

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improvement on youth SRH accessibility. The surveys used face – to – face interviews with structured questionnaires. And four stages of mixed sampling methods which combined stratified sampling and probability proportionate to size sampling is used. Survey results shows: Youth's SRH knowledge is limited; 22.4% of youth have sexual experience. The percentage of not using any contraceptive method at first and last sexual behavior is 51.2% and 21.4% respectively. Among female youth who have sexual behavior, the pregnancy rate is 21.3% and repeat pregnancy rate is 4.9%. Book/magazine, classmate/friend, teacher, network, and cinema/TV are the five main knowledge sources for youth. School based sexuality education have a positive effect on youth SRH knowledge, however, the percentage of youth who attended these course is less than 40%. More than 50% counseling and treatment demand of youth is not fulfilled and the reason for unmet demand is “embarrassment”, “not serious” and “don't know whom to consult/what agencies to turn to”. In all, present situation (availability, accessibility, acceptability, and quality) of sexual and reproductive health is worrying. The four following suggestions are proposed: multisectoral approach to improve youth SRH, gender – sensitive policies, focusing on disadvantaged and vulnerable youth group, and youth – friendly information and services within a supportive environment.

Key words: unmarried youth; sexual and reproductive health; knowledge; attitude; practice; accessibility; knowledge sources; counseling; treatment

1 Background

“Reproductive health” is one of the basic rights of youth, as mentioned in the ICPD PoA para 7.41 – 7.48 (United Nations, 1994) and the MDGs further emphasized that right with the target 5B of Universal RH by 2015. (United Nations, 2000) Based on the 2005 National Sampling Survey of 1% of the Population, it is estimated that there were 161 million unmarried youth (aged 15 – 24) in China, accounting for 12.6% of the total population. (National Bureau of Statistics, 2005) At present there is no policy relating specifically to the sexual and reproductive health (SRH) of youth in China.

As early as the 1950s the Chinese government has advocated for promotion of youth SRH. Adoption of the provisional regulations for Health – related work in primary schools and high schools in 1979 by the Ministries of Health and Education marked the first time the government officially declared to “improve adolescent health education.” (United Nations Population Fund, 2007) However, under the influence of a rapidly changing social environment, small scale surveys have shown that youth reproductive health remains under – addressed. (United Nations Population Fund, 2007) In addition to unsafe sexual behaviors, unplanned teenage pregnancy, HIV and the risk of other sexually transmitted infections (STIs) threaten youth reproductive health. Ensuring youth access quality and comprehensive SRH information, develop healthy SRH attitudes and make informed choices on SRH behavior is one of the current latent social issues which require actions, the emphasis thus on prevention.

The provision of SRH services to youth should be aligned with their right to services and their demand for services as well as with Chinese culture and policies which cover youth development. Additional policy development on the issue requires thorough analysis of the SRH needs of youth, however currently there is a lack of systematic national survey data on youth SRH.

This survey aims to determine the SRH knowledge, attitudes and practices of youth and to assess the availability and accessibility of SRH services and youth's satisfaction levels and preferred means of accessing these services.

The research includes quantitative and qualitative data; the later is still to be analyzed. The current report only includes preliminary basic quantitative data. Additional data and findings as well as more detailed analysis will be released during the course of 2010 and 2011.

2 Methodology

The survey was conducted between October 20 and November 30, 2009.

2.1 Sampling

The survey was a nationally representative sample of unmarried youth aged 15 – 24, living in 30 provinces of mainland China^①. The survey sample was divided into three sub – populations: school youth, household youth and collective households^②. The surveys used four stages of mixed sampling methods which combined stratified sampling and probability proportionate to size sampling (PPS). Samples were distributed in 40 cities/counties from 25 provinces/autonomous regions/municipalities in China.

2.2 Interview Techniques

The surveys used face – to – face structured interviews with questionnaires. They were conducted by 579 interviewers and 155 supervisors. A total of 22,535 questionnaires were distributed, and 22288 questionnaires were valid i. e. a rate of 98.9%.

To obtain high – quality data, interviewers were supervised in two ways, one supervisor from our team and a third – party supervisor; for interviewed youth, multiple method was used to ensure quality, this included independent environments, anonymity, provision for sensitive part of questionnaire to be filled by self, ballot boxes and so on, through the process gender perspective was respected.

2.3 Data Weighting for National Representation

Data was weighted according to the 2005 National Sampling Survey of 1% of the Population. After calculation, total number of unmarried young people aged 15 – 24 in 2009 is 164,719,905. (Without specification, the report below is based on this data). The male youth account for 50.8% and the mean age is 19.2 – years – old.

2.4 Peer Review Process

In the process of project implementation, multi – party technical expert comments and suggestions were sought to obtain effective and reliable data. Overall, the distribution of the survey sample was scientific. Research protocols were followed to ensure the reliability of the survey results.

3 Preliminary Findings

3.1 Current Status of Youth Sexual and Reproductive Health Knowledge and Attitude

3.1.1 Youth sexual and reproductive health knowledge

The survey explored the youth SRH knowledge from three aspects: General Sexual and reproductive health



Figure 1 The distribution of survey sample

①Excluding Tibet.

②School youth groups: Groups of young people in school, which do not distinguish live on campus or commuting. Youth groups with household resident: Youth groups living at home, have a job or being unemployed. According collective household youth groups: youth groups have the nature of collective living and have jobs.

knowledge, knowledge on contraception and HIV knowledge.

General Sexual and reproductive health knowledge. The survey revealed that youth had very limited levels of SRH knowledge. Only 4.4% of the youth interviewed were able to correctly answer all three questions^① on SRH, which was very low.

Knowledge on emergency contraception. Condoms, contraceptive pills and emergency contraception were the three contraceptive methods youth were most aware of. Only less than half of the youth knew how to avoid pregnancy following unprotected sex.

HIV knowledge. Although more than 95% of youth had heard of HIV, the knowledge on HIV prevention and its modes of transmission was not high. Only 14.4% of respondents answered all five HIV – related questions in the questionnaire^② correctly.

About the three aspects mentioned above, stratified analysis by gender all showed male youth had more comprehensive and accurate SRH knowledge than female youth.

It was also found that youth with the following characteristics had the lowest knowledge aged 15 to 19, education level at high school/secondary school and below, and residing in central/western region.

3.1.2 Youth attitude to premarital sex

Most youth are open to premarital sex. While one third of youth do not favor premarital sex, two thirds of youth stated they accept premarital sex or do not have a strong feeling about it.

Stratified analysis by gender showed male youth were more inclined to accept premarital sex than female youth.

It was also found youth with the following characteristics were ones more or most open to premarital sex: aged 20 to 24, non – students, having higher income and the one from “natural mother and stepfather” family.

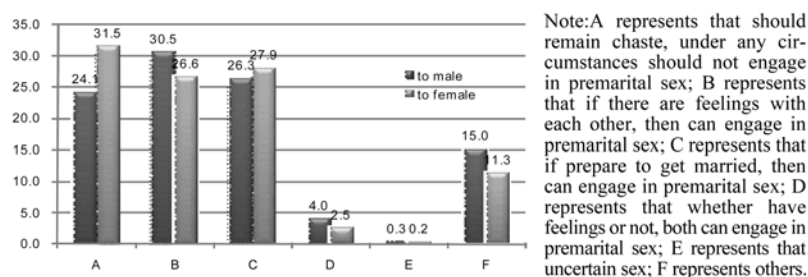


Figure 2 Percentage of premarital sexual behavior(%)

3.2 Sexual Behavior

3.2.1 Sexual behavior

22.4% of youth had sexual behavior^③. Stratified analysis by gender showed the percentage of male youth who had sexual behavior was higher than female youth. It was also found youth with the following characteristics had higher or highest percentage of having sex experience: aged 20 to 24, urban, those living away from their parents, single child, migrant, non – students and those residing in the western region. Analysis of income levels and student/non – student status showed that, the proportion of non – student youth having premarital sex had a clear link to in-

①The three questions include: 1 A woman can get pregnant on the very first time that she has sexual intercourse; 2 Masturbation causes serious damage to health; 3 Abortion will not influence women's pregnancy in the future.

②The five questions include: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy – looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected?

③In this study, “sexual behavior” means the inserting sex behavior, referring to one insert the penis, fingers or fake penis into the vagina or anus of another.

come levels. The higher levels of income, the higher proportion it would be. Besides, the attitude towards premarital sex had a relationship to the occurrence of sexual activity.

Among the interviewed youth, the minimum age of sexual debut was 12 years old. The median age at first sexual behavior was 20 years old. Stratified analysis by gender showed that, male youth's age of sexual debut was a little earlier than the female youth.

3.2.2 More than one sexual partner

In the past 12 months, 20.3% of youth who were sexually active had more than one sexual partner. Stratified analysis by gender showed that, male youth had a higher proportion of multiple sexual partners than female youth, and the proportion of youth aged 15 – 19 with multiple sexual partners was higher than the youth aged 20 – 24.

3.3 Contraception

Youth contraceptive use was low. In first instance of sexual activity, over 50% of youth do not use any contraceptive method. In the last sexual behavior, the percentage fell to 21.4%, which meant that there was one in five youth engages in unsafe sex and faces the risk of STIs/HIV infection, unplanned pregnancy leading to possible abortion. The high percentage of sexually active youth not using contraception also reflected that the vast majority of youth lacked the awareness of self – protection.

In the choice of the contraceptive methods, “condom” accounted for 60.5% usage in first sexual behavior, and 71.4% usage in last sexual activity. The percentage of youth who used emergency contraceptive after sex in last sex behavior was lower than the first sex behavior. And the total youth who used the two traditional contraceptive methods “external ejaculation” and “rhythm” in the last sexual behavior still accounted for about 15%.

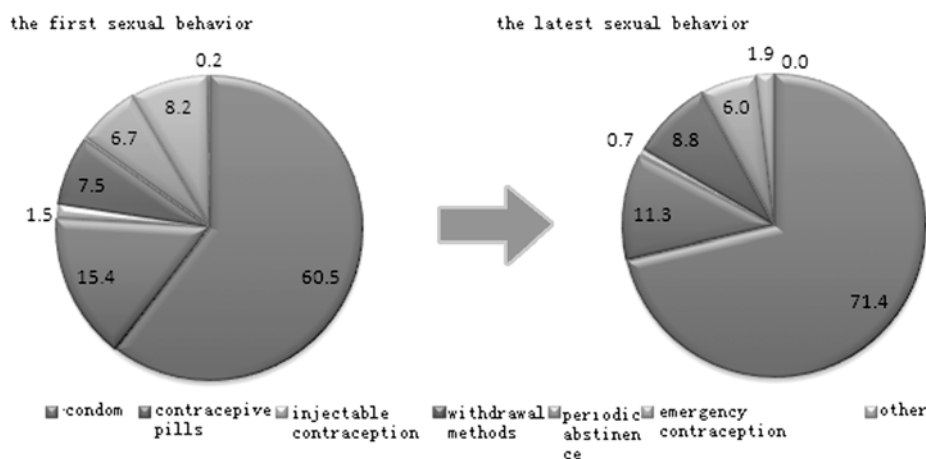


Figure 4 Structure of contraception methods at the first and last sexual behavior(%)

total youth who used the two traditional contraceptive methods “external ejaculation” and “rhythm” in the last sexual behavior still accounted for about 15%.

3.4 Pregnancy and Pregnancy Outcome

Among females who had been sexually active, 21.3% became pregnant and 4.9% had repeat pregnancies. Stratified analysis found that higher rates of pregnancy were shown amongst youth with the following characteristics: aged 20 – 24, rural, non – student, living away from their parents, only child, migrants, and residing in western areas. There were more repeat pregnancies amongst youth aged 15 – 19; the other distribution characteristics were similar to the previous results. The analysis by education level, by age and by student or non – student found that the percentage of pregnancy and repeat pregnancies of youth aged 15 – 19 in junior high school and below who were non – students, was significantly higher than the others.

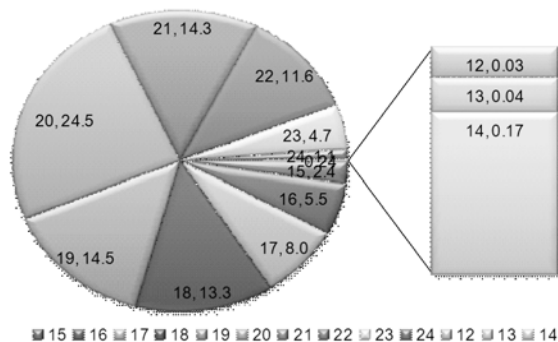


Figure 3 Age structure of first sexual behavior(%)

Table 1 Distribution of the number of abortions amongst female youth(%)

Times	percentage
0	9.1
1	72.0
2	16.3
3	1.5
4	1.2
Abortion rate	90.9
Repeat abortion rate	19.0

Among female youth who became pregnant, 90.9% resort to abortion and 19% had repeat abortions. Among the respondents, the highest number of abortions was 4 times, accounting for 1.2%, and 3 times accounting for 1.5%, twice accounting for 16.3%, once accounting for 72%. In addition, 2% of female youth had an abortion after the 16 week mark and 0.2% of female youth had live birth experience.

3.5 The Sources of Reproductive Health Knowledge

For puberty knowledge, knowledge of the reproductive system, or how to get along with opposite sex, books/magazines, classmates/friends, school teachers, networking, and film/TV were the five important sources of major youth reproductive health knowledge. From the acquisition methods of knowledge, youth obtained sexual and reproductive health knowledge by themselves more. Unregulated and informal sources were the primary methods through which youth attained SRH information.

The low awareness rate of youth SRH knowledge might be a consequence of the inconsistent quality of information in these informal channels.

3.6 The Effect of the School Curriculum on Youth SRH Knowledge

School based sexuality education had a positive effect on youth SRH knowledge; unfortunately these courses were not widely available. Reproductive health knowledge amongst youth who had attended sexuality education or related courses/lectures on puberty, prevention of STIs and HIV and contraceptive methods, was better than those who had not attended these courses/lectures.

While the classes had positive effects, there were less than 40% of youth who participated in the three types of courses. Furthermore, the participation rate for the lectures of contraceptive knowledge was only 4.3%. The smallest numbers of youth had attended this type of lecture; however, SRH knowledge of those who had attended such courses was the highest.

Through stratified analysis, it was found youth with the following characteristics had the lower or lowest percentage of participating the SRH classes/lectures: rural youth, migrants aged 15 – 19 and young people residing in central regions.

Table 2 Ranking of the reasons for not accessing consultation services

Sort of consulting need	1	2	3
Reproductive Health Care Issues	A	C	B
Sexual Psychology	C	B	A
Contraceptive knowledge and skills	C	A	B
STI prevention and treatment	C	A	D
Pregnancy/Abortion	C	A	B
Ethicality/Moral	C	B	A
Access to contraceptives	C	B	A
Sexual assault	C	A	B

Note: A They thought that their problem was not serious enough to warrant medical consultation; B Don't know whom to consult; C Embarrassment; D Worried about running into friends. 1, 2, 3 represent the three most important factors.

counseling were that they were embarrassed, they did not consider their condition to be serious enough to warrant

3.7 The Demand, Utilization and Accessibility of SRH Services for Youth

Consultations and phone calls to hotlines at medical institutions were the most widely known (60%) ways of youth receiving counseling services. Only 20% of the youth had ever used counseling services provided by various institutions, such as schools and non – medical institutions.

The three most important reasons that youth gave for not accessing SRH

consultation, and that they did not know whom to consult. Youth's main SRH problems to counsel are reproductive health care, sexual psychology and contraceptive knowledge and skills. However, around 60% of the demand is unmet. By stratified analysis of gender and age, at 20–24 years old, female youth have higher demand and realization of SRH counseling than male youth. The western rural youth group was the most disadvantaged group with both the highest demand and highest unmet need for counseling.

Youth's access to SRH treatment needs to be improved. Youth's perception that their condition was "not serious" is the primary reason for the unrealized demands. The main problems mentioned for treatment demands were menstrual problems, reproductive tract infections and genital abnormalities. However, more than half of the demands are not met. By stratified analysis, female youth have higher demand and realization of SRH treatment than male youth. The SRH demand and access of western rural youth aged 15–19 needs special attention. They are the groups who both have the highest needs rate and the lowest utilization rate of sexual and reproductive health services.

The three most important reasons youth gave for not accessing treatment services were: "Not serious", "fear to be ridiculed" and "do not know what agencies to turn to". Public hospitals are youth's most commonly accessed institution. Youth respondents ranked the following factors as the most important factors in choosing a service provider: the quality of the services (20.2%), privacy protection (14.5%), service price (10.8%) and staff's attitude (10.4%) (See Figure 5).

4 Conclusion and Preliminary Suggestions

The survey results show that the present situation of sexual and reproductive health is worrying, and accessibility of information and services is severely insufficient which necessitates attention of government and the society. The right to health has four major aspects: availability, accessibility, adaptability and quality of information and services. (1) Availability means public health information and services facilities

must exist in sufficient quantity. While the survey did not explore availability from supply side, we still can draw some conclusions from the information provided by interviewed youth. Data analysis shows though the school education has obvious positive on youth's SRH knowledge, there are only less than 40% of youth who participated in the three types of SRH courses at school, which implies the SRH education in school need to be enhanced. And, "not know whom/what agencies to turn to" are one of the three most key barrier – factors for youth's unmet counseling and treatment demands, which indicates the services youth aware of are not publicized where they exist. (2) Accessibility means health information and services must be physically and economically affordable. It must be provided to all on a non – discriminatory basis. Information on how to obtain services must be freely available. Survey results show that youth are not widely accessing services yet they do not know where to go, are embarrassed to try and service price is a concern. (3) Acceptability refers to all health facilities must be respectful of medical ethics, and culturally appropriate and acceptable to youth. Survey results show that embarrassment and worry about running into friends keep youth away from available counseling and treatment services. (4) Quality refers to health facilities,

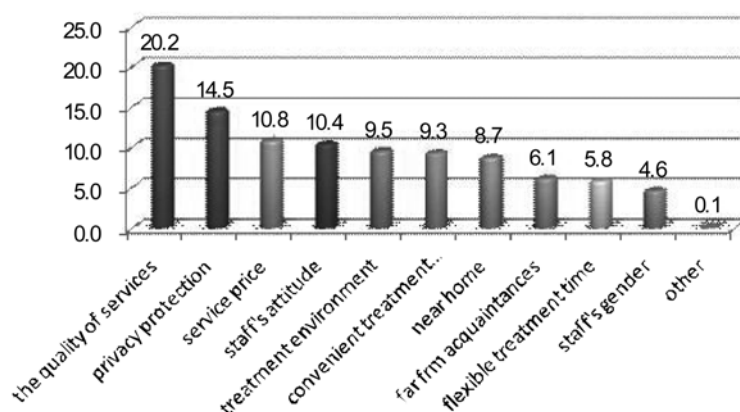


Figure 5 Youth's selecting criterion in choosing treatment agencies (%)

goods, information and services must be scientifically and medically appropriate and of good quality. The limited and inaccurate sexual and reproductive health knowledge of youth reflect the present information quality of various sources need to be improved. Besides, the low utilization of condoms and other contraceptive measures, the high rate of pregnancy and repeat pregnancy rate, and high abortion and repeat abortion rate all indicate youth's right to sexual reproductive health is under fulfilled.

China is one of the few countries to have already reported on MDG 5b (Universal access to RH by 2015) in her 2008 MDG progress report. This survey gives momentum to ensuring that Chinese Government continues in her endeavors to meeting the MDG targets including concerning youth SRH.

4.1 Multisectoral approach to improve youth Sexual and Reproductive Health

The preliminary findings show that as in other countries, in China too Being responsive to the sexual and reproductive health needs of youth will need to involve a range of public – sector stakeholders, including Ministry of Health, Ministry of Education, Population and Family Planning Commission, China Communist Youth League, Ministry of Public Security, China Women's Federation, Ministry of Finance, etc. . The private sector has a vital role to play——media outlets, and private providers and pharmacies. As seen from the survey, most youth attain their SRH related information through a variety of communication channels, effectively using those needs to be considered. Various international and domestic nongovernmental organizations currently making efforts for Chinese youth SRH are also an important force and lessons can be learnt from their work with Chinese youth. Youth have changing needs in China as in other parts of the world, and youth need information and services in ways different than adults. All sectors working with youth need to build that in their work with youth and ensure messages are consistent and interventions mutually supportive.

4.2 Gender – sensitive policies

Findings indicate that any interventions or policy formulation will need to be done using a gender perspective taking into account the dynamics in which young girls and boys live and grow. For effective behavior change, interventions need to be specifically designed for each gender. Young girls are at most risk, but also young boys need to be involved in the issues concerning them. Gender – differences appeared in almost all youth SRH aspects. Especially, the facts below need attention: female youth's SRH knowledge including general SRH knowledge, emergency contraception knowledge and HIV knowledge, is less comprehensive and accurate than male youth; Female youth face more social pressure pertaining to premarital sexual behavior; females bear the direct consequence of unprotected sex particularly unplanned pregnancy, while abortion /repeat abortion may exert long – term negative impact on female youth; meantime, there are more services demanded by female youth than male youth.

With the social, economical and cultural influence, male and female youth face different social expectation and position on the issue of sexual and reproductive health. Therefore, the gender – sensitive perspective in addressing their needs is essential.

4.3 Focus on disadvantaged and vulnerable youth group

Under the changing social, economical and cultural environment in China, youth sexual and reproductive health is an emerging policy issue. To focus on disadvantaged and vulnerable youth group's situation is the most cost – effective way, with the consideration of limited resource and time. Survey data analysis revealed groups who needs more attention on SRH: (1) on the aspect of SRH knowledge, the youth who are aged 15 to 19, educated level at high school /secondary school and below, and residing in central/western region, are more or most disadvantaged; (2) on the aspect of pregnancy and repeat pregnancy, the youth who are rural, non – student, living away from their parents, only child, migrant, and residing in western areas are more or most vulnerable to pregnancy and repeat preg-

nancy. Female youth aged 20 – 24 have higher pregnancy rate and Female youth aged 15 – 19 have higher repeat pregnancy rate; (3) on the aspect of attending SRH classes/lectures: youth who are rural, migrant aged 15 – 19 and residing in central regions have less or least accessibility of school education; (4) on the aspects of health care demand and realization, the rural youth living in western region are the most disadvantaged group with the highest demand and highest unmet need.

4.4 Youth – friendly information and services within a supportive environment

Increase the prevalence of youth – friendly information and services and thus improve the youth' access to SRH services. Data analysis showed, embarrassment is the key factor for youth not realizing their demands. Meantime, the quality of the services, privacy protection, service price, staff's attitude, institutional environment and convenient treatment procedure rank the five priority criteria when youth choose a treatment institution. All these reflect factors youth consider of importance when they seek services. Thus youth – friendly services promoted by government, NOGs and private medical institutions need to ensure these factors meet youth requirements. A key measure to ensure that they are youth friendly is to have youth participate in the design and provision of the services.

This report includes only the preliminary findings of the YSRH survey. The project team will undertake an in depth analysis of quantitative and qualitative research results, with the participation of government and the experts. Based on this, a detailed analysis will be released with specific and detailed policy recommendations during the course of 2010 and 2011.

Acknowledgements: This study was supported by NWCCW and UNFPA. Thanks for the participation of related public – sector stakeholders, institutions, and famous experts! Very grateful to China's well – known reproductive health and epidemiology experts, Professor GAO Er – sheng, ZHAN Shao – kang, etc. to study with the team and discuss the content and form of this report. Thanks for the support of Ministry of Health, Ministry of Education, Population and Family Planning Commission, China Communist Youth League, Ministry of Public Security, China Women's Federation, Ministry of Finance, etc. Some reproductive health research institutions, such as China Population Communication Center / Green Apple House, Marie Stopes International China, and some local "You and Me" health service centers, provided interview fields. In the period of report modification, SU Feng – jie, SONG Wen – zhen, HU Dao – hua, JIANG Xi – Ning, etc. from NWCCW; Mariam Khan, JIA Guo – ping, JIN Hua, GAO Cui – ling, WANG Yan, etc. from UNFPA gave us many valuable suggestions and recommendations.

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