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Seeing the invisible

Sexuality-related knowledge, attitudes and behaviour of children and youth with disabilities in China

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Seeing the invisible

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Translator: Zhiqian Wu

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Foreword

The 2030 Agenda for Sustainable Development encompasses important elements of the Sexual and Reproductive Health and Rights (SRHR), with the Sustainable Development Goals (SDGs) framework including several related goals and targets, such as those in support of health, education and gender equality.

Ensuring universal access to sexual and reproductive health (SRH) services and comprehensive sexuality education is an ambitious objective, which echoes what had already been agreed in the Programme of Action of the 1994 International Conference on Population and Development and in the 1995 Beijing Platform for Action, as well as in the outcome documents of their respective review conferences. The need to protect and promote the SRHR of persons with disabilities, and to provide quality and free or affordable access to SRH information and services, is also clearly stated in Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD), a binding international convention adopted by the UN General Assembly in 2006 and ratified by more than 175 countries as of 2017.

However, in spite of the SDGs' call to 'Leave No One Behind', many young persons with disabilities face significant barriers in accessing sexuality-related information and services, and their rights continue to be overlooked. This is in part due to the fact that there is very limited data available on the access to and needs for SRH information and services among young persons with disabilities, which hinders relevant policy making. For instance, China, as one of the first countries to ratify the UNCRPD, has put in place policy and legal frameworks to safeguard the rights of persons with disabilities, which, however, make no specific reference to SRHR.

Recognizing this gap, UNESCO Beijing and Humanity & Inclusion (formerly Handicap International) have joined forces to conduct a study to examine the sexuality-related knowledge, attitudes and behaviours of young persons with disabilities in China, as well as their access to sexuality-related education, information and services.

Our hope is that findings of the study presented in this report will provide decision makers, researchers, educators and practitioners in the education and health sectors with the evidence they need to further support realization of these important rights. We also hope that the report will inspire generation of additional evidence, to inform policies and practices that can support mainstreaming of a disability inclusive approach to SRH, in China and beyond.

Marielza Oliveira

Director, UNESCO Cluster Beijing Office
UNESCO Representative to the People's Republic of China,
the Democratic People's Republic of Korea, Japan, Mongolia
and the Republic of Korea

Alessandra Aresu

Inclusive Health Policy Lead
Humanity & Inclusion
(China Country Director from 2013 to 2017)

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This publication is the result of a study supported by UNESCO Beijing Office and Humanity & Inclusion (formerly Handicap International)[1] and conducted by the Shanghai Institute of Planned Parenthood Research (SIPPR). SIPPR designed the research tools and undertook the data collection, data analysis and drafting of a preliminary report. We would like to thank the members of SIPPR who undertook the research work, including Tu Xiaowen, Lou Chaohua, Hu Tajing, Lian Qiguo, Zuo Xiayun.

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1 The organization is officially registered as Handicap International Federation (France) Beijing Representative Office in China.

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Executive summary

Young people with disabilities have the same right to Sexual and Reproductive Health (SRH) as their peers without disabilities, but their needs and rights are often overlooked. Recognizing this, UNESCO Beijing and Humanity & Inclusion (formerly Handicap International) initiated a study to examine the SRH status of young people with disabilities in China. In particular, the study explored the sexuality-related knowledge, attitudes and behaviour of young people with disabilities as well as their access to sexuality-related information, education and services. The findings of the study are intended to provide evidence to support decision-making by government agencies, educators, development workers and other relevant stakeholders regarding developing and implementing disability-inclusive SRH and sexuality education policies and programmes for young people in China.

The study, using quantitative and qualitative methods, was conducted in 2015 among unmarried young persons aged 12 to 24 living with visual, hearing, physical and intellectual disabilities, in both urban and rural areas. The analysis was based on data collected through 707 completed valid questionnaires, 20 group interviews and 35 individual interviews with young people with disabilities, and individual interviews with 60 parents and teachers, along with one case study.

The study's main findings are summarized below.

Sexuality related knowledge: Overall, the surveyed young people with disabilities lacked sexuality-related knowledge. They were fairly well-informed with regard to self-protection, but their understanding of puberty, sexual physiology, contraception and sexually transmitted infections (STIs) was rather limited. The knowledge level varied depending on the type of disability, with participants with visual disabilities having the highest reported knowledge level and those with intellectual disabilities the lowest. In general, participants from rural areas demonstrated a lower level of sexuality-related knowledge compared to their counterparts from urban areas, regardless of the type of disability. No significant gender differences were identified in terms of sexuality-related knowledge.

Access to and expressed need for sexuality-related information: The majority of the surveyed young people, parents and teachers felt that young people with disabilities need sexuality education. The participants living in urban areas expressed a greater need for access to sexuality-related information than their counterparts in rural areas. Young people with intellectual disabilities expressed a greater need than those with visual and hearing disabilities for information about male and female anatomy and physiology, friendship, love, marriage, pregnancy and childbirth. School teachers and parents were identified as the main sources of sexuality-related information, but most participants reported they were not getting enough relevant information from either parents or teachers. Preference for the internet as a source of information was found to be more obvious among older group, especially for those living in rural areas. The participants reported little self-initiated learning about the subject, due to shyness and lack of awareness of alternative sources of information.

Attitudes towards sexuality and gender roles: More than 75 per cent of the surveyed young people with disabilities felt that people with and without disabilities should enjoy SRHR equally, and 70 per cent felt that all people have sexual needs, regardless of whether or not they have a disability. Over a quarter of the surveyed young people with disabilities aged 15 to 24 were accepting of consensual pre-marital sex between heterosexuals. However, only 13 per cent of the same group were accepting of intimate relationships between persons of the same sex. The majority of the participants, and especially young people aged 12-14, held beliefs supporting gender equality. Participants with different types of disabilities did not show significant difference in terms of their attitudes towards gender roles, but the male participants reported a lower level of awareness about gender equality than female participants, and rural participants also reported a lower level of awareness about gender equality than urban participants.

Intimate relations and sexual behaviour: About one in ten of the participants aged 15-24 reported having had sex, and fewer than half of the sexually active youth reported using contraceptive devices for their sexual debut. Participants with visual disabilities were, in general, found to be open to sexual relations, but were less sexually active than other young people with disabilities. Respondents with hearing disabilities, especially those living in rural areas, were found to be relatively conservative about sexual relations, but more sexually active. Masturbation in public was reported by parents and teachers to be an issue among participants with intellectual disabilities. Overall, male respondents were found to be more open to engaging in sexual relations than female participants, and were found to masturbate more.

Experience of sexual abuse: Participants from both age groups (12 to14 and 15 to 24) and with different disabilities reported experiencing sexual abuse. Participants aged 15-24 with hearing, visual and intellectual disabilities reported experiencing higher level of sexual abuse than participants with physical disabilities. Urban participants reported experiencing higher level of sexual abuse than rural participants.

Parents and teachers' attitude towards sexuality education: Parents in rural areas showed lower awareness of sexuality education than their counterparts in urban areas, but the majority of parents, from both urban and rural areas, showed support for sexuality education for children with disabilities. They faced challenges, however, in providing sexuality education due to lack of knowledge of how to teach the subject and lack of confidence in providing it. Parents tended to prioritize the topic of self-protection and proposed postponing the introduction of topics such as pregnancy, abortion, contraception and STIs until a later age.

The majority of the teachers also showed support for sexuality education for young people with disabilities, but lacked relevant training and appropriate teaching materials. They reported the lack of parent support and insufficient attention paid by schools a major barrier to conducitng sexuality education in schools.

Access to SRH services: The study showed that community-level provison of SRH services, such as counselling, provision of contraceptives and legal support is limited, and schools rarely provide counselling or service referrals concerning SRH.

Based on the the findings, UNESCO and Humanity & Inclusion offer the following recommendations:

- International and national organizations including Disabled Persons' Organizations (DPOs) need to collaborate and conduct activities to raise awareness among policy-makers, educators and parents of the importance of sexulity eduation and provision of SRH services to children and youth with disabilities so as to ensure their sexual wellbeing and prevent violence.

- National and local health authorities should put in place education policies and curriculum guidelines that are disability-inclusive and integrate sexuality education into the ongoing national efforts to develop inclusive education, to ensure that the sexuality education needs of students with disabilities are fully considered; measures should also be taken to build the capacity of teachers.

- Schools and educators shall develop and adapt teaching content and methods to respond to the learning needs and preferences of children and youth with disabilities.

- Schools and DPOs should mobilize the parents of young people with disabilities and support them in playing an active role in providing sexuality education to their children.

- Health authorities should put in place disability-inclusive SRH policies and support the provision of accessible and relevant SRH services; Schools, DPOs and SRH service providers should cooperate to improve the accessibility and relevance of SRH information and services for young people with disabilities.

1

BACKGROUND

More than 1 billion people in the world have physical, visual, hearing and/or intellectual disabilities (WHO and World Bank, 2011). The global population with disabilities under the age of 18 is estimated to be between 93 and 150 million (WHO and World Bank, 2011). According to the results of China's 2006 national survey of persons with disabilities (China Disabled Persons' Federation, 2006), persons with visual, hearing, intellectual or multiple disabilities make up 6.34 per cent of the total population of China. About 8 million of them are young people between the ages of 10 and 19 (China Disabled Persons' Federation, 2006; National Bureau of Statistics of the People's Republic of China, 2010). The number of people with disabilities in China is expected to reach 165 million by 2050 (Chen, 2008).

Although data on young people with disabilities is quite limited, one thing is clear: their proportion is significant in every society. Furthermore, 'children with disabilities are one of the most marginalized and excluded groups of children, experiencing widespread violations of their rights' (UNICEF, 2013).

The Programme of Action of the International Conference on Population and Development, held in Cairo in 1994, called on all levels of governments to meet the needs and uphold the rights of persons with disabilities, and to eliminate prejudice against their reproductive health and rights (United Nations Population Information Network, 1994). At the conference, China and other countries pledged to 'achieve reproductive health for everyone by 2015', such that all people, married or unmarried, with or without disabilities, and residing in urban or rural areas, would have access to information and services for Sexual and Reproductive Health (SRH) whenever needed.

In 2006, the Convention on the Rights of Persons with Disabilities (CRPD), adopted by the General Assembly of the United Nations, defined people with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Art. 1). The CRPD also stated the need to protect and promote Sexual and Reproductive Health and Rights (SRHR) of people with disabilities and to provide quality and free or affordable access to SRH information and services (Art. 25). In 2008, China was one of the first countries to sign and ratify the UNCRPD (United Nations, 2006).

The Sustainable Development Goals (SDGs) have been promoting SRHR for all since 2015 (goals 3, target 7; goal 5 target 6). When it comes to SRHR, the SDGs call to "Leave No One Behind" represents a significant shift from the Millennium Development Goals (MDGs) that did not explicitly prioritize SRHR.

Despite these commitments, the SRHR of people with disabilities are often overlooked (Pu, 2003; WHO & UNFPA, 2009; Isler et al, 2009). Insufficient attention is paid to this issue, and China lacks relevant data on the SRH needs of young people with disabilities to support decision-making. To fill the data gap, the UNESCO Beijing Office and Humanity & Inclusion jointly initiated a study, which was implemented by the Shanghai Institute of Planned Parenthood Research (SIPPR) with the assistance of the Able Development Institute (ADI) and the Guanzhou Yuexiu District Nurturing Relationship Education Support Center (GYDNRESC).

Under the overall supervision of UNESCO and Humanity & Inclusion, the three research partners (SIPPR, ADI and GYDNRESC) operated in the following way: SIPPR designed the research protocols; trained the interviewers; conducted data collection in Shanghai, the data analysis and the quality control; and drafted the report. ADI was responsible for data collection in Beijing and Shaanxi Province, and GYDNRESC was responsible for data collection related to young people with intellectual disabilities in the cities of Guangzhou and Foshan.

2

STUDY PURPOSE AND METHODS

2.1 Aim of the study

The study sought to explore sexuality-related knowledge, attitudes and behaviour of unmarried young people with disabilities, and identify their needs for SRH information and services, so as to provide evidence to inform government policy-making and to promote the provision of disability-inclusive[2] SRH information and services for young people with disabilities.

The specific objectives of this study were:

- To understand the sexuality-related knowledge, attitudes and behaviour of unmarried young people with disabilities.
- To explore the needs for and access to SRH information and services of unmarried young people with disabilities, as well as the associated barriers.
- To recommend policies and actions for supporting and improving access to sexuality education and SRH services for unmarried young people with disabilities.

2.2 Research sites

The study was conducted in both urban areas including Shanghai, Beijing, and Guangzhou and Foshan of Guangdong Province, and rural areas of Xianyang, Weinan and Baoji cities in Shaanxi Province. These sites were selected because of the well-established relationships of trust between the research partners and the targeted people with disabilities, their families, the local Disabled Persons' Organizations (DPOs), communities, schools and rehabilitation centres.

Other than special education schools and rehabilitation centres, the participants also came from welfare-oriented and disability-friendly enterprises, activity and sports training centres for people with disabilities, and regular schools.

2.3 Participants

The research participants included unmarried young people aged 12-24 with physical, intellectual, visual and hearing disabilities. All of the people with disabilities who participated in the study held disability cards issued by the China Disabled Persons' Federation (CDPF)[3], which certified their levels of disability .

Parents and school doctors also participated in the study, along with teachers of biology, science, health, moral and ethical values, life skills and psychology, who are often responsible for teaching SRH-related modules at Chinese schools.

The proportions of individuals with different types of disabilities and of female and male respondents reached by this study does not reflect the proportions in the Chinese population, but rather reflects the researchers' capacity to reach the different groups, as well as the availability and willingness of the respondents to participate in the study and discuss sexuality related issues.

2.4 Research methods

Considering the limited understanding of the intersections between gender, sexuality, disability, age, and education in China, UNESCO and Humanity & Inclusion gathered scholars and representatives of DPOs and other civil society organizations to form a technical advisory committee (TAC) to provide advice on the design of the study and to later provide feedback on the draft report.

The TAC recommended beginning with a qualitative study, the result of which could inform the content and format of the quantitative study, guide the quantitative study, strengthen the understanding of the research team regarding sexuality and disability, and raise their awareness of the challenges and the subtleties of conducting such a study. Focus group discussions with people with hearing disabilities, for example, indicated a need to adjust the phrasing of questions related to contraception and safe sex so as to ensure full understanding. For example, the word 'contraception' was replaced with 'prevention of pregnancy' in the questionnaire.

2. Based on the CRPD principles, the disability-inlcusive approach focuses on the following principles: 1)Participation; 2)Promotion of equality and non discrimination: 3)Accessibility (CRPD, Art. 11).

3. Established in March 1988, the China Disabled Persons' Federation (CDPF) is a national umbrella organization for persons with diverse disabilities, their parents and friends as well as Disabled Persons' Organizations (www.cdpf.org.cn).

The qualitative study also convinced the research team of the need to use different questionnaires for people of different age groups and with different types of disabilities. Moreover, the qualitative study brought to the attention of the researchers the challenges of conducting a study among people with intellectual disabilities in rural areas. It revealed, for example, that additional effort was needed to reach girls with intellectual disabilities due to the fact that they are largely underepresented in schools , especially in rural areas where there are fewer schools for persons with intellectual disabilities.

Qualitative methods

The qualitative part of the study included focus group discussions and individual in-depth interviews, as well as one case study. The focus group discussions were conducted only with young people with disabilities, while the in-depth interviews were also conducted with parents, school doctors and teachers.

The focus group discussions and interviews with young people with disabilities mainly explored: their sexuality related knowledge and its sources; attitudes and perspectives regarding sexuality related issues; and needs for and current access to SRH information and services.

The interviews with the parents and teachers mainly explored: their concerns about the sexuality of young people with disabilities; their attitudes and perspectives regarding sexuality education and SRH services for young people with disabilities; the perceived difficulties and barriers faced by young people with disabilities in accessing SRH information and services; and their ideas on how to improve access to SRH information and services for young people with disabilities.

Each focus group and interview began with an icebreaker activity in which the interviewers explained, either verbally or in written form, to the participants the purpose and significance of the study, as well as the related confidentiality principles. All the focus groups and individual interviews were conducted with informed consent of the participants. . The interviews were audio-recorded only when the interviewees gave their consent.

Participants from urban areas were recruited mainly through special education schools. In rural areas, young people with disabilities and their parents were identified through their communities, while teachers were recruited from both regular and special education schools. Interviews with the parents and teachers of young people with intellectual disabilities were conducted only in urban areas.

The research team conducted 20 focus group discussions (with five to eight persons per group), including 12 groups of participants with visual, hearing and physical disabilities (both male/female, and urban/rural), and eight groups of young people with intellectual disabiltiies (from urban areas only).

The research team conducted 35 individual interviews with young people with disabilities: 19 interviews with boys and 16 with girls. Of the interviewees, 20 were from urban areas and 15 were from rural areas; 15 had visual disabilties, 16 had physical disabilities and four had intellectual disabilities. The interviews with the young people with visual and physical disabilities and their parents and teachers were conducted in both urban areas and rural areas. See Table 1 for a summary of the information about the participants .

A total of 103 young persons (53 male and 50 female) with visual, hearing and physical disabilities participated in the qualitative study (interviews and focus group discussions). The average age was 17.6 (urban) and 18.4 (rural). Among them, 52 participants were from urban special education schools. The 51 participants from rural areas included students studying in regular schools, young people who had dropped out of school and young people who were in the workforce. Almost three quarters (70.2 per cent) of the participants from urban areas had completed or were attending high school, while 41.5 per cent of the respondents in rural areas were in this category.

A total of 57 persons (29 male and 28 female) with intellectual disabilities participated in the focus groups and interviews. They were between the ages of 15 and 24 and were recruited primarily from special education schools and rehabilitation centres, with 40 per cent being elementary school students or graduates, 37.3 per cent middle school students or graduates, 13.5 per cent high school students, and 10.2 per cent vocational school students.

The research team conducted individual interviews with 29 school doctors and teachers (subject teachers and class head teachers), including 20 from urban areas and nine from rural areas. Their average ages were 40.9 (urban) and 40.3 (rural). Most (85 per cent) of the interviewees in urban areas were

Table 1. Number of focus groups and number of interviews, by area, type of disability, sex and age group

Areas	Focus groups					Individual interviews				
	Male		Female		Total	Male		Female		Total
	<18	≥18	<18	≥18		<18	≥18	<18	≥18	
Urban										
Hearing	0	1	0	1	**2**	-	-	-	-	-
Visual	0	1	0	1	**2**	2	2	1	3	**8**
Physical	1	0	1	0	**2**	3	2	1	2	**8**
Intellectual	2	2	2	2	**8**	1	1	1	1	**4**
Rural										
Hearing	0	1	0	1	**2**	-	-	-	-	-
Visual	0	1	0	1	**2**	2	2	1	2	**7**
Physical	0	1	1	0	**2**	2	2	1	3	**8**
Total	**3**	**7**	**4**	**6**	**20**	**10**	**9**	**5**	**11**	**35**

Table 2. Interviewed school teachers and nurses as well as parents, by area, type of disability, and age of the young people under their responsibility

Area	Sexuality Education related teachers		Head teachers / Life Skills teachers		School doctors			Parents		
	<18	≥18	<18	≥18	<18	≥18	Total	<18	≥18	Total
Urban										
Hearing	1	1	0	2	0	1	**5**	1	1	**2**
Visual	1	0	1	2	0	1	**5**	3	2	**5**
Physical	1	1	1	0	1	0	**4**	2	2	**4**
Intellectual	1	1	0	4	0	0	**6**	1	1	**2**
Rural										
Hearing	1	0	1	0	0	0	**2**	2	3	**5**
Visual	0	0	1	0	0	0	**1**	2	1	**3**
Physical	0	2	1	2	0	0	**5**	3	2	**5**
Intellectual	0	0	0	1	0	0	**1**	2	3	**5**
Total	**5**	**5**	**5**	**11**	**1**	**2**	**29**	**16**	**15**	**31**

Note: <18 and ≥18 refer to the ages of the young people with disabilities.

female, while around two thirds (66.7 per cent) of those in rural areas were female. More than three quarters (80 per cent) of the interviewees in urban areas and all (100 per cent) of the interviewees in rural areas had completed college or a higher level of education. The school doctors targeted by this study were all from urban areas as none of the targeted schools located in the rural areas had school doctors.

The 31 in-depth interviews with parents were conducted with 22 mothers (12 from urban and 10 rural areas) and nine fathers (one from an urban area and eight from rural areas). They had children with various types of disabilities and of both age groups covered by this study. The average age of the parents was 49.3 (urban) and 43.3 (rural). Most (84.6 per cent) of the parents in urban areas and almost half (44.4 per cent) of the parents in rural areas had completed middle school or a higher level of education.

The case study examined the circumstances of a 16-year old girl with Down syndrome. She was interviewed about her experiences in terms of sexuality education.

Quantitative methods

Questionnaires

The research team used questionnaires to explore the sexuality-related knowledge, attitudes and behaviour of unmarried young people with disabilities, and their access to two questionaires relevant information and services, as well as their expressed needs for SRH information and services.

The team developed four questionnaires: two age-specific questionnaires (12-14 and 15-24) for participants with visual, hearing and physical disabilities and for people with intellectual disabilities (for 12-14 and 15-24 age groups respectively). The questionnaire for those aged 12 to 14 explored their knowledge about puberty but did not directly explore their knowledge about sexual relations and contraception. The latter two topics were included in the questionnaire for participants aged 15 to 24. The questionnaire for young people with intellectual disabilities explored their knowledge of, access to and need for sexuality-related information. This questionnaire, designed based on similar surveys conducted by Humanity & Inclusion in other countries, used pictures and simple language to make it easy to understand.

After the initial design, a face validity study was conducted, involving male and female participants of both age groups (12-14 and 15-24) and with different types of disabilities. The questionnaires were then revised based on the outcomes of the face validity study, and pre-tested with 35 participants. The research team took all the measures necessary to ensure the questionnaires were administered in an accessible way to the respondents. All of the investigators involved in the study were trained by SIPPR on the basic principles and practices of anonymity, informed consent and confidentiality, as well as on how to guide and support the participants in completing the questionnaire.

The questionnaires for respondents with low vision used a large font size, while the questionnaires for participants who are blind were prepared in audio format, and were presented to the respondents via computer software or using tape recorders. Participants with hearing disabilities received support from sign language translators and the investigators. The majority of the participants with physical disabilities completed the questionnaires independently, and the few who had difficulties were assisted by the investigators, who read the questionnaire to them and filled in the answers that the respondents provided verbally. Participants with intellectual disabilities were assisted by the investigators, who used pictures (e.g. about body parts and scenarios) and additional verbal explanations to ensure the questions were fully understood.

The quantitative study was delivered to 723 young people with disabilities, with 707 effective questionnaire returns (97.8 per cent). Of the 707 respondents, 180 were young people with visual disabilities, 236 with hearing disabilities, 183 with physical disabilities and 108 with intellectual disabilities. More than half of the respondents (408) were male, and the remainder (299) were female. The higher number of male participants reflects the imbalance between female and male students attending the special schools targeted by the study.

Table 3. Questionnaire respondents, by age, type of disability and location

Age	Type of disability	Urban	Rural	Total
12-14	Visual	22	0	22
	Hearing	18	11	29
	Physical	12	63	75
	Intellectual	32	-	32
	Total	84	74	158
15-24	Visual	66	92	158
	Hearing	127	80	207
	Physical	60	48	108
	Intellectual	76	-	76
	Total	329	220	549

The participants with visual, hearing and physical disabilities were selected from special education schools, vocational schools and sports training centres for young people with disabilities, welfare-oriented enterprises and employment centres, as well as from communities and regular schools. The local DPOs and the local education bureaus provided support in the recruitment of survey participants.

About half of the participants with physical, hearng and visual disabilities were from rural areas. Overall, more than 90 per cent of this sample group were students, but only 68.5 per cent of the participants with physical disabilities were students. Most of the participants were in middle school or high school at the time of the study. Around a fifth (21 per cent) were aged between 12 and 14, while 44 per cent were aged between 15 and 19, and 34 per cent between 20 and 24. More than half of them were male. The male proportion among the visually disabled was particularly high, with 71.67 per cent of this group being male. Nearly half of them were born with a disability (See Table 4).

All of the survey participants with intellectual disabilities were recruited from special education schools and rehabilitation centres, with the support of associations of parents of young people with intellectual disabilities. Almost a third (30 per cent) were aged between 12 and 14, 45 per cent were aged between 15 and 19, and 25 per cent between 20 and 24. More than 60 per cent were male. Over half (54.63 per cent) reported having been born with a disability (see Table 4).

Table 4. Demographics of the survey respondents (%)

Feature					Intellectual
	Visual	Hearing	Physical	Sub-total	
	(n=180)	(n=236)	(n=183)	n=599	(n=108)
Age group					
12-14	12.22	12.45	40.98	21.14	29.63
15-19	55.00	43.35	32.79	43.62	45.37
20-24	32.78	44.21	26.23	35.23	25.00
Sex					
Male	71.67	49.15	52.46	56.93	62.04
Female	28.33	50.85	47.54	43.07	37.96
Residential area					
Urban	48.89	61.44	39.34	50.92	100.00
Rural	51.11	38.56	60.66	49.08	-
Single Child?					
Yes	40.56	54.66	32.24	43.57	56.48
No	59.44	45.34	67.76	56.43	43.52
Student?					
Yes	100	99.15	68.85	90.15	89.81
No	0.00	0.85	31.15	9.85	10.19
Education level					
Elementary	0.00	6.52	5.74	4.14	22.22
Middle School	25.14	30.87	64.75	36.72	39.81
Vocational/ Technical secondary/ High School	70.95	60.87	27.05	56.50	37.96
College/University or above	3.91	1.74	2.46	2.64	0.00
First appearance of a disability					
At birth	64.61	38.63	37.08	46.01	54.63
From birth to 10	16.85	34.76	21.35	25.30	24.07
After 10	15.73	5.15	16.29	11.71	0.00
Do not know	2.81	21.46	25.28	16.98	21.30

Data analysis

The researchers transcribed the responses from the focus groups and interviews and checked them for accuracy. They used 'Atlas.ti7.0' for inductive analysis.

Epi-data was used for double-entry and consistency checking of the quantitative data. The data was then cleared and statistically analyzed with SAS9.2. The data for each of the four questionnaires were analyzed separately, taking into account the possible differences between the different age groups, type of disability , sex and location.

The researchers found no significant differences between the responses of the two age groups (15-19 and 20-24) in most cases, therefore combined these two age groups for the presentation of most of the results, providing additional explanation where significant differences were identified.

For questions on factual matters, the researchers assigned 1 point to each correct answer and 0 points to incorrect and 'do not know' answers. The sum of the points in each category was then converted into a score on a scale of 0 to 100, with higher scores indicating higher levels of knowledge.

Challenges and limitations of the research

This study represents the very first effort to conduct a sexuality-related knowledge, attitudes and behaviour survey among unmarried young people with disabilities in China.

With the aim of ensuring its comprehensiveness, the study was designed to survey a broad range of ages, and various types of disabilities, in both rural and urban areas. This resulted in challenges, however, in the recruitment of participants. Sexuality and disability is not widely discussed in China, hence many people felt uncomfortable talking about it and some refused to be involved in the study or dropped out half-way through. For example, a 19-year-old girl with a physical disability who initially agreed to participate in the study lodged a complaint with the local authority claiming that the researchers were violating her privacy. This case was resolved, but the loss of participants such as this reduced the number of respondents.

People with disabilities were involved in the design and implementation of the study, for example, the TAC included a member with disability, and ADI as one of the research partners is a DPO. However, with little previous experience in conducting studies on the intersections of sexuality and disability, the researchers encountered many challenges, especially in collecting data among young people with intellectual disabilities. This indicates the need to provide training in China on how to conduct research in the area of disability-inclusive SRH.

The study was based on a convenient sample and, as such, the findings are not representative. However, the study is still valuable as it sheds light on the intersections between sexuality and disability, and provides a basis on which future studies can build on. The approach used to design the questionnaires, especially in terms of the measures used to overcome communication barriers between the interviewees and the research team, could be of particular value to future studies.

3

RESULTS AND DISCUSSION

3.1 Sexuality-related knowledge

The questionnaires for young people with visual, hearing and physical disabilites explored four categories of sexuality-related knowledge:

- Sexual physiology (menstruation, nocturnal emissions, masturbation, pregnancy and childbirth).
- Human Immunodeficiency Virus (HIV) and other sexually-transmitted infections (STIs) (transmission channels and prevention).
- Self-protection (learning about which body parts are private ; identifying sexual abuse scenarios; and coping skills).
- Puberty (male and female physical changes during puberty) for the 12-14 age group and contraception (methods of contraception and how to obtain them) for the 15-24 age group.

The results indicated that young people with disabilities lack knowledge about sexuality. Overall, they scored between 37 and 43 points for knowledge related to the topics of: puberty, sexual physiology, HIV and other STIs, and contraception (see Figure 1). Their score was higher (70.73), however, for the topic of self-protection, which suggests that young people with disabilities had been exposed to more information about self-protection compared to the other topics. This is in line with the findings of the 'Disability, Gender and Sexuality' pilot project implemented by Humanity & Inclusion and partners in China, which found that parents and teachers paid greater attention to teaching children with disabilities about self-protection compared to any other sexuality related topic (Aresu and Mac-Seing, 2018). Young people's low scores on topics other than self-protection suggests that parents and teachers give less attention to topics that are perceived as being sensitive, such as sexual physiology and contraception.

These results correspond to what emerged from the qualitative study. When asked what topics 'sexuality education' should cover, parents from both urban and rural areas referred to self-protection as being exceptionally important for young people with disabilities, who were perceived as highly vulnerable to abuse. Many parents in both urban and rural areas felt that information on pregnancy, abortion, contraception and STIs could be provided at a later stage in life. However, parents in urban areas felt that sexuality education should cover the physiological changes during puberty, heterosexual relationships, self-protection and HIV prevention. The majority of parents in rural areas did not know what sexuality education should cover.

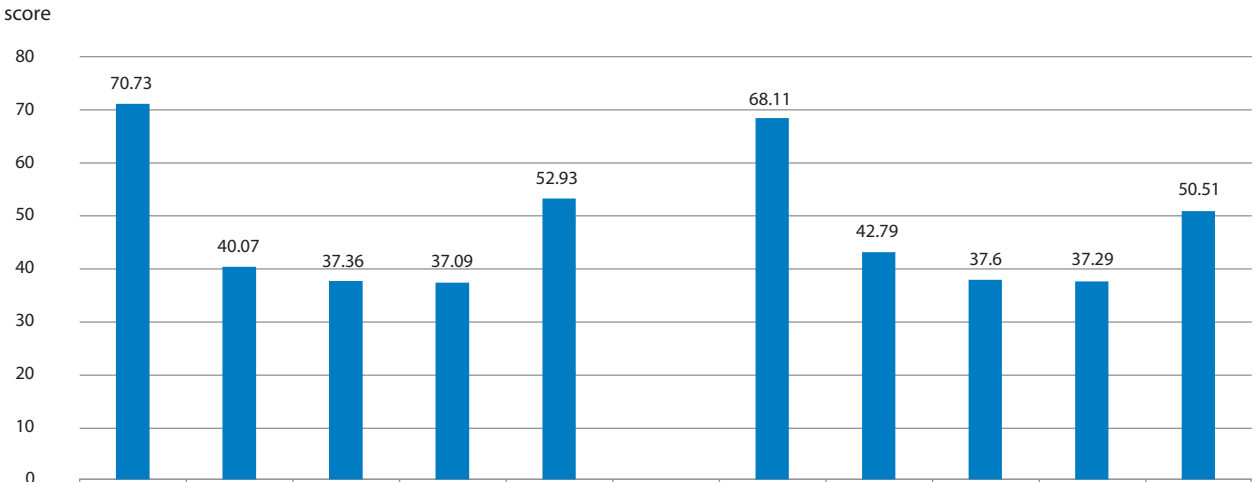
No significant difference was identified between the two age groups (12-14 and 15-24) in terms of their knowledge about sexual physiology and HIV/STIs, but those aged 12-14 reported a much higher level of knowledge about self-protection compared to the higher age group (see Figure 1).

Differences between the study respondents and their peers without disabilities

When the knowledge reported by the study respondents was compared to that of their peers without disabilities at a similar education level (vocational/high schools), the study participants were found to have a lower level of knowledge about sexuality than their peers. For example, in terms of sexual physiology, only 12.39 per cent of the study participants aged 12 to 14 knew that the first nocturnal emission marked boys' ability to conceive, and only 21.9 per cent of them knew that the onset of menstruation marked girls' ability to conceive. These findings are similar to those of a 2012 SRH study conducted in six Chinese cities and provinces among children without disabilities aged 9-11. Those children scored 12.39 per cent and 25.65 per cent for the two topics, respectively (Hu et al, 2015).

Among the study participants aged 15 to 24, only 31.13 per cent knew that masturbation is not harmful to their health, while according another relevant study, 40.84 per cent of high school students without disabilities knew this (Shanghai Institute of Planned Parenthood Research, 2012). While around two thirds (65.53 percent) of the study participants (boys and girls) knew about condoms, almost three quarters (73 per cent) of young people without disabilities of the same age group knew about condoms , according to another relevant study(Zheng et al, 2010).

Figure 1. Average sexuality-related knowledge scores of young people with disabilities, by topic and age group



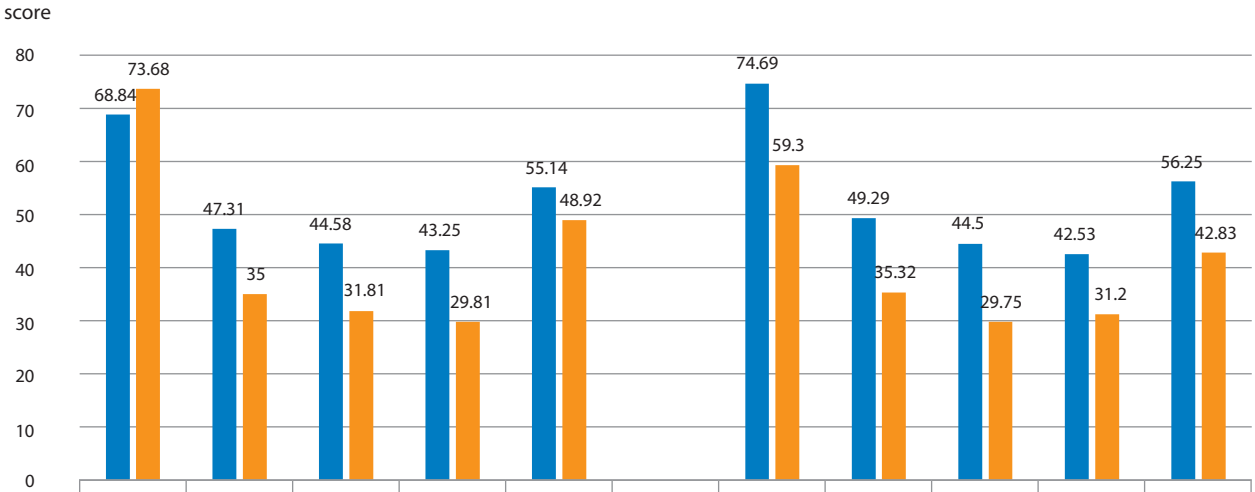
Differences in knowledge between girls and boys

Though the scoring did not show significant differences overall between boys and girls, girls aged 12 to 14 showed a better understanding of puberty than their male counterparts (girls scored 43.56 while boys scored 32.37). Similarly, girls aged 15 to 24 scored higher than their male counterparts on self-protection knowledge/skills (girls scored 73.17 while boys scored 64.1). These differences may be related to the special attention given by schools and families to girls' puberty changes and self-protection. According to the school nurses reached by this study, some schools offer special lectures on puberty and health only to girls.

Urban-rural gap in knowledge

Participants from urban areas scored between 11 and 15 points higher than their counterparts from rural areas for the sexuality-related topics, except for self-protection knowledge of the 12 to 14 age group registering a smaller urban-rural difference (see Figure 2). The responses in the discussion groups and interviews revealed a similar urban-rural gap. While most participants from urban areas showed a basic understanding of puberty changes and genitalia, nearly three quarters of the young people from rural areas who participated in the focus group discussions and individual interviews did not understand puberty changes. For example, these boys and girls had no knowledge of nocturnal emissions and menstruation before actually experiencing them. One of the female participants living in a rural area reported, 'When menstruation first came, I was scared; I thought I was going to die, so I hid in the restroom to write a will'. (Female student with a visual disability, 17 years old, second year in high school).

Figure 2. Urban/rural comparison of sexuality-related knowledge scores



	12-14					15-24				
	Self-protection	SITs/HIV	Puberty change	Sexual physiology	Total	Self-protection	SITs/HIV	Contraception	Sexual physiology	Total
Urban	68.84	47.31	44.58	43.25	55.14	74.69	49.29	44.5	42.53	56.25
Rural	73.68	35	31.81	29.81	48.92	59.3	35.32	29.75	31.2	42.83

The urban/rural knowledge gap is likely to be partly due to the differences in access to sexuality education in urban and rural areas. The study found that very little relevant information was integrated into biology and health related classes in schools in the rural research sites, and that neither regular nor special education schools offered sexuality education or had teachers specialized on the subject. Furthermore, very few of the parents living in rural areas reached by this study provided sexuality education to their children. In addition, adults in rural areas and parents with a low level of education had a more conservative attitude towards sexuality education than their urban counterparts. Some parents felt embarrassed to talk about sex, or did not know how to talk about it with their children. Some assumed that children would 'naturally understand these things' when they grew older, or that the children could be taught at a more 'appropriate' age (around 25 years of age, in their opinion).

Interviewees from urban areas observed that although sexuality education was provided at home to some extent, this was far from being enough, as parents tended to provide only very superficial knowledge. Interviewees from rural areas reported that sexuality education was rarely provided at home, and when available it was often limited to warning against 'puppy love' and providing basic information about managing menstruation. Parents tended to assume that children would naturally learn as they grow older, or that there was no need for children to know much about sexuality. The urban/rural knowledge gap inevitably has an influence on young people's attitudes and behaviours. Those living in rural areas are likely to be more vulnerable(WHO & UNFPA, 2009 De Beaudrap et al, 2014) than their counterparts from urban areas to SRH-related risks such as unintended pregnancies, violence and abuse, and HIV and other STIs. This issue therefore needs special attention.

Differences in knowledge by type of disability

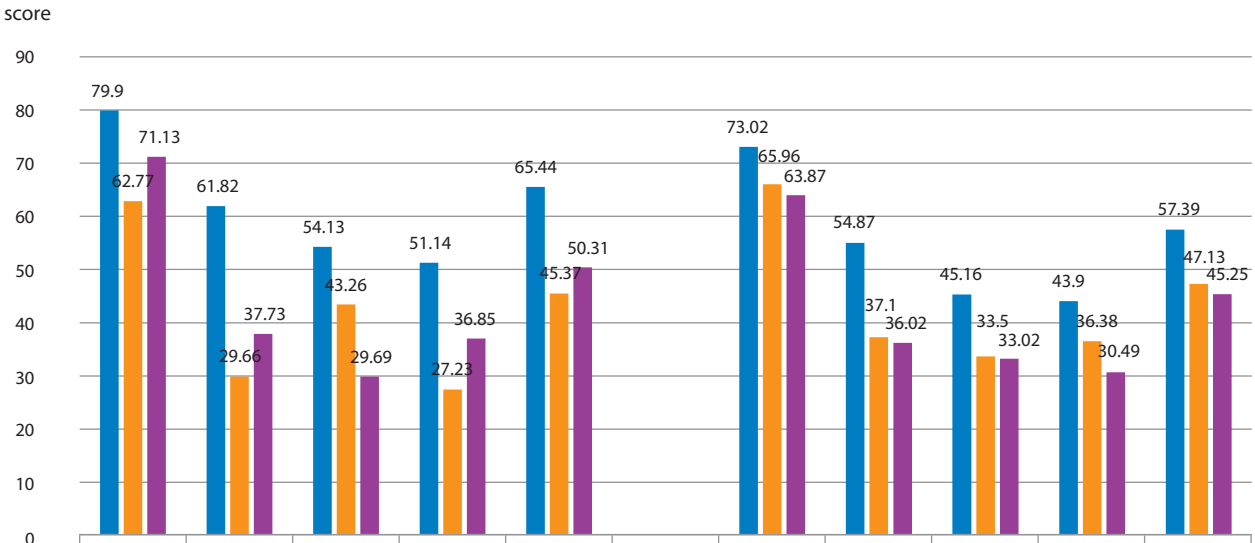
The participants with visual disabilities in both age groups scored significantly higher on all of the sexuality-related topics than the participants with hearing and physical disabilities. The participants with hearing disabilities in the 12 to 14 age group scored the lowest overall (see Figure 3).

These findings echo those of previous relevant studies, indicating that young people face different barriers in accessing sexuality-related information depending on the type of disability they have (Li, 2012; Yousafzai, 2005). For example, previous studies found that due to their isolation from society and due to verbal communication barriers, people with hearing disabilities are less likely to obtain information from educators, teachers, health workers or peers, who are mostly unable to communicate using sign language (Yousafzai, 2005; Lu et al, 2015). Moreover, communicating sexuality-related vocabularies through sign language can be difficult, which increases the obstacles hindering sexuality education for this group (Li, 2012; Mao & Luan, 2011).

The barriers to education faced by children with physical disabilities are linked to their need to dedicate a significant amount of time to rehabilitation (training related to their disability) during their childhood; this inevitably delays or affects their access to educational opportunities, including those related to sexuality. Meanwhile, available information is usually not tailored to their needs, nor it is made accessible (Wan and Yu, 2016).[20]

There is little recognition, in general, of the need for educators and service providers to offer information in accessible formats to people with disabilities. Thus, to ensure disability-inclusive sexuality education for such young people, it is necessary to implement interventions targeting educators and service providers' attitudes and capacity. There is an urgent need to challenge the widespread idea that the limited sexuality-related knowledge of young people with disabilities is a result of their disability and, instead, identify and address the barriers that prevent them from accessing information.

Figure 3. Sexuality related knowledge scores differentiated by type of disability



	12-14						15-24				
	Self-protection	SITs/HIV	Puberty change	Sexual physiology	Total		Self-protection	SITs/HIV	Sexual physiology	Contraception	Total
Visual	79.9	61.82	54.13	51.14	65.44		73.02	54.87	45.16	43.9	57.39
Hearing	62.77	29.66	43.26	27.23	45.37		65.96	37.1	33.5	36.38	47.13
Physical	71.13	37.73	29.69	36.85	50.31		63.87	36.02	33.02	30.49	45.25

3.2 Access to and expressed need for sexuality-related information

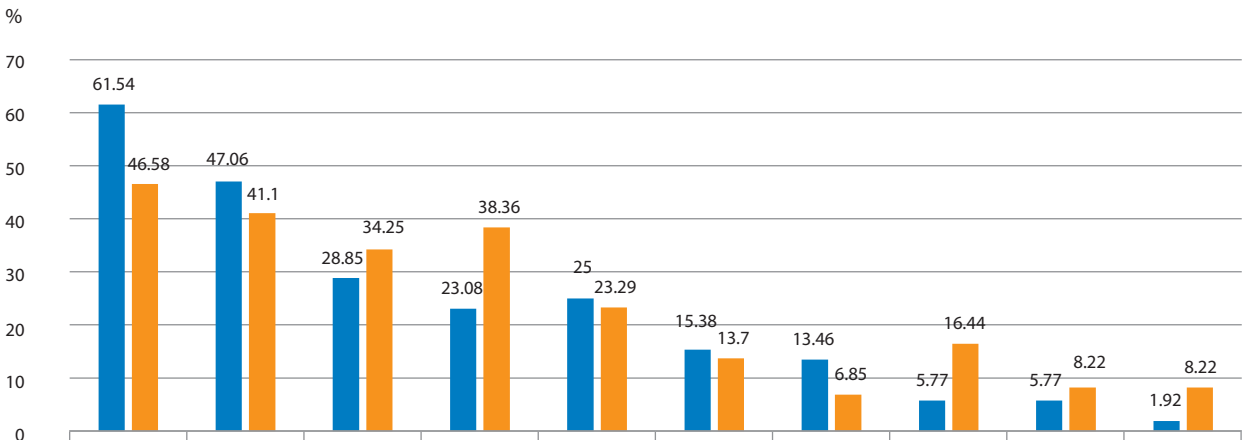
Access to sexuality-related information through schools and parents

Participants from the 12-14 age group reported the primary sources of sexuality-related information as being, in descending order: school/teachers, parents, peer/classmates/friends and books/magazines/the internet (see Figure 4a). For the age group of 15-24, the primary sources in decending orders are school/teachers, internt, peer/classmates/friends and parents (see Figure 4b). This suggests that promoting school-based and family-based sexuality education for young people with disabilities may contribute to increasing their sexuality-related knowledge.

Participants from urban areas had a greater tendency to access sexuality-related information through school and family compared with their counterparts from rural areas. For example, within the 12 to 14 age group, 61.54 per cent of the participants from urban areas reported acquiring information through school/teachers, versus 46.58 per cent of those from rural areas. For the 15 to 24 age group, the percentages were 72.9 per cent (urban) and 34.55 per cent (rural). Participants from urban areas aged 15 to 24 also reported a significantly higher rate of acquiring sexuality-related information from parents (35.46 per cent) compared to their counterparts from rural areas (26.36 per cent).

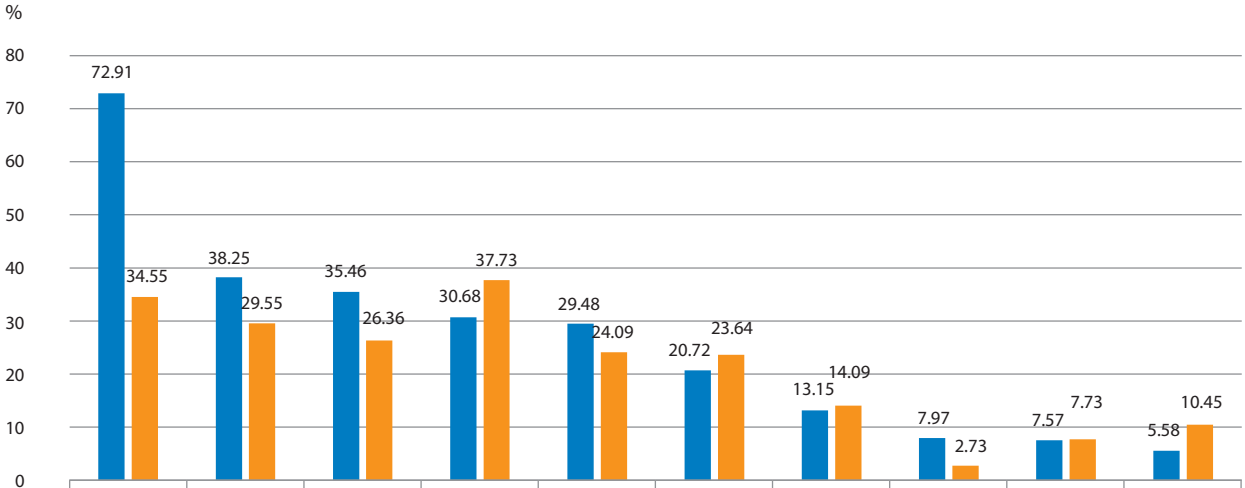
A higher percentage of participants from rural areas reported using printed and new media as channels to acquire sexuality related information than their counterparts from urban areas. For example, 38.36 per cent of the participants from rural areas aged 12-14 reported acquiring sexuality-related information through books, magazines and newspapers, versus 23.08 per cent of their counterparts based in urban areas. And 37.73 per cent of the participants aged 15 to 24 based in rural areas reported acquiring sexuality-related information through the internet versus 30.68 per cent of their counterparts from urban areas. This suggests the potential of using mass media and the internet to reach young people with disabilities in rural areas, and the importance of ensuring that good quality information is available through these channels.

Figure 4a. Urban/rural comparison of sources of sexuality related knowledge, 12-14 age group



	School/ teachers	Parents	Peers/ friends/...	Books/Maga-zines	Internet	TV/broad-cast/radio	Siblings/...	Professionals	Poster/exhi-bition/...	Training agency
	12-14									
Urban	61.54	47.06	28.85	23.08	25	15.38	13.46	5.77	5.77	1.92
Rural	46.58	41.1	34.25	38.36	23.29	13.7	6.85	16.44	8.22	8.22

Figure 4b. Urban/rural comparison of sources of sexuality related knowledge, 15-24 age group



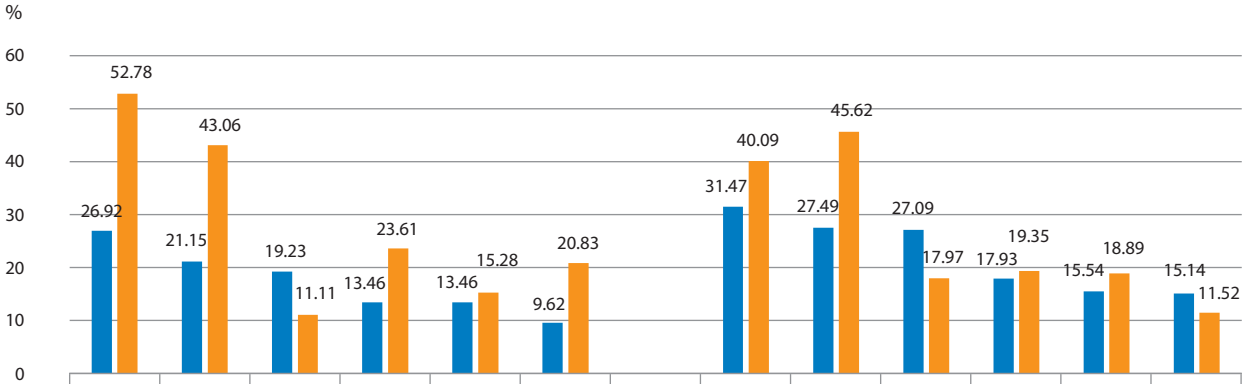
	15-24									
Urban	72.91	38.25	35.46	30.68	29.48	20.72	13.15	7.97	7.57	5.58
Rural	34.55	29.55	26.36	37.73	24.09	23.64	14.09	2.73	7.73	10.45

The responses of teachers and young people revealed that among the eight urban special education schools reached by this study, only two provided puberty education.One school for children with visual disabilities provided puberty education for students in Grade 6, while the other school for children with hearing disabilities provided it for students in Grade 10. The other urban special education schools reached by this study reported having integrated sexuality-related content into other courses, such as psychology, health, science, class meetings and large lectures. Most of these courses were offered at the lower secondary school level, and were reported as providing information on reproduction, physiology, puberty growth, self-protection and relationships with the opposite sex. Only one school (an urban vocational high school for young people with hearing disabilities) claimed to provide information on contraception.

None of the rural regular and special education schools reached by this study offered sexuality education classes. Only biology and hygiene classes provided some (basic) information on physiological anatomy and hygiene. Young people with disabilities interviewed in rural areas commented that schools and parents only cared about their academic performance and paid little attention to sexuality education. For example, one interviewee said, 'Nowadays parents and teachers say that our main task is to study, and not to think about anything else apart from preparing for the college entrance examination for universities' (Female student with a visual disability, 18 years old, second year of high school, rural area).

When asked about the main barriers to accessing sexuality-related information, around a third of the respondents felt that being ignorant regarding the available sources of accurate information (33.87 per cent of the 12-14 age group and 35.9 per cent of the 15-24 age group) was a key barrier, and a similar percentage felt that feeling embarrassed about seeking sexuality-related information (41.94 per cent of the 12-14 age group and 35.47 per cent of the 15-24 age group) was a key barrier. This suggests that future interventions need to focus not only on the provision of information but also on increasing the confidence of both boys and girls in proactively seeking such information.

Figure 5. Urban/rural comparison regarding difficulties in accessing relevant information



	12-14						15-24					
	Too shy	Don't know where	Too little from school	Lack appropriate books and magazines	Conservative parents	Hard to understand	Too shy	Don't know where	Too little from school	Hard to understand	Lack appropriate books and magazines	Conservative parents
Urban	26.92	21.15	19.23	13.46	13.46	9.62	31.47	27.49	27.09	17.93	15.54	15.14
Rural	52.78	43.06	11.11	23.61	15.28	20.83	40.09	45.62	17.97	19.35	18.89	11.52

A greater percentage of participants in rural areas reported difficulties in terms of accessing sexuality-related information compared to their counterparts in urban areas, but no significant gender difference was identified. Over half (52.78 per cent) of the participants in rural areas aged 12 to 14 reported that they were too shy to seek information on sexuality, versus around a quarter (26.92 per cent) of their counterparts living in urban areas (See Figure 5).

Low satisfaction with school and family-based sexuality education

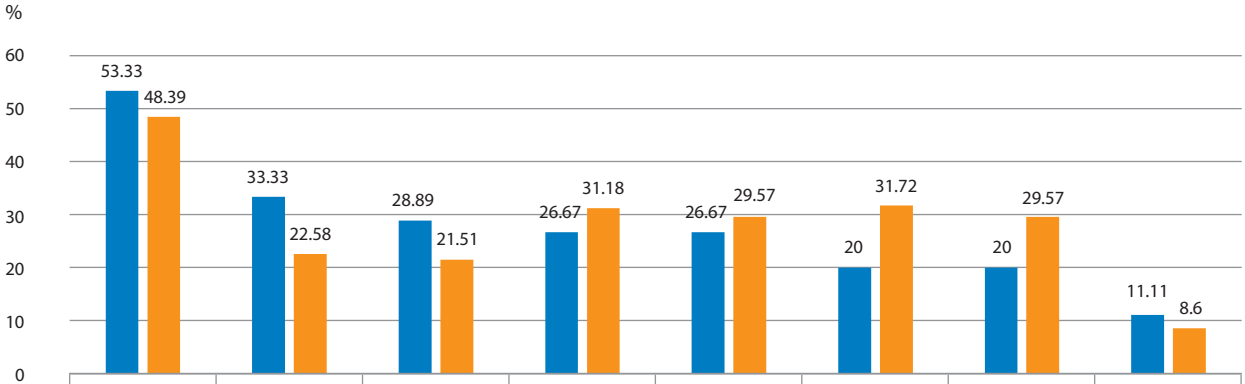
Just over half (53.15 per cent) of the participants aged 12 to 14 and over a third (39.32 per cent) of those from the 15 to 24 age group expressed dissatisfaction with the information and services relating to sexuality education received at school, describing the information as too little, shallow and incomplete. Other reasons for dissatisfaction included a lack of counselling and guidance, textbooks with outdated or incomprehensible content, scanty content, and an insufficient number of hours dedicated to sexuality education (see Figure 6.).

This dissatisfaction was echoed in the comments of the young people who participated in the discussion groups and interviews. Typical comments by interviewees in urban areas included the following: 'We say we have this course, but it has no real impact. We learn by ourselves (Male student with a visual disability, 17 years old, second year of vocational middle school). 'I feel we get relatively little sexuality education in school; sometimes through biology or psychology classes, none of which is systematic or comprehensive, so if we do encounter these matters in real life, we still do not know how to respond. Most of us just learn by ourselves' (Male student with a visual disability, 19 years old, second year of vocational middle school) .

All of the interviewees based in urban areas expressed a need to receive more comprehensive sexuality education in school. Similar feedback was provided by interviewees based in rural areas, who emphasized that the sexuality education they received was very limited, often vague and hard to understand. As one interviewee put it, 'Because it's a traditional society, these things are presented in a veiled fashion' (Male student with a hearing disability, 18, high school). Some young people noted that they had already forgotten what was taught at school on the subject.

As for sexuality education within the family, most of interviewees from the urban areas said that, what parents had told them, such as menstrual care, body changes during puberty, self-protection and warning agaist falling in love, was far from being enough and were mostly already known to them.

Figure 6. Reasons for dissatisfaction with school sexuality education and services



	Too little, shallow, incomplete	Lack of counseling or guidance	Audience too young	Too little class hours	Monotonous teaching	Outdated or obscure textbooks	Careless teaching or student self-learning	Lack of referral
12-14	53.33	33.33	28.89	26.67	26.67	20	20	11.11
15-24	48.39	22.58	21.51	31.18	29.57	31.72	29.57	8.6

The interviewees from the rural areas said their parents had hardly told them anyting more than warning against falling in love or menstrual care, and many parents just thought it was unnecessary to teach children about these things as they would understand it naturaly when they grow up.

Young people's dissatisfaction with school-based sexuality education and their parents' attitudes towards sexuality education is not only an issue among children with disabilities. This is a common concern in China (Cui et al, 2012; Zuo et al, 2013; Aresu, 2006), and efforts to promote better quality sexuality education at the school, family and community levels (UNESCO & UNFPA, 2018) are relatively recent. In a context in which a significant number of children with disabilities attend special education schools instead of regular schools (Human Rights Watch, 2013), it is important to build on successful experiences, adapt the good practices of regular schools for application in special schools, and ensure sexuality education is provided in both special education and regular schools.

Expressed need for sexuality-related information

This study shows that in the Chinese context the young people with and without disabilities have similar needs for sexuality-reated information. Almost three quarters of the study participants felt that young people both with and without disabilities are entitled to the same rights to sexual and reproductive health, and roughly 70 per cent felt that they have the same needs. The 15-24 age group reported a slightly greater awareness of SRHR (76.27 per cent) than the 12-14 age group (71.43 per cent), with young people with visual disabilities being the best informed, and those with hearing disabilities the least informed about their rights.

Regarding the right and need to acquire information on SRH, a male 19-year-old student (high school, year 2) with a visual disability commented that, 'I think it is necessary; everyone has an equal right to education, whether you are disabled or not'. Other participants referred to the fact that many young people with disabilities would get married and therefore needed to acquire some relevant knowledge. As one young man observed, 'Regardless of the type of disability, sexual knowledge is necessary for any human being' (male 18-year-old with a hearing disability in high school, year 3).

Unlike their counterparts living in urban areas, interviewees from rural areas were divided in their responses to the question of whether or not sexuality education should be provided to young people with disabilities. Only about half of these respondents felt that sexuality education was necessary. The respondents in favour of sexuality education felt that it helped them to protect themselves, in terms of both physical and mental health. As one interviewee said, 'Sexuality

Table 5. Top three topics for each age group

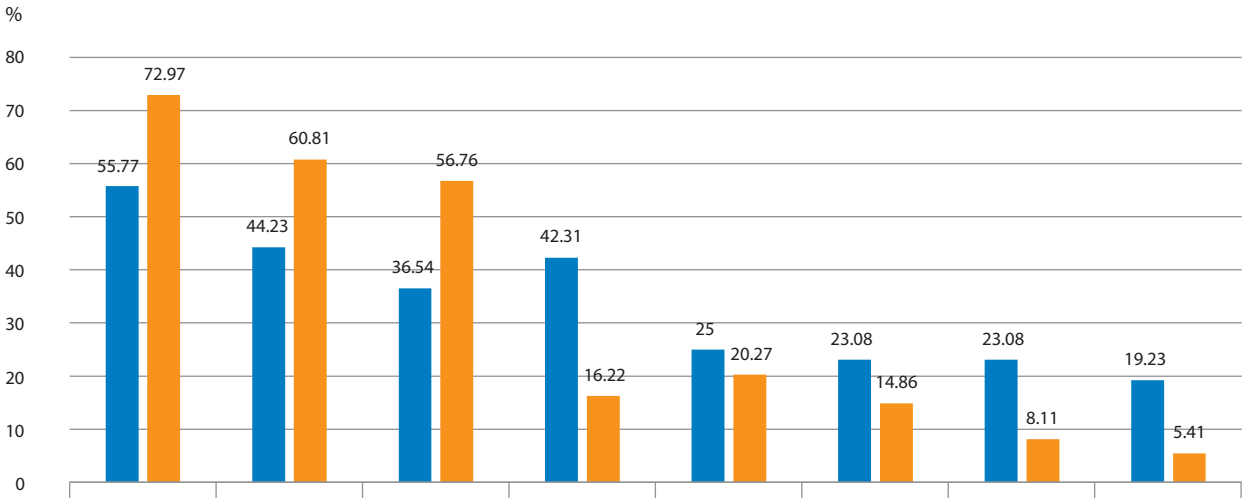
Age group	12-14 years	15-24 years
Topics	• Puberty physiological and mental changes, hygiene and health care (65.87%) • STIs and HIV prevention (53.97%) • Coping with sexual harassment/assault/self-protection (48.41%)	• Puberty physiological and psychological changes, hygiene and health care (61.19%) • Friendship, love, marriage (44.99%) • Coping with sexual harassment/assault/self-protection (41.58%)

education helps us to become more aware of our physical and mental health, and it is therefore necessary' (female student with a hearing disability, 18, third year of high school). A respondent who felt that there was no need for schools to provide sexuality education said that, 'Children these days are smart, they know everything, and they can go online'. Another commented: 'They will know naturally when the time comes'. One of the respondents was against sexuality education saying that 'Providing sexuality education is perverted'.

When asked about the most important topics to include in sexuality education, over 60 per cent of the respondents expressed an interest in learning about puberty, physiological and mental changes, hygiene and health care. The top three topics for each age group are listed, in descending order, in Table 5.

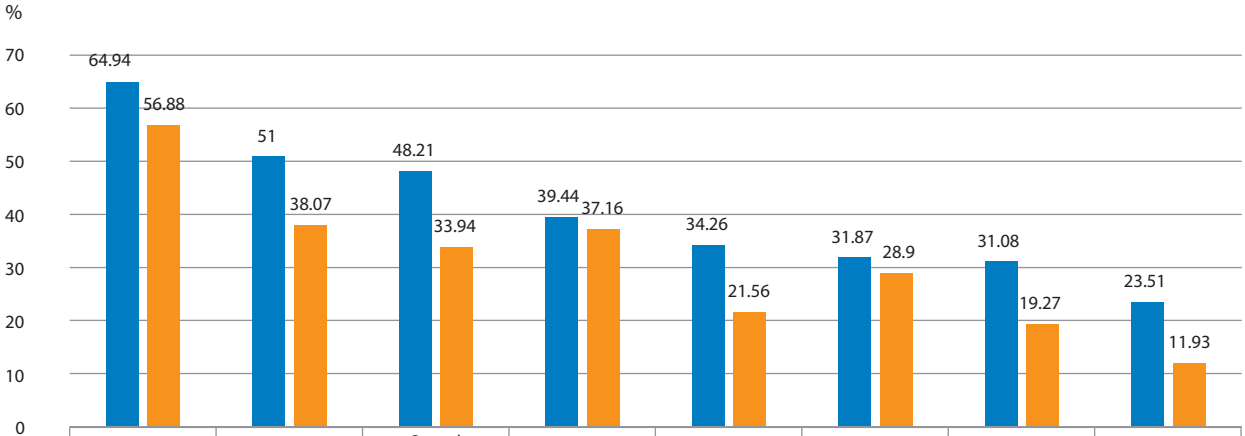
Participants living in urban settings expressed a higher level of interest in most of the topics than those living in rural areas, especially for the 15-24 age group (see Figure 7a and 7b). This may be linked to the higher level of awareness of the topics among those in urban areas, promoted by their better access to sexuality education.

Figure7a. Needs for sexuality-related information by area (urban/rural), 12-14 age group



	12-14							
	Puberty change	STIs/HIV prevention	Sexual harassment/abuse/self-protection	Friendship,love and marriage	Reproductive system	Sexual orientation	Pregnancy and childbirth	Contraception and abortion
Urban	55.77	44.23	36.54	42.31	25	23.08	23.08	19.23
Rural	72.97	60.81	56.76	16.22	20.27	14.86	8.11	5.41

Figure 7b. Needs for sexuality-related information by area (urbam/rural), 15-24 age goup



	Puberty change	Friendship,love and marriage	Sexual harassment/ abuse/self-protection	STIs/HIV prevention	Contraception and abortion	Reproductive system	Pregnancy and childbirth	Sexual orientation
	15-24							
Urban	64.94	51	48.21	39.44	34.26	31.87	31.08	23.51
Rural	56.88	38.07	33.94	37.16	21.56	28.9	19.27	11.93

Preferred ways to access sexuality-related information

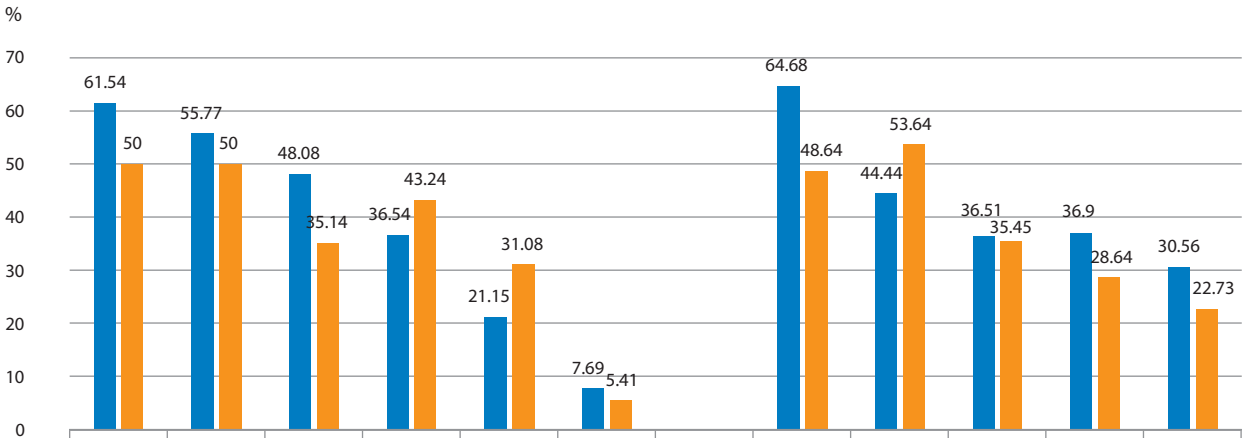
When asked about their preferences on the sources of sexuality-related information, over 60 per cent of the participants in urban areas and nearly half of all the participants in rural areas expressed a preference for learning about sexuality from school teachers. The next most preferred source of such information was parents (for 12-14 years old) and the internet (for 15-24 years old). (See Figure 8).

The internet was listed as a major preferred source because of its abundance of easily accessible online information, as well as it being a less embarrassing means of gaining information and a more private way to find out what they wanted to know. Accessing information online is particularly popular among young people with disabilities living in rural areas where school-based and family-based sexuality education remain limited.

The surveyed young people with disabilities and their parents expressed very little interest in or expectations regarding community-based sexuality education (only between 5 per cent and 12 per cent) (see Figure 8). This is probably due to the perception that communities are not capable of providing professional sexuality education. As one participant based in an urban area said during an interview, 'The teachers in schools are relatively professional; [while] those [community staff] are not professional' (female student with a visual disability, 18 years old, third year in high school).

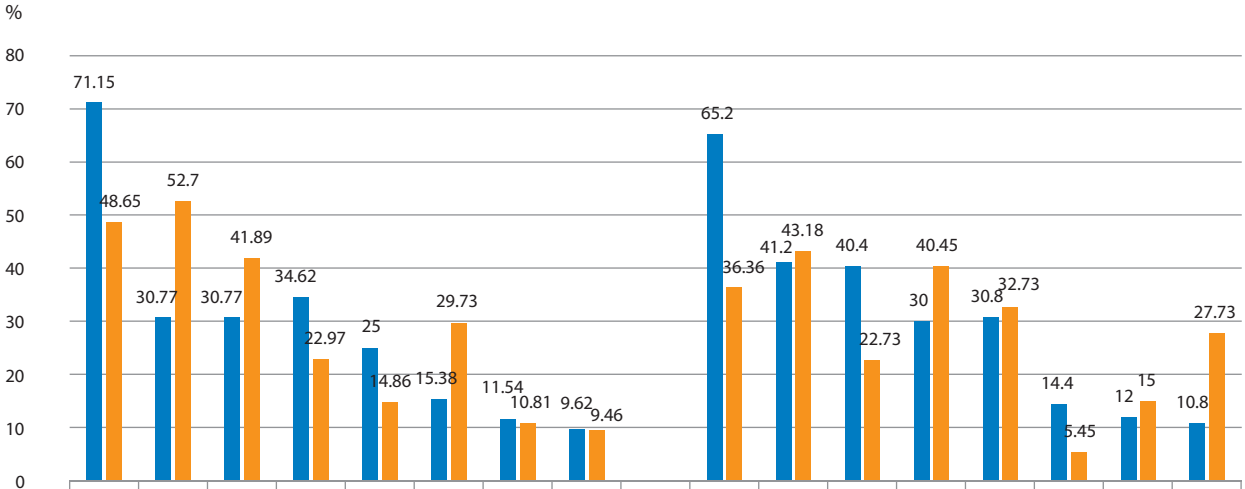
Despite the predominant preference for accessing sexuality-related information from schools, interviews with young people showed that when confronted with sexuality-related issues, they rarely feel comfortable in seeking support from schools, but instead prefer talking with their peers. This indicates a need to strengthen community-based counselling services and to invest in peer sexuality-education initiatives. In terms of preferred methods of acquiring sexuality-related information, participants from urban areas reported a preference for classes/lectures and discussions/activities, while those from rural areas reported a preference for internet-based information, books/newspapers, TV/ videotapes and radio broadcasts (Figure 9).

Figure 8. Urban/rural comparison regarding preferred sources of information



	12-14						15-24				
	School/ teachers	Parents	Peers/ class-mates/ friends	Internet	Hospital	Communi-ty	School/ teachers	Internet	Peers/ class-mates/ friends	Parents	Hospital
Urban	61.54	55.77	48.08	36.54	21.15	7.69	64.68	44.44	36.51	36.9	30.56
Rural	50	50	35.14	43.24	31.08	5.41	48.64	53.64	35.45	28.64	22.73

Figure 9. Urban/rural comparison of preferred methods of acquiring sexuality-related infromation



	12-14								15-24							
	Class/ lecture	Inter-net	Books/ news-pa-per/...	Discus-sion/ activity	TV/vid-eotape	Coun-seling	Broad-cast/ radio/ audio	Poster/ exhibi-tion/...	Class/ lecture	Books/ news-pa-per/...	Discus-sion/ activity	TV/vid-eotape	Inter-net	Coun-seling	Poster/ exhibi-tion/...	Broad-cast/ radio/ audio
Urban	71.15	30.77	30.77	34.62	25	15.38	11.54	9.62	65.2	41.2	40.4	30	30.8	14.4	12	10.8
Rural	48.65	52.7	41.89	22.97	14.86	29.73	10.81	9.46	36.36	43.18	22.73	40.45	32.73	5.45	15	27.73

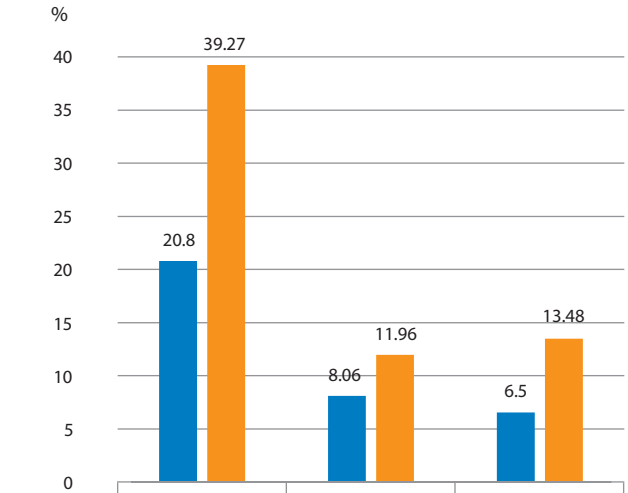
3.3 Attitudes towards sexuality and gender roles

Attitudes towards intimate relations

A fifth (20.8 per cent) of the study participants aged 12 to 14 and two fifths (39.27 per cent) of the study participants aged 15 to 24 were accepting of intimate relations[4] between two young persons of middle school age. However, only around 7 per cent of the participants in the 12 to 14 age group and only around 13 per cent of the participants in the 15-24 age group considered intimate relations with the same sex to be acceptable (Figure 10). This contrasts strongly with the findings of a study conducted with young people without disabilities, which found that almost half (49.1 per cent) of those young people were accepting of same sex intimate relations (Yu et al, 2013).

Only a very small number of respondents considered same-sex relationships to be normal, or said that they would respect other people's choices but would not want it to happen to themselves. Girls with disabilities reported a similar level of acceptance of same-sex intimate relations as their male counterparts. Participants in urban areas with visual disabilities expressed a positive attitude towards same-sex intimate relations more frequently than their rural counterparts and the participants with other disabilities (Figures 11, 12 and 13).

Figure 10. Attitudes towards intimate relations, by age group.



	It is OK for middle/ high school students to date	It is OK for a boy to date another boy	It is OK for a girl to date another girl
12-14	20.8	8.06	6.5
15-24	39.27	11.96	13.48

The vast majority of young people involved in this study, however, described homosexuality as 'repulsive, against the natural order' or 'pro blematic, perverted, incomprehensible, unreasonable'. One male student with a visual disability, for example, said, 'I'm against it, (it's) unacceptable; this is against the natural order, unacceptable. If it happens around me, I would persuade him not to; if it happens to me, I would be scared'.

Such perceptions reflect a widespread bias against homosexuality. Attitudes such as these can lead to further isolation of persons with disabilities who engage in same sex relations, and could lead to the violation of their rights to access SRH information and services. The intersections between homosexuality and disability have only started being explored (Goblet, 2011; Zhen & He, 2014), and deserve future discussion and attention, so as to ensure the well-being of all people with disabilities, including all sexual identities and orientations.

Attitudes towards pre-marital sex and safe sex

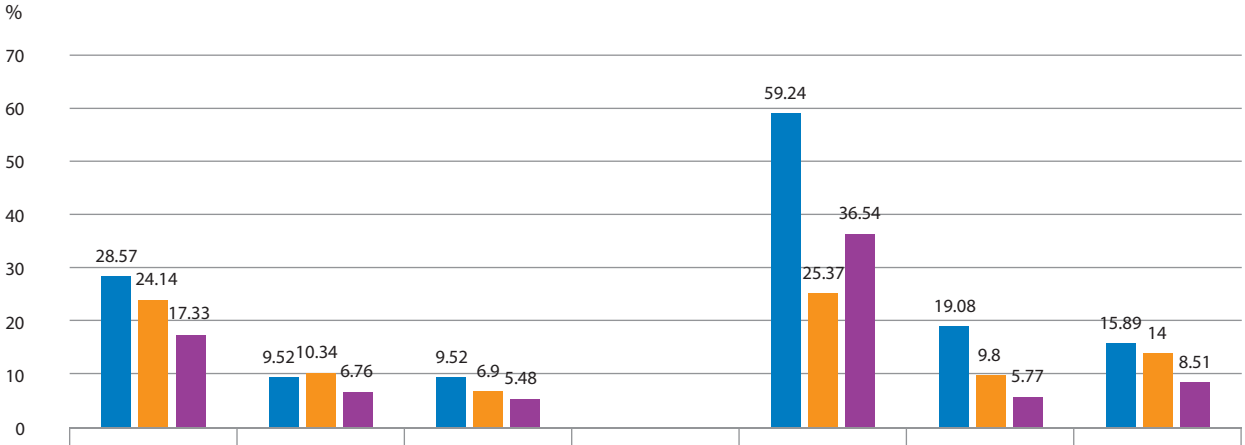
Only the participants aged 15-24 were asked questions about pre-marital sex. Overall, nearly 27 per cent of these participants felt that premarital sex was acceptable as long as it was based on mutual consent. This percentage is lower than that among young people without disabilities (39.9 per cent), as found by a study conducted in Shanghai in 2012 (Du et al, 2012).

Close to 38 per cent of this study's participants considered premarital sex to be acceptable only if the two parties were in love. In terms of their attitudes to safe sex, only 59 per cent thought that contraceptive/protective measures should be used during sexual intercourse.

The responses of participants with visual and physical disabilities indicated that these groups were more open to pre-marital sex and had greater awareness about safe sex than those with hearing disabilities (Figure 14). The lower level

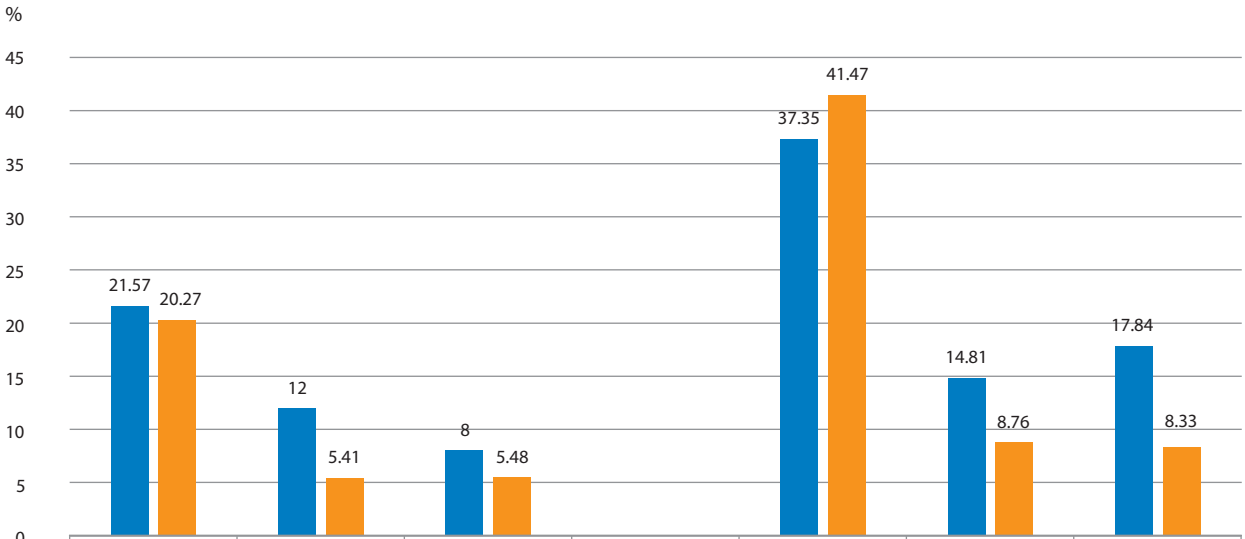
4. In this report intimate relations refer to physical and/or emotional intimacy such as holding hands, hugging, kissing and caressing.

Figure 11. Attitudes towards intimate relations, by type of disability



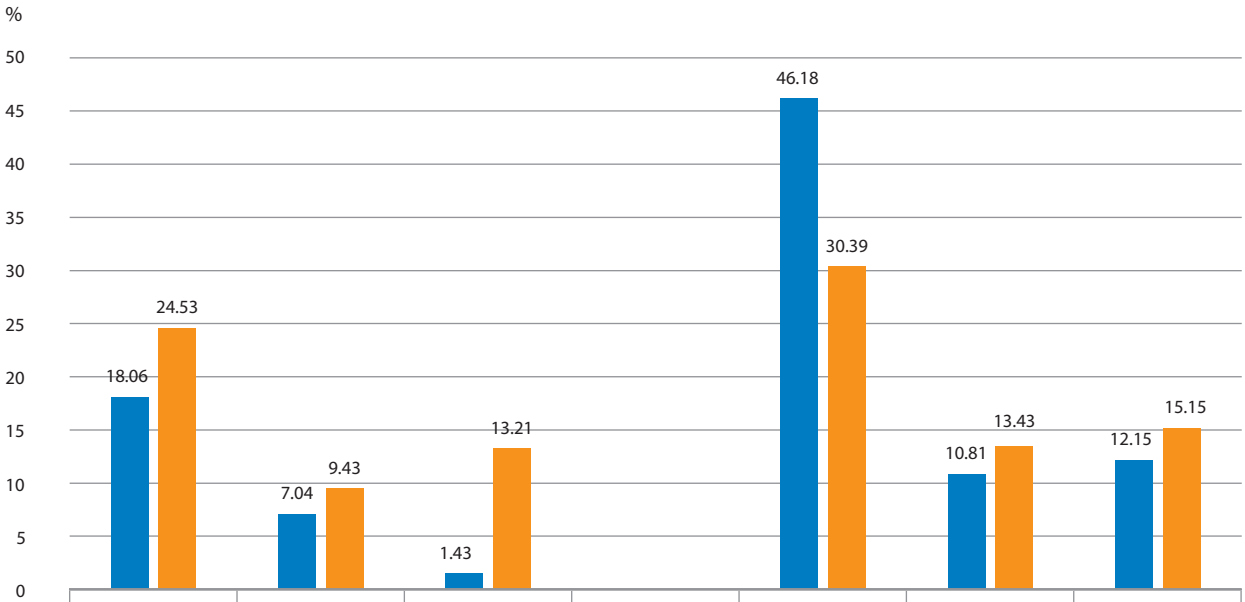
	It is OK for middle/ high school students to date	It is OK for a boy to date another boy	It is OK for a girl to date another girl	It is OK for middle/ high school students to date	It is OK for a boy to date another boy	It is OK for a girl to date another girl
	12-14			15-24		
Visual	28.57	9.52	9.52	59.24	19.08	15.89
Hearing	24.14	10.34	6.9	25.37	9.8	14
Physical	17.33	6.76	5.48	36.54	5.77	8.51

Figure 12. Attitudes to intimate relations, by area (urban and rural)



	It is OK for middle/ high school students to date	It is OK for a boy to date another boy	It is OK for a girl to date another girl	It is OK for middle/ high school students to date	It is OK for a boy to date another boy	It is OK for a girl to date another girl
	12-14			15-24		
Urban	21.57	12	8	37.35	14.81	17.84
Rural	20.27	5.41	5.48	41.47	8.76	8.33

Figure 13. Attitudes to intimate relations, by sex

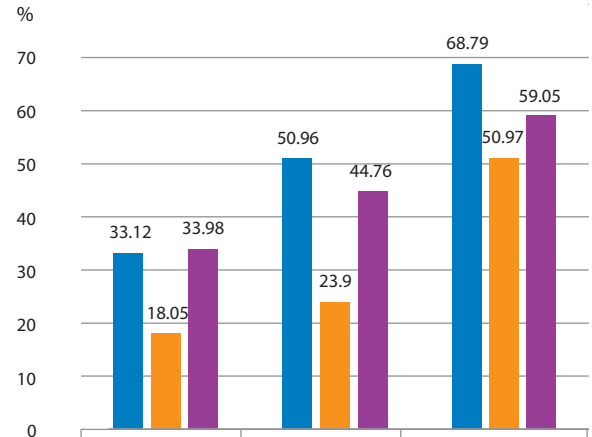


	12-14			15-24		
	It is OK for middle/ high school students to date	It is OK for a boy to date another boy	It is OK for a girl to date another girl	It is OK for middle/ high school students to date	It is OK for a boy to date another boy	It is OK for a girl to date another girl
Male	18.06	7.04	1.43	46.18	10.81	12.15
Female	24.53	9.43	13.21	30.39	13.43	15.15

of awareness of safe sex among young persons with hearing disabilities indicates a need for greater support for this group. Participants from urban areas were more aware of safe sex (Figure 15) than their counterparts from rural areas. However, no significant differences were identified in rural and urban areas in relation to young people's attitudes towards pre-marital sex.

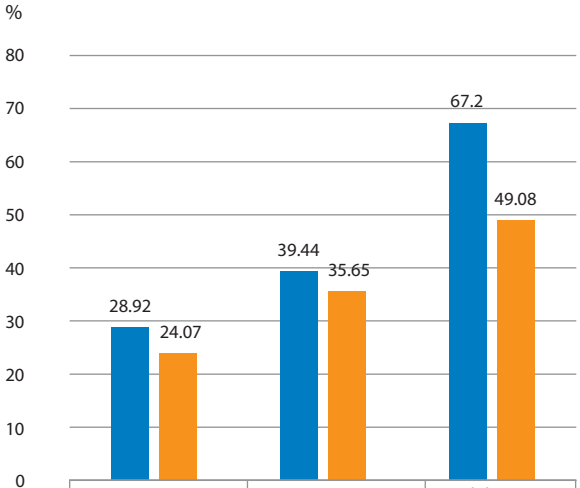
Male participants showed a more positive attitude towards premarital sex than females, but no gender differences were observed in terms of their awareness about safe sex (Figure 16).

Figure 14. Attitudes to premarital sex, by type of disability



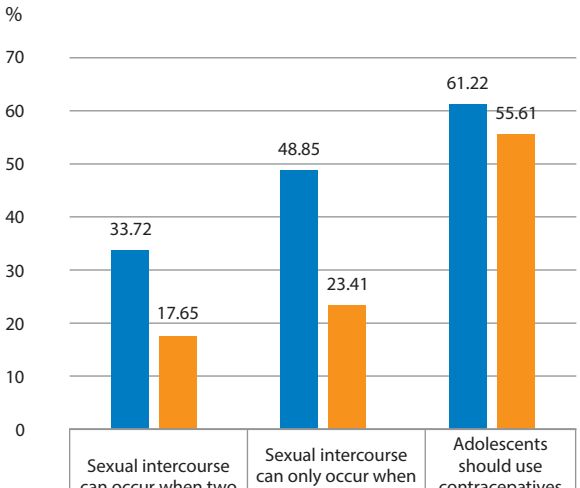
	Sexual intercourse can occur when two person are willing	Sexual intercourse can only occur when two person love each other	Adolescents should use contracepatives during sexual inter-course
Visual	33.12	50.96	68.79
Hearing	18.05	23.9	50.97
Physical	33.98	44.76	59.05

Figure 15. Attitudes to premarital sex by area



	Sexual intercourse can occur when two person are willing	Sexual intercourse can only occur when two person love each other	Adolescents should use contracepatives during sexual intercourse
Urban	28.92	39.44	67.2
Rural	24.07	35.65	49.08

Figure 16. Attitudes to premarital sex, by sex (male and female)



	Sexual intercourse can occur when two person are willing	Sexual intercourse can only occur when two person love each other	Adolescents should use contracepatives during sexual intercourse
Male	33.72	48.85	61.22
Female	17.65	23.41	55.61

Attitudes towards gender equality and gender roles.

In general, the majority of the study participants disagreed with statements representing unequal gender roles. Thus, most of the participants indicated support for gender equality. For example, around 79 per cent of those aged 12 to 14 and around 73 per cent of those aged 15 to 24 agreed with the statement, 'men and women have shared responsibility in childrearing and house chores' (Figure 17). However,

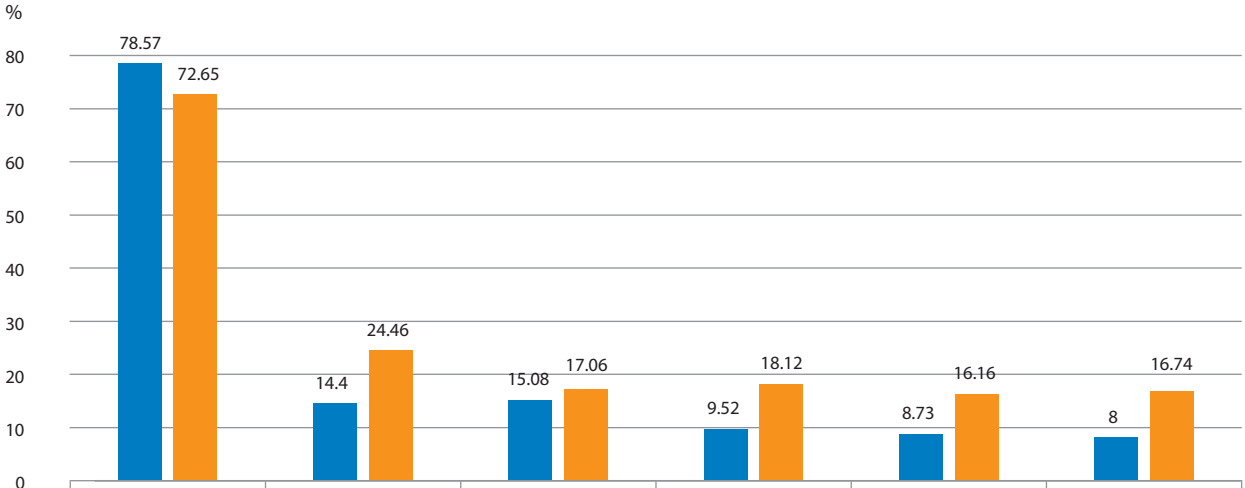
attitudinal differences were observed between the two age groups. For example, almost a quarter (24.46 per cent) of the participants aged 15 to 24 felt that 'It is more important for boys to do well in schools than for girls', versus only 14.4 per cent of the participants in the 12 to 14 age group (Figure 17). Similarly, only 8.73 per cent of the participants aged 12 to 14 agreed that 'preventing pregnancy is mainly a female responsibility', whereas 16.16 per cent of the participants in the 15 to 24 age group felt this way.

It would be interesting to explore whether attitudinal differences based on age are indicative of a trend in the larger population of young people with disabilities and, if so, it would be worthwhile to find out what might have caused these differences and how they could be addressed. Regardless, the findings indicate the importance of providing education about gender equality for children with disabilities, in schools, families and society.

When the results of the study were compared with those of a study conducted among students without disabilities in six Chinese provinces (Shanghai Institute of Planned Parenthood Research, 2012), the researchers found that a lower percentage of young people with disabilities express views supportive of gender equality compared to their peers without disabilities. For example, while 78.57 per cent of young people with disabilities from the 12 to 14 age group agreed with the statement 'Men and women should share responsibility for childrearing and house chores' (Figure 17), the percentage among their peers without disabilities was 92.23 per cent. The percentages for the 15 to 24 age group were 72.65 per cent and 94.39 per cent, respectively.

The attitudinal differences between young people with and without disabilities is starker for the 15 to 24 age group. For example, for the three statements expressing unequal gender roles: 'men/boys should have more authority than women/girls in families', 'preventing pregnancy is mainly a female

Figure 17. Attitudes towards gender roles, by age group



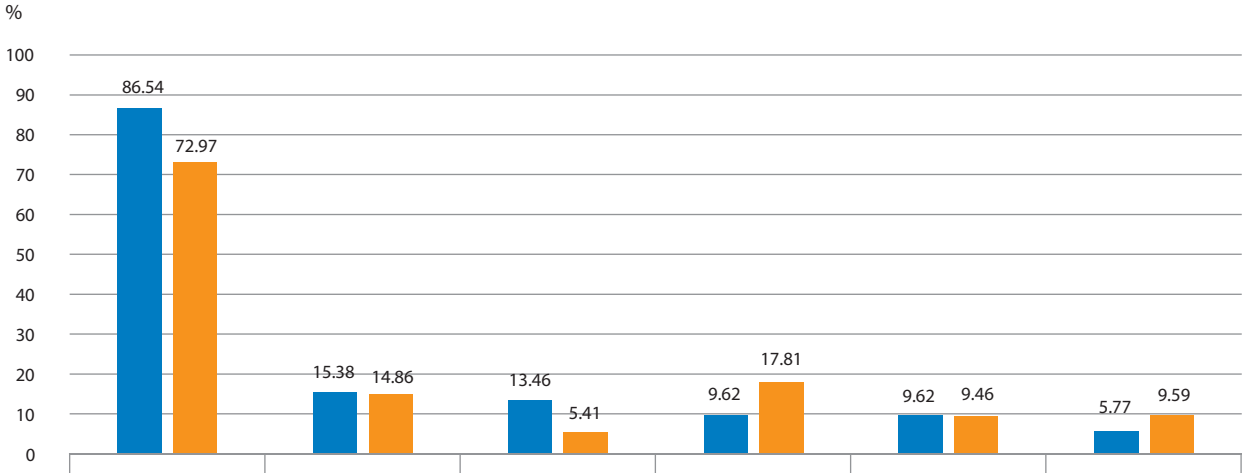
	Sharing childrearing and house chores	More important for boys to do well in schools	A girl/woman should not actively express her infatuation	Men should have more authority within family	Contraception is a female resonsibility	A girl/woman cannot refuse sexual requests from her partner
12-14	78.57	14.4	15.08	9.52	8.73	8
15-24	72.65	24.46	17.06	18.12	16.16	16.74

responsibility', and 'a woman/girl cannot refuse her husband/boyfriend's request for sexual intercourse', the percentages of participants in this study who agreed with these statements were 18.12 per cent, 16.16 per cent, and 16.74 per cent (Figure 17), respectively, compared to 12.7 per cent, 6.35 percent and 13.81 per cent, respectively, among their counterparts without disabilities.

When the responses of participants in urban areas were compared with those of their rural counterparts, the researchers found that those who agreed with the statements expressing unequal gender roles tended to be from rural areas and in the 15-24 age group. For example, 22.12 per cent of the participants aged 15 and 24 living in rural areas agreed with the statement, 'a woman/girl cannot refuse her husband/boyfriend's request for sexual relationship/sexual intercourse', versus 12.05 per cent of their peers from urban areas (Figure 18b). Moreover, only 57.41 per cent of the participants from rural areas agreed that 'men and women have shared responsibility in childrearing and house chores' against 85.71 per cent of those from urban areas (Figure 18). This indicates that participants from rural areas hold more conservative attitudes, which is probably related to the comparatively more conservative gender norms in rural areas.

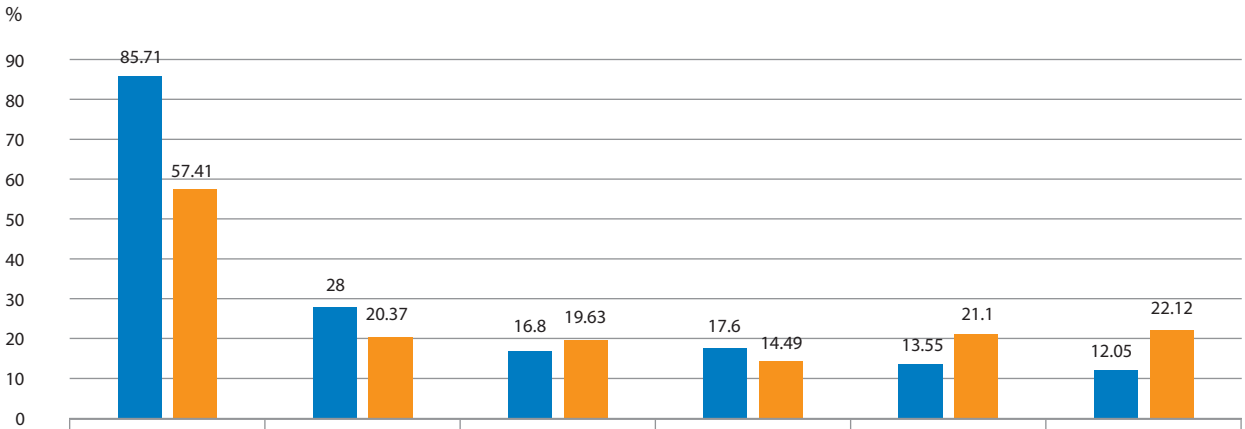
No significant differences were found in the attitudes toward gender roles among participants with different types of disabilities. However, a difference was found based on sex, with male participants aged 15-24 tending to agree with statements expressing unequal gender roles more than female participants. For example, while almost a quarter (24.15 per cent) of the boys aged 15-24 agreed with the statement that 'men/boys should have more authority than women/girls within families', only 10.29 per cent of the girls in this age group agreed. Likewise, while 29.66 per cent of the boys agreed that 'It is more important for boys to do well in schools than for girls', only 17.73 per cent of the girls of the same age group agreed (Figure 19b). Among the respondents aged 12-14, a higher percentage of girls than boys agreed that 'men and women should share child-rearing and hosue chores'. This shows a need to improve gender equality awareness among boys, therefore it is important to ensure boys' involvement in interventions aimed at promoting gender equality and the rights and well-being of women and girls with disabilities.

Figure 18a. Attitudes to gender roles, by area (urban and rural) among respondents aged 12 to 14



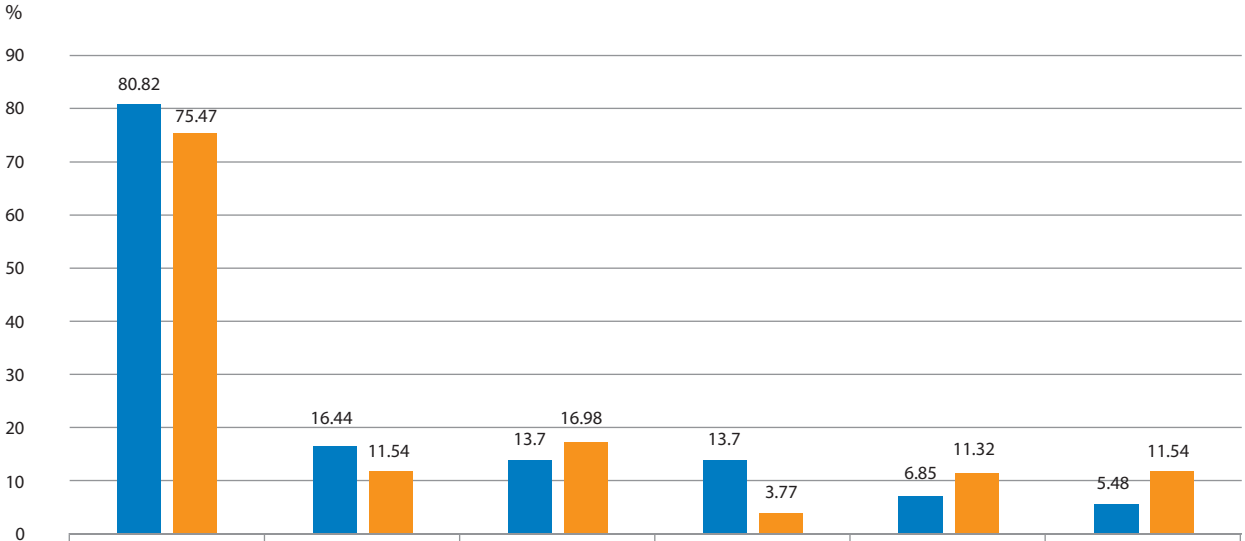
	Sharing childrearing and house chores	A girl/woman should not actively express her infatuation	Contraception is a female responsibility	More important for boys to do well in schools	Men should have more authority within family	A girl/woman cannot refuse sexual requests from her partner
	12-14					
Urban	86.54	15.38	13.46	9.62	9.62	5.77
Rural	72.97	14.86	5.41	17.81	9.46	9.59

Figure 18b. Attitudes to gender roles, by area (urban and rural) among respondents aged 15 to 24



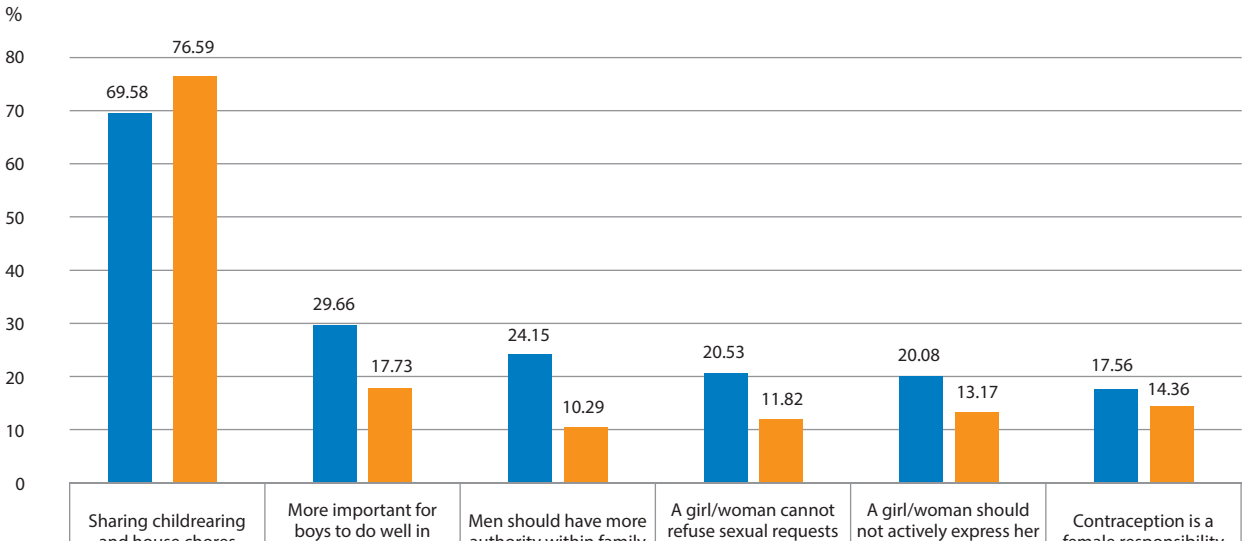
	Sharing childrearing and house chores	More important for boys to do well in schools	Men should have more authority within family	Contraception is a female responsibility	A girl/woman should not actively express her infatuation	A girl/woman cannot refuse sexual requests from her partner
	15-24					
Urban	85.71	28	16.8	17.6	13.55	12.05
Rural	57.41	20.37	19.63	14.49	21.1	22.12

Figure 19a. Attitudes to gender roles, by sex (male and female), 12-14 age group



	Sharing childrearing and house chores	More important for boys to do well in schools	A girl/woman should not actively express her infatuation	Men should have more authority within family	Contraception is a female responsibility	A girl/woman cannot refuse sexual requests from her partner
	12-14					
Male	80.82	16.44	13.7	13.7	6.85	5.48
Female	75.47	11.54	16.98	3.77	11.32	11.54

Figure 19b. Attitudes to gender roles, by sex (male and female), 15-24 age group



	Sharing childrearing and house chores	More important for boys to do well in schools	Men should have more authority within family	A girl/woman cannot refuse sexual requests from her partner	A girl/woman should not actively express her infatuation	Contraception is a female responsibility
	15-24					
Male	69.58	29 .66	24.15	20.53	20.08	17.56
Female	76.59	17.73	10.29	11.82	13.17	14.36

3.4 Intimate relationships and behaviour

Intimate relationships

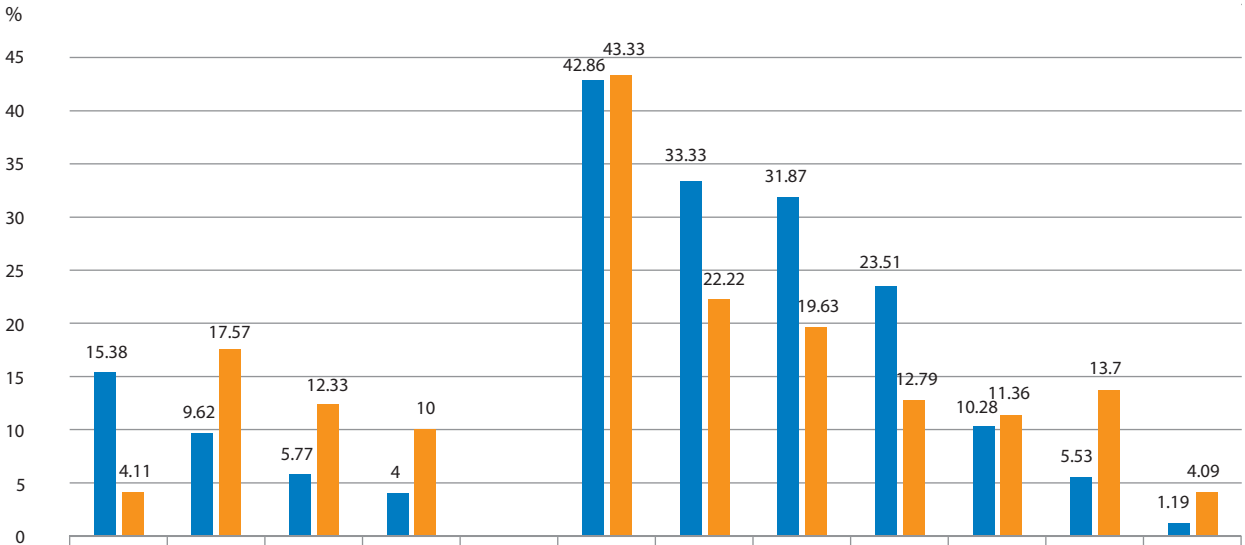
Among the participants in the 12 to 14 age group, 14 per cent reported having had intimate relationships with the opposite sex, while 26 per cent of those aged 15 to 24 reported this. No major differences were identified between the young people with and without disabilities for the age group of 12-14, but engaging in intimate relations appears to be less common among young people with disabilities aged 15-24 (26 per cent) in comparison to their counterparts without disabilities (42 per cent)(Shanghai Institute of Planned Parenthood Research, 2012), especially in rural areas.

Around a tenth (10.78 per cent) of the participants aged 15 to 24 expressed interest in having intimate relationships with persons of the same sex and 2.75 per cent reported having done so; these percentages are slightly lower than those of young people without disabilities (11.49 per cent and 5.96 per cent respectively).

Masturbation

Of the participants in the 12-14 age group, 8.8 per cent reported having experienced masturbation, while 18.51 per cent of those aged 15 to 24 reported having done so. The percentage was highest among participants with visual disabilities, and was lowest among those with hearing disabilities . Male and urban participants reported to maturbate more than girls and participants from rural areas. The percentage of participants with disabilities in the 15-24 age group who reported having experienced masturbation (male: 26.59 per cent, female: 7.88 per cent) was higher than that of their counterparts without disabilities (male: 24.4 per cent, female: 3.6 per cent) (Du et al, 2012).

Figure 20. Sexual behaviour among young people with disabilities, by area (urban and rural)



	12-14				15-24						
	Masturbation	Heterosexual dating	Interested in the same sex	Sexual acts	Using protection in heterosexual acts	Using protection in homosexual acts	Heterosexual dating	Masturbation	Interested in the same sex	Heterosexual acts	Homosexual acts
Urban	15.38	9.62	5.77	4	42.86	33.33	31.87	23.51	10.28	5.53	1.19
Rural	4.11	17.57	12.33	10	43.33	22.22	19.63	12.79	11.36	13.7	4.09

Sexual intercourse

Around a tenth (10.36 per cent) of the participants aged 15 to 24 reported having had sexual intercourse: 9.32 per cent with partners of the opposite sex and 2.54 per cent with partners of the same sex.

Further analysis of the data found that while 15.71 per cent of the young people with disabilities in the 20 to 24 age group reported having had sexual intercourse with the opposite sex, only 4.25 per cent of the participants from the age group 15 to 19 reported having done so. These rates are lower than those reported by young people without disabilities in a 2009 national survey, which found that 38.6 per cent of those aged between 20 and 24 reported having had sexual intercourse with the opposite sex and 9.4 per cent of the participants aged between 15 and 19 reported having done so (Peking University Population Research Institute et al, 2010).

In contrast, the percentage of the study participants aged 15-24 who reported having had sex with a partner of the same sex (2.54 per cent) was higher than that of young people without disabilities (1.75 per cent)(Shanghai Institute of Planned Parenthood Research, 2012).

Participants in rural areas reported being more sexually active than their peers in urban areas, with 15 per cent of rural young people aged 15 to 24 reporting being sexually active, versus 6.32 per cent of their counterparts in urban areas. Although not statistically significant, a similar urban-rural differnce was also observed among young people aged 12-14: 10 per cent of those living in rural areas reported having had sexual intercourse compared to 4 per cent of their counterparts in urban areas.

The study findings also indicate that young people aged 15-24 with hearing and physical disabilities are more sexually active (13.52 per cent and 12.96 per cent) than their counterparts with visual disabilities (4.43 per cent). Furthermore, a significantly higher percentage (20.25 per cent) of young people with hearing disabilities from rural areas reported being sexually active than those from urban areas (5.51 per cent), but no major urban/rural difference was identified for other types of disabilities. Participants with hearing disabilities also reported higher rates of homosexual behaviour than those with visual and physical disabilities, with a significant rural-urban difference (11.25 per cent of participants from rural areas versus 1.57 per cent of participants from urban areas).

Safe sex practices

Only 44.90 per cent of the participants from the 15 to 24 age group reported having used contraceptive/protective measures during their first sexual intercourse. This result is similar to the findings of a national survey of unmarried youth without disabilities, conducted in 2009, which found that 48.8 per cent of the respondents in the 15 to 24 age group used contraception at their sexual debut (Peking University Population Research Institute et al, 2010).

No significant difference was identified between male and female participants in terms of contraception/protection during their first sexual experience. There was no significant difference found either between the two age groups of 15-19 and 20-24 in this respect. Likewise, no significant difference was observed between the participants from urban and rural areas in terms of safe sex practices (Figure 20).

The data indicates that young people with disabilities are less likely to practice safe sex when in homosexual relationships than when in heterosexual relationships. While 43.18 percent of the sexually-active participants who had their first sexual experience with partners from of the opposite sex used protection during their sex debut, only a quarter of the participants with same-sex partners did so.

The findings suggest that some young people with disabilities could be highly vulnerable to SRH-related risks such as STIs (including HIV) and unintended pregnancies. Young people with hearing or physical disabilities, for example, were found to be more sexually active than their peers with other type of disability, but also less inclined to practice safe sex, especially when engaging in same-sex relationships, so are exposed to higher risks. It would be worth exploring if the lower rate of safe sex behaviour among young people with disabilities engaging in same-sex relations is related to their greater social exclusion and isolation, and how the accessibility of SRH information and services plays a part in this.

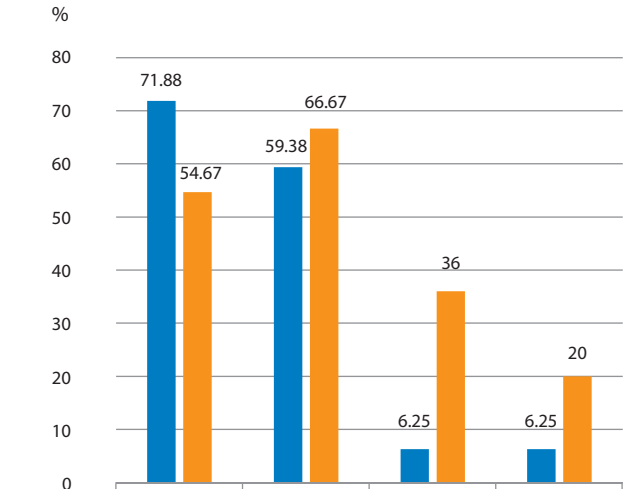
3.5 Sexuality-related knowledge and behaviour among young people with intellectual disabilities

Levels and sources of knowledge

Young people with intellectual disabilities demonstrated a much lower level of understanding about sexuality in comparison with their peers with other types of disabilities. For example, only 31.25 per cent of young people with intellectual disabilities aged 12 to 14 and 59.72 of those aged 15 to 24 reported having heard of HIV and AIDS, compared to 80.77 per cent and 92.03 per cent, respectively, of their peers with physical, visual and hearings disabilities. Similarly, only 19.57 per cent of the male participants aged 15 to 24 with intellectual disabilities reported knowing about nocturnal emissions, compared to 59.13 per cent of their peers with physical, visual and hearing disabilities.

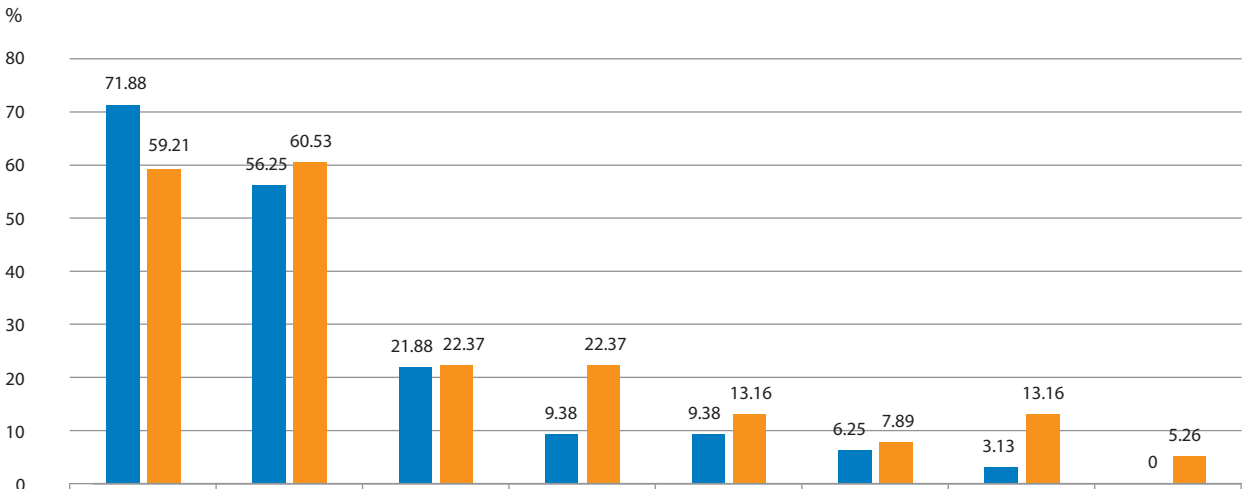
Parents and school teachers were reported to be the main sources of information about sexuality (Figure 21) and also the most preferred sources (Figure 22).

Figure 22. Preferred channels for acquiring sexuality-related information, by age group



	Parents	School/ teachers	Community	Hosptial
12-14	71.88	59.38	6.25	6.25
15-24	54.67	66.67	36	20

Figure 21. Sources of sexuality-related information, by age group



	parents	schools/teachers	TV/broadcast/ radio	Internet	peers/class-mates/friends	all plural	books/maga-zines/newspa-pers	professionals (doctors/nurses/ hotlines)
12-14	71.88	56.25	21.88	9.38	9.38	6.25	3.13	0
15-24	59.21	60.53	22.37	22.37	13.16	7.89	13.16	5.26

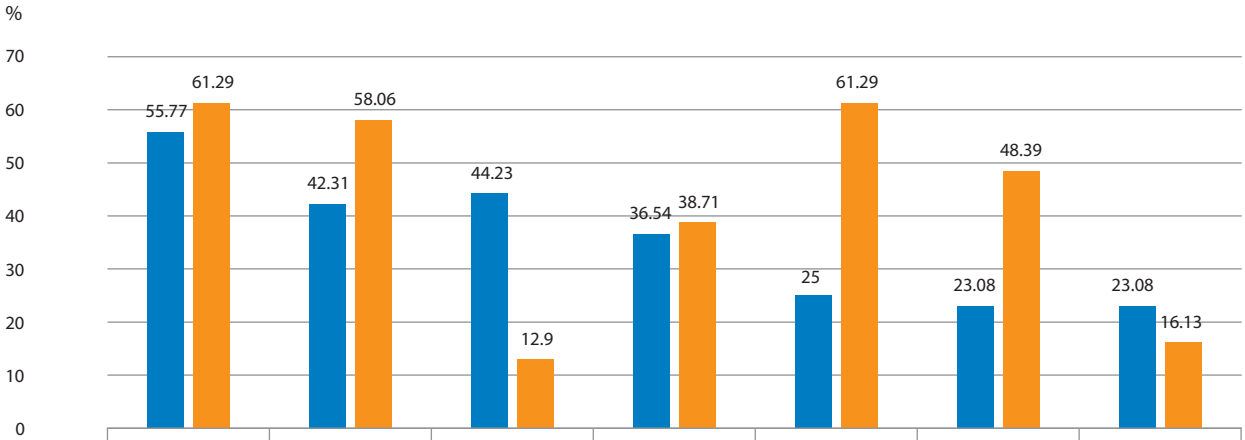
As illustrated in Figure 23a and Figure 23b, many of the surveyed young people with intellectual disabilities expressed a strong need for information on multiple sexuality-related topics. For certain subjects, such as reproductive system, friendship/love/marriage, pregnancy and childbirth, they reported a much higher interest than their counterparts with visual, hearing and physical disabilities.

Behaviour and relations

The lack of sexuality-related knowledge of young people with intellectual disabilities was accompanied by a high level of behaviour that teachers, among others, perceived as being inappropriate. Such behaviour included female students not being able to dispose of sanitary napkins appropriately; unintended pregnancies among some female students; male students undressing or masturbating in public; hugging or kissing somebody and touching other people's breasts and genitalia without permission.

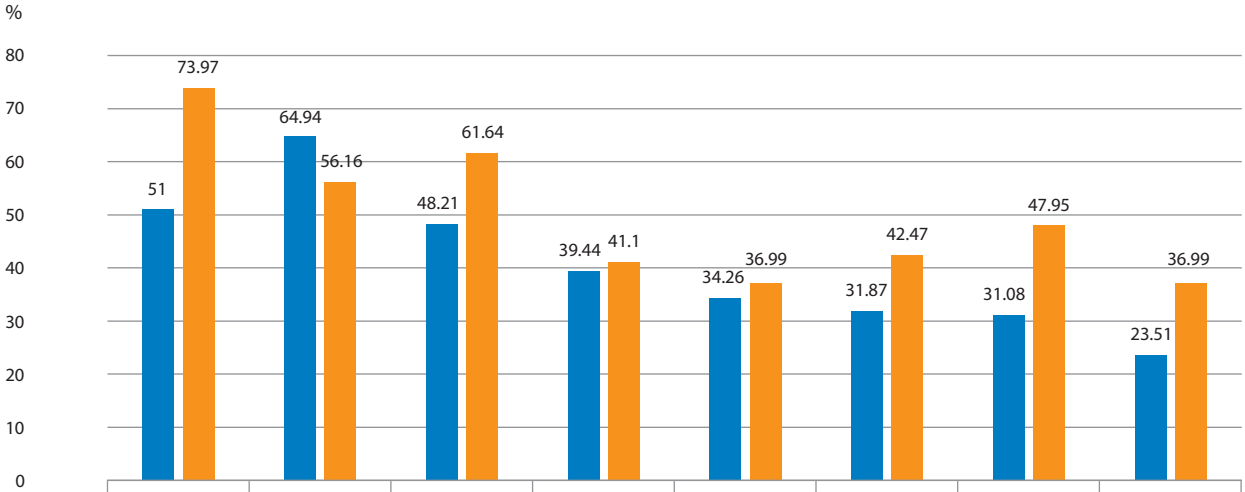
The study found that 15.63 per cent of the participants with intellectual disabilities aged 12 to 14 had had intimate relations with persons of the opposite sex, and 10.34 per cent of the participants with intellectual disabilities reported an interest in establishing intimate relationships with others of the same sex but had never been in such a relationship. Among the participants with intellectual disabilities aged 15 to 24, 18.67 per cent reported having had intimate relations with the opposite sex; 8.33 per cent had engaged in intimate physical contact such as kissing and caressing; 4 per cent had had sexual intercourse with the opposite sex; and 13.16 per cent expressed an interest in intimate relations with persons of the same sex. No significant differences were identified between the male and female participants for both age groups.

Figure 23a. Need for sexuality-related information among those aged 12 to 14, by type of disability



	Puberty change	Friendship, love and marriage	STIs/HIV prevention	Sexual harassment/ abuse/self-protection	Reproductive system	Pregnancy and childbirth	Sexual orientation
	12-14						
Other disabilities	55.77	42.31	44.23	36.54	25	23.08	23.08
Intellectual disabilities	61.29	58.06	12.9	38.71	61.29	48.39	16.13

Figure 23b. Need for sexuality-related information among those aged 15 to 24, by type of disability



	Friendship, love and marriage	Puberty change	Sexual harassment/abuse/self-protection	STIs/HIV prevention	Contraception and abortion	Reproductive system	Pregnancy and childbirth	Sexual orientation
	15-24							
Other disabilities	51	64.94	48.21	39.44	34.26	31.87	31.08	23.51
Intellectual disabilities	73.97	56.16	61.64	41.1	36.99	42.47	47.95	36.99

Box 1. Case study: Amy's story

Amy (a pseudonym) is 16 years old and lives in Guangzhou. She is a young person with Down syndrome and was transferred from her mainstream elementary school to a special education school when she was in Grade 3. When interviewed for this study, she was attending the first year of vocational school. Her mother worked at a Special Children's Parents Club for about three years and then became a school-based social worker at Amy's school.

At the age of about 11 or 12, Amy often said that she really liked her sports teacher. One day he got married and left the school. Amy stopped talking about him, but Amy's mother realized that her daughter could benefit from learning more about her own physical and emotional development and decided to enroll her in the special children's sexuality education courses at the children's activity centre. The course material was drawn from *We are growing up: Sexuality education lesson plans for children with disabilities (Quint, 2010),* the first sexuality education material for children with intellectual disabilities published in China. This material covers topics such as physiology, anatomy, puberty change, menstruation, nocturnal emissions, reproduction, sexual desire, private body parts, self-protection, etc. Amy was also able to attend sexuality education classes at her special education school, the first in her city to introduce sexuality education, and to access additional resources and information at home, thanks to the constant support of her mother.

Amy's mother did not receive any training on how to support her child in terms of sexuality education, she just used her common sense and did her best to acknowledge and address Amy's needs, attempting to educate her in the same way as any other child, regardless of her disability. Amy learned about menstruation and self-protection from

her mother before her menarche. Materials about puberty and privacy, and about preventing sexual abuse were important learning resources for Amy, together with other materials available at the the local library, where she registered with the support of her mother. Amy also had access to a mobile phone and a computer to watch videos.

Amy's mother reported that her daughter Amy had great interest in learning about sexuality, and had hopes for love, marriage and reproduction. Amy expressed the same during the interview in the following terms:

I like reading about that, always reading about puberty, growing up, pregnancy. I like reading every time, borrow books, borrow books from library. Medical books, pregnancy books are on the seventh floor, borrow two books at a time. I often read Angel Knows I Love You. [In this book] there is a love story, a five-year-old boy. He courted two little girls. I also [watched] much TV. I especially like watching 'If You are the One' (a dating show). The male guest comes out, the process of selecting female partner. First get to know, then if they know each other for a long time, they become friends, friends can be together, after half a year, they can engage in romantic relationship, after several years, four or five, then get married, after another half year, they can live in the same room, if they live in the same room, man can emit sperm. You know, when sperm is emitted, man can emit sperm into the uterus of the woman.

Amy was able to provide correct answers to the sexuality-related questions posed by the researchers during the present study, demonstrating that children with disabilities are able to learn about sexuality when appropriate education and support is provided, and that it is a lack of accessible sexuality education rather than their disability that prevents children from learning about sexuality.

Amy one day received a love letter from another student. She showed it to her mother, who recalled the letter ending with the question, 'Would you be my friend?'. The mother asked Amy how she intended to reply to the boy, and Amy took some time to think about it. One day she told her mother: 'I have replied already. I wrote: we are friends already!' Amy's mother was very proud to see her daughter dealing with the situation and to discover that she could properly express her feelings to the boy.

The way that Amy talks about sexuality, marriage and reproduction was different from that observed in other young people with intellectual disabilities who participated in this study. When asked about their sexual behaviour, most of the other interviewees directly jumped to 'sexual assault is bad', and when asked whether they had thought about marriage and having children they answered, 'we cannot'. Amy, instead, was able to show a positive attitude towards sexuality and human relations.

When asked about whether or not special education schools should provide sexuality education, Amy answered:

This is a human right, a right for the challenged and disabled. Whether disabled or not, they all have their rights. When a boy with autism likes a girl, he likes to stand shoulder to shoulder, lie down or have other behaviours. Sexuality education will be very helpful for autistic kids, and even greater help for children with Down syndrome and cerebral palsy.

3.6 Sexual abuse of young people with disabilities

Studies conducted in other countries have shown that people with disabilities face a greater risk of sexual abuse than people without disabilities.(Hughes et al, 2012; Jones et al, 2012). This study examined to what extent Chinese young people with disabilities experience sexual abuse by asking the questions:

Question 1:*'Has any adult forced or persuaded you to take off your clothes for him/her, to watch or touch your private parts or breasts?'* and
Question 2: *'Has any adult intruded in or hurt your private part with an object or forced you into sexual intercourse?'*

The responses to these questions indicated that 3.97 per cent of the participants with visual, hearing and physical disabilities aged 12 to 14 had experienced sexual abuse (answering 'yes' to either question 1 or 2), with 1.59 per cent answering 'yes' to the first question and 2.4 per cent answering 'yes' to the second question. A larger percentage (5.07 per cent) of those aged 15 to 24 reported having experienced sexual abuse (answering 'yes' to either question 1 or 2), with 3.81 per cent answering 'yes' to the first question and 2.35 per cent answering 'yes' to the second question.

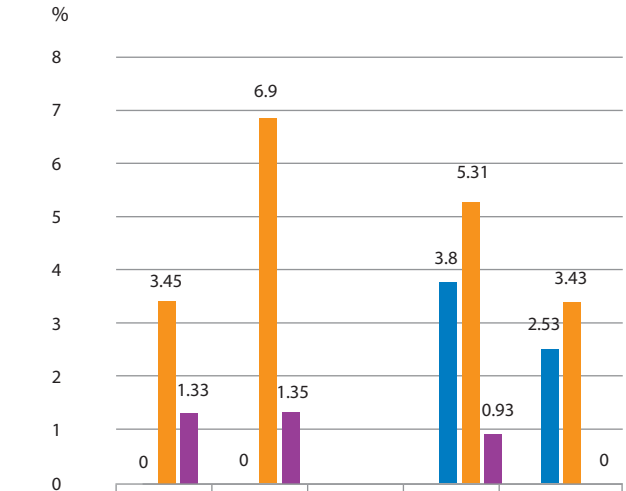
The participants with visual and hearing disabilities aged 15 to 24 had experienced higher rates of sexual abuse than their peers with physical disabilities, while the participants with visual and hearing disabilities aged 12-14 did not report experiencing significantly higher rates of sexual abuse than their peers with physical disabilities(Figure 24).

Analysis of the questionnaire responses found that participants from urban areas had experienced higher rates of sexual abuse than participants from rural areas (see Figure 25).

The responses to the questions indicate that for both age groups, a higher percentage of boys aged 12 to 14 have experienced sexual abuse, but no significant statistical difference was observed (Figure 26).

Participants with intellectual disabilities aged 12 to 14 did not report any experience of sexual abuse. Among those aged 15 to 24, 5.26 per cent reported experiencing adults forcing them to or deceiving them into taking off their clothes (answering 'yes' to Question 1), a percentage similar to that of their counterparts with visual, hearing and physical disabilities from urban areas (4.74 per cent, Figure 25).

Figure 24. Sexual abuse experienced by young people with visual, hearing and physical disabilities, by age group and type of disability



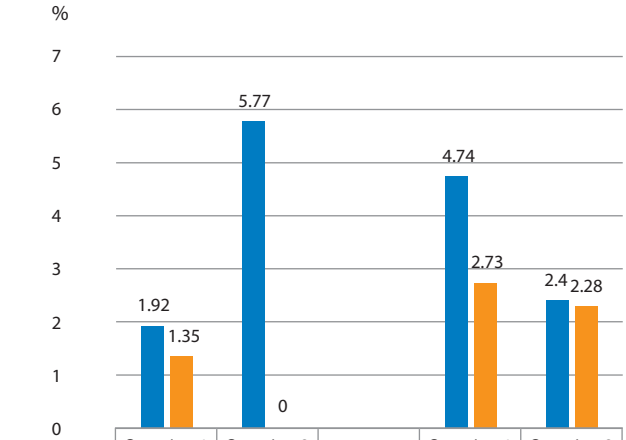
	12-14		15-24	
	Question 1	Question 2	Question 1	Question 2
Visual	0	0	3.8	2.53
Hearing	3.45	6.9	5.31	3.43
Physical	1.33	1.35	0.93	0

Overall, the level of sexual abuse found by this study was similar to that identified in similar studies conducted among young people without disabilities. A study conducted in six Chinese provinces and cities among university students without disabilities, for example, found that 7.4 per cent of the respondents had had their private parts or breasts touched by others against their will before they were 16, and 3.4 per cent had experienced attempts by others to have sexual intercourse with them against their will (Chen et al, 2010). Similarly, another study, conducted in six cities in China among middle school students (grade 9-12) without disabilities, found that 2.6 per cent of the respondents were victims of rape or had experienced attempted rape (Chan et al, 2012).

Previous studies have highlighted that young people with disabilities are at greater risk of sexual violence (Hughes et al, 2012; Chan et al, 2012), but no in-depth studies have been conducted in China so far on this topic. Violence against young people with disabilities is an area that deserves further

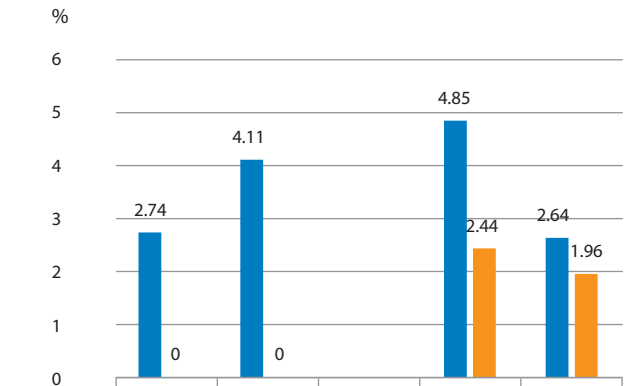
attention in China, as in many other countries, in order to fully understand the risks and vulnerabilities that young people with disabilities are exposed to. The first national domestic violence law, which entered into force in 2016 (The National People's Congress of the People's Republic of China, 2015), may create the space to further explore and address violence against people with disabilities in the domestic context. Exploring and discussing the intersections between violence and disability is the first step towards promoting a safer environment for all.

Figure 25. Sexual abuse experienced by young people with visual, hearing and physical disabilities, by age group and area (urban and rural)



	12-14		15-24	
	Question 1	Question 2	Question 1	Question 2
Urban	1.92	5.77	4.74	2.4
Rural	1.35	0	2.73	2.28

Figure 26. Sexual abuse experienced by young people with visual, hearing and physical disabilities, by age group and sex



	12-14		15-24	
	Question 1	Question 2	Question 1	Question 2
Male	2.74	4.11	4.85	2.64
Female	0	0	2.44	1.96

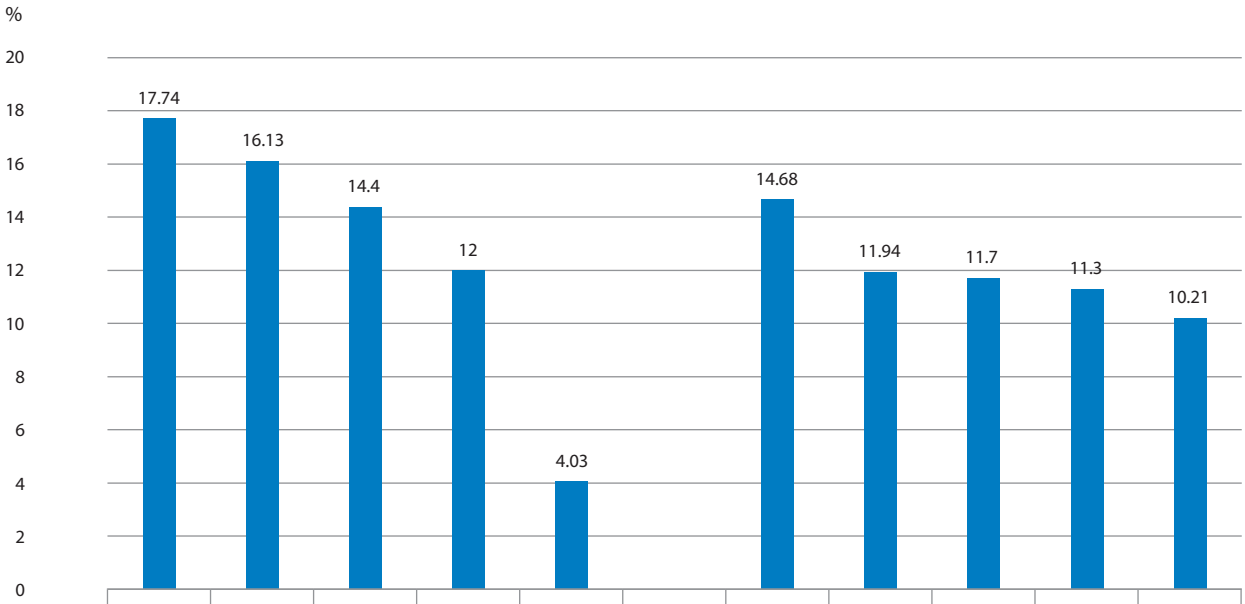
3.7 Access to SRH services

The findings of this study indicate that SRH services remain largely unaccessible for young people with disabilities, in both urban and rural settings. Less than 20 percent, or largely between 10 to 15 percent of the respondents of both age groups reported that their schools or communities had provided counselling or referral services or free contraceptives(see Figure 27).

Apart from the counselling services offered in some special education schools in urban areas, this study found no accessible SRH service programmes tailored to the needs of young people with disabilities. This limited access to counselling, referral, free contraceptives and legal assistance inevitably puts young people with disabilities in a more vulnerable position and exposes them to greater SRH risks. Schools and communities should respond to the SRH needs of young people with disabilities by addressing the barriers they face in accessing SRH services and ensuring that these are fully accessible.

Most of the participants from urban areas interviewed in this study supported the idea that young people with disabilities should have access to SRH services. Their counterparts from rural areas did not express a need to access SRH services as strongly.

Figure 27. Availability of school-based and community-based SRH services for young people with disabilities, by age group



	Community counseling	Community legal aid	School counseling	School referral service	Community free contra-ceptives	Community counseling	School referral service	Community legal aid	School counseling	Community free contra-ceptives
	12-14					15-24				
SRH services	17.74	16.13	14.4	12	4.03	14.68	11.94	11.7	11.3	10.21

3.8 Parents and teachers' attitudes

The vast majority of the parents and teachers reached by this study believe that sexuality education is necessary or important for young people with disabilities. Of all the parents and teachers interviewed in the study, only one parent (the mother of a child with physical disabilties) and one teacher (working with students with physical disabilties) reported that it was unnecessary to provide information about reproduction and contraception to children with severe physical disabilties. They did not consider it necessary because , in their opinion, engaging in sexual relations is directly linked to procreation within marriage and it is impossible for these children to get married.

Parents' attitudes

Almost all of the surveyed parents from urban areas felt that it is important to provide sexuality education for young people with disabilities and nearly two thirds felt that these young people are more in need of sexuality education than their peers without disabilities.

According to the parents' responses, sexuality education should cover the following topics: puberty change, sexual relationships, self-protection, and HIV and AIDS. The vast majority (80 per cent) of the parents also reported that self-protection is of vital importance for young people with disabilities. However, most were in favour of postponing the provision of information about pregnancy, abortion, contraception and STIs until young people graduate from high school. Some of parents felt that sexuality education should first prioritize young people against the danger of having sex too early in life.

Two thirds of the parents from urban areas reported that although they were willing to provide sexuality education to their children, they did not do so because: their children did not explicitly ask for it; they felt too shy to take the initiative in introducing the topic; and/or they were unprepared or unequipped due to lack of knowledge, guidance and relevant materials.

Three quarters of the parents in rural areas reported that sexuality education is necessary for young people with disabilities, but 80 percent of this group of parents were not able to describe what topics sexuality education should cover. For the 20 per cent that were able to explain the contents of sexuality education, the responses indicate that their understanding of sexuality education is limited to the topics of physical development, hygiene, health care and self-protection.

Most parents from rural areas think that schools are in a better position to provide sexuality education than parents. However, two thirds of the parents living in rural areas felt that if children asked for information about sexuality they would be willing to provide it without feeling uncomfortable. The one third who were unwilling to provide information gave reasons such as being 'too shy'; being subject to their 'own persisting "feudal"' ideology'; 'the kids are too young, wait until they are at least 25'; 'the kids will naturally know when they grow older'; 'internet and TV all have it, so no need to teach it'; and 'our education level is low, so I don't know what to say'.

Although the majority of parents from rural areas were not against sexuality education, they still prioritized their children's school grades far more than their children's needs, interest, confusion and concerns regarding SRH.

Teachers' attitudes

Almost all of the teachers interviewed, in both urban and rural areas, felt that sexuality education should be offered to young people with disabilities, and it should vary according to the type and degree of disability. Teachers from urban areas explicitly noted that sexuality education should be provided to all young people, including to those with intellectual disabilities.

According to the teachers in rural areas, lack of relevant knowledge and guidance during puberty could have negative impacts on the physical and emotional development of young people with disabilities. For example, they may develop misconceptions about sex and consider it as something dirty, feel ashamed by nocturnal emissions, become afraid of menstruation, end up having sex too early, and/or experience unwanted pregnancies.

Of all the teachers interviewed in this study, those who had taught or were specialized in areas related to sexuality

education felt more strongly about the importance of sexuality education for young people with disabilities. These teachers thought that sexuality education should cover topics such as physical and emotional development, relationships, gender equality and self-protection. The school doctors interviewed in the study were more concerned about topics relating to health care and disease prevention, and felt that sexuality education should provide information on puberty, health care and HIV. The head teachers tended to emphasize the importance of guiding students on 'proper interactions with the opposite sex'.

Overall, the teachers felt that young people with physical and visual disabilities had a better capacity to learn than young people with other disabilities, and therefore felt that, with young people with physical and visual disabilties, it was possible to use the same teaching methods used with students without disabilities (with the exception of video materials, which could not be used for students with visual disabilites). They felt that young people with hearing disabilities were at a disadvantage when it came to the reading and comprehension of written texts, and therefore felt that more pictures, hand gestures and illustrative teaching methods should be used with this group. Teachers frequently recommended using repetition and interactive scenarios and simulations when teaching young people with intellectual disabilities, and recommended avoiding vague vocabulary.

The surveyed teachers acknowledged the internet as a source of relevant knowledge, but they expressed concern that the information obtained online might be shallow or even incorrect, and might mislead young people, and therefore should not be relied on solely.

3.9 School-based sexuality education for young people with disabilities: challenges and barriers

Despite having a positive attitude towards sexuality education, the surveyed teachers noted several difficulties in providing sexuality education to young people with disabilities. Four major challenges were identified:

Lack of teaching materials and tools. Teachers of special education schools normally use regular school teaching materials as a base, online resources as supplement, and then make adjustments according to the class reactions and the teachers' intuition. Due to the lack of standard teaching materials for students with disabilities, some teachers were unsure about whether or not to teach certain topics, such as contraception. Furthermore, they felt that the lack of teaching tools, such as human body structures, for example, decreased the efficiency of communicating key messages. Schools in rural areas face even greater challenges in obtaining appropriate teaching materials than schools in urban areas.

Lack of professionally trained teachers. Of all the teachers reached by this study, only teachers from one special education school for young people with hearing disabililties reported having received training in sexuality education. Almost all of the surveyed teachers expressed a need for relevant guidance and training on sexuality education.

Lack of parental support. According to the teachers, parents provide little support for sexuality education and tend to prioritize children's school grades. Parents with a low level of education and living in rural areas tend to hold the idea that school sexuality education would 'lead the kids astray'. In such circumstances, the teachers tend to take a perfunctory approach to teaching about sexuality.

General lack of understanding and recognition of the importance of sexuality education. Even the mainstream education system is lacking when it comes to sexuality education, and most schools, both normal schools and special schools, choose not to include it in their curricula. The interviewed school teachers pointed to the exam-oriented education system as a main reason for insufficient provision of sexuality education in schools.

4

CONCLUSIONS AND RECOMMENDATIONS

The study reveals that, overall, young people with disabilities have a relatively lower level of knowledge regarding sexuality and are exposed to greater SRH-related risks than their peers without disabilities.

The young people with disabilities who participated in this study were found to be generally aware of their SRH rights and needs. Although their needs for SRH information and services differed across the different types of disabilities, they all demonstrated needs similar to those of their counterparts without disabilities, as well as similar attitudes and behaviour regarding SRH.

Young people with disabilities, especially those living in rural areas and those with intellectual disabilities, face great challenges in accessing SRH information and services. This study challenges the widespread understanding that identifies young people's disabilities as a key barrier to accessing SRH information and services, and sought to draw attention to the external challenges and barriers that this population faces in accessing sexuality information and services. For example, the limited availability of sexuality education resources tailored for this group of young people represents a major barrier, which needs to be addressed.

Pilot projects have proved that, with access to appropriate sexuality education tools and methods, children with disabilities are able to learn (Handicap International France, 2007). The first 'Disability, Gender and Sexuality' pilot project implemented in China by Humanity & Inclusion and partners, also found that collaboration between local and international NGOs can contribute to scaling-up promising local initiatives to reach larger groups of children with disabilities (Aresu & Mac-Seing, 2018). Such experiences deserve to be further analyzed to identify good practices that can inform future projects.

Based on the results of the study, the following recommendations were formulated:

- **Raising awareness among stakeholders is the first key step.**

Overall, the the lack of recognition of young people with disabilities' legitimate SRHR and needs are hindering their access to SRH information and services. It is necessary to make all stakeholders aware that all young people, regardless of whether or not they have a disability, need access to sexuality education and that SRH information and services needs to be made accessible to all, including to young people with disabilities. Accordingly, the relevant research institutions and organizations, including United Nations agencies, should make collective efforts to raise awareness among relevant government officials and among formal and non-formal educators about the importance of providing sexuality education in schools and communities and via the internet. Young leaders with disabilities and organizations of persons with disabilities can play an important role in raising awareness.

- **Develop policies and curriculum guidelines for school-based sexuality education and support teacher capacity building.**

Although schools are a preferred source of sexuality-related information for young people with disabilities, many schools, particularly those in rural areas, do not attach due importance to sexuality education and do not provide students with adequate information. It is therefore recommended that the local education authority develop disability-inclusive policies, curriculum guidelines and monitoring and evaluation systems to ensure the implementation of disability inclusive school-based sexuality education. in the process of promoting inclusive education in general, the government shall fully consider how to meet the sexuality education needs of students with disabilities.

Sexuality education should be implemented, in both regular and special education schools, by designated sexuality education/puberty health teachers, who should receive adequate training. In the longer-term, sexuality education should be integrated into teacher education and special education curricula.

- **Sexuality education initiatives need to be tailored to the needs of young people with disabilities and ensure their full participation.**

To ensure sexuality education is disability-inclusive, accessible and relevant, it is important for the youth to have an active voice and role in designing and developing sexuality education. In particular, given that youth differ in their preferences regarding contents and channels for accessing sexuality related information, educators should engage young people in designing the content of their classes and use methods that best respond to their needs and preferences. For example, besides traditional classroom teaching and lectures, teachers could get feedback from students regarding the use of audio materials, computers, and smartphones with screen-readers as well as touchable

models for providing accessible information to young people with visual disabilities. Group discussions, supported by sign-language interpreters, printed pamphlets and educational videos with subtitles, could be used to share information with young people with hearing disabilities. For young people with intellectual disabilities, it is recommended schools offer individualized support to ensure all students can attend and fully benefit from regular sexuality education classes. Teachers should avoid the use of vague and unclear vocabulary, and use easy-to-understand pictures, videos, slides, models and role plays to convey information.

- **Mobilize and support parents' participation in sexuality education.**

Given that family is the first social learning environment for young people, and that parents play a central role in shaping children's attitude towards sexuality and have great influence over their decisions and behaviour (Zuo et al, 2006), it is important to support parents in providing sexuality education to their children. It is particularly important to support the parents of young people with disabilities living in rural areas, where there is limited access to sexuality education in schools. Studies have shown that schools can increase parents' skills and awareness, and thereby reduce the parent-child communication gap regarding sexuality, through organizing seminars and parent-child interactive activities as well as by disseminating informative leaflets (Zuo et al, 2006). Meanwhile, the family and community members shall be mobilized to demand more support to the provision of sexuality education for children and youth with disabilities.

- **Develop disability-inclusive SRH policy and improve access to SRH services for young people with disabilities.**

In China, overall, young people with and without disabilities, lack access to SRH services. The findings of the study indicate that young people with disabilities face even greater challenges than those without disabilities, as their need for SRH services often remains unacknowledged. The first step towards the development of more disability-inclusive SRH services for young people with disabilities is the recognition of their SRH needs and rights by the relevant government ministries, non-governmental organizations and service providers. Collaboration between governmental and non-governmental actors is essential, as is the participation of young people with disabilities at all stages, for designing and implementing an action plan for the development of accessible, relevant and user-friendly SRH services. Furthermore, a system should be developed enabling schools to refer young people with disabilities to Disabled Persons' Organizations and SRH service providers who can offer timely and effective counselling support.

References

— Aresu, A. 2006. *Healthy in body and mind: Sex education in contemporary urban China.* London, University of Westminster.

— Aresu, A. and Mac-Seing, M. 2018. When sexuality meets disability: Experiences, attitudes and practices from China. P. Chappell and M. De Beer (eds), Diverse Voices in Disabled Sexualities in the Global South. New York, Palgrave Macmillan.

— Chan, K. L., Yan, E., Brownridge, D. A. et al. 2012. Associating child sexual abuse with child victimization in China. *The Journal of Pediatrics*, Vol. 162, No. 5, pp. 1028-34.

— Chen, Jingqi, Ping Han and Guangli Lian. 2010. Zhongguo liushengshi 2508ming daxuesheng ertongqi xingnuedai jingli huiguxing diaocha [Prevalence of childhood sexual abuse among 2508 college students in 6 provinces of China]. *Zhongguo Liuxingbingxue Zazhi* [Chinese Journal of Epidemiology], Vol. 31, No. 8, pp. 866-69.

— Chen, Kai. 2008. Woguo canjiren kangfu gongzuo de huigu yu zhanwang [Retrospect and prospect of rehabilitation work for people with disabilities in China]. *Zhongguo Kangfu lilun yu shijian* [Chinese Journal of Rehabilitation Theory and Practice], Vol. 14, No. 3, pp. 201-05.

— China Disabled Persons' Federation. 2006. 2006nian dierci quanguo canjiren chouyang diaocha—quanguo canjiren fen canji leibie he canji dengji de nianling goucheng [Second national sampling survey of persons with disabilities in 2006: Age composition of disability categories and disability levels]. Beijing, China Disabled Persons' Federation.

— Cui, Nian, Aiping Tian and Mingxiang Li. 2012. Fumu yu weihun zinv jiaoliu yu xingxiangguan wenti de kunnan ji yingxiang yinsu fenxi [Communication about the sex-related issues between parents and their unmarried children: Analysis of influencing factors]. *Guoji shengzhi jiankang/ jihua shengyu zazhi* [J Int Reprod Health/Fam Plan], Vol. 31, No. 3, pp. 203-07.

— De Beaudrap, P., Mac-Seing, M. and Pasquier, E. 2014. Disability and HIV: A systematic review and a meta-analysis of the risk of HIV infection among adults with disabilities in Sub-Saharan Africa. AIDS Care, Vol. 26, No. 12, pp. 1467-76.

— Du, Li, Ming Qin and Liping Zhu. 2012. Shanghaishi qingshaonian xingshengzhi jiankang zhixinxing xianzhuang[The current situation of KAP on the sexual and reproductive health of adolescents in Shanghai]. *Zhongguo fuyou baojian* [Chinese Journal of Maternal and Child Health Care], Vol. 27, No. 29, pp. 4592-94.

— Goblet, D. 2011. Handicap et homosexualité: double tabou, double discrimination? http://yagg.com/files/2011/08/TFE-HANDICAP-ET-HOMOSEXUALITE-DOUBLE-TABOU-DOUBLE-DISCRIMINATION.pdf (Accessed 2 May 2018.)

— Handicap International France. 2007. AVAS: Service d'accompagnement à la vie affective et sexuelle des personnes handicapées. Document de capitalisation. Lyon, Handicap International – Programme France (Accessed 2 May 2018.)

— Hu, Tajing, Xiayun Zuo, Qiguo Lian. et al. 2015. Liusheng chengxiang 6~14sui xiaoxuesheng xingxiangguan zhishi shuiping yu zhishi huode zhuangkuang diaocha [Study of the sexual knowledge level and knowledge acquisition situation of pupils aged 6 to 14 from six provinces]. *Zhongguo ertong baojian zazhi* [Chinese Journal of Child Health Care], Vol. 23, No. 12, pp. 1338-341.

— Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., Mccoy, E., Mikton, C., Shakespeare, T. and Officer, A. 2012. Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. The Lancet, Vol. 379, pp. 1621-29.

— Human Rights Watch. 2013. *As long as they let us stay in class: Barriers to education for persons with disabilities in China.* New York, Human Rights Watch. www.hrw.org/report/2013/07/15/long-they-let-us-stay-class/barriers-education-persons-disabilities-china (Accessed 27 April 2018.)

— Isler, A., Beytut, D., Tas, F. and Conk, Z. 2009. A Study on sexuality with the parents of adolescents with intellectual disability. *Sexuality and Disability,* Vol. 27, No. 4, pp. 229-37.

— Jones, L., Bellis, M. A., Wood, S. et al. 2012. Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. The Lancet, Vol. 380, pp. 899-907.

— Li, Na. 2012. Canzhang qiangshaonian chengzhang fazhan ji jiankang xiangguan gongneng zhangai de diaocha yanjiu [An investigation of the growth, development and health related dysfunctional status of adolescents with disabilities]. *shuoshi lunwen* [Master's dissertation]. Shandong University.

— Lu, Cong, Ping Zhou and Jinfu Zhang. 2015. Changshashi canzhang qingshaonian shuligan xianzhuang [The status quo of alienation of disabled youth in Changsha City]. *Zhongguo xuexiao weisheng* [Chin J Sch Health], Vol. 3, No. 7, pp. 1094-96.

— Mao, Rongjian Mao and Tao Luan. 2011. Tingzhang xuesheng qingchunqi xingxinli xianzhuang diaocha [Psychological status of deaf students in adolescence]. *Zhongxiaoxue xinli jiankang jiaoyu* [Primary and Secondary Mental Health Education], Vol. 1, pp. 12- 15.

— National Bureau of Statistics of the People's Republic of China. 2010. Diliuci quanguo renkou pucha zhuyao shuju gongbao(diyihao) [Sixth National Census Key Data Bulletin], No. 1. Beijing, National Bureau of Statistics. http://www.stats.gov.cn/tjgb/rkpcgb/qgrkpcgb/t20110428_402722232.htm.(Accessed 27 April 2018.)

— National People's Congress of the People's Republic of China. 2015. Zhonghua renming gongheguo fanjiatingbaoli fa [Anti-Domestic Violence Law of People's Republic of China]. http:// www.npc.gov.cn/npc/xinwen/2015-12/28/content_1957457.htm (Accessed 27 April 2018.)

— Peking University Population Research Institute, UNFPA and NWCCW. 2010. Zhongguo qingshaonian shengzhi jiankang diaocha baogao [Youth reproductive health survey in China]. Beijing, Peking University Population Research Institute.
— Pu, Shengnan. 2003. Jiaqiang qingchunqi jiaoyu, cujin manglong ertong jiankang chengzhang [Strengthening sex education in adolescence to promote the healthy growth of the deaf and blind teenagers]. *Zhongguo teshu jiaoyu* [Chinese Journal of Special Education], Vol. 3, pp. 22-27.
— Quint, G. S. 2010. *We are growing up: sexuality education lesson plans for children with disabilities* . Xie, H., trans.
— Shanghai Institute of Planned Parenthood Research. 2012. Zhongguo qingshaonian SRH zhuangkuang jiance xiangmu yanjiu baogao [Monitoring of sexual development and reproductive health of children and adolescents in China]. (Unpublished.)
— UNESCO and UNFPA. 2018. Zhongguo chuji zhongxue xingjiaoyu shishi zhuangkuang [Sexuality education in middle schools of China]. Beijing, UNESCO.
— UNICEF. 2013. Children and young people with disability fact sheet[M]. UNICEF, 2013. https://www.unicef.org/disabilities/files/Factsheet_A5__Web_NEW.pdf (Accessed 27 April 2018)
— United Nations Population Information Network. 1994. *Report of the International Conference on Population and Development.* Cairo, United Nations Population Information Network. http://www.un.org/popin/icpd/conference/offeng/poa.html (Accessed 27 April 2018.)
— United Nations. 2006. *Convention on the rights of persons with disabilities.* New York, United Nations.
— Wan, Xing and Xiaoming Yu. 2016. Guoneiwai canji qingshaonian xing yu shengzhi jiankang yanjiu jinzhan [Research advances on sexual and reproductive health of young people with disabilities at home and abroad]. *Zhongguo xing kexue* [The Chinese Journal of Human Sexuality], Vol. 25, No. 1, pp. 126-29.
— WHO and UNFPA. 2009. Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note. Geneva, World Health Organization.
— WHO and World Bank. 2011. *World report on disability*. Geneva, World Health Organization. p. 36. http://www.who.int/disabilities/world_report/2011/en/index.html (Accessed 27 April 2018.)
— Yousafzai, A. K., Edwards, K., D'Allesandro, C. and Lindstrom, L. 2005. HIV/AIDS information and services: The situation experienced by adolescents with disabilities in Rwanda and Uganda. *Disability and Rehabilitation*, Vol. 27, No. 22, pp. 1357-63
— Yu Jianping, Yinghua Ma, Ming Li, M. et al. 2013. Beijingshi mouchengqu 619ming zhongxuesheng tongxinglian renzhi taidu diaocha [Investigation of cognition and attitudes to homosexuality among 619 high school students in one district of Beijing]. *Shoudu gonggong weisheng* [Capital Journal of Public Health], Vol. 7, No. 3, pp. 110-13.
— Zhen, L. and He, X. 2014. Policy audit: *Sexuality and disability in policies affecting Chinese people with disabilities.* Brighton, Institute of Development Studies.
— Zheng, Xiaoying, Gong Chen, Youli Han, et.al. 2010. Zhongguo qingshaonian shengzhi jiankang kejixing diaocha jichu shuju baogao [Basic data report on the survey of adolescent reproductive health accessibility in China]. *Renkou yu fazhan* [Population and Development], Vol. 16, No. 3, pp 2-16.
— Zuo, Xiayun, Qiguo Lian, Xiaowen Tu, et al. 2013. Zhongguo qingshaonian yu fumu jiaoliu xingxianguan huati de zhuangkuang fenxi [Study on the current status of adolescent-parent communication on sex-related issues in China]. *Zhongguo jihua shengyuxue zazhi* [Chin J Fam Plann], Vol. 21, No. 3, pp. 170-80.
— Zuo, Xiayun, Xiaowen Tu, Chaohua Lou and Ersheng Gao. 2006. Shanghaishi zhongxuesheng jiating xingjiaoyu xiaoguo pinggu [Evaluation of family sex education among middle school students in Shanghai]. *Shengzhi yu biyun* [Reproduction and Contraception], Vol. 26, Suppl. 2, pp. 229-34.

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Seeing the invisible

Sexuality-related knowledge, attitudes and behaviour of children and youth with disabilities in China

The Convention on the Rights of Persons with Disabilities (CRPD) clearly states the need to protect and promote Sexual and Reproductive Health and Rights (SRHR) of persons with disabilities and to provide quality and free or affordable access to SRH information and services. Children and youth with disabilities enjoy equal rights to sexual and reproductive health (SRH) as their peers without disabilities, but their SRH needs and rights are often over-looked. This is partly because there is very limited data available about their access to and needs for SRH information and services, which hinders relevant policy-making and programing.

Recognizing this gap, UNESCO Beijing Office and Humanity & Inclusion jointly initiated a study to examine the sexuality-related knowledge, attitudes and behaviour of young persons with disabilities in China, as well as their access to SRH-related education, information and services. The findings of the study are intended to inform decision-makers, researchers, educators and disability and development workers in terms of policy-making and programing to promote disability-inclusive sexuality education and SRH services.

The study was undertaken in 2015 by Shanghai Institute of Planned Parenthood Research (SIPPR), with the assistance of the Able Development Institute (ADI) and the Guangzhou Yuexiu District Nurturing Relationship Education Support Centre (GYDNRESC).

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4 QUALITY EDUCATION

Sustainable Development Goals