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4. Highlights of Reproductive Health in Finland

Our definition of reproductive health focuses on issues and problems related to pregnancy and childbearing. Thus, to evaluate reproductive health care in a country, we need to examine the extent to which quality maternal care and family planning services and information are provided to all women; the availability of safe and effective contraceptives; and the prevalence and treatment of infertility problems. Important indicators of reproductive health are maternal and infant morbidity and mortality rates; rates and types of contraceptive use; abortion rates and unwanted and unplanned pregnancy rates; and morbidity and mortality rates due to abortion and genital mutilation. Other measures of reproductive health are general fertility rate, average age of mothers at birth of first child, average length of hospital stay for new mothers, and prevalence and duration of breast-feeding. Family planning, contraceptive use and abortion deal with both sexual and reproductive health and are discussed elsewhere in this book (e.g., Chapters 5, 14, and 21). Family planning services are provided free of charge by local health centres as a part of Finland's universal government subsidised primary care service. Contraceptive prevalence rates are high and abortion rates low by international comparison, and illegal abortions occur rarely if at all. The issue of female genital mutilation (FGM) has come up only during the 1990s for public discussion due to the recent influx of African immigrants. The general criminal law makes FGM as physical violation illegal in Finland, and these operations cannot be performed as part of the public health services. It has been recommended that immigrant families from countries where FGM is practised receive education from health professionals concerning the risks of this procedure (Mölsä 1994).

This chapter discusses the structure and outcomes of health care for pregnancy, maternity and infertility. We give a brief history of maternity care, describe the basics of its service provision and education, and examine some concerns about the future of maternal care. We also present indicators of reproductive health in table format, discuss some of the issues involved in the incidence and treatment of infertility, and highlight some non-medical factors which have an impact on maternal and infant well-being such as maternity leave policy.

Brief History of Maternity Care

Concern about infant and maternal mortality can be traced to the 18th century when the first midwife from Finland was educated in Stockholm (Rehnström, 1997). In 1816 the first school for midwives was founded in Turku, and a Finnish-speaking school for midwives was established in Helsinki in 1859. Nevertheless, until the 20th century most mothers had their children at home, often in the sauna with the aid of a family member and/or experienced woman neighbour, without the presence of a midwife or physician (Rehnström, 1997).

In the middle of the 1800s middle and upper class women formed voluntary organisations in order to improve the ability of poor women to care for themselves and their children. By the beginning of the 1900s, national organisations and clinics in cities were established to provide maternal health care and education services. Since the 1920s, national health programs have included the care of pregnant women and their children. An important characteristic of these programs has been the co-ordination of the provision of health information/education with health care in their services to women. The custom of giving poor mothers a package of supplies for their new baby also originated in the early decades of the 1900s. This practice led to the establishment in 1941 of the useful, valuable and carefully prepared "maternity package", which is still available to all new mothers today.

Finland is divided into over 400 local administrative units. These municipalities vary in size from 150 to 540,000 inhabitants. They are responsible for providing health care for their inhabitants. In 1944 the law mandated that all municipalities provide free health care for expectant mothers and their children. This care was arranged in special units, literally called "advice units" (neuvola), which were required to be staffed by midwives and public health nurses. Rehnström (1997, p. 6) emphasises that within a year of the law, "86% of all women giving birth had registered at a local maternity unit, and that the average number of visits (pre-and postnatal) was 5.6."

Registration and attendance in these maternity units increased steadily until 1975, when the average number of visits was 16.9. This increase was partly facilitated by the Maternity Benefits Law of 1949. A provision of this law was that new mothers would only receive the maternity package if they consulted a nurse or doctor before the fourth month of pregnancy. The timing of this visit allowed for the screening and treatment of syphilis, and due to this policy congenital syphilis almost completely disappeared in Finland. While the network of regional hospitals was completed during the 1950s, childbirth in hospitals steadily increased. Most cases were assisted by a midwife, with a physician called only in case of complications.

In 1972 the Public Health Act reinforced that municipalities continue to provide maternity and child health care as well as family planning services as part of their primary care services to their inhabitants. Today the local maternity unit is accepted by all social classes and attendance is nearly universal. The Public Health Act also changed the nature of the service provision: Public health nurses with special training in maternal and infant health increasingly joined midwives to provide maternity and well-baby care.

Recent and Current Maternal Care

A recent guideline by the Expert Group on Family Planning and Maternity Care at Stakes (National Research and Development Centre for Welfare and Health) states the following comprehensive purpose of maternity care in Finland: "to ensure the best possible health for the expectant mother, the foetus, the newborn and for family members. The goals include prevention of disturbances during pregnancy, early detection of any problems that may occur and prompt referral for treatment, efficient care and rehabilitation, good care during delivery, care for newborns and support for the ill and the handicapped" (Stakes, p. 7, 1996). Maternity care services are provided as part of Finland's national health care system. Delivery of these services at the local health centre in the context of primary health care helps in relating the individual's health to the whole family and community. This also facilitates continuity in family planning, monitoring pregnancy, and treatment of common problems close to the expectant mother's home.

The local maternity units are responsible for prenatal health examinations and screening, personal guidance and parenthood education while hospital maternity clinics deal with the treatment of problems and diseases during pregnancy and care during childbirth. The resources and qualifications of health professionals at the local maternity units and hospitals are distributed so that together they are able to provide for comprehensive maternity care. Because good collaboration between the local maternity unit and hospital professionals is considered important for high-quality care, multiple means of accomplishing this have been devised. These include client participation (each pregnant woman keeps her own copy of her maternity record - a card containing thorough documentation of information from each prenatal visit), team work across professional boundaries, job rotation, collaboration in monitoring and evaluation as well as regional development of collaboration structures. Regions also schedule regular meetings for maternity care providers to discuss problems and to provide continuing education about new treatments and practices (Stakes, 1996).

Almost all Finnish women start antenatal care early and have many visits (Hemminki and Gissler 1993, p.26). According to Medical Birth Register data, 97% of patients seek care before the 16th week of pregnancy with the first antenatal visit occurring typically at 10 weeks (Table 1). The average number of visits in 1994 was 14.9, including

an average of 2.2 visits to a hospital clinic. Less than a half per cent of women giving birth had not attended a maternity unit; these women were primarily foreigners or Finns living abroad who travelled to Finland for delivery.

Today almost all babies are born in hospitals where intensive care units for infants are available. Midwives and nurses with a specialisation in obstetrics and gynaecology work in hospital delivery rooms, prenatal and postnatal care wards, and maternity clinics. More than 70% of deliveries are normal and administered by midwives/specialised nurses. On average, 15% of deliveries involve some special procedure such as a caesarean section, vacuum extraction, or forceps delivery. Of these procedures, caesarean sections are the most common. Most hospitals allow the baby and mother to stay in the same room to facilitate breast feeding. In the 1990s about half of the mothers have breast-fed their baby for at least 6 months. A minority of mothers request an early postnatal discharge (within 6-48 hours of the delivery). There are strict requirements for this option, including additional home visits by a public health nurse or midwife.

In recent years the personal health professional system has increased in local health units. Thus the same nurse may see a woman through her pregnancy and provide care for the young child after delivery at the well-baby clinic. This system is thought to promote coordination and individuality of care. In response to a 1994 national survey, over 80% of women (n=2189) indicated that they thought it very important that the primary care maternity services continue to be financed by tax money (Marja-Leena Perälä, Stakes, personal communication). Women were also satisfied with the number of visits with the qualification that more visits may be needed for a first pregnancy and less for subsequent ones. In this same survey, 99% of women had visited the local maternity unit during their latest pregnancy and 22% reported additional visits to health professionals in the private sector (Hemminki et al., 1998). Thus, currently, local maternity units are the primary source of prenatal care in Finland.

In the 1996 guideline by Stakes entitled “Screening and Collaboration in Maternity Care”, the Expert Group in Family Planning and Maternity Care gave a detailed description of basic practices of and recommendations for maternity care in Finland. For over 50 years local municipalities have provided a uniform level of centrally planned and guided maternity services. The purpose of this book – distributed to all maternity care professionals – was to ensure that maternity care providers at both the local units and hospitals have the most up to date information on high quality maternity care. The book expanded on a previous maternity care guide published by the National Board of Health in 1988. An updated and enlarged edition of the guideline is in print (Stakes, 1999)

Besides experts’ opinions and findings from a survey of maternity care units in Finland about the strengths and needs of care, these guidelines are based on literature in the field, most notably on information from the Cochrane Library (1999). This international database, which is updated quarterly, contains several hundred reviews of interventions

in all areas of medicine, including pregnancy and childbirth. Each review includes "data from several studies and explains in detail how various procedures effect the course of pregnancy and childbirth, or the child's prognosis" (Stakes, p. 9, 1996). The recommendations in the maternity guideline were checked against the information in this database. The use of such data to validate medical guidelines is becoming increasingly common in medical practice, and such information can greatly assist both the health practitioner and patient in making decisions about medical care. The Stakes Expert Group updated the guideline in 1999, using this database along with feedback from local and regional providers of care.

Since 1993, local municipalities have been given more autonomy in their provision of primary care services including maternity care. It was hoped that local decisions might better adapt to the needs of their population. After initial enthusiasm in local planning, national guidelines are becoming popular again. Divergences from the national guidelines should usually have a clear justification. Despite increased local control, the expectation is that local providers of maternity care will continue to closely follow the national guidelines, with their emphasis on scheduled contacts throughout the pregnancy and the final check-up 5–12 weeks post-partum. Therefore, the high quality of maternity care should be maintained. Comprehensive local and regional statistics provide many indicators of maternity care quality. Thus, a system is in place to discover changes or trends in maternity care for each locality.

One of the scheduled contacts is a home visit by the local maternity unit midwife or public health nurse during the first few days after the new mother and baby have returned from the hospital, even during weekends. This tradition dates back to the late 1800s, when municipal midwives were important providers of health education (Niiranen, 1996). After a home delivery, the midwife often visited the new mother (especially those with their first child) several times to teach baby care and general hygienic measures. This tradition was continued when the 1944 law on local maternity units was enacted. Even today, the postnatal home visit is an integral part of care in cities and rural areas alike, giving the midwife or public health nurse a good picture of the social conditions of the mother and the child and helping her to evaluate the need for social and psychological support for the family together with the health centre team. All new mothers – including health care professionals – are visited in their homes so there is no social stigma attached. The midwife or public health nurse checks the condition of the mother and the child, weighs the baby, and discusses breastfeeding.

Education and Knowledge of Maternal and Infant Care

Preparation courses for new parents on delivery, parenthood and adjustments needed in a family when a new child is born, are also an essential part of the work of maternity care. In the 1960s childbirth education began to be offered at the maternity units, and during the 1970s fathers were also permitted to be present in the delivery room. Today the main responsibility for providing parenthood education and information to prepare parents for childbirth rests with the midwife or public health nurse at the local maternity unit. Future parents are given information about the course and development of pregnancy and the associated social, emotional and physiological changes, the course of childbirth and different modes of delivery, pain relief during delivery, abnormal deliveries, puerperium, child care and breast-feeding, need for support of the father and older siblings, and social support available in the community for pregnancy, childbirth and infant care (Stakes, 1996). Both mother and father are encouraged to attend antenatal classes. Parents are also invited to an introductory visit to the maternity hospital and receive written information including an up to date handbook on pregnancy and baby care called "We're Having A Baby". Research and feedback from parents indicates that the education program is most appreciated when started about halfway through the pregnancy and when implemented in small groups of four to six couples. Antenatal classes may be larger than this, especially in the cities; increasingly, the groups continue to keep in touch after the babies are born and act as self-support groups during the children's early years. The local health centre or day care centre often offers meeting rooms for such activities.

Attendance at an antenatal class is usually a requirement set by the hospital for the father to be present at the birth. In 1992, 61% of fathers participated in the birth of their child (Mikkola et al., 1995) and by 1997 the rate had increased to 70% (Vallimies-Patomäki 1998). Mothers appreciate the father's presence in helping to provide emotional support and a sense of security. Fathers generally appreciate the experience for it helps to create a bond with their child and enhances feelings of family togetherness.

Social Support for Pregnancy and Childbirth

Parental leave

Both the mother and the father are entitled to parental leave from their work for the birth of a child. Maternity allowance for the expectant mother is paid for 105 weekdays and typically begins 30 weekdays before the expected date of birth. In cases where the mother's medical condition or the external conditions in her work require her to quit work earlier in the pregnancy, special allowances are given. The paternity allowance of

12 days, which is not transferable to the mother, is paid from the time of the birth or homecoming of the baby or later during the time of parental leave. Paternity allowance is given to the married or cohabiting partner of the mother. In 1997, 95% of fathers took a paternity leave in connection with confinement and/or at a later time during the baby's first year (Kansaneläkelaitos 1998).

Parental leave subsidy begins after maternity leave and extends for 158 weekdays. Although parental leave can be divided between the mother and father, in the vast majority of cases it is taken by the mother. Reasons for this include the breast-feeding needs of the baby and the better economical outcome for the family when the lesser-earning spouse (usually the mother) takes the parental part of the leave. The maternity, paternity, and parental daily allowance is covered by the state and varied in 1999 from 60 FIM to 450 FIM (10-76 Euro) with an average near 250 FIM (42 Euro). It counts as taxable income and is calculated according to the receiver's earned income. A mother who has not been employed is paid the minimum; permanently employed parents usually receive their full salaries for the first three months, and the subsidy during this time goes to their employer. The parental allowance is continued on the condition that the new mother has a postnatal exam within 5 to 12 weeks of the birth of her baby. Because of the long paid parental leave, which covers about 10 months after delivery, it is rare for small babies to be placed in day care.

Maternity package, protective laws, and genetic counselling

A maternity package is given by the state to all pregnant women who undergo a medical examination before the 17th week of their pregnancy. This package contains baby clothes and items needed for the child's first year of life. It is carefully prepared so that its materials are of high quality, easy to care for, healthy, environmentally friendly, and attractive. Instead of the package, new mothers can also choose a cash benefit of 760 FIM (128 Euro), about half the value of the package.

There are eight homes in Finland for unmarried new mothers or expectant mothers who have nowhere else to go. These homes provide around the clock guidance for a variety of problems, such as breast-feeding or colic babies. Some of these homes also give antenatal classes for young families. The average stay in these homes is six months.

Two laws help to prevent hazards to a pregnant woman and foetus and also to the fertility of both men and women. A law on occupational safety requires the employer to ensure that working conditions are not likely to cause damage to the health of the fetus or pregnant woman or to an individual's fertility or genes. The employer is given a list of products capable of causing such damage. The second law enacted in 1991 allows women who have jobs which expose them or their prospective offspring to possible health damages to have a job transfer or special maternity leave benefits. This possibility

is yearly used by 80-90 mothers (Dr. Helena Taskinen, Institute for Occupational Health, personal communication).

All five university hospitals and the Family Federation of Finland support departments of medical genetics. These departments provide genetic counselling to individuals interested in learning about existing or suspected hereditary disease of their own or in their family. The service cost to the clients are nil or low with the municipal payment contract, as for other secondary care. The decision to seek genetic counselling or foetal diagnostics is always made by the family. As part of standard maternity care, the new guideline for screening (Stakes 1999) recommends ultrasound screening at either 13-14 weeks or screening for chemical markers at 15-16 weeks of pregnancy

Miscarriage and Infertility

According to the national hospital register, an estimated 9% of pregnancies ended in miscarriage in 1995. In a 1994 national survey (Hemminki et al, 1998), 15% of women reported that they had experienced at least one miscarriage in their life. The vast majority (97%) of these women had consulted a doctor after their miscarriage and 74% were treated as inpatients; in most cases, an operative evacuation of the uterus had been done. Hemminki et al. concluded that research regarding both the treatment and prevention of miscarriage is needed, even though miscarriage rates in Finland are comparable to those in other developed countries.

Infertility problems have increased in the last two decades. The average age of women at the birth of their first child rose from 25.7 years in 1980 to 27.4 in 1994 and the proportion of first pregnancies in the 30 to 39 age group has increased while the proportion of mothers aged 20 to 24 has decreased (Miettinen 1997; Mikkola et al., 1995). The older age of first pregnancy places new demands on maternity services for more infertility problems and complications during pregnancy occur for older women. A 1989 study (Nikander, 1992) indicated that 12% of women in the 40 to 44 age group had at some time experienced infertility, while in 1994 the corresponding proportion was 16% (Malin, 1997). Notkola (1990) estimated that 35,000 couples are in need of fertility treatments annually (Rehnström 1997).

Basic evaluation and treatment of infertility are provided at hospitals, some municipal health centres and private gynaecologists. Advanced treatments including intracytoplasmic sperm injection and frozen embryo transfers are available in all university hospitals and many private clinics. Infertility treatments are accepted as part of normal health care, but the scale of services, age limits, and number of treatments given to one couple vary by municipality. At university clinics the fees are lower but waiting lists can be long, whereas at private clinics waiting times are shorter but fees higher (currently reimbursed at a rate of between 50 % to 75%). More than half of the high technology infertility

treatments are offered at private clinics. Three of the most popular infertility clinics are operated by Family Federation of Finland (Väestöliitto) and are located in the major cities of Helsinki, Turku and Oulu. They also provide special miscarriage and maternity services. The clinic in Helsinki, for example, services 15000 clients and performs over 700 in vitro fertilisations annually. This clinic has its own sperm bank and receives donated eggs.

Discussion

Some indicators of reproductive health are shown in Table 1. A comparison of these with the corresponding indicators from other countries supports the view that maternal health and health of the newborn in Finland are among the best in the world. Areas of concern to health professionals concentrate on the experienced quality of the services, cost-effectiveness, and equity issues. There are also changes in the needs of patients. Changes since the early 1990s have given municipalities more control over decisions affecting health services. This extended local autonomy may increase the risk for inequitable service provision across municipalities. Also an increasing pool of couples with infertility problems and the recent increase in immigrants who have higher fertility rates than Finns present new challenges to the maternity health system.

Another concern among those who evaluate prenatal care is that hospital clinics may expand their services to include regular monitoring of non-problematic pregnancies. The local maternity centres have been known for their ability to provide a high degree of emotional and social support and continuity of care at facilities close to the residence of patients at lower costs and shorter waiting times than are characteristic of hospital clinics. Finally, some are worried about the trend in local maternity units toward replacing midwives, who have the most comprehensive specialised training in pregnancy, childbirth and confinement, with public health nurses who are generalists and obtain much less specialised knowledge and training in maternity care. Many attribute the past high quality of maternity care in Finland to the role of primary care midwives and thus hope that their important part in maternity care will continue. Nevertheless, close monitoring by comprehensive statistics, evaluation systems involving patients, and collaboration mechanisms among professionals at the local, regional and national levels offer important safeguards helping to ensure that Finland will continue to offer high quality maternal and infant care services to its citizens.

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Appendix: Table 1. Indicators of and factors relating to the quality of reproductive health in Finland

Year	1991	1992	1993	1994	1995	1996	1997	Source
Number of deliveries	65 268	66 742	64 563	64 726	62 767	60 434	58 900	1)
Number of live births	65 395	66 731	65 219	65 477	63 391	60 940	59 329	1)
Number of live births and stillbirths	65 701	67 019	65 496	65 730	63 694	61 426	59 540	1)
Mid-year population	5 013 740	5 041 992	5 066 447	5 088 333	5 017 790	5 124 573	5 139 835	2)
Birth rate: Number of births/1000 population	13,0	13,2	12,7	12,7	12,5	11,8	11,5	2)
General fertility rate per 1000 women of fertility age	51,8	52,7	51,0	51,2	49,7	48,2	47,5	2)
Maternal deaths	3	3	2	7	1	2		2)
Maternal mortality rate: Deaths/100 000 live births	4,6	4,5	3,1	10,7	1,6	3,3		2)
Perinatal deaths	532	490	438	441	439	381	341	1)
Perinatal mortality rate: Deaths/1000 newborns	8,1	7,3	6,7	6,7	6,9	6,2	5,7	1)
Infant deaths	382	344	287	308	248	242	232	2)
Infant mortality rate	5,8	5,2	4,4	4,7	3,9	4,0	3,9	2)
Mean age of mothers at birth of first child	26,9	27,0	27,2	27,4	27,6	27,7	27,7	1)
% Single mothers	5,3	5,5	7,2	9,8	10,9	10,1	8,3	1)
% Cohabiting mothers	21,3	22,9	22,9	21,8	21,6	23,2	26,6	1)
% Married mothers	71,6	70	68,5	67,3	66,2	63,3	62,9	1)
% Births outside hospitals	0,11	0,12	0,10	0,11	0,12	0,10	0,13	1)
% Pregnant women consulting before 16th Week	95,8	96,6	96,5	96,9	96,9			1)

Year	1991	1992	1993	1994	1995	1996	1997	Source
Mean pregnancy week of first antenatal visit	10,2	10,0	10,1		9,8	9,7		1)
Mean number of antenatal visits	15,1	15,0	14,9	15,4	16,0	16,4	16,5	1)
Mean length of hospital stay for childbirth, days *	5,0	4,6	4,4	4,2	4,1	4,0	4,0	3)
Mean birth weight	3 548	3 547	3 540	3 546	3 538	3 522	3 536	1)
% Very low birth weight babies (<1500gr)	0,9	0,9	0,9	0,9	0,9	0,9	0,9	1)
% Low birth weight babies (<2500 gr)	4	4	4	4,1	4,2	4,3	4,2	1)
% of Births to women < 20 years	2,8	2,7	2,6	2,5	2,5	2,6	2,5	1)
Average age of women with spontaneous abortion **	30,4	30,5	30,7	30,8	30,8	30,9	30,9	1)
% of Mothers breastfeeding for 3 months or more								
a) Predominantly					68			4)
b) Of these, exclusively					26			4)
% Caesarean sections	14,4	14,5	14,6	15,4	15,7	15,7	14,1	1)
% Fathers attending birth		61					70	5)
Pelvic inflammatory disease/1000 women aged 15-49						0,157	0,158	1)
Cervical cancer incidence	2,8	3,2	3,6	3,7	4,5	4,5	. .	

* Preliminary

Sources: 1) Medical Birth Register, 2) Statistics Finland, 3) Hospital Discharge Register, 4) Imeväisikäisten ruokinta Suomessa, 5) Vallimies-Patomäki 1998, 6) Cancer Register