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25. Conclusion: The State of Sexual Health in Finland

In this final chapter, we present methods to evaluate the sexual health of a country and then apply them to Finland. We base our methods of evaluating sexual health on principles of the new approach described in chapter 1.The authors of previous chapters have already discussed strengths and weaknesses of the provision of sexual health services and information for specific organisations and populations groups. We now summarise important aspects of service and education provision described by the authors and add our own observations in highlighting both effective programmes and areas of concern. We end the chapter with a discussion of how Finland can continue to offer leadership in sexual health expertise and promote sexual health throughout the world.

An underlying assumption in this discussion is that there is general agreement with the principles upon which the new approach to sexual health was based. Thus, it is assumed, for example, that we should work to promote equality of sexual standards, and in particular to promote policies that do not discriminate on the basis of class, race/ethnicity, religion, age, disability, gender, or sexual preference. We also assume that policies should be directed toward increasing sexual skills and knowledge and providing quality sexual health services for all. Of course, these assumptions are problematic for people with non-egalitarian views and for governments that either can not or choose not to assume the responsibility of providing universal sexual health services and sex education in schools. Yet, we strongly endorse these assumptions, based on a human rights approach to sexual health.

Our evaluation criteria are guided by listings of sexual rights (Tables 1, 2, and 3 of Chapter 1), Coleman's ways to promote sexual health (Table 4, Chapter 1), definitions of sexual health arrived at through international consensus, and the sexual health models described earlier (Chapters 2 and 3). We continue to provide arguments for the view that countries most closely approximating the actualisation of the aforementioned sexual rights also have the best records on many indicators of sexual health such as rates of sexually transmitted diseases and unplanned pregnancy.

One way to evaluate the sexual health of a country is to determine the degree that sexual rights are realised by the citizens of a country. Any one of the lists of sexual rights presented in Chapter 1 provides a framework for such a determination, i.e., one of the listings of rights formulated by the International Planned Parenthood Federation, the World Association of Sexology, or the subgroup (HERA) of the International Women's Health Coalition. A second approach is to use the list of ways to promote sexual health

suggested by Eli Coleman as evaluation criteria. A third way is to consider the models of sexual health described in chapters 2 or 3 and develop criteria of evaluation from one of those models. A fourth way is to use the components of the definition of sexual health to guide construction of indicators for evaluation. Because all four of these methods are based on the same principles, those adopted by international consensus at the Cairo and Beijing conferences, evaluation criteria developed from these methods would be similar.

We chose the fourth method to organise indicators and areas to examine in evaluating the sexual health of a country. Table 1 contains a list of these indicators and areas for each component of sexual health, and we use this table to summarise the state of sexual health in Finland. Because the three direct determinants of sexual health are sexual information, services, and ideology, these three determinants also need to be discussed in an evaluation of sexual health. Finally, aspects of reproductive health also need to be examined because of their relationship to sexual health.

Unwanted and Unplanned Pregnancies

Finland fares well with respect to unwanted and unplanned pregnancies. Women in Finland have access to traditional and most new contraceptive methods including emergency contraceptives. Teenagers are well acquainted with this as well as other older methods of birth control. In one list provided by the United Nations of teenage birth rates for 44 of the better industrialised countries for the first half of the 1990s, Finland had the 11th lowest rate (United Nations, 1996). Countries such as Japan, Switzerland and the Netherlands were among the countries with teen birth rates lower than Finland, and the USA reported the highest rate. In a comparison of Finland's 1995 teen birth rate with other countries, only Japan's rate was lower (Mackay, 2000).

Although many surveys of sexual behaviour have been conducted in Finland, apparently few have asked women to report the number of unplanned and unwanted pregnancies they have ever experienced. Myhrman (1992) found that from1966 to 1985/86, rates of unwanted pregnancies (not wanted at all) decreased from 12% to 1% in Northern Finland. Helmig (1997) reported that in this same regional study, the unplanned pregnancy rate (pregnancies that occurred earlier than desired or was not wanted at all) was 12% at the later date. A major study by the Alan Guttmacher Institute (Jones et al., 1989) found that more than 50% of all pregnancies were unplanned in Finland in 1978, a figure comparable with other Western countries at that time. Recent international data on this topic is limited although Helmig emphasised that Finland's rate is considerably lower than that in the United States, where the unplanned pregnancy rate is nearly 60% (Brown and Eisenberg, 1995). The decrease in rates of unwanted and unplanned pregnancies since the 1960's can be attributed to the high quality and free family planning services that became available to Finnish women in the early 1970's.

Table1. Indicators and areas to examine for the evaluation of a country's sexual health

Sexual Health Component	Indicator or Area
1. Planned and wanted pregnancies	- Contraceptive prevalence - Percent using effective methods - Cost, accessibility, and quality of family planning and abortion services including general and emergency contraceptives - Legality of abortion - Abortion mortality and morbidity rates - Teenage pregnancy, birth and abortion rates
2. Low risk of contracting a sexually transmitted disease (STD)	- Rates of major sexually transmitted diseases including HIV/AIDS by gender - Cost, accessibility and quality of STD diagnosis and treatment - Impact of prostitution
3. No sexual coercion, abuse, harassment, assault, rape, or mutilation	- Rates of sexual coercion, abuse, harassment, assault and rape - Extent of female genital mutilation - Cost, accessibility, and quality of services for victims and treatment for abusers
4. Lack of discrimination	- Extent of empowerment of and services for women, nonheterosexuals and transsexuals, and other groups who tend to be marginalised - Degree to which laws promote political, economic and social equality for all groups irrespective of gender, race, age, ethnicity, class, sexual preference or religion - Extent of social harassment based on gender, race, etc - Cost, accessibility, and quality of sexual health services for special population groups such as the disabled, elderly, sex workers and teenagers
5. Sexual enjoyment and pleasure	- Extent of sexual dysfunction - Degree of sexual satisfaction - Cost, accessibility, and quality of medical treatment and sex therapy for physiological and psychological sexual problems - Extent of sexual dissatisfaction due to lack of a partner - Degree of sexual knowledge and skills of the general population - Acknowledgment and consideration of the influence of diseases and treatments on sexual functioning by health professionals - Knowledge of sexuality based on scientific, multidisciplinary research
6. Sexual knowledge and education	- Comprehensiveness and quality of sex education in public schools - Uniformity, comprehensiveness, and quality of sex education of educators and health professionals - Extent of continued education for sex educators and health professionals - Extent of media coverage of sexual health issues with consideration of wide range of experts as well as topics
7. Reproductive health	- Infant and maternal morbidity and mortality rates - Extent and treatment of infertility problems

Several large-scale national surveys since 1971 have asked women to indicate their use of contraceptives. Rehnström (1997) emphasises two trends that emerge from these surveys: first, an increasing use of contraceptives, even among the young and second, the use of more reliable contraceptive methods. In one survey, Erkkola and Kontula (1993) found that only five percent of women who are in need of contraception use no contraceptives at all. Thus, the risk of having an unplanned pregnancy seems small in Finland for a majority of such pregnancies occur in women who use no contraceptive method. The most recent surveys indicate that the pill and IUDs are common methods, and that 25 to 35 percent of women rely on condoms. Some Finns use the condom for protection against sexually transmitted diseases as well as another method for birth control. Väestöliitto (1998) and Mackay (2000) note that condom use is widespread, and that Finland is second only to Japan in its use of condoms. Thus, contraceptive prevalence rates and the use of reliable methods are high. These favourable rates can be attributed to a high level of contraceptive knowledge by women and also to the easy accessibility of services.

Rimpelä (1998) attributes Finland's success in reducing abortion and unplanned pregnancy rates to the following five factors: (1) use of preventive approaches in public health (2) change of focus from abortions to the prevention of its main cause, unintended pregnancy, (3) good co-operation and co-ordination between the health and education sectors, (4) strong and skilled guidance from the national health authorities, and (5) professional attitudes of nurses and doctors in sex education and family planning.

Nevertheless, there are some reasons to be concerned. Väestöliitto (1998) has noted that the cost of some contraceptives likely inhibits their use by members of low-income groups, especially disadvantaged youth. Lowering the price of contraceptives would be an effective measure in increasing their use. One reason for the exceptionally low rates of abortion and unplanned pregnancy in the Netherlands is the free or low cost of contraceptives.

A few cases of violations of confidentiality of services to adolescents have recently caused concern (Dan Apter, personal communication, July, 2000). In one incident, a bill was sent to the home of a teenager who had obtained emergency contraception, and this caused family conflict when her mother read the description of service on the bill. In addition to violating the right of privacy, such publicised incidents may prevent other young people from seeking needed sexual health services. Besides teenagers, other population groups that need special attention with respect to contraceptive use are women intravenous drug users, the disabled, and the growing number of refugees and other foreigners.

Because abortion services are legal and provided by skilled professionals, Finland does not have a problem with health complications or deaths due to illegal abortions. A major

goal of health professionals has been to keep abortion rates low by supporting policies that promote contraceptive use. STAKES is currently conducting research on how to make abortion services better meet the needs of women. A world wide investigation by the Alan Guttmacher Institute (1999) revealed that in 1996 Finland had the 6th lowest abortion rate for women between the ages of 15 and 44 in a ranking of 28 countries where abortion statistics were considered complete. In 1994, Finland's abortion rate for those 15 to 19 was 9 per 1000. This is lower than corresponding rates in most other industrialised countries (this rate was 32 per 1000 in the USA, for example) (Henshaw, 1999; Kosunen and Rimpelä, 1996).

Some sexual health professionals fear that the decrease in sexual health services in some areas of Finland due to budget cuts and increased decision making powers of municipalities will cause the teen pregnancy rate to rise. These cuts have meant that some family planning clinics that have been staffed by specially trained nurses are no longer operating. Such clinics were popular with young women because of the highly trained personnel and reduced fears of anonymity violations. Currently, more family planning services are expected to be offered by primary care providers where some young people have greater concerns about privacy. Another cause for alarm is that the cost of obtaining an abortion as an outpatient has recently more than quadrupled (Kosunen, Chapter 5).

A major strength of the Finnish health care system had been the sexual health services provided by school nurses in the comprehensive schools. Since the recession of the early 1990's, school nurses have had less time to provide sex education and counselling in sexual matters. Services of these nurses to young people should be restored if Finland intends to emphasise prevention of health problems and avoid higher health costs of treating STDs and abortion services later.

Health providers in Finland are actively involved in collaborations with other countries that have good records in sexual health. Thus, frequent consultations, seminars, lectures, and conferences are arranged with other countries, especially with the Netherlands and their Nordic neighbours. Such international co-operation ensures that those providing sexual health services continue to be aware of high-quality and effective programs.

Sexually Transmitted Diseases

The next area to consider in Table 1 concerns sexually transmitted diseases. Professionals in this field in Finland agree that their country has excellent diagnostic and treatment for the major sexually transmitted diseases. For most of these diseases, including HIV/AIDS, treatment is low cost or free and confidentiality is protected. Treatment can be obtained from both public and private services.

Until recently, professionals thought rates of sexually transmitted diseases were low and under control. Fifteen percent of adult men and 12 percent of adult women acknowledged they had had some sexually transmitted disease (Kontula, 1994). In this same survey less than 2% of both men and women reported they had such an infection during the past year. Furthermore, Finland has been known for its exceptionally low AIDS rate and for its effective information campaign about this disease.

In the last couple years, higher rates of some diseases have caused health experts grave concern. First of all, the rate of HIV infection has increased alarmingly due to a new method of transmission in Finland – intravenous drug use (57% of new HIV cases in 1999). Response to this situation has been quick, and new strategies are continually being developed to deal with this growing problem. Clean needles and syringes are available for drug users at easily accessible safe places in major cities. Increased treatment programs including those using methadone have been arranged. Groups at higher risk of becoming drug users – the young, immigrants, and prisoners – have also been targeted for special programs and attention.

Another area of concern is the high rate of STD transmission from foreigners to Finns. With the increased travelling and mixing with members of states of the former Soviet Union, particularly to and from Russia and Estonia – where rates of STDs have increased dramatically in the 1990s –more and more Finns, men especially, are getting an STD from a foreigner and subsequently giving their partners an STD. Syphilis has slightly increased among the adult population, for example. So, further educational campaigns as well as additional components in school sex education need to be developed to help contain STDs in Finland. All population groups need to be considered, and people can not assume that they will not get a STD from their regular partners. A shortcoming mentioned by Väestöliitto (1998) in efforts to reduce STDs is the need for better follow-up of people treated for a sexually transmitted disease.

When determining how STDs are transmitted, one important factor to examine is the influence of prostitution. More information about the role of prostitution in the spread of STDs in Finland is needed. However, at a 1999 meeting of professionals in the field, the general agreement was that risk of getting a STD in Finland is greater from one's regular partner than from a sex worker.

Another problem requiring attention is the rate of chlamydia. There were more than 10,000 new cases in 1999. Infertility is now recognised as a growing problem in Finland, and chlamydia is one of its major causes. Public health information campaigns have attempted to reduce the incidence of this disease. Experts now believe that extensive screening programs for those at risk would be a cost efficient and effective way to reduce the incidence of this problem.

More versatile teaching methods – those requiring student participation and role practising of sex education would also help in giving adolescents better interaction skills with their peers. In a recent Finnish study, Papp et al. (2000) found that good social interaction skills reduced sexual risk taking for the young.

Sexual Abuse, Assault, and Coercion

As Riitta Raijas and Raisa Cacciatore (chapters 11 and 20) have emphasised, problems of sexual abuse and assault need to be addressed in Finland. In this regard, it is important that issues relating to the abuse of children be addressed more comprehensively in the sex education programs of schools as well as by parents. Raisa Cacciatore already stressed the need for children to understand their rights to control who touches them and when and how they are touched. Sexuality programs need to also address issues relating to consent and mutuality in all sexual relationships. If a rights approach to sexuality is used in schools, then perhaps more people will adopt a norm of mutual consent and reciprocal respect.

Results of surveys of the general population also indicate that problems of sexual abuse, harassment, and rape are present in Finland. Kontula and Haavio-Mannila (1993) report that 18% of women and 7% of men had experienced sexual harassment (defined as the receiving of an unwanted/one-sided physical or verbal sexual approach) before they were 17. In this same survey, 9% of adult women and 3% of adult men reported they had experienced unwanted offensive touching with a sexual intent in the last five years. One and a half percent of women reported they had been the victim of rape or attempted rape.

In the United States, social scientists (e.g., Lottes, 1988; Lottes, 1991a) have argued that rigid gender roles which link ideal masculinity with high numbers of sex partners and femininity with submissiveness and lack of sexual experience encourage dishonest communications between men and women. Thus, men often disregard a 'no' response for sexual interaction. Research (Hofstede, 1983; Löfström, 1997) suggests that these types of gender roles have less influence on Finnish women and men. Thus, Finnish men seem more likely than American men to interpret a 'no' as really meaning no and thus, not push for sexual intimacy. Another traditional difference between Finnish men and American men involves their patterns of communication in heterosexual relationships. American men are quick to say 'I love you' to a potential partner, and many American women believe that if they are in love, then a sexual relationship with their 'love' is morally acceptable. In fact, verbal sexual coercion by men toward women is common in the USA (Lottes, 1991b). A Finnish man generally does not tell a woman he loves her just to convince her to have sex with him.

Furthermore, sex among the unmarried is widely accepted in Finland. Women do not have to pretend they are not interested in sex or justify their sexual involvement by love.

Thus, it seems that some of the sexually coercive situations due to psychological coercion and pressure may be less in Finland than have been commonly reported in the USA. Nevertheless, Riitta Raijas (chapter 11) stressed that even though rates of sexual violence do not appear to be higher than rates in other European countries, such violence is a serious problem in Finland. The importance of mutuality to engage in sexual interactions needs to be stressed in sexuality programs, and young people need to be taught and given the opportunity to practice interactional competence skills. Research has supported the view that good interactional competence skills reduce the risk of sexual coercion and abuse by both psychological and physical means (Vanwesenbeek, 1999).

Female genital mutilation is not allowed in Finland but due to the increasing number of immigrants from countries where this is practised, policies will need to be developed to prevent its occurrence and also to sensitise health professionals in their treatment of women who have undergone this procedure.

In chapter 11, Raijas highlighted some promising trends that have the potential for reducing sexual violence. First, educational and informational campaigns have brought this problem to the attention of the public and illustrated the need to find ways to reduce sexual violence and provide support for its victims. These campaigns helped ensure that the rape crisis centre in Helsinki is now operating as a permanent provider of services for victims. Raijas also described many crucial areas of sexual abuse and assault that need to be investigated in future research. In this regard, it is worth repeating that the Academy of Finland has allotted a substantial sum of money for research on violence and gender topics. Policy makers, service providers, and educators need to learn more about contextual dynamics of sexual violence, coercion, and assault in Finland.

Sexual Discrimination

The harmful effects of discrimination on the sexual health of individuals are difficult to determine. Even listing all groups that are subject to this type of injustice is not an easy task. The obvious groups are women, gays, lesbians, and transsexuals. Other groups facing discrimination and in need of sexual health care and support services include the elderly, the sick, disabled, children, victims of sexual abuse and assault, prostitutes, immigrants, and people in institutions. Some may even include individuals having serious difficulties in finding a partner as a group that deserves special attention. Elderly women and marginalised men are in this group and the number in the latter category has increased in Finland during the economically hard years of the 1990s.

Nevertheless, in our evaluation of the discriminatory damages suffered by the citizens of a country, we can make some definite guidelines to follow. First, norms, attitudes, laws and policies with respect to these groups, as well as the services and education/ information available to them, of course need, to be examined. The official policies in

Finland generally support equality between the genders and between heterosexuals and non-heterosexuals. Yet with respect to gender equality, particularly in regard to issues involving economic and political resources, more work needs to be done (see chapter 2). Certainly, gays and lesbians are still victims of cruel acts of discrimination, starting at young ages (Stålström and Nissinen, chapter 9 and Lehtonen, chapter 22). These acts of harassment throughout the school period have devastating long-term effects on the self-esteem and sexual health of many gays and lesbians.

Despite, these acts of intolerance, we must emphasise that non-heterosexuals enjoy more rights and better sexual health in Finland than their counterparts in most other areas of the world. The main official areas of legal inequality for same gender couples involve: (1) the right to have their relationship legally registered, (2) the right to receive inheritance from a partner under the same rules that apply to heterosexual couples, and (3) the opportunities to have children through adoption or using reproductive technologies. With respect to the sexual health of other groups, it is important to listen to and take action concerning the recommendations of those who provide services to them (see chapters 21 to 24). At least in Finland, the need for sexual health services for the elderly, disabled, adolescents, and children has been acknowledged. Health authorities at the national level have also facilitated the work of many of the sexual health support groups by providing both funding and expertise.

Effective public campaigns can reduce sexual discrimination. An example of one such campaign aimed at improving attitudes about the sexuality of older people took place in 1999 and 2000 in central Finland (at Kutemajärvi) and was advertised as a “sex festival for the over 40”. This three-day event attracted both young and old and received media attention all over Finland. It combined informational activities like films, educational exhibits, and lectures on sex and love with opportunities to enjoy art, craft demonstrations, singing, music and dancing. In a similar way, “sex festivals“ targeted primarily for the young have been organised annually since 1996 and are characterised by both educational and recreational activities.

Sex workers comprise another group that requires special sexual health services, and we have not focused on them in this book. The major reason for this is that important research on prostitution is currently in progress, and much of the information that we could include at this time would be outdated. The nature of prostitution has changed greatly since the break up of the Soviet Union. For example, in the last decade, many women from Russia and Estonia have come to Finland to make money as sex workers. Whereas earlier prostitution was largely hidden, in the early 1990’s it became more visible as new sex workers sought clients in the streets and other public places. Thus, policy makers and those who provide services for sex workers have responded to the need to carry out research on prostitution in order to form a basis for future policy. We now give a brief description of the research and describe a support centre for sex workers.

One research project entitled "Prevention of Prostitution 1998-2002" is sponsored by STAKES. A major goal of the research is to find ways of reducing prostitution and its harmful effects on both sex workers and the society in general. The other major project – EUROPAP – involves all the European Union countries. EUROPAP stands for European Intervention projects AIDS prevention for prostitutes. The goals of EUROPAP are to support and develop interventions to reduce HIV, STD and other communicable diseases in prostitution and to assess the most successful and appropriate approaches for sex workers. Major goals of the Finnish part of EUROPAP are to learn from interviewing sex workers ways to design programs and services that better meet their needs and also, of course, to help guide political and policy decisions on prostitution.

In Helsinki, there is a Prostitutes' Counselling Centre (PCC) which provides support services for sex workers and their friends and family members. The primary goal of this organisation is to promote the health, well being and safety of sex workers. Services provided are confidential and free of charge, and the will to stop sex work is not a condition for service. The PCC employs 2 full time and 3 part time workers, including a social worker, psychiatric nurse, and a doctor with a speciality in STDs. These highly trained professionals take personal appointments, offer help by telephone, provide information about safer sex techniques, and perform STD diagnosis and treatment, both at their centre and through outreach activities in sex bars and the streets.

Prostitution is linked to sexual health problems and has been a major area of concern for Europe. In this regard it is worth noting that the two countries Sweden and the Netherlands have recently adopted diametrically different policies. Sweden has chosen to punish the clients of prostitutes with fines and short imprisonment, whereas the Netherlands has now lifted bans on prostitution while still keeping strong restrictions on the trafficking of individuals for sex work, the forcing of individuals into prostitution, and the participation in prostitution by those under 18.

After the Finnish research findings are known, it will be interesting to see which approach Finland favours. Prostitution has never been criminilised in Finland. Attitudes among men toward prostitution are favourable (Kontula and Haavio-Mannila, 1993), and during the 1990's they have become even more tolerant (Haavio-Mannila, Kontula and Kuusi, 2000). It is interesting that the different approaches to prostitution in Sweden and the Netherlands were both motivated by the desire to reduce violence against women. One attempts to do this by strict punishment and the other by trying to regulate and control it.

Sexual Enjoyment and Pleasure

Finland is one of the rare countries for which national survey data exist that provide some measures of sexual satisfaction. We do not claim that these data tell the whole story, but they are certainly worthy of examination and may help professionals in other countries in their planning of evaluations of sexual health. One major finding supported

by the longitudinal survey analyses (from 1971 to 1992) was that the sexual health of Finns – or at least the sexual enjoyment component of sexual health – has improved in the last 20 years. This seems to be true especially for young adults. Kontula and Haavio-Mannila (1993) report that compared to 1971, the sex life of Finns has become more versatile, sexual intercourse is rated as more pleasurable and satisfying by a higher proportion of adults, intercourse orgasms are more frequent for women, the amount of foreplay is rated better, discussions of sexual matters with a partner are easier, relationships are happier, and sex life is rated as more satisfying.

Findings from the survey analysed by Kontula and Haavio-Mannila also indicate that sexual attitudes of Finns are moving away from endorsing a double standard of sexual behaviour for men and women and toward an egalitarian sexual ideology. A similar proportion of men and women in the 1992 survey thought that temporary sexual relationships could provide happiness and satisfaction. The vast majority of respondents in all age groups reported that women should be able to initiate sex rather than simply giving the control and responsibility to men in sexual interactions. About three-quarters of both men and women agreed that 'a decent woman can openly show interest in sex' and this proportion was highest for younger adults. Although half the total sample reported that the sex drive was greater for men than for women, among the young, the more common view was that the sex drives of men and women are equal. Experiences of men and women have become more similar since the early 1970s. Thus, the stronger societal position of women with respect to their power in basic institutions seems to have contributed to greater equality in their sexual lives.

Some additional positive findings from the survey include the following: Over 80% of men and women report that their sex life is at least somewhat satisfying. Over a quarter report their sex life as 'very satisfying' and 6% or less report their sex life as 'unsatisfactory'. Over 90% of women rated their last intercourse 'at least fairly pleasant', almost half of both men and women rated their last intercourse as 'very pleasant', and 90% of both men and women rated their permanent relationship at least 'fairly happy' and less than 2% rated it as 'unhappy'. The majority reported they were in a steady relationship. Some 39% of men and 30% of women rated themselves as 'sexually very skilled' and 66% of men and 44% of women rated themselves as 'sexually active'.

Despite these rosy statistics, problems were revealed in the 1992 survey. For example, 19% of men and 23% of women had no steady sexual partner. Women over 50 were especially likely to be without a partner. Lack of sexual desire was a problem for significant proportions of men and women. Of men, 50% and of women, 26% reported no sexual desire problems in the last year. Lack of vaginal lubrication, inability to have an orgasm and painful intercourse were reported frequently by women. About one third of women of all ages had continual difficulties in having an orgasm. Similarly, erectile dysfunction and coming too quickly were problems for men. In addition, relationship problems also contributed to an unsatisfactory sex life for many couples.

Thus, the ability to enjoy sex has not been possible for many Finns. Nevertheless, it seems unlikely that Finns have more sexual problems than people from other countries have. Indeed, the probability is that they are more able to enjoy sex for many other components of sexual health are more problematic in most other countries. Possibilities for sexual pleasure are increased when other aspects of sexual health are not a concern, that is when worries about unwanted pregnancy, sexually transmitted diseases, force, coercion, and discrimination are minimised.

Sexual Knowledge and Information

An important influence on the sexual pleasure and satisfaction of individuals is their degree of sexual knowledge and skills. Adequate knowledge is, of course, important for every aspect of sexual health. As discussed previously in several chapters, Finns seem to have an adequate knowledge of sexual issues. Nevertheless, it has also been stressed that sex education in the schools needs reform (see Lähdesmäki and Peltonen, chapter 15 and Liinamo, chapter 17). It is alarming that the subject is no longer compulsory, that there are no specific requirements for its content, that there is not much co-ordination of teaching of this subject, that there is great variability in the amount and comprehensiveness of sex education curricula across schools and municipalities, that the training and competence of those who teach it varies greatly, and that many who are assigned to give sex education regard their skills as inadequate to do so properly.

Of concern as well, as mentioned earlier, is the reduction of opportunities by school nurses to provide sex education. Thus, we urge that educational professionals take action to improve sex education in their schools, and thereby work to improve the aforementioned conditions. The first step is for each school to assign someone in charge of the co-ordination of teaching sexual topics. Second, comprehensive sex education should be offered, if not required at every school. Third, teachers who feel they need more skills to adequately give instruction in sexuality should have opportunities to do so. Such training is offered throughout Finland in special seminars and at polytechnics. Teachers should also be made aware of the many new sex educational materials recently developed with the support of STAKES and Väestöliitto.

The 1992 survey of the Finnish population indicated that over 60% of adults had received some information about sex from their parents. These respondents also said they preferred to be informed of sexual matters in the school, and less than one third (half of the youngest generation) considered the information learned in school adequate. Thus, these findings also support the view we have stated earlier that sex education curricula need to be more comprehensive.

The training and knowledge of those in the education and health sectors has a great impact upon the quality of information and services provided to people. As contributors to this volume have indicated, there is a need for professionals in these two sectors to

increase their knowledge and acquire skills that enable them to deal more effectively with sexual issues and problems of students and clients in their work. Part of the instruction to these professionals needs to include training in communication and listening skills. They must feel comfortable in talking about sexual matters and topics that often cause embarrassment.

Some polytechnics started in the 1990s to give sexological training at the basic level (10 credits) and specialized level. Specialized level (40 credits) leads to a further professional degree which complements an earlier degree of at least an institutional level. The need for training is indicated by the number of applicants which is many times larger than the training places. At the moment these specialized studies are attended by, among others, nurses, midwives, physicians, health workers, teachers, psychologists, as well as professionals and researchers in the social and welfare fields. There are plans to establish a higher degree in the sexuality field in order strengthen professional expertise.

The specific title of a sexologist has not been used in Finland. The situation is changing for in 1999 the Nordic countries approved a common specialized education program for sexologists. There are three levels in this training model. The first level of 20 credits provides a sexological "general education" or the information to give sex education. The second level of 20 credits prepares one to be a sex counselor. After completing the third level of 40 credits, one can claim the competence of a clinical sexologist in either sexual medicine or sexual therapy.

Finland will begin to formally establish the above education and titles starting in 2001 together with other Nordic countries. Training modules at least on level three will be produced which can be attended by students from various countries. The professional titles (sexual counselor/therapist and clinical sexologist) will have to be applied for from the Nordic Association of Clinical Sexology (NACS). Applications for professional titles in Finland will first be sent to the Finnish Association for Sexology for review. The similarity of other previous sexological training and work experience to the new training program will be assessed. The new sexology programs will lead to the significant development of professional special expertise and thus improve the sexual health services for the population.

Statistics Finland and other information gathering organisations provide very accurate records and data on sexual health. The efficient registrars and tabulations of statistics and other information are valuable sources for researchers in academia, educators, health policy experts, and health professionals. They provide a means for identifying needs and problems and for monitoring services and programs throughout Finland.

Many involved in sexual health have suggested that a multidisciplinary sexological department be established in one of Finland's universities. The duties of this department would be to educate sexual health professionals and co-ordinate research projects that

relate to sexuality and sexual health. To support this research, a section for sexology could be established within the Academy of Finland. Members of this proposed department could offer clinical services in sexual health and develop materials for school sex education.

Despite the fact that universities do not offer much sexological training, many health and academic professionals are involved in research that includes sexual topics. Departments of Public Health, Sociology, Psychology, Medicine, Social Policy, History, Education, Communications, Philosophy, and Literature have all been involved in research overlapping with or focusing on sexual topics.

The first national survey of the sexual attitudes and behaviour of Finns was carried out in 1971 (Sievers et al., 1974). This research was quite an accomplishment for it was only the second time any country had attempted to conduct a sex survey representative of its population. The Academy of Finland which funds research in universities all over Finland financed two (1971 and 1992) of Finland's three sex surveys. The most recent one (1999) was funded by the Ministry of Social Affairs and Health. Such support for sex surveys by a government is uncommon for most countries. The National Research and Development Centre for Health and Welfare has also funded numerous projects to guide development efforts and evaluation of sexual health programmes and needs. Thus, there has been much support to increase the knowledge in sexual health by educational and governmental institutions. Nevertheless, there is still a need to continue government funding of sex research and to broaden the range of topics examined.

Opportunities to bring new sexual knowledge to Finland are also facilitated by the active participation of Finns in many sexuality-related professional organisations. Finns have regularly attended the meetings of the Scientific Study of Sexuality in the USA, sexuality sessions of the European Association of Sociology, the European Federation of Sexology, the International Lesbian and Gay Association, and the World Association of Sexology. In addition, of course, they attend meetings of Nordic organisations whose members are STD specialists, sex therapists, clinical sexologists, and gynaecologists with a special interest in adolescent or women's health. In 1997 two Finns were nominated to join the International Academy of Sex Research.

The media has been an important sex educator for all age groups. As discussed in chapter 18, the media often provides important information about sexual health issues. Finns follow the media keenly and learn about sexual matters from international as well as national perspectives. Television, radio, and newspapers can be given credit for their good coverage of important developments or happenings related to sexuality, including even interviews and panel discussions with those doing sex research or providing sexual health services. For example, if STAKES sponsors a national seminar on some aspect of sexuality, the media will cover this. If a new book on sexuality appears, there will be a press conference that is well attended by reporters. Even graduate students get press

coverage such as a TV interview when they complete a major project on a sexual topic. Nevertheless, the scope of coverage could be extended to take better advantage of the wide variety of expertise in Finland on sexual matters. For example, more attention is always needed to highlight inequities of health service or problems of groups that are victims of abuse, harassment and discrimination.

The Internet provides a great deal of information about sex, and promises to be an increasing source of knowledge about sex in the future. However, there is great variability in the accuracy and value of material presented in Internet sites. Some guidance is needed to help users distinguish between reliable and non-reliable information. At times, media presentations may overly generalise, simplify sexual issues, or create pressures and conflicts involving sex and gender roles. Criticism of the sources of sexological information is often missing. For example, users of the Internet may get answers to their questions that many in the sexual health field in Finland would regard as harmful. Other examples of sex-related material provided by those lacking sexological training are sex magazines and videos sold in sex shops. Internationally and within Finland, there is a debate among social scientists about whether these types of sexually explicit materials promote views that are in conflict with the principles of sexual health and sexual rights that we advocate in this book. A discussion of possible benefits or harm from these materials is, however, beyond the scope of this book (see Lottes et al., 1993 for the range of views and their support).

Health Services for Sexual Problems

Although some physicians are well trained and sensitive to sexual needs and problems of their patients, many are not. Jukka Virtanen (chapter 6) pointed out that formal medical education in Finland does not require or include many courses on sexual health. Currently, those with expertise in sexual problems have had to get their training abroad or in special programmes in Finland organised by a special agency such as the Ministry for Social Affairs, SEXPO, or the Family Federation of Finland. Thus, the formal training of doctors should be revised to include more about sexual problems and should provide greater opportunities to specialise in clinical sexology or sexual medicine. Doctors need to at least understand that patients should be told in advance about how medications they prescribe might affect sexual functioning. Physicians should also regularly inquire about possible sexual side effects in their monitoring of medication. For example, depression and anxiety disorders are common in Finland. It seems likely that many Finns have noticed changes in their ability to have an orgasm and fail to understand that this change is due to the medication they are taking.

A long-term goal to improve services for sexual problems is to establish sexological units, each comprised of a team of experts, that can offer clinical services in several hospitals around Finland to treat sexual problems. Then those with sexual problems

would have more options for treatment and would also know where appropriate treatments are provided.

The World Health Organisation as early as the 1970's considered sexual health important. At that time WHO listed the following as basic and essential services needed for adequate sexual health care: (1) basic information on the biological and psychological factors of sexual development and procreation, the various forms of sexual behaviour, and sexual functional disorders and diseases, (2) a positive attitude toward sexuality and a possibility to objectively discuss sexual matters, (3) personnel that shows understanding and objectivity toward the wishes related to sexuality and gives advice and information about sexual matters and problems, (4) adequate sexological training of the health care personnel, and (5) adequate knowledge and resources to deal with the often complicated problems related with sexuality.

From a comparative perspective, Finland does a good job in the above areas. But as has been pointed out, there are many improvements are needed in order to provide better sexual health care for Finns.

Reproductive Health

In Chapter 1 reproductive and sexual health were discussed. Certainly women should be able to control the timing and spacing of their pregnancies. Women who are always worried about an unwanted pregnancy would have trouble having enjoyable sexual relationships. Furthermore, if women and their babies are confronted with serious health problems resulting from their pregnancies, then the quality of their life including their sexual health will be adversely affected.

In the chapter 4, many measures of reproductive health are listed and with respect to other countries, Finland fares remarkably well on these indicators.

The one issue we need to highlight here is the influence of infertility problems on the sexual health of a couple having difficulty conceiving a child. Research both within and outside of Finland has confirmed the negative impact of infertility on the sexual enjoyment of infertile couples. Sex becomes a task, a duty. Men feel they must perform during the short time period when their partner is fertile, and women are motivated by the pressure to have sex only for the purpose of getting pregnant. Thus, sexual interactions become associated with stress, pressure, and other unpleasant emotions. Couples who have gone through this tense experience often find it difficult to return to an enjoyable sex life after the infertility problem has been resolved or after they have given up their attempts to have a child. In far too many cases, the sexual relationship ends and satisfactory sexual relations can only be experienced with new partners, who are not associated with the unpleasant and sad traumatic period of their lives.

Unfortunately, infertility problems are not decreasing in Finland and there is a waiting period for treatment. In this regard, we re-emphasise the need for better screening for chlamydia. Due to the increased decision making power of municipal health care centres, the cost and availability of infertility services varies across Finland. This inequity also needs to be addressed in health policy.

One of the most alarming trends in Finnish health care in the 1990s, due to lack of adherence to national guidelines and the greater autonomy given to municipalities, is the decrease in diagnostic tests for both breast and cervical cancer (Helsingin Sanomat, 6 August 2000). (The Helsingin Sanomat is the most respected and widely read newspaper in Finland.) Apparently, in efforts to save money, fewer women have been encouraged to have the important diagnostic mammogram and pap tests and costs for these tests have increased. In Turku, for example, when mammograms were free, about 90% of women called had these tests. When payment was required, this figure dropped by nearly 30 percent. The failure to ensure these important preventive health measures varies throughout Finland. Of course, the general physical and psychological health, as well as sexual and reproductive health, of women has been seriously threatened by these oversights of municipal decision-makers. Public campaigns need to take immediate action to correct this neglect of the welfare of women.

Conclusion

Finns have a favourable attitude toward sexual matters and understand that sexual health contributes to general well being. In 1992, 88% of men and 79% of women thought sexual activity promoted general health (Kontula and Haavio-Mannila, 1993). With the exception of elderly women, the vast majority indicated they wanted their lives to include a sexual relationship. Furthermore, a majority of respondents (75% of men and 70% of women) supported the right of those in institutions to have a private place for sexual interactions. Only 5% were against such a right for the ill and elderly. The general positive views about sex make it easier for health officials to offer high quality sexual health services and for teachers to provide good sex education in schools.

The positive attitudes of Finns toward sexuality are the result of a combination of characteristics of Finnish society. One is the general acceptance of an egalitarian ideology, and another is the lack of strong religious forces that associate sexual health problems, and sex in general, to morality and sin. Although Finns generally do not link their sauna culture to sexuality (it is just a very pleasant and efficient way for people to wash themselves in a cold culture), the frequent acts of going nude to the sauna with people of a different age or gender seem to have given them a comfortable feeling about being without clothes in the presence of others.

It is also important that Finns have accepted a rights view of health. Finns regard the provision of basic health care as the responsibility of government. The Finnish Parliament has even enacted laws on patient rights. Thus, it is not surprising that Finns have been among the leaders at internationals meetings in their acceptance and promotion of sexual rights.

Despite these positive aspects, we offer some cautionary remarks about the future. Improvements must occur in the basic structure of the Finnish health care system. Finland has the expertise and resources to rank higher than 31st in the 2000 report of the World Health Organisation (WHO). Deficiencies in the Finnish healthcare system have a great impact on sexual health. Changes made during the recession must be re-evaluated.

In traditional Finnish fashion, working and action groups must be organized to help remedy the weaknesses cited in this book as well as those mentioned by the WHO. In fairness to those who had to make health policy decisions early in the last decade, we need to restate that this was a period of recession and there were not enough funds to adequately fund Finland's social and health care programs. Yet, we find it alarming that even today, when economic conditions have improved, some important officials in the Finnish government support reductions in funding proposals of the Ministry of Social Affairs and Health.´This seems ill-advised given the deep cuts in funding of social and health programs that occurred throughout the 1990's. Outside evaluations by both the OECD and WHO have already stressed that decreases in health funding should not continue.

We advocate restoring funds to help correct problems in the delivery of health services to the Finnish population.´The promotion of sexual health in the future requires more stable public funding than was given in the 1990's. Part of the budget of the Ministry of Social Affairs and Health should be allotted on a permanent basis to fund sexological training, sex research and sexual health information and education campaigns. Financial support by the Finnish Slot Machine Association to organizations offering sexual health services should be evaluated to ensure that such funding is sufficient. In addition, family planning projects of STAKES need to have permanent status for such projects have been successful in improving sexual health for Finns. Resources from the Ministry of Education are also needed to support the new Scandinavian model of training in sexology. Finally, local municipalities need to be more aware of the importance of continuing school sex education and family planning services.

As of 2000, even though experts in healthcare both within and outside of Finland have cited evidence of problems in need of attention, overall, Finland deserves praise for its high quality of sexual health services and education. In international comparisons, Finland fared well on almost all indicators of sexual and reproductive health in the 1990's. Support by the major societal institutions for sexual health has been strong in many

ways. There are no signs that a powerful organization working against sexual health and sexual rights will emerge in the future. Citizen's rights to health care are acknowledged by the government, strong and highly skilled expertise is provided by national health policy makers and health providers, the church supports many sex education and equity issues, rights of and services for many minorities are accepted, and the principle of equality between the genders is endorsed by a majority of Finns. The Family Federation of Finland is an avid advocate of sexual rights and especially works to promote the sexual health of adolescents. Finns also generally support sex education in the schools and understand that sexual well-being is part of general well-being.

The first sexological unit of a school for higher education was established in 2000, and a new organization, the Finnish Association for Sexology, founded in 1997, is yet another professional group that is working to promote sexual health. International cooperation by Finnish organizations (e.g., The Family Federation of Finland) in countries with serious sexual health problems will continue. Positive developments include the integration of sexual health care into family planning and maternity care services. With new and existing sexual health services and adequate funding from its government, Finland should be able to maintain its leadership position in sexual health in the new millennium.

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