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5. Family Planning Services

Introduction

During the last thirty years, Finland has been more successful than many other western countries in promoting sexual health in its population, at least with respect to rates of unplanned pregnancies and abortions. After the renewed abortion law (1970) and the Primary Health Care Act (1972), induced abortions decreased by more than half compared to the early 1970s. Since the 1970's, decreases in adolescents' unwanted pregnancies and abortions were exceptional compared to many other developed countries.

Low abortion rates or decreases in induced abortions in cannot be explained by differences in sexual activity between Finland and other countries. In Finland, sexual behaviour was studied using representative samples of the adult population, both in the early 1970s and in the early 1990s, the same period induced abortions sharply decreased. Sexual activity increased rather than decreased during this period. When sexual activity among Finnish people is compared to people in other European countries using frequency of intercourse as a measure, Finnish people are a bit less active than the French, but more active than the British (Bozon and Kontula 1998). However, differences among countries are small. One crucial explanation for the decrease in induced abortions is effective organisation of family planning services, and, therefore, wide use of contraceptive methods in the population.

This chapter describes how the organisation of family planning services, contraceptive counselling, delivery of contraceptive methods and access to induced abortion is organised in Finland.

Contraception

Provision of contraceptive services

The enactment of the Primary Health Care Act in 1972 led to the current organisation of health care in Finland. This law stipulated that every municipality must provide (alone or with another municipality) a health centre for primary health care services to its citizens. In addition, the act mandated that the municipalities provide a large variety of preventive health care services. These include school, maternal, and child health

care, all of which already had a long tradition in the country. Modern contraceptive methods had been introduced to Finnish markets only a few years earlier and, an effective way was needed to allow all women easy access to contraception. Thus, family planning services were added by the 1972 Act as a new field of preventative heath care. This was also important because many had feared that the number of abortions would increase because of the new abortion law; many thought this law would lead women to use abortion as a means of birth control instead of the established and recommended contraceptive methods.

Following the enactment of the Primary Health Care Act, family planning services were carefully monitored. The National Board of Health issued detailed instructions for the operation of family planning clinics and delivery of contraceptive methods. These instructions were considered requirements and highly necessary to be followed by health care personnel. Implementation of these new activities was effective. Within a few years, more than 90% of municipalities had founded a family planning clinic or provided these services in combination with maternal health care.

A public health nurse or a midwife with specific training in family planning, together with a general practitioner, who was especially appointed for the task, gave contraceptive counselling. This model of differentiated and specialised service-units was a common model of working until the early 1990s (Kosunen and Rimpelä 1997). During the first few years, the provision of services and number of visits were monitored by detailed statistics. When declining abortion trends indicated the system was effective, instructions, and follow-up were reduced.

All preventive services including visits to a family planning clinic were free of charge. They have remained cost-free, although fees for visits were introduced during the 1990s in health centres for medical services. In 1982, a circular letter of the National Board of Health advised that the first contraceptive method should be given free of charge. Municipalities have applied these guidelines in many different ways. In most cases, the first three months of oral contraceptives as well as the first intrauterine device (IUD) were delivered free of charge.

Family planning services were also provided by private gynaecologists in cities and villages, student health care clinics in towns with a university, as well as the Family Federation of Finland (Väestöliitto), and in some municipalities, Folkhälsan. A study in 1994 indicated that one third of urban women used private services the last time they needed contraceptive services, and in the capital area, the proportion was as high as 47%. Women living in rural areas mostly used health centre services (Sihvo et al. 1995).

Family planning services in change

In the primary health care organisation mandated by the Primary Health Care Act, a health centre was responsible for providing health services to its citizens. When somebody became ill, he/she went to his/her own *health centre***,** not to his or her own *doctor.* Then, the health centre organisation assigned any available doctor to care for the person. Consequently, the continuity of care was poor and the population was unsatisfied with the frequent change of doctors (Aro and Liukko 1993). Problems similar to these involving treatment were not seen in preventive services of health centres.

At the end of the 1980s, the population responsibility principle was suggested as a solution to the problems of medical services in primary health care. From the viewpoint of a health centre, this meant that a population living in a geographically defined area was assigned to a doctor and a public health nurse. It was their duty to provide all primary health care services to the population in their own area. From the viewpoint of individual patients, this renovation meant that in an ideal situation all citizens in the municipality had a doctor and a nurse of their own whose responsibility was to provide them all necessary primary health care services.

Municipalities created many models in their application of the population responsibility principle, the two extreme alternatives being the narrow-scale and the large-scale model. The narrow-scale model meant that the population responsibility principle only concerned medical services, and preventive services were provided similarly as before, that is, by doctors and nurses who had specific training in these areas. The large-scale model meant that a doctor and a nurse provided both medical and preventive services (including family planning services) to their own population.

A study on the structure of public services carried out in 1995 showed that 27% of municipalities had applied the large-scale model of the population responsibility principle by including family planning services as one of the tasks of the small area units (Koponen et. al 1998). Thirty-one percent of the municipalities provided health services similarly as before, based on differentiated and specialised tasks. The rest of the municipalities used some kind of intermediary model, so that family planning services were partly provided by the population-responsibility units. Altogether, a differentiated and specialised model of work was still more common in family planning services than in maternal and child health care or general medical care. The family planning study carried out by STAKES in 1994 showed that 28% of women had a personal doctor and 20% had a personal public health nurse in the health centre. One half of the respondents did not have a doctor of their own.

In the 1994 study (Stakes), 43% of respondents preferred private doctors and 32% preferred family planning clinics for contraceptive counselling. One fifth of the women thought that the position of the service provider did not matter. Nearly half of the respondents seemed to favour the large-scale model of work for 41% of the women indicated they preferred to visit the same doctor, whether the reason for a visit was contraception or another health problem. Most of the women thought the best ways of organising family planning services were either to provide them completely on a specialised basis or combine them with maternal health care. Only 12 % thought that the best solution was to combine contraceptive counselling with the medical services provided by a health centre doctor.

Women's knowledge of reproduction and contraceptive methods

The survey study in 1994 showed that women had good knowledge about topics concerning pregnancy, but facts about fertility were not as generally known. One third of the youngest respondents (18-19 year-olds) did not know which days during the menstrual cycle when it is easiest to get pregnant and even in the 20 to 29 year old group, this proportion was as high as one quarter (Sihvo and Koponen 1998). Knowing the timing of the most fertile period is important not only when one wants to get pregnant but also when coitus dependent methods of contraception are used. For example, one has to evaluate the need of emergency contraception after breakage of a condom.

In the 1994 survey, adult women's knowledge about contraceptive methods was measured by supplying a list of seven contraceptive methods. They were asked if they knew about these and how to use them. The widely used methods were well known, but implants, emergency contraception, and diaphragms were less well known. Knowledge about emergency contraception was high only among women under 25. On the other hand, young women were less aware of the IUD than older respondents were. (Table 1). Knowledge about the IUD was best among women who had been pregnant; in other words, among those women who constitute the pool of potential users of that method. Knowledge about other contraceptive methods by experience of pregnancy showed no substantial variation (Sihvo and Koponen 1998).

Use of contraceptive methods

In Finland, modern contraceptive methods have been the most common in contraceptive practices. This may be because their delivery was so effectively organised at the beginning of the 1970s. The proportion of natural family planning methods was small in the 1970s, and they have not increased in popularity during the more recent years as in Sweden, for instance, not even as a fashionable trend.

Table 1. Proportions (%) of positive responses to the question "Do you know these contraceptive methods and how to use them?" by age. (Source: Kosunen et al. 1997a)

Method	18-24 year-old	25-34 year-old	35-44 year-old	All
Condoms	99	99	98	99
Oral contraceptives	97	99	95	97
IUD	76	85	92	86
Implants	59	65	52	58
Emergency contraception	79	53	36	52

(Source: Kosunen et al. 1997a)

At the end of 1970s, the IUD was more widely used in Finland than in other Nordic countries, but its popularity decreased during the 1980s when the use of oral contraceptives increased among women, especially for those less than 30 (Makkonen and Hemminki 1991). At the end of the decade the use of oral contraceptives started to increase among women over 30 when new types of the pill more suitable for this age group became available (Kosunen et al. 1997b).

Different studies give very different information on the use of condoms depending on the age group and sexual activity of respondents in the sample. In general, figures describing condom use among the Finnish population have been quite high compared to many other countries. According to the population study in 1992, 27% of all women and 40% of all men who needed contraception had used a condom at their most recent intercourse. Among those who had sexual intercourse at least two or three times a week, condom use was less frequent (20% in women and 25% in men). Instead of condoms, they more often used oral contraceptives or IUDs (Erkkola and Kontula 1993). Another study in 1994 (Taloustutkimus) showed that 20% of women aged 15-49 used a condom as their main method of contraception and 6% used it as an additional method (Toivonen 1997). Similar percentages were found in the 1994 family planning survey of Stakes (Table 2).

The revision of the Law of Sterilisation in 1985 greatly affected contraceptive practices among those over 30. The revised law made it possible for women and men who were at least 30 to be sterilised if they requested, regardless of the number of children they had. The annual number of sterilisation's more than doubled after the revision of the law. Unlike other Nordic countries, sterilisation's were performed almost exclusively

for women in Finland. The number of male sterilisation's did not start to increase until the late 1990s, when there was more active promotion of using this method. In 1998, there were 9,593 female and 1,918 male sterilisation's in Finland (unpublished information from the national register).

Table 2. Distributions of current contraceptive method (%) by age among sexually active women (regular need of contraception al least monthly or almost monthly). Source: Sihvo and Koponen 1998

Age in years (n)	18-19 (65)	20-24 (250)	25-29 (304)	30-34 (312)	35-39 (294)	40-44 (239)	All (1464)
Oral contraceptives	63	60	52	25	16	5	33
Double contraception*	14	17	4	5	3	0	6
Condoms**	15	13	25	25	23	26	22
IUD	0	2	6	29	42	39	23
Sterilization	0	0	0	4	10	26	7
Implants	0	2	0	1	1	1	1
Spermicides	0	1	1	2	1	1	1
Do not use/ need at the moment	8	7	11	10	4	2	7

* a condom combined with oral contraceptives or IUD or implants
** a condom alone or combined with spermicides or a method of natural family planning

The most recent large surveys (in 1989, 1992 and 1994) on the use of contraceptive methods suggest that current contraceptive practices with respect to age differences are quite stable; no signs of major change have been found. The news of an association between increased risk of venous thrombus embolism and the use of third generation oral contraceptives, which was widely reported in mass media in 1995, did not have any permanent effect on sales figures or proportions of oral contraceptive users in Finland. (Kosunen et. al 1999).

Of women who participated in the family planning survey in 1994 (Stakes), 94% had at sometime used contraception, and 75% of respondents were using some method at the time of the study (Sihvo and Koponen 1998). About half of women under 30 were currently using oral contraceptives or an IUD. For women over 30, this proportion was smaller and the proportion who had been sterilised increased with age. Of sexually active respondents, about 80% of women under 25 and 62 to 72% of women over 25

used highly effective methods like oral contraception, IUD, implants or sterilisation. Almost all of the rest reported that they used condoms as their main contraceptive method (Table 2).

Emergency contraception was introduced to Finnish markets in 1987. Sales figures of the four-tablet package increased every year so that in 1998 about 44,000 packages were sold (Schering Oy, unpublished information). The family planning survey in 1994 showed that most users were unmarried and nulliparous women under the age of 25. Women over 25 were clearly less aware of this method and how it is used compared to younger women. Knowledge of emergency contraception was less than that for other methods (Kosunen et. al. 1997a). Adolescents receive information on emergency contraception in sex education classes at school, and they know the method very well. Thus, information directed to the adult population on more recent methods of contraception needs to be increased.

The possibility of using the copper-IUD as a method of emergency contraception is not well known among the population, and health centres do not frequently offer it for this purpose, according to research in Central Finland (Kosunen and Poikajärvi 1998). Copper-IUD can be used as emergency contraception when the time limit of 72 hours for hormonal emergency contraception has been exceeded. The application of the copper-IUD should be carried out within five or six days after an unprotected sexual intercourse, and is even more effective than the hormonal method. The copper-IUD is a practical option if a long-time contraceptive need exists and there are no contraindications for the use of IUD. Thus, the copper-IUD can be left in the uterus to take care of contraception in the future, as well as for the acute need of emergency contraception.

Induced Abortion

Legislation on induced abortion

The first Finnish abortion law in 1950 allowed termination of pregnancy almost exclusively on medical grounds. Women did not have the right to have an induced abortion because of their young age or for social reasons alone. Therefore, mental disorders like neurosis were often used as a medical reason for an induced abortion during the 1960s.

The Abortion Law was thoroughly revised in 1970. Finland was among the first countries in Western Europe that accepted more liberal abortion legislation. The most essential revision in the new law was the allowance of termination of pregnancy on social grounds, if two doctors provided a permission statement (2nd section, 2nd paragraph, see Table 3). The Law also specified limits on age and the number of children, so that in some circumstances an abortion was permitted with a statement from only one doctor (the

performing physician). These circumstances applied if the woman was less than 17 or older than 40 at the time of conception or if she had already given birth to at least four children. Since the year 1970, only some minor revisions concerning time limits for duration of pregnancy had been made to the Law, and the core elements of the law have remained the same.

Most induced abortions are permitted on social grounds. The abortion statement form that a doctor completes when referring a patient to a hospital for an abortion includes a box where the social grounds must be defined in detail. In 1992 a sample of the grounds were studied and the most frequently mentioned reasons were being an unmarried or a single mother, economic concerns, unemployment, difficulties in the couple relationship, and unfinished education (Rasimus 1993). Currently, an application for an induced abortion due to social reasons is hardly ever denied. According to current interpretation, a woman is the best expert of her life conditions and in knowing when childbirth and child care would be a considerable strain for her and her family.

According to the law in 1970, an induced abortion had to be carried out by the 16th week of pregnancy. In 1979, the limit was decreased to 12 weeks. For specific reasons, termination may occur even up to 20 weeks. Since 1985, it has been possible to perform an abortion up until the 24th week of pregnancy if a reliable examination shows that the fetus has a serious disease or injury/handicap. Currently about two percentages of abortions each year are performed on the grounds of a potential fetal injury (Gissler 1999).

An abortion can be granted to a woman asking for it when:

1) Pregnancy or childbirth would risk her life or health

2) Childbirth and child care would be a considerable strain on her and her family economically and socially

3) She is made pregnant againts her will

4) She was not yet 17 years of age or was over 40 at the moment of conception or already had four children

5) There is a reason to expect the child to be mentally defective or to have a difficult illness or physical defect

6) Illness, disturbed psychological functioning, or a comparable factor of one or both parents seriously limits their capacity to take care of the child

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Source: Abortion Law 24.3.1970/239 in Finland
Source of translation: Rolston B, Eggert A (eds). Abortion in the New Europe. A Comparative Handbook. Greenwood Press, Westport 1994.

The Main trends of abortion epidemiology in Finland

At the end of 1960s, during the last years of the old Abortion Law, the number of legal abortions was about 8000 per year. It has been estimated that the number of illegal abortions was 19,000 in 1966. Obviously, some of these illegal abortions led to serious complications, even death.

The enactments of the new abortion legislation in 1970 stipulated that a doctor who performed an abortion had to notify the abortion register (currently administered by Stakes) within one month, using a specific notification form. According to a study in 1993, the time limit of one month is not often adhered to, but other than being late, notifications are sent very reliably to the register. Only 1% of induced abortions was missing from the register when data of the abortion register were compared with the case reports from the operating hospitals (Ulander et al 1995).

After the revision of the law in 1970, the highest abortion rates were recorded in 1973 when more than 23,000 abortions were performed (19.6 abortions per 1000 women aged 15-49 years). When the Primary Health Care Act became effective in 1972 and the delivery of contraceptive methods was organised throughout the country, abortions started to decrease. At the beginning of the 1980s, the figure fell under the limit of 15,000 abortions (Table 3). In the early 1990s, the number of abortions was down fifty percent compared to twenty years earlier. In 1995, it was lower than 10,000 for the first time. However, during the last few years decreases in abortions have levelled off, and the latest figures suggest a slight increase. Age-specific abortion trends show that induced abortions are most frequent among women aged 20-24, and this has been the case throughout the current abortion law. The decrease in abortion rates was greatest among women under 20 (see chapter 14). About one quarter of all abortions are performed for married women and more than half for never-married women (Gissler 1999).

Table 3. Number of induced abortions and abortion rate (per 1000 women aged 15-49 years). Source: Gissler 1999, Vikat et al. 1999.

Year	Number	Number per 1000 women
1973	23 362	19,6
1975	21 547	17,9
1980	15 037	12,3
1985	13 833	11,0
1990	12 232	9,7
1995	9 884	7,8
1996	10 438	8,2
1997	10 274	8,2
1998	10 654	8,6
1999*	10 800	8,7

*preliminary data in June 2000 (national abortion register)

One of the main goals of the Finnish health policy has been to ensure equal opportunities for health care regardless of place of residence. However, the regional variation of abortion rates has remained similar throughout the time the current Abortion Law has been in effect. During the 1990s, the abortion rates have been highest either in Lapland in the north or in Uusimaa (Helsinki metropolitan area and its surroundings in the south). In addition, the island of Ahvenanmaa has been ranked high, but due to its small population, the variation is great there. In 1998, the abortion rate for women aged 15 to 49 was highest in the hospital districts of Helsinki and Lapland (11.8 and 11.6 per 1000 women) and lowest (5.5/1000) in the hospital district of Keski-Pohjanmaa in the western Finland (Vikat et al. 1999).

Eighty-seven percent of induced abortions were carried out on social grounds in 1997, and 11% were for age or number of children in the family (Gissler 1999). The distribution of the grounds for abortions has not changed during recent years. However, since the early years of the law, the distribution of the grounds has changed to some extent so that the proportion citing social grounds increased. This mainly reflects differences in interpretations of the grounds in different areas. Ninety-four percent of abortions are performed before the 12th week of pregnancy, and this proportion has remained fairly constant for several years. In 1997, National Agency for Medicolegal Affairs (TEO) permitted a termination for 568 pregnancies that had passed the limit of 12 weeks. Seventy percent of all abortions are for women who have a termination of pregnancy for the first time, 21% have it for the second time and 9% have had at least two previous abortions. Compared to the early 1980s the proportion of repeated abortions has increased somewhat steadily, but the changes were minor during the 1990s (Gissler 1999).

Abortion care

Different stages of abortion care typically constitute a series of events where primary health care and hospital specialists each have their own role and where collaboration between professionals of different levels of health care is supposed to proceed smoothly without friction. Almost all clients wanting to terminate their pregnancy have to pass through all the stages, because a referral is needed for hospital care and most clients also need a doctor's statement on their need and grounds for an abortion (see section 3.1 of this chapter). When a woman wants to have an induced abortion on social grounds, she needs a permission statement from a primary health care doctor. If a woman fulfils the criteria of age or number of children, a statement from another doctor is not needed. Usually a woman makes an appointment with a doctor at either a health centre or private clinic in order to get a referral to a hospital. Then the referral and the statement (if needed) are sent to the hospital as soon as possible. The hospital clinic informs the client about the timetable of the procedure which is carried out within one week whenever possible.

Until recently hospitals usually followed the practice of two visits. First, a woman visits an outpatient clinic of the hospital, where a gynecological examination is performed. In addition, potential contraindications for general anesthesia are examined and then an appointment for the procedure in a hospital inpatient clinic is made. Up to the 1990s a major part of induced abortions were performed in inpatient wards. There are medical arguments for this practice, because a general anesthesia has been widely used in abortion care in Finland instead of local anesthesia. Therefore, a careful follow-up is needed after the procedure.

After leaving the hospital a series of abortion care events continues in primary health care. The patient is expected to visit her own doctor for a check-up a few weeks after the procedure. The purpose of the visit is to check on not only physical but also psychological recovery. In fact, the abortion legislation says that contraceptive counselling should be provided for the client after the procedure.

Currently abortion care is changing and developing in Finland. As in operative care, in general, abortion care is also adopting new practices of care by shortening the time spent in the hospital. This means that the procedure is carried out in the outpatient clinic of a hospital and the patient can go home during the same day, a few hours after a follow-up to the procedure. A questionnaire study in 1994 showed that 86% of the women who had experienced an induced abortion within the past year had had the procedure in an outpatient clinic, while the proportion was only 12% for those women who had had an abortion ten or more years ago (Sihvo et al 1998). One of the patients' most crucial requests for development of future abortion care was to organise the care so that only one visit to a hospital would be needed. Some hospitals have already tried this practice with success.

In Finland, a major part of induced abortions are carried out before the end of the 12th week of pregnancy and in 64% of all cases, the duration of pregnancy is less than eight weeks (Gissler 1999). From a technical viewpoint this means that abortions are mainly carried out by using a vacuum aspiration combined with curettage if needed. A medical abortion, in other words, an abortion induced by an oral medicine such as mifepristone will change practices of abortion care in the near future. This method was officially adopted in Finland at the end of 1999.

The costs of abortion care include expenses in primary health care and expenses of hospital care. Visits to a health centre (a family planning clinic or a general practitioner) before and after the procedure are generally free of charge or the expenses are very low. The costs are much higher if private services are used (about 40 or 50 dollars per visit). The costs of hospital care used to be from 30 to 50 dollars, but the charges were

raised in 1999. Currently, the total costs of abortion care in a hospital are about 80 US dollars (the first visit 20 dollars and the procedure 60 dollars in an outpatient clinic).

Women's experiences of an induced abortion

An induced abortion is still somewhat taboo. It is an event that people would rather like to hide and forget about as soon as it is over. Therefore, women who have experienced an induced abortion seldom talk about their experiences, and this topic has not been studied in Finland until recently.

Women's experiences of an induced abortion were included as one of the topics of the family planning questionnaire study of Stakes in 1994. A structured multi-choice question was used to ask about the amount of discussions with a doctor and a nurse before and after the abortion. An open-ended question was used to ask about topics that women would have liked to include in these discussions. Altogether 34% of women who had experienced an abortion would have liked more discussion with a doctor or a nurse either before or after the procedure. Psychological effects of an abortion such as feelings of guilt, sorrow and depression as well as justification of the decision were ranked highest as topics of discussion. The second most requested topic to discuss centred around abortion as a procedure. Women were concerned about health risks and possible influences on post-abortion infertility (Sihvo et al. 1998). The same topics also emerged in another study in which data were collected from women right after their abortion using a narrative technique (Poikajärvi 1998). These studies indicate that many women need more support and discussion in connection with abortion care. The discussions should focus on a variety of topics including women's groundless fear of infertility. This specific issue should be automatically dealt with in counselling before a termination of pregnancy to reduce unnecessary feelings of anxiety. Preparation of written material for women seeking for an abortion is also necessary.

Future Challenges of Family Planning

The most crucial challenge of developing family planning services is to increase the range of services. The aim of the work cannot only be contraception and effective delivery of services, but comprehensive promotion of sexual health. When activities are considered in this framework, services should include planning and timing of pregnancy, prevention of sexually transmitted diseases, examination for infertility, and counselling in sexual problems.

During the last decades, Finnish men have started to participate in the birth and care of their children, but family planning has remained a female concern. However, men do have a favourable attitude toward assuming part of the responsibility. In the family planning survey in 1994, almost one hundred percent of 20 to 24 year-old men and 86% of 40-44 year-old men thought that the responsibility of contraception belongs

equally to men and women. In practice, participation in birth control was limited to use of condoms; even sharing the expenses of contraception was rare (Sihvo and Koponen 1998). Increasing male participation and developing services tailored for men are challenges of sexual health promotion. It would be easy to develop this new area of services for boys often come to a waiting room of a family planning clinic with their girl friends. It would be very natural to ask them to come in and join the discussion.

Money is an essential issue from an adolescents' point of view. Although visits and examinations are free of charge, the price of oral contraceptives is relatively high in Finland compared to many other countries. Subsidising the price of pills for adolescent clients in some way is extremely important. In the current situation, the Medicines Act has prevented attempts at delivering oral contraceptives free of charge (except initial prescriptions) from health centres, but certainly, a solution for this problem could be found by changing current legislation. Arranging sales of condoms at a lower price would probably increase use of double contraception (both condoms and pill) at the beginning of new relationships or in cases of multiple partners.

Emergency contraception was introduced to Finnish markets more than ten years ago and sales of these products have continued to increase steadily. However, when compared to the number of abortions, the use of emergency contraception is still far too low. All men and women, regardless of age, should have knowledge of emergency contraception, its time limits, as well as how to get it. Access to emergency contraception would be easier if delivery of the method was included as one of the duties of public health nurses.

Recent studies have shown that young clients would like to discuss subjects other than contraceptive methods when visiting a family planning clinic. Sexuality problems, relationships, and sexually transmitted diseases are topics of great interest for young clients. One crucial reason for neglecting these topics is insufficient education and training in handling sexual concerns (Nurmi 2000). However, clients' expectations have increased. They are now capable and brave enough to ask for help, even about sexual problems.

Skills of counselling in sexuality are needed in preventive and medical care. Developing these skills, as well as communication skills, is a challenge for undergraduate and postgraduate education in health care. Improving communication and client-centred skills are also challenges for professionals who work with abortion patients. Since an abortion can occur in only one visit to a hospital outpatient clinic, a danger exists that there is even less time for discussion than before. The new practice puts new demands on staff of primary health care units before and after an induced abortion. A substantial proportion of abortion clients would like more discussion about the abortion. They need both practical information on the procedures as well as emotional support. It is important for women to be able to honestly and openly discuss their feelings.

In 1993, Stakes appointed a working group to make a proposal for the development of family planning services. After a long silence, this was the first time that family planning services became a focus of a more comprehensive evaluation. The Committee gave some recommendations of developing services on a general level, and many of the recommendations have been, or will be, put into practice. (Stakes 1994, Rimpelä et al. 1996). Developing services has raised questions, which the working group Family Planning 2000 had not considered. One of these concerns the relationship of sexual health services to the population responsibility principle in primary health care. Expectations of the population and general trends of developing primary health care seem to be contradictory here. Declining fertility during the 1990s also raises a question about the goals of Finnish population policy and its relation to developing services for family planning and sexual health.

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