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21. Adolescent Sexual Health

Introduction

When evaluated from a medical perspective using statistical data, adolescents' sexual health has developed favourably in Finland during the last two or three decades. Teenage pregnancies and abortions have decreased by fifty percent since the 1970s, and these declining trends continued until the mid-1990s. Because these trends in pregnancies and abortions cannot be explained by changes in sexual activity, they are indications of more effective use of contraceptives. Age of initial sexual intercourse has remained fairly constant since the late 1980s. Sexually transmitted diseases have decreased among adolescents. Gonorrhea is rare and chlamydia infections decreased during the first half of 1990s. So far, HIV has not gained a foothold among Finnish adolescents. This can be considered an achievement in the promotion of sexual health.

Promotion of sexual health also includes components of psychological and social health. We know substantially less about the status of adolescents' psychosocial sexual health than we know about their physical health. So far, less attention has been given to studying and describing these aspects of their health. In addition, adolescents have seldom been studied as users of health services, not to mention as users of sexual health services. We know very little about adolescents' experiences and needs as clients.

International comparisons have shown that low teenage pregnancy and abortions rates are associated with sex education and easy access to contraceptive services (Jones et al. 1985). This means that services must be located close to young clients and that the cost of using these services is low. In addition, it is important to adolescents that services are confidential. A prerequisite for carrying out effective sex education and providing sexual health services is an accepting attitude, one which acknowledges sexual experiences as a normal part of adolescent growth and development.

In Finland, many of these criteria were met to a large degree during the last two decades. In this chapter, I describe in more detail those factors that have created prerequisites for favourable development of adolescent sexual health, as well as its present status. In addition, the topic of adolescents' sexual and reproductive rights in Finland will be addressed. Sex education, which is necessary for the promotion of sexual health, is discussed in other chapters of this book.

Adolescents' Health Services

Provision of Sexual health services

A major part of adolescent health services is carried out within the system of public services, that is, as a part of primary health care services. Unlike many other European countries, Finland has not founded a specific organisation of youth clinics; only the health centres of the large cities have separate clinics for teenagers.

In practice, when in need of sexual health services, adolescents mostly use services provided by their own health centre. They can make an appointment with a general practitioner or they can visit a family planning clinic or school health care unit.

Providing health services at schools has a long tradition in Finland, originating at the end of the 19th century. In 1972, the Primary Health Care Act included school health care as a part of services provided by health centres. A school nurse carried out age-specific physical examinations for all children and adolescents and was available at school at specified times for counselling and treatment of minor health problems. A school physician also participated in this work, but with clearly less time resources. From the viewpoint of promoting sexual health, school health care has had an important role as a provider of sex education and as a first contact with health care organisations. When adolescents begin their sexual activity and are in need of contraception, it is easier for them to first contact a school nurse to get advice. Mostly the school nurse helps the adolescent in making an appointment with a family planning clinic. In many schools, it is possible for a school nurse to give out the first package of oral contraceptives on advice of the school doctor, and thereafter, the girl is guided to a family planning clinic for follow-up.

A school nurse probably has the more important role as an information channel and a guide to family planning services in the bigger towns and health centre organisations. In 1998, a questionnaire study was conducted among youth clinic clients aged less than 18 in the city of Tampere. One of the questions asked the clients how they received information about youth clinic services. Friends were the most important source of information (63%), but almost as often (58%), clients got the information from their school nurse (Kosunen 1998).

Family planning clinics in health centres have provided services to adolescents using the same principles that are used for the adult population. Direct access to services without making an appointment, which would lower the threshold of obtaining services, has been used in only a few clinics. Sex education directed to large groups of adolescents has not been included in services of family planning clinics, but information and education has mostly been given in a counselling session with a client. Some municipalities have

had the staff of the family planning clinic participate in sex education at schools, while in others, whole classes from schools have visited the family clinic to learn about its services.

Besides public services, "Opened Doors" of the Family Federation of Finland (Väestöliitto) has provided sexual health services to adolescents since 1988 in the capital of the country, and Folkhälsan has provided some services in the Swedish speaking areas on the coast. Use of private services is minimal among adolescents.

Costs of sexual health services

Visits to family planning clinics as well as services in schools and student health care in health centres are free. The circular letter given by the National Board of Health in 1982 stated that the first method of contraception should be given free of charge. In practice, this meant that adolescents got their first oral contraceptives cost-free for 3 to 9 months, but after that, they had to pay the full price for the pills.

Currently, the price of a one-month package is about seven dollars; in larger packages, the price per month is a bit lower. Nurses working in family planning clinics have found that even the price for one month is a problem, at least for those girls who try to pay this expense from their pocket money, without any support from their parents. Besides oral contraceptives, adolescents also pay the full price for condoms, and so far, the delivery of condoms for adolescents has not been organised at a subsidised price.

Confidentiality of services

In Finland, there has been hardly any public discussion about prescribing oral contraceptives for minors without parental consent. For instance, in the USA and England there have been trials about such prescriptions, and even currently in England, the lack of confidence in teenagers complicates obtaining contraceptives by adolescents less than 16. However, court decisions in England have been consistent with The International Convention for the Rights of Children which stipulates, If a minor is considered mature enough, she or he has a right to decide about his/her own business without parental consent. In Finland, the Act on the Status and Rights of Patients that has been in effect since 1993 correspondingly places emphasis on the developmental level of a child or an adolescent, when it stipulates, a minor has the right to make the decision on his or her care or on releasing information about his/her health. The law does not stipulate any age limits that could be generally applied.

Adolescents themselves find confidentiality of services very important (Scally 1993). This issue has also emerged in countries, which are generally considered to have an open-minded sexual culture (Jones et al. 1985). Regardless of adolescents' insistence on confidentiality, parents often know about their use of contraception. The Finnish

practice allows prescription of oral contraceptives without parental consent, and no minimal age limit has been set. However, a young client is advised to tell her parents, because eventually they will find out. In practice, the youngest clients of family planning clinics are 14-year-old girls, of which some one to two percent are using oral contraception. This proportion has remained about the same since the mid-1980s, and contrary to public opinion, the users of oral contraceptives are not getting younger and younger (Kosunen et al. 1999a). According to a Finnish study, 15 year-old girls who use oral contraceptives have a steady relationship; they are sexually active and like adults need contraception (Kosunen 1996).

Current Situation of Adolescent Sexual Health

Initiation of Sexual Activity

Sexual experiences in adolescence are important for the discovery of one's own sexuality and formation of ones sexual identity. Even children as young as 9 to 11 try to find out how it feels to be close to somebody of the opposite sex by slow dancing " at school discos or home parties. In adolescent surveys, pupils of the 7th grade (between 13 and 14 years old) report quite frequent experiences of kissing and fondling. Real dating relationships become more common after age 13. Girls are more active in dating than are boys, and this difference can be seen even several years later.

According to the School Health Survey in 1996-97, about 60% of 8th grade boys and girls have experienced their first kiss, and about half of them have experienced fondling with clothes on (Table 1). Experiences of intimate fondling (under clothes or naked) sharply increase between 15 and 16, among boys and girls (Kosunen et al. 1998).

By the end of the last year of comprehensive school (mean age 15.8) about one quarter of adolescents have experienced sexual intercourse (Table 1). Girls are a bit more active than boys, if total number of coital experiences or the frequency of sexual intercourse during the past month are used as criteria for sexual activity. This is mainly due to the difference in biological sexual maturation, which starts two years later in boys than in girls. On the other hand, compared to girls of the same age, experienced boys reported having had more sexual partners. In the second year of high school (mean age 17.8) girls are still more active than boys in terms of the frequency of sexual intercourse during the past month. Forty percent of sexually experienced girls and 23% of boys, respectively, reported having intercourse during the last month. There was no longer a difference in the number of sexual partners at this age.

Finnish adolescent surveys between 1986 and 1997 have provided very similar results on the proportion of adolescents having experienced sexual intercourse. Contrary to popular belief, the age at which sexual experimentation begins has not decreased during

the last few years. From the viewpoint of promoting sexual health, this is an important finding. Although sex education has been provided in Finland since the 1970s and contraceptive methods are quite easy to obtain for adolescents, this has not led to a younger age of initial sexual intercourse.

Table 1. Proportions (%) of adolescents reporting sexual experiences by gender and grade at school according to the School Health Study 1996 and 1997 (Source: Kosunen et al. 1998).

Gender	Girls			Boys		
grade	8th grade	9th grade	USS*	8th grade	9th grade	USS*
N	17 627	16 765	10 649	17 814	16 841	7 321
Going steady	16	25	39	12	16	22
Kissing	64	77	89	58	69	81
Fondling with clothes on	50	67	84	48	62	76
Fondling naked/under clothes	30	49	73	27	43	61
Sexual intercourse	15	29	53	14	24	42
Sexual intercourse during the last month	8	18	36	8	13	21
Sexual intercourse at least ten times	5	14	36	4	8	19

*upper secondary school (high school)

Contraception

General points of adolescent contraceptive methods

Contraceptive methods suitable for adolescent use are few compared to those of the adult population. A condom is the most important method that teenagers use. It is a coitus-dependent method and suitable particularly if sexual intercourse occurs infrequently and irregularly, as often happens in the case of adolescents. The strong point for using condoms is that, if used properly, they protect relatively well against *both* pregnancy *and* sexually transmitted diseases. The weak point is that condom use requires great care and proper use to be reliable. This is important for young and inexperienced users to understand. A shift to oral contraceptive use often happens in a steady relationship where coital events occur more frequently. At the beginning of a new relationship, oral contraceptives should be used together with condoms, as methods of double contraception

(Table 2). Hormonal emergency contraception is not applicable for regular use because of its low contraceptive efficacy, but it is a *reserve method* for a failure or omission of regular contraception.

Table 2. General outlines for choosing contraceptive method for adolescents for prevention of unplanned pregnancies and sexually transmitted diseases according to type /length of couple relationship and coital activity

Type of relationship	Length of relationship	Coital frequency	Contraceptive method
Occasional	-	Less than 2 per month	Condoms (+ emergency contraception*)
Occasional	-	At least 2 per month	Oral contraceptives + condoms
Steady	Less than 6 months	Weekly	Oral contraceptives + condoms
Steady	At least 6 months	Weekly	Oral contraceptives

*advice on emergency contraception for all condom users in case of failures

Condoms

Information and education of condom use targeting adolescents was substantially increased in the latter half of the 1980s because of a threat of an HIV epidemic. A survey of adolescent sexual behaviour in 1992 (the KISS Study) showed that teenagers' opinions of condoms were more positive compared to earlier studies, and proportions of adolescents using or having ever used condoms increased (Kosunen 1993).

The main contraceptive method used at the first sexual intercourse is a condom; the second most common option is that no method is used. The figures of the KISS Study describing the first sexual intercourse indicate that use of condoms between 1986 and 1988 increased: in that period, the proportion of non-use of contraception decreased from 40% to 27% among girls and form 30% to 20% among boys.

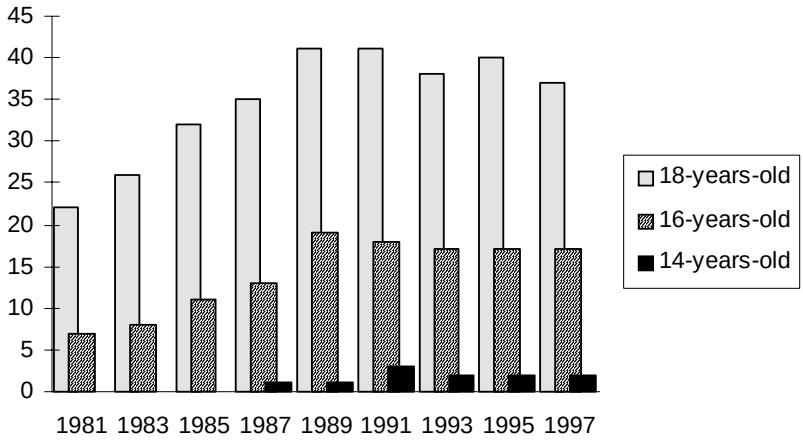
The prevalence of contraceptive use has also been studied by asking which contraceptive method adolescents used at their most recent intercourse. The results of the WHO cross-national survey (Health-Behaviour in School Aged Children) suggest that practices of condom use improved again during the early 1990s. The proportion of girls who had not used a contraceptive at their most recent intercourse decreased from 25% to 15 % between 1990 and 1994, and the respective figures for boys were 25% and 11%. When comparing distributions of contraceptive methods, the proportion of condoms had increased by ten percent (Pötsönen 1998).

Oral contraceptives and double contraception

In Finland, oral contraceptives were recommended for the first time for adolescents at the end of 1970s. According to the Adolescent Health and Lifestyle Survey in 1981, about one fifth of 18 year-old girls used oral contraceptives. Among younger girls, the use was infrequent. During the 1980s, the proportion of users also increased among younger age groups. Among 16 year-olds, it almost tripled, and one to two percent of 14 year-olds were users (Figure). During the 1990s, the use of oral contraceptives remained steady. Neither the rise in prices nor the pill scare in 1995 had an effect on their popularity. According to the Adolescent Health and Lifestyle, in 1997 41% of 18 year-olds, 17% of 16 year-olds and 2% of 14-year-olds used oral contraceptives (Kosunen et al. 1999a).

Many efforts have been made to promote the use of double contraception during the era of HIV. The recommendation has been that it should always be used at the beginning of new relationships for 3 to 6 months. The proportion of such users has been small, and use of double contraception has not increased during the 1990s. According to a recent study, five to seven percent of sexually experienced comprehensive and high school students had used double contraception at their last intercourse. The figures are somewhat lower than at the beginning of the decade. One reason often given is that the combination of pills and condoms is far too expensive a method for adolescents at current unsubsidised prices of contraceptives.

Figure 1. Proportions of oral contracpetive users (%) among girls aged 14, 16 and 18 years from 1981 to 1997.



The four-tablet package of hormonal emergency contraception was introduced to the Finnish markets in 1987. Its sales have risen annually, so that in 1998 about 44,000 packages were sold. According to a study in 1994, the users are mainly unmarried women under age 25 (Kosunen et al. 1997). Older women knew less about this method

than conventional methods. According to the School Health Survey in 1996, almost all girls in the 8th and 9th grade (mean age 14.8 and 15.8 years) knew about hormonal emergency contraception. In the 8th grade, the proportion of girls who had ever-used emergency contraception was 2%, in the 9th grade the figure was 6%, and in high school, it was 15%. Two thirds of those users had used the method only once, while the proportion of multiple users varied between 4 and 6 percent in all groups (Kosunen et al. 1999b).

Teenage Pregnancies and Abortions

Teenage pregnancy and abortion rates have decreased by more than half since the mid-1970s. Because teenage pregnancies are usually unplanned, the trend of pregnancies reflects changes in sexual activity or contraceptive use or both of them. Based on research data it is obvious that changes of adolescent sexual activity do not explain trends in teenage pregnancies and abortions in Finland.

Around half of pregnancies of girls less than 20 years of age will end in induced abortion. The younger the girls concerned, the higher the proportion. As in western countries in general, the trends of pregnancy and abortion rates highly correlate. The only exception in the Nordic countries is Iceland, where the prevalence of teenage pregnancies is the highest of these countries. However, most pregnancies are carried to term there, and the abortion rate has been lower than in other Nordic countries until quite recent years. However, the situation is changing and the number of teenage abortions is now sharply increasing in Iceland (Gissler 1999).

Sexually Transmitted Diseases

When HIV became public knowledge in the mid-1980s, versatile campaigns were started in Finland to increase condom use and prevent an epidemic of HIV (Tikkanen and Koskela 1992). One form of public campaign targeted to adolescents was a personal letter mailed to the home address of all young people between 15 and 24 years of age in 1987. The Ministry of Social Affairs and Health sent the letter and it included information on preventing HIV and other sexually transmitted diseases. The campaign has continued so that every year all adolescents who will be sixteen years old receive this information package. Besides a pamphlet, the material includes a condom and a letter to the parents. Since the very first years, the content of the package has increased so that currently, different topics of sexual health information are covered more thoroughly.

At the beginning of the 1980s, gonorrhea was still a quite common disease. A decreasing trend started in the early years of the decade, and this trend accelerated at the end of the decade, perhaps only as a result of increasing condom use. The incidence of gonorrhea was 13 cases per 10,000 girls aged 15 to 19 years; the new figure was 2 per 10, 000 in 1994. From 1995 to1998, the total number of cases has been around twenty cases among adolescent boys and girls combined.

Statistics on chlamydia infections have been recorded since 1988. The incidence of chlamydia decreased simultaneously with the decreasing trend of gonorrhea: between the years 1988 and 1994, chlamydia infections decreased 41% in girls aged 15 to 19 (Kosunen 1996). After that, the method of compiling statistics changed twice, so that the numbers of the recent years are probably not comparable with those of earlier years. However, the statistics of 1997 and 1998 suggest that chlamydia infections are increasing in young age groups. Twenty-three percent of all reported venereal chlamydia infections in 1998 were found in adolescents aged between 15 and 19 years. Altogether, the proportion of young people's (aged 15 to 24) infections was two thirds of all chlamydia infections in 1998 (source: www.ktl.fi/ttr). So far, HIV transmissions have not spread among the teenage population in Finland. The total number of HIV transmissions found in adolescents aged 15 to 19 is eleven, but the figure is 137 in 20-24 year-olds by June 2000 (National Public Health Institute, unpublished information). Now, HIV is spreading as an epidemic among users of intravenous drugs in the capital area. Therefore, more effective preventive measures must be taken in the very near future.

Psychosocial Sexual Health

The concept of sexual health was created to emphasise, among other goals, that good sexual health also includes psychosocial well-being. This means that an individual person is free to discover his/her sexuality in that way which is best for him/her, without any pressure, fear or anxiety, and with respect for other people.

We know very little about the status of psychosocial sexual health among adolescents. What are those teenagers who are just starting their active sexual life thinking? Sexual maturation of an adolescent includes powerful and rapid changes, both physically and psychologically. Events of maturation raise many questions in a teenager, even feelings of fear and anxiety. Ideally, adolescents should be surrounded by safe adults, adults adolescents feel comfortable with and with whom they can discuss their problems freely and openly. Relevant knowledge will lessen misunderstandings and unnecessary fears. For example, masturbation is still associated with hiding and feelings of shame, even with severe feelings of guilt. Therefore, it is important that adolescents get relevant information through school sex education lessons, which include information about a variety of topics including masturbation and its role in a young persons sexual development.

The KISS study in 1992 showed that during the HIV campaigns in the late 1980s adolescents' knowledge about sexuality improved, but, on the other hand, their sexual fears increased. These kinds of studies have not been carried out in the latter half of the 1990s. Studies among young clients of family planning clinics show, however, that adolescents need discussion, and they would like to talk about sexuality and couple relationships during their visit to the clinic.

Gender socialisation is a developmental process that begins in early childhood. In spite of the trend of increasing equality between genders, old sex-related attitudes still influence the sexuality of young people. Sexual activity is "macho" for boys, but for girls expressions of sexuality can still mean stigmatisation and loss of reputation.

In very recent discussions, some public health nurses working in family planning clinics have expressed concern about sexual pressure on young girls. In particular, a question has been raised about the possibility of the misuse of emergency contraception for pressing girls to engage in sexual intercourse. Research data on this topic is non-existent for the 1990s. The KISS Study in the late 1980s showed that between five percent and ten percent of girls had reluctantly agreed to their first sexual intercourse after persuasion (Kontula and Meriläinen 1988).

Increasing commercial sex and its visible role in all types of mass media can also be regarded as a threat to adolescent sexual well-being. This probably shapes teenagers' understanding of sexuality and may cause unnecessary pressures for both genders. As an alternative to commercial information, adolescents need additional sources of relevant information about dating, human relationships, and sexuality.

We know very little about growth and development of those adolescents whose sexual orientation is different from the majority. Homosexuality and bisexuality are seldom addressed in sex education lessons at school. Although attitudes towards homosexuality have changed and become more open and accepting in Finnish society, the dominance of a heterosexual perspective is obvious in the society and among different service providers.

Adolescents' Sexual Rights in Finland in the 1990s

Finland and other Nordic countries are among the leading countries in both the realisation and promotion of adolescents' sexual rights. It is not purely by chance that the trends of different indicators of adolescent sexual health (e.g., induced abortions, HIV transmissions) are favourable here. However, during the 1990s, some changes occurred which may have a deteriorating effect on the realisation of adolescents' sexual rights.

In 1994, curricula of comprehensive schools were changed so that the municipalities had more power to decide about what was taught in their schools. Sex education, which used to be an obligatory subject at school, was *no longer* included in the required curriculum of a school. Consequently, comprehensive sex education and sufficient level of sexual knowledge are not provided in every school any more, thus compromising the foundation for the successful promotion of sexual health later in life.

School and student health care funding was substantially reduced during the early 1990s in many municipalities because of the economic depression (Latikka et. al 1995). These

reductions are very significant because the Finnish organisation of primary health care does not provide any other services targeted for young people in particular. Although the economic depression is now over and there are many signs of improved health and well-being among adolescents, no improvement in the provision of services is scheduled.

The changes in services and education provided by the health and education systems are important from the viewpoint of sexual health; promotion of adolescent sexual health requires services tailored for adolescents' needs with easy accessibility and availability. Those who counsel adolescents must have specific requirements: they must have a broad understanding of bio-psycho-social development and good communication skills. At its best, school health care has provided this kind of service. Developing, not cutting off these services would be the easiest and most economical way of meeting adolescents' increasing needs for health services.

Occasionally, there have been discussions about limiting adolescents' access to contraceptive services, for example, by setting an age limit. However, this is very difficult, not only because of individual rate of growth and maturation, but also due to the large variation of normal development. Putting strict age limits for access to contraception would also be against international recommendations and agreements concerning sexual and reproductive rights. Commitments and legislation related to such rights include the International Convention for Children's Rights and the Act on the Status and Rights of Patients, which both give the right of self-determination to a child if he/she is mature enough to understand them.

If an exceptionally young teenager comes to ask for oral contraceptives, she should not be given them automatically. Rather the girls' life conditions should be examined more thoroughly than usual. Need of contraception at an early age (in Finland this usually means younger than 14 years) is often associated with a wide range of social problems. When a child or young adolescent comes for a visit to a family planning clinic, she may need assistance with other problems. If access to contraceptive services were limited by enforcing a strict age limit, it would be the end of one way to identify and help children and adolescents with serious problems

Several indicators during the last two or three years suggest that the favourable development of adolescent sexual health has levelled off. Trends of induced abortions have turned upwards since 1994. Laboratory reports indicate that chlamydia infections have statistically increased. Increased use of intravenous drugs, in particular, has already created a small epidemic of HIV in the capital area, which can easily spread through the rest of Finland. Society must react soon to the worsening conditions by increasing information and education directed to individuals and communities, as well as by developing sexual health services that more adequately reflect their current needs.

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