Ilsa Lottes

2. Macro Determinants of Sexual Health

What factors improve or impede sexual health? This question can be addressed from both macro and micro perspectives. A macro level analysis examines entire social systems and the way basic institutions and values influence people's lives. A micro level analysis focuses on interactions and communication among individuals and small groups. Osmo Kontula uses the approach where the individual is typically the unit of analysis (see Chapter 3). My purpose here is to lay the foundation for a macro level analysis of sexual health. Thus, I will look at how institutions of society, namely those related to the economy, government, the family, education, religion, and medicine as well as values and norms impact upon sexual health. In the approach I take, an entire society is studied. Basic questions include: What are the characteristics of countries where people enjoy good sexual health? In what ways do societal institutions affect sexual health? If the determinants of sexual health at the macro level are understood, then policy makers and legislators can direct their efforts to promote programs which have high probabilities of improving sexual health.

Issues and Problems in Explaining Sexual Health

To develop an explanation of sexual health, I first review its definition. *Sexual Health* is the ability of women and men to enjoy and express their sexuality, and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. Thus, sexual health is a complex, multi-dimensional concept that is not easily measured. But based on this definition, it is possible to define indicators of sexual health, and it is also clear that there is great variation in sexual health among individuals both within one country and between countries. Indicators can be used for within country evaluations and between country comparisons of sexual health. For example, countries which keep statistical records of rates of sexually transmitted diseases, contraceptive prevalence, unplanned pregnancy, abortion, and rape can be compared, or trends in these rates within one country can be studied. To investigate discrimination, values and laws related to various groups can be examined and compared. Is there a double standard of sexuality which punishes women more harshly than men for the same sexual act? Does the country have laws restricting gays and lesbians from engaging in sexual activities? Sexual enjoyment is difficult to measure directly. However, countries conduct national surveys on partner status, amount of satisfaction with sex life, and degree of loneliness. Thus, even though a comprehensive reliable and valid measure of

sexual health is impossible to calculate for a country, there are indicators that give some idea of at least some of the dimensions of sexual health.

The multi-dimensionality of sexual health also makes the task of developing its explanation difficult. Not all aspects of sexual health have the same set of determinants. Indeed, it would be a challenge to develop an explanation for any one dimension. It might even be best not to attempt a construction of a general model but instead focus on trying to understand each separate component of sexual health. I believe both approaches are important because although there are different models for each aspect of sexual health, there are factors that impact upon every aspect. Furthermore, the state of well-being in one area of sexual health is related to the state of well-being in other areas. Another problem in developing a general model of sexual health is that somewhat different models are likely needed for different types of countries (e.g., industrialised vs. developing) and different population subgroups (e.g., women vs. men or heterosexuals vs. non-heterosexuals). Nevertheless, although refinements are needed to account for differences in types of countries and population subgroups, some principles have general application. Common determinants of the multiple aspects of sexual health can be identified.

Literature Review

In my review of the literature in a variety of fields including sexuality, health, family planning, and sociology, I could find no previous attempts to provide a macro level explanation or model of sexual health. This is not surprising for sexual health is a relatively new concept. Only in the past decade have attempts been made to define it by identifying its specific components. Furthermore, the study of sexuality has only recently become legitimised by established disciplines. It was not until the 1990s, for example, that the American Sociological Association formed a separate section on sexuality. Nevertheless, social scientists have tried to provide explanations for various aspects of sexuality, including some, but not all, of the components of sexual health and for behaviour and attitudes that relate to sexual health. From these studies, we can get extensive guidance and clues on how to develop an explanation for sexual health.

The works of American sociologist Ira Reiss (1980, 1986, 1990, 1997) have been particularly valuable in providing insights into understanding sexuality. In his 1986 book, he attempted to provide macro level explanations for aspects of sexuality and also stated several propositions which he argued applied to all societies. Some of these are relevant to sexual health. First, he emphasised that all societies view sexuality as important, irrespective of the permissiveness or restrictiveness of their sexual norms. He argued that sexuality was valued not so much because of its reproductive outcome but because of its value as a source of pleasure –physical pleasure as well as psychological and emotional pleasure. Reiss also stated that stable relationships are valued in all societies and that physical pleasure and intimacy are the "building blocks" of stable

social relationships (p. 215, 1986). Reiss further argued that the ability to have sexual relationships was a valued social goal. A basic premise of sociology, in general, is that there is great variation in people's ability to obtain valued social goals. This access depends on people's location in the social structure as determined by many factors including their social class, gender, race, and power. Social scientists generally agree that from both historical and cross-cultural perspectives, men have had and continue to have more power than women. Thus, one may expect that men enjoy sex and satisfy their sexual needs more than women because of their greater power in important societal institutions. In addition, norms regarding sexual expression have usually been more permissive for men than for women, with the exception of norms for same sex interactions; here restrictions have generally been harsher for men.

Sexual Health of Women

Since the 1960s, as a result of the new feminist movement, women's sexual freedom and the control of their sexuality have been topics of scholarly investigation. McCormick and Jessor (1983, p.68) listed five characteristics of societies where women have more sexual freedom, including low militarism, and high egalitarianism in the family, politics, the economy and religion. Thus, the same principle is supported, namely that the degree of power in the basic institutions of society determines people's ability to enjoy and express their sexuality. By sexual freedom, the authors mean the ability for women to exercise control over their sexual lives. The first characteristic was stated as follows "women enjoy more sexual freedom where there is little or no emphasis on warfare or militarism." It is clear that military organisations are male dominated and allow greater opportunities for men than women to advance in the hierarchy. Second, "women control their own sexuality more where men participate in child rearing or where child-care services are available." One basic theme throughout feminist literature is that women's role as primary care taker of children has prevented them from assuming other roles and duties in society that are more highly valued and rewarded. The other three characteristics seem self-evident: Women are more sexually emancipated when "they have greater political representation", when they have "economically productive roles" and when they have "helped mold the mythology, religious beliefs, and world view of their groups." McCormick and Jessor (1983, p. 68) conclude that the more power women have in society, the weaker the double standard of sexuality, which favours men and restricts women.

In preparation for and in response to the conferences in Cairo and Beijing, there has been an emphasis on the 'empowerment of women' as a means for improving their sexual health and acquiring sexual rights. Here empowerment means gaining control over material assets, intellectual resources, and ideology (Batliwala, 1994). Thus, the empowerment of women involves a process whereby power or control over material

resources, and access to knowledge and information would be more evenly distributed between men and women. Empowerment mechanisms commonly cited include the formal and informal education of women, women's political participation, and group formation to build solidarity so women can work more effectively to achieve goals such as improving their economic security or increasing their self-esteem and self-worth. In addition, social scientists have attempted to examine how many types of social policies are gendered, that is how they differentially affect women and men, often resulting in greater empowerment for men than women.

Previously I emphasised that the Nordic countries and the Netherlands are the leading countries with respect to many indicators of women's sexual health – rates of abortion, teenage pregnancy and birth, unplanned pregnancy – as well as indicators which influence the sexual health of both women and men such as sexual knowledge and rates of sexually transmitted diseases (Alan Guttmacher Institute, 1994; David et al., 1990; David and Rademachers, 1996; Eng and Butler, 1997; Friedman, 1992; Jones et al., 1986, 1989; Ketting, 1994; Kosunen and Rimpelä, 1996; Population Action International, 1995; Skjeldestad, 1994; Vilar, 1994). Women in these countries have many rights (e.g., the right to safe, accessible, low cost or free abortion; the right to low cost or free family planning services; the right to information about sexuality via education and the media) denied to their counterparts in other countries. In the aforementioned countries women also have positions of power in the basic societal institutions. Women are well, albeit not equally, represented in their country's national legislature. In addition, maternity and family social benefits are comparatively high and with the possible exception of the Netherlands, a high proportion of women are in the labour market. A comparison of many aggregate indicators (e.g., educational attainment of women and poverty levels of women and their children) also supports the view that in the Nordic countries women have a higher degree of material assets and information resources than do women in most other countries (Bradshaw and Wallace, 1996; Population Crisis Committee, 1988; Siaroff, 1994; Smeeding, 1997; UNICEF, 1996; United Nations Development Programs, 1996, 1997, 1998). Indeed, on the United Nations gender empowerment measure calculated for 94 countries, Norway, Sweden, Denmark and Finland consistently rank in the top 5 with the Netherlands ranking as 9th or 10th (United Nations Development Programme, 1997, 1998). Thus, these countries illustrate a strong association between the empowerment of women and their sexual health.

Sexual Health of Men

In contrast to the emphasis on the sexual freedom of women, the sexual and reproductive health of women, and women's empowerment, the topics of men's sexual health and men's empowerment have received little attention. The common assumption is that men have the freedom to enjoy their sexuality because men historically have had more power than women and because the norms regarding sexual behaviour for men have been quite liberal. Indeed, men are often blamed for the poor sexual health of women and for the lack of control that women have had over their sexuality. Men's role in sexual restriction and coercion is well-documented; men have put the sexual health of women at risk and have denied women sexual autonomy. The conferences of Cairo and Beijing and much work since those conferences has continued to highlight the disadvantaged position of women in sexual relationships. Yet, it would be wrong to state that the majority of men in most societies have excellent sexual health. Men are also subject to systems of inequality, and in many countries, class, and race/ethnicity are more powerful means of determining access to valued resources than gender. In almost every society one can identify groups of 'dis-empowered men', such as minorities, homosexuals, transsexuals, and those living in poverty. The status of gay men is problematic in countries where there have been and continue to be, numerous violations of their rights, which have resulted in serious negative physical, mental, and sexual health outcomes (Blumenfeld and Raymond, 1988; Rofes, 1983; West and Green, 1997).

Although women are more prone to contract many sexually transmitted diseases, more affected by an unwanted pregnancy, and more likely to experience sexual violence, men also have many unmet sexual health needs. Many men lack knowledge about sexual and gender issues, or suffer from sexually transmitted diseases, infertility, impotence or premature ejaculation. Rape and sexual abuse of men and boys – although less common than for women and girls – result in serious health consequences. In addition, for many economically disadvantaged men, it can be difficult to find a partner. Studies on mate selection continually highlight the importance of status and wealth as factors that attract women to men (Buss, 1990).

Basu (1996) makes some important comments about the 1994 Cairo conference. First Basu points out that the barriers to improving the sexual and reproductive health of women involve more than gender issues. A focus entirely on patriarchy ignores other important socio-economic and cultural problems that need to be addressed. Basu (1996, p. 226) emphasises that poor, illiterate, unskilled, and/or unemployed men may exploit their women at home, but "their situation can be described as advantageous only in very relative terms". Further, Basu states that the "sexually able, fertile male is much less likely to exploit his male prerogative to abandon or ill-treat his wife" than a male with sexual problems. Basu questions the strategic value of documents containing

antagonistic one-sided rhetoric that focus exclusively on the sexual health needs and rights of women and the responsibility of men to change and support women. Basu wants the needs and rights of men as well as the responsibilities of women to be part of sexual health programs. This approach is advocated as the best way to improve the sexual health of both women and men. Principles that apply to women's ability to control their sexual lives and enjoy their sexuality can be extended to men – namely that the higher the level of power in basic institutions of society, the more opportunities a man or a woman has for sexual enjoyment. People's degree of power in institutions also determines their ability to access valued resources such as education and health services. Thus, a person's institutional power influences the amount of sex education and sexual health services he or she receives.

Other Determinants and Considerations

There is great variation within and between countries regarding the distribution of power, wealth and income of their citizens. One way to evaluate a country's sexual health is to examine the extent of inequality of wealth and power. If wealth and power are concentrated in only a small proportion of the population, then it is likely that only this small proportion will have access to reliable and comprehensive sources of information and quality sexual health services. If a high proportion of the population is living in poverty, then this population group is unlikely to have access to adequate sexual health information and services. Levels of both absolute and relative poverty can be approximated for a country and provide indicators of the extent of poor sexual health. The gross national product per member of the population gives one measure of the wealth of the entire country and thus offers some information about the general amount of resources available to all citizens. One measure of the distribution of wealth is to compare the incomes of a top group with a bottom group. The higher this ratio, the greater the inequity of income distribution (see Awad and Israeli, 1997; Osberg and Xu, 1997; Smeeding, 1997 for details about measures of poverty and income distribution).

The sexual ideology of a culture is another major determinant of sexual health. By sexual ideology I mean the belief system about what is acceptable and appropriate sexual behaviour for men and women at various stages of their life and in various types of relationships. In most countries, the degree of religiosity and the commonly accepted doctrines of the major religions are dominant factors influencing sexual ideologies. Societies vary considerably with respect to their sexual belief systems. Some only approve of sexual relationships for married couples and even approve of the murder of a young women suspected of having premarital sex. Some have strict punishments for both men and women suspected of engaging in sexual relationships with someone other than their spouse. Other societies leave most sexual relationships that do not involve force, abuse or fraud outside the legal system and regard the majority of sexual interactions

between consenting adults as private matters, not appropriate for public consideration. Sexual ideologies also differ in their degree of egalitarianism. As stated earlier, most sexual ideologies still grant men and heterosexuals more freedom to express their sexuality than they do for women and non-heterosexuals. If one examines the definitions of sexual health and sexual rights provided by international organisations and conferences, it is clear that a sexual ideology regarded as promoting sexual health and sexual rights is egalitarian, one that does not discriminate on the basis of gender, race, religion, class or sexual orientation. In evaluating the sexual health of a country, the attitudes toward gays and lesbians need to be examined. Such attitudes, if condemning or disapproving, also often contribute to job discrimination and the denial of benefits provided to heterosexual couples, which in turn hinders the economic status of homosexuals. Thus, in addition to the general level of a country's wealth and the distribution of wealth, power and income, the dominant sexual ideology accepted by its citizens is a major determinant of their sexual health.

Next, consider determinants of another threat to sexual health, force in sexual interactions. Since the 1970s, rape, sexual coercion and sexual abuse have been studied extensively by social scientists and numerous models have been proposed to try to understand these phenomena (e.g., Finkelhor, 1984, Finkelhor et al. 1990; Lottes, 1988; Malamuth and Donnerstein, 1984; Pirog-Good and Stets, 1989; Reiss, 1997). A review of these studies is beyond the scope of this book. What is relevant here is to stress that since the early 1980s, socio-cultural theories of sexual violence and sexual abuse have received more support compared to the previously commonly accepted psychological and pathological ones. General findings regarding rape of women by men, for example, support the views that rape occurs more frequently in cultures where violence and sexual involvement with women are highly valued male characteristics. In such societies rates of interpersonal violence and other types of crimes are high, women are not highly valued compared to men, punishment for rape is lenient and difficult to ensure, and there are harsh infant-child raising practices. Factors that overlap with the determinants of other aspects of sexual health include power differentials between the victim and the aggressor and the general sexual belief system.

Another aspect of sexual health that has received a good deal of attention is contraceptive use. From a comparative perspective, the most comprehensive work in this area has been done by the Alan Guttmacher Institute (AGI) of the USA. The AGI is a not-for-profit corporation for reproductive health research, policy analysis and public education. In the 1980s AGI published two books – one on teenage pregnancy in industrialised countries and the other on pregnancy, contraception and family planning in industrialised countries. The teenage pregnancy study involved an analysis of factors influencing teen pregnancy for 37 countries together with an in-depth case study of six countries. The other study involved 20 countries with case studies for four countries. Factors that were associated with higher rates of teenage pregnancy were restrictive ideas and lack

of openness about sexuality, less equal distribution of income, high levels of poverty, low availability of contraceptive education and contraceptive services, low level of tolerance of teenage sexuality, and higher levels of religiosity.

The main emphasis in the second book was to explain why the USA had higher rates of abortion and unplanned pregnancies than most other countries. Reasons include the lack of an integrated national health care service which encourages preventive care, the reliance on specialist private doctors for family planning services and the high cost of such services, the high cost of contraception, and low advertising of contraception methods. The model presented to explain contraceptive use in the AGI study had three major types of explanatory variables: laws and policies, service delivery, and information delivery. A fourth type of variables, national characteristics, was hypothesised to influence these direct explanatory variables.

The AGI model of contraceptive use can also be applied to explain the variation of rates of sexually transmitted diseases (STDs). Factors that influence both contraceptive use and safer sex activities involve both educational information and access to quality and affordable services. Other factors influencing rates of STDs include poverty, inequity of wealth and resources, lack of sex education and media coverage of information about STDs, conservative attitudes fostering secrecy, shame, and punishment, inadequate access to health care, alcohol and drug use, and inadequate attention to special population groups, such as substance abusers, sex workers, teenagers, the homeless, immigrants and those in detention facilities (Eng and Butler, 1997).

Model of Sexual Health

Now that I have presented a general overview of the literature related to determinants of the components of sexual health, I propose a model of sexual health. Figure 1 presents a model of direct influences on sexual health. For this model, I define a direct influence as one where the arrow starts at the influencing variable and ends at the 'sexual health' box. In the model three basic determinants of sexual health are sexual ideology, sexual health information/education and sexual health services. A sexual ideology which includes an acceptance of the views endorsed at the Cairo and Beijing conferences is one that is supportive of positive sexual health outcomes. These views were stated in the list of rights in Chapter 1. Although the quality and comprehensiveness of school sex education curricula, media programs related to sexual health issues, and sexual health services are obvious determinants of sexual health, it is difficult to obtain measures of these determinants. Evaluations would have to include equity, access and cost investigations of services, content analyses of curricula and media text, and examination of sexual health outcomes.

Figure 1. Model of direct influences on sexual health

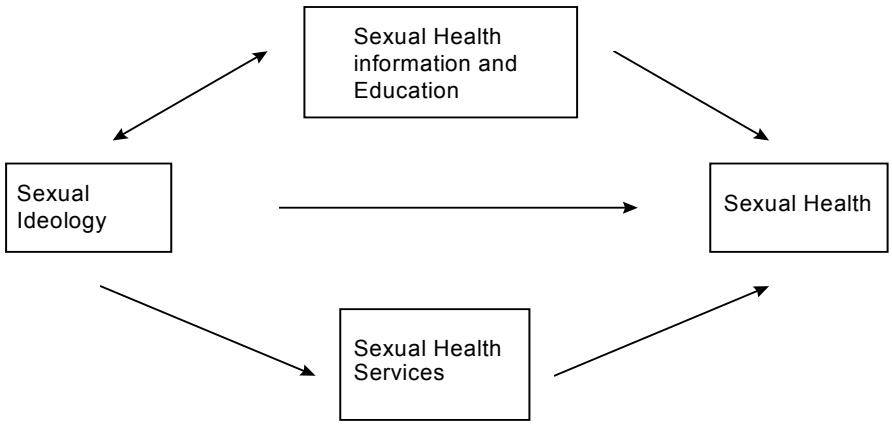
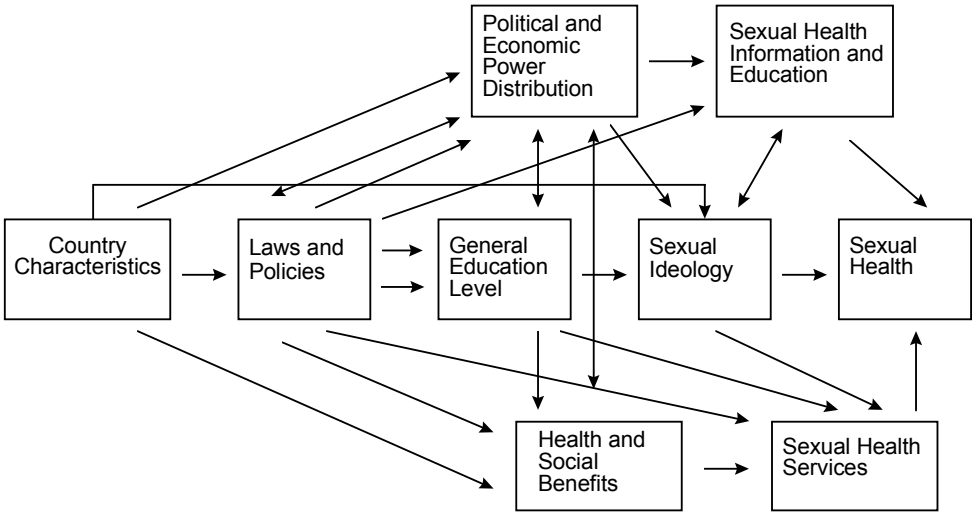


Figure 2. Model of direct and indirect influences on sexual health



The model presented in Figure 2 is considerably more complex for it shows how other aspects of society are inter-related and influence the three direct determinants of sexual health. An indirect determinant is one where the arrow starts at the determining variable and ends at one of the three direct determinants or at another indirect determinant. Here I focus on a brief discussion of the indirect determinants of sexual health for the contributors to this book describe the direct influences on sexual health. Some of the connecting lines have an arrow at both ends, indicating that the hypothesised relationship is reciprocal or operates in both directions. For example, consider the relationship between laws and policies and distribution of economic and political power. Laws and policies

about elections influence the choice of candidates for political office and those with political power – elected officials – influence the content and passage of laws. The basic message of this diagram is to promote an understanding and acknowledgement of important factors that influence the more obvious direct determinants of sexual health. These indirect factors – country characteristics such as religiosity and political ideology, laws and policies, general level of education attainment, distribution of economic and political power, and quality and delivery of health and social benefits – all need to be included when sexual health policies are examined.

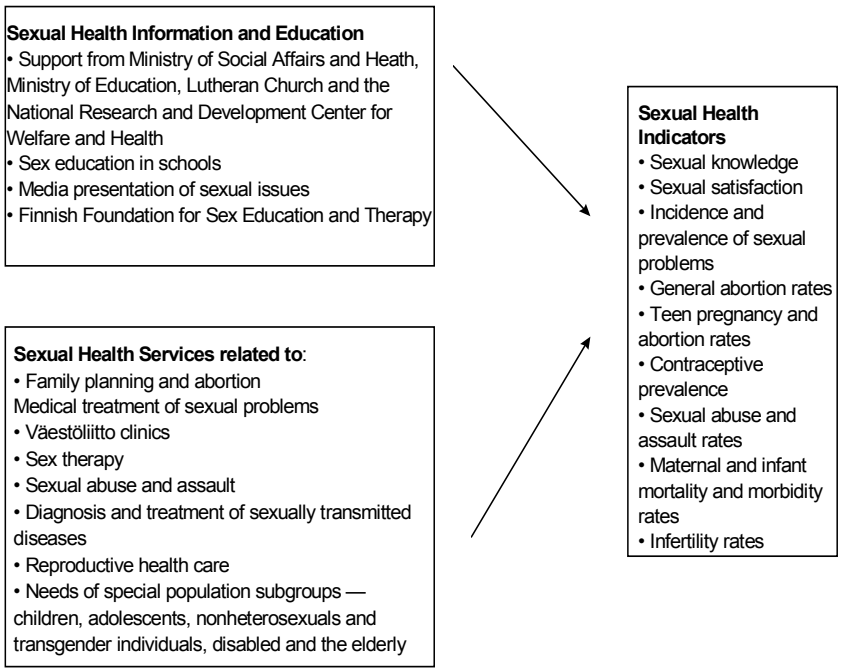
Table 1 lists the values of indicators of these indirect influences on sexual health for Finland. Overall, Finland compares favourably with respect to other countries on indirect indicators. Finland's welfare state policies are guided by principles of equity and social justice and the goal is to ensure basic services for all citizens. In my examination of these indirect factors, I could discern only a few areas of concern. One definite problem has been the high rate of unemployment of this past decade. This has contributed to lower tax revenues which in turn has led to reduction of social and health benefits. Cuts in benefits – which have disproportionately hurt people with the lowest income and assets – combined with long term unemployment have produced problems associated with poverty, social exclusion and alienation (Heikkilä, 1996; Mäntysaari, 1994; Ollila et al., 1997; Taipale, 1998; Uusitalo, 1996,1998). Another concern regarding the indirect indicators involves the increased autonomy given to local governments. The fear is that without adherence to national guidelines, local and regional inconsistencies will result in inequities of or differences in services, benefits, information provision, and educational curricula. However, the excellent monitoring, statistics and record keeping, and evaluation programs in Finland provide some check on ill-advised decisions.

In Table 1, laws and policies that relate to gender equality and 'women's empowerment' are highlighted due to their importance in affecting the sexual health of women. A recent national survey in Finland reflects the views about attitudes toward women and gender equality. The majority of respondents felt that on the whole women did not enjoy the same status as men. Still, only 22 percent of men and 10 percent of women thought that the status of women was clearly inferior to that of men (Statistics Finland, 1999). Both women and men gave strong support to the views that men and women should share family responsibilities and that women should continue to take active and important roles in politics. From an international perspective, Finnish women fare quite favourably with their counterparts in other countries. Yet as Table 1 shows and others (e.g., Rantalaiho and Heiskanen, 1997) have illustrated, Finland is still not a gender equal country.

Laws and policies which affect the direct determinants of sexual health – information, education and services are omitted from Table 1 for they are discussed by the experts who have contributed to this book. In addition, authors describe aspects of sexual ideology related to their area of expertise in sexual health.

Figure 3 lists components of two direct influences on sexual health as applied to Finland. These components correspond to the chapters of this book. For organisational and conceptual purposes, the distinction between information provision and service provision has been made. In reality, information provision is a part of service provision and some organisations described in this book (e.g., Väestöliitto, SEXPO, SETA and STAKES), are involved in supporting and providing both services and information delivery. I have also listed some of the indicators of sexual health for they will be discussed in the forthcoming chapters and included in the conclusion when the strengths and shortcomings of sexual health policy in Finland are summarised. To conclude this chapter, I present a short overview of elements of the health care system in Finland. The quality and delivery of *general* health services is a major determinant of *sexual* health services in all countries. Also this overview will help the reader understand how specific sexual health services are provided in Finland.

Figure 3. Components of Sexual Health Information / Education and Services Applied to Model



Basic Elements of Finland's Health Care System

Finland has a national system of health care that is funded by general taxation. Traditionally, major goals have been to provide universal access and equity in service provision, to promote prevention strategies and high quality of primary care, and to increase efficiency and cost containment. Finland also highly monitors its health care quality by obtaining comprehensive and detailed statistics and by regularly obtaining evaluations from both clients and health care providers. Every two years reports on public health, health services and health policy are given to the Parliament by a Health Policy Monitoring of the Country Action Team. Health care costs accounted for 7.7% of the GDP in 1996 (Salo, 1998).

A basic strategy and assumption of Finnish health policy is that one's state of health is an important part of one's well-being and thus access to health care is the *right* of everyone. In 1992, the Act on the Status and Rights of Patients was enacted. This law establishes "patients' rights to get good care and treatment within the limits of resources, to information, self-determination, access to documents, complaining procedures, and medical ombudsmen" (Ministry of Social Affairs and Health, p. 117, 1995). Additional provisions of this law require that patients must be informed about their health condition, alternatives and risks involving care, and where to obtain treatment. Patients must also understand enough about their treatment to give their consent to it.

Finland has three levels of government – central, provincial and municipal. The 453 municipalities – which range in size from 150 people to 500,000 in the most populated area – are responsible not only for providing public health care but also general social services and education. Until the end of 1992, health services were provided locally by the municipalities but were strongly controlled by the central government. The municipalities received state subsidies amounting to 29% to 66% of their costs for health care services, social welfare and running schools and the municipalities supplied the remaining financing (Ministry of Social Affairs and Health, 1995). As a result of the recession that began in the early 1990s, the principle of state subsidies changed to a block grant system in 1993. Thus, currently, each municipality determines the proportion of money to be spent on the three areas of health, social services and education. According to Hermanson, Aro, and Bennett (1994), the tight system of central planning was criticised for high costs involved in monitoring, rigid uniformities across municipalities that inhibited incentives to cut costs and improve organisational efficiency, and lack of responsiveness to patient preferences. The size of the block grants to the municipalities is determined by a special formula which takes into account population size, age distribution, morbidity rates, population density, land area and financial capacity of the municipality.

As stated earlier, a basic feature of health care in Finland is its focus on primary health care (Hemming, 1995; Hermann, 1994). The Primary Health Care Act of 1972 states that the emphasis on health care should be at the primary level. This act made municipalities responsible for the provision of primary care, and listed the basic tasks that should be provided at local health centres. The municipalities are required, for example, to provide family planning services and maternal and child health care. The specialists at local health centres are mostly general practitioners and public health nurses. Patients who need consultation or extra care are referred to other specialists in hospitals or within the private sector. The health centres also offer laboratory and x-ray services, physiotherapy, and bed wards mainly for long term care.

A private system of health care also exists in Finland and a portion of the payment to private health professionals is reimbursed by the state through a special fund. Hermanson et al. (1994) report that public expenditure on health (75%) still outweighs private expenditure. In 1998, out-of-pocket payment for health care represented about 20% of total health care expenditure; these expenditures comprised mainly user charges in public health services, purchases of private physicians' examinations and treatments, pharmaceuticals, and adult dental care. The proportion of health care provided by private expenditures and by the municipalities compared to the central government has increased (Salo, 1998). A minority of Finns has private health insurance and this is mostly used by parents who want their children to have access to a private pediatrician.

A sizeable part of health care for the adult population is provided by occupational health care (OHC). Employers are required to offer services to their employees, and a special funding covers a large part of the cost. For the employee, the preventive OHC services are free of charge. Many employers also offer a number of curative services as part of their occupational health care including consultations to private specialists.

Hermanson et al. (1994) state that the standard of education of Finnish health care personnel is high. In 1998, 48% of all physicians were women (Taskuheto 1999). To attract public health physicians to the health centres, pay for physicians has been higher than physician pay in hospitals. Partly due to strong unionisation, the medical profession in Finland has managed to retain its high status and leadership roles. Hemminki (1995) emphasises that the goal of prevention of health problems is facilitated by the high proportion of public health nurses in Finland. In health centres public health nurses outnumber physicians. These highly educated professionals who traditionally have worked in maternity and child health have broadened their services to include a focus on health promotion and prevention of health problems in all age groups.

In a recent evaluation of Finland's health care system by an OECD report (OECD Economic Surveys, 1998), its functionality and quality were praised. According to the

report, "Finland's health care infrastructure is modern and the personnel are highly skilled" (p. 15, Socius, 1998). The report also emphasises that among all EU member states, Finns are the second most satisfied with the health care they receive; only the Danes are more satisfied. A few recommendations for changes were made to eliminate inequities and increase efficiency. For example, the OECD recommended a new pay scheme for doctors that would encourage doctors working at the municipal health centres to decrease their work as private practitioners, facilitate longer term care of patients, and reduce unnecessary consultations. A second recommendation was that no more cuts should be made in governmental appropriations for health care.

In summary, health services have been considered a public responsibility for decades in Finland. The health care system has been characterised by an emphasis on primary care, where a variety technological services are also available. Malpractice issues are not a problem. It is rare for malpractice actions to occur despite the fact that the legal system permits such suits. The major concerns seem to be to guard against forces which reduce equity in and access to health care provision and which decrease preventive health care. Despite longstanding persistent efforts to achieve these goals, statistics have consistently indicated that the more affluent are characterised by more positive indicators of healthy well-being. Under the new system of decentralised control, Rehnström (1997) already reports some problems in the area of preventive health care and health promotion. Decisions by some municipalities to decrease funding for health prevention and promotion efforts have resulted in higher curative expenses. From an international perspective, health care services in Finland have fared well in terms of equity, access and prevention goals. Under the new decentralised system in which municipalities have been granted new powers and control, it seems the greatest challenge for health care professionals and policy decision makers will be to find ways to continue to maintain and improve health services so they are characterised by equity, universal access and good preventive care.

Just before this book was to go to print in June of 2000, Finns got upset when their country's health system performance was ranked 31st out of 191 countries by the WHO World Health Report (www.who.int/whr/2000/en/report.htm). Finns have traditionally taken pride in the high quality of their health care, and so this low ranking was both a disappointment and surprise. Health officials, measurement experts, and statisticians examined the means by which countries were ranked. Although they did find flaws in measurement techniques, authorities were in general agreement that the World Health Report had indeed identified weakness – known to some experts – in Finnish health care. Weaknesses acknowledged by the report and Finnish commentators were 1) high mortality of men of working age, 2) wide differentials in health outcomes by social class, 3) reduction in funding and health services, especially for the elderly, chronically ill, and mentally ill patients, 4) over-burdening of those providing health care, 5) lack of dental care support for the entire population, and 6) health problems linked to crowded living conditions, the environment, and traffic and workplace

conditions. Nevertheless, concerned policy makers, health professionals, and legislators hope to use the low WHO ranking as an advocacy measure to stop the reduction in health care funding and work for restoration of monies for vital health care needs.

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Table1. Values of Indirect Influences of Sexual Health for Finland

Country Characteristics	
Political Ideology:	Democratic and egalitarian; Presidential elections every 6 years and parliamentary elections every 4 years, voter turnout in final vote for president in 2000–83% for women and 77% for men.
Stability:	No wars, internal or external since the 1940s
Gross Domestic Product:	$20,150, per capita (US$, 1997)[1]
Information access:	Finland leads the world in internet connections and mobile phones per capita[2] and printing and writing paper consumed in 1995.[3]
Number per 1000 persons who have the following[4]:	Share of households with 1 - 6 radios – 99%, television licenses (each covering several television sets) – 382, daily newspapers - 455, mobile telephones – 572, main telephones – 553, internet connections – 107.
Religiosity:	Religious leaders generally support rather than oppose sexual health policy
Damaging Cultural Customs:	No obvious ones such as female genital mutilation
Alcohol and Drug use:	Since 1998 HIV cases have increased due to intravenous drug use; Alcohol consumption in liters per capita in 1995 – 6.4[3]

Laws and Policies

1878 Women and men receive equal rights with regard to inheritance

1901 Women receive the right to study at university on equal terms with men

1906 Women receive voting rights in national election (first country in Europe to do so) and the right to be electoral candidates (first country in world)

1917 Women receive general voting rights for local governmental elections

1919 Women gain the right to work without their husbands' permissive

1930 Marriage Act released wives from the guardianship of their husbands= and wives given the right to own property

1962 The principle of equal pay for work of equal value established both in public and private sector

1978 The father receives the right to 12 days= paternity leave for birth of his child

1980 Law passed granting the father the right to share parental leave with the mother
The first Plan of Action for the Promotion of Gender Equality of the Government of Finland proposed

1986 Finland ratifies the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

1987 The Act on Equality between Women and Men passed

1988 The first female priests consecrated in the Evangelic Lutheran Church of Finland

1990 Children up to age 3 guaranteed a municipal child care place

1996 Children under school age guaranteed municipal day care
An Updated Plan of Action for Promotion of Gender Equality of the Government of Finland proposed

Education Level

Literacy rate:	99%[1]	
Percent of population aged 15 or over with basic education, grades 1-9 only, 1997[4]	Women 44%	Men 42%
Percent of population with at least upper secondary level qualifications, 1997[4]	Women 56%	Men 58%
Percent of population in 1997 with a tertiary education[4]	Women 7%	Men 7%
Percent of graduates from universities in 1997 by gender[4]	Women 58%	Men 42%

Political and Economic Distribution of Power

The first woman, Tarja Halonen, was elected President, 2000		
Percent women elected to parliament, 1999[4] (This percent has varied from 23% to 39% from 1975 to 1995)	37%	
Percent women cabinet members (8/18), 1999[4]	44%	
Percent women in municipal councils, 1997[4]	32%	
Percent women on municipal executive boards, 1997[4]	45%	
Percent women on municipal committees, 1997[4]	47%	
1998 labour force participation rate (15 - 64 years)[4]	Women 70%	Men 75%
1998 unemployment rates[4]	Women 12%	Men 11%
Percent of population below 50% of median disposable income, 1995[3]	6.2%	
Long term unemployment, 12 months or more as percent of all unemployment[1]	Women Men	28.2% 33.9%
Long term unemployment, 12 months or more as percent of total labour force, 1995[3]	6.1%	
Women's earnings as a percent of men's averaged over 7 levels of education, 1996[5]	80%	
Women's average assets subject to taxation per income recipient as a percentage of men's, 1997[4]	64%	
Percent of women administrators and managers, 92-96[3]	25%	
Percent of women professional and technical workers, 1992-96[3]	63%	
Income distribution measure - Ratio of high to low incomes, 1991[5] (Most equitable of 15 industrialised countries compared)	2.74	
Extent of Poverty in 1991[5]	Elderly Adults Children	14.4% 5.8% 2.7%

United Nation GEM rank out of 102 countries participation and decision making where 1 is least gender inequality and 102 = most gender inequality	4 in 1996[6] 4 in 1997[7] 5 in 1998[3] 6 in 1999[1]	

Health and Social Benefits

Average life expectancy, 1998[4]	Women Men	80.8 73.5
Social protection expenditure as percent of gross domestic product[8]	32% in 1996 30% in 1997	
Rate of taxation as percent of gross domestic product, 1997[8]	47% in 1997	
Overall budget surplus/deficient as percent of gross national product[1]	-6.3% in 1996	
Public expenditure on health as percent of total public expenditure[7]	14.7% 1989 - 91	
Private expenditure on health as percent of total health expenditure[7]	19.1% 1989 - 91	

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