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DISCUSSION PAPER

Promote, prevent, influence

The action programme for the promotion of sexual and reproductive health in 2014–2020

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Foreword

The action programme for the promotion of sexual and reproductive health in 2007–2011 by the Ministry of Social Affairs and Health was the first sexual and reproductive health action programme in Finland. The intermediate assessment of the action programme was carried out in 2009, and the final assessment seminar was held in December 2011. Both the intermediate assessment and the seminar conclusions stated that significant reforms in sexual and reproductive health promotion had been carried out during the programme implementation in Finland. Nevertheless, there was still a lot to do, and thus the action programme was updated according to the original plan.

The updating task was given to the Sexual and Reproductive Health Unit (SELI) of the National Institute for Health and Welfare. In addition to the SELI unit, numerous internal and external experts took part in the updating process (Appendix 1). During the updating process, the SELI department convened two meetings, inviting organisation representatives in order to discuss the action programme from their point of view. After that, the action programme was further developed, taking account the valuable feedback received from the organisations. In addition, the SELI unit heard the experts that took part in the preparation of the previous action programme. The National Institute for Health and Welfare received total of 50 advisory opinions, and the action programme was finalised accordingly.

The updating of the action programme was carried out at the time when the social and health care structure reform was still under preparation. Therefore, the division of responsibilities was difficult. Suggestions for optimal choices as project actors were made in common meetings of the National Institute for Health and Welfare and the Ministry of Social Affairs and Health. The action programme on sexual and reproductive health promotion will be implemented as a part of the re-structuring of local government services and development and reform of preventative municipal services. Furthermore, the National Institute for Health and Welfare recommends that municipalities will take advantage of the action programme when drawing up action and financial plans for the forthcoming years.

The action programme combines all the goals of the sexual and reproductive health promotion work in Finland for the next few years and presents proposals for action in order to reach these goals. In addition, the programme deals with the gaps in the sexual and reproductive health research and gives proposals for research topics. The action programme is intended for social and health care management, staff, organisations of the industry and other key cooperation partners, as well as for persons of trust. Furthermore, the target group consists of sexual and reproductive health researchers, universities, research institutes, universities of applied sciences and sponsors of researches, teachers and students in the social and health care field, as well as health education teachers at basic education, general upper secondary education and vocational institutions, and those providing their education.

We extend our warm thanks to all those who were involved in the updating process and gave their opinions. Cooperation is the best way to promote sexual and reproductive health and, consequently, the health and welfare of the whole nation.

In Helsinki, 17 March 2013

Marjaana Pelkonen
Ministerial Adviser, Ministry of Social Affairs and Health

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Introduction

Sexual and reproductive health is an essential part of human health and well-being, and hence a significant part of public health. The term ‘reproductive health’ has already been in use for a long time both in the international and national vocabulary, and attention has been paid to reproductive health in Finland for decades. According to the World Health Organization (WHO), reproductive health entails a possibility to responsible, satisfying and safe sex life, the capability and freedom to reproduce and to decide when and how often to do it, the right to have appropriate and acceptable methods of fertility regulation of their choice and the right of access to services that will enable safe pregnancy and childbirth and provide the best chance of having a healthy neonate.[1]

The term ‘sexual health’ became common as late as the 1990s. According to WHO, 'sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[2]

WHO defines sexuality as an essential part of being human in all phases of life. (See more WHO 2010.)3 The meaning of sexuality may differ in different phases of life. People can also live a satisfactory life without a relationship or sex. However, intimate partner relationships have been found to bring about health maintaining influence. A satisfactory sexual life is an essential part of welfare and life quality also for the elderly people.

The hierarchy of the terms ‘reproductive health’ and ‘sexual health’ has been under discussion and in some extent even under debate since the term ‘sexual health’ was determined and introduced. Some people thought and still think that sexual health is included in the concept of reproductive health (figure 1, A), whereas some thought and still think that sexual health is an umbrella conception for reproductive health (figure 1, B). Both concepts convey special dimensions and, on the other hand, overlapping aspects. In this action programme, sexual health and reproductive health are thus perceived as parallel and much overlapping concepts, each of which having its own special meaning and completing each other. Together they form a wholeness: sexual and reproductive health (figure 1, C). This is already an internationally established conception, too. Thus, we do not talk about reproductive and sexual rights only but sexual and reproductive health and rights (see chapter 2 Sexual and reproductive rights). The use of this term is established also nationally, which is reflected by the fact that the sexual and reproductive health action programme for 2007–2011 was the first national action programme published by the Ministry of Social Affairs and Health in this field and it was the Sexual and reproductive health unit (SELI) that was established in the National Institute for Health and Welfare (THL) in 2010. Both the action programme and the SELI unit have significantly promoted one of the public health fields in Finland, namely sexual and reproductive health. The tasks of the SELI unit are described in more detailed in chapter 19.

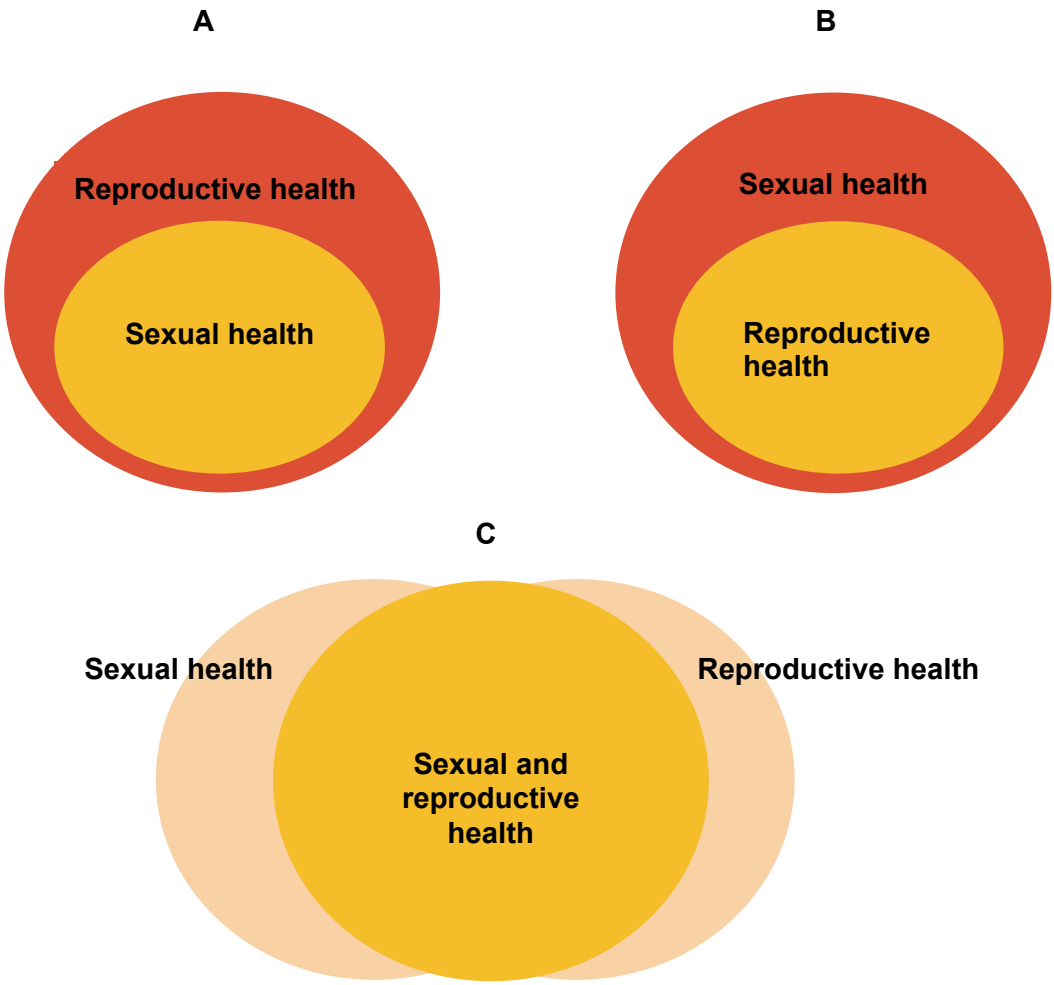

***Figure 1**. The hierarchic relationship between sexual health and reproductive health, when reproductive health is considered to be an umbrella term (A), when sexual health is considered to be an umbrella term (B) and the current definition of sexual and reproductive health in the action programme (C) where the overlapping and the intertwined effects of sexual health and reproductive health are seen.*

Regulation and guidelines on sexual and reproductive health services

Sexual and reproductive health services are regulated through various laws and decrees in Finland (Appendix 2). Furthermore, the Government Programme4 of Prime Minister Jyrki Katainen's Government contains several goals, related to sexual and reproductive health promotion or general service organisation (concerning sexual and reproductive health as well), such as the goal to reduce the number of induced abortions and violence against women, or development of social and health care services in sign language or using interpreting services through the Social Insurance Institution of Finland (Appendix 3).

In addition to the legislation and the Government Programme, several national action programmes, recommendations or strategies, significant from the perspective of this action programme, regulate or guide sexual and reproductive health and related services. These are, for instance, the Action Plan for the prevention of circumcision of girls and women, published by the Ministry of Social Affairs and Health in 2012[5], the guidelines on extended health examination by the National Institute for Health and Welfare[6], the recommendations for maternity clinics, drawn up by a national expert group on maternity care and published by the National Institute for Health and Welfare in 2013[7], the action plan to reduce violence against women[8], the HIV strategy[9] and the Disability Policy Programme[10]. In the guide for maternity clinics, the recommendations on monitoring and treatment during pregnancy and postnatal period as well as support to mother and her family during this time are described in high detail. These topics are hence

mentioned in this action plan in brief only. Different programmes, strategies and recommendations are briefly presented in the context of each particular theme.

The basis and structure of the action programme

This action programme is based on the first action programme for promotion of sexual and reproductive health for 2007–2011.[11] The action programme is based on client-orientation and equality: clients in sexual and reproductive health services are to be treated equally, individually, and with dignity, respecting their autonomy and promoting equally highlighting of their needs and wishes without discrimination on the basis of sex, sexual orientation, age, disability, ethnic or national origin, language or other individual characters.

With the purpose to update the previous action programme, this programme follows much the same structure. Sexual counselling and sexual and reproductive health services have been integrated into corresponding themes. The chapter that deals with sexual behaviour, combined with sexual and reproductive health knowledge, is new, as well as the chapters on sexuality education, multiculturalism and mental health. Objectives and actions for achieving them are described in the end of each chapter. Some of the objectives are highly detailed, some are more general. Representatives of the National Institute for Health and Welfare and the Ministry of Social Affairs and Health have discussed the choices of responsible actors for the actions in their common meetings. The responsible actors are recommendations, being best choices to implement the actions. However, these recommendations do not exclude any person or organ not stated as a responsible actor.

Sexual and reproductive health as a basis of the action programme

Sexual and reproductive health and related changes over time can reliably be monitored in Finland by means of different registers. The changes to be monitored are, for instance, mode of childbirth, inductions of labour, and use of analgesia. As for neonates, prematureness, low birth weight and mortality are the changes to be monitored. In induced abortions, the focus is on prevalence, methods, and reasons, and in sexually transmitted diseases, it is on prevalence. Furthermore, information on sexual and reproductive health have been received both via various national surveys, such as Terveys 2000 and Terveys 2011 (Health 2000 and Health 2011), FINRISKI, FINSEX and Maamu, Kouluterveyskysely (School Health Promotion study), Health Behaviour in School-aged Children by WHO, PESESE survey, and separate qualitative and quantitative surveys. Nevertheless, the follow-up information on sexual health or needs of sexual consultancy for men, elderly people, and special groups, for instance, is missing or it is scarce.

From international perspective, the sexual and reproductive health in Finland is at outstanding level, assessed by several indicators. The total fertility rate has remained for many decades relatively high compared with other European countries, being 1.8 in 2012.[12] According to the birth register, the amount of children born during the last ten years has increased approximately by 5%.[13] Health of newborn infants is excellent.

Perinatal mortality rate (stillborns and deaths at under seven days of life), for instance, was in 2012 at the lowest level during the whole 25 year history of the birth register information collection: 3.9 per thousand births. The Caesarean section rate was 16% in 2012, and the rate has remained low in international comparisons. The percentage of parturients under 20 years of age has decreased, too: 2% in 2012. The rate of induced abortions among women under 20 years has also decreased in the 2000s: 11 induced abortions per thousand women in the same age group. Hospital districts have focused on their personnel's know-how.[14] Most hospital districts have employees who have completed continuing education in sexual counselling and/or sexual therapy. Furthermore, most hospital districts offer sexual counselling and/or sexual therapy services.

Despite this, there are still several needs and targets for development in sexual and reproductive health promotion also in Finland.

- Primiparas are increasingly older: the average age was 28.4 years in 2012.[13]
- The number of parturients over 35 years of age has increased: a fifth of all parturients in 2012.[13]
- Parturients have more often chronic diseases: around 8% in 2010.[15]

- In 2012, one in three (35 %) parturients was overweight (body mass index, BMI 25 or more) and one in six was obese (BMI ≥30).[13]
- The rate of those smoking during pregnancy has not changed from the end of the 1980s: the percentage of smokers is still 16%.[13]
- The rate of repeated chlamydia infections has grown, gonorrhoea infections have increased among young women in particular, and syphilis cases of men have increased in the capital area.[16]
- Sexual health awareness among young people has weakened.[17]
- Sexual harassment and violence are common in the everyday life of young people.[17]
- The percentage of induced abortions for women aged 20–24 years is still high (18 per thousand women in the same age group in 2012) and the number of repeated induced abortions has increased.[18]
- The results of the Terveys 2011 (Health 2011) survey suggest that involuntary childlessness has slightly increased.[19]

The percentage of immigrants has increased, and the challenges related to their sexual and reproductive health differ from those among the original population.

- For example, 70% of Somali women and 32% of Kurdish women have been circumcised.[20]
- The number of miscarriages is above average among Somali women.[21]
- The number of induced abortions is above average among Russian women.[21]
- The women with African origins have more problems during pregnancy, and their neonates have more health related problems than those in other ethnic groups.[22]
- The status of undocumented immigrants in the Finnish healthcare system is unsolved. Healthcare service needs among undocumented women in particular are largely related specifically to sexual and reproductive health.[23]

Sexual and reproductive health services

Sexual and reproductive health services include:

- reproductive health promotion and care,
- pregnancy counselling and care,
- childbirth and puerperium period,
- contraception,
- infertility investigations and treatment,
- induced abortions,
- prevention, investigation and treatment of sexually transmitted diseases,
- counselling and other sexual health promotion services for different age groups,
- sexual counselling and therapy and clinic examinations and treatment.

Municipalities and health centres provide sexual and reproductive health services, e.g., contraceptive counselling services, in variety of ways.[24-26] The organisation of delivery services will change a lot in the near years due to centralisation of delivery. In the early 2013, there were 30 maternity hospitals in Finland. During 2013, two of them made decisions about the closure of birthing services. The Decree on emergency care by the Ministry of Social Affairs and Health will enter into force for deliveries in 2017.[27] The common quality standards, determined in the decree, will give rise to centralised emergency care services and the amount of birth service unit closures will increase.

Organisations of the field play an important role as sexual and reproductive health service providers. Cooperation between municipal actors and the third sector service providers is needed in order to provide employees with sufficient information, concerning the third sector actors to which direct clients, as needed.

Main results of the intermediate assessment, needs and targets for development and responding to them

The intermediate assessment of the sexual and reproductive health action programme for 2007–2011 was carried out in spring 2009 through structured information collection and surveys.[28] According to the assessment, sexual counselling has professionalised, prerequisites for pregnancy and delivery care, as well

as care after delivery, have been improved, recommendations and forms for induced abortion management have been revised. In addition, guidelines on sexually transmitted disease treatment and prevention had been produced. Research on the theme had been done, management and prevention of sexual violence issues have been addressed, know-how among the professionals has strengthened and improvements in statistics, follow-up and research fields have taken place. Nevertheless, sexual and reproduction health awareness had increased unequally, and the contraception service provision was characterised by the multiplicity of practices.

The intermediate assessment foregrounded the following issues as key targets and needs for development in:

- contraception and prevention of sexually transmitted diseases,
- integration of sexual health into health promotion and welfare/health promotion plans,
- organisation of sexual counselling and therapy work at the hospital district level,
- update of the maternity care guidelines,
- work against sexual violence,
- incorporation of sexuality education into early childhood education and basic education,
- training of sexual and reproductive health teachers,
- addressing sexual and gender minority issues,
- addressing substance abuse, mental health problems and violence in the services for young people,
- sexual and reproductive health among immigrants,
- preparation of multidisciplinary and extensive sexual and reproductive health research programme.

The final assessment of the action programme, targeted at hospital districts, stated that hospital districts have in many ways promoted sexual and reproductive health.[14] Some examples of the foregrounded targets and needs for further development in hospital districts are:

- to integrate sexual and reproductive health into health promotion programmes and treatment chains,
- to involve primary health care units in the development of the area in question,
- to develop, clarify and coordinate cooperation with primary health care (e.g., common treatment paths, treatment chains, patient information system, competence in sexual health in primary health care),
- to exploit networks,
- to increase staff resources in sexual counselling and in planning and coordination of sexual health promotion,
- to establish regional working groups for coordination, assessment and development of sexual and reproductive health,
- to determine sexual counsellor's job description and establish appointments for them,
- to define the task and role of a sexual health contact person,
- to ensure equal availability of sexual counselling services,
- to decrease the amounts of induced abortions and sexually transmitted diseases,
- to intervene at early stage in alcohol abuse, economic problems and mental health issues,
- effects of population ageing on sexual and reproductive health.

Some of these targets and needs have partly been overcome after the intermediate and final assessments, some of them being still current. New recommendations have been drawn up for maternity clinics and for cooperation between primary health care and specialised care.[29] Sexual and reproductive health has been researched both through separate studies[22, 30-33], and the Maamu survey in 2010–2012 by the National Institute for Health and Welfare.[34] A new immigrant health data collection was started in 2014. Various practices have been developed in order to prevent and recognise sexual violence and help victims, such as broaching violence as a part of health care services, the Action Plan for the Prevention of Circumcision (FGM)[5] of Girls and Women and a guide Turvataitoja nuorille (Safety skills for the youth).[35]

Goals and key points of the action programme

The goal of the action programme is to promote sexual and reproductive health by increasing awareness, developing services and strengthening sexuality education so that it reaches equally all the people of all

ages and is included in education, teaching and training as well as in health and welfare promotion. Detailed goals and actions to achieve them are described in context with the respective thematic entities.

The first priority area of the action programme is children and adolescents. The intermediate assessment of the previous action programme disclosed future challenges to include sexuality education in early childhood education and basic education, prevent sexual violence, address sexual and gender minority issues, and prevent unwanted pregnancies and sexually transmitted diseases. These challenges are in great deal related to sexual and reproductive health promotion among children and young people and thus justify the choice of the first key point sphere.

Accumulation of problems among young people, increasing inequality and exclusion or being set aside entail new challenges also in the development of sexual and reproductive health of young people. Sexuality education can be used to strengthen self-esteem and self-knowledge of children and adolescents and to teach them safe and positive sexuality. Sexuality education at comprehensive school is in the key role as it reaches the whole population within the age range of compulsory education. Increased sexual and reproductive health awareness among children and adolescents and development of related services will promote not only sexual and reproductive health of these children and adolescents but also the health and well-being of the future generations.

Traditionally, the sexual and reproductive health issues are perceived as female issues. Men have not seen it easy to seek contraception counselling and maternity clinic services as these have been perceived to serve women. So far, we have little information about men’s sexual and reproductive health, their level of knowledge, use of services and expectations on services. Therefore, the second key point of the action programme is men's sexual and reproductive health. The focus should be on an arrangement of services in a way that men know how to and are able to seek them. Furthermore, targeted services are needed for the male groups in which the needs are biggest.[36]

The third priority area of the action programme is multiculturalism, which was already addressed in the intermediate assessment of the previous action programme. Despite the fact that Finland has for a long time been a multicultural country, the immigration rates in Finland have been lower than in Scandinavian countries. However, Finland has gradually become more and more multicultural. The promotion of sexual and reproductive health among immigrants requires both more information and culture-sensitive counselling and services in their own language. Undocumented people should also have access to sexual and reproductive health services.

The fourth priority area is good delivery care. New guide for maternity clinics29 provides recommendations for maternity clinics and the collaboration between maternity clinics and different actors, such as delivery hospitals, but do not include recommendations on the childbirth itself. Therefore, good delivery care has been selected as one of the key points of this action programme. The aim is to promote health and welfare of mother, her newborn and the whole family by supporting the parturient's and her partner's own resources, reducing needless interference in the course of delivery and promoting early contact with the newborn. The goal of delivery care is to secure the best possible health of the parturient and the newborn, to enable a holistic and empowering delivery experience to families and to support mothers in breast-feeding after the birth.

Implementation and follow-up of the action programme

The update process of the action programme took place at the time when the structural reform of the Ministry of Social Affairs and Health was still ongoing. Proposals and responsible actors of the action programme will conform to the future structural and functional changes in the health and social service system and in the educational sector, cooperating with a range of sectors at the national, regional and local levels. The action programme on sexual and reproductive health promotion will be implemented as a part of the re-structuring of local government services and development and reform of preventative municipal services. For this purpose, the Ministry of Social Affairs and Health and the National Institute for Health and Welfare recommend that local authorities utilise the action programme in compilation of action and financial plans for the forthcoming years and in preparation of reports, related to the restructuring of local government and services.

The National Institute for Health and Welfare and the Ministry of Social Affairs and Health will together organise a national seminar in order to introduce the updated action programme and to start its implementation in 2014. Information on the programme will be given also in other events in future years. Additionally, regional level actors are responsible for including the action programme as a topic in regional training day agendas. The action programme will also be published in electronic form in the website of the National Institute for Health and Welfare. In addition, the National Institute for Health and Welfare will inform about the action programme via SELI network newsletters and other channels. The follow-up of the implementation will be carried out horizontally in different sectors and at all administrative levels as well as in the organisational field all over Finland. The National Institute for Health and Welfare and the Ministry of Social Affairs and Health will convene a follow-up seminar in order to evaluate the implementation progress. The programme will be updated in 2020 at the latest.

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2. Sexual and reproductive rights

Sexual and reproductive rights as concepts

Definition of reproductive rights started already in the 1960s as a part of the definition of human rights. Definition of sexual rights began in the 1990s. At that point, more attention began to be paid to questions of sexual health in addition to family planning and sexually transmitted diseases. Gradually, the discussion was expanded to also include sexual rights. Key contents of the rights related to both reproductive health and sexual rights include that each individual or couple is entitled to consciously and responsibly decide on matters related to his or her life, such as engaging in a personal relationship, getting married, having children and using contraception. Sexual rights also aim, among other things, to protect the individual's right to bodily integrity, sexual safety, gender and sexual diversity as well as sexual well-being.

There are two international declarations concerning sexual and reproductive rights: the Declaration of Sexual Rights by the World Association for Sexual Health (WSA)[1] and the Declaration of the International Planned Parenthood Federation (IPPF)[2], which covers both sexual and reproductive rights. Sexual and reproductive rights are also discussed in the Yogyakarta Principles[3], developed by an international group of human rights experts, as well as in the mission statements of other actors, such as the Institute for Advanced Study of Human Sexuality[4]. The concept of sexual and reproductive health and rights has been established in international use to encompass both previous reproductive rights as well as the more recently determined sexual rights.

Many organisations, such as the Sexpo Foundation and the Family Federation of Finland (Väestöliitto), have embraced the promotion of sexual rights as their goals. This goal has been made visible, for example, as the topics of training days, statements, project work and publications.[5] In Finland, the goals of the 2000s for the promotion of sexual and reproductive rights have included the implementation of the rights of persons dependent on care (among others, persons with long-term illness, disables persons, elderly persons and those with mental health issues), undocumented immigrants, gender and sexual minorities, as well as the improvement of the sexual rights of young people.

In Finnish legislation, sexual and reproductive rights as well as sexual and reproductive health services are regulated through various laws (Appendix 2). The national action programme[6] and the establishment of the SELI unit as part of the National Institute for Health and Welfare have been major advancements in the promotion of sexual and reproductive rights and the development of services in Finland.

The updated action programme draws on the rights of the entire population related to sexual and reproductive health. The promotion of sexual and reproductive health must be implemented equally according to the need of the client or patient regardless of his or her age, gender identity and diversity in gender expression, sexual orientation, cultural background or other personal characteristics. Equality is not always achieved in Finland. Therefore, the action programme highlights special needs related to the sexual and reproductive health and services of so-called special groups, such as sexual and gender minorities, immigrants and disabled people. Inclusion in a special group and special needs vary according to context. The goal is that the rights and responsibilities of all people will be equally addressed in questions of sexual well-being and reproduction and that effective functions will be secured in order to decrease inequality

International conventions

Important milestones in the global promotion of sexual and reproductive health and rights include the International Conference on Population and Development (ICPD) of 1994 held in Cairo and the Fourth World Conference on Women of 1995 held in Beijing. The ICPD Programme of Action set a number of important population and development goals for the international community. The 179 member states of the United Nations (UN) adopted the 20-year Programme of Action, which concluded that the empowerment of women and the realisation of education and health ensuring reproductive health are preconditions for the implementation of the rights and a balanced development of the individual.

In addition to the action programmes of the Cairo and Beijing conferences, the UN Millennium Development Goals are also closely connected to sexual and reproductive health and rights. The 189 UN member states of the day adopted the Millennium Declaration at the UN Summit held in 2000. The declaration was used as a basis for the Millennium Development Goals (MDGs).[7] The Millennium Declaration and the Millennium Development Goals are an agreement of the UN member states, UN organisations and international financial institutions on the development goals of international cooperation. These targets are to be met by 2015. Millennium Development Goal 5 on improving maternal health is most closely related to sexual and reproductive health and rights. Its subgoals include decreasing deaths caused by pregnancy and childbirth by three quarters and expanding reproductive health services to be universal by the year 2015.[8]

In 2010, WHO updated its Reproductive health strategy[9], which is based on the above-mentioned international agreements. The strategy defines five key action areas:

1) Strengthening health system capacity
2) Improving information for priority setting
3) Mobilising political will
4) Creating supportive legislative and regulatory frameworks
5) Strengthening monitoring, evaluation and accountability.

In the 2000s, sexual and reproductive health has been the topic of several EU documents, including the European Parliament resolution on sexual and reproductive health and rights[10] in 2002 and the European strategy for the promotion of sexual and reproductive health and rights[11], drawn up by the Council of Europe in 2004. Finland has adopted the 2007 Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, also known as the Lanzarote Convention.[12,13] The UN Convention on the Rights of Persons with Disabilities and the Optional Protocol to the Convention were adopted by Finland in 2007 and ratified by the EU in 2010.[14]

The Convention on the Rights of Persons with Disabilities complements existing UN human rights conventions. The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.

The European Consensus on Development of 2005 includes a specific mention of sexual and reproductive health and related rights as they have been determined in the Programme of Action of the International Conference on Population and Development.[15] Moreover, according to Council Conclusions issued on the EU and global health in 2010, sexual and reproductive health is one of the four main challenges of the health sector.[16] European Parliament has frequently expressed its support for the promotion of sexual and reproductive health and related rights, for example, on its report on achieving the Millennium Development Goals, which was adopted in June 2010. In 2013, the European Parliament adopted a non-binding resolution on sexual and reproductive health and rights[17] which states that "The formulation and implementation of policies on sexual and reproductive health and rights and on sex education in schools is a competence of the Member States." However, the resolution also stated the European Union can promote the exchange of best practices between Member States.

Due to an alternative resolution proposed by the Group of the European People's Party (EPP) and the European Conservatives and Reformists Group (ECR), the so-called Estrela Report[18] was rejected and the sexual and reproductive health issues mentioned in the report were not discussed by the Parliament. The issues discussed in the Estrela Report included female sexual and reproductive rights, contraceptives, access to safe abortion, sexuality education for all, sexual and reproductive services targeting young people, prevention of sexually transmitted diseases, as well as prevention of violence related to sexual and reproductive rights.

The so-called Istanbul Convention, awaiting final ratification in the spring of 2014, is the first legally-binding European convention for preventing violence against women and domestic violence.[19] Different action programmes and declarations have previously been used to aim combat the issue. The Istanbul Convention will notably extend these pre-existing international responsibilities. The Convention will obligate its parties to make several forms of violence against women punishable by law, including female circumcision, forced marriage, persecution and sexual harassment. Violence against women and domestic

violence are also serious problems in Finland. The Finnish working group examining the Istanbul Convention submitted its report to the Ministry of Foreign Affairs in April 2013.

Despite the fact that a number of human rights conventions do not specifically mention traditional harmful practices, these are considered to ban female circumcision. Human rights conventions are legally binding.

- Important human rights conventions regarding female circumcision include:
- Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, 2011)
- UN Convention on the Rights of the Child (1989)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- International Covenant on Civil and Political Rights (1966)
- The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) The international human rights agreements form the basis for national legal systems and action plans.

The Convention relating to the Status of Refugees was adopted in 1951. In recent years, more and more attention has been paid to special issues of female immigrants, such as sexual violence against women.[20]

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3. Sexual and reproductive health awareness at national level and sexual and reproductive health behaviour

The objective of the promotion of sexual and reproductive health is that the population is aware of the factors promoting and, on the other hand, preventing sexual and reproductive health. Up-to-date and high-quality information about sexual and reproductive health must be available for everyone. The right to information and instruction has a key role in sexual and reproductive health rights. Nevertheless, there is not enough research information available on the level of awareness among the population.

Level of awareness and monitoring it

The School Health Promotion study[1] of the THL regularly monitors the level of awareness on sexual and reproductive health of 8th and 9th graders from comprehensive school, 1st and 2nd graders from upper secondary school and 1st and 2nd graders from vocational school with questions and statements on the contents of education. The Good sexual health awareness indicator[1] has been formed out of eight statements on sexual health.[2] The indicator is available of pupils in comprehensive schools and students in upper secondary school for years 2006–2013 and students in vocational school for years 2008–2013.

According to the School Health Promotion study, the awareness of young people on sexual and reproductive health has decreased since the years 2008/2009 on all educational levels and among both genders.[3] In 2013, only 20 per cent of girls and 13 per cent of boys in comprehensive school had good knowledge of sexual and reproductive health. 34 per cent of girls and 18 per cent of boys studying for vocational qualifications had good knowledge. Among students in upper secondary schools, 43 per cent of girls and 30 per cent of boys had good knowledge. In particular, awareness of sexually transmitted diseases has notably decreased.

The School Health Promotion study has indicated that sexual and reproductive health awareness is poorer among boys than girls, and weaker among those studying in vocational institutions than in upper secondary schools.[3] Based on sexual health awareness quizzes of the Family Federation of Finland realised in 2000 and 2006 for 8th graders, the difference in awareness between genders has remained significant, with girls having consistently more awareness.[4]

Similarly, poor success at school of the young person and low level of education of his or her parents have been indicated to correlate with poor level of awareness on sexual and reproductive health.[5] There are also indications that there is poorer sexual health awareness among young people with an immigrant background than among the pupils in higher comprehensive schools in general.[6] Young people with immigrant backgrounds often estimated their knowledge as better than what was actually the case, and they felt that they needed no further information. Nevertheless, the level of awareness did not primarily correspond with the objectives of the curriculum. Also among young people with immigrant background,

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[1] The good sexual health knowledge indicator consists of eight statements related to sexual health. The respondent must know all statements correctly in order to have good knowledge. The statements are: 1) When a girl begins menstruating, it means that she can become pregnant; 2) Of all contraceptives, only condoms protect against sexually transmitted infections; 3) Sometimes a sexually transmittedinfection can be completely asymptomatic; 4) A woman cannot get pregnant from her first experience of sexual intercourse; 5) When a boy can ejaculate, it means that he has become sexually mature and can conceive children; 6) A chlamydia infection can cause infertility; 7) If you have had a sexually transmitted infection once, you cannot becomeinfected with it again; 8) When a person has become infectedwith HIV, he or she can spread the infection for the rest of his or her life.

there was more awareness among girls than boys. In the future, the School Health Promotion study can be used to gain information about the level of knowledge about sexual and reproductive health of young people with immigrant origins, as the background information questions have been expanded to include the respondent's and his or her parents' country of birth and time spent living in Finland.

Both Finnish and international studies have investigated the level of knowledge among young adults on the effect of age on the decline in fertility and the risks of pregnancy.[7–9] According to the results, there are shortcomings in the knowledge of young adults. Most of them do not know when and how significantly fertility begins to decline. Among Finnish university students, one sixth of female and one third of male students do not know that it is harder to get pregnant aged 35 than aged 25.9 In group interviews of university students, fertility counselling, i.e., advise on issues such as the effect of age on fertility and the risks of pregnancy, was considered acceptable.[10]

The level of awareness among the adult population on sexual and reproductive health has not been studied in recent years.

Sexual and reproductive health behaviour at national level

Information on the population's sexual and reproductive health behaviour can be acquired from registers (induced abortions, register on newborns, infectious diseases, mass screening registries), questionnaire studies (e.g., the School Health Promotion study, WHO Health Behaviour in School-Aged Children, University Student Health Survey, FINSEX, the 'Health 2000' and 'Health 2011' surveys, FINRISKI, Maamu Migrant Health and Wellbeing Study, Survey on the welfare and services for families with children) and qualitative studies. The questionnaire studies will be presented later in connection to different sections of this document and in more detail in the chapter on research.

From pre-teens to young adults

The foundations for sexual well-being are laid already during childhood. Therefore, it is important to study children's attitudes towards a variety of interpersonal relationships and changes in their own bodies. In 2013, the National Institute for Health and Welfare implemented a survey which was responded to by over 3,000 5th graders from all over Finland.[11] According to preliminary results, two out of three 5th graders considered growing into adulthood as natural and pleasant. Nearly one in ten found entering into adulthood to be scary or distressing; girls slightly more frequently than boys. Around one in four was unable to say how it felt to grow into adulthood with the included changes. Nearly two out of three reported having or having had a crush on somebody and had told about this to someone, such as his or her best friend; girls more often than boys. Two out of three had at least one adult among their family and friends with whom they could talk about matters related to puberty or dating, again with girls having these slightly more often than boys. One in ten did not have such an adult in his or her life, and one in four replied that they also did not want or feel that they needed more information on issues related to puberty or dating.

Causes of both joy and worry can be perceived in the sexual and reproductive health behaviour of adolescents and young adults. The proportion of girls in upper comprehensive school of basic education and in upper secondary school who have had sexual intercourse has decreased during the 2000s.[12] In 2013, 22 per cent of 8th and 9th graders in basic education had had sexual intercourse.[3] There were no differences between the genders, but among upper secondary school and vocational school students, girls were more likely to have had sexual intercourse than boys. At the same time as sexual intercourse rates have decreased among young people in the 2000s, the induced abortion and childbirth rates among young people have also declined (see. chapter 11 Contraception). The rate of induced abortions among women under 20 years, especially, has decreased in the 2000s. Starting sexual intercourse at an early age appears to correlate with earlier physical development of the young person: the adolescents aged 14–16 who had had sexual intercourse had an earlier onset of menstruation or ejaculations than those who had not had intercourse.13 Nevertheless, there was no connection between getting periods at an early age and a high number of sexual partners in girls.[14] An intimate relationship, emotions and feeling ready for intercourse were important for girls when having sex for the first time.

Desirable development had not occurred in the prevalence of contraceptive use among young people since the beginning of the 2000s.[12] According to the School Health Promotion Study[3], the previous intercourse of 18 per cent of boys and 14 per cent of girls in upper comprehensive school had been unprotected in 2013. The rates from upper secondary level education were nearly as worrisome: 13 per cent of boys and 11 per cent of girls studying to get vocational qualifications and 8 per cent of boys and 6 per cent of girls in upper secondary school had not used protection during their previous sexual intercourse. Simultaneous use of a condom and hormonal contraception (dual protection) was also rare among the young people. Fewer than one in ten of the young people who had had sexual intercourse reported having used dual protection during their previous intercourse.

According to the 1987 Finnish Birth Cohort study, the indicators of sexual and reproductive health were clearly connected to other indicators describing problems in well-being.[15] During the follow-up period, girls in the cohort who had not obtained a degree after basic education had a higher number of chlamydia infections (15.8% vs. 5.5%), terminations of pregnancy (20.7% vs. 3.9%), and teenage deliveries (16.0% vs. 0.7%) than those who had attained a matriculation examination or a higher education institution degree. Sexual and reproductive health problems often accumulate in those with also a number of other health-threatening risk factors.

Sexual risk behaviour of young people, such as negligence of contraception and a high number of sexual partners, correlated with the use of intoxicants.[13, 14] However, it was positive that the use of alcohol did not necessarily cause the loss of self-management and control in girls or the neglect of the use of contraception.[16] The management of sexually charged situations was promoted by certain personal characteristics, such as being intrinsically motivated and having a good self-esteem. In addition to personal factors, the sexual behaviour of girls was influenced by situational factors, such as intoxicants, and social factors, such as parents and friends.[14] Girls had also adopted the predominant Western cultural conception according to which girls carry the responsibility in sexual matters. Similar studies have not been conducted among boys.

In recent years, behaviour of adolescents online has also been studied in relation to sexual health. Out of the young people responding to a survey by Save the Children Finland, over half had discussed matters related to sex on the internet.[17] Matters related to sex were primarily discussed with friends that the adolescent knew in real life or with online acquaintances. According to the results of the School Health Promotion Study[3], 18 per cent of boys and 23 per cent of girls among 8th and 9th graders in basic education had discussed sex in the internet with a stranger who was not a health care professional. The rates were even slightly higher among those in upper secondary level education.

15–16% of boys and 12–14% of girls among 8th and 9th graders in comprehensive school as well as in upper secondary and vocational schools had recorded or viewed intimate parts of the body or masturbation via a web camera.[3] Less than five per cent had distributed his or her own or somebody else's intimate pictures online for other people to see. There were major differences between genders regarding viewing pornography online on both comprehensive and upper secondary schools. 74 per cent of boys and 22 per cent of boys in 8th and 9th grades had watched pornography.

A study conducted among army conscripts revealed that there had been no significant change on the level of sexual risk behaviour during the years 1998–2005.[18] Approximately half of the men had not used a condom during their previous sexual intercourse. Sexual risk behaviour and sexually transmitted diseases were connected to the use of intoxicants. The results of the study emphasise the necessity for monitoring and preventing risk factors related to the spread of sexually transmitted diseases.

According to the University Student Health Survey, two out of three students were in a steady relationship.[19] Around 60 per cent of the students were satisfied with their sex life; women slightly more often than men. Half of the women aged 30–34 studying in universities of applied sciences had children, in contrast to one third of those studying in universities. Overall, only around 7 per cent of those studying in higher education institutions had children. Highly educated people will often postpone having children until the later years of the fertile age, which increases the risk for unintentional childlessness. Nearly one in three of university students without children is unsure whether he or she aims to have children in the future.[9]

Adults

The research on sexual and reproductive health behaviour has traditionally been heteronormative and sex has been considered to be penis-in-vagina intercourse. For example, population studies surveying sexual and reproductive health rarely include questions about sexual orientation or on the respondents' personal experience of gender. Indeed, there remains to be very little information available on the sexual and reproductive health behaviour of sexual and gender minorities.

Changes in the sexual behaviour of the Finnish adult population have been monitored with the FINSEX study since the year 1971. According to the follow-up study, the number of sexual partners during one's lifetime has increased during previous decades. In 1971, women reported having been with 2.6 and men with 11 partners during their lives. In 2007, the number was 10.4 among women and 14.7 among men.[20, 21]

According to the FINSEX study of 2007, 61 per cent of men and 53 per cent of women aged 18–74 had had intercourse during the previous week.[22] The difference between the genders can be partially explained by the fact that the women in the eldest age group included more elderly widows who were no longer interested, or had no opportunity, for a relationship involving sex. The proportions had decreased by a few per cent compared to the year 1999 and by approximately ten per cent compared to the early 1990s.

In 2007, 66 per cent of men and 62 per cent of women aged 18–34 had had intercourse during the week prior to the survey.[21] Among 35–54-year-olds, the corresponding number was 65 per cent among men and 60 per cent among women, and among 55–74-year-olds, 53 per cent among men and 35 per cent among women. 82 per cent of men and 86 per cent of women reported that their last sexual partner had been their spouse or other steady partner. Around 14 per cent of Finnish men reported that they had paid for sex at some point over the course of their lives.[23]

According to those participating in the FINSEX study, two in three women and four in five men would like to have sexual intercourse at least twice a week if they could personally decide on the frequency of having sex.[22] In a European comparison participated by Finland, Spain, Italy, Greece, Portugal and Norway, both men and women in Finland had lower incidence of sexual intercourse than those in other countries. In addition to intercourse between partners, masturbation is also a form of sex in a relationship. The number of those who had masturbated during the previous month had increased from 39 per cent to 51 per cent from 1999 to 2007. In 1971, this number was only 20 per cent. The growth in masturbation rates appears to have in part replaced the declining intercourse numbers in relationships in 2000s.

Relationships considered happy included the highest incidence of sexual intercourse.[21] In addition to sex, happiness in a relationship was also increased by other physical intimacy and the ability to talk about sex with one's partner. Having little touching was related to a decrease in relationship happiness as the length of the relationship increased. The relationships that had only lasted for a few years and where there were sufficient amounts of intimacy and touching were the happiest. On the other hand, sexual satisfaction is not enough to save a relationship without reciprocity, understanding, commitment and team spirit.[24]

Lack of sexual desire in a relationship causes problems to both individuals and the relationships.[21] Lack of sexual desire was four times more common among women than men, and was found as frequently reoccurring in every other relationship. Differences in sexual desire between partners cause stress and conflicts and these days also more and more often also lead to divorces and break-ups. Couples counselling, sexual counselling and sexual therapy can be used to help couples also in problems with a lack of sexual desire and in reaching orgasm. According to the definition by the WHO, a key content of sexual health is to provide an opportunity to enjoy sexual relationships satisfying to both partners.[25]

According to the WHO, a state of physical, emotional, mental and social well-being in relation to sexuality is essential to sexual health.[25] Good sexual health can be attained regardless of illness, injuries or dysfunctions. Many chronic illnesses, cancers and other serious diseases can have an impact on the human sexuality and sexual behaviour. Three in four patients at a cancer clinic considered it necessary to discuss matters related to sexuality at a hospital.[26] The respondents wished for a doctor or nurse to initiate the discussion. The contents of sexual counselling and guidance must be patient-oriented, the guidance must be automatically included as a part of the care plan and sexual counselling must be implemented by trained staff.[27, 28] In 2010, the guidance and counselling of inpatient wards was a part of the work of only some few sexual counsellors or therapists.[29] Some of the sexual counsellors and therapists provided counselling work

alongside their day jobs, while some offered certain consultation hours. Indeed, some hospital districts provided consultations of a sexual counsellor or therapist, for example, at urologist, surgical, cancer, spinal injury and fear clinics.

The Migrant Health and Wellbeing Study (Maamu) of the National Institute for Health and Welfare produced some information about the sexual and reproductive health behaviour of immigrants with Russian, Somali and Kurdish origins.[30]

The study indicated that the use of reliable contraceptive methods was the lowest and spontaneous miscarriages were the most common among women with Somali background.[31] Childbirth rates were also the highest among them. Induced abortions were common among women with Russian background. Approximately 70% of Somali women and 32% of Kurdish women have been circumcised.[32]

In the future, studies surveying sexual and reproductive health behaviour must take into account sexual orientation and gender diversity. If behaviour is investigated using heteronormative assumptions, incorrect information will be obtained, for example, regarding contraceptive use. Sexual well-being should also be examined more holistically than currently and by utilising both quantitative and qualitative research approaches. In order to bridge the gap in health differences, it is essential that attention is paid particularly to the groups whose level of knowledge is poorer and behaviour is more risk-prone than among the rest of the population.

Objectives

- Information on sexual and reproductive health awareness and behaviour among adult population will be yielded.
- National sexual and reproductive health awareness will be improved and inequality in sexual and reproductive health and awareness, caused by gender, educational differences or other reasons, will be reduced.
- The diversity of gender and sexuality will be acknowledged in the sexual and reproductive health research.

Actions

- Research institutes and higher education institutions will determine sexual and reproductive health awareness level and sexual and reproductive health behaviour through population surveys.
- The Ministry of Education and Culture, the Finnish National Board of Education and other actors, responsible for planning and implementation of education, will connect sexual and reproductive health education to curricula with a more comprehensive approach, e.g., including fertility counselling in health education as early as at upper basic education level and as a part of vocational college and upper secondary school education.
- Health care professionals will diversify sexual and reproductive health information delivery, which is done as a part of their work.
- Research institutes and higher education institutions will take into account gender and sexuality diversity in research question setting and outcome reporting.

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4. Sexuality education: education, guidance and counselling

Sexuality education promotes sexual and reproductive health. The action programme draws on the WHO Standards for Sexuality Education, translated into Finnish in 2010.1 The guidelines for the implementation of the standards[2] were published by WHO in 2013 and translated into Finnish by THL in 2014.

The WHO Standards for Sexuality Education1 define sexuality education as learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts early in childhood and progresses through adolescence and adulthood. For children and young people, it aims at supporting and protecting sexual development.

According to WHO, holistic sexuality education

- starts at birth
- is age-appropriate with regard to the young person's level of development and understanding, and culturally and socially responsive and gender-responsive. It corresponds to the reality of young people's lives.
- is based on a (sexual and reproductive) human rights approach
- is based on a holistic concept of well-being, which includes health
- is firmly based on gender equality, self-determination and the acceptance of diversity
- has to be understood as a contribution towards a fair and compassionate society by empowering individuals and communities
- is based on scientifically accurate information.

Sexuality education consists of sexuality education at national level, sexuality education and counselling.[3] Sexual guidance is also part of sexuality education.[4, 5] Sexuality education at national level is a form of one-sided distribution of information using, for example, campaigns aimed at the population. Sexuality education is a form of teaching occurring in a group including an opportunity for reflection. Sexuality counselling is help organised in the form of a dialogue offered for one or two people. Sexual guidance is a form of goal-oriented and situation-specific activity, which can be conducted as a part of any encounters in nursing and guidance work. Sexuality education may be provided by both official (formal educator) and unofficial (e.g., families) entities. The sexuality educator does not make assumptions on another person's gender or sexuality in the education process.

Sexual and reproductive health education at national level

Sexual health education at national level is a form of efficient distribution of information allowing quickly reaching large groups of people and directing information to certain population group. Sexual health education at national level is one-sided and does not always offer a direct opportunity for asking for more details. The purpose of a sexual health education campaign is to raise an issue requiring more attention once or recurrently. Previous sexual and reproductive health education campaigns have included, for example, a campaign for recognising testicular cancer in young men (http://www.cancer.fi/taskubiljardi/), the so-called 'summer rubber' campaign (http://www.punainenristi.fi/kesakumi), the Movember sexual health campaign on male prostate cancer, the National Institute for Health and Welfare's Mun Kroppa. Mä päätän ('My Body. My choice') campaign and the City of Helsinki's campaign for distributing condoms free of charge. The implemented campaigns for education at national level have primarily been aimed at young people or young adults. Not all of their impacts or effectiveness has been studied.

Education at national level must be conducted with a long enough time perspective and by several different entities in order for them to be effective.[1,6,7] Education at national level supports a cultural change through which knowledge, attitudes and behaviour can be transformed. It is not possible to immediately

assess the effectiveness of an individual education campaign, as a number of factors in addition to the education itself affect the changes in sexual health, such as teenage pregnancy rates and the number of sexually transmitted infections. Nevertheless, the implementer of a project must always consider and be able to justify the presumed effectiveness of the project. The assessment of immediate effects should always be part of the campaign project. Effect can be assessed, for example, by measuring the immediate reaction to the campaign and the amount of publicity afforded to the campaign in the media.

In Finland, no specific actor has the official responsibility to arrange or monitor the communication or campaigning related to sexual and reproductive health aimed at the population. The Sexual and Reproductive Health Unit (SELI) of the National Institute for Health and Welfare should be informed about education campaigns in order to increase cooperation between actors and transfer of information. A newsletter by the SELI unit can be used to spread information about campaigns on a national level.

Sexual and reproductive health education, guidance and counselling

Sexual and reproductive health education influences knowledge, skills and attitudes. The education is dialogue-based and learners have an opportunity to discuss issues with their teachers and to specify the education with their own further questions. Knowledge is built on what is already known. The education can be provided to persons of all ages in different situations and places, such as schools, occupational health care services or elderly care services.

In primary schools, sexual and reproductive health education is currently a responsibility of classroom teachers and has been integrated in the instruction of several subjects. In upper comprehensive school, there is a separate subject on health education taught by a person who has acquired the qualifications of a health education teacher. In upper secondary level education, both upper secondary schools and vocational institutions offered one compulsory course in health education in 2014. The national core curriculum for basic education will change in 2016. As a result, health education will be provided as a part of the environmental studies integrated subject (including biology, geography, physics, chemistry and health education) in grades 1–6 and as a separate subject in grades 7–9. Finnish National Board of Education (FNBE) evaluated the learning outcomes in the subject of health education in 2013.[8] The purpose was to find out how well the objectives set for the subject had been reached and what the national level of competence in the subject was. Pupils' (n = 3652) competence was evaluated based on assignments and a questionnaire aimed at them. Further questionnaire surveys were conducted among teachers (n = 193) and principals (n = 62). A little under 40 per cent of teachers had the qualifications of a subject teacher in health education, even though the transition period for obtaining the qualifications had ended in July 2012. The most frequently used teaching methods were teaching discussion, questions from the teacher, presentation or lecture, as well as work in pairs and groups. The use of functional methods had positive impact on learning outcomes. There was no connection between whether the teacher was qualified and learning outcomes, but continuing education appeared to have a positive effect on pupils' competence.

The pupils' competence in health education was only satisfactory; on average, 59 per cent of the maximum number of scores.[8] The level of competence was better among girls than boys. There were also regional differences in competence: Pupils from Eastern Finland had the best scores. Nonetheless, all had a positive attitude towards health education. Those who had continued their studies in an upper secondary school were more successful than those in vocational education. The basics of sexual health were included in a section on health in everyday choices. The average level of competence was 62 per cent in this section. Again, in this section, girls faired better than boys (65% vs. 58%).

The school health nurse brings up the topic of sexuality during health examinations and may also participate in the instruction. Attention must be paid to the training of school health nurses and cooperation between health education teachers and public health nurses also in the future. Studies for teachers and public health nurses in sexual health and sexology vary notably in scope and content.[9]

Information on sexual and reproductive health can be obtained from multiple sources of information, but the population is required good basic awareness so that they can critically evaluate the quality and validity of the information. 85 per cent of Finnish people aged 16–89 use the Internet.[10] Evaluating the validity of the information available online is particularly problematic. Media education is part of sexuality

education and can be used to provide means to deal with the society and the media, particularly for children and adolescents. The image of sex shown in the media may narrow down the conceptions of many adolescents and young adults on how they perceive their own sexuality and the expectations and demands others have for them.[11]

Sexual guidance is everyday work of a person with professional training in social and health care involving giving advice to clients and patients and broaching the topic of sexuality. Sexual guidance is also conducted as a part of youth work and leisure time activity guidance. The context of the guidance is less formal than formal education, but nevertheless provided by a trained professional. Sexual guidance can be provided, for example, in adaptation training courses related to different health issues.

Sexual counselling involves goal-oriented and professional handling of issues and problems related to human sexuality and sexual health realised in an interactive relationship between a professional and a client. Sexual counselling usually comprises of 2–5 meeting sessions (see more information on the training of a sexual counsellor in chapter [17] Development and support of professional skills). There is only fragmented research information available on the need for sexual counselling, and more research on the topic is therefore required. The majority of hospital districts offer sexual counselling and/or sexual therapy consultation, but the methods used in arranging this vary by hospital districts.[12] Most hospital districts also include persons who have been trained as sexual counsellors or sexual therapists.

Sexual counselling is an essential part of preventive health care services. The services can be arranged in multiple ways in health centres.[13] Nurses trained as sexual counsellors worked only in few health centres. Nurses other than those trained as sexual counsellors reported to have to some extent brought up questions related to sexual counselling as a part of contraception counselling.

Sexual counselling is a part of couples guidance and counselling. Issues most frequently leading to the end of a relationship are most commonly unfaithfulness, difficulties in discussing and overcoming disagreements, falling in love with a person outside the relationship, not taking care of the relationship and the lack of love.[14] Inability of the couple to deal with difficult situations causes and worsens problems in the relationship. In order to solve conflicts or a break-up crisis, people seek help from professional counsellors either in therapy or relationship courses. Couples wish to gain readiness for interactive and problem-solving skills with the help they receive. The means of counselling can be used to help couples discover solutions to their problems. More information and counselling on difficulties in interpersonal and intimate relationships and preventing these could be provided as a part of municipal preventive maternity and child health clinic work than is currently available. This would promote the well-being of the parents of young children and the preconditions for preserving their relationship. This would be likely to at least in part reduce the number of divorces and break-ups of parents in families with small children. The recommendations for maternity clinics (e.g., the Sexual well-being and Support for parenthood chapters) include descriptions of sexual counselling as a part of the contents for counselling during pregnancy and paying attention to supporting intimate relationships.[15]

The network for sexual counsellors coordinated by the National Institute for Health and Welfare has increased cooperation between various actors, spread models for organising activities, distributed peer information and support as well as made sexual counselling services and their importance visible.[16]

The services of many actors in the third sector, such as the Family Federation of Finland, Seta, the Sexpo Foundation, Finnish Red Cross and HIV Foundation, include counselling related to sexuality, sexual health and intimate relationships. The prevention of sexual issues should be focused on sexuality education, easy attainability of information, low-threshold services, and activities taking information straight to the target groups.

Objectives

- Sexuality education will be included in education and teaching from early childhood education to higher education as well as in services for adult population.
- National campaigns will be implemented systematically and in cooperation between different actors and the target group, such as young people, when possible.
- Attention will be paid to effectiveness and influence of the educational campaigns.

- The diversity in sexual orientation, gender identity and gender expression will be taken into account in sexuality education and planning of educational material.
- A specific electronic form for sexual counselling and therapy will be developed to support sexual counselling work.

Actions

- Different professional groups and fields will cooperate at local, regional and national levels aiming at shared, mutually supporting goals in sexuality education and sexuality education services.
- Public sector and organisations will regularly arrange national campaigns in order to improve and maintain national awareness, and create a cooperation body, which will discuss actual focus areas and agree on distribution of duties as well as the means to get various target groups involved in the campaigns.
- The implementers of the national campaigns will evaluate the immediate effects of the campaigns as a part of the project.
- Research institutes and higher education institutions will establish long term efficacy of sexuality education by determining the national knowledge level, attitudes and behaviour through population studies.
- Providers of sexuality education material will produce the material in plain language, taking target groups into account (e.g., mother language and culture) and respecting the diversity of sexual orientation, gender identity and sexual expression.
- Professionals in social and health care, teaching, education and other fields as appropriated will deliver updated, non-commercial, norm critical and evidence-based material in the context of sexuality education and services.
- In municipalities, a person responsible for the electronic patient information management system will create a specific sexual counselling and therapy form with a read and write permission for authorised consultants, therapists or clinic sexologists. The access rights are granted by a trained person in charge of sexual counselling in the municipality.

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5. Sexuality education

Children and adolescents

Children and adolescents gradually acquire information about sexuality and develop perceptions, values, attitudes and skills related to the human body, intimate relationships and sexuality.[1] Learning occurs both through unofficial and official sources. Unofficial sources include, for example, parents. The younger the child, the more significant is the role of the parents. Official sexuality education, for example, provided in early childhood education and schools, must respect the rights and diversity of children. According to a UNESCO report, sexuality education is not linked to the early initiation of sex.[2] In one third of the studies, sexuality education lead to a later initiation of sexual relationships and did not increase the amount of sexual contacts. According to one third, this also decreased the contacts. Sexual risk-taking was decreased in over half of the studies and increased in only one of them.

The timing and the planning and implementation of contents should be founded on the WHO's Standards for Sexuality Education,[1] based on which education begins at birth. As communication skills in the relationship lay the foundation for raising a child, supporting expectant parents and relationships, e.g., by teaching communication skills, also promotes a child's upbringing. Sexuality education includes discussing sexual rights and cultural and social differences.

Particularly in the sexuality education of children and young people, it is important to remember that the education work of a sexuality educator is not founded on assumptions on another person's gender or sexuality. Occasionally, problems may arise due to conflicts in values between official and unofficial actors. This is the case in situations such as those where the adolescent's freedom to choose a girlfriend or boyfriend is limited or where non-medical circumcision of boys is performed. The parents' freedom of religion and freedom to practice religion is in conflict with respecting the rights of the child (right to bodily integrity, autonomy and the right to privacy).

Sexual health in early childhood education and at school

Sexuality is a central part of humanity in all stages of life.[1] Sexuality education for children below school age and in primary school must lay a foundation for a good self-esteem and intimate relationships as well as respect for others.[3] Sexuality education must develop the learner's understanding of his or her body and self-determination. According to the WHO Standards for Sexuality Education, sexuality education must take into account engaging children and adolescents, gender and sexual diversity, continuity of the activities, being situation-oriented and interactive as well as cooperation with parents and communities.[1]

In the national core curriculum for early childhood education, the objectives for education are determined as the promotion of personal well-being, strengthening forms of behaviour and approaches taking others into account, as well as gradual increase of independence.[4] Equality between the genders is identified as an ethical principle for education, but the content-related orientations do not separately include a mention of supporting the sexual development of the child. In connection with the topic of health, the key content areas of the National Core Curriculum for Pre-primary Education include a mention that the child is guided with actions and teaching of manners towards building positive relationships and emotional health as well as avoiding violence.[5] Supporting sexual health is not separately mentioned in the content areas.

In the WHO Standards for Sexuality Education, a key theme for sexuality education for 0–3 year-olds is discovering and exploring.1 Babies aged 0–1 years focus entirely on their senses. The child develops trust in other people in the early interaction. Sexuality education for 2–3 year-olds should take into account that toddlers are very interested in their own bodies. Children develop ideas of what kind of different gender roles there are and gain interest in genders. Children also want to explore their own bodies. A child must never be made embarrassed for being curious.

A child learns rules aged 4–6. Being in a group and playing also support sexuality education. Sexuality education includes consideration of gender roles, talking about liking somebody and finding suitable vocabulary related to sexuality.

Themes of sexuality education in primary school include, e.g., shame and first love. Children start forming groups based on gender and play also includes competition. Early puberty begins at around 10–11 years of age. Children start to gain interest in sexuality and changes in it. Emotional and safety skills as well as the prevention of violence are a part of sexuality education in primary school.

Puberty takes place during the transition phase between primary and upper comprehensive school and during upper comprehensive school. However, children must be taught about the changes already before their bodies start changing. Masturbation, dating, sexual-self image and identity, and taking care of sexual and reproductive health are key contents of sexuality education. Children must be informed about and taught to discuss, e.g., the impacts of peer pressure, the media, pornography, culture, religion and laws on sexuality.

In upper comprehensive school (grades 7–9), health education is taught as its own subject for three annual weekly hours.[6] The young person must be provided with information to support his or her personal growth and development. In upper comprehensive school, the education must deal with dating, love, intimate relationships, sex and porn, and the media as a source of information on sexuality. The topic of violence offensive to intimate relationships and sexuality must be included in the contents of the instruction.

The curriculum for upper secondary schools includes one compulsory and two optional courses of health education. The contents also include topics of sexual health.[7] There is one credit unit worth of health education in the curriculum for basic vocational qualifications. The objectives include, for example, understanding the importance of mental health, sexual health and intimate relationships for the person's well-being.[8] Health education included as one subject area for the general studies essay of the matriculation examination since the spring of 2007.

Sexuality education can be used to increase equality in schools. Young people belonging to sexual and gender minorities (rainbow youths) face different forms of discrimination affecting their well-being.[9] The majority of rainbow youths has experienced difficulties and problems caused by the normative conceptions of the society on gender and sexual orientation. Rainbow youths are more frequently dissatisfied with their mental health status than heterosexual youths and young people who are not facing gender dysphoria. Compared to other adolescents, rainbow youths have more depression and anxiety symptoms, self-destructive thoughts, and self-destructive behaviour. In order to promote the well-being of rainbow youths, there is a need for more appropriate information on diversity and support for the professionals working with young people. When providing sexual counselling, professionals must have good readiness to understand the meanings of gender and sexual diversity among their clientele.[10]

In upper secondary level education, the young people continue to be supported in developing their sexual identity and self image, interpersonal relationships and intimate relationships. The education also involves discussing taking care of sexual and reproductive health and continuing dealing with the topic of violence that offends intimate relationships and sexuality. In addition to health education, sexual and reproductive health can also be included in the contents of other subjects, such as biology, social studies, psychology, religion and mother tongue.

There are many health education textbooks, but the information on sexual and reproductive health education contained by them has not been evaluated in a systematic or norm-critical manner. According to a master's thesis, the topic of sexuality is not apparent in primary school books, even though the holistic well-being of the child is the objective of the instruction based on the Core Curriculum for Basic Education.[11] Puberty is discussed little on primary school even though some pupils enter puberty already during this time.

State churches and organisations as sexuality educators

Sexuality education can be integrated in all activities conducted with adolescents. Approximately 84 per cent of Finnish 15-year-olds attend confirmation training annually.[12] The training includes sexuality education which is supported by material published for camp group leaders.[13] The Orthodox Church has a Christianity school and young people may attend a Christianity camp if they like, which functions as a rite of passage for Orthodox youths.[14] Some young people attend Prometheus camps, where sexuality is included as one of the discussed themes.[15] Sexuality education can also be implemented as a part of other

youth activities, such as scouting or exercise activities. The Federation of Finnish Midwives has produced the IhmiSeksi[16] material to support sexuality education. The material can be utilised in comprehensive schools, confirmation training and Prometheus camps. The Family Federation of Finland has published the Steps of Sexuality model[17] to support sexuality education and a guide to educators in the poikaS project focused on the special needs for sexuality education for boys.[18]

Nuorten Akatemia ('academy of youths') has trained young people as educators who have been going around schools and implemented the Seksimyytin murtajat ('sex myth busters') training as small-group activities. The aim of the training is to dismantle the most common misconceptions related to sexuality and contraception. This also includes coming up with ideas for how the theme could be further discussed at the school. Several ready-made sets of learning material have been formulated for the training.[19]

The task of the adults working with children, adolescents and their parents is to

- consider their own sexuality; values and perception of humans and to recognise their own role as an example for the young person
- be aware of and recognise the development stage of the child and young person, according to which adults provide trust and security, but also responsibility, and acquire sufficient basic knowledge of the sexual development of children and young people
- ensure that good means and services are available for the young person to obtain knowledge, guidance and instructions, recognise his or her own limitations in knowledge and skills and, if necessary, guide the young person to sources of further information and help
- help the young person in recognising and expressing different emotions
- set boundaries for the young person and guide him or her in taking responsibility for his or her own choices
- discuss facts with the young person if he or she has unrealistic conceptions or goals
- provide the young person with an opportunity for learning from his or her mistakes and get a 'new chance'.

Adapted from The Family Federation of Finland[20]

Sexual and reproductive health services for young people

Encountering adolescents in social and health care services creates a good opportunity for sexuality education. The sexual and reproductive health services for adolescents are founded on easy availability.[21] The services must be easy to reach physically, i.e., they must be local services or accessible by public transportation. Access to the services must be gained preferably without having to schedule an appointment or by making an appointment effortlessly and with a short waiting period. Seeking services is accommodated by the availability of alternatives, for example, beginning the use of contraception either in centralised contraception counselling or in school or student health care. Services should be integrated so that sexual counselling is always provided as a part of pregnancy prevention. Economic availability, i.e., reasonably priced or cost-free services is important for services aimed at young people. The services should also be psychosocially available, i.e., approved by young people. In addition, it is important that the services are available and accessible both physically and in terms of information provision.

School and student health services

International comparison has indicated that sexual and reproductive health services that are integrated, intended for adolescents and located at the school premises are most likely to promote the sexual and reproductive health of adolescents.[22, 23] Sexual counselling has already been the responsibility of school and student health care for a long time.[24, 25] New legislation has further clarified this task.[26, 27] Contraception and other sexual health counselling have been determined to be a part of the services of maternity and child health clinics and school and student health care, but can also be provided as a part of other services.

According to the Health Care Act, local authorities shall provide schoolhealth services for pupils enrolled in educational institutions providing basic education in their area and student health care services tostudents enrolled in upper secondary schools, educational institutions providing vocational education, and

universities and other institutes of higher education located in their area regardless of the students' place of residence.[26] Subject to the consent of the local authority in question, student health care services for students enrolled in universities and other institutes of higher education may also be provided in another manner approved by the National Supervisory Authority for Welfare and Health. More extensive promotion of sexual and reproductive health is included in student health care: counselling on sexuality and relationships, prevention of infertility, support for sexual orientation and gender identity, prevention of sexually transmitted diseases and sexual violence as well as other counselling related to sexual health and referral to further treatment if necessary.[27]

School health services must provide health checks for the pupil on each grade, so that so-called extensive health examinations are conducted on the first, fifth and eight grades.[27] In connection with sexual and reproductive health, the extensive health examination for fifth graders should include an evaluation of the pupil's development and stage of puberty, preparation of both the child and his or her parents for the changes entailed by puberty and support for them.[28] The extensive health examination for eight graders should take into account, in addition to counselling related to intoxicants, viewpoints related to dating, sexual health and contraception.

Two scheduled health checks must be provided for students enrolled in upper secondary schools and vocational institutes; an examination by a public health nurse on the first year of studying and by a doctor on the first or second year of studying, and further examinations according to individual needs.[27] This allows both the public health nurse and the doctor to meet each secondary school student at least once during his or her studies. The public health nurse's and doctor's work as partners is utilised in the health examinations. This includes familiarisation with the student's personal resources, well-being, health habits, risks and needs for support. Health checks in student health care, other health care appointments and medical consultation visits provide public health nurses and doctors with an opportunity for individual, targeted health promotion, including the promotion of sexual health. Mental health and substance abuse work, promotion of sexual health and early recognition of special support of examinations for the student, supporting the student and referring him or her to further examinations or treatment if necessary are part of the statutory student health care services for students.

The new Pupil and Student Welfare Act will come into force in August 2014.[29] The aim of the Act is to promote the health and well-being of pupils and students from pre-primary education until the end of upper secondary education in a cooperation between social, education and teaching and health authorities. Among other things, pupil and student well-being must be provided so that it is possible to get access to a public health nurse's help without having to schedule an appointment. Sexual and reproductive health is part of health promotion, which can be implemented more systematically than previously as a part of communal student welfare.

School and student health care staff has special competence required in working with young people. The strengths also include that school health care services are available for all pupils in basic education. However, young people not continuing their studies are left outside student health care services. They in particular might be in most dire need of low-threshold sexual and reproductive health services. Lifestyles, such as smoking and intoxicant use, as well as repeated abortions, harm sexual and reproductive health or increase risk behaviour. Sexually transmitted diseases and teen pregnancies are more common among those less educated and taking risks is more frequent among those with multiple sexual partners.[30–35] Poor performance at school of the young person and low level of education of his or her parents are also connected to substandard level of knowledge on sexual and reproductive health.[36] Intergenerational accumulation of problems in adolescents has also been recognised.[33, 37] The parents of children and adolescents in outpatient child welfare services had most frequently separated and the families included one parent, usually the mother, which usually resulted in a family income less substantial than in two-parent families.[37]

Initiative by the Advisory Board on the Health and Welfare of Children and Youths

The Advisory Board on the Health and Welfare of Children and Youths of the Ministry of Social Affairs and Health suggests that the social and health care services for children, young people and families should

be provided as a functional service entity. The service entity would be constructed of services for children under school age, children of school age and young people of studying age. The services for young people of studying age would also apply to the young people previously left outside student health care services and could be used to, e.g., better reduce differences in health and prevent exclusion.[38] The initiative has proposed that the entity of social and health services for young people of studying age which the social welfare and health care region is responsible for providing should contain, in addition to student health care, psychologist and curator services, child protection, social work, disabled services, occupational health care for those who work, health centre services, youth stations and other services aimed at young people by the services for substance abusers as well as the services of the current somatic and psychiatric specialised medical care.

Kaste 2012–2015 and SOTERKO

A special objective of the sub-programme of The National Development Programme for Social Welfare and Health Care, 'More effective services for children, young people and families with children' (Kaste 2012–2015), is to reduce inequality and prevent social exclusion of children and young people.[39] Particular attention is paid on immigrant and Roma adolescents and social work carried out with young people and outreaching youth work are reinforced. A further aim is to increase specialised forms of health and well-being promotion and low-threshold services as well as to introduce operating models that support families, parenthood and the adults working with children and young people. The objectives do not include a separate mention on the promotion of sexual and reproductive health and sexual well-being or sexuality education, but the creation of operating models for helping abused children, adolescents and their families is presented. The so-called SOTERKO research consortium described political measures for preventing the social exclusion of children and young people beginning in the 1990s and noted that there is little research and assessment knowledge available on the effectiveness of political actions, and that particularly little is known about the use of services and needs for support of children, young people and families with immigrant origins.[40]

The Swedish youth health clinic model

In Sweden, adolescent sexual and reproductive health services have been organised as separate youth health clinics.[41] Appointments at youth health clinics are intended for youths from 12 or 13 years to either 21, 22, 23 or even 25 years of age. The young person may seek an appointment at a youth health clinic, for example, to discuss questions or problems related to his or her own body, health, lifestyle, well-being, sexuality, interpersonal relationships or puberty or, if he or she so wishes, to use services related to sexual and reproductive health, such as contraception counselling or a pregnancy test.
Professionals from a variety of fields work in the youth health clinics in Sweden, answering to the needs of the young people, or, when needed, the young person is directed from the clinic to an consultation of a suitable professional.[41] The multiprofessional team may include a midwife, curator, nurse, nursing assistant, general practitioner, gynaecologist, psychologist, psychotherapist, a specialist in dermatology and venereal diseases and a therapeutic dietitian. School and student well-being services are provided alongside the youth health clinics, but regular health examinations are not part of the school and student health care services in Sweden. Clinics located in larger cities and towns also offer an opportunity to participate in different groups lead by professionals, such as groups for young people who have experienced sexually offensive violence, who want counselling on contraception, or who are low-spirited or depressed. Appointments at the clinics are normally scheduled by telephone, but can also be booked online more and more frequently. In smaller localities, the services are available on a certain day or days and times each week. Larger cities and towns offer services more flexibly. The service emphasises individuality and confidentiality.

The use of services in Finland

According to the School Health Promotion Study, the majority of Finnish youths still find it difficult to schedule an appointment with a doctor or a public health nurse in a matter related to sexuality[42] (table 1).

***Table 1**. The proportion of those finding it difficult* to schedule an appointment related to sexual health with a doctor or a public health nurse according to gender and level of studies, %*

	Boy	Girl	Total
Pupils in grade 8 and 9 (n = 96,399)	40	38	39
Upper secondary school students (n = 47,781)	35	24	30
Vocational institute students (n = 33,920)	27	20	23

*Rather and very difficult

Source: School Health Promotion Study 2013

A positive finding is that since 2008/2009, boys in secondary education have considered scheduling an appointment to be easier than previously, even though the number of those finding the issue difficult continues to be large.[42] A further positive fact is that the proportion of those finding it difficult to gain access to a public health nurse's consultation due to any reason has diminished for groups other than girls in comprehensive schools. Out of the girls, 15 per cent continued to consider that it would be difficult to get an appointment with a public health nurse. Gaining access to a psychologist (25–42%) or a school physician (21–45%) was considered difficult notably more frequently.

The School Health Promotion Study does not provide an answer to why scheduling an appointment related to sexual and reproductive health issues continues to be difficult. According to an international estimate, consultations aimed at young people would provide the best possible approach for organising services for young people.[43] According to a study conducted in the region of Tampere University Hospital, three of the largest towns had consultations aimed at young people.[21] The fact that these appointments have been to a large extent limited to sexual and reproductive health and mental well-being, similarly as in Sweden, may raise the threshold for the young person to seek the service due to a fear of being stigmatised, even when the service would be in every way attainable, and even without having to book an appointment. It is important that the services for young people apply to the age group in which induced abortions are the most common (20–24 year-old) and which would already benefit from getting fertility advice in addition to contraception counselling. Young people should be aware of factors affecting female and male fertility, such as age, lifestyles and sexually transmitted diseases, at a sufficiently early phase. It would also be important for students to get equal student health care services on sexual and reproductive health everywhere in Finland regardless of the region where the education institution is located. A comprehensive approach and taking young people into account offer the best possibilities for the promotion of sexual and reproductive health among young people and their growth into harmonious adulthood.[34]

Needs for information of young people and online and telephone services available for them

Young people have a desire for both basic information about sexual health as well as more in-depth and detailed information about the matter. According to a study by Rinkinen, one third of questions by young people concerned sexual activities.[44] Most often, the young person suspected having some sexual problem. The questions were also concerned with having sex, preparing for it and its acceptability. Questions on growing to be a man or a woman and pregnancy were the second most common. Questions concerned with one's body dealt with appearances, the possibility to affect the changing body and fear about whether or not one is normal. A lot of questions on sexual abuse had also been submitted to the service.

The internet is a key environment in sexuality education; it is an outlet for young people to gather information but also one through which harassment and violence occur. Webpages for young people have been established online for providing information on sexual health and through which young people get to present questions for experts. Among others, such websites include the Pointti site for all young people in Southwest Finland (www.pointti.info), the bilingual Decibel.fi of Ostrobothnia and online counselling for

young people of the Sexpo Foundation (www.sexpo.fi/nuorille/nuorten-nettineuvonta). The Child and Youth Phone, founded in 1980 by the Mannerheim League for Child Welfare (MLL), is the only nationwide, Finnish-speaking helpline for all children and young people. The Online Letter Service for children and young people is a part of an online service of the MLL for young people, the Youth Online Services (www.mll.fi/nuortennetti). Since 2011, young people have had the opportunity to have a one-on-one chat with an adult via the MLL online service. The Family Federation of Finland was the first one in Finland to launch an online service aimed at young people in 2001 (www.vaestoliitto.fi/nuoret). The service offers an opportunity for young people to ask about issues related to sexual health and to have one-on-one discussions with experts.

Objectives

- Sexuality education will equally reach all the children and adolescents at early childhood education, basic education and upper secondary levels.
- In sexuality education, children and adolescents will be taught to respect their personal integrity, private life and autonomy.
- Aspects of sexual orientation, gender identity and diversity of gender expression as well as increasing multiculturalism in the society will be taken into account in sexuality education at school. No one is left outside of sexuality education due to disability or other individual characteristics.
- Identification and prevention of sexually offensive violence will be included in sexuality education programmes at schools. Schools and educational institutions will be safe environments where no one is exposed to harassment or violence.
- Sexual teaching, included in health education, and school health care tasks will be planned in cooperation in order to ensure that sexual teaching and sexuality education support and complete each other, forming wholeness with common goals in sexual and reproductive health promotion.
- The young people will be provided with unobstructed and physically, economically and psychosocially easily accessible sexual and reproductive health services, taking account the diversity of gender and sexuality.
- Services for young people will reach young at risk of exclusion and, in particular, those who do not continue their studies after basic education.

Actions

- Professionals in teaching and education at early childhood, pre-primary, basic and upper secondary levels will establish supporting of sexual development and sexual welfare of children and adolescents as one target in their work.
- School and student health care personnel will support sexual and reproductive health development among the young, according to the regulations and recommendations provided in guidelines for school and student health care, and provide sexual and reproductive health services integrated into school and student health care services.
- Municipalities or joint municipal authorities will integrate sexuality education into programmes and actions, aimed at the young at risk of exclusion, e.g., into outreaching youth work.
- The National Institute for Health and Welfare, the Ministry of Social Affairs and Health, the Ministry of Education and Culture, the Finnish National Board of Education, the Finnish Institute of Occupational Health, the Finnish Student Health Service, the Association of Finnish Local and Regional Authorities and other key actors will work out how to implement networking of school and student health care services into multisectoral service entireties for school children and students.
- Schools will take into account diverse teaching methods in their curricula for sexuality education, providing not only informational preparedness but also interactive and social preconditions and safety skills.

- Teachers and public health nurses will cooperate in planning, implementation and development of sexuality education at schools and educational institutions.
- The Sexual and Reproductive Health Unit (SELI) of the National Institute for Health and Welfare and its networks will be responsible for development of quality assurance system for sexuality education materials and evaluation of teaching material, related to sexual and reproductive health education.
- Research institutes and higher education institutions will regularly monitor the implementation of sexuality education, and the results will be followed by surveys for students.

Young adults

Several significant changes often occur in the life of a young adult within a short period of time, including moving to another area due to studies or work, changes in the circle of friends, becoming emotionally and financially independent, and possibly establishing the first longer term relationships. There is some knowledge about the sexual and reproductive health and use of services of students in higher education institutions, but none or hardly any on other young adults. Therefore, it would be important for these young adults to gain easy access to the sphere of sexual and reproductive health services (see chapter 4 Sexuality education: education, guidance and counselling).

Military service and non-military service

Nearly all young men and some women take part in either military service or non-military service. Examination for recruitment to armed forces reaches practically the entire age group of young men. Indeed, the examinations for recruitment could be utilised better than currently in the promotion and research of the sexual and reproductive health of young men, for example, by investigating the sexual and reproductive health behaviour and level of awareness among young men. So far, students of health care and other fields have participated in individual examinations for recruitment, for example, in the Helsinki metropolitan area, among other things by handing out educational material as a part of their own study projects. Some theses have measured the sexual and reproductive health awareness among conscripts.[45] As sexual risk behaviour in conscripts was connected to the use of intoxicants,[35] this should particularly be taken into account when planning preventive strategies during the military and non-military service.

Leaving one's girlfriend or boyfriend or family to the civilian life may cause difficulties and influence one's performance during the service. It might be difficult to keep in touch with the girlfriend or boyfriend or home at the beginning of the service. Having less authority to make decisions may diminish sexual well-being. The cost-free and anonymous Varusmiespuhelin helpline for conscripts maintained by the Family Federation of Finland is a telephone service offering discussion support for the men and women in military service taking part in conscription call-ups, their family members and those who have returned home from the service.[46] Conscripts may call the helpline already at an early stage when problems can still be averted. A multiprofessional work group operates behind the helpline, including a psychiatric nurse, sexual therapist, sexual counsellor, psychotherapist, paediatric psychiatrist, bachelor of social services specialised in youth issues, and professionals in providing help via telephone.

The health education provided in conscript training includes a lesson held by a physician on sexual behaviour and sexually transmitted diseases. Arranging a one-day theme day on a public health and health education related topic has also become established at the beginning of the military training. The day includes 1–2 checkpoints of 30–60 minute training in health education. The health education checkpoint produced by the medical staff of the Finnish Defence Forces or an outside actor, often health care students, has often been focused on sexual health.[47]

The health examination guidelines of the Finnish Defence Forces published in 2012 includes no separate mention of sexual health. [48] Sexual and reproductive health must be a part of the health examinations of those in both military and non-military service. Sexual and reproductive health must be supported by increasing sexual guidance and counselling during the military service.

Students in higher education institutions

After upper secondary education, some young adults will continue their studies in universities of applied sciences and universities. Three years after the matriculation examination, around 70 per cent have obtained a place of study either in a university or a university of applied sciences.[49] In Finland, Finnish Student Health Service (FSHS) is responsible for providing health care services for university students, including both science and arts universities. Students in universities of applied sciences fall within the sphere of municipal student health care.

The Finnish Student Health Service has studied the health of university students, including sexual and reproductive health, since the year 2000. Since 2008, universities of applied sciences have taken part in the study. According to the previous study, 40 per cent of students in higher education institutions lived on their own in their household and 37 per cent lived together with their partner.[50] 64 per cent of women had experienced gynaecological problems within a year. 27 per cent of male student had experience problems related to sexual health. 5 per cent of students from universities of applied sciences and 7 per cent of students from universities hoped to get help for sexual health issues. 14 per cent of students from universities of applied sciences and 13 per cent of students from universities hoped to get help for relationship and self-esteem issues. Relationship issues are a significant cause for dropping out of studies. Increasing guidance and counselling related to interpersonal and intimate relationship skills may prevent these issues. Help offered by service providers is successful at reaching students, as very few reported not being heard and understood on appointments.

The fact that some spend long time studying creates challenges for the sexual and in particular reproductive health counselling for young adults. With advanced age, students have had time to be exposed to a variety of factors reducing fertility. These include a chlamydia infection and different environmental and lifestyle factors, such as smoking and overweight.[51] Uncertainty about whether or not to have children in the future may further postpone decision-making, and thus young adults must be conscious of the possible outcomes and risks for postponing having children. Factors reducing fertility and increasing students' awareness must be taken into account in student health care. Possibilities for better reconciliation of studies and starting a family must be investigated and increased.

Objectives

- Availability and accessibility of sexual and reproductive health services among young adults will be improved, and the services will be established to reach all young adults.
- Fertility advice and pre-conception health, care and counselling will be a part of health promotion, integrated into health services, as appropriate.
- Opportunities to combine studies and a family life will be improved and students will be informed about these opportunities.
- Information about sexual and reproductive health and the use of related services among all young adults will be collected.

Actions

- The National Institute for Health and Welfare, the Ministry of Social Affairs and Health, the Ministry of Education and Culture, the Finnish National Board of Education, the Finnish Institute of Occupational Health, the Finnish Student Health Service, the Association of Finnish Local and the Regional Authorities and other key actors will work out how to implement networking of school and student health care services with other services for school age children and students into multisectoral entireties.
- Professionals in student health care will intensify sexual counselling and direct their clients to sexual and couple relationship counselling, as needed.
- Municipalities and joint municipal authorities will offer sexual and reproductive health related counselling with context of other health counselling.
- The Ministry of Social Affairs and Health, municipalities and joint municipal authorities, the Social Insurance Institution of Finland, vocational institutions,

- higher educational institutions and other actors will work out how to better support combining of studies with starting a family.
- The National Institute for Health and Welfare will together with the Finnish Defence Forces provide information on sexual and reproductive health for Varusmies guide (Conscript), delivered to conscripts.
- Professionals will pay special attention to needs for counselling when meeting boys and young men at school and student health care or other services for young people, as well as during conscription and non-military service.
- Research institutes and higher educational institutions will work out the state of sexual and reproductive health and the use of services among young people.

Adults

There is little research information available on the sexual and reproductive health of men and related use of services and need for counselling, one of the priorities of this action programme. Habits decreasing sexual and reproductive health, such as smoking and alcohol consumptions, are more usual among men than women.[52] There is some knowledge available primarily about sexual behaviour, the prevalence of unintended childlessness and the incidence of sexually transmitted diseases, sexual and reproductive health among conscripts, prostate and erectile dysfunction, violence in intimate relationships and offending sexuality committed by men, and paying for sex, fatherhood, experiences of fathers or the effects of fatherhood on the relationship and sex life.[53–58]

Fatherhood can introduce changes in the relationship: 20 per cent of fathers had not noticed a particular change in the couple's sex life, 5 per cent reported that the relationship had changed to even better than previously, around three quarters reported a decrease in sexual activity and 30 per cent described a significant decrease in sex in the relationship.[58] The decrease in sex was not considered a solely negative issue: more time was left for discussions, affection and relaxing together.

An increased risk for HIV infections and other sexually transmitted diseases has also been found in Finland related to sex between men.[59] The incidence of HIV is approximately twenty times higher in this population group than on average among the population. The majority of infections from sex between men are diagnosed in Finnish men. More than half of the infections are domestically contracted. As noted in the Multiculturalism chapter of this action programme, there is hardly any information on the sexual and reproductive health and needs for sexual counselling of immigrant men.

Sexual and reproductive health has been traditionally linked to women and seeking sexual and reproductive health services is still not effortless or easy for men, as contraception counselling and maternity health clinic services are considered to be aimed at women. There is a desire and need in health care for discussing male health issues, such as sexuality related to ageing.[60] According to men themselves, expressing the need for and using health services for men can be decreased due to a fear of being stigmatised as having an illness and possible loss of occupational status.

The health and well-being of the father-to-be is discussed in the extensive medical examinations at a maternity clinic.[28] The guide for maternity clinics, published in 2013, includes reflection on the ways that could promote the involvement of men in maternity clinic visits.[61] In the national monitoring of maternity clinics of 2012, 60 per cent of health centres reported for both parents to participate in the extensive medical examinations at maternity clinics.[62] 30 per cent of the health centres sent a separate invitation for fathers to the extensive medical examinations, and 20 per cent reported providing a separate group for fathers as a part of family training services.

In a study investigating services for families with children, mothers reported more concerns related to parenthood and the child than men did, but they also found it easier to talk about their worries with those closest to them than did the fathers.[63] The fathers were less satisfied with the manner with which the employees worked with the parent or family at a maternity clinic or school health care as well as with the cooperation with other service providers (the Social Insurance Institution of Finland, the police and rescue services, peer group activities, private service providers, organisations etc.). Maternity and child health clinics provide the initial contact for new fathers to the services for children and families, and it would thus

be important that there would be competence to encounter the fathers in a way that would leave them with a positive idea of the services for families with children and a willingness to also participate in these in the future.

A report by a work group considering the male issue in gender equality policy does not as such mention the topic of sexual and reproductive health; nevertheless, it also notes that there is a need for more means for encountering and supporting fathers and sons among the professionals in maternity clinics, early childhood education and schools.[64] Municipalities should organise the services so that men would know how and would be able to seek them. The services should also be targeted at more specific groups of men who have the greatest need for services. These include, for example, boys studying at vocational schools whose level of awareness is poorer than of those in upper secondary schools, [42] young men with risk behaviour[35] or men who have sex with men.[59] The need of men for sexual counselling should also be recognised in other health care services, such as in the treatment of different chronic or acute illnesses or health examinations in occupational health care. Men should be provided counselling or referred to the services they need.

Regardless of the change in the structure of households, supporting interpersonal and intimate relationships is key to the promotion of sexual and reproductive health of adults. The number of single-person households and childless couples has increased, while families with children has decreased.[65] Part of those living in single-person households are in a relationship, and therefore the mode of living does not alone give information about a person's relationship or the well-being of a relationship. In 2011, childless married couples were the most common type of family in Finland, accounting for 36 per cent of all families. 30 per cent of all families were families formed by a married couple with children. The number and proportion of cohabiting couples of all families is increasing. Approximately 14 per cent of all families are cohabiting couples without children, and 8 per cent are cohabiting couples with children. In 2012, there were around 800 male couples and 1,200 female couples in registered relationships in Finland.[66]

In the year 2012, one in five families built on a registered relationship was a family with children and more than one third of the female couples had children.[66] Families with children in which at least one of the parents belongs to a sexual or gender minority are referred to as 'rainbow families'. However, only such rainbow families in which the parents have registered their relationship can be examined based on statistics. Other rainbow families include, for example, cohabiting couples with children, and so-called 'clover families'. In a 'thee-leaf clover' family, the child has three parents since his or her birth: a biological parent, i.e., a residential parent, with whom the child lives; a biological parent who the child meets more or less regularly, i.e., a non-residential parent, and the partner of the residential parent who can be referred to as a social parent.[67]

The so-called 'four-leaf clover families' include four parents. Children in rainbow families have been conceived with the help of either fertility treatment or home insemination or are children from the previous relationships of the partners.

It is typical for the Finnish culture that the person dates, has intimate relations and is in a relationship with a number of people during his or her lifetime. The significance of relationship has changed; previously, relationships were established to ensure a livelihood, whole today, they are based on emotions.[55] The significance of sexual well-being and sexual self-determination has increased. According to the romantic conception of relationships, partners are together based on sexuality and emotional intimacy as well as parenthood (see also chapter 3 Sexual and reproductive health behaviour at national level).[53] Education is organised for the support of relationships for both couples and the professionals providing their care. The Family Federation of Finland has published the Tahdolla ja Taidolla ('with Will and Skill') programme, the Evangelical Lutheran Church of Finland the Building Blocks of a Relationship programme and the Kataja Association different relationship courses and materials. Men accounted for 42 per cent of the customers of family work counselling meetings of the Evangelical Lutheran Church of Finland and for 49 per cent of the customers of the Church's helpline in 2011.[12] Messages sent by the customers of the online service do not always clearly state the gender of the writer, but those definitely identified as men accounted for 16 per cent in 2011.

There are numerous opportunities for promoting sexual and reproductive health of the adult population. Broaching the topic of sexuality in occupational health care, providing information about counselling opportunities and online services would be a natural way for this and would reach an extensive share of the population. Periodic medical examinations, appointments for medical issues at health centres, screenings related to sexual and reproductive health as well as relationship courses and social welfare appointments provide situations in which the topic of sexuality can be broached. Where appropriate, the extensive health examinations at maternity and child health clinics can also be situations where the topics of the relationship and sexuality can be naturally broached.[28] Based on the models created for broaching the issue of sexuality, sexual guidance is part of the work of every professional in the field of social and health care.[68, 69]

According to the Sateenkaariperhekysely questionnaire for rainbow families implemented in 2006, parents were primarily satisfied with, among other things, services provided during pregnancy and childbirth.[70] Shortcomings were also found in the services, including insufficient support for parenthood and the relationship. For example, parents had expected a discussion on the relationship and sexuality after childbirth at the maternity clinic. However, discussions on the relationship had hardly ever taken place in the maternity clinic, delivery hospital or family training according to the respondents. All sexuality education encounters must be founded on equality, and the client's gender or sexual orientation must not be presumed on behalf of him or her. The type of relationship the client is in must not influence the quality or availability of services.

Objectives

- Sexual welfare and supporting of couple and human relationship skills as well as access to services will be taken into account, as appropriated, in all encounters in the social and health care sector, irrespective of gender of clients.
- Broaching sexuality issues will be established as a practice in the social and health care sectors.
- Use of sexual and reproductive health services for men will be supported by enabling boys to learn to use these services as early as at comprehensive school level and understand that sexual and reproductive health and responsibility for it apply also to boys. Thus, the use of sexual and reproductive health services will be natural in adulthood as well.
- Realisation of equality in sexual and reproductive health services, such as sexual and couples counselling, will be assured.

Actions

- Employers will arrange work place specific training in order to ensure skills in broaching sexuality.
- Municipalities, joint municipal authorities and actors in occupational health care will provide and market sexual and reproductive health services to their clients, irrespective of their gender, sexual orientation, disability, physical condition, age or ethnicity.
- Occupational health care workers and those providing support measures for the unemployed will develop their skills in handling sexuality and sexual and reproductive health related issues.
- Municipalities or joint municipal authorities will provide services, enabling those belonging to sexual and gender minorities to get competent counselling as a part of public social and health care.
- Municipalities or joint municipal authorities, parishes and private actors will increase different counselling services for men, in particular, and develop the contents of services, facilitating men to seek these services and offering also targeted services to those in need.
- Municipalities or joint municipal authorities, primary health care and special health care and organisations of the field will increase both the number of sexual counselling services in the Internet and the information on them.

Elderly population

Today, Finnish people live to be older and are on average healthier than before. As a result of the ageing of the baby boomers, the population structure is rapidly changing. The majority of the elderly live in their own homes on their own volition: in 2011, nearly 90 per cent of those over 75 lived at home.[71] Even when

elderly, men often have a partner, whereas women are more frequently left alone as men die at a younger age. On the other hand, women's previous attitude, favouring settling with widowhood, has turned more accepting towards dating between elderly people.[72]

Sexual activity of those in a relationship may remain high, and the impact of an illness on sex life is not significant until at the age of above 70.[55] Persons who have been sexually active when young are also active at an advanced age.[73] For men, maintaining physical capacity sustains sexual interest. For women, having a positive attitude towards sex and previous sexual experiences from earlier life supports sexual vitality in old age. The elderly people of today are more satisfied with their sex lives than those living in the previous decades, but they still wish to have more sex in their lives as they grow older.

Supporting the sexuality of the elderly

According to the Act on the Care Services for Older Persons, the municipality must organise counselling services supporting the well-being, health, functional capacity and independent management of the ageing population and to guide the elderly in using these services.[74] Even though the Act and the quality recommendations for care and services for older people do not separately mention the promotion of sexual health, they emphasise high-quality services, individuality and the possibility for the elderly person to participate in decision-making as well as encourage taking into account possible loneliness and lack of social relationships.

Even if attitudes in the society changed to be more favourable towards sexuality among the elderly, this will not necessarily lead to changing practices without the employment of guidelines. Health care professionals should prepare themselves for sexual counselling for the elderly and flexible rules for elderly services.[55, 73] The promotion of sexual health should pay more attention than currently to the impacts of loneliness, lack of a partner and functional disturbances and have a positive and supporting regard towards warm interpersonal relationships between two elderly people. It must be ensured in 24-hour care units for the elderly that no member of staff or a person treated in the unit can violate the sexual integrity of a person being treated. The entire staff must be aware of the ethical principles. It must be ensured for elderly persons requiring 24-hour care that couples automatically have a right to live together even in these care units. The possibility for those living in 24-hour care units or care communities to establish and maintain close personal relationships must be supported, and their possibilities for undisturbed, intimate moments must be improved.

Gender and sexual diversity is similarly present in the work conducted with elderly people as with work with children, young people and adults. A survey conducted in connection with the Equal Aging project provides information about the inadequate awareness of gender and sexual minorities among Finnish elderly care professionals.[75] 92 per cent of the respondents to the questionnaire conducted among practical nurses and nursing assistants, nurses and charge nurses of elderly homes in Helsinki reported that they had not obtained information about gender and sexual orientation diversity (54 per cent) or the ageing and service needs of gender and sexual minorities (75 per cent) as a part of their studies. A fear of not having one's life partner identified and recognised as a life partner emerged in a questionnaire for members of gender and sexual minorities aged 50–80 years.[76]

The use of sexual aids of disabled or ill elderly people alone or with a partner must be made possible. Each elderly person and his or her sexuality must be encountered with respect both in addressing them as well as in general when dealing with the person.

Masturbation can be a source of pleasure for both those living alone or in a relationship. The attitudes towards masturbation have become more accepting than previously.[73] Elderly men can contribute to the functional capacity of their erectile tissue by regular masturbation.[72] In a relationship, masturbation provides an opportunity for sexual satisfaction in situations in which partners' sexual needs differ. When faced by physical limitations, it is possible to experience intimacy through hugging, kissing and other kinds of endearment as an alternative for sex.

Illnesses and factors related to ageing that disturb sexuality

Among men, erectile dysfunctions of organic origin and related to health are most common when over 50 years of age. The onset of erectile dysfunction may be an initial symptom of a progressing cardiovascular disease. Other diseases (e.g., depression) and their medication may also initially bring on erectile dysfunctions. Anxiety and pressures to perform also cause erectile dysfunctions among the elderly, especially if they have not had sex for a long time.[72]

Among women, mucous membranes turn dry, thin and sensitive due to the lack of oestrogen during menopause, and having sexual intercourse may become impossible and sexual desire may decrease. Mild local treatment with oestrogen content may be used to treat mucous membranes of elderly women, and these also prevent urinary tract infections. There is no maximum age limit for the use of these, but the use must be regular and follow instructions. Lubricant may be used as an additional help during intimate moments.[72]

With increased age comes weight gain, an increase in chronic diseases such as diabetes, an increase in cancers and growing numbers in prostatic hyperplasia and erectile dysfunctions. It is helpful for professionals to explain to their patients that sexuality will initially be overlooked at the onset of a sudden illness. As recovery takes place or the situation gets less acute, there will also be room and new forms of expression for sexuality.[72]

Out of chronic illnesses, type 2 diabetes causes sensory nerve damages, numbness and circulatory disorders in women, which in turn diminish physical reactions and sensations. In addition to these, diabetes causes erectile dysfunctions in men, which are also often related to high cholesterol, cardiovascular diseases and blood pressure, partially also due to medication.[72]

Some cancers have a profound effect on sexuality. In men, erectile dysfunctions are often related to the treatment of prostate cancer, although these may heal in time. The current medicinal treatment available for prostatic hyperplasia does not cause significant dysfunctions in sexual functions. Surgical treatment is usually realised as transurethral prostatic resection, which involves the removal of only a part of the prostate. When the entire prostate is surgically removed (as is also the case with prostate cancer), so-called 'dry' ejaculation occurs, i.e., semen entering the urinary bladder, in which the man is left with an experience of ejaculating, but the semen passes with urine.[72]

Both breast cancer and gynaecological cancers may change the woman's body image, which may affect her relationship and experience of her desirability or attractiveness. Mild local oestrogen treatments are also suitable for breast cancer patients after their treatments for preventing the dryness of mucous membranes and urinary tract infections. Surgical procedures performed on the vagina may make sexual intercourse painful or impossible. The healing of tissues after radiotherapy may take some time. Gentleness is required due to different changes and possible issues with pain after surgeries. In such cases, all other forms of intimacy become particularly significant.[72]

The services of a sexual counsellor must particularly be offered at cancer treatment and surgery units as well as the care units for treating persons with long-term illnesses and the elderly. When a patient is in a relationship, his or her partner should be included in the counselling. Health care professionals must remember to discuss the impacts of medication and surgeries on sexual functions. Support and information provided by professional staff might be needed for strengthening sexual self-confidence and the relationship. In cases where intercourse is not possible, encouraging other forms of expressing sexuality as well as intimacy, gentleness and playfulness supports the self-confidence and sexual well-being of the elderly person.[72]

Professional information related to sexuality in the elderly is openly available via the Finnish Online UAS network at www.seksuaaliterveysasema.fi.

Objectives

- Sexual welfare in elderly care will be increased, e.g., training the personnel.
- Sexual counselling for the elderly will be increased in health care and it will be established as a regular service.
- Sexual counselling for those in 24-hour care units will be increased and established.

Actions

- The Finnish National Board of Education will include teaching of sexual counselling in the curriculum of practical nurse education, and universities of applied sciences will offer continuing education on sexuality of elderly for those working among elderly people.
- Municipalities and joint municipal authorities will train and hire sexual consultants enough for elderly people's services, and hospitals will ensure that all hospitals are provided with a sexual consultant and central hospitals and university hospitals, additionally, with a sexual therapist.
- Those working within services for ageing population will take into account special sexuality issues and the need for counselling of elderly people.
- Physicians will define needs for sexual counselling of elderly patients in the course of diagnosis and after the procedure.
- Actors offering long-term care for the elderly will enable intimate privacy and continuity of intimate partner relationship to those living in round-the-clock nursing institutions.

Special needs groups

This chapter highlights some groups requiring special support in sexuality education. Some people may belong to a number of special groups. The goal is that the rights and responsibilities of all people will be equally addressed in questions of sexual well-being and reproduction and that effective functions will be secured in order to decrease inequality.

Disability

A person is considered disabled when his or her full and efficient involvement in the society in a manner equal to others is prevented by a long-term bodily, mental or intellectual impairment or a sensory impairment together with a variety of other hindrances.[79] Disabled people have the right to consciously and responsibly decide on matters related to their own sexuality.[78]

The UN Convention on the Rights of Persons with Disabilities emphasises that persons with disabilities have equal right

- to found a family and too decide freely and responsibly on the number and spacing of their children
- to have access to age-appropriate information, reproductive and family planning education, and the means necessary to enable them to exercise these rights.[77]

Persons with disabilities also have the right to retain their fertility and must not be sterilized or be forced to use a contraceptive without their will. Disabled people must also have equal rights for fertility treatments in practice pursuant to the Act on Assisted Fertility Treatments. They have individual preferences, hopes and worries. They need equal and competent sexuality education and sexual health services as a support for their decision-making.[79] All plans and actions must respect the client's wishes and solutions proposed by him or her. Persons with disabilities face more barriers related to the use of services and access to information than other population groups.[80–82]

Particular attention must be paid to equality in sexuality education and sexual health services provided in basic education, upper secondary education and further studies. The sexuality education must be primarily founded on the age level development of the learner, not his or her special characteristic. The sexuality education of the disabled child or young person does not primarily in any shape or form differ from the sexuality education for other children and young people.

Safety skills training and prevention of sexually offensive violence are essential parts of the sexuality education. Disabled people may be more likely to be exposed to actions that violate sexuality and disturb

sexual development than other children and young people, as they may require assistance also in performing the daily functions that are considered intimate.[81] Sexual rights are also a key part of the sexuality education of disabled children and young people. The young person is always the best expert for his or her own sexuality.

Other special needs groups

For sexual counselling, other special needs groups include, e.g., persons with physical or mental long-term illnesses, adolescents in foster care, those committed to prison or community sanctions as well as those currently or previously working in the sex or erotic industry. The promotion of their sexual and reproductive health might not be realised as a part of normal health care services.

In 2012, there were 17,830 children or young people placed outside their own families.[83] According to the Child Welfare Act[84], child welfare institutions include children's homes, correctional schools and other comparable child welfare institutions. In addition to six state-owned residential schools, there are two private residential schools in Finland. In 2011, around 2,500 children lived in the institutions due to placement. The Finnish National Board of Education provides performance guidance and the Department for Social and Health Services (LAPO) of the National Institute for Health and Welfare regulates the state residential schools.[85] A report by the Central Union for Child Welfare revealed that children and adolescents leaving their institution without permission were at a major risk for experiencing sexually offensive violence or abuse during unauthorised absences.[86] There is no research knowledge on the sexual and reproductive health or use of services of young people placed in institutions.

The Health Care Unit of the Criminal Sanctions Agency is responsible for the health services for those committed to prison or community sanctions.[87] The Pro-tukipiste support unit provides services for those currently or previously involved in the sex or erotic industry.[88]

According to a study on the well-being and health of sex workers, sex workers find it difficult to tell a doctor about their job.[89] A significant portion of those with foreign backgrounds working in the sex and erotic industry are completely left outside public services. Based on the study, specialised and planned low-threshold services are particularly important for erotic and sex workers.

Objectives

- Sexuality education will be implemented equally, according to the needs of a client, irrespective of his/her chronic disease, disability or other individual characteristics.
- Sexuality education will be provided integrated into normal health care services, interlinking a sexual and reproductive health promotion aspect with preventive work and care of diseases in primary health care.
- Different needs among minorities and special groups will be identified in sexual and reproductive health services.
- Accessibility and availability of sexual and reproductive health services will be addressed.
- Special attention will be paid to integrity of children and safety of the young people in institutional care.

Actions

- Municipalities and joint municipal authorities will ensure that each health centre provides an adequate number of employees, who has undergone in-service training for authorised sexual consultants and have skills to counsel special groups as well.
- Service providers will ensure that clinic premises are unobstructed and accessible. For instance, it must be possible to lower the patient table down enough to ensure an effortless and safe transfer of the patient to the table in different situations.
- Municipalities and joint municipal authorities will ensure that materials on sexual and reproductive health are distributed also in alternative forms: in Braille, large print, audio records, plain language or illustrated forms. In addition, interpretation will be arranged for hear impaired, visually impaired and speech impaired clients, as needed.

- Both the actors providing services for chronic patients and those offering services for the disabled will integrate counselling and guidance, related to sexuality and sexual and reproductive health, into their other services.
- The National Institute for Health and Welfare will ensure that the young people in state reform schools are provided with needed sexual and reproductive health services and sexual counselling and the staff in reform schools has obtained adequate competence on sexual and reproductive health and safety skills of the young.
- The National Institute for Health and Welfare will ensure that counselling and guidance on sexual and reproductive health are integrated into health services for prisoners.
- Pro-tukipiste will arrange targeted and well planned low-threshold sexual and reproductive services for those working in the sex and erotic industry, involving them in the development of these services. The municipalities and joint municipal authorities that do not have Pro-tukipiste support centres will plan low-threshold sexual and reproductive services, such as test of sexually transmitted diseases, for those working in sex and erotic industry, providing also sexual guidance and possibly sexual counselling in pursuance of these services.

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6. Multiculturalism

Need for services among traditional minorities

Finland has been a land of many cultures for centuries by now. Traditional cultural minorities living in Finland include the Roma, Sami, Finnish-Swedes, Jews and Tatars. Statistics depicting ethnicity in Finland were last published in the context of the census of 1970. At the time, information was gathered on the Roma, Sami and Swedish-speaking population. No separate statistics have been published on Tatars and Jews. The current number of Roma population living in Finland has been estimated at 10,000–12,000.[1] The Sami Parliament has estimated the number of Sami people living in Finland to be around 9,350.[2] The number of Finnish-Swedish people was around 5.4 per cent of the population in 2012.[3]

Roma population

There is no research knowledge available on the sexual and reproductive health of the Roma population, but the National Institute for Health implements the Roma wellbeing survey in the upcoming years, which also includes studying sexual and reproductive health as a part of the wider research contents. In the hearings for the preliminary Roma wellbeing survey, Roma representatives raised the issue that sexual and reproductive health is in many ways a sensitive topic in the Roma culture. Indeed, the set of services related to sexual and reproductive health must be planned in a manner taking the Roma culture into account.

The Roma and health care services guide aimed at health care professionals[4] notes that Roma adolescents for not discuss matters related to sexual health with older members of the Roma community. Therefore, school and student health care must take care of providing counselling related to puberty, contraception and sexuality. Roma adolescents often face culturally-related expectations to start a family at a young age. The Roma population also uses maternity clinic services during pregnancy less frequently than the rest of the population.

Roma women and adolescents were also particular target groups in monitoring the National Policy on Roma.5

In 2013, a survey was conducted on the intimate partner and domestic violence encountered by Roma women as a part of the national Action Plan to Reduce Violence against Women 2010–2015.[6] The survey recommended increasing awareness on the Roma culture among the staff of shelter services and aiming information about the available support services at Roma women. A need to provide more services for children in situations involving domestic violence was also identified based on the data. According to the study, shelter services are important for Roma women.

The Child and Youth Policy Programme 2012–2015 (LANUKE)[7] for the current government term contains the objectives laid down in the Youth Act for improving the environment for growth and the living conditions of young people under 29 years. Concern for young Roma people has been expressed in many contexts. For example, the seminar of the Advisory Boards on Romani Affairs focused particular attention on supporting the employment and education of Roma youth. The concern over some young Roma people becoming marginalised also is topical. No research-based information is currently available on whether the Roma have access to, or seek to use, services indicated by their life situations and ages.

Sami population

Less than half of the Sami people in Finland live in their home region. Three different Sami languages are spoken in Finland: North Sami, Inari Sami and Skolt Sami.[2] Long distances in the Sami home region and the lack of services available in the Sami language are a challenge for organising social and welfare services.[8] There is little research available on the promotion of the sexual and reproductive health of Sami people in Finland.

Based on a survey conducted in Lapland Hospital District, half of nurses (n = 100) had encountered linguistic problems in providing nursing for Sami patients.[9] The nurses primarily considered it important for Sami patients to receive care in their mother tongue. The nurses assessed the number of Sami-speaking

nursing staff to be insufficient. The help of an interpreter was considered necessary, but getting an interpreter was not always easy. There was also not enough awareness among the nurses on the Sámi Language Act, and they assessed that information received on the Act had not been sufficient.

Increasingly multicultural Finland

Since the beginning of the 1990s, the Finnish population has become increasingly diverse, both culturally and linguistically, due to immigration. Since the year 1990, the number of those born in foreign countries has grown fourfold, the number of foreign citizens has grown sevenfold and the number of foreign speakers has grown tenfold.[10] Nevertheless, the number of persons with foreign background in Finland is still moderate, for example, compared to other Nordic or European countries.[11]

Those with foreign origins form a highly heterogeneous group. They are women, men and children with very different backgrounds. They range from illiterate to highly educated people. The reason for immigration may be, for example, studying, work or marriage. Some arrive in the country as asylum seekers or refugees.

People may also be relocated from country to country and may at times temporarily return to their homeland. Immigration causes cultural and societal changes in both the country of departure and arrival. Immigrating has an impact on both those moving to another country as well as the people in the receiving country.[12]

Around 280,000 people of foreign origin lived in Finland at the end of 2012, amounting to nearly five per cent of the entire population. Around 85 per cent of them were first-generation immigrants, i.e., those born abroad, and 15 per cent were second-generation immigrants, i.e., those born in Finland.[13] Overall, more than half of the population with immigrant origin lived in the Uusimaa region. The majority of the people immigrating to Finland came from the neighbouring countries. One in four of those of foreign origin had come from the former Soviet Union or Russia. The second largest groups were those with Estonian, Somali or Iraqi origins (figure 2). Other immigrant groups were small.

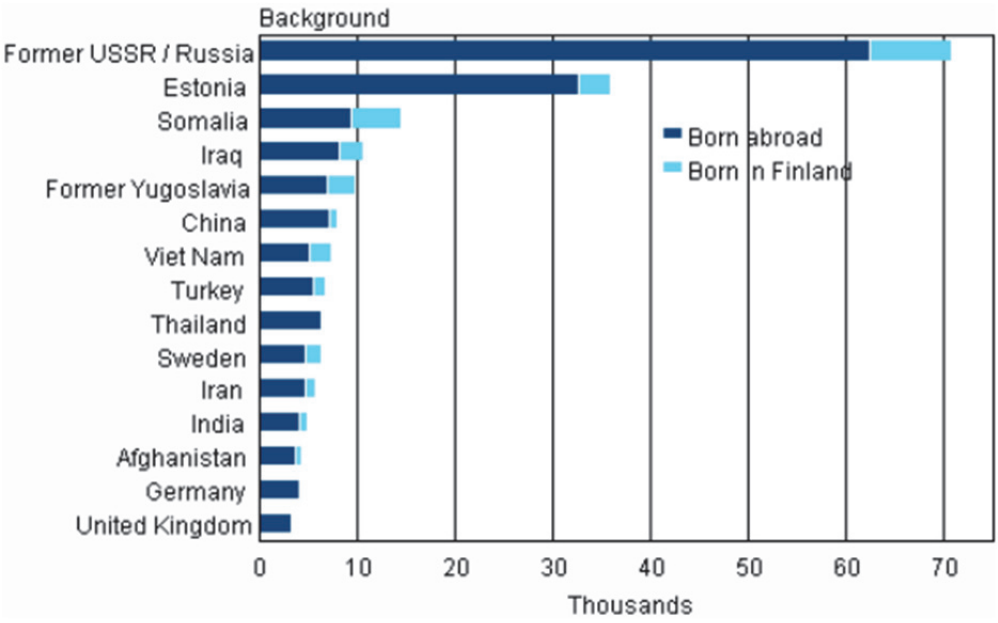

Figure 2. *The largest groups of people with foreign origin in the Finnish population on 31 December 2012.13*

Intercultural marriages and families

Multiculturalism is also increasing in Finland due to intercultural marriages and relationships. Annually, 3,500–4,000 people enter into intercultural marriages.[14] According to the Family Barometer of the Family Federation of Finland, the majority of female partners in the intercultural marriages come from Russia or Estonia. The male spouses came from Turkey, United Kingdom, USA and Sweden. There was variance in the language-learning of the spouses. 45 per cent of the women and 19 per cent of the men were fluent in their partner's language. The spouses with foreign origin were highly educated: 80 per cent had studies corresponding to at least upper secondary level education. 12 per cent of the women and 15 per cent of the men did not have any proficiency in their spouse's language. Good language skills made it easier to understand one's partner, but were not considered of vital importance. Willingness to discuss problems, faithfulness, children and good sexual relationship were considered the most important factors for the success of the relationship.

Special issues affecting sexual and reproductive health of people with foreign origin

Among other issues, the sexual and reproductive health of immigrants is influenced in a concrete way by the following factors: the reason for immigrating, the socioeconomic status in the country of departure and in Finland, education and language skills, age, gender, personal sexual history, sexual orientation and family situation, and cultural and religious background.[15] Sexual and reproductive health is one of the most intimate parts of health, perceived as the most private area, and discussing this in a foreign language in a new environment may cause difficulties for anyone.[16]

Regardless of their backgrounds, immigrants have to think about how to take care of their sexual and reproductive health in their new homeland. In 2012, over half of the people with foreign origin were 15–49 years of age, and therefore of fertile age (figure 3),[13] and thus the availability and accessibility of sexual and reproductive health services is important for them. In the near future, a group of multicultural young people who have one or two parents who have moved to Finland from a foreign country are entering into adulthood and starting their own families. Their needs regarding sexual and reproductive health issues are also becoming more and more topical.[16]

An action plan formulated by the Family Federation of Finland for promoting sexual and reproductive health among immigrants divided the challenges of the sexual and reproductive health of immigrants to three groups: 1) the epidemiology of diseases and risks 2) psychosocial and cultural factors and 3) the challenges of communication.[16] When planning services, it would be important to take into account the diversity of immigrants in terms of their language, cultural background, social status as well as education.[15]

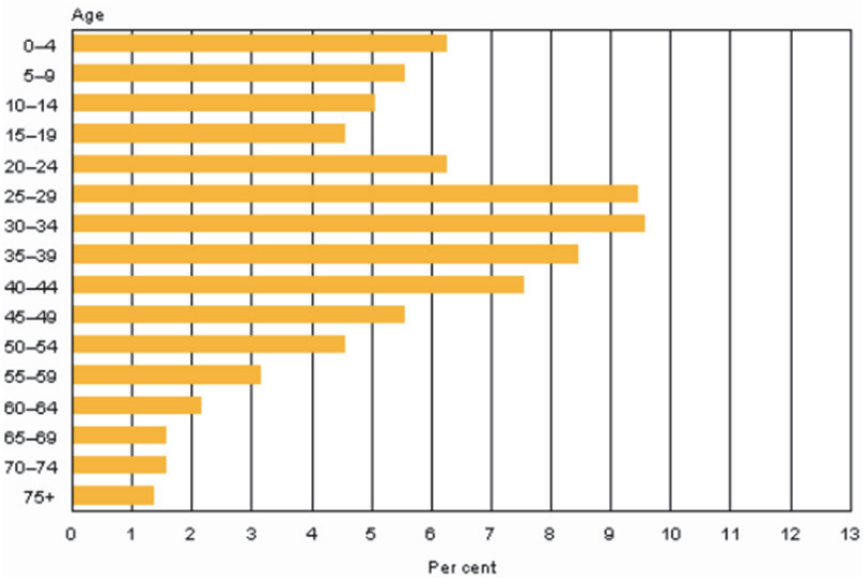

***Figure 3**. The proportion of people of foreign origin of the population according to age on 31 December 2012.*[13]

Situation of undocumented immigrants

There is no research knowledge available on the sexual and reproductive health or need for and use of services among asylum seekers and so-called undocumented immigrants in Finland. Based on a request by the Ministry of Social Affairs and Health, the National Institute for Health and Welfare conducted a study on the health care of undocumented immigrants in Finland.[17] Only estimated numbers are available on the amount of undocumented immigrants in Finland. The City of Helsinki Department of Social Services and Health Care estimated the number of undocumented immigrants to be around 5,000, which might be an overestimate according to the study by the National Institute for Health and Welfare. The majority of the undocumented immigrants live in the Helsinki metropolitan area. Some undocumented immigrants live in Finland for the time being. For example, they have a spouse with a permission to stay in the country. The undocumented immigrants have been treated in private clinics named Global Clinic, primarily based on voluntary activities, in Helsinki, Oulu and Turku. The majority of the clients of the clinics are of fertile age and require sexual and reproductive health services. One fifth of the 400 visits to the Global Clinic in Helsinki in the years 2011–2013 was related to pregnancy or contraception.[17]

During the first nine months of 2013, 47 appointments related to sexual and reproductive health took place at the clinic in Helsinki, out of which 36 were related to pregnancy, 2 to the postnatal period, 10 to suspected sexually transmitted infections and one to gynaecological cancer.[18] The clinic does not allow taking laboratory samples. Pregnant women are referred to the HIV Foundation for a free HIV test. The pregnant woman gets to choose whether or not to use the service. The client must personally book an appointment at the Foundation. Lack of or insufficient language skills are often a problem. HIV positive, undocumented pregnant immigrants are often left without the antiretroviral medication that would protect the foetus against a HIV infection.

As the woman comes in for labour, the appropriate infection screenings (HIV, hepatitis B, syphilis) are performed, but the results are obtained after a delay, which results in the patient being left without protective medication during labour.[18] If the results have been obtained, the medication is started during labour. If necessary, the infant will receive the first vaccination against hepatitis B and possibly also against tuberculosis, but none of the other vaccinations in the national vaccination programme. The status of the newborn babies of undocumented immigrants is poor. After being discharged from the delivery hospital, they are left without follow-up appointments at child health clinics, which results in, for example, neither vaccinating the child nor monitoring the child's weight and growth.

The Government of Sweden has decided to provide the undocumented immigrants with the same rights for health care as asylum seekers.[17] This includes practically all child health clinic services and deliveries free of charge. A report by the National Institute for Health and Welfare presented three alternative models for securing the health services for undocumented immigrants in Finland. According to the first alternative, undocumented immigrants would receive the same services as those whose municipality of residence is in Finland. The second alternative would allow securing the same services for them as for asylum seekers, i.e., it would follow the Swedish model. The third alternative would include securing their emergency care, pregnancies, deliveries and health care services for children.

Honour-based violence

Few studies have investigated the honour-based violence apparent in certain cultures. Those resorting to honour-based violence strongly associate honour particularly with the modesty of girls and women, but the violence might also be targeted against boys and men. Each professional encountering honour-based violence in his or her work needs education on the phenomenon and its prevention. The Kasvun kumppanit online service of the National Institute for Health and Welfare includes education material for the preventive work by professionals. Material for independent study[19] and educating is available.[20]

The website of the Mannerheim League for Child Welfare also has a first-aid kit for authorities suspecting a threat of honour-based violence in a client case.[21]

The Kitke project of the Finnish League for Human Rights has been operating since 2010 to prevent honour-based violence. Among other issues, the project involves maintaining a helpline providing guidance

and counselling for both the authorities as well as individual people and families in conflict situations related to honour.

Female circumcision

Female circumcision is also related to honour-based violence. This is a cultural tradition that has been going on for thousands of years and is still practised around Africa, the Middle East and Asia.[22] A number of different terms are used to refer to female circumcision. The most commonly used term on the international level is FGM (female genital mutilation). A more neutral term, FGC (female genital cutting), has also been established alongside this term. This term best corresponds to the Finnish translation. A combination of these two terms, FGM/C, has also been introduced in the use on the international level.

This tradition violates human rights and has negative impacts on sexual and reproductive health (see chapter 15 Sexually offensive violence). Multiple reasons underlie the tradition of female circumcision, and these vary from one country and culture to the other. The age at which girls are circumcised also significantly varies in different regions and among different ethnic groups. Most commonly, girls are circumcised at ages 4–10. The international migration has made this issue is topical and important also in Finland. According to the Criminal Code, female circumcision is a punishable act.[23] This also applies to taking a girl living in Finland to be circumcised in a foreign country. The Child Welfare Act also obligates the authorities to take action if a girl is in danger of being circumcised.[24] The Action Plan for the prevention of circumcision of girls and women of the Ministry of Social Affairs and Health aims at preventing female circumcision.[22] An information package related to preventing female circumcision can be accessed at the website of the National Institute for Health and Welfare, www.thl.fi/tyttojenymparileikkaus.

Male circumcision

Mate circumcision refers to a procedure conducted based on medical, cultural or religious reasons, which involves partially of fully removing the foreskin of the penis. Boys are usually circumcised in the time between infancy and teen-age years. The non-medical male circumcision is a tradition that has been going on for thousands of years and that has spread all over the world. In Finland, boys have been circumcised for at least 150 years among the Jewish and Tatar population as a part of religious tradition. There has been a lot of discussion on the non-medical circumcisions of boys in Finland, as the issue has become topical as the number of immigrants with Muslim background has increased.[25] There are multiple viewpoints related to male circumcision. Continuing the tradition has been justified with cultural reasons, health benefits and religion.

Around 2000 male circumcisions are annually performed in Finland.[26] According to an estimate by the Finnish Medical Association, there would be medical grounds for around 300 of the operations. According to the representatives of religious communities, around 400 non-medical male circumcisions are performed due to religious reasons in Finland each year.[27]

There is little reliable research evidence supporting the health impacts of non-medical male circumcision, and this is also conflicting. According to a study conducted at a paediatric surgical unit in Denmark, 2.9 per cent of the circumcised boys (aged 3 days to 16 years) suffered from immediate health hazards, such as infections or leakage and 2.2 had later complications (such as imperfect circumcision), but no severe complications were discovered.[28] According to a literature review conducted by the MEKA unit (unit for assessing methods and practices) of the National Institute for Health and Welfare for the Ministry of Social Affairs and Health, severe harms related to male circumcision are rare.[29] There are mild and moderate harms, and these are more common when the procedure is performed after infancy, in non-sterile circumstances or by an inexperienced person.

According to an Australian study, circumcision did not correlate with sexually transmitted diseases in adulthood, but protected men against yeast infections.[30] It also did not correlate with sexual problems: circumcised men reported less pain during intercourse and fewer erectile dysfunctions. According to the Danish study, there was no significant difference in the appreciation of sex life and sexual activity between circumcised and uncircumcised men or the women whose husbands were circumcised or uncircumcised.[31] Circumcised men were more likely to report having problems related to reaching an orgasm and their wives

were more prone to report imperfections in their sex lives, such as problems related to reaching an orgasm and pains during intercourse.

In their statement, Nordic children's rights commissioners have suggested asking for the boy's personal consent for male circumcision.[32] The National Advisory Board on Social Welfare and Health Care Ethics (Etene) approves of religion-based male circumcisions.[33] If parents have a differing opinion on the matter, the boy must get to decide on whether or not he will be circumcised according to Etene. The aim of the Ehjä ('intact') project of the Sexpo Foundation is to reduce non-medical male circumcisions with education.[34] The project provides information about the risks, disadvantages and ethical issues of circumcisions.

Health and welfare research

There is little information in Finland on the sexual and reproductive health of people with foreign origin, similarly as regarding their overall health and well-being. A few individual studies[12, 35–38] and the Maamu study of the National Institute for Health and Welfare[39] conducted in 2010–2012 have been used to investigate the issue. New data collection on the health of immigrants was started in 2014.[40] The objective of the Maamu study was to collect reliable data on the health, functional capacity and work ability, lifestyles and service needs among the largest immigrant groups in Finland. The target group of the study was formed by 18–64-year-old people with Russian, Somali and Kurdish origins.

Sexual and reproductive health

According to a study investigating induced abortions among women with foreign origin, the number of unwanted pregnancies was above average among young women from Estonia, China and Sub-Saharan Africa (excluding Somalia).[37] However, women with foreign origins participated in prenatal examinations at maternity clinics as often as women born in Finland.[38] There was variety between the different ethnic groups regarding the frequency of interventions implemented during pregnancy and labour, such as ultrasound examinations, pain alleviation during childbirth, induction of labour and Caesarean section. For instance, more Caesarean sections were performed on first-time parturients with African background. Women with African and Somali backgrounds had more health problems, which manifested as higher perinatal mortality compared to the other ethnic groups.

A dissertation study developing family training for Somali families indicated that Somali women wish to receive family training in small groups that include discussions, familiarise themselves with the delivery hospital in their mother tongue, and would like the training to include bringing up issues related to Somali culture; on the other hand, they would also like to obtain more information on matters related to the Finnish culture.[41] They also wished for the topic of female circumcision to be included in the contents of family training. Family training taking into account special needs of the Somalian culture should particularly be aimed at primiparas and their support persons, and Somali men should be encouraged to participate in family training. The aim must be to establish a culturally sensitive maternal care which allows better responding to the needs of women and infants with immigrant origin.[38] Regional and local treatment chains have been created for encountering immigrant families in maternity care, including the treatment chain established in cooperation between Metropolia University of Applied Sciences, HUCH Women's Hospital and primary health care.[42] Staff in maternity care need further training on multicultural nursing and women with immigrant background on their personal rights.[38] The maternity clinic guide of the year 2013 contains a chapter on encountering multiculturalism at the maternity clinic.[43]

Some of the questions in the Maamu study were also related to sexual and reproductive health. According to the research findings, the use of reliable contraceptive measures (see chapter 3 Sexual and reproductive health behaviour at national level and chapter 11 Contraception) and spontaneous miscarriages were most common among women with Somali background.[44] The number of deliveries was also the highest among them. Induced abortions were high among women with Russian backgrounds; more than every other had had an abortion. Approximately 70% of Somali women and 32% of Kurdish women have been circumcised. A significant portion of the circumcised women had experienced health problems related to the procedure.[45]

In all of the studied immigrant groups, the women participated in cancer screenings, such as mammographs and Pap smear tests, less frequently than women in the general population.[46] International studies have also noted that immigrant women participate in cancer screenings less frequently than women in the majority population.

Mental health

The questions in the Maamu survey on mental health revealed that immigrants with Kurdish backgrounds often suffered from current severe depression and anxiety symptoms.[47] Women with Kurdish background had more symptoms than men. Women of Russian origin also often experiences severe depression and anxiety symptoms. Among the Russian women, the oldest age group was most prone to suffer from psychological symptoms. The prevalence of severe depression and anxiety symptoms among women of Somali origin or were similar as the numbers among the entire population. 78 per cent of the women of Kurdish, 57 per cent of the Somali and 23 per cent of the Russian origin had experienced some significant traumatic event in their former homeland. The most common traumas experienced by women with Kurdish and Somali background were related to living in a warzone and witnessing the violent death or injury of another person. Women with Russian background had traumas connected to being the subject of severe physical damage or witnessing the violent death or injury of another person. Mental well-being has a significant impact on the person's holistic functional capacity, and therefore the challenges produced by multiculturalism in health care should be recognised and fixed in time.

Health and well-being of children and adolescents

There is little information available on the health and well-being of children and adolescents of immigrant origin (see also chapter 5 Sexuality education). The ETNOKIDS project was implemented in the Helsinki metropolitan area in connection to the Maamu Study in the years 2011–2012.[48] This was a separate study for adolescents aged 13–16 in families of Russian, Somali and Kurdish origins. The aim of the study was to collect information on factors influencing the health, well-being and integration of children and adolescents of immigrant origin as well as on how service systems and adults support the growth and development of children at home and school. The results of the study will be published in spring 2014.

Issues to be taken into account when planning service systems

Promotion of sexual and reproductive health of immigrants was highlighted as one of the future development targets in the intermediate assessment of the previous action programme for the promotion of sexual and reproductive health, Developing services for immigrants as a part of the integration of immigrants was also an objective in the Government Programme of 2011.[49] In order to hear and take into account the needs and wishes of immigrants, professional interpretation and translation services are needed in the service system, as obliged by the Act on the Status and Rights of Patients.[50] In larger cities, materials have been prepared for immigrants in their mother tongues. These materials should also be available for use in other municipalities in the areas where some of the population have immigrant origins. On its website, the Family Federation of Finland offers education and consultation services as well as publications, for example, on multicultural relationships and parenthood.[51]

The norms and values related to immigrants' family life, sexuality and gender roles may significantly differ from Finnish conceptions, which in turn might cause problems between service providers and users. Language issues, problems in interaction and difficulty in obtaining information may prevent seeking sexual and reproductive health services or finding and obtaining the correct service.[16]

Objectives

- Sexual and reproductive health services will be provided equally, irrespective of client’s cultural background or language.
- Sexual and reproductive health awareness will be raised among the Roma, especially the young, thus supporting well-being and children’s health in Roma families.

- Work among the Roma at maternity and child health clinics and within family work and early childhood sectors will be intensified. Roma youths will be directed to upper secondary level education and thereby to school and student health care services.
- Provision of sexual and reproductive health services to the Sami in their own language and taking account their cultural background will be secured.
- The specific needs of people with immigrant background will be taken into account in sexual and reproductive health services.
- Research on health and well-being of immigrants will be increased (including specific issues, such as honour-based violence and female circumcision).
- The status of undocumented people in the social and health care system of Finland will be solved at national, regional and local levels.
- Training on honour-based violence for professionals will be arranged in different sectors.
- The actions to prevent female circumcision and to improve health and life quality of already circumcised girls and women will be implemented in Finland according to the action programme by the Ministry of Social Affairs and Health.
- The need of regulation of non-medical circumcisions, performed on under-age boys in Finland, will be investigated, respecting children's rights and the culture-sensitive nature of the issue.

Actions

- Municipalities and joint municipal authorities will ensure availability of appropriate and culture-sensitive sexual and reproductive health services.
- Professionals working at school and student health care and child health clinics will intensify guidance and counselling on family planning, health awareness, basic rights and support services for Roma families, particularly among female and young Roma.
- The actors responsible for continuing and further education in sexual and reproductive health will recognise the need for services in Sami language.
- The Ministry of Education and Culture, the Finnish National Board of Education, universities of applied sciences and universities will ensure that multicultural studies are included in the mandatory studies in basic professional education (in health care, social, education, teaching, and youth work education).
- Higher education institutions and other actors responsible for continuing education will provide professionals in different sectors with continuing education on encountering immigrants and on specific needs related to sexual and reproductive health. Supervisors will enable their employees to participate in the continuing education.
- Municipalities and joint municipal authorities will ensure that specific needs (e.g., interpreting) of those having different cultural background will be taken into account in counselling of sexual and reproductive health issues.
- Higher education institutions will direct research in different disciplines to health and well-being of immigrants, including special issues, such as honour-based violence and female circumcision.
- The Ministry of Social Affairs and Health will ensure through legislation or national decision making that undocumented people have access to appropriate sexual and reproductive health services and give instructions on regional and local operation.
- Supervisors will enable their employees to participate in training on honour-based violence.
- All professionals working in social welfare and health care, daycare, child welfare, education and cultural sector, youth work or reception centres will broach female circumcision with the immigrant background families, in whose countries of origin female circumcision is practised, even if a direct threat of female circumcision does not exist.
- The Ministry of Social Affairs and Health and the Ministry of Justice will investigate juridical status of circumcisions on boys and consider whether the specific legislation or directives are needed.

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7. Pre-conception health, care and counselling

A number of factors related to the parents-to-be have an effect on the conception, the course of pregnancy and the health of the child. Some of these factors have existed or occurred already before the pregnancy. The care preceding pregnancy and promoting reproductive health is referred to as pre-conception care and health in international literature.[1] There is no good Finnish equivalent for this concept. This action programme aims to emphasise the importance of counselling, and therefore uses the concept of 'pre-conception health, care and counselling'.

This covers the promotion of sexual and reproductive health so that it is safe to get pregnant, once achieved, the potential pregnancy goes as well as possible and results in a safe and good delivery and the best possible health of the unborn child. This encompasses all counselling and care preceding pregnancy and maintaining fertility even when planning a pregnancy is not (yet) topical, there is no desire (yet) to plan a pregnancy, a pregnancy is not achieved despite the person's wishes, or a pregnancy has ended in miscarriage or termination, but the aim is to maintain and promote sexual and reproductive health and to receive support for the relationship.

Even before conception, the health, well-being and health habits of the parents-to-be affect the development of the foetus in the womb and the health of the unborn child once in adulthood.2 There is strong evidence supporting pre-conception health, care and counselling.3 Pregnancy and neonatal care have been promoted by the use of folic acid supplement, immunisation against rubella and hepatitis B, avoidance of the use of several harmful medical substance before pregnancy or at the latest as soon as the pregnancy has been confirmed, quitting smoking and alcohol use already before pregnancy or at the latest immediately after the pregnancy has been confirmed, weight management, preventing, diagnosing and treating HIV and sexually transmitted diseases (chlamydia and gonorrhoea), and good care for diabetes.

Pregnancy planning and pre-conception counselling

The Finnish recommendations for maternity clinics of 1999 suggested pregnancy planning for women with a long-term illness, problems in previous pregnancies or genetically inherited diseases in their family.4 In the recommendations for 2013, the concept has been expanded to also include families with psychosocial problems or a need for information or support related to pregnancy (chapter Contacting a maternity clinic when planning a pregnancy).5 In international literature, the contents of pre-conception health, care and counselling have been expanded even further, and it is considered to apply to both women and men of fertile age. [1, 3, 6-8]

Systematic screenings aim at recognising possible risks and problems for sexual and reproductive health, but also positive factors promoting sexual and reproductive health. Counselling grounded in the needs of the individual or the couple is used to increase knowledge, support and encourage them to take care of their sexual and reproductive health and relationship, and to help clients make conscious choices that fit their personal values. A further aim is to take care of possible recognised diseases and other problems. In case of chronic diseases, the aim is to attain the optimal health considering potential pregnancy and the unborn child.

Detailed key contents of pre-conception health, care and counselling according to international literature have been compiled as an appendix in this action programme (Appendix 4).[1, 3, 6–8] The contents of pre-conception health, care and counselling may vary and can be applied according to the situation in each country. According to WHO, pre-conception health, care and counselling are a part of the prevention and control of noncommunicable diseases, and national health promotion plans should also cover these issues.[9]

Objectives

• Evidence-based and neutral information on reproductive health promoting counselling and care will be provided in easily available format both electrically and within all sexual and reproductive health services.
• Pre-conception health promoting counselling and care will be understood widely and they will be a natural part of sexual and reproductive health services for women and men, giving a positive perspective on sexual and reproductive health promotion both for couples and single people without unnecessary medicalisation of pregnancy.
• Sexuality education at schools will include not only contraceptive counselling but also fertility advice and fertility maintenance counselling. • Pre-conception health, care and counselling will be addressed also in student health care services.

Actions

• The National Institute for Health and Welfare will create a website providing evidence-based and neutral information on reproductive health promoting counselling and care.
• Professionals, working within school, student and occupational health care services, at gynaecology, contraceptive, family planning and maternity clinics, childbirth clinics and delivery hospitals and other health care system units will broach reproductive health promoting issues actively and in a positive way.
• Municipalities and joint municipal authorities will offer reproductive health promoting maternity clinic visits in primary health care as low-threshold services, reaching also those young women and men who do not (yet) plan pregnancy but who want to promote their sexual and reproductive health.
• Municipalities and joint municipal authorities will provide reproductive health promoting counselling and care as a part of multisectoral services, targeted at young people (see chapter 5 Sexuality education by age groups).
• The Finnish National Board of Education and those responsible for school curricula will ensure that pre-conception health, care and counselling are included in the sexuality education contents of basic education and upper secondary school curricula.

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8. Involuntary childlessness

Involuntary childlessness may be caused by issues related to fertility, other physiological cause, life situation or sexual orientation. In the Health 2011 survey, 19 per cent of women and 11 per cent of men reported having experienced involuntary childlessness at some point of their lives.[1] Involuntary childlessness appeared to have slightly increased in comparison to year 2000.

Heterosexual couples are considered to have a problem with childlessness when they have not conceived after a year of unprotected, regular intercourse or when pregnancies have repeatedly resulted in miscarriage.[2] This definition is founded on the fact that a woman has a possibility of around 20 per cent for getting pregnant each month. Involuntary childlessness may result from the man (25%), the woman (25%) or both (25%). No cause for childlessness can be found in one fourth of the cases of childlessness.

Decreased fertility (subfertility) is most commonly the primary cause for involuntary childlessness. Fertility decreases in women after the age of 30, and significantly after the age of 35.[3] In men, fertility also decreases after the age of 40, although this occurs less rapidly than in women.[4] In addition to age, other factors decreasing fertility include, for example, overweight and underweight, excessive smoking and use of alcohol, certain medical substances and anabolic steroids. Sterility, i.e., complete infertility is rare (4%).

There are socioeconomic differences in the prevalence of childlessness and seeking related treatments in Finland.[5,6] More highly educated women often postpone trying for pregnancy until more advanced in age, at which point fertility may already be decreasing. In contrast, in young age groups, childlessness is more common among less educated women, which is likely to result from differences in lifestyles. Seeking fertility treatments is more common in urban areas and among more highly educated and wealthier women.

Involuntary childlessness is not only a medical or biological phenomenon, but also a psychosocial crisis. Emotions that are difficult to tolerate and deal with as well as stress are connected to involuntary childlessness.[7,8] Psychosocial support provides important help in dealing with the issue and preventing exhaustion. For many, involuntary childlessness is one of the major adversities faced in adulthood, which also includes fear of being left alone and without a family. Mood changes, depression and grief may impact the sexual desire of women and men. Timing sexual intercourse may cause performance pressures and erectile problems for men. Social and health care professionals should broach the topic of sexuality and relationship in appointments related to involuntary childlessness. If the client or couple feel that they are in need of sexual counselling or support for their relationship, they are to be referred to sexual or couples counselling.

There are several alternatives for treating involuntary childlessness or coping with it. A person who wants to have a child may consider adopting, acting as a foster or support parent, or seeking fertility treatments. Many of those experiencing involuntary childlessness also choose a life without children.

Adoption

The purpose of adoption is to promote the best interests of the child by confirming a relationship between the child and the parent between the adoptee and the adopter.[9] An adopted child holds the same legal position in the family as a biological child. In 2012, 466 adoptions took place in Finland.[10] 208 of the adoptees had been born in a foreign country and 258 in Finland. 91 adoptions took place within the family of those in registered relationships.

The Adoption Act was reformed in 2012.[9] The new provisions include, for example, a definition of the minimum and maximum age difference of the adopted child and the prospective parent. The Act stipulates that the adopter must have attained the age of 25 years, and if the adoptee is a minor, the adopter may not be over the age of 50 years. If the adoptee is a minor, the age difference between the adoptee and the adopter must be at least 18 years and no more than 45 years. The reformed Adoption Act also enabled the so-called open adoption. The District Court can decide that a minor adoptee must have the right to meet his or her former parent or maintain contact with him or her in another manner on condition that maintenance

of contact is not contrary to the child's best interests. The child's best interest must be the primary concern in decisions and other measures regarding the adoption of a child.

In Finland, a man or a woman may adopt alone and marital spouses may adopt together. For each adoption, statutory adoption counselling is required, involving dealing the preconceptions, expectations and motives related to parenthood, economic situation, relationship as a couple and other factors connected to parenthood, always as a whole and individually. Social welfare offices in municipalities and Save the Children Finland provide the adoption counselling. Permission from the Adoption Board of the National Supervisory Authority for Welfare and Health (Valvira) is required for the adoption of an underaged child in both domestic and international adoptions.

Financial support can be obtained for the costs of an international adoption.[11] This grant covers some of the costs caused by the translation of documents, fees paid to the service provider, travel costs and different administrative costs.

Foster parenting

If a child's biological parents have difficulties in providing a safe and balanced living environment for their child, the child may be placed away from home, in institutional care or family care.[12] In 2012, 17,830 children and adolescents had been placed outside of their homes.[13] Half of those taken in custody had been placed in foster homes. Although the vast majority of foster parents had biological children of their own, foster parenting may also provide an alternative for parenting for those involuntarily childless. Family care provides the child with an opportunity for experiencing stable family life and creating close interpersonal relationships. Couples, persons living alone, single parents and parents of reconstituted families may become family carers. The foster parents receive training, and no specific educational or occupational background is expected from them. Foster parents may also be the child's relatives or other persons close to them.

In addition to foster parenthood, for example, support person and support family activities are offered.[14] Support person activities include meetings of the supportee and the supporter in the child's own environment, where they participate in shared activities or hobbies. In support family activities, the supported child participates in the everyday activities of the support family and stays overnight with the support family, for example, for one weekend per month. Support families may be a childless couple, a family of one adult living alone, a single parent family, a two-parent family with children or a 'surrogate grandparent's house' of a couple whose children have already reached adulthood. Different kinds of children in different life situations need support families. The aims, frequency and duration of meetings and the planned duration of the support relationship are agreed upon together with the child and his or her biological family and the support family.

Assisted fertility treatments

Assisted fertility treatments are medical procedures that aim to improve the chances of pregnancy. The success of assisted fertility treatments depends on the original reason for infertility and the patient's age.[15]

The Finnish Act on Assisted Fertility Treatments, which took effect in 2007, does not impose restrictions on assisted fertility treatments based the woman's age, sexual orientation, gender identity, gender expression, disability, or marital status.[16] Both non-donor and donor oocytes, sperm or embryos can be used in assisted fertility treatments. Assisted fertility treatment may not be provided if it is apparent that the child’s balanced development cannot be guaranteed or that there is reason to presume that the child will be given up for adoption. The latter condition prohibits surrogacy arrangements. Service providers must provide the National Institute for Health and Welfare with information about assisted fertility treatments for purposes of supervision, monitoring and compilation of statistics as is provided by the Act on Assisted Fertility Treatments and a Decree of the Ministry of Social Affairs and Health.

Altogether 23 health care units provided assisted fertility treatments in Finland in 2012, 13 of which were private clinics operating in major cities.[17] Public health services provide assisted fertility treatments across the country in five university hospitals and five central hospitals. In 2011, some 14,460 treatment cycles were started in Finland. The assisted fertility treatments given consisted of more than 9,300 in vitro

fertilisations (IVF) and intracytoplasmic sperm injections (ICSI) and related frozen embryo transfers (FET), and just under 5,000 intrauterine insemination treatments (IUI).[18] The treatments resulted in a total of 3,150 pregnancies, and 2,540 infants were born as a result. This was about 4 per cent of all the children born in Finland that year. Some 40 per cent of assisted fertility treatments were performed in the public sector in 2012.

Around 20–25 per cent of assisted fertility treatments using non-donor gametes result in a live birth.[18] The results of IVF treatments have remained relatively stable over the past decade, while the results of ICSI and FET treatments have shown a clear improvement. There are some health risks associated with both single and multiple pregnancies resulting from assisted fertility treatments. These include prematurity, low birth weight, intensive care and Caesarean section.[5, 19, 20] Multiple pregnancy is the single most important factor affecting the health of the mother, the foetuses and the newborns. Assisted fertility treatment still involves a more than four-fold risk of multiple gestation.[18]

Section 9 of the Act on Assisted Fertility Treatments state that, in the event that donated gametes or embryos are used in the assisted fertility treatment, the service provider must furthermore counsel the person receiving treatment on the potential impact which the biological origin of the child to be born as a result of treatment may have on the relations between family members and on ways to prevent or alleviate any problems that may arise.[16]

Nevertheless, in any case, seeking and undergoing fertility treatments, and ending the treatments without the desired outcome is a psychologically taxing process. Those seeking fertility treatment are worried about the strain caused by the treatments, their own and their spouse's management and the health impacts of the fertility treatments.[21] Approximately 30 per cent of those who have sought IVF treatments withdraw from the treatments, and the most common reason for this was the mental strain of the process.[15] It takes years to adapt to childlessness after unsuccessful treatments. The provision of psychosocial support at every stage of the treatments is justified.

Objectives

- Involuntary childlessness will be reduced by promoting healthy lifestyles and improving awareness on the relationships of age and sexually transmitted diseases to fertility.
- Foster parenting or working as a support person or a support family, adoption, assisted fertility treatments and living childless are equal alternatives to involuntary childlessness. • Information about all these alternatives will be provided in order to give an individual an opportunity to choose the alternative that best suits to her/his specific needs.
- Socio-economic inequalities, related to the different alternatives in involuntary childlessness, will be reduced in order to give all an equal opportunity to make a choice that best suits for her/him.
- Mental burden, caused by involuntary childlessness, will be addressed in social and health care services.

Actions

- The Ministry of Education and Culture, the Finnish National Board of Education and other actors, responsible for education planning and implementation, will include sexual and reproductive health promoting information in curricula for comprehensive schools, upper secondary schools and vocational schools in order to prevent reasons behind involuntary childlessness and reduce risks of them.
- Social and health care professionals will provide counselling about fertility maintenance and fertility promotion as a part of primary health care and student health care services (see chapter 7 Reproductive health promoting counselling and care).
- Social and health care professionals will have an equal and unprejudiced attitude to foster parenting, working as a support person or support family, adoption, fertility treatments and living in childless and will give information equally on all the alternatives.

- Social and health care professionals will provide equal treatment for those, applying for adoption, foster parenting or fertility treatments, not leaving any person out of legal rights due to discriminating application directives or working practices.
- Professionals at fertility treatment clinics will provide realistic and evidence-based information both on the successes and the risks in assisted fertility treatments in order to help those interested in the treatments to make information based decisions when comparing various alternatives.
- Municipalities or joint municipal authorities will ensure a flexible way to treat and support involuntary childless people through multiprofessional cooperation and consultations.
- Social and health care professionals, participating in involuntary childlessness treatment will address psychosocial support and peer support, establishing them as an inseparable part of the treatment path in involuntary childlessness treatment at primary and specialised levels as well as in private sector services.

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9. Gestation period

The core task of care during the gestation period is to secure the best possible health and well-being for the pregnant woman, the foetus, the newborn and the family. The working approaches aim to highlight a family-centred approach and service grounded in the needs of the client. Holistic care during the gestation period promotes and safeguards the health and well-being of the pregnant woman and her family as well as the health of the unborn child from the foetal period up to adulthood.

Health Care Act[1], the Government Decree issued on its basis[2] and the Government Decree on Screenings[3] construct the legal basis for recommendations guiding maternity clinic operations. The maternity clinic guide[4] provides highly detailed recommendations for monitoring, screening and care during the gestation period and organisation of multidisciplinary cooperation. Therefore, this action programme only briefly deals with the gestation period. The Sexual and Reproductive Health Unit (SELI) of the National Institute for Health and Welfare assesses and follows the recommendations for maternity care as a part of the monitoring and assessment of this action programme.

Monitoring of pregnancy

All pregnant women residing in Finland and their families are entitled to maternity clinic services. The monitoring of pregnancy is realised individually with 8–9 scheduled appointments with a midwife/public health nurse and two doctor's appointments. There is also a possibility for additional appointments which aim to secure early detection and possible referral to further treatment for everyone in need of special support and/or monitoring.

The WHO has determined the principles of perinatal care (starting at 22 completed weeks of gestation until 6 days after delivery), which are also complied with in Finland (table 2).

***Table 2**. WHO principles of perinatal care.*[5]

Principle	Content
1. Care for women with a normal pregnancy and birth should be demedicalised.	Essential care should be provided to women with the minimum set of interventions necessary.
2. Care should be based on the use of appropriate technology.	Appropriate technology refers to an entity of activities including the methods, techniques, equipment and other instruments applied in solving a specific problem. Sophisticated or complex technology should not be applied when simpler procedures may suffice or be superior.
3. Care should be evidence-based.	Care should be supported by the best available research, and by randomised controlled trials where possible and appropriate.
4. Care should be local.	Care should be based on an efficient system of referral from primary health care to specialised health care.
5. Care should be multidisciplinary.	Effective care may involve contributions from a wide range of health professionals, including midwives, obstetricians, neonatologists, nurses, childbirth and parenthood educators as well as social work professionals.*
6. Care should be holistic.	Care should include consideration of the intellectual, emotional, social and cultural needs of women, their babies and families, and not only their physical care.
7. Care should be woman-centred.	The focus of care should be meetings the needs of the woman and her baby. Each woman should negotiate the way that her partner and significant family or friends are involved.
8. Care should be culturally appropriate and culturally safe.	Care should consider and allow for cultural variations in meeting clients' expectations.
9. Care should provide women with information and support so they can make decisions.	–
10. Care should respect the privacy, dignity and confidentiality of women.	–

* In Finland also other professionals working at maternity clinics such as public health nurses, physicians, physiotherapists, and family therapists.

Challenges for monitoring of pregnancy

The number of those with chronic illnesses, gestational diabetes and increase in overweight are significant challenges for care provided during the gestational period. In addition, multiprofessional cooperation is needed in treating depressive disorders.[6–8] Multiculturalism and increased immigration introduce new demands for competence and resources in care during the gestation period, as there are clear differences between different population groups regarding both sexual and reproductive as well as perinatal health.[9–11] Further resources are also still needed in the prevention and treatment of smoking and alcohol and drug use during pregnancy.[12] The number of those smoking while pregnant continues to be 16 per cent.[13] However, 42 per cent of all smoking parturients in 2012 reported that they had quit smoking during gestation, while only 14 per cent had done so at the beginning of 2000s. In 2012, every other expectant mother under the

age of 20 smoked at the start of pregnancy; one in three (33%) out of this group stopped smoking during the first trimester. The Medical Birth Register includes data about smoking during pregnancy but not about alcohol use during pregnancy. Ensuring treatment and rehabilitation for pregnant women and families with children with intoxicant use has been an aim in the Government Programme (Appendix 3).[14] It is extremely important that maternity clinics reach pregnant women with substance issues as early as possible and that there are clear national, regional and local instructions and care paths for helping and supporting them. If there are reasonable grounds to suspect that the child will need supportive child welfare measures immediately after birth, child welfare authorities shall, before the birth of a child make an anticipatory child welfare notification.[15]

Objectives

- Pregnancy care will be implemented according to the instructions, given in the maternity clinic guide by the National Institute for Health and Welfare.
- Preventive work against female circumcision will be implemented as early as during pregnancy, according to the Action programme by the Ministry of Social Affairs and Health.[16]
- Regional inequality in pregnancy care will be reduced by means of consistent instructions.
- Pregnancy care will be carried out individually, using need and client based solutions in a family centred way.
- As a part of prenatal screening, versatile information will be provided on, for example, the voluntariness of prenatal screening, its purpose, objectives, methods, effects, any further examinations and risks of screening, the right to decide on abortion or continuing a pregnancy based on prenatal screening when meeting the criteria of serious disability, as well as information on support actions, provided by society for living with a disabled child.
- Prenatal screening quality and effectiveness will be monitored regionally and nationally.

Actions

- The National Institute for Health and Welfare will publish the recommendations of the maternity clinic guidance through as many channels as possible and introduce them during regional and national training seminars.
- Cooperation will be developed regionally between primary health care, specialised health care and social administration, according to the maternity clinic guidance recommendations.
- The Sexual and Reproductive Health Unit of the National Institute for Health and Welfare will coordinate the determination of a low risk pregnancy as a basis for care practices.
- The National Institute for Health and Welfare will provide web sites with information how to broach female circumcision already during pregnancy.
- Public health nurses, midwives and doctors will broach the subject of circumcision with the pregnant women coming from the areas where circumcision is practised. The issue will be discussed with focus on both mother and her possible future daughter.
- Health care professionals within primary and specialised health care will provide the circumcised women with a possibility of defibulation, as needed.
- Public health nurses, midwives and doctors will assess treatment, support and follow-up needs of pregnant women at every maternity clinic visit.
- Public health nurses, midwives and doctors will include sexual counselling in pregnancy guidance and direct clients to couple and/or family coaching, as needed.
- Public health nurses, midwives and doctors will provide additional visits according to regional arrangement plans, when identifying problems, diseases or need for special support, stated in the maternity clinic guide.
- Primary health care and specialised care will undertake workable and flexible consultation and referring practices in risk pregnancy care.
- Primary health care and specialised care will ensure sufficient competency of staff by providing supplementary and further education.

- The National Institute for Health and Welfare, the Ministry of Social Affairs and Health and a working group, appointed by the National Institute for Health and Welfare will plan and implement a screening registry to be combined with the birth registry, in order to monitor the effectiveness and quality management of foetal abnormality screening at national level. The National Institute for Health and Welfare will plan the registry and carry out its implementation and maintenance.
- Research institutes and higher education institutions will work out in their studies how the prenatal screening and related counselling have been arranged in Finland and how the clients and service providers experience these services.

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10. Childbirth and the postnatal period

Trends in childbirth and childbirth care

No major changes have taken place in the Finnish birth rate since the previous action plan: 59 856 children were born in 59 038 deliveries in 2012.[1] The ratio between primi- and multiparous women has also remained fairly unchanged: some 40 per cent were primiparas and 60 per cent multiparas. However, there have been changes in the parturient population and in the use of services. The mean age of parturients has been rising steadily. In 2012, the mean age was 30.3 years for all parturients and 28.4 years for primiparas. One in three parturients was overweight (35% in 2012), i.e., had a BMI ≥ 25, while 3.6 per cent were underweight, i.e., had a BMI < 18.5).[1]

The number of unplanned deliveries outside hospital increased somewhat from 46 deliveries in 2002 to 63 deliveries in 2012.[1] There have been very few planned home deliveries in Finland, although the number has increased a little from 12 in 2002 to 18 in 2012. The Caesarean section rate has remained low in international comparison: being 16.3 per cent in 2012. The share of vacuum extraction deliveries rose to nearly 9 per cent in 2012. Forceps cephalic deliveries are nearly extinct. Altogether 91 per cent of all parturients received some form of pain relief in 2010–2011.[2] The most common form of pain relief was nitrous oxide. There were no great differences between hospitals. Epidural anaesthesia has become more common. In 2012, parturients who received epidural and/or spinal anaesthesia accounted for 66.5 per cent of all women with vaginal delivery.[1] Small hospitals have increased their use of epidural anaesthesia, while university hospitals use epidural anaesthesia the most[2]

The number of third or fourth degree perineal tears during vaginal delivery increased at turn of the millennium, but has since stabilised to 1.2 per cent (in 2012), which is still fairly low percentage in international comparison.[1] The number of episiotomies decreased, while other delivery procedures became more common. In 2012, 22 per cent of all women with vaginal delivery had episiotomy, which was 10 per cent fewer compared to 2007.

In Finland, the health of newborns is excellent in international comparison. Multiple deliveries accounted for 1.4 per cent of all deliveries in 2012, showing a slight decrease on the 1990s due to the reduced number of embryos transferred in assisted fertility treatments.[1] Prematurity has not increased in Finland, contrary to international trends. Premature births (less than 37 weeks of gestation) accounted for 5.7 per cent all births in 2012, while 4.2 per cent of all newborns had low birth weight (less than 2500 g). Perinatal mortality was 3.9 per mil in 2012.

The Decree on emergency care by the Ministry of Social Affairs and Health will cause changes in delivery procedures.[3] At the beginning of 2013, there were 30 delivery hospitals in Finland, out of which two made a decision to discontinue their activities in 2013. A recent trend in Finland has involved focusing deliveries to larger units and discontinuing small delivery hospitals. The birth environment has a significant impact on the parturient's feeling of security.[4]

Long distances to delivery hospitals and long duration of stays in the hospital create pressures for monitoring the status of the pregnant woman, emphasise the importance of the delivery plan and the significance of the clinical work in the delivery hospitals. The centralisation of deliveries requires monitoring factors that threaten the well-being of the parturient and the newborn, including the development in the numbers of out-of-hospital deliveries and operative deliveries. Cooperation between municipalities and the hospital must be seamless and the responsibilities of each actor must be clearly defined.

Multiprofessional delivery planning, treatment during delivery and planning of the postnatal period are needed in the treatment of all pregnant women and their partners in need of special support (for example, due to fear of delivery, problems in previous delivery, mental health disorders or a substance abuse issue in the family).

Objective

- Regional inequality will be decreased in delivery and postnatal care.

Actions

- The regional actors responsible for arranging delivery services, higher education institutions and research institutes will determine the reasons behind the operative and unplanned out-of-hospital deliveries, as well as the reasons for the regional variation.
- The regional actors responsible for arranging delivery services will develop well-defined care paths between maternity hospitals and parturients' home municipality.

Antenatal training and delivery planning

The aim of the family coaching maternity ward is to help provide families with a holistic, positive birth experience and to back up their own resources.[5] Finnish municipalities must arrange multi-professional family coaching, which includes parent group activities.[6] Antenatal classes must be provided in accessible premises and any written material handed out must be in a form that is accessible for everyone. The classes must meet the needs of families and provide visual information on the childbirth process and local care practices. Good results have been obtained by using customer-oriented, participatory methods and peer support, and offering visits to the birth environment in advance.

The maternity clinic recommendations (chapter on Family Coaching)[7] cover the key areas of antenatal classes (in Finnish). Antenatal classes cover the latent (early) phase of childbirth. This is the point at which the birth is just beginning and the contractions become painful, but not necessarily continuous.[8] In relation to the latent (early) phase of labour, good antenatal classes can mean later arrival at the hospital and fewer medical procedures needed during childbirth.[9]

A birth plan is a means of presenting one's own, specific wishes on issues such as pain relief during the birth, labour positions and the first moments with the newborn.[10,11] The birth plan also includes a discussion of the possibility that the birth will not go as planned. If the family has any special wishes regarding the place of birth or treatment times, this should be taken into account when preparing for the birth and in the birth plan. Guidance on departing for the maternity hospital should take account of the distance between home and the hospital, particularly now when the number of maternity hospitals is being reduced.

Objectives

- All pregnant women will be provided with a possibility to participate in delivery planning and antenatal training as a part of family coaching.
- Parturients will be provided with a safe and peaceful environment, ensuring privacy and a possibility to move around and relax.

Actions

- Professionals within primary health care and specialised care will utilise evidence-based and regionally updated information in antenatal training.
- Public health nurses and midwives will utilise client-oriented and inclusive methods as well as peer support, such as support person work, in antenatal training.
- Public health nurses, midwives or doctors will draw up a delivery plan together with a pregnant mother within primary health care or specialised health care, record and report the plan in order to ensure continuity and take the latent phase of delivery into account in the plan.
- Midwives or public health nurses will give self-care guidance for a latent phase in antenatal training in order to provide the parturients who do not have special delivery or pregnancy related risks with skills to manage the latent phase at home with a support person or receiving advice from the delivery department personnel by phone.

- Midwives, public health nurses or doctors, responsible for hospital departure instructions, will take the distance between the home and the hospital into account to ensure the delivery in the planned environment.

Childbirth and immediate postnatal care

The risk status of the pregnancy, and the course of labour and delivery must be taken into consideration in defining a normal (low risk) birth.[12] Risk assessment does not only take place once, but also continues during the pregnancy and delivery. Complications may occur at any given stage, and these may influence a decision for referring the pregnant woman to treatment involving higher levels of medical intervention. Whether a woman has a normal (low risk) or complicated delivery can be conclusively determined only after the delivery. According to the WHO, this has often led to the conclusion that careduring normal childbirth should be similar to the care in complicated deliveries.[12] The previous action programme for sexual and reproductive health[13] already proposed the care for low risk deliveries as a topic for national care recommendations. This would enable determining pregnant women as low risk parturients already before the onset of labour or as it begins.

WHO (1996) defines normal (low-risk) birth as:[12]

- spontaneous in onset
- taking place between 37 and 42 weeks of gestation
- low-risk at the start of labour and remaining so throughout labour and delivery
- The infant is born spontaneously in the vertex position
- after birth, mother and infant are in good condition.

WHO (1996) defines the tasks of the caregiver in low-risk births as:[12]

- support of the woman, her partner and family during labour, at the moment of childbirth and in the period thereafter
- observation of the labouring woman; monitoring of the foetal condition and of the condition of the infant after birth; assessment of risk factors; early detection of problems
- performing minor interventions, if necessary, such as amniotomy andepisiotomy; care of the infant after birth
- referral to a higher level of care, if risk factors become apparent orcomplications develop that

The latent phase of the delivery is usually treated at home, which highlights the importance of the support of one's partner or loved one and the availability of a midwife in a delivery ward by telephone. It is important that the antenatal training includes discussing the latent phase so that the parturients know how to utilise the relaxation and pain management techniques at home.

A precondition for a good delivery is provided by the personal nurse model in which the parturient is assigned a personal charge midwife/doctor responsible for the holistic care of the delivery following the delivery plan and by taking care of the continuation, recording and reporting of the care.[8,14] The staff taking care of the delivery are responsible to make sure that the parturient is aware of the progress of her delivery so that she can actively participate in the decision-making related to her labour. In all delivery environments, support during childbirth is an important part of the delivery, childbirth experience and promotes the natural physiological progress of the delivery as well as the parturient's feeling of control.[15,16] Interactive support provided during delivery can be carried out as physical and mental support, guidance and provision of information as well as acting as the parturient's advocate. Labour support also includes taking the support person into consideration.10 Continuous support during labour increases the likelihood for vaginal delivery, decreases the need for medicinal pain management and decreases the duration of childbirth.[10,15,16]

The care of the first stage of labour involves monitoring the progress of delivery, following the status of the parturient and the foetus, and particularly the management of labour pains.[17] The delivery care is founded on the delivery plan and the situation during childbirth, which may change rapidly. Supporting the parturient in taking charge and making active decisions together with the charge midwife and doctor increases her feeling of control and trust in her own ability as a parturient.[18]

The delivery plan should contain a plan related to the parturient's wishes related to dealing with labour pains. When planning non-medicinal pain management methods for labour pains, what is available in the selected delivery hospital should be taken into account beforehand. The use of medicinal pain management methods should include information about the potential risks related to these so that the parturient has an opportunity for informed decision-making.

The second stage of labour includes the deceleration, i.e., transition phase and the stage of active pushing.[19] If there are no specific risk factors for the parturient, she is supported to push in a position of her choice, but to avoid pushing positions related to the risk of supine syndrome. The valid treatment recommendations are complied with in order to prevent 3rd and 4th degree tears, and evidence-based suture techniques are used in stitching the tears.[8,20–22]

The third stage of labour can be treated physiologically (low risk delivery) or actively (low/high risk delivery).[23] Active care for the third stage of labour is implemented in situations where there is a reason for accelerating the delivery of the placenta and preventing heavy bleeding.

Apgar scores are given to the newborn aged one and five minutes to assess his or her condition.[19] The importance of breastfeeding right after birth and early skin-to-skin contact with the baby should be discussed already during gestation period in maternity health clinic and family training. The newborn should be guaranteed a possibility for early skin-to-skin contact. After labour, the mother is provided guidance for peaceful first-time breastfeeding if necessary; routine operations may be postponed if allowed by the condition of the newborn.

Breastfeeding support

The Breastfeeding Promotion in Finland. Action Programme 2009-2012 set guidelines for the support of breastfeeding counselling in maternity and child health clinics and delivery hospitals.[24] The programme was based on research knowledge on the health impacts of breastfeeding and functional breastfeeding counselling practices. The maternity clinic guide by the National Institute for Health and Welfare (chapter on Breastfeeding) discusses breastfeeding counselling, [25] so the topic is only briefly discussed in this action programme.

Breastfeeding counselling is one method for reducing health differences.[24,26] Less educated and lower-income mothers breastfeed their children less frequently and for a shorter period of time than highly educated mothers.

Breastfeeding counselling must be implemented systematically in a cooperation of primary health care and specialised medical care based on evidence in a manner fully utilising the international Baby Friendly Hospital Initiative of the WHO and Unicef.[27] Breastfeeding counselling is provided already during the gestation period and continued all the way until weaning. Breastfeeding counselling and support provided by a professional is particularly important at the beginning stage of breastfeeding. All mothers must receive counselling in breastfeeding, but particular attention should be paid to recognising and providing specific counselling to the pregnant women and mothers who have given birth in need of special support. Support must also be provided for those unable to breastfeed. Sufficient training of staff must be arranged.

Postnatal discussion

The postnatal discussion offers the mothers and their partners or support persons an opportunity to discuss the delivery after the birth of the infant and a possibility for staff to develop the quality of their work. The aim of the postnatal discussion is to go through and understand the experience of giving birth, creating a sense of security and emphasising successes, resulting in an empowering experience on the delivery for the mother.[28] The positive experience on giving birth has a positive influence on issues such as the mother-infant relationship, the self-esteem of the mother and her conception of parenthood.[29] The impacts of a

negative delivery experience might be long-term and correlate with postpartum depression, early mother-infant interaction and even the family's further plans on a new pregnancy and delivery method. The postnatal discussion is preferably realised with the midwife responsible for care during the delivery, but the doctors involved in taking care of the delivery must also discuss with the family if necessary. The postnatal discussion includes going through the entire labour in order to avoid any confusion and form an intact experience. Postnatal recovery, attaining sexual well-being and supporting the couple's relationship are also taken into account. The postnatal discussion is recorded into the mother's delivery record.

Objectives

- Holistic perinatal support will be offered to all parturients.
- In delivery care, the parturient's own resources will be supported, avoiding needless interference in the course of delivery.
- Parturients will be offered pain relief according to their wishes and needs, with information of the related benefits and possible adverse effects.
- The parturient and her family will be supported in delivery care in order to enable an empowering experience.
- Parturients will have a positive attitude towards, and sufficient knowledge and skills for breastfeeding.
- All parturients will have a possibility to discuss the delivery and their own experiences at hospital and later at maternity clinic.

Actions

- Midwives and doctors will implement delivery care in a holistic, client-oriented and empowering way, taking advantage of the individual delivery plan on the delivery course.
- In delivery care, midwives and doctors will take into account the factors affecting a delivery experience, interaction level, presence, sense of control, participation in decision making, communication and the delivery environment.
- Public health nurses, midwives and doctors, participating in delivery, will give evidence-based information about pain relief choices, conforming to the actual conditions at the local delivery hospital, during antenatal training as well as in the course of delivery.
- Public health nurses, midwives and doctors, working with pregnant and delivering mothers, will update their knowledge of delivery pain relief.
- Actors, responsible for regional delivery services, will ensure delivery environment with various delivery pain relief methods. Midwives and doctors will offer pain relief in various ways as per parturients’ wishes and needs.
- Public health nurses, midwives and doctors within primary health care and specialised care will give information on the importance of skin contact during pregnancy, antenatal training and after delivery.
- Supervisors will ensure that all midwives at delivery hospitals and public health nurses at maternity clinics have received breastfeeding counsellor training and doctors have sufficient level of breastfeeding knowledge.
- Professionals within primary health care and specialised care will provide breastfeeding support paying special attention to young people, those with low education and single parents.
- Public health nurses, midwives and doctors as well as peer supporters will develop their cooperation in breastfeeding support work.
- Charge nurses at maternity wards will arrange work in a way that all families at delivery hospitals have a personal nurse, who counsels and supports in breastfeeding, neonatal care and in the early interaction with the baby.
- Midwives and doctors, responsible for the delivery at maternity hospital, and midwives and public health nurses at maternity clinics will afterwards offer all families an opportunity to discuss delivery experiences. Families with a traumatic childbirth will be offered a possibility to discuss at

maternity hospital again in 4–6 weeks after the delivery, and they will be given support in going through the traumatic experience, when needed.

Shorter hospital stays and early postnatal discharge

The duration of puerperium care in a hospital has decreased (figure 4). While in 1992, 54 per cent of parturients were discharged on the fourth day after birth at the latest, the corresponding figure was 90 per cent in 2012, and 45 per cent were discharged within two days.[1] The mean length of stay for parturients after delivery was 2.9 days in 2012. The mean length of stay was 2.7 days with vaginal delivery and 4.0 days with Caesarean section. The shorter care periods at maternity wards require increasingly intense guidance in a short period of time, efficient monitoring of the condition of the newborn, and breastfeeding counselling and support for the entire family in outpatient health care services.

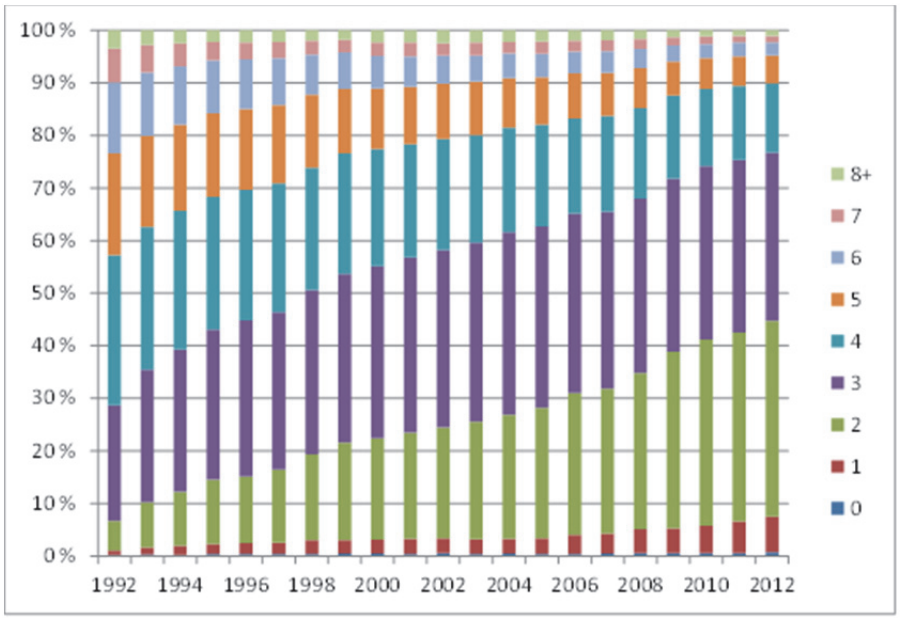

Figure 4. *Number of care days after delivery in 1992–2012.*[1]

Early postnatal discharge and home birth

In an early postnatal discharge, the mother who has given birth and the baby are discharged from the hospital less than 48 hours after the delivery. Deliveries in which the discharge occurs within six hours of childbirth are referred to as outpatient deliveries. After an early postnatal discharge, the follow-up of the mother and newborn varies depending on how soon the discharge occurred after the delivery. Early postnatal discharge is suitable for women with normal pregnancy and delivery who have expressed an interest in a speedy discharge from the delivery hospital and whose infant's condition shows no signs of anything abnormal. A chapter on early postnatal discharge in the maternity clinic guide by the National Institute for Health and Welfare deals with the recommendation related to early postnatal discharge.[25]

Health care professionals are required to provide the families planning a home birth with unbiased information on the risks, criteria and legal questions related to this as well as information on its practical realisation. The parties (the health care professional and the parturient and/or the family) are recommended to sign an agreement on the home birth. A delivery hospital is informed about the home birth plan based on the consent of the parturient, and after the delivery, the parents or a midwife/doctor contact the delivery hospital to schedule a health examination for the infant. As the parents carry the primary responsibility for monitoring the child's condition after a home birth, the professionals taking care of the delivery must instruct the family to observe the newborn and contact a paediatrician if necessary. The maternity clinic

guide does not recommend home birth, but includes recommendations for those planning a home birth (chapter on home birth).[25]

Home visiting as a method of supporting families

According to a Government Decree[6], at least one home visit must be arranged for all first-time parents either during the pregnancy or the post-natal period. Whenever possible, a post-natal home visit is made in the homes of all newborns. The home visit is arranged by a public health nurse or a midwife at a maternity clinic, accompanied by, for example, a family worker or a social worker in needed. Home visits are made according to need in families requiring special support, in which case the number and timing of home visits and the workers participating in these are based on the individual needs of the family. The maternity clinic guide contains detailed recommendations on home visits (chapter on home visits).[25]

Objectives

- Continuity of services and treatment after early postnatal discharge will be implemented in a client-centred way with a regional perspective as a starting point.
- Early postnatal discharge and home delivery management and control will be implemented according to the recommendations of Maternity clinic guidance.25
- Maternity care experts will have special skills for childbirth and postnatal care in a case of early postnatal discharge.
- Families will have adequate capacities to cope with confidence at home after an early postnatal discharge.
- A home visit after delivery will be provided to all families, if possible.

Actions

- A midwife or a public health nurse at the maternity clinic will arrange a home visit shortly after an early discharge or the family will be given an opportunity to meet their midwife/doctor at hospital.
- Midwives in specialised care settings (a health care professional responsible for the delivery in home deliveries) will support family's well-being after an early discharge, e.g., through phone consultations and ensuring communication between specialised care and primary health care.
- Public health nurses, midwives and doctors in primary health care and specialised care settings will maintain and complete their skills, if needed, in order to identify risks, related to physical health disorders of neonates and to post-delivery recovery of mothers, and to diagnose possible disorders in time.
- Public health nurses, midwives and doctors in primary health care and specialised care settings will instruct families by means of consistent guidelines, drawn up in cooperation, to observe and timely identify the risks related to the neonate's well-being and postnatal recovery.
- Midwives and public health nurses in primary health care will carry out home visits multi-professionally, e.g., with a family worker or social worker, as needed. The course of the labour, experiences, well-being and recovery of mother, well-being of the neonate, the family's social network and a possible need for breastfeeding support or any need for additional help are determined during home visits.

Identification and treatment of postnatal depression

Around 9–16 per cent of women who have given birth have been estimated to suffer from postnatal depression in Finland.[30, 31] Fathers have also been found to suffer from postnatal depression, which is at its peak 3–6 months after childbirth and which is related to the depression of the mother.[32] Postnatal depression may vary from mild symptoms to psychotic depression. Puerperal psychosis is a severe mental health issue typically occurring two weeks after labour, and characteristically involving distorted sense of reality and hallucinations. 1–2 mothers out of one thousand are affected by puerperal psychosis. Mothers with the condition are treated in specialised medical care.[33,34]

Health care staff is required to have good interaction skills, special competence in mental health work and multiprofessional cooperation in the early recognition and treatment of postnatal depression. In addition to treating the depression itself, the treatment also requires holistic support for the well-being of the entire family. The Edinburgh Postnatal Depression Scale (EPDS) form and a related discussion are utilised in the care for both pregnant women and families with a newborn. The use of the EPDS form requires the availability of well-functioning care pathways.

The maternity clinic guide includes discussion on the topic of postnatal depression and recommendation on recognising and treating the condition (chapter on postnatal depression).[25]

Objective

- Postnatal depression will be identified and the mother, her partner and the rest family will be provided with the care and support they need.

Actions

- The advantage of home visits by primary health care and/or specialised care professionals will be taken to identify postnatal depression.
- The home visits will be carried out multiprofessionally, when needed. Actors responsible for regional services will ensure workable treatment pathway for those with postnatal depression.
- Public health nurses, midwives and doctors within primary health care and/or specialised care will use EPDS-forms in screening of postnatal depression for all mothers and refer them to get treatment according to care pathway.
- The National Institute for Health and Welfare will create a national care recommendation on postnatal depression identification and treatment in cooperation with experts of this field.

Postnatal examination and prevention of postnatal depression

A post-natal examination will be performed to check on the mother's health and identify any possible injuries caused by the birth. A condition for the payment of parental allowance is that the mother has visited a doctor or – after a routine birth – a sufficiently qualified midwife or nurse working for the public health services, for a post-natal medical examination performed at least five and at most 12 weeks after the birth. The content of the post-natal medical examination and the related recommendation is presented in the maternity clinic guide (in the chapter Postnatal examination - in Finnish). A preliminary discussion on family planning is held during the late pregnancy period and the need for contraception is discussed again after the birth, in order to identify a suitable contraceptive method.

Objectives

- The overall situation and any obstetric injuries of the parturient will be determined in a postnatal examination.
- The amount of induced abortions during the first year after childbirth will decrease.

Actions

- Public health nurses, midwives and doctors will carry out postnatal examinations, including a physical examination of mother but also an assessment of the psychosocial condition of the family as well as guidance and support to help the family to cope at home. Family planning will be discussed both in the last stage of pregnancy and after the delivery, and postnatal sexual counselling will be provided, as necessary.
- During a postnatal examination, a public health nurse, midwife or doctor will intensify support for the couple's relationship and starting of postnatal contraception and related counselling, emphasising particularly long-acting contraception, such as use of an intrauterine contraceptive device or capsules.

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11 Contraception

In Finland, information about contraception methods on the population level is primarily available in the School Health Promotion studies, University Student Health surveys, the FINRISKI, the 'Health 2000' and 'Health 2011' surveys and some individual studies. The Maamu Study of the National Institute for Health and Welfare contains information on the contraception use among women with Russian, Somali and Kurdish origins. The Register of Sterilisations provides annual information on sterilisations.

Contraception use

Young people and students

An increase in oral contraceptive use among girls roughly reached the current level at the beginning of 1990s.[1] According to the School Health Promotion Study, 16 per cent of adolescents in the upper comprehensive school, 7 per cent of those in upper secondary schools and 12 per cent of those in vocational schools had not used any contraception the last time they had sex.[2]

Condom was most commonly used contraception among primary school pupils.[2] Hormonal contraceptives were the most commonly used contraception method among girls in vocational education. The use of hormonal contraceptives was more prevalent when moving from the lower grades to upper grade levels and from comprehensive school to upper secondary level education. Dual protection using a condom and birth control pills or other hormonal methods was uncommon among adolescents. In the 2000s, the use of post-coital oral contraceptives has increased in all grade levels.[3] In 2010/2011, 28 per cent of girls in primary school, 39 of girls in upper secondary school and 43 per cent of girls in vocational education who had had sexual intercourse had at some point used post-coital oral contraceptives.

Among those studying in universities and universities of applied sciences, 47 per cent of women and 39 per cent of men reported having used the birth control pill as a contraceptive method during the previous month.[4] 45 per cent of men and 36 per cent of women had used a condom. Nearly half of women studying in universities in Finland had used post-coital oral contraceptives.[5] No similar study has been conducted among other adult students.

Adults

In the Health 2011 survey, around one fifth of men (21%) and women (22%) aged 30–44 reported using a hormonal contraceptive (women's contraceptive pill, ring or patch).[6] Men (27%) reported condom use more frequently than women (21%). The dual use of hormonal contraceptive and a condom was less common among 45–54-year-olds than 30–44-year-olds, especially among women. Intrauterine contraceptive device was used in equal amounts in both age groups. After an induced abortion, women more frequently planned an intrauterine method as their future contraceptive method.

Among the women participating in the Maamu Study, nearly all reliable contraceptive methods were less frequently used than among the women participating in the Health 2011 survey.[7] Of the women under 55 years of age, 43 per cent of those of Russian and Kurdish and less than 12 per cent of the women with Somali origin reported using some contraceptive method. 9% of the women with Russian, 3% of the women of Somali and 16% of the women with Kurdish origins aged 18–54 reported using hormonal contraceptives (contraceptive pill, ring or patch). Around 20% of the women with Russian, 2% of the women with Somali and 8% of the women with Kurdish background reported using condom as the contraceptive method.

The availability of post-coital oral contraceptives as self-management drugs in 2002 was hoped to decrease the number of induced abortions specifically in the age groups in which the use of post-coital oral contraceptives is most frequent (under 25-year-olds). According to statistics on induced abortions, the

desired aim has not been reached. According to the School Health Promotion Study, adolescents' awareness on post-coital oral contraceptives was good and increased with advanced age.[1]

Sterilisations

The total number of sterilisations has decreased considerably over the past 15 years despite a slight increase in the previous year (figure 5).[8] The decrease can be attributed to, for example, an increasing use of intrauterine contraceptives, an expanding range of contraceptives, a shift to a later age of first parenthood and long waiting times to sterilisation. While female sterilisations still account for the majority (55%) of all sterilisations, the difference between male and female sterilisations has continued to diminish. In proportion to the population, the sterilisation rate was 2.2 sterilisations per thousand persons aged 25–54: 2.4 for women and 1.9 for men. In 2012, the highest percentage of female sterilisations was carried out in the 35–39 age group (38.1%), despite a growth in the percentage of female sterilisations in the 30–34 age group. Also male sterilisation was most common in the 35–39 age group (31%). Male sterilisations were more evenly distributed across age groups than female sterilisations.

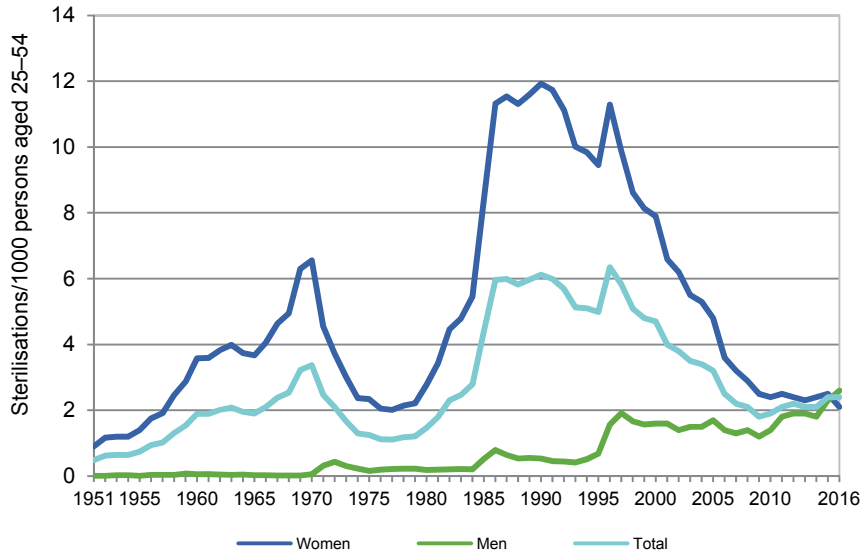

Figure 5. *Sterilisations per 1000 persons aged 25–54, 1950–2016.*[8]

Unplanned pregnancy

In Finland, there is very little information available on the proportion of planned pregnancies and how well families have succeeded in planning the size of the family and timing of the births of children. In the survey on the welfare and services for families with children conducted by the National Institute for Health and Welfare in 2012, 19 per cent of the female and 16 per cent of the male respondents reported that the pregnancy leading to the birth of their first-born child had been unplanned.[9] This was more common among younger and less educated respondents. The influence of age was more significant than education: unplanned pregnancy was three times more common in under 30-year-old women than women aged 30 and over.

The effectiveness of contraception can be assessed based on statistics on induced abortions. Moreover, pregnancies among young women can be used as a further indicator, as over half of the pregnancies in under 20-year-olds and nearly all in under 18-year-olds (70–85 %) are likely to be unplanned as they result in induced abortions (figure 6). Regardless of a growth in the 1990s, the total number of induced abortions and deliveries in under 20-year-olds has been decreasing since the year 1987 and has stabilised in the 2000s.

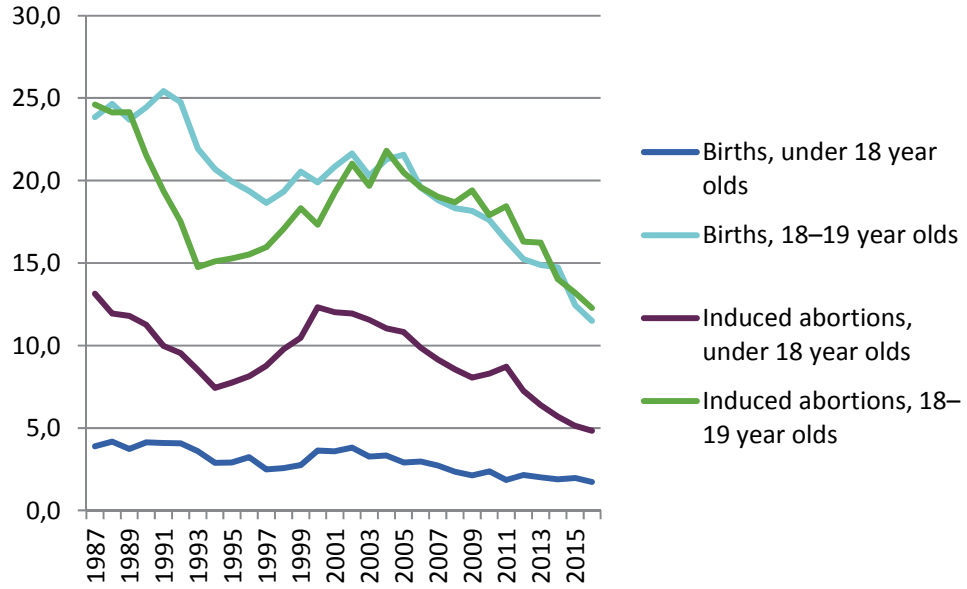

***Figure 6**. Births and induced abortions of under 18-year-olds and 18–19-year-olds per 1000 women aged 15–17/18–19.* [10, 11]

The share of those with a previous induced abortion among all induced abortions increased from the year 1990 to 2009 and has since been in a slight decline (figure 7). Repeated induced abortions in a short period of time are a particular cause for worry. In 2012, 37 per cent had at least one previous induced abortion and nearly half had given birth at least once.[12] Therefore, both groups had previously been within the scope of the health care service system, but contraception counselling had not resulted in the desired outcome. The fact that the risk for induced abortions 6–8 months after delivery has increased is an indication of the difficulties of family planning.[13] In 2011, a little over 11 per cent of the women undergoing induced abortions had given birth in the same or the previous year.[10, 14]

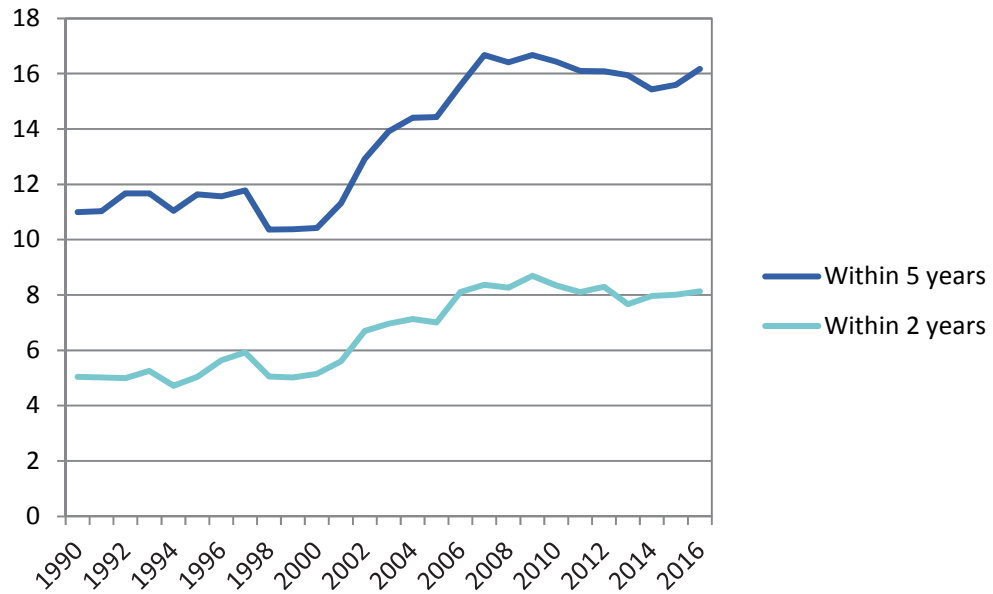

***Figure 7**. Induced abortions when previous pregnancy was terminated within the last 2 and 5 years, 1990–2016, %.*[10]

According to statistics on reproduction, contraception is not realised to the desired extent, especially among under 25-year-olds. This might also be affected by the lack of contraception services corresponding to the needs of these age groups. Contraception services and availability after delivery and induced abortion must also be improved.

In 2012, 35 per cent of abortion patients reported having used no contraceptive method at the start of pregnancy.[12] The corresponding figure for the under-20s was 33 per cent. Just over half of the under-20s reported having used condom and 14 per cent oral contraceptive pill or implant. Even when accounting for the possibility of failure of contraception, at least one third of induced abortions could be avoided with the use of sufficient contraception.

As of 2002 post-coital oral contraceptives have been free of prescription to anyone over 15 years of age. The use of post-coital oral contraceptives increased slightly after 2002, but has stabilised in recent years.[12] In 2012, 3.4 per cent of all abortion patients reported having used post-coital oral contraception. The corresponding figure for the under-20s was 2.3 per cent.

In 2012, the contraceptive method planned to be used after an induced abortion was contraceptive pill or capsule (57%).[12] These were planned as the contraceptive method in 84 per cent of under 20-year-olds. Intrauterine contraception was planned for 28 per cent in 2012. The share of this contraceptive method in planned contraception has been increasing. Among all women having induced abortions, either no contraception had been planned or this has not been reported for 7.2 per cent. The corresponding figure in under 20-year-olds was 2 per cent.

Contraception services

The organisation of contraception services was assigned to municipalities under the Primary Health Care Act[15] in 1972. The Health Care Act[16] regulates and guides regional contraception counselling, and the Act on Client Fees in Social Welfare and Health Care17 the provision of free-of-charge sexual and reproductive health services. There are no national recommendations on contraception in Finland. The WHO published its international criteria in 2009.[18]

In 2008, one fourth of health centres included a separate contraception counselling clinic.[19] This was the most common way to arrange services in places with a population exceeding 50,000. The service was most frequently connected to other maternity and child health clinic activities (combined maternity and contraception counselling clinic 45%, maternity, contraception counselling and child health clinic 21%). There were few separate clinics for young people, but adolescents received contraception services via school and student health care in the majority of municipalities. Adolescents could get an appointment related to sexual health issues within a week from scheduling it in 41 per cent of the health centres. Contraceptive method support for under 20-year-olds was realised in one third of the health centres. It is essential for contraception counselling that the services can be reached quickly and are easily available.

In order to make contraception services more efficient, it is important to

- enhance the involvement of boys and men in contraception counselling
- lower the threshold for contacting contraception counselling services
- enhance the contraception counselling for women seeking induced abortions by getting familiar with her life situation, previously used and possibly failed contraception alternatives, and by considering together with her long-term solutions (intrauterine device, capsule) for contraception after the induced abortion (see chapter 12 Induced abortion)
- receive support from the municipality or the Social Insurance Institution of Finland for acquiring contraceptive devices for under 25-year-olds
- provide information on alternatives that are easy, effortless and reliable for the user
- decrease the preconceptions related to contraception with hormonal intrauterine device and consider this as an alternative also for young women who have not given birth and may need contraception for a number of years.[20]

Postpartum contraception

The topic of postpartum contraception should already be broached in the counselling provided during gestation.[21] The contents and effectiveness of the counselling should be assessed and developed. On the national level, there is a need for shared practices as well as counselling and operating methods efficiently reaching couples.

Full breastfeeding and lack of menstruation during the initial six months after the birth of the baby (Lactational amenorrhea method, LAM) have contraceptive efficiency equivalent to condom use.[21] At the latest, the postnatal examination must include considering contraception alternatives and ensuring that a plan on contraception has been drafted and can be implemented as soon as possible, unless there is a wish for a new pregnancy. However, it is important to remember that full breastfeeding and lack of menstruation during the initial six months after labour do not protect one against sexually transmitted diseases.

Young people and contraception

According to a Government Decree[22], contraception counselling and other sexual health counselling are a part of the services provided by maternity health clinics as well as school and student health care services. According to recommendations, there should be a possibility in school health care to provide young people with condoms and post-coital oral contraceptive kits free of charge when necessary. A practice in which a school health nurse may conduct an interview related to the beginning of the use of contraceptive pills and give the young person a starter package according to a doctor's instructions has been found to work well.[23] A doctor's appointment for the first examination is booked at the same time.

Finnish Student Health Service (FSHS) provides services for university students. Appointment for contraception was the single most common reason for a doctor's consultation during the follow-up period of 1986–2005.[24] The Handbook on health care during studies provides guidelines on issues such as the sexual health services for students and emphasises access to contraception services without delay.[25]

As of 2002, post-coital oral contraceptives have been available free of prescription to anyone over 15 years of age. Nevertheless, there continues to be a need for health care services in the implementation of post-coital oral contraceptives.[26] Those under 15-years-old still need a prescription for acquiring post-coital oral contraceptives, and pharmacies must instruct the client to book a follow-up examination if there is a delay of over one week in her menstruation. All under 18-year-olds are also guided to a follow-up examination for an individual sexual and contraception counselling. Screening for sexually transmitted diseases is also important to remember in connection to post-coital oral contraceptives. Health centres should also provide the intrauterine device for the purpose of post-coital contraception.

Development of contraception services

The main ideas of contraception services are to a large extent the same as in the previous action programme: developing the services towards holistic promotion of sexual and reproductive health. An aim set in the Government Programme[27] involves integrating holistic promotion of sexual health into contraception counselling, including prevention of sexually transmitted diseases, sexual counselling and prevention of sexually offensive violence. Choosing a suitable contraceptive method requires an interview on the client's sexual behaviour, the character of their relationship and life situation, which provides a natural situation for implementing this objective of the Government Programme. More attention than previously should also be paid to counselling related to age and fertility.[24,28]

The majority of Finnish people aged 15–79 use the internet, which is also used to seek information about contraception to some extent.[29,30] Indeed, when developing contraception services, the internet should be utilised, for example, in providing information to clients and developing electronic scheduling of service appointments. Taking services and counselling to an online environment lowers the threshold for seeking services and increases geographic equality.

Family planning services should be developed so that men could also be included in the appointments related to family planning and sexual health appointments in a natural way.[24] It would be ideal that the

partner could participate in both beginning and follow-up appointments for contraceptive use. This would allow providing sexual counselling for both parties.

The Act on Health Care Professionals[31], regulations on symptomatic care[32] and the limited right to prescribe medicines[32] as well as a decree of the Ministry of Social Affairs and Health for the prescription of a drug[33] regulate the hormonal contraception initiated by and issue of repeat prescription based on a doctor's prescription by a midwife, nurse or public health nurse. According to the Decree, a midwife, nurse or public health nurse who has received additional training and has sufficient experience may prescribe contraceptive pills, plastic intrauterine devices with progesterone and contraceptive vaginal rings. The legislation does not state, for instance, what the doctor, midwife, nurse or public health nurse may do when inserting an intrauterine device. They gain competence in training and division of duties can be developed based on the legislation on health care professionals. In addition to beginning hormonal contraception, the nurse may also take care of a significant share of the follow-up appointments for a healthy woman.[34]

Objectives

- National recommendations on contraception will be created.
- Sexual counselling will be provided along with pregnancy contraception services and after delivery.
- Contraception services will be offered to all fertile age groups free of charge all year round. Examinations performed before starting contraception and for monitoring purposes will be included in these services.
- Special needs of young people, men, the disabled and immigrants, as well as the diversity of sexual orientation, gender identity and gender expression will be taken into account in pregnancy contraception and family planning services.
- Pregnancy contraception counselling will be developed according to international recommendations, and development projects will be financed as a part of health promoting work.
- Skills in pregnancy contraception among doctors and nurses will be developed, and distribution of duties will be clarified.

Actions

- The Current Care Guidelines (Käypä hoito) work group by Duodecim will draw up Current Care Guideline recommendations on pregnancy contraception.
- Regional and local sexual and reproductive health service providers will draw up operating instructions on implementation of pregnancy contraception counselling and related services on the basis of Current Care Guidelines. The quality criteria of contraception counselling will be further developed.
- Health care professionals will offer cost-free contraceptives, chosen after induced abortion and delivery (e.g., pills, contraceptive ring or patch, contraceptive capsules, intrauterine contraceptive device). Long-acting contraceptives (capsules, IUD) will be recommended, specifically after induced abortion.
- Municipalities or joint municipal authorities will ensure adequate and multichannelling information on the contraception counselling services that are provided by maternity and/or child clinics, as well as round-year availability and accessibility.
- Municipalities or joint municipal authorities will centralise contraception counselling services at sites where employees have required special skills: in bigger municipalities or joint municipal authorities the services are provided in a separate contraception or family planning clinic, and in smaller units along with the other counselling services.
- Municipalities or joint municipal authorities will ensure that the range of contraceptives covers all methods in use, access to clinics is unobstructed, starting of contraception will be arranged as soon as possible and young clients will be able to make an appointment within a week at latest after contacting health care staff.
- Municipalities or joint municipal authorities will offer cost-free contraception to clients under 20 years, as per their choice.

- Municipalities or joint municipal authorities will ensure that material on contraception counselling is available both in plain language and in number of foreign languages, and that both interpreters of foreign languages and signers are available, when needed.
- Actors responsible for sexual and reproductive health services will provide access to sterilisation for men of their area.
- Municipalities or joint municipal authorities and organisations of the field will develop service practices, taking boys and men into account as well.
- In the future, especially big municipalities or joint municipal authorities will arrange contraception services and counselling for the young as a part of multisectoral services for young people, paying special attention to counselling of young immigrants.
- Professionals working in youth services will take notice of confidence, availability (local services), accessibility, cultural differences and access to multi-professional consultations.
- Health centres and pharmacies agree locally about referring emergency contraception clients under 20 years old to follow-up check and sexually transmitted disease tests, according to the Current Care Guidelines (Käypä hoito) recommendations.
- Supervisors will ensure that professionals in contraception counselling are given further training in contraceptive counselling, including information on sexual and reproductive health, various contraceptive products, rights to prescribe, needs of special groups, such as the disabled and immigrants, and ways to take different cultures into account.
- Professionals in contraception counselling will create multi-professional networks, e.g., for child welfare measures or sexual mistreatment cases.
- Health centres will designate responsible employees for contraception counselling management and development, in bigger units both a doctor and a nursing worker.

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12 Induced abortion

Induced abortion is based on legislation and a decree issues under it.[1,2] There is also a Current Care Guidelines (Käypä hoito) recommendation on induced abortions in Finland.[3] Reducing the number of induced abortions was recorded as a goal in the Government Programme of 2011.[4]

Induced abortion is a safe medical procedure in countries where it is legal and the related case-fatality rate is very small at 0.7/100,000.[5] However, on the global level, the case-fatality rates continue to be significant in all developing regions at 220/100,000. Repeated induced abortions have been found to increase the risk for pre-term births and low birthweight for the first delivery after the abortions.[6]

Number and method of induced abortions

In 2012, the total number of induced abortions was 10,060, i.e., 8.6 abortions per 1000 women of childbearing age (aged 15–49).[7] In 2013, 92 per cent of abortions were performed on social grounds and some 3 per cent on ground of possible and diagnosed foetal defect. The total number of induced abortions has remained relatively stable throughout the 2000s, while the number of abortions among women under 20 has decreased significantly. Most abortions are performed in the 20–24 age group (17.5 per 1000 women of the same age in 2012). The proportion of women who have repeated induced abortions has increased considerably in the past three decades.[8] According to an estimate based on the Register of Induced Abortions, 17 per cent of women aged 20–54 have had an induced abortion.[9]

Medical abortion in the first trimester (gestational age < 9 weeks) was introduced in Finland in 2000. The use of pharmacological drugs to terminate pregnancy has become more commonplace than surgical methods, already amounting to nearly 90 per cent of all induced abortions.[7] Medical abortion in weeks 9–12 of gestation has become more prevalent in recent years, as has medical abortion partially implemented at home in gestation under 9 weeks in length.

The statistics on induced abortions signal that the contraception counselling provided in connection to the abortion has not become more effective since the publication of the Current Care Guidelines (Käypä hoito) recommendation, as the share of repeated induced abortions has increased in recent years. Currently, slightly over one third of women having induced abortions have already had at least one abortion and nearly 15 per cent have had at least two.[7] Contraception with intrauterine device or capsule has been found to decrease the number of repeat induced abortions,[10,11] The costs of contraception will soon be less expensive for municipalities than those related to a repeated abortions. Moreover, avoiding the mental and physical strain on the woman related to an induced abortion and the cost savings related to absences from work also support taking care of contraception well and efficiently.

Life situation and necessary support

There are a number of different reasons for deciding to have an abortion. A pregnancy ending in termination may be planned and long-awaited, an unplanned positive or negative surprise, or the consequence of a crime. The decision to have an induced abortion and the experience of going through one stir a variety of emotions in women, and these are also affected by the cause for the abortion and the woman's life situation. The emotions and attitudes of others, such as the woman's partner or a doctor, may also have an impact on the emotions and activities of the woman having an abortion.[12] The right kind of support from a professional may influence the mental well-being of the woman deciding to have an induced abortion. No studies conducted in Finland have focused on the need for therapy related to an induced abortion.

Women with widely different life situations may require special support.[3] The client must be actively offered a possibility for discussing with, for example, a health centre psychologist, psychiatric nursing specialist or a social worker. In connection to a late or repeated induced abortion, special attention must be paid to determining the need for support and providing this (see maternity clinic guide[13], chapter Induced abortion). If the pregnancy has been terminated due to a foetal anomaly, the parents are provided with a

possibility for counselling at a clinical genetics unit in addition to mental support if necessary. The psychosocial care and planning of efficient contraception is more and more reliant on the unit referring the woman to treatment and conducting follow-up examinations, i.e., primary health care services, which must also be taken into account in the implementation of services. The need for mental support is again assessed in connection to the follow-up examinations and, at the latest, contraception is also discussed at this point if the woman is not planning a new pregnancy.

Objectives

- Induced abortion care will be carried out according to the Current Care Guidelines (Käypä hoito) recommendations in a safe and high quality way.
- A holistic approach to a client's counselling needs will be ensured through the treatment chain.
- The amount of those seeking their second abortions will reduce.
- Long-acting contraception (intrauterine contraceptive devices and capsules) will be offered after an induced abortion free of charge.
- The amount of induced abortions among those under 25 years old will reduce to the level in the middle of 1990s at the least.

Actions

- Regional actors responsible for sexual and reproductive health services will create local and regional treatment chains according to Current Care Guidelines by the end of 2015. Sites will draw up and introduce site specific patient instructions and arrange training.
- Primary health care professionals will actively offer to induced abortion patients an opportunity to discuss and get psychosocial support by scheduling sufficiently time for their visits in order to discuss the issue in pursuance of referral writing. An opportunity for a new visit will be offered, as needed.
- Primary health care professionals will discuss pregnancy contraception and give printed guidance material during the referred visit.
- Special health care professionals will determine a patient's support need in pursuance of discharge, paying special attention to the subsequent contraceptive choices.
- In a case of an unwanted pregnancy, health care professionals will ensure that contraception is started as early as at an abortion visit or at an after-abortion visit at the latest.
- Health care professionals will ensure that start-up contraception is free of charge. Clients will be encouraged to choose a long-acting method.
- Health care professionals will comprehensively assess follow-up treatment for women with a repeated abortion (life situation, necessary supportive actions and cost-free contraception, supporting long-acting methods).
- In a case of a partially at home implemented medical abortion, a health care professional will ensure that a young client has an adult support person available.
- A health care professional will give instructions for situations requiring contact with an abortion unit (pain, fever, profuse or prolonged bleeding), especially in a case of partially at home implemented abortions.
- A health care professional, primarily a midwife or a public health nurse, will ensure termination of pregnancy through a post-abortion check-up.
- A health care professional will determine physical and mental recovery, refer the client to further care, as needed, discuss contraception use, provide sexual and reproductive health related counselling and assess the need for further support.
- The National Institute for Health and Welfare and organisations of the field will develop sexual and reproductive health related web material for the whole population on the national level and produce it not only in domestic languages but in foreign languages as well (e.g., in English and Russian).

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13 Sexually transmitted diseases

The National Institute for Health and Welfare maintains a national register on infectious diseases[1], to which doctors, dentists and microbiological laboratories submit reports of the diagnosed sexually transmitted infections considered dangerous communicable and reportable diseases. Chlamydia is an exception, as this is only reported by laboratories. Syphilis is considered a dangerous communicable sexually transmitted disease. Reportable diseases include chlamydia, gonorrhoea, HIV, hepatitis B and C, as well as chancres, which rarely occur in Finland. A complete reform of the Communicable Diseases Act is currently underway. This may also introduce changes in the monitoring and prevention of sexually transmitted diseases.

Prevalence

In addition to the case follow-up data on sexually transmitted diseases, sufficiently wide information must also be gathered on behaviour, conceptions of risks and attitudes. Moreover, studies targeting population groups with high prevalence of sexually transmitted diseases or susceptible to these diseases must be conducted.[2] There have not been significant changes in the rates of sexually transmitted diseases during the last five years in Finland (figure 8).[3] On the other hand, the number of new infections has not increased, but it has also not taken the desired downward turn.

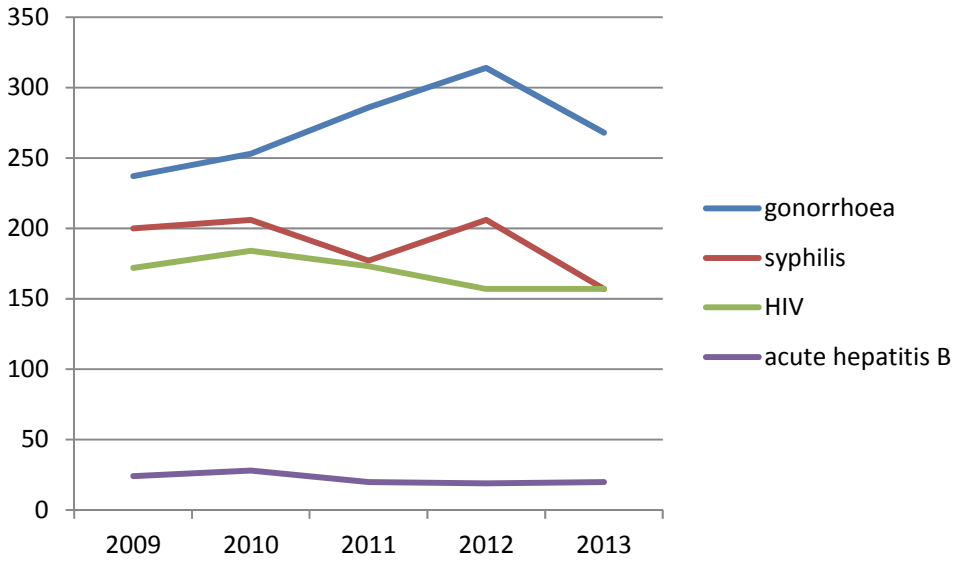

Figure 8. *Annual cases of infections with HIV, gonorrhoea, syphilis, and acute hepatitis B.*[1]

Diagnosed chlamydia infections outnumber any other sexually transmitted diseases by dozens (table 3). The majority of the infections are diagnosed in persons under 25 years of age. The most significant secondary disease caused by a chlamydia infection is pelvic inflammatory disease, which may result in a decline in fertility. Regardless of the stable rate of chlamydia infections, the number of secondary diseases has decreased since the 1990s.[4] Antibodies confirming a chlamydia infection are found less frequently than in the 1980s.[5,6] This conflict between chlamydia infection rates and reduced secondary diseases is partially explained by recurrent infections, whose share has significantly increased since the 1990s.[7] Key approaches for reducing chlamydia infections include increasing targeted testing, preventing recurrent infections and enhancing tracking down the infection. In addition to the statistics on the disease, there is a need on the national level for information on the numbers of chlamydia samples extracted annually in order to assess the coverage and focusing of the testing.

Gonorrhoea infections have increased among young women in particular, even though the majority of cases continue to be diagnosed in men. An increase in resistant strains causes a problem for the treatment of gonorrhoea. Concurrent gonococcal and chlamydial infections have increased.

A clear increase in syphilis infections among men has been detected in the Helsinki metropolitan area. The majority of the infections have been contracted in sexual contacts between men. A significant change has occurred in diagnosing the infections; more and more often, the infection is not diagnosed until at the late stage of the infection.

The majority of HIV infections in Finland are sexually transmitted. It is worrying that every other infection is not diagnosed until years after the contraction of the virus. HIV tests must be made more efficient in order to find the infections earlier than is currently achieved. Around 40 per cent of the HIV infections are contracted in heterosexual sex, and approximately one in three infections are found in men who have sex with men. Finland has been successful at preventing mother-to-child transmissions by utilising comprehensive screenings and active treatment.

Very few acute hepatitis B infections have been reported during the past five years. The majority of these few cases have been sexually transmitted. The increase in the immunisation coverage has decreased the number of hepatitis B infections.

Papillomavirus (HPV) is the most common sexually transmitted virus; one in three women over 20 carries an HPV infection. Some of the HPV infections progress to cancer. Around 2,800 precancerous changes and 150 cervical cancers are annually found in screenings in Finland.[8]

Table 3. *Sexually transmitted diseases in 2008–2012, mean values and %. The numbers are based on data from the Infectious Diseases Register and the Sensor Centres.*[3]

			Infections by age group, %				
	Reported infections/year	Women, %	Under-20s, %	20–29, %	30–39, %	+39, %	Infections abroad, % *
Chlamydia	13 390	59	25	60	11	5	<10
Gonorrhoea	258	26	10	40	25	25	55
Syphilis	201	35	2	15	27	57	66
HIV	168	32	3	26	33	39	69
Acute hepatitis B	25	26	10	28	22	40	70

* Excluding cases where country of infection not available.

Infection prevention

The work for preventing sexually transmitted diseases is based on increasing the awareness of sexuality among the population. When establishing new counselling and consultation services, special features of different population groups should be taken into account. The staff must have sufficient social skills and medical knowledge in order to encounter its customer base. Negative attitudes among staff should not slow down seeking testing and treatment.

Condom use

Condom use is the only method providing protection against sexually transmitted diseases. Free distribution of condoms for young people and special groups and a decrease in their cost prices would be

likely to promote their use. Indeed, condom use has been marketed for young people using education and distribution of free condoms in festivals during summers. The education campaigns provide a good opportunity for teaching condom use. There is also need for information campaigns about protection against sexually transmitted diseases aimed at special groups and the entire population. The importance of using lubricant in connection with condom use should be emphasised particularly in case of sex among men.

Guidance for travellers

Finnish people travel to and reside a lot in areas where the prevalence of sexually transmitted diseases is higher than in Finland. When travelling, people may also take more risks than in their homeland. In fact, a significant proportion of the HIV, gonorrhoea and syphilis infections of Finnish people are contracted in foreign countries. Some travellers contact the health care services before departing, for example, in order to obtain the vaccinations needed for the trip. These situations should be utilised by also discussing the situation of sexually transmitted diseases in the travel destination and the ways people can protect themselves against these. There is also a need for reaching the travellers who do not use health care services before their trip. They can be reached with different campaigns and through the travel operator. A traveller seeking health care services after his or her trip should be offered a possibility for testing for sexually transmitted diseases in order to detect possible infections at an early stage.

New testing practices

In order to enhance testing for sexually transmitted diseases, new approaches are needed alongside the old testing practices. Home samples are already in use elsewhere in the world, for example, for chlamydia testing. This involves examining the sample in a laboratory and allows the client to obtain the results online. There are online services like these as well as rapid chlamydia tests taken at home available in Finland, but these are chargeable. The problem is to get the person with the positive result to treatment and to track down the infection. Indeed, there is a need for integrating an operating model in the available municipal service structures guaranteeing not only smooth and cost-free examinations but also the entire treatment chain all the way to follow-up examinations. This would allow guaranteeing equal rights for all in getting examinations and treatment.

Vaccination

Out of the sexually transmitted diseases, hepatitis B and papillomavirus infections can be averted with the use of vaccinations. The hepatitis B vaccination is administered as a part of a specialised vaccination programme, e.g., for the sex partners and children of hepatitis B carriers and intravenous drug users as well as sex workers.[9] The more widespread use of the vaccination has clearly decreased acute hepatitis B infections.[3]

The papillomavirus vaccination (the HPV vaccination) was approved in the general vaccination programme in 2013. The vaccination prevents cervical cancer by preventing the HPV infection. The vaccination is provided in school health care. In addition to the main target group, i.e., girls in 6th grades, the vaccinations are provided for girls in 7th–9th grades during the two initial years of the vaccinations. Out of young women under 25 years of age, around one fourth carries the HPV type with a high risk for cancer. The majority of HPV infections heal on their own, but occasionally the infection is prolonged and may progress into precancerous changes or cancer. Around 2,800 precancerous changes and 150 cervical cancers are annually found in the screenings in Finland. Based on modelling conducted by prevention work group appointed by the National Institute for Health and Welfare, the vaccination programme is cost-effective and vaccinating can notably decrease the burden caused by HPV.[10]

Contact tracing

Contact tracing has a significant role in preventing sexually transmitted diseases. Contact tracing means referring all sex partners exposed to infection to medical examinations and treatment. Tracing aims to break

off the chains of transmission and referring those who have contracted an infection to treatment at an early stage. The doctor treating the patient has the primary responsibility for contact tracing. This context provides a good opportunity for counselling which involves motivating those exposed to infection to protect themselves from sexually transmitted diseases in the future.

Cooperation between different parties

In addition to the authorities, non-governmental organisations play a central role in the prevention of sexually transmitted diseases. The targeted testing, prevention and outreaching work provided by the organisations are of primary importance in reaching certain population groups, such as men who have sex with men. The role and target group of each actor should be carefully determined in order to avoid unnecessary, overlapping work and to be able to allocate the limited resources in a cost-effective way. Those involved in the prevention work should also be guaranteed a funding basis ensuring the continuation and sufficient extent of the activities.

Testing and treatment of sexually transmitted diseases

Communicable Diseases Act defines the actors involved in combating communicable diseases transmitted sexually.[11] The combating work involves prevention, early diagnosis and monitoring as well as the examination and treatment of a person who has a sexually transmitted disease or is suspected to have the disease. Ministry of Social Affairs and Health is in charge of the general planning, counselling and supervision of the work for combating communicable diseases and the National Institute for Health and Welfare acts as an expert organisation. Regional State Administrative Agencies are responsible for the planning, counselling and supervision of the work for combating communicable diseases in their operating areas. The counselling and expert support related to combating communicable diseases is realised at the regional level.

Municipalities are responsible for organising the work for combating communicable diseases in their areas as a part of public health work. The doctor treating the patient is responsible for referring a patient with a sexually transmitted disease and possibly others with the infection to examinations and treatment.

The early diagnosis and treatment of sexually transmitted diseases can be used to reduce the effects of the disease, suffering of the individual and costs to the society. Early diagnosis is also essential when aiming at preventing new infections. Efficient prevention and treatment require an opportunity for all for testing and counselling. Testing provides a good opportunity for discussing means for avoiding risk situations in the future. The examination and treatment of sexually transmitted diseases are provided free of charge in primary health care.

The Current Care Guidelines (Käypä hoito) recommendation for sexually transmitted diseases covers the diagnostics and treatment of the sexually transmitted diseases (chlamydia, gonorrhoea, genital herpes, condyloma, syphilis) of young people and adults generally treated in primary health care.[12] The objective is to standardise the diagnostics and care practices and to provide instructions for tracing the infection. Moreover, an expert group appointed by the National Institute for Health and Welfare has prepared guidelines for the examination and differentiation of the treatment of sexually transmitted diseases in the Helsinki metropolitan area.[13] The purpose of the guidelines is to clarify the division of duties in primary health care and specialised medical care. The treatment of those with an HIV infection has been centralised in specialised medical care. Best practices based on international evidence are followed in the treatment of HIV infections as there are no national recommendations. A separate recommendation has been issued on HIV testing.[14]

Syphilis, HIV and hepatitis B infections are screened in maternity clinics during the first trimester of pregnancy in compliance with a decree issued by the Ministry of Social Affairs and Health.[15] Participation is voluntary, but the number of those refusing to participate is very low. Children's infections can usually be prevented by providing medicinal care for mothers with syphilis and HIV infections and vaccinating children of hepatitis B carriers.

A central task of primary health care is to provide health counselling and diagnosing infections as early as possible. There is also a need for low-threshold testing and counselling facilities aimed at special groups,

which are easy to reach without having to book an appointment or fear of stigmatisation, and where the staff is equipped to take into account the special needs of each group.

Updating the national HIV strategy was one of the aims of the Government Programme (Appendix 3).[16] The HIV expert group led by the National Institute for Health and Welfare published its updated strategy in 2012.[2] This action programme supports the HIV strategy updated for the years 2013–2016. The objective of the HIV strategy is to reduce the number of new infections, to ensure that all HIV positive people receive treatment according to the recommendations, and to decrease the stigma and discrimination faced by those with the infection. The HIV strategy highlights problems related to HIV in Finland and presents measures for reducing these. Non-governmental organisations have long-standing experience in counselling, testing and support activities aiming at the prevention of HIV infections. They have a significant role in organising services and meeting key population groups.

Objectives

- Sexually transmitted infections and their consequences will be reduced.
- National awareness about protection against sexually transmitted diseases will be improved.
- Targeted services to different population groups will be arranged.
- An easy access to tests for sexually transmitted diseases, without a fear of stigmatisation, will be provided.
- Monitoring of sexually transmitted diseases and their background factors will be developed.
- Expertise on sexually transmitted diseases among health care actors will be improved.
- The coverage and focusing of chlamydia testing will be assessed.
- HPV immunisation coverage of 80% for girls will be reached.
- Prevention of sexually transmitted disease will be implemented in close cooperation between different actors.
- Reaching of the HIV strategy goals will be supported.

Actions

- Municipalities or joint municipal authorities will arrange low-threshold testing and counselling for special groups, including young people, immigrants, men with male sex, and sex workers.
- Municipalities or joint municipal authorities and organisations of the field will offer free condoms and lubricants to special groups.
- The Ministry for Foreign Affairs, the National Institute for Health and Welfare, health care professionals and organisations of the field will intensify health counselling about sexually transmitted diseases for travellers and provide information about sexually transmitted diseases, targeted at the whole population.
- The Finnish National Board of Education will ensure that teaching on sexually transmitted diseases will be included in the national core curriculum, beginning already from basic education level.
- Professionals of school and student health care, health education teachers and other teachers, as appropriated, will offer information about sexually transmitted diseases and protection against them to young people at earlier stage and more extensively as a part of general sexual and reproductive health education, taking account diversity of sexual orientation, gender identity and gender expression.
- Regional providers of sexual and reproductive health services will update testing, care and infection tracing practices to reflect the Current Care Guidelines (Käypä hoito) recommendations.
- Research institutes and higher education institutions will develop and evaluate new testing methods.
- The National Institute for Health and Welfare will collect national level information, based on the annual chlamydia samples, in order to assess the coverage and focusing of chlamydia testing.
- Municipalities, joint municipal authorities and actors responsible for regional sexual and reproductive health organisation will train specialists, familiar with venereal diseases, to work as responsible persons at health care sites.

- The National Institute for Health and Welfare will continue its intensified information campaign on the benefits versus risks of the HPV immunisation. The campaign is targeted at girls, their parents, teachers and school nurses through several different information channels.
- The National Institute for Health and Welfare will define factors possibly impairing HPV vaccine coverage and give instructions, when needed, for simplifying both vaccination and vaccination permission processes.
- The National Institute for Health and Welfare, other research institutes and higher education institutions will assess the need to include boys in the HPV vaccination programme.
- The National Institute for Health and Welfare, other research institutes and higher education institutions will take the advantage of the existing follow-up systems and national health and welfare studies to collect and analyse behavioural knowledge, related to sexually transmitted diseases.
- The National Institute for Health and Welfare, other research institutes and higher education institutions will implement studies, focused on population groups with a high venereal disease prevalence or vulnerability to these diseases.

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14 The connection between sexual and reproductive health and mental health

Sexual and reproductive health has an impact on mental well-being and its promotion may also possibly further mental health.[1] On the other hand, the promotion of mental well-being may also potentially further sexual and reproductive health.

Sexual and reproductive health and mental well-being

The most important interfaces between sexual and reproductive health and mental health are related to depression occurring at different stages of life, which is the single biggest individual health issue for women according to the WHO.[2] Women are 2–3 times more likely than men to suffer from depression and it has been estimated as the most common disease causing the lack of functional ability by the year 2020. The strong psychophysical strain related to pregnancy and delivery may also expose the parturient to the onset of other mental health disorders or the worsening of previous conditions. Postpartum psychoses are an example of such issues – a difficult delivery may be a traumatic experience. It is important to recognise post-traumatic stress disorder in women who have given birth, regardless of whether this has been caused by traumatisation at an early age and dissociative disorder or by giving birth. If untreated, the condition may hinder the early mother and child interaction and become chronic. When a mother is suffering from depression or when there are problems in the early interaction after a difficult delivery, if would be important to refer the mother to focused post-traumatic psychotherapy whenever possible.[3]

According to WHO, the shared problems of sexual and reproductive health and mental health are related to pregnancy, childbirth, family planning, menopause, gynaecological diseases such as cancers, sexual violence, HIV infections, involuntary childlessness and fertility treatments, and female circumcision.[4] All of these areas of sexual and reproductive health may include depressive and anxiety symptoms, sadness, mood switches or changes in the quality of life.

Less is known about mental symptoms during pregnancy than about postnatal depression, which is clearly more prevalent in the developing countries than in the developed countries due to the poorer social status of women. Mood symptoms are commonly related to sterilisation and the use of contraceptives, caused by the combined impact of factors related to the relationship and the used contraceptive methods.[4] According to a Finnish study, the use of hormonal contraception did not correlate with mental ill-health or depressive symptoms.[1]

In addition to grief, an induced abortion or spontaneous abortion may result in mental symptoms and depression, possibly even for a long period of time. According to studied based on Finnish data, the number of miscarriages correlated with mental symptoms or mental health disorders.[1] Among menopausal women, those with a history of depression had suffered from most mental symptoms.[4] Nevertheless, Finnish studies indicate that depression and anxiety symptoms are common among menopausal women, and that the use of hormone replacement therapy correlated with mental ill-health.[1,5] Gynaecological infections and cancers were often related to mental symptoms, which health care services should take into account. Involuntary childlessness may correlated with mental symptoms and increased use of intoxicant among men and women.[4,6,7] According to Finnish study, women suffering from eating disorders were at a more considerable risk for involuntary childlessness, miscarriages and induced abortions.[8] The mental health of children born as a result of fertility treatment should also be investigated as the currently available information on the topic is limited.[4]

Sexual and reproductive health as part of mental health promotion

A person's well-being is comprised of the well-being of the physical body, mind and social relationships. The prevention and treatment of mental health problems must address the prevention of stigmas and availability of services.[2,9] In addition to preventing mental health issues, promotion of mental well-being as

a part of citizen skills is also important. Sexuality and mental health questions are both issues whose treatment requires professionals to show sensitivity and courage in bringing up the topic. In work with clients, mental health must be highlighted as an equally important and as easily approachable issue as physical health.

Awareness should be increased on the stages in the life-course posing challenges to mental well-being. [9] Psychosocial development crises, events related to reproduction, crises in the relationship as well as falling ill and becoming a widow may be challenging stages. For example, supporting family life and parenthood as well as mental well-being during pregnancy and after delivery promote supporting mental health. Involving the client's loved ones in the support and treatment of sexuality and mental health is also worth remembering.

Development in puberty is fast and changes are big.[10,11] In order to promote the well-being of young minds, it is important that there is cooperation between the professionals from different fields, the young people and their parents as well as understanding on the holistic support of the young person in the services for children and adolescents.[9,11] Supporting sexual development is also central to the services for children and young people. It must be ensured that children and young people receive information and support. There is literature available for professionals in youth work where sexuality is dealt with as a resource.[10] At schools, sexuality education is a part of the shared tasks of teachers, the entire pupil welfare services and parents.

Sexual well-being should always also be discussed in relation to falling ill or treating some other crisis. The promotion and support of mental health should be included in all sexual and reproductive health programmes and operations. Problems and difficulties in intimate and sexual relationships may unsettle one's mental well-being, and therefore broaching the topic of sexuality should also be included in health examinations in appropriate parts. Clients must also be able to gain access to sexual and couples counselling at a sufficiently early stage so that the family's coping with separation crises could be promoted. Detecting risk factors and other mental well-being challenges in relationships should be improved. In particular, men requiring help should gain access to the sphere of mental health work more efficiently by increasing multidisciplinary cooperation in order to prevent separation crises to result in homicide or other destructive deeds.

Services must be provided for everyone regardless of their other health status, sexual orientation, ethnic background, gender identity or gender expression.[2,13] The planning and implementation of mental health services should also more comprehensively take into account the special needs of immigrants as they are at a notable risk for depression and post-traumatic stress disorder. The Maamu Study of the National Institute for Health and Welfare reported that the prevalence of depression and anxiety symptoms was notably higher among the women with Kurdish and Russian backgrounds than the entire population.[12] Furthermore, those belonging to sexual and gender minorities should also gain access to the sphere of mental health services more efficiently, as they suffer from mental health issues and psychological symptoms, such as self-destructive behaviour and eating disorders more frequently than other groups.[13] All involved in providing basic services must cooperate both in organising services as well as in providing information about these. Services promoting mental health as a part of the entity of sexual and reproductive health should also be taken into account in the local government and service reform.

There should be an increase in training on mental health issues for sexologists, and education on sexology for mental health professionals. Bringing up the questions of sexual and reproductive health and mental well-being is a natural part of finding out about the background information of a client or patient. The mental health perspective must also be included in the material provided for clients or patients on sexual and reproductive health.

Objectives

- The meaning of sexual and reproductive health to mental health, mental health disorders and their prevention will be identified in all sexual and reproductive health research and care.
- The meaning of sexual and reproductive health to mental well-being will be identified in the mental health care system, and sexual and reproductive health services and their availability will be developed.
- Mental health care professionals will have expertise to meet and support people belonging to sexual and gender minorities or coming from different cultures.
- Professionals within sexual and reproductive health services will have expertise on mental health issues related to different age, development and life phases as well as skills to meet mental health care clients.
- The meaning of sexual and reproductive health to mental health will be a part of continuing education of mental health sector professionals, and the meaning of mental health to sexual and reproductive health will be a part of continuing education of sexual and reproductive health professionals.

Actions

- Universities of applied sciences and regional actors responsible for continuing education will increase continuing and further education, targeted at mental health care professionals, on sexual and reproductive health, broaching of sexuality issues, diversity of sexual orientation, gender identity and gender expression, and meeting clients belonging to sexual and gender minorities. Supervisors will enable professionals to participate in the education.
- The Finnish National Board of Education, the Ministry of Education and Culture, higher education institutions and other actors responsible for professional training and its contents for those working in social and health care, early childhood education, pre-primary and basic education sectors will ensure that basic training of those working with children, young and elderly people includes information on connections between sexual and reproductive health and mental health in different age phases. Universities of applied sciences and actors responsible for continuing education will increase knowledge on connections between sexual and reproductive health and mental health in different age phases in continuing and further education. Supervisors will enable professionals to participate in the further education.
- The Finnish National Board of Education, the Ministry of Education and Culture, higher education institutions and other actors responsible for training and its contents for professionals from different fields will ensure that the basic professional training includes information on sexual and reproductive health and mental health and their connections in different cultures. Universities for applied sciences and actors responsible for continuing education will increase these contents in the continuing education for professionals (see also chapter 6 Multiculturalism).
- Public sector and organisations will enhance communications and cooperation in issues related to mental health and sexual and reproductive health.

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15 Sexually offensive violence

Sexually offensive violence is usually referred to with the concepts 'sexual violence' and 'sexual abuse'. These concepts indicate that violence would be a sexual experience, which it is not from the viewpoint of the victim. It is a matter of an offence to sexual autonomy and integrity, which traumatises the victim. Therefore, this action programme recommends using, and uses when appropriate, the concepts of 'sexually offensive violence and mistreatment'. The Criminal Code of Finland[1] includes a number of terms for sexually offensive violence. This action programme uses the concept of sexual violence when referring to the Criminal Code.

The prevalence of violence in different population groups

All close personal relationships may include violence regardless of the persons' gender, age, sexual orientation or type of relationship. According to an estimate by the WHO, violence manifested in relationships often also includes sexually offensive violence and words or acts.[2] According to an EU-wide study, 47 per cent of Finnish women have experienced physical violence or sexually offensive violence, while the European average is 22 per cent.[3] In addition to intimate partner or domestic violence, sexually offensive violence can also occur in other close personal relationships. The person committing the violence may also be some other acquaintance or a total stranger to the victim. The forms of sexually offensive violence include, e.g., sexual disturbance, harassment, name-calling, unwanted physical advances and rape. Sexually offensive violence also takes place online.

Violence related to cultural tradition

Violence or a thread of violence based on cultural differences may be related to some immigrant backgrounds.[4] The nature of this violence often threatens sexual health and rights, for example, honour-based violence, forced marriages and circumcisions. Honour-based violence is generally linked to the modesty of girls and women, but may also concern boys and men. In a forced marriage, one (or both) of the spouses has not been allowed to have a say on getting married or to choose the partner in marriage without a thread or pressure from his or her family or relatives, or in which he or she has agreed to get married under pressure in fear of physical or mental violence. A forced marriage can concern both girls and boys. For example, there is an action plan in Norway against forced marriage and female genital mutilation.[5] The personal history of those with a refugee background may also include experiences of torture, which often also include sexually offensive violence for both men and women.

Female genital mutilation (FGM), or the circumcision of women and girls, is one form of violence against women. It is globally considered a practice that violates the human rights of girls and women. Like other forms of violence, it is an attack against the dignity, equality and integrity of girls and women.[6] As a result of international migration, girls and women who have been circumcised or are under the threat of being circumcised are living all over the world. In the Maamu Study, 70 per cent of women of Somali and 32 per cent of the women of Kurdish origin living in Finland reported being circumcised.[7]

Non-medical circumcisions of boys (see chapter 6 Multiculturalism) has not been perceived as violence and has thus far not been banned in any country. Nevertheless, it offends the child's personal integrity and self-determination. All unnecessary surgical procedures should be avoided. According to the Finnish League for Human Rights, boys' non-medical circumcisions should be approached specifically from the human rights perspective.[8]

Children and adolescents

It continues to be difficult to obtain an overall image of the prevalence of sexually offensive violence, as the violence often remains hidden. Violence and particularly sexually offensive violence is an issue causing significant amounts of shame. Some might find it difficult to talk about sexuality. The underaged people who have fallen victim to sexually offensive violence are often unable to recognise the violence and are

incapable or afraid to talk about their experiences with anyone.[9] The lack of natural vocabulary in the everyday language of children and young people make it more difficult for them to seek help.[10] Young people in sexual and gender minorities often find it difficult to tell about abuse and experiences of violence, as speaking out would require the person to reveal his or her identity to an adult, which is often not an easy task for the young person.[11]

According to the Convention of the Rights of the Child, the child has the right to be heard (Article 12) and the right to protection from information and material injurious to his or her well-being (Article 17). [12] The child must be protected from all forms of violence, injury or abuse (Article 19) as well as from sexual abuse (Article 34).

According to a report by the National Research Institute of Legal Policy, the rate of sexual abuse of children has remained relatively stable for the past two decades, and the number of more severe cases has decreased.[13] However, sex offences are more and more likely to be recorded by the authorities. The number of acts recorded by statistics has doubled during the last decade. A total of 1567 cases of sexual abuse of children were registered in 2012 (table 4).

***Table 4**. Sex offences in Finland in 2007–2012*.[13]

Sex offences	2007	2008	2009	2010	2011	2012
Rape, aggravated rape, coercion into sexual intercourse (Criminal Code 20:1–3)	739	915	660	818	1039	1009
Sexual abuse of a child (Criminal Code 20:6–7)	1025	1321	1068	1102	1682	1567
Other sex offences (Criminal Code 20:4–5, 8–9)	562	670	477	497	531	935

Harassment and sexually offensive violence occur frequently in the everyday lives of young people. Out of 8th and 9th grade pupils in comprehensive school and those on 1st and 2nd year of vocational and upper secondary school education, 60 per cent of girls and 33–46 per cent of boys had experienced sexual harassment, i.e., disturbing sexual propositions, harassment or sexually offensive name-calling, with slight variance between the grade levels.[14] Over one fifth of girls, and as many as one third of girls in vocational education, had experienced sexually offensive violence, i.e., being pressured or coerced to have sexual intercourse or participate in some other sexual activity, being offered money, objects or intoxicants in return for sex, or being touched in intimate areas against the person's will. Around one in ten of boys had experienced sexually offensive violence.

According to the Self-reported Juvenile Delinquency 2012 report, 9 per cent of young people had experienced sexual harassment during the previous year.[15] 41 per cent of the most recent incidents had involved the offender persuading the young person to partake in sexual behaviour. The offender pressured the young person in 13 per cent, used physical violence in 10 per cent and gave money or some other reward in return for sex to the young person in 6 per cent of the cases.

Over one fifth of young people in grade 9 with prior sexual activities with an adult over five years older than him or her had experienced sexual abuse.[16] The young people found it hard to talk about this with others, but some had nevertheless told someone close to them or a professional about the experience. Recognising early sexual activity as a risk for abuse helps nursing staff to develop operating models for the recognition and help of youths at risk.

Special needs groups and groups at risk

The sexual and gender minority youths (lesbian, gay, bisexual, and transgender, i.e., LGBT youths) who had experienced sexual harassment estimated that telling someone about the experience would not lead to repercussions.[11] The young people faced most harassment related to gender or sexual orientation at school. Girls who develop early are particularly likely to be exposed to sexual abuse and violence, and should be

provided with sexuality education corresponding to their development stage and also taking into account the viewpoints of self-protection at a sufficiently early stage.[17]

The gender of an intersex person cannot be unequivocally determined based on gender features. An intersex person may have characteristics from both genders or have unclear sexual characteristics. Around 10 intersex children are annually born in Finland. Gender assignment surgery is irreversible, and can be considered a form of sexually offensive violence, as the decision on the gender is made before the child has determined a gender identity for himself or herself.

Sexually offensive violence is targeted more frequently to disabled girls and women, and it takes more forms and lasts for a longer time than the violence experienced by able-bodied women.[18] The woman's age, type of disability, severity of disability, need for support and living environment as well as access to services affect the risk for becoming a victim of sexually offensive violence. The risk is particularly high for disabled women and girls as well as those with developmental disability, mental illnesses or major difficulties in communication or who live in large housing units and institutional circumstances.[18,19]

Both disabled women and men might face sexually offensive violence. According to an American study, nearly 27 per cent of disabled women and nearly 14 per cent of disabled men had experienced sexually offensive violence, while the rates among able-bodied persons were 14 and 4 per cent respectively.[20]

Disabled persons are also made more vulnerable by attitudes in the society, which creates a perception of them as defenceless and non-sexual beings. Disabled persons have also often received insufficient information about their rights and sexuality.[21] They may also fear no longer being able to live independently if they report sexually offensive violence.[22] There is not enough research knowledge on the violence experienced by disabled people and the use of safety and support services of those who have experienced violence.[23]

Sex workers are often in a particularly vulnerable position, as they do not necessarily trust the help of the authorities.[24] Violence or the thread of violence may be related to sex work and procurement and the related human trafficking. The legal system may not recognise the violence and threat of violence against prostitutes, and thus prostitutes may not be perceived as the victims of violence or other crime; instead, violence is perceived as a normal part of prostitution and procurement of women.[25]

Impacts of violence

Sexually offensive violence can cause post-traumatic stress syndrome, which may occur either immediately after the incident or after a delay. The situation may cause a crisis months or even years after the offence.[26] Sexually offensive violence includes cognitive, emotional and neurophysiological impacts, which expose the victim to mental health problems and may be manifested as diverse mental and somatic symptoms, such as depression, states of fear (e.g., fear of childbirth), self-destructive behaviour, chances in the ability to concentrate, avoidance behaviour, decrease in functional capacity, underachievement and changes in sexuality.[27–30]

Female circumcision causes numerous health hazards which vary due to reasons such as the method and extent of the procedure and the prevailing circumstances for it. The immediate health hazards include pain, bleeding, infections, difficulty to urinate and psychological problems.[31] The long-term health hazards include severe menstrual cramps, pain during intercourse, further complications caused by scarring, problems with urination and psychological issues. In addition, repercussions related to childbirth can involve fear of childbirth, difficulty to monitor the progress of labour and the condition of the foetus, unnecessary Caesarean sections, and psychological issues.

Genital reconstructive surgery performed on intersex children can cause pain, numbness and lack of sexual pleasure later in life. The gender assigned to a young intersex child may differ from his or her later gender experience.[32] Reconstructive surgery performed at an overly early stage is a violation of the child's bodily autonomy.

Prevention and treatment

The prevention and treatment of sexually offensive violence also includes matters concerned with the support for and the legal protection of the victim. The occurrence of long-term hazards resulting from sexually offensive violence or abuse is prevented by recognising the violence as early on as possible. Systematic screenings can be used to influence referring those who have experienced violence in close personal relationships to treatment and the prevention of violence. Only half of health centres had recorded shared practices for recognising situations where intimate partner or domestic violence was suspected and identifying sexual abuse of children.[33]

Prior experiences of sexual abuse or sexually offensive violence do not necessarily come up in health care appointment situations unless these are separately asked about. There is a need in health care for the recognition of these kinds of situations and for skills in subtly broaching the topic of violence and abuse, as the client may also be personally unable to see the connection between his or her experiences and symptoms.[34] In fact, everyone should be asked about their experiences of violence, including members of special groups.

Policies on the prevention of violence

An objective in the Government Programme of 2011 was securing an unbroken treatment chain for victims of sexually offensive violence, increasing shelters for victims and paying attention to a more regionally balanced distribution of such places.[35] Improving cooperation between the police and social services in connection with house calls concerning domestic violence was also proposed.

The cross-administrative National Action Plan to Reduce Violence against Women 2010–2015 aimed to intervene with violence in a preventative manner by influencing attitudes and behavioural patterns, prevent repeated acts of violence, improve the status of and crisis help and support for the victims of sexually offensive violence, develop means for recognising and intervening with the violence against those in a vulnerable position, and increase the knowledge and skills of authorities and professionals.[24] The programme included developing material to support safety education, teaching sexual rights and safety skills, improving the legal status of the victims, increasing the services for the victims, as well as providing training on decreasing violence against women for those liable for non-military service and receiving basic training in the Finnish Defence Forces. The organisations of both new immigrants as well as the traditional ethnic minorities, such as the Roma and Sami population, are instructed to provide information on violence against women and services in Finland. As a part of this programme, national recommendations on the quality of the services for shelters were prepared in the National Institute for Health and Welfare.[36]

Other key measures of the National Action Plan to Reduce Violence against Women also included developing the legislation on sexual crimes (such as procurement and human trafficking), processing sexual crimes in criminal proceedings as well as providing training for the authorities on the violations of justice occurring in connection to prostitution, procurement and human trafficking.[24] A report on developing gender sensitive youth work will be compiled in 2014–2015. The aim is to acquire research knowledge on the prevalence and forms of the violence experienced by sexual and gender minorities, the causes and prevention of gendered violence, the support needed by victims as well as the close relationship and domestic violence experienced by ethnic minorities. The Ministry of Social Affairs and Health, the Ministry of Interior and universities have been determined as the responsible actors.

A Safer Tomorrow[37] is the third programme for internal security approved by the Finnish Government. The purpose of the programme is to prevent sexual harassment and sexual crimes against children and young people, create a network coordinating the distribution of information on the violence against children and young people and its prevention for young people, their parents and those working with the young people, and to give recommendations on the provision of basic information on human rights education for all students in teacher training, teachers and the educators of teachers.

It will be established in the programme what legislative amendments are required to enable telecommunications interception in order to prevent and investigate the sexual abuse of children, and what amendments are required to enable telecommunications monitoring in order to prevent and investigate the offence described in chapter 20, section 8b of the Criminal Code[1] (‘grooming’). New provisions on tracing

sexual crimes committed against children online will be adopted at the beginning of the year 2014. The legislative amendments required will be proposed in line with the results of the assessment. The programme will be implemented by preparing a youth work strategy to the internet and by increasing the presence and multiprofessional cooperation of the authorities online while taking into account outreaching youth work.

Recognition of violence and treatment of victims

A chapter in the maternity clinic guide on additional monitoring of pregnant women and their families in special situations[38] instructs health care professionals to ask about violence in maternity clinics from both parents (to-be) so that one of them is not present, and to refer the clients to further measures when necessary. Extensive health examinations conducted in child health clinics and school health care also involve screening for domestic violence.[39] Asking about violence in the presence of the presumed perpetrator is a safety hazard for the victim, and therefore it is extremely challenging to uncover violence experienced by children in the extensive health examinations. Therefore, situations or moments should also be arranged in the examinations in which the child or the adult gets to spend time alone with the public health nurse. Unit-specific forms are in use in student health care, but practices for asking about violence vary.[40] In the 21st century, studies and guidelines on the research and treatment of sexual abuse experienced by children in their families have been completed in Finland.[41, 42] The current Child Welfare Act[43] has clarified the obligation of the authorities for filing a child welfare notification and increased the number of those subject to notification duty.

The Handbook of Child Welfare[44], Handbook for doctors[45] and the Current Care Guidelines (Käypä hoito) [46] recommendation include information about recognising and treating child abuse, care pathways and child welfare measures. The Kasvun kumppanit website of the National Institute for Health and Welfare includes a section on the prevention of intimate partner and domestic violence and a coordinator's job description model, which contains practical instructions and suggestions for the prevention of violence and a model for a coordinator's job description.[47]

The victimisation of disabled people can be prevented by providing them with information about sexuality in an accessible, positive and understandable manner.[48] Sexuality education helps a person to perceive the issues that are a normal part of sex and those that are a matter of sexually offensive violence and violations of autonomy. Violence or abuse is likely to be revealed more easily and at an earlier stage when the person has trustworthy and safe relationships with other people. The information about available accessible services also makes it easier for disabled people to seek the services and intervene in the violence. Accessible transportation and shelters also make it easier to get help.[36, 49]

In an acute situation, the victim of sexually offensive violence or abuse is in need of an appropriate forensic medical examination, counselling related to his or her legal protection and psychosocial support measures. In order to process the caused trauma, the person needs expert diagnostics, professional support and, in some cases, long-term therapy.[26] The RAP Help for a rape victim[50] and the two-year national violence prevention programme for the years 2007–2008 have been used to develop, improve and provide guidelines for the services related to the treatment of those who have experienced violence.[51] Services have been developed alongside the emergency care services in hospitals and health centres where the victim of sexually offensive violence can obtain services at the acute stage and appropriate medical and psychosocial treatment. Examples of these services include the treatment pathway for the rape victim of Southwest Finland Hospital District and the joint sexual violence prevention work group of the City of Turku and third-sector actors, as well as the RAISEK morel of the city of Jyväskylä. Regardless of these development activities, there is notable variance in obtaining help and the quality of the received help.

Emergency telephone consultation help from professional can be obtained, e.g., from Rape crisis centre Tukinainen, the University of Helsinki's Department of Forensic Medicine and some local police stations. Federation of Mother and Child Homes and Shelters is a national child protection organisation which aims to support children and families living in difficult and unsafe conditions and to prevent domestic and close personal relationship violence. The organisation has 12 centres around the country and also provides outpatient services.[52]

Prevention, recognition and treatment approaches

The National Institute for Health and Welfare implemented the 'Mun Kroppa. Mä päätän' ('My Body. My choice') campaign aimed at 15–17-year-old adolescents in cooperation with the Ministry of Social Affairs and Health, the Ministry of Interior, the police and a number of non-governmental organisations and communities as well as the students of the Visual Arts School of Helsinki upper secondary school.[53] The campaign emphasised the sexual self-determination of young people and encouraged young people to define their own limits, recognise threatening situations and talk about violations to their rights. The campaign also produced support material for parents and other adults working with the young people.

The purpose of the national website of the Family Federation of Finland is to support young people under 20 years of age in matters related to sexual health, also including issues related to sexual rights and sexual abuse. The Poikien Puhelin helpline for boys of the Family Federation of Finland also receives a lot of questions on sexually offensive violence. The Rajat association provides training for professionals on encountering and treating the sexually offensive violence experienced by men (http://www.rajat.fi/). Victim Support Finland provides services for young crime victims (http://nuoret.riku.fi/).

Rape crisis centre Tukinainen provides help, counselling and guidance on matters regarding sexually offensive violence. It works in Helsinki and Jyväskylä and also provides services nationally through its networks (e.g., Nettitukinainen). The Tyttöjen Talo® ('Girls' House') partnership house for gender sensitive girl work is a service maintained by Kalliola Youth association, Settlement Youth Federation and the youth department activities of different cities (Helsinki, Turku, Tampere and Oulu) supporting girls and young women in special issues related to growth and development, also those who have experienced intimate relationship violence or sexually offensive violence.

Kalliola Youth association maintains the e-Talo ('e-House'), a gender sensitive low-threshold help service for 10–28-year-olds (www.e-talo.fi). In 2012, 23 per cent of the customers of Victim Support Finland were victims of sexually offensive violence. Victim Support Finland provides national telephone and online services and support person activities for crime victims, persons close to them and witnesses of criminal acts and support person activities in 29 service points.

Sexually offensive violence experienced by boys and men is an even less talked about issue than that faced by women. It is even more difficult to reach male victims to within the sphere of help without services aimed particularly at boys and men. Boy's House is a four-year (2011–2014) development project of the Kalliola Youth association aimed at 10–28-year-old boys and young men at a particular peril for social exclusion.[54] The low-threshold activities of the Boy's House are used to carry out conductive and stabilising counselling work to help the boys and young men who have experienced sexual abuse and violence and to support the psychosocial growth and development of holistic gender identity for the boys and young men.

In Turku, there are professionally guided peer support groups for young people and adults who have experienced sexually offensive violence, and there is a practice in place in the Hospital District of Southwest Finland, in connection to the treatment received by clients in an acute situation, that entails asking clients who have experienced violence for a permit to submit their contact information to Victim Support Finland, which will contact the client.[55] The Nuorten Exit ('Youth EXIT') project aims to prevent sexual harassment, proposition, attempts to purchase sex and purchase of sex targeting young people by providing information for young people on their rights and the approaches used by adult abusers, for example, by meeting the young people around cities and at schools as well as by conducting outreaching work online and intervening with the detected abusive action towards young people.[56] The Youth EXIT - EXIT prostitution coordinates the project. In addition to the victim of violence, those closest to him or her may also need support.

The Mediaeducation.fi website contains the Suojele minua kaikelta ('Protect me from everything') material and information for professionals working with and for children on how child may be exposed to sexual abuse via the internet and media. Among others, the Ministry of Justice, the Ministry of Transport and Communications, Helsinki Police Department and several organisations have participated in producing the material. The Transgender Support Center of Seta ry provides psychosocial services for intersex and transgendered persons and those close to them.

Even though respecting the client's culture is one of the essential principles of the work conducted with immigrants, violence must not be justified as a part of the culture. Multicultural Women's Association, Monika helps the immigrant women who have been the victims of violence and acts to prevent violence (http://www.monikanaiset.fi). The association has published support material for helping immigrants aimed at the social and health sector.[57]

The purpose of the Action plan for the prevention of circumcision of girls and women is to create permanent national and regional structures to prevent female circumcision.[58] A further purpose of the Action Plan is to achieve more effective cooperation, a clearer division of duties and better coordination between various authorities and other actors. At the same time, Finland fulfils its international commitments regarding the promotion of the human rights of women and children and the prevention of violence against women. The main objectives of the national Action Plan are to prevent circumcision of girls in Finland and to improve the welfare and life quality of circumcised women. KokoNainen / The Whole Woman project of the Finnish League for Human Rights has been operating since 2002.[6] The project involves working among immigrant communities and has included training professional staff and producing material for national use, including 'Female circumcision in Finland. Recommendations of an expert work group for social and welfare staff.' (in Finnish)

Intersex persons must always have the right to personally decide whether or not to have genital reconstructive surgery in cases where there are no health problems related to being intersex.[59] Intersex must be approved alongside the male and female gender and added as an alternative in the medical birth register and population register. This will accomplish reducing the pressure for a surgical intervention for an intersex child. Possible surgical procedures can be performed once the person himself or herself knows what kind of reconstructive procedures he or she wants.

The requirement of infertility or unmarried status of transgender persons set for gender reassignment surgery violate the right for bodily integrity and family life of persons correcting their gender. Council of Europe Commissioner for Human Rights has requested for Finland to remove these requirements.[60] The Ministry of Social Affairs and Health has appointed a working group for amending the Act on the Legal Recognition of the Gender of Transsexuals.[61]

The Centre for Torture Survivors operating in connection to the Helsinki Deaconess Institute is specialised in taking care of situations related to torture.[62] The SOS Crisis Centre of the Finnish Association for Mental Health also provides special services for immigrants.[63]

Since 1998, a programme aimed at sex offenders based on the English Sex Offender Treatment Programme: Core Programme model, referred to in Finland with the abbreviation STOP, has been in use in correctional treatment.[64] Offenders from all prisons in Finland may apply to the STOP programme, which is implemented in the Riihimäki Prison located in the Criminal Sanctions Region of Southern Finland. The purpose of this programme is to increase the offender's awareness of the causes that have led him or her to commit the sexual offence and how he or she can lead a life without crime in the future. The results from the follow-up of those who took part in the SOP programme have been promising, but more research evidence is needed on the effectiveness of the programme. By September 2012, 200 prisoners had participated in the programme, out of whom 180 had been released. Six of them had been re-convicted of a sexual offence.

Objective 1

- Those experienced sexually offensive violence will be provided with an appropriate examination and care, irrespective of their location, economic class, age, ethnicity, disability, sexual orientation, gender identity or gender expression.

Actions

- Each municipality will appoint a responsible person and draw up a plan for sexually offensive violence prevention and development of this work.

- Social and health care professionals within all social and health care services will provide information on support and help, available to those experienced sexually offensive violence and mistreatment, and direct the clients to respective services.
- Municipalities or joint municipal authorities will develop cost-free and easy accessible (so called low-threshold) public basic services, taking account the special needs of young people and men in particular.
- Municipalities or joint municipal authorities, school and student health care, the Finnish Student Health Service, the National Institute for Health and Welfare and media will clearly inform the population about the importance of early examination and treatment seeking in sexually offensive violence examinations and care work, and available services.
- Homes, professionals in early childhood education, school, social and health care sectors, and organisations of the field will provide children and adolescents with emotional and safety skills training, in order that they have better abilities to identify sexually offensive violence and mistreatment, have courage and ability to tell about it and get the help they need.
- Social and health care professionals will identify needs for psychosocial support among closely related of intersex and transsexual people and refer them to appropriate services.
- Various financing actors will understand the role of the third sector in sexually offensive violence prevention and in treatment of the victims, and will secure continuity of the third sector services.

Objective 2

- Holistic, immediate examination, care, and crisis support offered to those experienced sexually offensive violence at the acute stage will be improved and long-term care and psychosocial support for the victims will be developed.

Actions

- Each municipality will appoint a responsible person and draw up a plan on development of treatment and support for victims of sexually offensive violence.
- Local and regional responsible actors will develop treatment paths and chains for victims of sexual violence and organise acute phase examination and care (including sample collection and storage), unifying regional treatment practices and clearly instructing cases of suspected intimate partner violence or any other close relationship violence.
- Primary health care, specialised care and the third sector will increase and establish cooperation in the fields of violence recognition and prevention and victims' treatment.
- The National Institute for Health and Welfare and regional responsible actors will inform all social and health care professionals about the RAP-folder (Help for a rape victim). Local actors will ensure that the folder is available in all emergency units.
- The third sector will establish and maintain professionally led peer support groups.
- Local and regional responsible actors will plan actions aimed at violence reducing, together with the young who have seen or experienced sexually offensive violence or harassment.

Objective 3

- Permanent national and regional structures will be created to prevent female circumcision and improve well-being and life quality of those already circumcised.

Actions

- The National Institute for Health and Welfare will produce material on female circumcision through its website and a brochure for professionals and communicate information in national, regional and local training events.

- Professionals in social and health care, early childhood education and teaching sectors will broach female circumcision with the clients coming from the regions where girls and women are circumcised.
- Professionals in social and health care, early childhood education and teaching sectors will prevent female circumcision according to their duties. • When broaching the issue, they will highlight the human right view and health risks, caused by the procedure. • In addition, they will tell that a girl's circumcision is a crime in Finland, and thus a punishable deed for those performing a circumcision and for those in some way involved in it or incited to perform it.
- Regional actors responsible for social and health care services will draw up action instructions and care paths for cases where a threat for a girl's circumcision exists or the procedure has already done.
- The Ministry of Social Affairs and Health and the National Institute for Health and Welfare will arrange annual seminars in order to communicate information and maintain a network for key contact persons of various actors.
- The Finnish National Board of Education, the Ministry of Education and Culture and higher education institutions will include female circumcision as a one item in basic, continuing and further education of different professional groups. Universities of applied sciences and universities will prepare entities, applicable for teaching.
- The National Institute for Health and Welfare and the Finnish National Board of Education will arrange continuing education or information package on female circumcision for basic education teachers and early childhood educators, especially for those working with immigrant children. Supervisors and leading office holders will enable their employees to participate in advanced, further and/or continuing education, handling a female circumcision subject.

Objective 4

- Sexually offensive violence and mistreatment will be recognised more effectively than before, and more systematic information will be collected about their prevalence.

Actions

- Professionals will systematically broach violence within social and health care services, particularly at child health clinics and in school and student health care as well as within services for the disabled and elderly, using questions developed specifically for these groups.
- Research institutes and higher education institutions will produce information on sexual harassment and sexually offensive violence, targeted at sexual and gender minorities and the disabled and applying to ethnic groups.
- The National Institute for Health and Welfare and actors responsible for organising local and regional services will hear sexual and gender minorities and special groups, and take them to participate in development of sexually offensive violence prevention work.
- Research institutes and higher education institutions will add sexual and gender identity issues to the regular welfare surveys, implemented at the national level.

Objective 5

- Professional skills and networking in social, health and education fields will be developed through municipal-specific solutions and local models for violence recognition and prevention will be created.

Actions

- Higher education institutions and other educating actors will increase continuing training for sexual counsellors, working with victims of violence.
- The Ministry of Education and Culture, the Finnish National Board of Education, universities of applied sciences and universities will ensure that issues of sexually offensive violence and mistreatment are included in the mandatory studies of professional training (in health, social, educational, teaching and youth work).
- Employers will take charge of continuing training and supervision of work for employees who at their work encounter children, adolescents or adults, experienced sexually offensive violence.
- Universities will intensify training on forensic medical examination of those experienced sexually offensive violence in medical basic and further education for physicians.
- Educating actors will exploit the experience on research, care and support of violence victims, accrued in the third sector services.
- In youth work, municipalities and joint municipal authorities will promote educational work, aimed at prevention and reduction of violence, and develop material on domestic and sexually offensive violence for young people.

Objective 6

- Legal protection of victims of sexually offensive violence or mistreatment will be developed.

Actions

- The Ministry of Justice and the Ministry of Social Affairs and Health will develop legislation related to sexually offensive violence and mistreatment.
- The Ministry of Justice will start legislative work, related to the sterilisation of those seeking gender reassignment and to genital surgery of intersex children.
- Professionals inform sexually offensive violence victims on their legal protection, including a possibility to have a cost-free trial counsel and a support person from Victim Support Finland (Rikosuhripäivystys) during legal process.
- Professionals, working in emergency units, will ensure that those units are able to carry out appropriate forensic medical examinations and store samples. Victims of sexually offensive violence will be informed on their right to a forensic medical examination, whether the crime is reported or not.
- The Ministry of Interior and the Ministry of Social Affairs and Health will work out how the implemented law reforms have impacted on the reports of an offence done by social authorities on violence against children.

Objective 7

- Sex offenders' treatment and access to care will be improved.

Actions

- The Ministry of Justice and the Criminal Sanctions Agency will continue the STOP programme, aiming at reducing the risk of sexual offenders to commit a new crime, and develop further rehabilitation programmes for outpatients.
- The Ministry of Justice, the Ministry of Social Affairs and Health and the Ministry of Interior will develop the national centralisation of the treatment for minors who have committed sex offences or sexually offensive deeds.

Non-violence education

School legislation introduced in 2003 reinforced the implementation of work to prevent violence and harassment.[65] The possibility of discussing topics associated with safety and violence in the context of different subjects and thematic entities was added to the curricula for basic education, general upper secondary education and vocational education and training. Examples of these topics are consideration for other people, tolerance, respecting physical and psychological integrity and human rights. In the requirements of the vocational upper secondary qualification in social and health care, the vocational skills requirements of the qualification units have been reviewed, and they now also include updated learning outcomes related to recognising intimate partner or domestic violence, bringing it up and directing clients to further treatment.

The themes of preventing and finding help for sexually offensive violence and harassment, violations of the right to self-determination as well as intimate partner and domestic violence are part of the learning outcomes and contents of the subject of health education as well as the materials prepared to support it, and they are introduced from early childhood education and care on. The Non-Discrimination Act also obliges educational institutions to prevent and intervene in sexual harassment and gender-based discrimination. In a guide published by the Finnish National Agency for Education, educational institutions are urged to pay particular attention to preventing sexual harassment when preparing their equality plans.[66] Support material associated with the pupil and student welfare guide was prepared in cooperation between the Finnish National Agency for Education and the National Institute for Health and Welfare.[67]

Measures for preventing violence can be divided into three categories according to their target group (Table 5). General measures target entire groups or the population at large, including courses at educational institutions intended for all pupils or students, or media campaigns directed at children of a certain age in the entire community. Selected measures are targeted at the presumed high-risk groups: measures aiming to prevent female circumcision, for example, are addressed to those concerned by this tradition. Measures intended for interested parties are targeted at those who have already become victims of violence in order to prevent re-victimisation, or at perpetrators of violence to intervene in violent behaviour, with direction to treatment as an example.[2]

***Table 5**. Measures for preventing violence, adapted from WHO report[2], Bildjuschkin & Raussi-Lehto.*

	General measures	Selected measures	Measures for interested parties
Target	Population, entire groups	High-risk groups	Those who have encountered violence
			Perpetrators of violence
	Courses, campaigns	Attitude education	Safety skills
			Psychological support, Direction to treatment
			Intervention in violent behaviour

The programme on reducing violence against women contains measures for preventing violence at all levels (see above). The Safety skills for children material68 is directed at lower comprehensive pupils, whereas the Safety skills for young people guide 48 is intended for teachers, social workers and public health nurses at higher comprehensive schools and secondary education institutions.

They contain comprehensive information about key phenomena, including sexual violence, sexual harassment and dating violence. The Finnish National Agency for Education has participated in preparing the guide and spreading it to educational institutions. The teaching of safety skills promotes the inclusion of

safety education contents in the basic and continuing education of pupil and student health care personnel, school social workers and psychologists, teachers and early childhood education and care personnel (kindergarten teachers, child-minders, practical nurses).

Objectives

- Safety skill education will be provided to children under school age at pre-school at latest. Violence prevention will be a part of all sexuality education.
- Children and young people will know their sexual rights, they will able to protect their rights, respect for others' rights and recognise violent treatment and abuse.
- Information on safety skills and sexual rights will be given to parents of children and adolescents.
- Professionals within health care, social affairs and education affairs will have skills to teach non-violent behaviour and early interference, particularly prevention of sexually offensive bullying and harassment.
- Children and adolescents will be protected from contents that are violent and harmful to sexual health in the media and entertainment culture, e.g., by establishing the age of consent.
- Anti-violent and sexually safe atmosphere in school and student communities and at work places will be supported.

Actions

- Professionals in early childhood education, pre-primary education and basic education will write non-violence education as a target into programmes on teaching of safety and good relationships and include violence prevention in all sexual health education programmes.
- Professionals in early childhood education, pre-primary education and basic education will further develop non-violence education, including teaching, targeted to give understanding of sexual rights and individual integrity, as well as knowledge and skills related to self-protection (safety skills). Also those working within youth work, confirmation training and suchlike work will handle these same themes in their work and events.
- Higher education institutions will provide continuing education for early childhood education and basic education teachers and develop material for teaching of non-violence.
- Personnel in daycare, early childhood education and school sectors will inform parents on safety skills and sexual rights.
- Professionals working at maternity and child clinics and in school, student and occupational health care and other preventive services will work actively to prevent sexually offensive violence and other forms of violence, and screen victims of violence, document them and develop care paths.
- Professionals at child health clinics will discuss child's sexual development and advise parents to support harmonious development from the point of view of sexual health. • They offer help in sexuality and domestic relationship issues through counselling and discussions, as needed.
- Organisations will continue the ongoing programmes and projects aiming at intimate partner violence and domestic relationship violence reduction, in order to embed the action practices, highlighting also the perspective of sexual violence.
- Municipalities and joint municipal authorities will support and extend the work targeted at the young in risk groups.
- The Defence Forces will handle sexually offensive violence within sexuality education, aimed at conscripts.
- Parents, professionals of early childhood education and schools, representatives of media, the National Audiovisual Institute (KAVI), youth work professionals and organisations of the field will cooperate in order to restrict violent media entertainment, intended for children, such as programmes for children and adolescents, commercials, plays and films.
- Professionals at comprehensive schools will teach critical media literacy.

- Research institutes and higher education institutions will work out prevalence of experiences of sexually offensive violence through periodically implemented youth surveys, e.g., School Health Promotion Study (Kouluterveyskysely), Health Behaviour in School-Aged Children and Adolescent Health and Lifestyle Survey (Nuorten terveystapatutkimus).

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16 Sexual and reproductive health research

Sexual and reproductive health as a field of research in Finland

The field of research of sexual and reproductive health is multidisciplinary and is determined through both sexual and reproductive health. Sexual and reproductive health includes research in the fields of, for instance, health sciences, social sciences and behavioural sciences, as well as culture and communication. Part of the research can be placed under sexual health, including sexological studies and studies on sexual behaviour. In addition, some studies belong to reproductive health research, including studies on pregnancy, childbirth and fertility and the end of fertility. Some of the studies concern both sexual and reproductive health, including studies related to sexually transmitted diseases and induced abortions. The fact that sexual and reproductive health studies have been conducted in different scientific fields, using diverse methods and located in different places is part of the richness of this field of research. All researchers, such as those focused on health behaviour or health care research, have not necessarily perceived their studies as a part of the field of sexual and reproductive health.

Universities and universities of applied sciences

In Finland, sexual or reproductive health has been successfully studied in multiple sectors even though there is no university chair for the field in Finnish universities. Significant studies have been conducted on, for example, gynaecological cancers and particularly the screenings for these. Reproductive health has been used as an example for many approaches related to health and health care, including the assessment of technology, health care research and research questions on health policy.

Educational programmes have not been systematically examined for this action programme. The global questions of international medicine related to reproduction are included in the current educational programme of the University of Tampere, where a course on sexual and reproductive health has been organised for the doctoral students of international health. The inclusion of sexual and reproductive health research in education programmes is usually up to the interest of individual researchers.

The clinical research of reproductive health is a part of traditional medical research. In universities and specialised medical care, this is usually placed in the discipline of gynaecological diseases and obstetrics, and the majority of research in the field is also conducted in this area. Moreover, sexual health topics are also studied in urology (men's sexual dysfunctions) and dermatology and venereal diseases (sexually transmitted diseases). A lot of Finnish research in the field has been published in both international and national journals.

In addition to health sciences, research related to sexual health has also been conducted in the field of social sciences. There is already established research on sexual and reproductive health conducted in cooperation between universities and research institutes, which allows obtaining follow-up information. Population studies provide information about sexual behaviour, contraception, pregnancies, deliveries and fertility.

There has been qualitative research on topics of sexual and reproductive health in nursing science. In universities of applied sciences, a lot of reports aimed at sexual and reproductive health service system and client work are completed in the form of final theses and cooperation projects with the labour market, and also as applied research.

National research institutes

The National Institute for Health and Welfare is responsible for conducting the majority of health surveys for the adult population, of which the 'Health 2000' and 'Health 2011' surveys cover most issues on sexual and reproductive health.[1] The FINRISKI and 'Health 2000' studies have contained a separate section on reproductive health, which has enabled monitoring the issues related to reproductive health at the population level.[2,3] In 2010–2012, the National Institute for Health and Welfare implemented the Migrant

Health and Wellbeing Study (Maamu Study) which included questions on, e.g., HIV awareness, circumcisions and contraception.[4]

When analysing the contents of the questions on sexual and reproductive health in regularly implemented surveys, it was noted that the questions were most frequently concerned with (women's) reproduction and were typically problem-oriented.[1] Questions on positive matters related to sexual and reproductive health were rare. Moreover, data collection related to service use or needs is insufficient, particularly in case of women not of childbearing age, men and elderly people.

The National Institute for Health and Welfare has conducted research based on follow-up and register data on the risk factors, epidemiology and long-term effects of chlamydia infections, papillomavirus vaccinations as well as on the exposure of the population to environmental toxins and the concentration of environmental toxins in breast milk.[5–9]

The National Institute for Health and Welfare also conducts national monitoring of the work at maternity and child health clinics as well as research connected to the work at maternity and child health clinics.[10,11] Research themes include, for instance, parenthood and close personal relationships and supporting these at consultations at the clinics, family training and home visits. These themes are included in the forms on the everyday resources of families expecting a child and families with children. Feedback is collected on the use of these forms, with the aim to recognise the best practices. Furthermore, a multidisciplinary researcher group studies the availability and continuity of maternity care services. Questionnaires aimed at families with children have been used to find out about issues such as the timing and planning for and success in having children in the years 2006 and 2012.[12]

The Sexual and Reproductive Health Unit (SELI) of the Child, Adolescent and Family Services Unit of the Division of Health Services of the National Institute for Health and Welfare has 3–5 part-time researchers whose task involves research on sexual and reproductive health, expert work, distribution of information and coordinating cooperation both within the National Institute for Health and Welfare (networks for sexual and reproductive health and maternity care researchers) as well as with outside actors.

Internationally significant register research was also conducted in the National Institute for Health and Welfare before the establishment of the SELI Unit, for instance, on the service systems for reproductive health and epidemiology. The registers of the National Institute for Health and Welfare on reproductive health have also been, and continue to be, used as the source for information in a large number of studies conducted outside the National Institute for Health and Welfare or in cooperation with the institute (in more detail in chapter 18). Small-scale research projects and reports on the promotion of sexual health have also been implemented in the National Institute for Health and Welfare. The School Health Promotion Study, realised once every two years and covering the entire Finland, continues to be a source of information on the sexual behaviour of young people.

Finnish Institute of Occupational Health (TTL, Työterveyslaitos) is a multidisciplinary research and expert institute operating in the administrative sector of social and health care in six localities. The aim is to secure healthy and safe working life over the course of the person's entire career. The field of occupational toxicology is concerned with studying issues such as the impacts of occupational exposure on pregnancies and miscarriages. The topics of occupational well-being include, for instance, discrimination on the basis of gender and sexual harassment in workplaces, on which TTL has conducted research and prepared instructions for workplaces. Coordinating work and family life and return to work from a family leave are also significant research areas which the National Institute for Health and Welfare has studied in cooperation with the TTL.

Other activities and international cooperation

In addition to the researcher networks described above, the Society for Social Medicine in Finland (division of reproductive health) and the Finnish Association for Sexology maintain organised researcher networks for sexual and reproductive health. The Population Research Institute of the Family Federation of Finland conducts significant sexual and reproductive health research.

There are numerous research institutes in Europe that include sexual and reproductive health research in their programmes, but these have often been limited to only certain sub-issues or approaches. On the

international level, research on sexual and reproductive health is presented more though viewpoints such as HIV, population growth or maternal and child health.

Finnish universities and governmental research institutes conduct project-based international research cooperation, for example, in Estonia and in the St Petersburg region. The National Institute for Health and Welfare has conducted studies on reproductive health, for example, in China and Mozambique. HIV and AIDS and combating sexually transmitted diseases have been key topics in the projects of the International Affairs Unit of the National Institute for Health and Welfare. The Ministry for Foreign Affairs has particularly provided funding for research and development activities related to maternity care.

Challenges and financing

There are no teaching posts for sexology, sexuality education, sexual health or reproductive health in the university institution, and therefore there is no 'home base' in the university level for the research on the field. In addition, the multidisciplinary nature of the field partially makes in more difficult to place the research under any certain field of education in the universities. It is possible to acquire research funding from a source for competitive funding, such as the Academy of Finland, but it is also difficult. Science policy decisions could significantly further the research in the field, for instance, by starting a research project of the Academy of Finland, the largest financier for science, on the question of sexual and reproductive health.

Sexology, sexualty education, sexual health and reproductive health researchers are fragmented into different universities and universities of applied sciences as well as in research institutes dedicated to certain sectors, which results in a lack of cooperation, coordination and continuation. There is no systematic networking in the field, and, for example, there are so far no ongoing researcher schools or research programmes produced by different operators.

Research financing in health sciences and other research fields

Sexual and reproductive health is not separately mentioned in the Health 2015 public health programme. Nevertheless, sexual and reproductive health is closely related to a number of themes which there has been a desire to emphasise when setting objectives for the Finnish society, such as prevention of social exclusion, promotion of the health of children and adolescents and reduction of violence. In Sweden, the promotion of sexual and reproductive health has been included in the subject areas of the public health programme as a separate area.

From the viewpoint of research funding, the problem with sexual and reproductive health is that people still fail to see the connection between the subject and the entire field of health and well-being. For a long time, health promotion has been limited to traditional topics, such as smoking, intoxicant use, overweight and exercise. Sexuality education is one of the sub-areas of health education in certain other countries, but not in Finland. Similarly, behaviour promoting sexual and reproductive health is its own subject area with links to other health habits and socioeconomic background factors. Preventive health care guides, contents of the quality recommendations for health promotions as well as the instructions for applying provisions for health promotion have come to include more themes related to the subject area. The subject area of sexual and reproductive health is still not separately named anywhere in the research programmes aimed at health care research, and the subject area is not included in the separately named funding priorities of any foundation.

There are no reports on the funding obtained by sexual and reproductive health research from different sources. Appropriations for health promotion have been, and continue to be, used to finance research and development work related to sexual health. Clinical research on reproductive health is strongly focused on specialised medical care, and therefore receives funding from the same sources as other research on specialised medical care, specified government transfers (so-called EVO funding). There is also sexual and reproductive health research outside health sciences and between different disciplines and research organisations. No overall picture of the funding sources or amounts of funding received by research implemented this way is available.

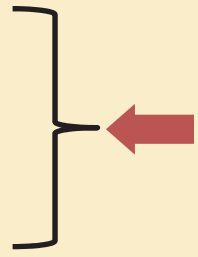
Research programme

A number of issues important for the promotion of sexual and reproductive health have emerged with updating the action programme. There continues to be lack of information on these topics regardless of the fact that this information is fundamental in its nature or applies to large population groups. Chapter 18, Development of statistics and monitoring systems, includes description of data collection and monitoring indicators, which have a major significance for the formulation of national recommendations on sexual and reproductive health and health policy decision-making. Combining data from high-quality health care registers allows obtaining research information based on large datasets that is unique also on an international level. This opportunity has already been significantly utilised, but combining register data could be utilised in an even more efficient and versatile manner. This chapter does not include separate examination of the registers, but contains consideration of the most common sub-areas for sexual and reproductive health research and related thematic questions. In addition to the data obtained from registers, there is also a need for qualitative research.

The research programme for sexual and reproductive health can be divided into five central areas which all include the cross-cutting themes of health services and health policy, socioeconomic health differences and lifestyles and environmental factors. The seven central thematic areas of sexual and reproductive health research are presented in table 6.

A cross-cutting theme refers to, for example, the research of health services related to maternity or the assessment of the practical functionality of maternity clinic guidelines (table 6). Socio-economic health differences are an important area to study in all of the sub-areas, for example, in the interfaces of chronic illnesses and sexual and reproductive health as well as for family planning. The significance of lifestyles, such as smoking, is major, for instance, for involuntary childlessness. Environmental factors refer to the impacts of the built environment, chemicals or indoor air. A study on occupational health care can take into account the effects of indoor air or other exposure agents, for example, on pregnancy or its planning.

Table 6. *Central themes and cross-cutting contents of sexual and reproductive health research.*

Central themes	Contents of cross-cutting themes
• Adult population • Children, adolescents and young adults • Family planning • Maternity and involuntary childlessness • Sexually transmitted diseases • Sexually offensive violence and circumcisions • Chronic diseases and ageing	 Health services and health policy Socioeconomic health differences Lifestyles and environmental factors

Sexual and reproductive health services are a central part of sexual and reproductive health research and their connection to separate themes is important. Topics for future research include, for example, the sexual and reproductive health service needs and experiences of sexual and gender minorities, disabled people and immigrants, which may not always come up in the division presented below.

The seven research areas of sexual and reproductive health are described in more detail below. The suggestions for research and assessment subjects presented in other chapters of this action programme are also included in the sections below.

The sub-area of sexual and reproductive health of the adult population includes research topics concerned with the sexual health awareness, changes in sexual attitudes and sexual well-being of the adult population. This sub-area also contains questions on the impacts of the media culture on sexual behaviour and health. The promotion of clinical sexology and sexual health is developed and studied in cooperation with universities and other higher education institutions. Sexual and reproductive health services should be founded on scientific evidence. Indeed, sexual and reproductive health issues should be established as parts

of the significant national population surveys (such as the FINSEX study), and also use other than problem-oriented viewpoints.

The theme of children, adolescents and young adults contains the special questions of sexuality education for children and young people, counselling supporting the sexual maturing and development of school-age children (so-called safety skills), the connection of the child's development to mental health, and the influence of the media culture on sexual behaviour and health. No academic research on the exchange of sex for money or gifts has been conducted in Finland, even though there have been signs of this phenomenon, e.g., in the School Health Study and studies on criminal behaviour by the National Research Institute of Legal Policy. The student health care applying to young adults also includes services promoting sexual health and research in the field. Important questions in student health care include couples counselling, issues related to mental health, prevention of infertility, support for sexual development, combating sexually transmitted diseases and prevention of sexually offensive violence.

The sub-area of family planning includes the family planning viewpoints, contraception, induced abortions, miscarriages and stillbirth. Trends in the use of contraceptive methods and the realisation of the planned family size and timing of the birth of children should particularly be monitored and assessed in national population studies. The quality criteria for contraception counselling should be developed further. There is also need for more detailed research on the increase of repeated induced abortions, particularly paying attention to socio-economic health differences, and also research on the links between mental health and sexual and reproductive health.

The sub-area of maternity and involuntary childlessness includes the health of mothers and unborn children, the postnatal period and involuntary childlessness and infertility. Needs for research regarding the health of mothers and unborn children touch on the viewpoint of services (development of the distribution of duties of doctors and public health nurses or midwives, service needs of special groups), effectiveness (antenatal training, prevention and treatment of the fear of childbirth, prevention and treatment of postnatal depression, infection screening during gestation) or care practices (treatment practices for perineotomy, prevalence and health effects of Caesarean sections, breastfeeding support). There is also need for studying the significance of lifestyles, such as intoxicant use and smoking, weight gain during gestation and environmental exposure agents on the health of mothers and unborn children and the course of pregnancy. The effectiveness and methods of prenatal screening and the potential risks of the screening process should be studied. A definition for a low risk pregnancy should be determined and investigated more widely. The increase in the age of parturients in the population is a significant public health issue whose societal impacts should be assessed more extensively, also in terms of costs. The monitoring and assessment of applying the maternity clinic guide published in the autumn of 2013 should be implemented as a part of the action programme.[13]

The prevalence of involuntary childlessness and infertility as well as fertility treatments has been included in some population studies, but particularly changes in time should be investigated and assessed. In addition to the prevalence of infertility treatments, the health of children born as a result of these is an important research topic. The connection between involuntary childlessness and lifestyles, such as smoking and weight, as well as mental health, should be investigated in more detail.

The sub-area of sexually transmitted diseases is concerned with the prevalence of sexually transmitted infections and follow-up data in population studies. Changes in sexual attitudes and screening for sexually transmitted diseases are a part of the prevention of sexually transmitted diseases and should be examined in more detail in this context. New practices for sexually transmitted disease testing should be assessed. The collection and research of the data on behaviour related to sexually transmitted diseases should be implemented as a part of the available monitoring systems. The inclusion of boys in the HPV vaccination programme should be assessed based on the evidence obtained on vaccinating girls. National data on the number and quality of chlamydia samples should be collected for assessing coverage and focusing.

The sub-area of sexually offensive violence and circumcisions is focused on determining the prevalence of violence and the research questions related to female and male genital circumcision. More

research would also be needed on the violence targeted against disabled people and sexual and gender minorities.

The sub-area of chronic diseases and ageing contains research on the connection of chronic national diseases, such as cancer, diseases of the arteries and diabetes to sexual and reproductive health, using Finnish population studies as a basis. Research areas significant for ageing include treatment alternatives, prevalence of menopausal symptoms and connections with chronic diseases. Moreover, special questions of the elderly and the services for the elderly should be investigated from the viewpoint of sexual health.

Objectives

- Needs for sexual and reproductive health research will be identified and added to forthcoming public health programmes.
- Connections between sexual and reproductive health and mental health and the related needs for research will be identified, and volume of the research will be increased consequently.
- Universities, research institutes and universities of applied sciences will be informed about the action programme for sexual and reproductive health and the needs for research.
- Sexual and reproductive health will be strengthened and clarified as a field of research, with an established university chair and financing, settled for research.

Actions

- The Ministry of Social Affairs and Health will take a sexual and reproductive health perspective into account in the researches and projects funded under Terveys 2015 (Health 2015) programme.
- The Ministry of Social Affairs and Health and the National Institute for Health and Welfare will support national networking of sexual and reproductive health researchers and development of research traditions. In addition, utilisation of data produced by reproductive health registers will be supported, aligning adequate resources for this.
- Sexual and reproductive health expertise centre (National Institute for Health and Welfare / Sexual and Reproductive Health Unit) will maintain its research networks, follow domestic and international research of the field and communicate this information electronically as a part of SELI newsletters.
- Funding actors (ministries and the Academy of Finland) will maintain funding of the research and development work at an adequate level and ensure funding for the primary health care service research and health care research (including sexual and reproductive health and mental health services).
- The Ministry of Social Affairs and Health will start prioritisation of the research needs. Comprehensive research topics may include among others:
    - sexual and reproductive health in Finland 2020: impacts on careers, inequality, and health and welfare services
    - sexual and reproductive health in vertical and horizontal integration of social and health care services,
    - starting a family in the future Finland: timing of having a baby, health and societal consequences and effects on the use of social and health services.

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17 Development and support of professional skills

Teaching staff in early childhood, basic, and upper secondary education

Early childhood and pre-primary education curricula contain the objective of supporting the sexual growth and development of the child. This must be noted in the degree and supplementary education for the professionals in these fields. Early childhood education is an important time for learning values, norms and words. Therefore, sexuality education must be apparent in the curriculum for early childhood education as its own entity, using the concept of sexuality education. Health education is not its own subject in the lower year classes in basic education; instead, health education (and thus also sexuality education) has been included in other subjects. Indeed, the systematic integration of the topics of sexuality education in the lower year classes requires paying special attention to the planning of instruction.

Provisions on the instruction of health education were issued in 2001 and the core curriculum for basic education in 2004. Instruction of the subject in primary schools began soon after. The basic and subject studies in health science as university studies provide teachers who have obtained a university degree with the qualifications to act as health education teachers.[1, 2] The scope of the studies is 60 credit units. In 2014, it was possible to study health education, for example, at the Department of Health Sciences of the University of Jyväskylä, the Faculty of Education of the University of Turku and in many other localities through open university. In the academic year 2012–2013, sexual health was taken into account in the form of a separate course with the scope of three credit units, for example, in studies organised by the Universities of Jyväskylä, Turku and Oulu.

Since 2011, health education could be taught by those with health education subject teacher qualifications. Previously, health education was taught by physical education, home economics and biology teachers in upper comprehensive schools, and physical education, biology and psychology teachers in upper secondary schools.[3] In general, teachers have considered there to be a major need for supplementary education, and have been worried that not enough time has been reserved for teaching the contents of health education.[4]

The supplementary training for vocational education teachers has dealt with the topic of sexuality, for example, by practising emotional and interactive skills and encouraging young people to hold onto their personal limits.[5]

Objective

- Trained professionals will give sexual and reproductive health education at all educational levels with adequate resources.

Actions

- The Ministry of Education and Culture, the Finnish National Board of Education and other actors responsible for planning of education and its contents will ensure that child's sexual development, identifying of gender diversity and supporting of equality and guidance for parents are included in training for professionals, working in nursery care.
- The Finnish National Board of Education will ensure that curricula of comprehensive school and upper secondary level education include a comprehensive view of sexual and reproductive health and gender diversity, as well as training that supports to broach sexuality issue.
- The National Institute for Health and Welfare will through its website maintain teaching and counselling materials, related to sexual and reproductive health of children and adolescents.

Training of teachers for social and health care education

No requirements have been determined for the qualifications of teachers in institutes educating social and health care professionals regarding sexology or sexual health. The Nordic Association of Clinical Sexology (NACS) has prepared the criteria for the sexology teacher and researcher education.[6] Education aimed at teachers fulfilling the criteria was not available in Finland in 2014. Some teachers in universities of applied sciences have completed specialisation studies in sexology, which are available with a pedagogical orientation in the Jyväskylä University of Applied Sciences.

Only a small number of those working as sexual health or sexology teachers or educators have written an academic thesis on the topic at the university level (master's thesis, licentiate's thesis or doctoral thesis), and the majority of them continue to have obtained their education in short supplementary training, training days or projects.[7]

Objective

- The teachers that train professional staff have education in sexual and reproductive health education and they will maintain their skills participating in continuing education.

Actions

- Public educational organisations will develop sexology and sexual health education.
- Universities of applied sciences will ensure continuity and development of multi-professional education.
- Teachers of sexual and reproductive health will systematically participate in continuing education.
- The aspect of sexual and reproductive health and its current challenges will appropriately be integrated into contents of national training events.

Training of social and health care professionals

The legislation on professional practice in health care and social welfare is presented in Appendix 2 of this action programme. A directive for the recognition of professional qualifications lays down rules for the education and degrees of doctors, nurses and midwives in EU member states.[8]

Degrees from Universities

The key topics of sexual and reproductive health are studied in the basic education for medical doctors particularly in studies on gynaecology and obstetrics, urology, dermatology and venereal diseases, and psychiatry. Education on the maternity and contraception counselling clinic work in primary health care is realised in a versatile manner in different faculties in cooperation between teachers in gynaecology and general medicine by carrying out a part of the instruction in the clinics. Half of doctors estimate that the instruction included in their basic education poorly responded to the clinic work conducted in health centres.[9, 10]

Based on studies conducted among medical teachers and students, contraception, sexually transmitted diseases and sexually offensive violence are well represented in the basic education. In contrast, questions related to ageing or long-term illnesses and sexuality, women's sexual issues and sexual diversity are dealt with briefly or not at all.[10, 11–13]

Universities are responsible for providing specialisation studies for doctors of the duration of five or six years.[14] Specialities significant from the viewpoint of sexual and reproductive health include gynaecology and obstetrics, urology, general medicine, dermatology and venereal diseases, oncology and psychiatry. Competence in sexual medicine is often also needed in other medical specialities. The contents of specialist education have not been studied from the viewpoint of sexual health.

The implementation work group for sexual medicine, established in 2011, determined the sexological contents of education in the faculties. It appeared that there was a lot of variation in the amounts and contents of education on sexuality, and the studies were often optional or so-called advanced studies. The personal attitudes of subject teachers appeared to influence whether room was given to the subject.[15]

The implementation work group ended up recommending the term sexual medicine when referring to sexology in the context of medicine, as this integrates sexuality clearly in the field of medicine. This recommendation is also supported by the fact that European Society for Sexual Medicine (ESSM), an umbrella organisation for sexual medicine and the joint body for several medical specialities in Europe, invests in education in sexual medicine and aims at the inclusion of sexuality education as an equal among other medical specialities. The Finnish implementation group aims to integrate sexual medicine in all speciality courses in the education. The planning of the contents of education proceeds with the support of the Ministry of Social Affairs and Health, the Ministry of Education and Culture, and the faculties, the Finnish Medical Association and the Sexual and Reproductive Health Unit of the National Institute for Health and Welfare.

The human mental development and all its dimensions are the contents of the basic education for psychologists (qualified psychologist/Master of Psychology). Human sexual development is an essential part of this entity. The education provides basic competences for the psychological assessment of human development and problems in it, and basic knowledge of interventions related to psychological problems. Human sexual development and its variations are developed as a part of the human psychophysical and socio-emotional development. The study programmes of different universities slightly vary in terms of how widely studies particularly related to sexuality are offered. The psychologist education produces basic readiness for conducting psychological assessment, counselling and psychotherapeutic work. The basic education does not always offer training specialised in problems related to sexuality.[16]

Sexuality is included in the questions on human well-being and life course in the basic studies of the students of social science majoring in social work. In this case, the themes of sexuality are dealt with from the perspective of societal factors and psychosocial issues. The studies produce basic competences and research skills on phenomena and problem solving related to, for example, abuse, violence or cultural encounters, in which sexuality is one factor. However, if they so desire, students have an opportunity to include an extensively versatile thematic entity on sexuality in their degree through optional studies. Sexual and reproductive health is not as such a central theme in the basic education of social work; instead, people can specialise in this area in practical work tasks through continuing education.[17]

The studies for the degrees of Bachelor and Master of Health Sciences with nursing science as the major subject do not include studies on sexual and reproductive health; instead the student's competence is based on a vocational degree in the field, which he or she may expand with, for example, optional studies, a practice period or a bachelor's or master's thesis.[18] This is also the case, for example, with the studies for the degrees of Bachelor and Master of Health Sciences with health education as the major subject in the University of Jyväskylä.[19] In a multidisciplinary study module in health sciences at the University of Jyväskylä, health science contents are studied in two sections, in total with the scope of 15 credit units, and the contents of the latter section include sexual health as its own subject.[20]

Degrees from universities of applied sciences

A report on the education of sexual health and sexology in Finland in the years 2003–2009 commissioned by the National Institute for Health and Welfare indicated that instruction on sexual health was included primarily in the degrees of midwives, public health nurses, nurses, paramedics, naprapaths, occupational therapists and geriatric nurses.[7] One third of the education of Bachelors of Social Services and physical therapists included no education on sexual health. In one university of applied sciences, students could attain a master's degree on the promotion of sexual health.

The competence requirements of the degrees from universities of applied sciences act as recommendations for the formulation of curricula specific to individual universities of applied sciences. In the field of health care, these were updated in 2006 to better respond to national and international competence requirements.[21] In 2014, new descriptions of the competences in the degrees from universities of applied sciences in the field of health care are published, and each university of applied sciences decides whether or not to utilise these.

Upper secondary qualification in the social and health care field (practical nurses)

The education for practical nurses, similarly as all basic vocational qualifications, includes one credit unit of health education, and the objectives include, for example, knowing the importance of mental health, sexual health and interpersonal relationships for the well-being of humans.[22] The goal of the basic education in social and health care field is that practical nurses know how to recognise the threat of violence and its different forms of expression and can participate in work preventing violence and social exclusion. Students in the vocational education differentiated into study programmes must obtain competence on a very good level for supporting the client's sexuality as a part of his or her identity and personality and providing safety skills training as a member of a work group when necessary. In order to obtain the very good level, students in the study programme or specialisation of the care and upbringing of children and young people, must acquire competence in treating a newborn, supporting and guiding the family of the newborn, taking into account the needs of the family and giving versatile justifications for, for example, breastfeeding an infant.[23] Youth and leisure instructor studies contain courses on providing guidance, in addition to including health education as a subject.[24]

Continuing education, further education and educational needs due to job description changes

The legislation on continuing education for health care and social welfare professionals is presented in Appendix 2. In addition to legislation, national recommendations also regulate the continuing education for both health and social welfare staff.[25, 26]

A questionnaire organised by the National Institute for Health and Welfare indicated that more continuing education related to sexual and reproductive health had been provided in 2011 than in 2009.[27] The majority of hospital districts had organised internal training on breastfeeding counselling and sexually offensive violence as well as early interaction. Training on sexual counselling had been organised both internally as well as aimed at health centres. Less training had been provided on diseases and sexuality as well as on induced abortions.

The contents of training have included, for example

- sexual trauma
- broaching the topic of sexuality
- Pap smear lesions, papillomavirus vaccination (HPV)
- sexually transmitted diseases
- contraception
- gestational diabetes
- disorder of the cerebral circulation and sexuality
- medication and sexuality
- third and fourth degree lacerations
- women's sexuality
- young people's sexual health
- fear of delivery
- mental health and pregnancy
- supporting sexuality after delivery
- gynaecological cancer
- patient with narcotic, alcohol or/and pharmaceutical drug use
- sexual diversity and
- domestic violence and sexually offensive violence.

The maternity clinic guide for 2013–2020 presents recommendations for developing and supporting the competence of professionals.[28] According to the recommendations, the knowledge base and competence of both medicine and midwife and health care work are combined in the care for gestation, delivery and the postnatal period. Seamless cooperation of maternity clinic, delivery hospital and related social services is also essential. According to the recommendations, new competence requirements must be taken into account in the education leading to vocational basic degrees, continuing education and other further education for those working in maternity clinics as well as the education for the teachers in the field.

One of the aims of the Action plan for the prevention of circumcision of girls and women is to spread awareness on the circumcisions of girls and women among professionals.[29] The topic must be included in the basic and continuing education for different professionals, national training events aimed at different professional groups as well as different multiprofessional events.
Education needs related to the expanded job descriptions in the field of sexual and reproductive health include, e.g., ultrasounds during the first trimester, assessment of the impending preterm delivery, postnatal examination, insertion of intrauterine contraceptive device, early postnatal discharge and discharge after Caesarean section, and treatment of the fear of delivery at an outpatient clinic.[30] Recommendations and proposals for legislative changes on the development of the distribution of duties are prepared in the Ministry of Social Affairs and Health. Information on the changing service system is also expected to be included in the education related to changes.
The new competence areas of nurses, public health nurses and midwives regarding the beginning of contraceptive use and issue of repeat prescription (see chapter 11 Contraception for more details) and the right to conduct a postnatal examination (see chapter 10 Childbirth and postnatal period) are taken into account in developing the education leading to the midwife and public health nurse qualifications and in organising further education. The recommendations given by the Ministry of Social Affairs and Health on the level which should be implemented by all municipalities and joint municipal authorities in order to meet the contents and objective of the Government Decree on Screenings are taken into account when performing ultrasound examinations.[31] Guides and other material on screenings for foetal anomalies have been compiled on the website of the National Institute for Health and Welfare for both professionals and families.[32]

Levels of education and authorisation in sexology in Finland

Education in the field of sexology can be divided into three orientations, of which two (counselling and education) can be further divided into three different levels (table 7). Progress from one level to the next requires completion of education on the previous level. The basic level contains the education of a sexual counsellor and a sexuality educator. Since 2008, the Finnish Association for Sexology (FIAS) (www.seksologinenseura.fi) has granted authorisations to work as a sexologist. FIAS will publish its authorisation criteria for sexuality educators during the year 2014.

Therefore, both sexual counsellors and in the future also sexuality educators apply for authorisation from the FIAS. Authorisation for the second and third levels, i.e. the titles of therapist and pedagogue and clinical sexologist and so-called sexuality educator and sexual health promoter is sought from the Nordic Association of Clinical Sexology (NACS) (www.nacs.eu).

The third orientation is scientific and aims at research; this orientation contains no levels, and includes the qualifications of a person authorised in sexual science. NACS grants the authorisation.

Table 7. *The orientations and levels of sexology education and the body granting authorisation.*

	Orientation	
Level	Counselling	Education
I	Sexual counsellor (FIAS)	Sexuality educator *
II	Sexual therapist (NACS)	Sexual pedagogue (NACS)
III	Clinical sexologist (NACS)	Sexuality educator and sexual health promoter (NACS)

* The Finnish Association for Sexology will publish its authorisation criteria in 2014

It has not been possible to study sexuality education in Finland as separate studies before. The Sexpo Foundation will begin providing education on the field in the autumn of 2014. The studies in sexology have

focused on sexual counselling and therapy. Studies at the basic level comprise of 30 credits. In order to gain entrance to the studies, prospective students are required to have completed at least a basic degree in a vocational institute or a university of applied sciences in an applicable field. Vocational qualifications will be the minimum requirement for gaining entrance to the sexuality educator education. A trained or nationally authorised sexuality educator can work in official sexuality education tasks, providing sexuality education for people of all ages. Education at the basic level is provided by universities of applied sciences and organisations.

Education at the second level authorises the person to use the title of a sexual therapist or sexual pedagogue. This education requires completing a study unit of 30 credits in addition to the basic studies. The education is provided by universities of applied sciences and organisations. At the third level, education for clinical sexologists and sexuality educators and sexual health promoters have the extent of 90 credits (basic studies 30 credits and further studies 30 credits + 30 credits).

Information on available education in the field of sexology can be requested from universities of applied sciences and organisations in the field of sexology. Education in sexology has been previously offered in universities of applied sciences and summer universities in Jyväskylä, Helsinki, Turku, Tampere, Vaasa, Kuopio, Joensuu and Rovaniemi as well as by the Sexpo Foundation, the Family Federation of Finland and Seta.

Those seeking further education in sexology in the universities of applied sciences have been primarily graduates from health care education institutions and universities of applied sciences. The number those with university degrees has been relatively low in the education.

Educators and teachers in the field of sexology must have completed studies in sexology and have obtained pedagogical qualifications in order to act as teachers. They can apply for the Nordic authorisation. National criteria for the competence of educators and teachers should be prepared.

Objectives

- Sexual medicine will be implemented in the basic studies of physician education, taking it into account in all specialised courses.
- Adequate basic information on sexuality, gender and their diversity as well as on sexual and reproductive health will be included in the basic and university degrees of social and health care professionals.
- Each qualification in the social and health care studies will offer and guarantee basic knowledge in sexual health and will take sexuality into account.
- During education, it will be ensured that students of social and health care sectors are provided with in-depth knowledge on sexual and reproductive health, required in their professions, as well as skills to offer sexual counselling.
- Basic studies in sexuality education will be launched in higher education institutions.
- Regular continuing education on sexual and reproductive health will be provided to teachers and other professionals, covering the whole country, e.g., in universities of applied sciences.
- Sexual and reproductive health education will be carried out according to the continuing education regulations and national recommendations.
- Continuing education in sexual and reproductive health will be developed to be multidisciplinary and to serve also students with diverse backgrounds. Possibilities to get apprenticeship training will be supported.
- An authorisation (by NACS or Finnish Association for Sexology) will be required from professionals, working as sexual counsellors, therapists or clinics.
- Sexuality educators will be authorised according to national criteria for authorisation of sexuality educators, published by Finnish Association for Sexology in 2014.
- Professionals' basic skills and knowledge on female circumcision prevention and care of girls and women already circumcised will be increased and maintained.

Actions

- Universities will extend the contents of sexual and reproductive health teaching in the basic education of physicians.
- Universities will increase sexual and reproductive health promotion in the specialised studies in medicine and, in particular in general practice, gynaecology, urology, psychiatry, paediatrics, child psychiatry, and oncology.
- Research universities will develop education in clinic sexology and sexual health promotion through multisectoral cooperation.
- The Ministry of Education and Culture and the Finnish National Board of Education will ensure that curricula of social and health care degrees in universities of applied sciences include basic knowledge of sexual and reproductive health.
- Universities will ensure that all academic qualification programmes, required for social and health care duties (teaching, social work, psychology), include sexual and reproductive health studies as optional studies at minimum.
- The Ministry of Education and Culture, the Finnish National Board of Education and other actors responsible for the contents and implementation of education will ensure that social and health care studies provide skills to meet diverse clientele.
- Municipalities and social and health care regions will develop multi-professional work at child clinics, used for teaching, in cooperation with universities and higher education institutions.
- Higher education institutions will launch sexuality education studies of 30 ECTS, according to the criteria by NACS.
- Higher education institutions and research institutes will investigate the needs for regional further and continuing education, concerning sexual and reproductive health contents.
- Universities, universities of applied sciences and regional actors responsible for continuing education will draw up continuing education plans on sexual and reproductive health promotion both as an independent topic and integrated in disease treatment and rehabilitation. Plans will be implemented in regional cooperation, according to the strategies for continuing education.
- The Finnish National Board of Education, the Ministry of Education and Culture and universities will include sexual counselling and guidance in the basic studies of those working in school and student health care (psychologists, curators, public health nurses, doctors), and universities, universities of applied sciences and regional actors responsible for continuing education will include sexual counselling and guidance in the continuing education. Supervisors will support this process by developing occupational guidance, ensuring easy access to updated material and taking account this subject in managing.
- Supervisors of professional staff will support development of skills in work community by job rotation, occupational guidance, career development models, developing programmes, and skills control systems.
- The Finnish National Board of Education and the National Institute for Health and Welfare will arrange continuing education or information package on female circumcision and regional actors responsible for continuing education will include this topic in continuing and further education. Supervisors and leading office holders will enable the professional staff to participate in advanced, further and/or continuing education.

Treatment recommendations and support material for professionals

Treatment recommendations are founded on the best research evidence and clinical expertise and act as the basis for decision-making in solving a particular health problem. Multiprofessional processing and agreement on a joint operating method in a health centre have been proven to be important for the implementation of national treatment recommendations.[33]

The Finnish Medical Society Duodecim prepares Current Care Guidelines (Käypä hoito) recommendations to act as a basis for treatment decisions of doctors, health care professional staff and citizens.[34]

At the time of the publication of this action programme, 11 Current Care Guidelines (Käypä hoito) recommendations related to sexual and reproductive health had been published on the following topics: resuscitation of a newborn (updated 2011), preterm delivery (2011), post-coital oral contraceptive (updated 2010), cellular changes in the uterine cervix, vagina and external female genital organs (updated 2010), extrauterine pregnancy (updated 2012), ovarian cancer (2012), corticosteroid treatment at the threat of preterm delivery (updated 2009), investigation of a suspected sexual abuse of a child (updated 2006), induced abortion (updated 2013), gestational diabetes (2008), heavy menstrual flow (updated 2009) and sexually transmitted diseases (2010).[34]

The Nursing Research Foundation (www.hotus.fi) coordinates the formulation of national nursing recommendations and produces support structures for the development and establishment of evidence-based practices. The nursing recommendation on breastfeeding counselling, related to sexual and reproductive health, was published in 2010. A recommendation on the early recognition of and help for postpartum depression is currently under preparation. The Nursing Research Foundation also acts as Finland's affiliated centre of the Joanna Briggs Institute (JBI). One of the most important objectives of the Australian JBI centre is to provide summarised research evidence and to support evidence-based practice in the health centre. JBI recommendations related to sexual and reproductive health translated into Finnish include a recommendation on the management of nipple pain and/or trauma associated with breastfeeding[35] and a recommendation on women's perceptions and experiences of breastfeeding support.[36] Works is also currently underway for recommendations on breastfeeding problems in acute and primary healthcare setting. The Federation of Finnish Midwives has published a recommendation on the treatment of the parturient and the protection of the perineum in the second stage of labour.[37]

The maternity clinic guide[28] for the years 2013–2020 contains recommendations for care during the postgestational and postnatal period. The Terveysportti health portal (www.terveysportti.fi), intended as a support for the work of professionals, includes features such as databases for doctors and nurses and the Oppiportti learning portal, a continuing education tool for health care organisations. Some of the contents of the Terveysportti portal are available for the public, while others are chargeable.

The National Institute for Health and Welfare maintains the Kasvun kumppanit online service,[38] which, in order to support professionals, provides information about the primary services for children, young people and families as well as information to support developing these (for example, the Vauvankaa.fi website for supporting parenthood). The aim is to promote a multidisciplinary, participatory, communal and dialogical approach for professionals' development of their own work and to produce research findings, statistics and legislative information for decision-makers.

Objective

- The supporting material for sexual and reproductive health subject will be up-to-dated, based on scientific evidence, and easy accessible for professionals.

Actions

- Actors responsible for Current Care Guidelines (Käypä hoito) recommendations, national treatment recommendations, regional treatment programmes, patient instructions, treatment chains, collaboration practices, occupational guidance and consultation practices will expand the instructions to include also a sexual and reproductive health perspective.
- Public and private sectors and organisations of the field will accelerate the launch of national treatment recommendations.

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18 Development of statistics and monitoring systems

In Finland, health monitoring is based on health registers and statistics, which are complemented by regularly conducted questionnaire surveys. The National Institute for Health and Welfare and Statistics Finland are key authorities for compiling statistics on data related to sexual and reproductive health.

Data collection and reporting

The National Institute for Health and Welfare collects the majority of the statistics on sexual and reproductive health. Most of these are based on register data on the individual level (table 8). Data on specialised medical care (Hilmo)[1] and primary health care (Avohilmo)[2] related to sexual and reproductive health is also compiled in a Hospital Discharge Register.

The collection of register data of the National Institute for Health and Welfare is based on the Act and the Decree on National Personal Records Kept Under the Health Care System.[3,4] According to the legislation, health care personnel is subject to notification duty in matters on which registers are compiled and there is no obligation to request the consent of those registered. According to the Personal Data Act, the right of the person to inspect personal data on himself/herself does not apply to data collected for purposes of statistical research.[5]

Table 8. *THL's register-based data collections relating to sexual and reproductive health (2013).*

Register	Since	Data Electronic register Since
Births		
• Parturients, deliveries and newborns	1987	1987
• Small premature infants	2004	2004
Cancers	1953	1953
Mass screenings (cervical and breast cancer)	1968	1987
Infectious diseases (STDs, HIV/Aids)	1932	1995
Congenital anomalies	1963	1986
Induced Abortions	1950	1983
Sterilisations	1939	1987
Assisted fertility treatments	1992(statistics)	–
Care notifications		
• inpatient care	1967	1967
• periods of care with procedures	1994	1994
• outpatient care visits	1998	1998
• primary health care visits	1990 (statistics)	2011

In addition to the register based data collection, the National Institute for Health and Welfare gathers clinic-specific data on the numbers and outcomes of performed fertility treatments. Inclusion in the statistics on fertility treatments was voluntary until 2006, but became compulsory after the Act on Assisted Fertility Treatments came into effect in 2007.[6]

Some data on the activities of maternity clinics can be obtained from the medical birth register (date of first check-up visit, all check-ups during pregnancy, number of outpatient clinic visits), but this data collection only covers pregnancies ending in delivery.

National Institute for Health and Welfare publishes annual reports free of charge on all the knowledge reserves available on sexual and reproductive health. Indicators on sexual and reproductive health are also published in the Sotkanet data bank at the municipal level.[7]

Hilmo and Avohilmo

As a part of the Hospital Discharge Register (Hilmo), the National Institute for Health and Welfare has also been collecting data on primary health care visits, school health care and maternity and child health clinic and other counselling clinic activities (Avohilmo) since the year 2011. Prior to this, data were only collected on visits at the statistical level in primary health care, and had inconsistent comparability.

The Avohilmo allows monitoring the functions of primary health care and the health of the population better than what has been possible to accomplish in the past. With the use of Avohilmo, it is possible to monitor, among other things, the implementation of the Government Decree on Maternity and Child Health Clinics and School and Student Health Care and Preventive Oral Health Care of Children and the Young.[8] It can also be partially utilised in monitoring the practices related to screening for foetal anomalies; however, for example, data on the results of screenings cannot be obtained through Avohilmo. In the future, the data can be used to observe regional differences in the functions of the service system. A classification of functions in outpatient primary health care (SPAT) has been introduced as a part of Avohilmo. SPAT allows obtaining data on the contents of individual service events.

Follow-up data and biobanks emerging in research

In addition to basic registers, the National Institute for Health and Welfare also maintains the Drugs and pregnancy research data set, in which data from the Medical Birth Register, Register on Induced Abortions and Register of Congenital malformations of the National Institute for Health and Welfare have been combined with the Register on Reimbursed Drug Purchases and the Register on Medical Special Reimbursements maintained by the Social Insurance Institution of Finland (KELA).[9] The objective of the project is to evaluate the volumes, extent and effects of drug use during pregnancy and to estimate the effect of drug use on pregnancy outcomes, perinatal health and the prevalence of congenital anomalies. This is a joint project between the Finnish Medicines Agency (FIMEA), the Social Insurance Institution of Finland (KELA) and the National Institute for Health and Welfare that was started in 2003.

The Finnish Maternity Cohort (FMC) serum bank also operates in the National Institute for Health and Welfare. The material of the bank comprises of prenatal serum samples collected for screening for congenital infections.[10] Following an informed consent, the screening samples drawn at maternity health clinics are stored in the FMC serum biorepository, and the samples can be utilised in research aiming to promote the health of the population. At the beginning of 2014, the data comprised of nearly two million samples collected from a little under million mothers since the year 1983.

The National Institute for Health and Welfare examines the exposure of the population to organic environmental pollutants permanently in the environment and their connection to different health hazards, e.g., breast milk biobank. A number of studied chemicals have also been linked to reproductive health problems, including hormonal dysfunctions, endometriosis, human sex ratio, cryptorchidism, decline in sperm quality and counts as well as testicular cancer.

Population studies

In addition to national registers, population studies are also used to produce statistical data.. The population studies implemented as questionnaire surveys produce unique data which cannot be collected, e.g., into registers. Questions related to sexual and reproductive health are an important part of the health surveys, and their status must also be reinforced in the future.[11] Questions related to sexual and reproductive health included in population studies have not decreased people's willingness to respond.

The School Health Promotion Study collects data on the living conditions, health and health habits of young people and the student and pupil welfare services.[12] The study is conducted once every two years, and the data collection has also covered vocational institutions since the year 2008. The questionnaire

includes collecting data, e.g., on physical development, sexual behaviour and level of knowledge on sexual and reproductive health, use of contraception, and sexually offensive violence and harassment.

The National Institute for Health and Welfare has surveyed the well-being of families with children in questionnaire studies conducted in 2006 and 2012.[13] Themes related to sexual and reproductive health have included having children, timing of having a baby and success in this.

The Maamu Study of the National Institute for Health and Welfare[14] produced information on the sexual and reproductive health of adults of Russian-speaking, Somali and Kurdish origins and the ETNOKIDS Study[15] collected information about the health of immigrant children. New data collection on ethnic minorities, Survey on work and well-being among people of foreign origin (UTH)[16], was started as a combined effort of the National Institute for Health and Welfare (THL) and Statistics Finland in 2014.

Data of Statistics Finland

Statistics Finland collects register data on family structures, education, citizenship and maternal and child mortality rates. Data on stillborns and babies that have died during the first week of life are also included in the birth register of the National Institute for Health and Welfare. Information in the two data systems are annually examined in comparison to each other in order to improve the reliability of the data. Legislation is in place to regulate the collection of data on causes of death by Statistics Finland.[17,18] Statistics Finland annually reports on the statistics on causes of death. The information can also be obtained in the StatFin statistics service of Statistics Finland.

Other data collection

- Data collection related to sexual and reproductive health conducted outside THL and Statistics Finland: The realisation of breastfeeding recommendations and the extent of breastfeeding have been monitored with a national survey conducted by the Ministry of Social Affairs and Health and the National Institute for Health and Welfare (last implemented in 2010).
- As a part of its register on the sales of medicines, the Finnish Medicines Agency Fimea collects data on, e.g., the sales numbers of hormonal contraceptives and post-coital oral contraceptives.
- National Supervisory Authority for Welfare and Health Valvira maintains the Luoteri register on gamete and embryo donations.
- The Sexuality in Finland (FINSEX) project of the Population Research Institute follows the sexuality of Finnish people and changes in this. Special interest in this monitoring has focused on sexual attitudes, sexual desires, sexual behaviours, sexual problems and sexual pleasures. The latest nationwide sex survey was conducted in 2015.
- Adolescent Health and Lifestyle Survey (Nuorten terveystapatutkimus, NTTT) carried out by the University of Tampere began in 1977 and is conducted once every two years. NTTT provides information about dating and the use of oral contraceptives, but not about other features of sexual behaviour.
- The WHO Health Behaviour in School-Aged Children (HBSC) was started in 1984 and data are collected once every four years. Among other things, data are collected about maturing (13- and 15-year-olds), sexual behaviour and contraceptive use (15-year-olds). The research is implemented by the University of Jyväskylä in cooperation with WHO.
- Finnish Student Health Service (FSHS) has collected data on the health and health behaviour of students in higher education institutions in four year intervals since the year 2000. This has included questions on having children, fertility counselling, sexuality and gynaecological problems.
- The Sex Education in Finland - PESESE Research Project of the Family Federation of Finland has involved using data collected in 1996 and 2006 to determine change in the sexuality education provided at school and the knowledge on sexual issues among pupils. There are plans to continue the data collection.

Development of data collection and reporting of statistics and monitoring indicators

In Finland, statistics and registers on sexual and reproductive health are comprehensive and of high quality. As the legislation, practices and the field change, developing activities and reacting quickly enough become challenging. It should be possible to utilise and report on the collected data even more efficiently. It is necessary to develop registers measuring health care operations for both the development of practical work and improvement of quality, as well as for research purposes. Further resources are required for developing the register systems.

In order to be able to respond to needs for data as comprehensively as possible, legislation must be up to date. Allowing quicker reporting is a key strategic goal which improves the quality, effectiveness and user-friendliness of all registers and statistics. In order to attain this, there is a need for constant development of data transfer, processing of automatic data and electronic reporting, and sufficient resources must be allocated for this. In order to decrease the strain caused by data registration, development of data systems should be employed to ensure an automatic transfer of data collected in the registers from the operating unit to authorities maintaining the statistics.

Hospital Discharge Register

The use and reporting of the Hospital Discharge Register (Hilmo and Avohilmo) must be promoted. Data on issues such as hysterectomies and procedures related to gender reassignment are collected in the register, but reporting on these issues is insufficient. As more data are included in the Avohilmo register, possibilities for complementing areas where there is a lack of information must be actively determined (e.g., the use of contraception and treatment of miscarriages).

It is important for the user-friendliness of the Hospital Discharge Register and particularly the Avohilmo primary health care to keep developing the coverage and quality of the register also in the future. The continuous development of registering practices (e.g., data on diagnoses and visit types) is a requirement for the usefulness of the data registers.

So-called real-time monitoring, in which data are automatically transferred from the service points to the National Institute for Health and Welfare once a day, is also included in the Avohilmo system. This enables, e.g., the up-to-date monitoring of the prevalence of infections. In 2013, data collection encompassed 92 per cent of the population, and 95 per cent of municipalities submitted their data on time.

Limitations and development needs for register data collection

Currently (in 2016), collecting information on nationality or ethnic background in health care registers is not allowed, which will cause more and more significant issues for compiling national statistics, as treatment becomes increasingly international (e.g., EU Directive on Cross-Border Health Care, health tourism). In particular, the rates of deliveries, fertility treatments and induced abortions performed on foreign nationals are likely to increase due to the good quality of care. In order to retain the comparability and user-friendliness of national statistics, it would be essential to enable separating data of the service use of foreign nationals in Finland to avoid hindering statistics use, e.g., in steering of activities and planning of measures. The health tourism from Finland to other countries also makes it more difficult to monitor the extent of the functions.

As the borders of municipalities are changing, it would be essential for the routine data to include more specific regional information (e.g., using GIS codes) than the current data on municipalities, also in registers on sexual and reproductive health.

It is not possible to monitor the implementation of the Government Decree on Screenings[19] without collecting register data. Including the screening data in the Medical Birth Register and, in the case of abortions based on the condition of the foetus, in the Register of Congenital Malformations has been presented as one alternative. However, multiple challenges are related to collecting screening data and assessing the effectiveness of screenings. For example, this requires data collection on both the mother and the foetus/child, combining data from a number of registers as well as data accumulating from a number of service points in the long term as well as the development of new kinds of screening indicators.

There are many questions to which the current statistics on fertility treatment cannot respond. Information on whether a pregnancy has been achieved though fertility treatments are collected in the context of the Medical Birth Register; however, this only applies to treatments that have resulted in delivery. In Finland, no information is available on, e.g., the number of women/couples that have received treatments annually or the number of times it took for the fertility treatments to work. There is also no data available on the equality of those participating in the treatments (e.g., socio-economic status) or the number of treatments performed on female couples and single women.

Discontinuation of the Register of Sterilisations was surveyed in 2004. At this time, it was noted that the Hospital Discharge Register does not provide reliable information on sterilisations, and therefore the discontinuation of the sterilisation register was not supported. Due to a strong decline in sterilisation rates since the 1990s, the possible continuation of register activities must be reassessed in the future. However, the fact that there is a fairly significant demand for statistics on sterilisation must be taken into account at the same time.

Based on the notifications of infectious diseases, data are collected on the incidence of infections verified in laboratory tests (HIV, syphilis, gonorrhoea, chlamydia, hepatites and chancres) in the National Infectious Diseases Register. In order to obtain a comprehensive overall picture of the situation, systematic data on the number of samples extracted would be needed alongside the incidence rates. In addition, more data on behaviour, risk concepts and attitudes should be collected.

Archives and statistics on causes of death will be transferred from Statistics Finland to the National Institute for Health and Welfare once the entire data collection and archiving is implemented electronically. When the division of duties between the institutes is changed, legislation must also be updated in accordance with the final report investigating statistics cooperation and division of duties by the Ministry of Social Affairs and Health, the National Institute for Health and Welfare, and Statistics Finland.[20]

Data utilisation must be enhanced

The utilisation and particularly the combined use of the statistical and register data on sexual and reproductive health already currently collected must be further enhanced for both monitoring the health of the population as well as research purposes. This requirement for enhancing data use applies to units providing health care services, research institutes under the Ministry of Social Affairs and Health as well as universities, other higher education institutions and universities of applied sciences. Enhancing the use of statistical and register data requires good cooperation between the registers and an opportunity for reciprocal use of the data.

The use of the public data sets related to sexual and reproductive health must be promoted in a manner taking into account data protection issues in order to allow the use and further analysis of the data to be as extensive as possible. Changing the exchange of information between authorities to be free of charge to all parties would promote more regular examination and monitoring of factors related to sexual and reproductive health (e.g., combining Statistics Finland's data on socioeconomic factors and immigrants with registers on reproduction).

The presentation of indicators for sexual and reproductive in public statistical databases is currently fairly limited. Out of the indicator services of the National Institute for Health and Welfare, only Sotkanet contains an entity on sexual and reproductive health. E.g., little attention has been paid to sexual and reproductive health in the Terveytemme, TEAviisari, Palveluvaaka and Welfare Compass online services of the National Institute for Health and Welfare. With the exception of infant mortality, sexual and reproductive health has also not been taken into account in the Findicator service of the Prime Minister's Office and Statistics Finland.

International statistics

Collection and development of indicators depicting public health is also topical on the international level. The European Union aims to build a comprehensive monitoring system for public health (European Core Health Indicators, ECHI), but no decision on the implementation of the system has been made regardless of the long-term development work. Statistical indicators for monitoring systems have been developed in

projects on reproductive and sexual health funded by EU's Directorate General for Health and Consumer Protection.

OECD collects annual data on low birth weight of newborns, certain congenital anomalies, fertility, certain surgical procedures (hysterectomies, Caesarean sections), infant and maternal mortality, the coverage of screening, and cancers related to reproduction. The quality indicator project (HCQI) of the OECD also collects data on the cancer survival rates (breast cancer and cervical cancer) and obstetric lacerations once every two years. Finland is able to provide all collected information.

The WHO collects data on maternal, perinatal and infant mortality, sexually transmitted diseases, fertility, induced abortions, Caesarean sections, low birth weight and certain malformations as well as the contraception used by married 15–49-year-olds. Apart from the lastly mentioned (contraception use), Finland is also able to provide the data for the WHO.

The EURO-PERISTAT EU project, investigating perinatal health on the European level, was started in 2001. Reports presenting the project were published in 2008 and 2012.[21, 22]

The EURO-PERISTAT data collection of the year 2012 was comprised of core indicators (11) and recommended indicators (14). All core indicators (mortality rates on an annual basis, not as cohort data) as well as the recommended indicator data could be produced based on the Finnish health registers,

The EU-funded REPROSTAT project involved developing and collecting indicators (18) related to sexual and reproductive health on the EU level.

In connection to the project, it was noted that no regular and comprehensive data collection takes place in Finland on the following indicators: median age at the time of the first intercourse, contraceptive method use of the adult population (excluding those using oral contraceptive pills and those who have undergone sterilisations), the rate of those who have tried to conceive for over a year unsuccessfully, the extent of urinary incontinence problems among women, self-reported satisfaction with sexual health, and the proportion of those who have experienced sexually offensive violence.[23] The final report of the project was published in 2011.

In particular, the extent of contraceptive use among the adult population is a key indicator for sexual health for which systematic and sufficiently up-to-date data collection should be organised. Among other issues, data are needed in the assessment of the functionality of the service system and is also often requested for international comparisons.

Development of the quality of services and monitoring of the quality is also necessary for the promotion of sexual and reproductive health. After developing general statistical monitoring indicators, developing indicators for measuring the quality of health care services is the next important development step. Successful quality work has been conducted in multiple health care units, but the work accomplished by these does not lend itself to national comparison. International experiences are used as a basis for developing national quality monitoring indicators in the National Institute for Health and Welfare. The indicators will also benefit monitoring the quality of the promotion of sexual and reproductive health. The incidence of third and fourth degree lacerations in vaginal deliveries is the only indicator currently proposed by the OECD and the health care quality indicator groups of the Nordic Council of Ministers that is regularly reported on in Finland.

Kanta project

National Archive of Health Information (Kanta; www.kanta.fi) is a national data system service for healthcare services, pharmacies and citizens. The services include the electronic prescription, a pharmaceutical database, My Kanta pages for viewing personal information, and a patient data repository. Utilisation of the data submitted to Kanta in the collection of national statistics is an essential development target for statistical and register activities. The aim is that the Kanta service could help in complementing the areas where information is currently lacking, also in the area of sexual and reproductive health. It is essential for the statistical use of electronic patient records that the data are presented in a structured form, which enables coherent data recording in all operating units.

The standardisation of electronic data collection improves compiling statistics on local, regional as well as national levels. This is particularly the case with the parts of the health data system where compiling

statistics has been insufficient. The best examples of this are primary health care and maternity and child health clinic activities as its part. The amalgamation of the multiple data systems of primary health care and specialised medical care is a part of the development of the electronic data systems of health care.

Statistics authorities consider it important that the electronic patient data system and register data remain separate; in other words, national health care registers will continue their operations. Nevertheless, these could utilise the data in the electronic patient data system in order to improve the quality and reliability of register and statistical data and to accommodate quicker data collection and publication of statistics. However, it is not possible to expand the data contents of health care registers or use new sources of information without legislative changes.

Objectives

- Register legislation will be updated and developed in order to enable required development actions through up-to-date legislation. The need to maintain existing registers and to create new registers will be assessed during preparation of the legislation.
- Hospital Discharge Register (Hilmo and Avohilmo) will be utilised more effectively in reporting and monitoring of sexual and reproductive health issues.
- Research material of Drugs and pregnancy study will be changed to a permanent data collection process.
- Register data will be completed as automatically as possible through electronic medical reports.

Actions

- The National Institute for Health and Welfare and other actors will plan and implement more extensive and regularly implemented sexual and reproductive health related reporting practice.
- The National Institute for Health and Welfare will establish sexual and reproductive health issues to be a permanent part of all its demographic surveys.
- The National Institute for Health and Welfare will reform data collection from the Medical Birth Register in order that the Medical Birth Register will in the future contain information on father, more detailed background information on both parents, such as place of residence (more accurate than a city), possible immigrant background and the highest education degree.

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19 Development of work distribution, cooperation and coordination

The national action programme for the promotion of sexual and reproductive health in 2007–2011 directed, activated and expanded the promotion of sexual and reproductive health in Finland. There is a need for further development of the activities on the national, regional and local levels.[1, 2]

Work distribution and responsibilities at the national level

Ministry of Social Affairs and Health and the subordinate agencies

Ministry of Social Affairs and Health (STM) (www.stm.fi) steers the promotion of and services for sexual and reproductive health with legislation, social and health care policy strategies and quality recommendations and guides for health promotion. Themes related to sexual and reproductive health include, for example, health promotion, prevention of infectious diseases, development of family policy, prevention of domestic and intimate partner violence, and development of the service system. The Kaste programme[3] and the local government and service reform also influence the structure and organisation of sexual and reproductive health services. International cooperation is conducted with, for example, WHO, EU and UN. Advisory boards subordinate to the ministry, such as the Advisory Board for Public Health, the Advisory Board on Communicable Diseases, the Advisory Board on Romani Affairs and the Advisory Board for the Ombudsman for Children deal with issues related to the health and well-being of the population in connection to their duties.

The Government Programme of Prime Minister Jyrki Katainen emphasises, e.g., the development of sexual and reproductive health services, services for the victims of intimate partner and domestic violence and the inclusion of sexual health (sexual counselling, prevention of sexually transmitted diseases, prevention of violence) in contraception counselling.[4] The Ministry of Social Affairs and Health also coordinates the prevention of domestic and intimate partner violence, guides and supervises the mediation of criminal and civil disputes as well as participates in the prevention of human trafficking and helping its victims.

The Ministry of Social Affairs and Health steers the National Institute for Health and Welfare, Regional State Administrative Agencies, National Supervisory Authority for Welfare and Health Valvira, Finnish Institute of Occupational Health and other agencies and institutions in its administrative sector. A four-year performance agreement is contracted with these actors.

The objective of the National Development Programme for Social Welfare and Health Care[3] is to reduce differences in well-being and health and to organise the structures and services of social and health care in a customer-oriented manner.

The restructuring of the social welfare and health care services aims to accomplish equal social and health care services as well as reinforce the currently insufficiently operating primary services.[5] The new integrated, two-level service system would include a more extensive primary level for social and health care and a shared special catchment area for social and health care. According to the service structure work group, an adequate population base and sufficient production volumes are required at the primary level of social and welfare services in order to guarantee a nationally compatible service system and quality and safety of services. According to the work group, an adequate population base for organising social and health care should contain at least 50,000–100,000 people, depending on capacity factors. Other capacity factors include the economic sustainability and stability of the provider, securing competence, availability and sufficiency of staff and infrastructure.

The Decree on emergency care entering into force at the beginning of 2015 (beginning of 2017 for deliveries) creates coherent criteria for urgent care.[6] The most central aim of the Decree is to improve the quality of emergency care and patient safety. This objective is sought by ensuring the availability of

sufficient resources and expertise, particularly in demanding medical specialities. The implementation of the Decree requires focusing demanding emergency care to hospitals whose emergency operations fill the conditions of the Decree or, correspondingly, demands further investments in emergency care in the hospitals whose operations do not currently meet the presented requirements in medical specialities.

The National Institute for Health and Welfare (THL) (www.thl.fi) is a research and development institute operating under the Ministry of Social Affairs and Health. It seeks to serve the broader society in addition to the scientific community, actors in the field and decision-makers in central government and municipalities in order to influence work that protects and promotes the health and welfare of people in Finland. THL works to promote the health and welfare of the population, prevent diseases and social problems, and develop social and health services. It has a wide range of tools to carry out its responsibilities: research, follow-up and evaluation, development, expert influence, official tasks as well as international co-operation. THL is the statutory statistical authority in health and welfare and maintains a strong knowledge base within its own field of operations. THL is also responsible for the application of this knowledge.

In 2010 THL's organisation was divided into four divisions. The Department for Social and Health Services (LAPO) in the Division of Health and Social Services is divided into three units: Sexual and Reproductive Health Unit (SELI), Child and Adolescent Health and Welfare Unit (LAHY), and Child, Adolescent and Family Services Unit (LANU). The objective of the SELI unit is to promote sexual and reproductive health:

- by studying the sexual and reproductive health of the population
- by studying and developing sexual and reproductive health services
- by studying the connection of lifestyles to sexual and reproductive health
- by maintaining a register of screenings during pregnancy and a related serum sample bank
- by disseminating information on sexual and reproductive health.

The SELI unit cooperates with the other units of LAPO and more widely also with the other departments of the National Institute for Health and Welfare, such as the Service System Department, the Epidemiologic Surveillance and Response Unit, the unit for health, functional capacity and well-being and the Information Structures Unit, and utilises, for example, the questionnaire and register data of the department in its studies. The unit aims to support multiprofessional networking between those interested in promoting sexual and reproductive health. The networking partners include, among others, municipal actors (e.g., maternity and child health clinics, experts in school and student health care in municipalities), researchers, organisations, educators and education institutions, a safety skill network and the networks of sexual counsellors and the contact teachers for sexual health. The Kasvun kumppanit web portal (www.kasvunkumppanit.fi) functions as a channel for information distribution among professionals.

The SELI unit produces the SELI newsletter[7] on sexual and reproductive health, which conveys information about topical matters, such as training, events, publications, development projects and research findings. It is aimed at all working in the field of sexual and reproductive health and interested in the topic, and people can subscribe it to their personal e-mail at the unit's website free of charge. The National Institute for Health and Welfare's internal expert network for the promotion of sexual and reproductive health meet regularly 4–6 times per year.

The MEKA unit (unit for assessing methods and practices) operates under the Department for Social and Health Services in the Service System Department of the National Institute for Health and Welfare. It aims at promoting good approaches founded on scientific evidence in Finnish health care and thus developing the efficiency and effectiveness of health care.

The National Supervisory Authority for Welfare and Health Valvira maintains and promotes patient safety and does its share in taking care of the quality of health services. The National Committee on Medical Research Ethics (TUKIJA) operates in connection to Valvira. In cooperation with regional administrative authorities, National Supervisory Authority for Welfare and Health Valvira has formulated a national supervisory programme for maternity and child health clinic activities, school and student health care and preventive oral health care for children and youths (supervision of Decree 338/20118). The supervisory programme is used to increase the systematicality, openness and transparency of supervision

and to guide the service providers to develop their own operations and self-supervision for the operations.[9] Permissions in compliance with the Act on Assisted Fertility Treatments, the Act on Induced Abortion and Act on Sterilisation are also a responsibility of Valvira. The Adoption Board of the National Supervisory Authority for Welfare and Health Valvira acts as the expert, permission and supervisory authority for adoptions.

Finnish Institute of Occupational Health (TTL, Työterveyslaitos) (www.ttl.fi) is a multidisciplinary research and expert institute operating in the administrative sector of social and health care in six localities. Its operations aim at healthy and safe working life throughout the course of the person's career, and this also contains the reproductive health of employees, especially during pregnancy.

Administrative sector of the Ministry of Education and Culture

The Ministry of Education and Culture (www.minedu.fi) is responsible for pre-primary and basic education and early childhood education. The Ministry of Education and Culture is responsible for the education provided in universities and universities of applied sciences as well as vocational training. The Ministry of Education and Culture is also in charge of the basic education and the education leading to vocational qualifications for social and health care professionals. Legislation is used to influence the allocation of lesson hours in basic and secondary education and, for example, the amount of health education included in this. Once in every four years, the Government authorises the Education and Development Research Plan which determines the education and research policy strategies for the following few years.

In addition to the Government Programme, Education and Development Research Plan and legislation, agreements between the Ministry and universities guide university operations. Negotiations take place at the beginning of a three-year agreement period and involve agreeing on the operational and quantifiable objectives for the universities and the required appropriations, monitoring and assessment of the accomplishment of objectives, and the development of the operations.[10] In addition to the Government Programme, Education and Development Research Plan and legislation, agreements between the Ministry, those responsible for providing the operations of the universities of applied sciences, and the universities of applied sciences themselves. The central aims for the operations of universities of applied sciences, monitoring these and developing the operations are set in the three-year agreements. In years when negotiations do not take place, the Ministry of Education and Culture provides written feedback for the higher education institutions.[11]

The Finnish National Board of Education (www.oph.fi) is an agency for developing education, responsible, e.g., for the policies for early childhood education and the development of pre-primary and basic education, upper secondary school education and vocational upper secondary qualifications. The Finnish National Board of Education prepares the core curricula for basic education and general upper secondary education (division of subjects, e.g., health education), criteria for vocational qualifications and competence-based qualifications, and uses different development projects for improving education. Its tasks also include, among other things, the assessment of education, producing information services and support services for education, for example, further education for teachers and other staff in municipal educational administration.

The Centre for Media Education and Audiovisual Media (www.kavi.fi) is an agency operating under the Ministry of Education and Culture whose task is to promote media education and a safe media environment for children as well as provide image programmes for children. The agency acts as an expert body in the development of children's media environment, promotes research in the field, follows the international development of the field, and provides information on matters concerned with children and the media.

Administrative sector of the Ministry of Justice

The Ministry of Justice (www.om.fi) maintains and develops the legal order and legal protection as well as ensures the structures of democracy and the basic rights of citizens. The Ministry's field of operations is related to the promotion of sexual health in relation to the work for preventing violence and particularly

sexually offensive violence as well as the activities aiming to provide treatment to convicted sex offenders and reduce the risk of sexual offenders to commit a new crime.

The Ministry of Justice has an advisory board for the criminal sanctions field, set up by the Government, which acts as the expert body in issues related to the development of the criminal sanctions field and supports and promotes cooperation in re-socialising convicts and reducing repeat offences. The National Council for Crime Prevention (www.rikoksentorjunta.fi) is a crime prevention expert and cooperation agency whose goal is to plan and implement actions for preventing crime. These include, for instance, work preventing violence, which also includes the prevention of sexually offensive violence.

The Criminal Sanctions Agency (www.rise.fi) is an authority, which enforces prison sentences and community sanctions under the direction of the Ministry of Justice. The employees of the Criminal Sanctions Agency and other officials see that sentences are enforced lawfully and safely in Finland. The agency's duties include the treatment of sex offenders and conducting measures whose goal is to prevent sentenced offenders' risk of reoffending. Municipalities are responsible for providing a continuous treatment chain for criminal sanctions clients. For underaged people, particularly those under 15 years of age, treatment measures are a responsibility of municipalities and the administrative sector of the Ministry of Social Affairs and Health.

The National Research Institute of Legal Policy (www.optula.om.fi) is a research institute subordinate to the Ministry of Justice whose task is to conduct independent legal policy research and related publishing activities. The institute produces an annual summary on the crime situation, including categorised summaries on rapes, sexual offences committed on children and pre-teens and other sexual offences.

Other administrative sectors

Ministry of the Interior (www.intermin.fi) is responsible for the safety of people, builds a competitive society and ensures that all people are treated equally. Of the four departments of the Ministry, the Police Department is responsible for the strategic guidance and supervision of the police sector. Investigation of sexually offensive violence and abuse are primarily an official responsibility of the police, but also require close cooperation with social and health care authorities both at the national and local levels. The Ministry of the Interior has published the third Internal Security Programme[12] (see chapter 15 Sexually offensive violence). A publication has also been compiled on the good practices related to the measures of the previous programme.[13] The good practices are related to issues such as work with violent offenders, such as domestic violence work as well as the Boy's House project. There are plans to implement the good practices nationally.

The Ministry of Employment and the Economy is responsible, for example, for securing the functionality of the labour market and workers' employability. Its sphere of authority contains issues such as employment and public employment service, development of regions and integration of immigrants. The ministry promotes gender equality by mainstreaming the gender aspect in all basic processes in line with the Government Action Plan for Gender Equality 2012–2015. The Ministry of Employment and the Economy implemented the Gender Mainstreaming Programme Valtava for promoting and mainstreaming gender equality in the 2007–2013 programming period of the European Social Fund (ESF). Among other things, the programme included developing methods for promoting gender equality. The Youth Guarantee project aims to promote the employment of young people and prevention of their social exclusion.

The Ministry of Defence (www.defmin.fi) is responsible for, among other things, Finland's Defence Forces and health education provided for conscripts, including sexuality education.

The Ministry for Foreign Affairs' (www.formin.fi) has kept its development policy based on human rights, elimination of inequality, and promotion of sexual and reproductive health and rights as visible features in international development policy. These are also central themes in Finland's Development Policy Programme, in which the promotion of gender equality is a cross-cutting theme. Finland promotes the participation of women in decision-making and is against discrimination, such as sexually offensive violence and domestic violence as well as unequal rights of ownership and inheritance.

Association of Finnish Local and Regional Authorities

The primary tasks of the Association of Finnish Local and Regional Authorities (www.kunnat.net) are to represent the rights of municipalities and their cooperation organisations, and to serve and develop these. The services provided by the association include, e.g., social and health care services and education and culture. The association has been involved in creating the electronic patient record system, which has a key significance, for instance, for the development of sexual and reproductive health services. Similarly, the association has been involved in developing the electronic well-being report for municipalities. The Terveempi Pohjois-Suomi ('Healthier North Finland', TerPS) project (http://sp.terps.foral.fi) included formulating a structure for the well-being report, preparing requirement definitions, implementing piloting and compiling and implementing basic indicators.

Finland's state churches

The operations of the Evangelical Lutheran Church of Finland (www.evl.fi) focusing on sexual and reproductive health include confirmation training and family counselling and family work carried out by the centre for negotiations on family issues, for which the church's unit for education and family issues is responsible. For example, the Virtaa välillämme project currently organises events and courses around Finland, particularly for young couples. The Orthodox Church organises a voluntary Christianity school for young people, which is most typically completed as a Christianity school camp with the duration of around one week, a rite of passage for Orthodox youths.

Non-governmental organisations

The third sector contains a large number of organisations and associations whose duties are related to sexual and reproductive health. The third sector includes, for example, customer work, data production aimed at the population and professionals, and online services. Some of these operations are local, while others are implemented at regional or national levels.

It was determined in the action programme for the promotion of sexual and reproductive health[14] in 2007–2011 that cooperation conducted with the third sector should be strengthened. Nevertheless, the cooperation has so far been unsystematic.[1] In the future, cooperation with non-governmental organisations must be enhanced and expanded in the implementation of the action programme.

Finnish Federation for Social Affairs and Health, SOSTE, (www.soste.fi) is a national umbrella organisation joining over 170 social and health care organisations and dozens of other partners. The federation was founded by the cooperation centre for social and health care organisations YTY ry, central union for social and health security and the Finnish Centre for Health Promotion.

Trade unions

In addition to representation of interests, trade unions and organisations in the field of social and health care develop professional practices and organise continuing education.

Development of work distribution, coordination and cooperation at the national level

The action programme for promotion of sexual and reproductive health[14] for 2007–2011 determined the establishment of a cooperation body for management of cooperative issues and coordination between various administrative sectors as well as the organisation of a permanent, national expert organisation as necessary measures. The latter has been accomplished with the establishment of the SELI unit of the National Institute for Health and Welfare at the beginning of 2010. The national cooperation body has not been established yet.

In practice, a national cooperation body with meetings at regular intervals is needed to operate alongside the SELI unit, which implements expert work for promoting sexual and reproductive health, as the number of key operators is high. Cooperation between the operators in sexual and reproductive health issues has been unsystematic. The lack of overall responsibility and cooperation is a central problem, as the development of the promotion of sexual and reproductive health requires regular cooperation between a

number of administrative sectors. The third sector has significant experience on developing and producing new services. There are already national networks in the field of sexual and reproductive health in existence and under development, but some of these may be focused on one, narrow sub-area. Actors in different networks may not be familiar with the information and competence available in other networks, which often results in overlapping work and losing the synergy that combining different kinds of expertise could bring. There are also some uncertainties in the distribution of duties, for instance, in the management of research and development work. There are also some important fields of operations where no assignment of responsibilities has taken place. Examples of such areas include providing information for the population via the mass media, planning and implementing national campaigns and producing support material for services.

The national cooperation body should include representation from at least the Ministry of Social Affairs and Health, the Ministry of Education and Culture, the Finnish National Board of Education, the SELI unit of the National Institute for Health and Welfare, the Finnish Institute of Occupational Health, the Association of Finnish Local and Regional Authorities, primary health care and specialised medical care as well as representatives of educators, educational institution and higher education institution networks, and numerous organisations. For consultative purposes, the cooperation body could invite to their meetings experts and representatives from other administrative sectors, for example, from the Finnish Ministry for Foreign Affairs, the Ministry of Justice and the Ministry of the Interior.

The tasks of the cooperative body could include the following:

- monitoring and assessing the national and international development of and resource allocation for sexual and reproductive health and related services
- promoting and coordinating the cooperation between different administrative sectors, municipalities, research institutes and educational institutions, non-governmental organisations and other actors for developing sexual and reproductive health
- making suggestion for the long-term development of the promotion of sexual and reproductive health
- following issues of educating professionals in the field, promoting cooperation with the already established educator networks and making suggestions for the development of education.

Objectives

- Sexual and reproductive health will be steered, developed and followed systematically and regularly at the national level.
- Duty division and cooperation in the sexual and reproductive health field will be defined and the agreed practices will be communicated to all parties. Cooperation will be carried out in a systematic and goal-oriented way.

Actions

- The National Institute for Health and Welfare and the Ministry of Social Affairs and Health will establish a cooperation body for management of cooperative issues and coordination between various administrative sectors.
- The cooperation body will plan, intensify and carry out cooperation in the implementation of the action programme.

Work distribution and cooperation at regional level

The regional promotion of sexual and reproductive health has been developed in recent years. The assessment of the national action programme 2007–2011[14] conducted in 2011 indicated that the promotion of sexual and reproductive health had been included in the action programme of five hospital districts and was in planning stages in further two, while it had been included in the programmes of only three of the districts in 2009.[15] A contact person for sexual health had been appointed in eight hospital districts. A work group for planning and coordinating sexual and reproductive health promotion had been appointed in eight, and a work group for sexual and reproductive health promotion on the regional level had been appointed in

six hospital districts. Compared to the year 2009, the hospital districts were more active in organising continuing education in 2011.[18] Hospital districts reported having developed the care and operating practices for supporting parenthood according to the action programme for sexual and reproductive health. The most frequently used statistics of the National Institute for Health and Welfare used in monitoring the promotion of sexual and reproductive health were the Register of Induced Abortions (17), Medical Birth Register (15) and Infectious Diseases Register (14). SOTKAnet was used by only eight of the hospital districts.

By 2011, also other initiatives for promoting sexual and reproductive health on the regional level had been made in the hospital districts. These have included, for example, establishing sexual health clinics, starting sexual counsellor education in the region, formulating care pathways and chains, data-protected care records in sexology, developing practices for recording patient data, an online course and other electronic materials and implementing these, establishing a work group for planning education, developing a family training model, starting a breastfeeding clinic, and different projects.

None of the health care provision plans, obliged by the Health Care Act[16], of the 12 hospital district responding to the question had taken sexual and reproductive health promotion into account, or had not yet prepared a plan for this.[15]

The job description and resources of sexual counsellors and therapists varied in the hospital districts in 2011. Their work should be described and organised, and resources should be allocated to it. Patient instructions must be systematically assessed and developed from the viewpoint of sexual and reproductive health.

The promotion of sexual and reproductive health must be included in the action programmes of regional responsible bodies and regional health care provision plans, municipal well-being reports and other health promotion programmes. Treatment chains must be assessed from the perspective of sexual and reproductive health. A further challenge is to strengthen the cooperation between primary health care and specialised medical care and to utilise primary health care units in the promotion of sexual and reproductive health.[15]

In 2011, the majority of hospital used treatment chains in organising prenatal screening, treating mothers with substance abuse issues, in breastfeeding counselling, treatment of induced abortions and miscarriages and in abnormal Pap smear results.[15] Treatment chains for the diagnostics and treatment of sexually transmitted diseases were found in 12 hospital districts and for postpartum depression and recognition, examination and treatment of victims of sexually offensive violence in 10 hospital districts.

Only four hospital districts had introduced a treatment chain for demanding sexual counselling requiring special expertise. Some individual treatment chains were also in use.

The Health Care Act[16] is applied in the implementation and contents of the health care included in municipal service provision responsibilities laid down in the Primary Health Care Act[17] and the Act on Specialized Medical Care[18] unless otherwise provided in another Act. Health care comprises of the promotion of health and well-being, primary health care and specialised medical care. According to the Health Care Act, the municipalities included in the same joint municipal authorities for hospital districts must prepare a health care provision plan based on the health monitoring data and service need of the population in the area. Negotiations on the plan must take place with the joint municipal authorities for hospital districts. The plan must include agreement on issues such as cooperation between municipalities, objectives and responsible parties related to the promotion of health and well-being, organisation of health care services, as well as necessary cooperation between primary health care, specialised medical care, social welfare, medical care and other actors. The primary health care unit provides expertise and coordinates the research, development, formulation of treatment and rehabilitation chains, and continuing education in its region, and takes care of predicting the need for human resources and the coordination of specialised medical care, primary health care and, where applicable, social welfare.

Regular cooperation occurs naturally among the actors in the promotion of sexual and reproductive health on themes that include continuous clinical cooperation between different actors and especially when a specific party is clearly in charge of the clinical work. For example, a maternity health clinic and a delivery hospital share a client and form a treatment chain in which functional cooperation lays the

foundation for good care outcomes. The cooperation between the actors in maternity care was described in national recommendation published in 2013 (chapter Cooperation).[19] It is possible to reduce overlapping operations by introducing shared treatment practices created and agreed upon together; the implementation of these requires for the real-time records of the parturient to be available in different organisations and for the latest information on the harmonised treatment and counselling practices to be always available.[20]

Universities and universities of applied sciences are also regional actors whose tasks include, in addition to education, to conduct research and development cooperation in the respective regions. Educational institutions operate on the interface of education and service production and forward information about the needs for research, development and education related to sexual and reproductive health emerging in their area.

Objectives

- Responsible regional organs and actors will improve division of duties, coordination and cooperation in their region.
- Responsible regional organs and actors and municipalities or joint municipal authorities will cooperate with various actors of the region (such as universities, educational institutions, organisations) regularly and systematically in order to promote sexual and reproductive health.

Actions

- Responsible regional organs and actors will found working groups for cooperation with regional and primary health care actors, or extend the operational field of existing working groups to include also sexual and reproductive health.
- Responsible regional organs and actors will appoint a person/persons to coordinate sexual and reproductive health promotion in their region.
- Responsible regional organs and actors will check modes in operation, instructions and cooperation practices within sexual and reproductive health services according to the action programme.
- Primary health care and specialised care actors will continue to develop and update treatment chains in cooperation (e.g., induced abortion, chlamydia examination, treatment and prevention, sexual counselling, requiring special know-how, treatment of victims of sexually offensive violence, treatment of substance abusing pregnant women, post-natal depression, breast-feeding counselling).
- Responsible regional organs and actors will arrange regular continuing education on sexual and reproductive health.
- Responsible regional organs and actors will increase systematic monitoring of sexual and reproductive health promotion as a part of development of their work.
- Responsible regional organs and actors will provide municipalities with support in coordinating of sexual and reproductive health promotion, e.g., as a part of the health care provision plan, required by the Health Care Act, and municipal welfare reports.

Work distribution and cooperation at local level

Municipalities are tasked with promoting the health of their inhabitants and organising sufficient social and health care services. The implementation of the health promotion task has been enforced with the Health Care Act,[16] Government Decree on Maternity and Child Health Clinics and School and Student Health Care and Preventive Oral Health Care of Children and the Young,[8] and quality recommendations for health promotion.[21] The municipality must provide contraception counselling and other services promoting sexual and reproductive health services to those living in its area.[16]

In primary health care, maternity care and contraception counselling as well as school and student health care can be clearly distinguished as the actors in charge of the promotion of sexual and reproductive health. However, a wider conception of the promotion of sexual and reproductive health is also integrated

in many other areas of operations in primary health care. Tasks related to the promotion of sexual and reproductive health in different primary health care functions have been compiled in table 9.

***Table 9**. Responsibilities in the fields of operations of primary health care in the promotion of sexual and reproductive health.*

Field of operation	Task of promoting sexual and reproductive health
Consultation (doctor, nurse) and emergency operations	Treatment of illnesses and health issues and related sexual counselling
Maternity and contraception counselling clinics	Sexual counselling, prevention of sexually transmitted diseases, prevention of sexually offensive violence and other forms of violence, contraception, planning and monitoring of contraception and postnatal care, family training (incl. antenatal training), couples counselling (incl. sexual counselling), counselling and support for sexual and gender minorities
Child health clinic activities	Support for the sexual development of the child, support for the parents' relationship, prevention of violence
School health care	Sexuality education, contraception, prevention of sexually transmitted diseases, vaccinations (HPV), prevention of sexually offensive violence, sexuality education and participation in planning sexuality education
Student health care	Treatment of illnesses and health issues, pre-conceptive counselling, sexual counselling, contraception, prevention of sexually transmitted diseases, prevention of sexually offensive violence
Occupational health care and appointments for the unemployed	Assessment of working conditions for reproductive health, counselling and treatment promoting reproductive health, sexual counselling, prevention of sexual harassment at workplaces
Home care and home nursing	Taking into account the sexual needs of those with long-term illnesses, disabled people or elderly people, sexual counselling
Health centre hospitals and institutional services	Taking into account the sexual health and sexual needs of those in institutional care
Health counselling for the elderly	Sexual counselling and treatment of issues related to ageing and long-term illnesses
Oral health care	Dental care during pregnancy, diagnostics for sexually transmitted diseases and HIV
Mental health services	Prevention and treatment of illnesses and mental health issues and the related sexual counselling, pre-conception health, care and counselling, sexuality education
Rehabilitation, physical therapy	Sexual counselling in the rehabilitation of multiple and long-term illnesses and injuries, incontinence, postnatal counselling
Screening	Cervical cytology, mammography screenings, prenatal screening samples, antenatal screenings, opportunistic screenings for chlamydia

Social welfare and education services are the primary partners in cooperation within municipalities for the promotion of sexual and reproductive health. Common rules are needed, for example, with police authorities. The private services and actors in the third sector are taken into account in the cooperation as supplementary resources. Examples of issues where cooperation within the municipality or between regions is needed in the promotion of sexual and reproductive services have been compiled in table 10.

***Table 10**. Cooperation partners of health care and central areas of cooperation in the promotion of sexual and reproductive health in the municipality.*

Cooperation partners of health care	Central areas of cooperation
Social welfare services • child protection • services for the elderly • disabled care	Building networks and agreeing on approaches when suspecting sexually offensive violence and exploitation Taking into account the sexual needs of the elderly population in 24-hour institutional care Understanding and taking into account the sexuality of disabled people
Youth services	Prevention and recognition of sexually offensive violence; approaches supporting the sexual growth and development of the young person that also take into account sexual and gender minorities
Education services • Day-care centres • pre-primary education • basic education • upper secondary education • liberal adult education	Approaches supporting the sexual growth and development of children Planning and implementing the sexuality education in pre-primary, basic and upper secondary education; student welfare Education and public events of adult education centres and community colleges
Police	Approaches used in the forensic medical examinations of those who have experienced sexually offensive violence or abuse; continuing education
Private services	Sexual counselling and therapy services
Parishes	Couples counselling and training, child and youth work
Third sector	Complementary services, education

Tables 11a and 11b describe the 2012 results obtained in the health promotion capacity building in Finland concerning sexual and reproductive health. All health centres in Finland responded to the survey. The health centre specific information has been published in the TEAviisari database at www.thl.fi/teaviisari. The action programme for the promotion of sexual and reproductive health had been provided for informative purposes in one third of the health centres, but two thirds had not discussed this at all in their elected municipal bodies. One fifth had distributed the programme to its board of directors, one fifth had presented it, and nearly one fifth had discussed it and made decisions based on it. A practice involving provision of support and counselling in sexual health issues had been recorded in around 40 per cent of the health centres.

***Table 11a**. Sexual and reproductive health promotion capacity building in health centres in 2012: positive responses, %*

The content of the question	N	%
Implementation plan for sexual and reproductive health	153	44
Appointed physician responsible for the management and development of contraseptive councelling and other sexual health counselling	117	62
Appointed nurse responsible for the management and development of contraceptive counselling and other sexual health counselling	144	90
Appointed specialist coordinator responsible for the management and development of contraceptive counselling and other sexual health counselling	104	16
Appointed someone responsible for the management and development of contraceptive counselling and other sexual health counselling	152	91
The health center has a person who has been trained in providing sexual counselling	151	38

N = number of responses (www.thl.fi/teaviisari)

***Table 11b**. Sexual and reproductive health promotion capacity building in health centres in 2012: established practice, %*

The content of the question	N	At some officies	At all officies
Young people have access to sexual health matters within a week.	155	46	45
Condoms are free of charge until the age of 20.	154	30	10
All contraceptives are free of charge until the age of 20.	152	7	11
New clients for contraceptive counselling emphasize the need for dual prevention in the prevention of sexually transmitted diseases and HIV.	155	32	65
New clients for contraceptive counselling are offered a chlamydia test.	154	23	60
HIV test can be obtained without a doctor's appointment.	153	12	81
Women who have undergone an induced abortion are offered a follow-up examination.	155	23	66
Free-of charge contraception is offered after repeat abortions.	152	13	18
The counselor doing prevention counseling has time reserved for telephone counselling.	154	29	62

N = number of responses (www.thl.fi/teaviisari)

In fairly small and medium-sized municipalities, the questions on the internal sexual and reproductive health cooperation can be dealt with in the same cooperation working group for health promotion as any other issues belonging to health promotion. Separate work groups for sexual and reproductive health can be established in major urban areas. In small municipalities, the entire health promotion work could be based on regional collaboration, in which case the work group would serve a number of municipalities, and having sufficient expertise from multiple fields would be accomplished. Issues such as sexual counselling demanding special competence and special services for the victims of sexually offensive violence require an extensive population base.

Objective

- Sexual and reproductive health will be steered, managed, developed and followed in municipalities as a part of health promotion work.

Actions

- Municipalities and joint municipal authorities will found a cooperation working group, responsible also for sexual and reproductive health promotion in the municipality.
- For the cooperation working group, municipalities and joint municipal authorities will select representatives from social and health authorities and education and teaching authorities at a minimum and, additionally, representatives of police, parish and the third sector, as needed.
- The cooperation working group for health promotion will cooperate with the actors of specialised health care and the local third sector.
- Management groups at health centres will agree on steering responsibilities, modes of operation (especially on sexual counselling and encountering victims of sexually offensive violence), distribution of duties and cooperation.
- Municipalities and joint municipal authorities will ensure that sexual and reproductive health promotion will be included in the health care provision plan.

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20 Implementation and supporting of the action programme

The purpose, goal and schedule of the action programme implementation

The aim of this implementation plan is to support the implementation of the **action programme for the promotion of sexual and reproductive health** horizontally in different sectors and at all administrative levels as well as in the organisational field all over Finland. The aim is to ensure the commitment of key agents and actors to the objectives of the programme and the implementation of the proposed measures.

The measures related to the action programme will conform to the future structural and functional changes in the health and social service system and in the educational sector, cooperating with a range of sectors at the national, regional and local levels.

The aim is to implement the action programme as a part of the re-structuring of local government services and development and reform of preventative municipal services. For this purpose, the Ministry of Social Affairs and Health and the National Institute for Health and Welfare recommend that local authorities utilise the action programme in the context of the compilation of action and financial plans and in preparation of reports related to the restructuring of local government and services for the Government.

The aim is that the programme will become well-known during the years 2014–2015. At this time, the implementation phase of this programme will be commenced, aiming at establishing the actions proposed in this programme as a part of normal activities. The proposals of the action plan have been prepared for the years 2014–2020.

Key actors in implementation

Social and health care and general and vocational education are key sectors in the implementation of the programme. As the action programme is related to the promotion of equality, equal availability of sexual and reproductive health services and programmes for preventing violence, the implementation of the programme is also a concern of the defence forces, the judicial system, the police authorities and the field of operations of the Ministry of Employment and the Economy.

The Department for Social and Health Services and Department for Promotion of Welfare and Health are responsible for implementing the programme in the Ministry of Social Affairs and Health. The tasks of the National Institute for Health and Welfare in the implementation of the programme are determined by the basic task, current distribution of duties and performance agreement of the department. The responsible officers at the Ministry of Education and Culture and the Finnish National Board of Education have a central role in the implementation of proposals related to general and vocational education.

In regional administration, the Regional State Administrative Agencies are in charge of the control and supervisory duties of the social welfare and health care authorities. Hospital districts or corresponding regional actors coordinating health care are responsible for the regional implementation of the action programme and the statutory duties of specialised medical care for the promotion of sexual and reproductive health. At the local level, the strategic management of the social and health services of municipalities, joint municipal authorities or the cooperation area of social and health care authorities is responsible for the implementation. Persons in charge of health promotion in hospitals, health centres and municipal government in different sectors have a key role in the practical implementation of the programme and the coordination of cooperation between the administrative sectors. Cooperation with the police forces is necessary for agreeing on local approaches for examining the victims of sexually offensive violence. The third sector has a significant task in the development of new operating models and highlighting challenges in the operations.

In the education system, key persons include those in charge of fields of education and education programmes and the teachers educating social and health professionals in universities, universities of

applied sciences and upper secondary education. The promotion of research in the field and accommodating closer cooperation between researchers can be triggered by the initiative of an individual department or faculty.

Health education teachers in basic education and upper secondary schools are responsible for using the action programme in the preparation of curricula, development of teaching and as learning material. Key persons in universities, universities of applied sciences and secondary vocational institutions include the managers of the fields of education and education programmes, as well as the teachers educating health care and social welfare professionals. The professional organisations also have an important role in providing professional continuing education. The promotion of research and intensifying the research cooperation in the field require initiatives from individual departments or faculties as well as national coordination (see chapter 16 Sexual and reproductive health research).

All health care and social welfare professionals have statutory responsibilities for using well-justified approaches and continuously developing their professional competence. The key persons include the preventive health care staff in maternity and contraception counselling clinics, child health clinics, school and student health care and occupational health care, the sexual and reproductive health professionals in primary health care and specialised medical care, and the staff in early childhood education, child welfare and youth services.

Communication on the action programme

On the national level, the National Institute for Health and Welfare is responsible for providing information on and publishing the programme. The National Institute for Health and Welfare and the Ministry of Social Affairs and Health will organise a national seminar in order to introduce the programme and to start its implementation in the spring of 2014. Information on the programme will be given also in other events organised in the years 2014–2015. The action programme will also be published in electronic form in the website of the National Institute for Health and Welfare.

The National Institute for Health and Welfare, the Association of Finnish Local and the Regional Authorities and the Finnish National Board of Education provide information on the programme on their websites and arrange training on the programme. The SELI unit of the National Institute for Health and Welfare provides information about the programme, the progress of its different sub-areas and related current issues on its website and via the SELI newsletter. Other important information providers include trade organisations and other organisations.

The regional actors responsible for sexual and reproductive health services organised regional press conferences and training. In municipalities, the managers of different administrative sectors are responsible for providing information on the programme at the local level. The managers also inform elected officials.

The launching and supporting of the action programme

The objective is that the action programme for the promotion of sexual and reproductive health is utilised in the strategy and development work concerned with health care and social welfare and education authorities.

Municipalities and primary health care

In compliance with the Health Care Act, municipalities have appointed responsible bodies for the promotion of health and well-being. These bodies are responsible for creating structures and organising cooperation for and other implementation of the promotion of sexual and reproductive health. These bodies also integrate the promotion of sexual health in preventive work and the treatment of illnesses, and develop the planning, monitoring and provision of information of these services. Particular development targets include youth services and the prevention, early recognition and treatment of sexually offensive violence. Municipalities prepare a broad-based well-being report for each term of the local council and an annual, summarised well-being report. The well-being report can also be used in monitoring the situation with the

themes contained by the action programme for the promotion of sexual and reproductive health on the local level.

Hospital districts or corresponding regional organisations

The responsible local organisations check and, when necessary, expand and establish the approaches, instructions and modes of cooperation regarding the sexual and reproductive health in their operating units and also develop these in line with the action programme together with staff. In addition, they appoint contact persons for sexual and reproductive health, take care of training them and establish, e.g., a temporary work group in order to start activities at the regional level and create permanent service structures. They are also responsible for building regional treatment chains, and compile regional networks and expert groups (e.g., regional cooperation network for maternity care).

Social administration

Cooperation is conducted in social administration in the prevention and treatment of violence together with health administration and other necessary actors. The objectives and contents of the action programme are taken into account in the development of child protection, youth work, services for the elderly and services for the disabled.

Health and social field education at upper secondary and university of applied sciences levels and within university health science and medicine education

The programme is used for developing the contents of education and as learning material, for educating and assessing the competences of educators, and for targeting research and development work to support sexual and reproductive health.

Regional State Administrative Agencies

Regional State Administrative Agencies guide and monitor the promotion of sexual and reproductive health and production of services in their areas.

The Ministry of Social Affairs and Health in cooperation with the National Institute for Health and Welfare, Association of Finnish Local and Regional Authorities, the Ministry of Education and Culture and the Finnish National Board of Education

The Ministry of Social Affairs and Health, the National Institute for Health and Welfare, Association of Finnish Local and Regional Authorities, the Ministry of Education and Culture and the Finnish National Board of Education participate in regional and national education and cooperation meetings, which include conveying new information and planning the implementation of proposals. The bodies also organise education contents related to this theme in their own education events, such as the National Institute for Health and Welfare's Healthy Municipality days, school health days, the healthy SOS event, student health day, the Association of Finnish Local and Regional Authorities' hospital day and health centres' negotiation days for the management.

Trade organisations

Trade organisations support the implementation of the programme in regional and local cooperation with health service managers and discuss the programme in training events, publications and on their websites.

Other organisations of the field

Other organisations of the field support the implementation of the programme in their sectors and cooperate with other actors.

Monitoring and evaluation of implementation

The National Institute for Health and Welfare organises the regular monitoring for the implementation of the programme. In 2017, the National Institute for Health and Welfare and the Ministry of Social Affairs and Health will organise a national monitoring seminar for assessing the progress of the implementation of the action programme for the promotion of sexual and reproductive health and recognising problems that have emerged. The National Institute for Health and Welfare will update the programme at the latest in 2020.

21. Summary

The action programme for the promotion of sexual and reproductive health was updated to promote sexual and reproductive health and reduce inequality related to this. This objective is sought by increasing knowledge, developing services and strengthening sexuality education in 2014–2020. By promoting sexual and reproductive health and reducing potential health differences in this, we also promote the health and well-being of the entire population. The aim is that key actors commit themselves to the objectives and suggested actions in this programme and that the action programme is used when preparing the next Government Programme, developing the service structure and preventive services of municipalities, and as a part of the well-being reports of municipalities. Moreover, the action programme is necessary at all levels of education of professionals in the field of social and health care, early childhood education and the education sector. Based on the final report of the previous action programme, there continues to be a need to support and further develop the good practices and functions promoting sexual and reproductive health. Children and adolescents, men's sexual and reproductive health, multiculturalism and good delivery care were selected as priority areas in the updated action programme.

The objectives and actions are aimed at the Government, political decision-makers, elected officials, social and health care management and staff, non-governmental organisations in the field, and other central cooperation partners, universities, research institutes, universities of applied sciences, sources for research funding, early-childhood education, and the teachers in different fields and levels of education and those in charge of educating them. More than 100 objectives for promoting sexual and reproductive health by the year 2020 are presented in this action programme. In order to reach the objectives, the action programme contains proposals for in total over 200 actions. It has been recommended that the actions should be carried out by various actors deemed best possible for the task.

Updating the action programme occurred at the exact same time as the reform of social and health care services and local government was taking place in Finland. In addition, the weak global economic situation that had continued for a long time had already, and continues to force the Finnish Government and municipalities to take action in order to adapt its operations. In this situation, the objectives proposed in the action programme may seem difficult to accomplish and the suggestions for actions may appear difficult to implement. As the effectiveness and cost-effectiveness of preventive work will only materialise and become visible in the future, the authorities may be tempted to make savings on preventive work. If made correctly, even small solutions may promote sexual and reproductive health, while short-sighted decisions may significantly hinder it. A good example of this is the new increase in induced abortion rates among under 18-year-olds in the mid-1990s. The climb was a result of cuts to public health care after the recession, increased prices of contraception and major variation in the amount and quality of sexuality education provided in schools, brought on by the fact that since 1994, municipalities could independently decide on the curricula of the schools within their borders. Government Decree on the instruction of health education was issued in 2001 and the core curriculum for basic education was reformed in 2004. In the 2000s, teenage pregnancy rates and the numbers of induced abortions among teenagers have been reduced by one third. There is no research knowledge on the strength of the connection between the instruction of health education and the reduction in abortions among young women and on what other possible factors have influenced the improved situation in the 2000s, but sexuality education can be assumed to have had a significant role. Sexuality education at comprehensive school is in the key role as it reaches the whole population within the age range of compulsory education.

Approximately one sixth of the suggestions for actions in the action programme concern the Government. Around seven per cent apply solely to the National Institute for Health and Welfare. The suggestions are primarily connected to new national guidelines, legislation, education contents and provision, planning of new services promoting sexual and reproductive health, or introducing already existing action programmes or instructions for the promotion of sexual and reproductive health by professionals at the regional and local levels. For example, the Ministry of Social Affairs and Health already has an action plan for the prevention of female circumcision, the implementation of which requires

an education package, regional training days and a website allowing professionals to seek information to support their work, realised in cooperation with the Finnish National Board of Education and the National Institute for Health and Welfare.

Little under one fifth of the suggestions for actions is concerned with the services provided by municipalities or joint municipal authorities, and some five per cent apply to the actors responsible for organising regional sexual and reproductive services. Some of the objectives in this action programme are already accomplished in certain regions and municipalities or joint municipal authorities. As the aim is to promote the sexual and reproductive health of and prevent inequality among the entire population, the objectives should be accomplished everywhere in Finland. Many suggestions for actions require appointing responsible persons (e.g., a doctor responsible for contraceptive counselling), reorganisation of duties (e.g., postnatal examination), organising care pathways (e.g., care pathways for postnatal depression or for induced abortion clients), developing cooperation and utilising the action programme in the well-being reports of municipalities.

As many as one third of the suggestions for actions in this action programme are concerned with the activities of professionals, i.e., it is possible to accomplish a lot of the measures of this action programme by paying attention to professionals' work approaches, education, occupational guidance and managerial work. Around eight per cent of the suggestions for actions are related to reforming education or organising new kind of education, such as introducing sexuality educator studies at the higher education institution level or including the promotion of sexual and reproductive health in the specialisation studies of doctors. Around six per cent of the suggestions for actions are related to research conducted in research institutes and higher education institutions. For example, questions related to sexual and reproductive health or gender identity, gender expression and sexual diversity should be included in population studies. In addition to these, some individual suggestions for actions concern non-governmental organisations in the field and cooperation between different actors.

It can therefore be said that the majority of the suggestions in this action programme can be implemented with the already available resources or with minor additional resources, new kind of organising, planning and targeting of education, defining responsible actors and utilising the action programme in the well-being reports of municipalities. It is suggested that the actions connected to the priority areas of this action programme should be implemented first during the nearly seven-year validity period of this agreement.

Sexuality education can be used to strengthen self-esteem and self-knowledge of children and adolescents and to teach them safe and positive sexuality. It is important to include sexuality education in early childhood education and pre-primary education, make sure that health education teachers receive proper training, add fertility counselling in the contents of health education and enhance education on sexually transmitted diseases, and to not reduce the number of health education lessons. Municipalities must ensure that services are provided for adolescents in an accessible, easily reachable, free of charge and customer-oriented manner, i.e., that they are approved by the young people themselves and can also reach the young people outside the school and student health care services. The currently ongoing structural change provides a good opportunity for reorganisation of services for young people. Over one third of the clients for induced abortions under the age of 20 had not used contraception. If successful, the suggested action of providing contraception free of charge for those under 20 years of age will pay itself back. When merely taking into account the direct costs of a medically induced abortion in euros (€ 720, HUCH rates 2013), one medically induced abortion could pay for, for example, oral contraceptive pills for six young women for an approximate one-year period. When starting contraception, sexuality education must always be provided; guiding the client towards safe and responsible sexual behaviour. If the benefits brought on by the provided sexuality education and the avoidance of an induced abortion for the well-being of the young person are included in the calculation, the price of one abortion will pay for free contraception for a notably higher number of people than just six.

As women have traditionally carried the responsibility for sexual and reproductive health and the services have been considered to be aimed at them, more attention should be paid to men's sexual and reproductive health and the development of services that are appropriate and targeted for men. The part and

responsibility of boys should be discussed in sexuality education already beginning at the early childhood education level so that men no longer will have to perceive sexual and reproductive health promotion and services as something that does not concern them. For now, there is still a need for services and counselling aimed particularly at boys and men, such as aiming counselling clinic services to men, for example, by a separate invitation to the extensive prenatal health examination, flexible times for arranging appointments and family training, special services for risk groups and by including sexual counselling in the treatment and counselling for other illnesses influencing men's sexual and reproductive health.

Finland has become increasingly multicultural. There are special features related to the sexual and reproductive health of both our traditional minorities as well as those who have immigrated to Finland, and these must be taken into account when planning and organising services. There is a need for increasing multicultural expertise in early childhood education, schools and social and health care services as immigration becomes more common. Without sufficient preparation measures, multicultural encounters in the service system may cause disappointments for both clients and workers. It is also important that the different sexual and reproductive health services pay attention to the fact that some persons with immigrant origins may have a lack of basic knowledge related to the topic, as sexuality continues to be a taboo subject in many cultures. Continuing and further education for professionals, services provided in the client's own language and sexuality education for those with immigrant origins are essential factors in developing multicultural sexual and reproductive health services. A solution must be quickly found to combat the situation of undocumented immigrants in Finnish health care.

There have previously not been national guidelines or recommendations for good delivery care. Good delivery care promotes the health and well-being of the parturient, newborn and the entire family. The suggested actions are primarily connected to care during gestation and delivery, the work of those involved in preparing families for the arrival of the baby and the education of these professionals. It is suggested that preparing families for the arrival of the baby should include evidence-based and regionally up-to-date information as well as provision of information about the significance of skin contact and breastfeeding. Preparing a delivery plan is recommended. Parturients must be physically and mentally supported by providing them with guidance and information and looking after their interest. Personnel at delivery hospitals are hoped to actively participate in treating labour pains. It is suggested, that attention should be paid in delivery care on the factors affecting the delivery experience, such as the quality of communication, being present, feeling of control, participation in decision-making, provided information and the delivery environment.

Those regions and municipalities where the aforementioned issues have already been accounted for are also likely to find suggestions for actions in the action programme whose implementation can help them in further improving sexual and reproductive health within their borders. All suggestions for actions presented in the action programme are intended to be implemented, or the actions to be started, during the validity period of the action programme. Promote, prevent, influence – an investment in sexual and reproductive health is an investment in the future.

Appendix 1.

Experts who participated in formulating the action programme for the promotion of sexual and reproductive health

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Parekh Seija
National Institute for Health and Welfare, expert, MA, Public Health Nurse
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Surcel Heljä-Marja
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Family Federation of Finland, Chief Physician, Gynaecologist, Docent, MD (medicine and surgery)
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Hannula Leena
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Weiste-Paakkanen Anneli
National Institute for Health and Welfare, Researcher, MSc (social sciences)

Appendix 2.

Finnish legislation related to sexual and reproductive health

Adoption Act 22/2012
Polytechnics Act 351/2003
Decree on the investigation of the cause of death 21.12.1973/948
Decree on the implementation of the Convention on Protection of Children and Co-operation in respect of Intercountry Adoption 497/1997
Decree on the qualification requirements for teaching personnel 986/1998
Decree on induced abortion 239/1970
Decree on National Personal Records Kept Under the Health Care System 774/1989
Marriage Act 234/1929
Act on Child Maintenance Allowances 580/2008
Act on Specialized Medical Care 1062/1989
Personal Data Act 523/1999 Paternity Act 700/1975
Primary Health Care Act 66/1972 Act on Vocational Education 630/1998
Act on Assisted Fertility Treatments 1237/2006
Act on the implementation of the Paternity Act 701/1975
Act on the investigation of the cause of death 1.6.1973/459
Act on the organisation of investigation of sexual abuse of a child 1009/2008
Act on checking the criminal background of persons working with children 504/2002
Act on genetic testing to establish paternity 378/2005
Act on the recognition of Nordic paternity solutions 352/1980
The Act on the Status and Rights of Patients 785/1992
Act on Induced Abortion 239/1970 Act on Registered Partnership 950/2001
Act on amending the Health Insurance Act 437/2010
Act on client fees in social welfare and health care 734/1992
Health Care Professionals Act 559/1994
Act on amending the Health Care Professionals Act 433/2010
Act on National Personal Records Kept Under the Health Care System 556/1989
Act on the Legal Recognition of the Gender of Transsexuals 563/2002
Act on the Openness of Government Activities 621/1999
Act on Social Assistance 1412/1997
Child Benefit Act 796/1992
Child Welfare Act 417/2007
Upper Secondary Schools Act 629/1998
Youth Act 72/2006
Pupil and Student Welfare Act 1287/2013
Basic Education Act 628/1998
The Constitution of Finland 731/1999
Criminal Code 39/1889, Chapters 17 and 20
Sickness Insurance Act 1224/2004
Decree of the Ministry of Social Affairs and Health on the prescription of a drug 1088/2010
Decree of the Ministry of Social Affairs and Health on Assisted Fertility Treatments 825/2007
Decree of the Ministry of Social Affairs and Health on vaccinations and screening of communicable disease during pregnancy 421/2004
Decree of the Ministry of Social Affairs and Health on the arrangement of examinations and treatment aiming at gender reassignment as well as on the medical investigation related to the legal recognition of the gender of transsexuals 1053/2002
Act on Military Support 781/1993
Act on Sterilisation 283/1970
Decree on Sterilisation 427/1985
Decree of the Ministry of Social Affairs and Health on patient documents 298/2009
Communicable Diseases Act 583/1986

Communicable Diseases Decree 786/1986
The Act on Equality between Women and Men 609/1986
Health Care Act 1326/2010
Government Decree on Adoption 202/2012
Government Decree on specialist decrees in medicine and dentistry 420/2012
Government Decree on the implementation of the European Convention on the Adoption of Children and the Entry into Force of the Act on the Implementation of the Provisions of a Legislative Nature in the Convention and the section 86(2)(2) and section 94 of the Adoption Act 388/2012
Government Decree on maternity and child welfare clinics, school and student health care and preventive oral health care for children and young people) 338/2011
Government Decree on genetic testing to establish paternity 755/2005
Government Decree on amendments to sections 14 and 28 of the qualification requirements for teaching personnel 614/2001.
Government Decree on screenings 339/2011
Government Decree on maternity grants and child allowance 885/2002
Early Childhood Education Act, proposal for Finnish Parliament in the spring of 2014
Non-discrimination Act 21/2004
Universities Act 558/2009
Maternity Grant Act 477/1993

Appendix 3.

Objectives related sexual and reproductive health promotion or service organisation in the Programme of Prime Minister Jyrki Katainen's Government (Finnish Government, 2011)

- developing services to promote reproductive and sexual health
- integrating the promotion of sexual health (including protection against sexually transmitted infections, sexual counselling, prevention of violence) into family planning services
- updating the HIV strategy
- decreasing induced abortions
- guaranteeing counselling and support for women seeking an abortion throughout the entire care chain and investigating need for changing the legislation regarding the time limit for abortions
- developing measures in cooperation with the various administrative sectors to prevent interpersonal and domestic violence and enhancing services for the victims of interpersonal, domestic and sexual violence
- continuing the implementation of the action plan to reduce violence against women and increasing the amount of shelter activities to promote regional equality
- reinforcing the capacity of third-sector organisations to create and promote conditions for health and well-being and channels of participation, and to provide various types of assistance and support for daily life
- securing the availability of services in the Sami language
- developing sign-language social and health care services
- developing the interpretation services organised by the Social Insurance Institution
- taking into consideration the special needs of immigrants when developing social welfare and health care services in order to promote their integration
- aiding the health and independent living of older people by means of services promoting well-being and health
- continuing the reinforcement of the Disability Policy Programme (VAMPO)
- guaranteeing the care and treatment of pregnant substance-abusing women and families with babies by means of legislation
- improving and increasing support for parenthood and relationship counselling for children's parents
- improving adoption-related services at the various stages of the adoption process in cooperation between the Ministry of Social Affairs and Health and the Ministry of Justice

- decreasing regional inequalities in school health care and paying particular attention to the development of health services for students in vocational education
- ensuring equal position of university students with regard to obtaining health services
- increasing the amount of paternity leave earmarked for men, making the use of the father's parental leave more flexible and making it possible to care for children at home for longer than currently with the help of parental daily allowance

Appendix 4.

Central contents in pre-conception health, care and counselling according to international literature

Health counselling
Fertility
Sexuality
Intimate relationship
Family planning (incl. contraception)
Parenthood
Physical activity
Sleep and rest
Weight (Body Mass Index, BMI)
Nutrition
Special diet
Oral health care
Folic acid supplement
Vaccinations
Smoking
Intoxicants
Sexually transmitted diseases
Violence
Immunisation
HPV (Pap smear, vaccination)
Hepatitis B
Varicella (chickenpox)
Mumps, measles, rubeola
Influenza
DPT vaccine
Nutrition
Vitamin A
Folic acid
Multivitamins
Vitamin D
Calcium
Iron
Iodine
Essential fatty acids
Overweight
Underweight
Eating disorders
Nutritional supplements
Mental health
Depression, anxiety
Mental illnesses

Pregnancy history
Preterm birth
Caesarean section
Spontaneous abortion
Stillbirth
Induced abortion
Disease or disability of previous child/foetus
Congenital anomaly of previous child/foetus
Uterine malformations
Other problems
Involuntary childlessness
Age and fertility
Prevention of involuntary childlessness
Examination and treatment
Psychosocial factors
Economic situation
Access to treatment
Unwanted pregnancy
Rape
Emotional violence
Physical violence
Sexually offensive violence
Fear of delivery
Lifestyles
Living conditions
Leisure time activities
Travel
Herbal supplements
Alcohol
Tobacco
Narcotics
Genetic diseases
Family background
Genetic diseases of ethnic groups
Genetic disease in previous pregnancy
Risk for a known genetic disease
Screenings
Genetic counselling
Prenatal screenings
Special groups
Disabled people
Immigrants, refugees and undocumented immigrants
People with cancer
People with dwarfism

Chronic diseases/conditions
Diabetes mellitus
Disorders of thyroid gland
Phenylketonuria
Epilepsy
Hypertension
Rheumatism
Autoimmune diseases
Nephropathy
Heart disease
Thrombophilia
Asthma
Use of medications
Prescription of medications
Long-term medication
Over-the-counter medications
Nutritional supplements

Infections
HIV
Hepatitis C
Tuberculosis
Toxoplasmosis
Cytomegalovirus
Listeriosis
Parvovirus
Malaria
Gonorrhoea
Chlamydia
Syphilis
Herpes simplex
Asymptomatic bacteriuria
Gingivitis
Bacterial vaginosis
Streptococcus B
Environmental agents
Mercury
Lead
Soil and water quality
Work-related exposure agents
Exposure agents at home
Female circumcision (FGC/FGM)