UNIVERSITY OF
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A Comparative Exploration of Social Policy Relating to Teenage Pregnancy in Finland and Scotland

by

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Abstract

The purpose of this thesis is to comparatively explore a selection of policies relating to teenage pregnancy in Finland and Scotland. Although much comparative research has explored teenage pregnancy and policy relating to it in England with other countries, very little work has explored either the policy situation within Scotland or comparatively explored Scottish policy responses to teenage pregnancy with other countries. Although the trends in teenage pregnancy rates are similar between England and Scotland, there are noted policy differences between the two countries that warrant further exploration of the situation particular to Scotland.

Finland presents an interesting comparison for Scotland, in particular due to a number of important constants that exist including; the sexual behaviour rates of young people, the legal age of heterosexual consent and similar ages of first intercourse, and yet considerably lower rates of teenage pregnancy. Between the 1970s and 1980s the rate of teenage pregnancy declined in both Finland and Scotland. Since that time Finland has witnessed further decline, whilst the rate in Scotland has remained relatively unchanged.

Utilising a variety of primary and secondary data including in-depth interviews with key personnel at three levels of policy development and implementation: government, local authority/ municipality and schools, as well as policy documentation from both countries, this research has located, mapped and comparatively analysed three areas of policy relating to teenage pregnancy: sex education, sexual health and education.

The findings of this research illustrate that policy developed in Finland since the 1970s has taken a pragmatic approach to the prevention of unintended teenage pregnancy, combining sex education provision in a range of core subjects throughout the curriculum at the school level with a national system of school nurses located in school-based clinics. Additionally, the Finnish education system was structured in such a way from 1970 so as to offer a high level of vocational

and academic choice at the school level and actively encourage a high level of continuation beyond the age of sixteen.

In relation to policy development in Scotland, the findings of this research illustrate that whilst the foundations for successful future policy development are now present, policy developed prior to the mid-1990s failed to meet the needs of young people in Scotland in relation to the provision of sex education, sexual health services and educational choice at the school level beyond academically-orientated examinations.

Since the mid-1990s there have been changes in the direction of policy within the areas under exploration. Whilst a level of complacency appears to have set in with regard to the lower level of teenage abortion in Finland, the opposite has been occurring in Scotland, with raised awareness of the sexual health rights and needs of young people being placed at the forefront of policy development. As this thesis has detailed, the various changes have the potential to influence the rates of teenage pregnancy in both countries, negatively in Finland and positively in Scotland.

In addition to highlighting potential policy options to aid in the future reduction of unintended teenage pregnancy in Scotland, a better understanding of the relationship that each area of policy has to teenage pregnancy has also been developed within this thesis. The findings contribute to the on-going debate concerning a number of important areas, first, the provision of 'effective' sex education, second, the necessity to base sexual health services on the needs of young people and third, the importance that continued education post-16 can play as an indirect means to delaying pregnancy and parenthood.

Tiivistelmä

Tämän väitöskirjan tarkoituksena on tutkia ja vertailla teiniraskauksiin liittyviä poliittisia valintoja ja toimenpiteitä Suomessa ja Skotlannissa. Sekä Suomessa että Skotlannissa teiniraskauksien määrä väheni 1970-luvulta 1980-luvulle. Sen jälkeen teiniraskauksien määrä on edelleen vähentynyt Suomessa, kun taas Skotlannissa määrä on säilynyt suhteellisen muuttumattomana. Sosiaalipoliittisilla valinnoilla ja toimenpiteillä on merkitystä raskauksien ehkäisemisessä, mutta aikaisempi tutkimus on yleensä keskittynyt vain yhteen erillisalueeseen, kuten seksuaalikasvatukseen tai terveyspalvelujen tarjontaan. Hyvin harvoissa tutkimuksissa on tarkasteltu teini-ikäisten raskauksiin vaikuttavien toimenpiteiden kokonaisuutta. Koska kyseessä on monimutkainen problematiikka, tutkimuksen tulee tarkastella laajemmin useiden toimenpiteiden yhteisvaikutuksia, mikäli ennaltaehkäisevien toimenpiteiden halutaan tulevaisuudessa vaikuttavan mahdollisimman tehokkaasti ei-toivottujen teiniraskauksien määrän vähenemiseen Skotlannissa.

Tutkimuksessa hyödynnetään useita primaari- ja sekundaarilähteitä, tärkeimpinä toimenpiteiden kehittämisen ja toteutuksen kannalta keskeisten avainhenkilöiden laajat haastattelut sekä keskushallinnossa, paikallishallinnossa/kunnissa että kouluissa, ja aiheen kannalta oleelliset dokumenttilähteet molemmista maista. Näiden avulla tutkimuksessa on kartoitettu, paikallistettu ja analysoitu vertaillen teiniraskauksiin liittyvää kolmea osa-aluetta: seksuaalikasvatusta, seksuaaliterveydenhuoltoa ja koulutusjärjestelmää.

Tutkimuksen tulokset osoittavat, että Suomessa on 1970-luvulta lähtien suhtauduttu ei-toivottujen teiniraskauksien ehkäisemiseen pragmaattisesti. Toiminnan keskeisinä kulmakivinä ovat olleet koulujen seksuaalikasvatuksen opetussuunnitelmat ja valtakunnallinen kouluterveysjärjestelmä kouluterveydenhoitajineen. Tämän lisäksi Suomen koulutusjärjestelmää on 1970-luvulta lähtien rakennettu siten, että koulu tarjoaa runsaasti sekä ammatillisia että yleissivistäviä vaihtoehtoja ja kannustaa aktiivisesti koulutukseen hakeutumiseen myös pakollisen oppivelvollisuusiän jälkeen. Koulutusjärjestelmän kehittämisen ajoituksen yhteys muiden tutkittujen alueiden kehitykseen näyttää olevan

enemmän onnellisten sattumien summa kuin varsinainen yhdistelmästrategia teiniraskauksien vähentämiseksi. Joka tapauksessa, jälkikäteen tarkastellen, kaikkien kolmen osa-alueen yhtäaikainen kehittäminen ja teiniraskauksien lukumäärän samanaikainen vähentyminen osoittavat selvästi kokonaisvaltaisen näkökulman tärkeyden tarkasteltaessa ja kehitettäessä toimenpiteitä, joilla pyritään ei-toivottujen teiniraskauksien vähentämiseen.

Skotlannissa on viime vuosien aikana kehitetty perusta menestykselliselle yhdistelmästrategialle. Tutkimustulokset osoittavat kuitenkin, että 1990-luvun puoliväliä edeltäneet toimenpiteet eivät pystyneet vastaamaan skotlantilaisten nuorten tarpeisiin liittyen seksuaalikasvatuksen tarjontaan, seksuaaliterveyspalveluihin ja koulutuksellisiin valintoihin.

1990-luvun puolivälin jälkeen molemmissa maissa on tapahtunut useita muutoksia tutkimuksessa tarkastelluilla osa-alueilla. Suomessa näytetään tuudittautuneen nykytilanteen positiivisuuteen, josta osoituksena pidetään teini-ikäisten aborttien alhaista määrää. Skotlannissa puolestaan on lisääntynyt tietoisuus nuorten seksuaalisista oikeuksista ja tarpeista ja nämä on asetettu kehittämistyössä etusijalle. Viimeaikaiset muutokset saattavat vaikuttaa teiniraskauksien määriin molemmissa maissa; Suomessa negatiivisesti ja Skotlannissa positiivisesti.

Tutkimus korostaa monipuolisen yhdistelmästrategian tarvetta, jos Skotlannissa halutaan edelleen alentaa ei-toivottujen teiniraskauksien määrää. Sen lisäksi tutkimus tuottaa lisäymmärrystä kunkin osa-alueen suhteesta teiniraskauksiin. Tutkimus ottaa kantaa ja osallistuu useista tärkeistä kysymyksistä parhaillaan käytävään keskusteluun. Tällaisia kysymyksiä ovat ensinnäkin 'tehokkaan' seksuaalikasvatuksen tarjoaminen sekä seksuaaliterveyspalveluiden kehittäminen nuorten tarpeista lähtien. Lisäksi tutkimuksen tulokset perustelevat kouluterveydenhoitajan roolin kehittämistä koulussa läsnäolevaksi keskeiseksi seksuaalikasvattajaksi. Lopuksi tutkimus korostaa koulutuksen ja koulujärjestelmän roolia nuorten motivoinnissa opiskeluun ja samalla raskauksien ja vanhemmuuden siirtämiseen myöhemmäksi.

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Introduction

Setting the scene – Context, Rationale, Aims and Objectives

Introduction

This thesis presents a comparative exploration of three policy areas relating to teenage pregnancy in two European countries, Finland and Scotland. Due to the fact that both countries are often subsumed into 'Nordic' and 'UK' examples in much policy research and in relation to teenage pregnancy research, neither country's policy response to unintended teenage pregnancy amongst compulsory school aged young women has been effectively explored or compared with other countries.

The purpose of this comparative exploration, therefore, is to locate and map policy responses to teenage pregnancy within three policy areas; sex education, sexual health and education, with the central aim of identifying and analysing key similarities and differences between Finland and Scotland that may further understanding about effective policy measures in promoting the reduction of unintended teenage pregnancy.

The purpose of the remainder of this introduction is to set the scene for the area of study under exploration by outlining the context, rationale, aims and objectives of this research as well as setting out the structure of this thesis.

Research Context

In many countries and cultures, motherhood under the age of twenty has been viewed as a normal pattern of reproduction (Rhode & Lawson 1993). In recent decades however, in some countries of the Western world, teenage pregnancy has increasingly been viewed by many as a 'social problem' (Rhode & Lawson 1993). In Britain prior to the late 1980s, concern lay primarily with the issue of unmarried mothers, regardless of age. By the late 1980s there was growing anxiety around this issue of teenage motherhood and by the 1990s the issue of teenage pregnancy and teenage motherhood had received more political and media attention than ever before (Selman 2002 (forthcoming)).

Of particular concern to the British government has been the question of why the rate of teenage pregnancy declined in line with most European countries from the early 1970s until the 1980s and then further decline halted, whilst the majority of European countries witnessed further continual decline (Kane & Wellings 1999). Viewing a high rate of teenage pregnancy in itself as a reason for concern, is however, a culturally-bound perception (MacIntyre & Cunningham Burley 1993). Many countries in the developing world have considerably higher rates of teenage pregnancy than is the case in Scotland and Britain as a whole, and yet in many of those countries teenage pregnancy is considered to be a normal pattern of reproduction (Rhode & Lawson 1993).

Despite the growth in concern in Britain over teenage pregnancy and a desire by government to reduce the rates of teenage pregnancy, so far policy in Britain has had little notable impact on those rates (Ingham 1992; Lawson & Rhode 1993).

Much research conducted during the 1980s and 1990s, which explored how best to approach the desired reduction in teenage pregnancy rates, focused on pregnancy prevention programmes. Research on the effectiveness of school-based prevention programmes took centre stage during this time, although most was USA-based (For example see Zabin et al. 1986; Kenny et al. 1989; Eisen et al. 1990; Kirby et al. 1991; Olsen et al 1991a, 1991b; Eisen et al. 1992; Stout & Kirby 1993; Kirby et al. 1994; Visser & Bilsen 1994; Kirby 1995; Kirby 1997a, 1997b; Kirby 1999).

From the end of the 1980s however, research did begin to explore the potential of the sex education programmes being utilised throughout Europe (in the Netherlands in particular), specifically because of the relative success in declining teenage pregnancy rates seen in Europe which were not visible in the USA (For example see: Meredith 1989; Donovan 1990; Gallard 1991; Koral 1991; Patsalides 1991; Friedman 1992; Kontula et al. 1992; Doopenberg 1993; van Bilsen & Visser 1993; Persson 1993; Braeken 1994; Clark & Searle 1994; Vilar 1994; Wall 1994; Burström et al. 1995; Silver 1998). The tendency to continue to look to the USA for answers (despite having a pregnancy rate considerably higher that in England) is however still apparent within government funded research in England (for example SEU 1999).

In addition to this primary focus on sex education, research during the 1980s and 1990s became increasingly focused on sexual health service provision, initially in

response to the AIDS[1] crisis. The recognition of young people's needs in this area of service provision in relation to the reduction of teenage pregnancy, however, did not begin to gain momentum until the early-mid-1990s. At this time large research studies including Allen's study of family planning projects (1991), Shucksmith et al.'s study of health advice centres for young people (1993), the SNAP report in Scotland (McIlwaine 1994) and the Wessex study in England (Clements et al. 1997), began to look at the availability of sexual health services for young people and the potential importance of services set up specifically for young people.

Developing on from this type of research, during the latter half of the 1990s through to the early 21st century, research began exploring the actual views of young people. For example, research such as that undertaken by Aggleton et al. (1999) has explored young people's views about the types of services that they feel are needed and desired by young people in order to maximise their use.

In relation to research on teenage pregnancy and education, whilst the association between low educational achievement and the likelihood of teenage motherhood has been well documented (Jones et al. 1985; Hayes 1987; Hofferth 1987; Kirby et al. 1994; Kiernen 1995; Moore et al. 1995), there has been a general misconception that pregnancy is the reason that young women drop out of school or are low achievers. In fact, it is often the case that the young women had already been performing poorly, had dropped out of school or had been excluded from school prior to pregnancy (Phoenix 1991; Selman 1998; Selman et al. 2001; Turner 2000).

[1] AIDS stands for Acquired Immune Deficiency Syndrome.

Recognition of the need to focus on the educational and life aspirations of young people, women in particular, as a means to reducing unintended teenage pregnancy, however, was only formally acknowledged during the latter half of the 1990s (Selman & Glendinning 1996; SEU 1999).

Research into teenage pregnancy within a Scottish context over the last ten years has focused on the provision of sex education (see Wight & Scott 1994; Bagnall & Lockerbie 1995; Wight 1996; Wight et al. 1999), the sexual knowledge and behaviour of young people in Scotland (For example see Currie & Todd 1993; Graham et al. 1996; Currie et al. 1998; Glasier 2000; Shucksmith 2000; Wight et al. 2000), and the availability of certain services for young people (For example see Shucksmith et al. 1993 & McIlwaine 1994).

While it is acknowledged that Scotland and England have very similar trends with regard to teenage pregnancy rates over the last twenty years (Singh & Darroch 2000), what is not as well known is the fact that policy, which could impact upon the rate of teenage pregnancy in Scotland is very different from that in England, in particular in relation to the education system and the provision of sex education.

For example, because Scotland has its own education system, a separate set of Acts is in place that relate only to Scottish educational policy. In turn this means that none of the English Education Acts relating to sex education are relevant to Scotland. This includes important Acts such as the 1986 Education Act, which states that all schools are required to have a policy on sex education and that that

policy must be made available to parents; and the 1993 Education Act, which states that all schools must provide sex education, including education on HIV and AIDS, but that parents have the right to remove their child from any sex education that is not part of the national curriculum. In Scotland there is no legal requirement for schools to teach sex education and parents do not have the right to remove their child from any sex education that is provided.

However, despite the Scottish research noted above and the wealth of research conducted since the 1980s on the issue of teenage pregnancy in other countries, very little comparative research has been undertaken to explore teenage pregnancy between Scotland and other countries. A great deal of research purports to comparatively explore the situation in the UK or in Britain with the USA or Europe, however, on closer inspection, it is usually the case that the statistical data and policy discussed is only relevant to England, or England and Wales.

For example Kane & Wellings (1999) set out to explore a variety of policy issues related to teenage pregnancy utilising evidence from a range of European countries. Their main aims were to explain the patterns of conceptions throughout Europe as well as to situate the UK within a European context. On one level, this research is useful in identifying trends throughout Europe and the case studies of specific countries provided some detailed information about the history and development of sex education and sexual health services for young people. They fail, however, to identify that the information they provide for their home country, the UK, is incorrect in so far as it applies only to England and Wales and yet purports to apply to the whole of the UK.

Further to this, even where research has attempted to break down information for the countries within Britain (for example see SEU 1999), legality around the provision of sex education, for example, is still incorrectly stated to be the same for Britain as whole.

Similar to Scotland, whilst there has been a range of research conducted into sex education, sexual health services for young people and the sexual behaviour and knowledge of young people in Finland (see Kontula and Meriläinen 1988; Kosunen 1993b Väestöliittö 1994; Kosunen 1996; Kosunen & Rimpelä 1996a; Liinamo et al. 1997; Kontula 1997; Kosunen et al. 1999a, 1999b; Liinamo 2000), it too, has been the focus of little comparative policy research relating to teenage pregnancy.

As Scotland is often subsumed into the 'UK' or Britain, Finland has often been subsumed into a 'Nordic' example in policy research, possibly due to its difficult language (Kuronen 1999). Therefore, the originality of this research lies in the fact that little comparative research into teenage pregnancy has been conducted between either Finland or Scotland and any other country and no comparative research into teenage pregnancy has been conducted between Finland and Scotland.

This particular combination of countries also provided an excellent comparison due to a number of important basic similarities that existed between the two countries, which suggested that there might be useful policy differences between the two countries that may help to account for the differences in teenage pregnancy and

related rates[1]. These similarities included; the same legal age of heterosexual consent, similar estimated rates of teenage sexual activity (Wallace & Vienonen 1989; Currie & Todd 1993; Papp 1997), the same legal age at which compulsory schooling ends, as well as potential similar difficulties in service access by young people due to the geography of both countries.

Before progressing to set out the rationale, aims and objectives of this research, the issue of why this research is concerned with the issue of teenage pregnancy is identified. Researchers exploring the issue of teenage pregnancy have been criticised for failing "to specify why we should be worried... [which] often proves particularly irritating because it leads to a lack of precision about the nature of the perceived problem of adolescent pregnancy" (MacIntyre & Cunningham Burley 1993: 61).

This research is approaching teenage pregnancy from the perspective that it is not justifiable to define teenage pregnancy as 'problematic' in itself. Rather, taking the rate of live births to teenagers as an indicator of planned and wanted births (although often they are unplanned but not necessarily unwanted), the fact that a large proportion of teenage pregnancies are unintended and subsequently unwanted shows that they perhaps should have been prevented. Therefore the high rate of unintended teenage pregnancy in Scotland is a visible sign that young people are not taking (or able to take) adequate precautions to prevent pregnancy. Since pregnancy is only one negative outcome of unsafe sexual practice. others being

[1] Reference here and throughout the thesis is made to 'related rates', these are abortion and birth rates.

STIs and HIV[1]/AIDS, the concern of this thesis lies with the broader issue of teenage sexual health despite the primary focus being that of teenage pregnancy.

Rationale, Aims & Objectives

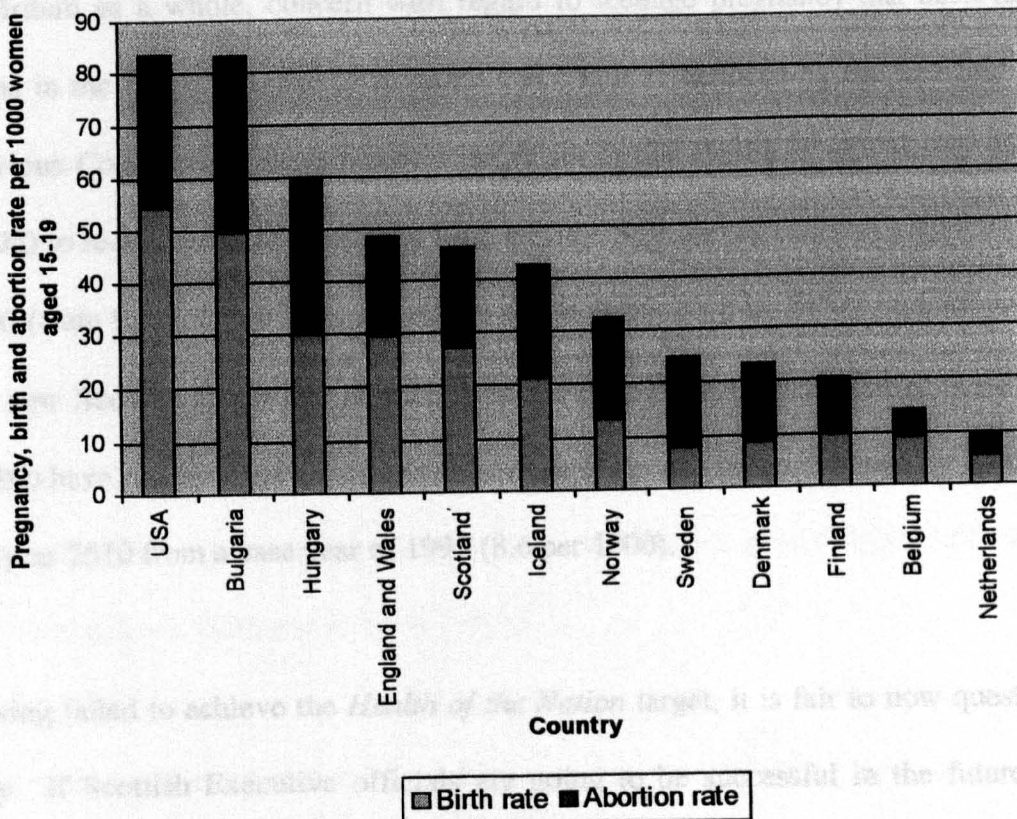
In 1998 and for the previous two decades, the UK has had the highest rate of teenage pregnancy in Western Europe (Kane & Wellings 1999). Scotland has fluctuated from being marginally higher to lower in comparison to England and Wales. Scotland's rate however is still considerably higher that the rest of Western, Northern and some areas of Eastern Europe, with only the USA as a comparably developed Western nation having a considerably higher rate, as can be seen below in Figure 0.1[2].

The trends in teenage pregnancy and related rates across Scotland and Europe are explored in detail in Chapter one. An important point to note, however, is that the rate of births to teenagers in Scotland is at present lower than it was thirty years ago and has not significantly risen in recent years. Additionally, the overall teenage pregnancy rate in Scotland has changed remarkably little during the last two decades.

[1] STI stands for Sexually Transmitted Infection. This is a change from STD or Sexually Transmitted Disease, as an individual can be infected but not diseased. HIV stands for Human Immunodeficiency Virus.
[2] Data for Figure 0.1 can be found in Appendix i.

Figure 0.1

Pregnancy, birth and abortion rates per 1000 women aged 15-19 in a selection of countries in 1996 (or latest available year)



General notes
Year for birth and abortion data is 1996 unless noted below:
1998 Birth and Abortion data for Scotland.
1995 Birth data for Bulgaria, Norway and Denmark
1995 Abortion data for England and Wales and Belgium
1992 Birth and Abortion data for the Netherlands
Data for Scotland and the Netherlands - birth & abortion data are for women younger than 20 not just 15-19.
Sources: Abortion data from ISD Scotland 2000; Singh & Darroch 2000.
Birth data from UN Demographic Yearbooks 1997,1998,1999; ISD Scotland 2000.

Therefore perhaps, rather than continuing to ask the question 'why are the rates so high in comparison to Europe?', what needs to be asked is 'why have the rates not

declined in line with most of Europe?' Then in turn, as this research has done in relation to Finland, ask what policy options are being utilised in other European countries that have enabled the continually declining rates that have eluded Scotland since the beginning of the 1980s?

In Britain as a whole, concern with regard to teenage pregnancy has been most noted in the rate of pregnancy to under 16s. This is deduced by the fact that the previous Conservative government's target set in the *Health of the Nation* paper (1992) to reduce pregnancy rates in England[1] by 50% for the under 16s by the year 2000 (from 9.5 in every 1000 in 1989 to 4.8 in every 1000 in 2000). Additionally, the new Scottish Executive in their White Paper *Towards a Healthier Scotland* (1999) have also now set a target to reduce the under 16s pregnancy rate by 20% by the year 2010 from a base year of 1995 (8.6 per 1000).

Having failed to achieve the *Health of the Nation* target, it is fair to now question why. If Scottish Executive officials are going to be successful in the future in reducing the rate of teenage pregnancy in Scotland, then there has to be an acceptance that as a whole, there has been a failure so far to provide today's young people with 'something'. Whether it be education, support, sexual health services, motivation not to become a parent, achievable life-goals or most likely a combination of the above, something is missing from their lives that they require in order to enable themselves to (want to) be sexually responsible and delay pregnancy and parenthood.

[1] Although this target was set specifically for England, with no separate target of their own, officials in Scotland used the *Health of the Nation* target as well.

In contrast to the situation in Scotland, Finland has witnessed relative success in reducing the rate of teenage pregnancy and related rates over the last three decades. Therefore, this research explores and analyses a selection of policies relating to teenage pregnancy in Finland and Scotland, looking for key similarities and differences, which may help to explain why these differing trends exist.

This research has also explored the different levels of policy at work within each country, by looking first at the national framework within which local level policy is expected to be operationalised, before examining what has been implemented at the 'ground level'. This is a very important issue to consider when comparing policy at any level because what may present itself as an excellent policy framework does not guarantee the implementation of that policy at the local level (For example see Thomson & Scott 1992).

After a thorough examination of the literature, three policy areas were chosen for comparison as those most likely to have a strong effect on unintended teenage pregnancy amongst young women of compulsory school-age. The process of reaching the decision of which policy areas to explore is described further in Chapters Two and Three, however, in short, because the focus of this research is on pregnancy amongst women of compulsory school age (16 in both countries), three policy areas were chosen that were most likely to impact on young people of school age. Those areas are school-based sex education, sexual health and education.

Although debate exists in Britain (and the USA) as to the potential impact that welfare provisions such as social security and housing benefits have on the active decision of some young women to deliberately become pregnant and therefore act as an incentive to early parenthood (Selman 1998; 2002 (forthcoming)), the area of welfare policy has been deliberately excluded from this thesis. The rationale behind this choice is that this thesis is primarily concerned with pregnancy amongst young women of compulsory school age, to whom no direct welfare benefits are available in Scotland.

After deciding on which policies to explore a total of six months of fieldwork was undertaken, three in each country, in order to map and locate those policies within their national and local frameworks. Having achieved this, the final aim was to compare and contrast the national frameworks at government level and local level policies within three local authorities and municipalities and four schools. One school in each country was chosen as a pilot school, followed by three further main schools, one within each local authority/ municipality[1].

The overall aims of this thesis therefore, have been to undertake a comparative analysis of a selection of policy areas in Finland and Scotland, which will enable the findings of this research; to add to the existing knowledge base on policy relating to teenage pregnancy; to explore potential options for Scottish policy makers, that aspects of Finnish policy offer for the reduction of unintended teenage pregnancy and finally to identify areas warranting further research.

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[1] Further details of how the case-study areas and schools were chosen and the methods by which the research was undertaken are explained in depth in Chapter Three.

The structure of the thesis

This thesis consists of eight chapters. Chapter One begins by reviewing the trends in teenage pregnancy and related rates across Europe, before progressing to explore the trends in Scotland and Finland. In order to gain an overall picture, the chapter focuses not only on the trends in pregnancy and related rates, but also considers a number of associated factors, such as inequality, poverty and education level and aspiration, as well as causal factors including, rates of sexual activity and contraceptive use.

Chapter Two provides the main literature review of this thesis. The Chapter begins by establishing why sex education, sexual health and education were the three policy areas chosen for exploration in this thesis. This is followed by a discussion of a range of the literature available regarding each area of policy under exploration, namely; sex education, sexual health and education. The chapter summary then provides further rationale as to the decisions behind the inclusion of each policy area within this research.

Chapter Three considers issues relating to the methods and methodology of this research. It begins by exploring the methodological process of reaching the final research design. This is then followed by a consideration of the many methodological issues relating to qualitative, cross-national, comparative social policy research, as well as locating my work methodologically within those fields. Finally the chapter presents the methods of the data collection as well as issues

relating to the methods by which the research was undertaken, analysed and written up.

Chapter Four instigates the process of locating and mapping the various policy areas under exploration, beginning in this chapter with the national framework of policy provision in both countries. Each area has been examined in turn to set out the development of policy at the national level, and the framework within which those implementing policy at a local level work.

Chapter Five continues the process of locating and mapping at the local level of implementation. Particular attention is paid in this chapter to the relationship between the national framework and what is implemented at the local level in both countries.

Chapter Six compares various aspects of policy at both national and local levels to focus attention on the key similarities and differences between the two countries and to draw out the main themes that have arisen from the research. In doing so, drawing upon the main comparisons, this chapter raises a number of potential connections between the key policy differences and the rate of teenage pregnancy in each country. Many of these connections then produce a variety of questions that warrant further exploration, which are discussed in further detail in the concluding chapter.

Chapter Seven explores the direction of change in the three key policy areas that have occurred in both countries since the mid-1990s. In every area of policy,

continuity, development and change are common features. Whilst the policies under exploration in this thesis remained relatively unchanged for a number of years, since the mid-1990s there have been some developments, which have resulted in what appears to be a change in direction for both countries. Chapter Seven therefore outlines these main developments and pays particular attention to the effect that these changes could potentially have on the rate of teenage pregnancy, in light of the analysis of the data in Chapter Six.

Finally, Chapter Eight presents the concluding section of this thesis and addresses a number of issues. First, there is a discussion of the potential policy options derived from the analysis of the key similarities and differences between Finnish and Scotland policy, which could aid in the reduction of teenage pregnancy in Scotland. Second, there is a discussion of what this thesis adds to existing literature on teenage pregnancy in relation to the selected areas of policy under exploration and finally, issues relating to the future research agenda are discussed.

Chapter One

International Trends - Data from Europe

Introduction

Concern with the rate of teenage pregnancy in Britain is heightened when it is viewed in direct comparison with many of its European counterparts and therefore, in order to understand why this concern exists, consideration needs first to be given to the European trends. The first section of this chapter, examines the recent trends in teenage pregnancy and related rates within a European context[1].

The chapter begins by examining trends in live birth, abortion and pregnancy rates across a number of European countries over the last three decades. This is followed by an exploration of some associated factors including socio-economic and educational factors as well as an exploration of potential causal and related factors such as, teenage fertility, coital activity, contraceptive behaviour.

This is then followed by a descriptive account of the Scottish and Finnish national pregnancy, birth and abortion data[2] and an examination of the trends in these rates,

[1] Much previous research often includes within its international contextualisation a comparison with USA rates. I have chosen not to do so here. First, because this information is already widely available (e.g. SEU 1999) and more importantly, because British research often looks to the USA for future directions in many areas of policy. With regard to teenage pregnancy this is not necessarily the best way forward considering that the USA has significantly higher rates of teenage pregnancy than are found in Britain and most of Europe. Therefore the decision was taken to focus on European countries within this thesis, although reference will be made to the USA within the review of the main literature.

[2] Whilst acknowledging that there are regional and local differences in both Scotland (ISD Scotland 1987, 1998, 1999, 2000; Turner 2000) and Finland (Kosunen & Rimpelä 1996a, 1996b), this research focuses on national trends alone and therefore only national trends will be compared within this chapter.

in particular between the 1980s and 1990s. In attempting to account for the trends in Scotland and Finland, the latter section of the chapter presents an exploration of some associated and causal factors.

European trends

Comparable statistics

Before considering international trends in teenage pregnancy, a number of limitations of the available data require comment. First, despite literature often claiming to present data on conception rates (for example see Kane & Wellings 1999), it is not possible to obtain total conception data (Turner 2000). Also, obtaining an overall picture of teenage pregnancy rates across Europe is difficult, it is often not possible to make direct comparisons because obtaining like data is problematic.

Most noted are the difficulties in acquiring accurate data on abortions. Whilst in most European countries induced abortion is legalised, the statistics that represent this procedure are often far from complete. According to David (1992) only eleven countries in Europe currently provide reliable data on abortions with countries such as France, Italy and Germany providing data which is either incomplete or inaccurate. In most industrialised nations, however, comparisons of live birth rates can be used as a useful indicator as these rates are closely correlated with abortion rates (Kosunen 1996).

Additionally, pregnancy, live birth and abortion rates are often grouped together for comparison, the most common grouping for the teenage years being the

grouping 15-19. As illustrated later in this chapter however, when comparison focuses on the trends in Scotland and Finland, direct comparisons are not possible. In Scotland, because there are a significant number of pregnancies to women under the age of sixteen, the main source of published data on teenage pregnancy produced by ISD Scotland is done so with three groupings namely, 13-15, 16-19 and 13-19. With so few pregnancies under sixteen in Finland, there is only one grouping namely, 15-19. Further to this, countries such as Finland often include the very small number of pregnancies to under-15s within the rates of the 15-19 age grouping without including the baseline population data within which those pregnancies have occurred.

In relation to those age groupings, the European rates as a whole presented in this chapter should also be viewed with caution as the base population used to calculate the rates often varies between countries. Whilst some countries will calculate rates for 15-19 year olds with the population data for that age grouping, others such as the Netherlands use data for the under 20s.

For the purpose of this study, it is the trends that are important and therefore it is not imperative to have directly comparable rates. When consideration is focused on comparing the trends in Scotland and Finland however, it is important to remember that the rates cannot be directly compared.

Comparable Terminology

'Teenage' is an ambiguous term in all contexts as it refers to a number of different age groupings, some of which are perceived to be of more concern than others in

relation to pregnancy. Additionally, there are considerable differences in the actual rates and the outcomes of pregnancy between younger and older teenagers, which is not always obvious when rates are grouped by ages 15-19.

The term 'teenage' is often used interchangeably with 'young', 'adolescent' and 'under-age', all of which can translate to mean different age groupings. Throughout this thesis I commonly refer to policy relating to young people (men and women), as well as 'teenage pregnancy'. For the purpose of this thesis, when referring to the literature, the terminology used will be that of the original author/s.

Where reference is made to young people or 'teenage pregnancy' within the data and analysis of this research, the age definition unless otherwise stated is for those under 16[1], which is the age group targeted by the British government's *Health of the nation* White Paper (1992)[2] and the Scottish Executive's White Paper *Towards a Healthier Scotland (1999).* Additionally reference is made within this chapter to 'older' and 'younger' groups of teenagers. Unless otherwise stated these definitions relate to 16-19 and 13-15 year olds respectively. Whilst the concern of this research lies primarily with compulsory school-age pregnancy, due to the limitations of the European data, the overview of European trends in this chapter refers primarily to the category of 15-19 year old women. Therefore, reference to 'teenage' in relation to the European trends and rates in this chapter, unless otherwise stated, refers to those aged 15-19.

[1] The lower limit of this age grouping has not been stated because although teenage technically refers to those aged 13 plus, pregnancies to young women has transcended that age barrier. There are a number of pregnancies that occur at age 10,11 and 12. Therefore, within this research when reference is made to 'teenage pregnancy' this should be taken to include the small number of pregnancies to those under the age of 13.

[2] This White Paper is relevant only to England and Wales.

Within this thesis, a number of terms are used when reference is being made to the countries that make up the UK. As I make a very strong case for the proper use of such terminology and so as to avoid falling into the same trap as those who I criticise, the following sets out the way in which these various terms are used throughout this thesis. The UK refers to Scotland, Northern Ireland, England and Wales, Britain refers only to Scotland, England and Wales. Where I use either term of reference within the literature, I am using the term used first by the original author.

Trends in the Live Birth Rate

Throughout most of Western Europe, increased sexual activity amongst teenagers throughout the 1960s resulted in an increased rate of live births peaking between 10 and 57 per 1000 women aged 15-19 during the 1970s for most countries (UN 1988a). For most of Northern and Western Europe between the 1970s and 1980s the live birth rate amongst teenagers saw a continual decline whilst during the early to late 1970s many countries in Eastern and Southern Europe saw a steady rise, before once more starting to decline in the mid-1980s.

By the mid-1980s most countries in Northern and Western Europe had live birth rates per 1000 women aged 15-19 of between 7 and 30. In Southern Europe the live birth rate in countries such as Greece and Portugal ranged between 30 and 50 per 1000 women aged 15-19, others such as Spain and Italy however, were already seeing declines more like those of Western and Northern Europe. At the same time some Eastern European countries such as Czechoslovakia, Romania and Hungary

(a notable exception being Poland), had rates averaging over 50 per 1000 women aged 15-19 (UN 1988a).

By the mid-1990s, most countries throughout all areas of Europe with the exception of Scotland, England, Wales and Northern Ireland were still witnessing a continual decline in live birth rates for women aged 15-19. Although some countries in Eastern Europe still had higher rates than the UK, for the rest of Europe, the rate of live birth in the 1990s ranged between 5.5 and 21.5 per 1000 (Kane & Wellings 1999).

What is most notable in the declining trend in live birth rates to women aged 15-19 over the last three decades, is the percentage reduction. Although almost every country in Europe of those reviewed in Table 1.1 (below) had a reduction of between 30 to 70%, the UK had only managed a reduction of 8.6% in Scotland, 14% in Northern Ireland and 0% in England and Wales.

Table 1.1

European Live Birth Rates for the female population aged 15-19 by country and year.

	Year							
	1977	1980	1983	1986	1989	1992	1995	% reduction 1977-1995
Country								
Bulgaria	78.6	79.0	79.4	77.1	69.9	67.2[13]	54.0	31.3
Romania	71.7	72.9	58.2	57.8[9]	60.0	48.0	40.5[15]	43.5
Hungary	74.2	68.7	53.9	49.3	41.2	36.1	29.9[15]	59.7
Eng & Wales	29.8	30.9	26.9	30.1	32.0	31.7	29.8[15]	0
Scotland	**32.6**	**32.6**	**28.8**	**30.8[3]**	**31.2**	**33.1**	**29.6[15]**	**8.6**
N. Ireland	30.1	29.7	28.1	30.3	29.2	30.5	25.9[14]	14.0
Iceland	56.2	56.8	41.0	31.8[8]	29.1	27.1	21.5[15]	61.7
Poland	33.6	32.9	34.2	35.1	31.6	32.2	21.1[15]	37.2
Portugal	48.0	40.2	37.4	30.1	26.3	22.7[13]	20.9[15]	56.5
CZEC rep	56.1	51.3	53.7	49.3[10]	44.3	42.9[13]	20.6	63.3
Austria	37.6	35.3	29.7	24.8[9]	21.8	23.1	15.6[15]	58.5
Ireland [1] [3]	21.2	23.0	19.0	16.8[9]	15.1	16.5[12]	15.4[15]	27.4
Norway	32.4	25.3	19.8	17.7[10]	17.8[1]	16.0[1]	13.6	58.0
Greece	48.6	53.1	43.7	41.2[8]	21.8[11]	18.9	13.0	73.3
Luxembourg	19.3	17.1[5]	14.1	10.7[9]	11.6[10]	14.1[13]	10.7	44.6
Malta	15.7	13.1	15.3	12.7	11.9	12.3	10.3	34.4
Finland	**24.2**	**18.9**	**15.7**	**12.9**	**11.8**	**11.7**	**9.8[15]**	**60.0**
Denmark	22.0	16.3	10.6	9.7	9.1[11]	9.9	8.8	60.0
France[2]	22.1	18.1	13.9	10.9	9.2	7.9[13]	7.9	64.3
Spain	26.7[4]	25.6	18.3	16.7	13.4[11]	8.3	7.8[13]	70.8
Sweden	22.1	15.8	11.7	11.4	12.7	12.0	7.8[15]	64.7
Italy	26.3	19.9	16.9[6]	13.7[8]	9.8[11]	8.0[12]	6.8	74.1
Switzerland	10.4	9.9	7.9[7]	6.5	7.1[11]	7.4	5.7[15]	45.2
Netherlands	10.1	9.2	7.7	6.8	7.6	7.7	5.6[15]	44.6

General notes

Rates are the number of live births by age of mother per 1000 corresponding female population.
Rates are computed on female population aged 15-19 unless otherwise stated.
Order of countries is set by rate of live births for the year 1995.
[1] Age classification based on year of birth of mother rather than exact date of birth of child.
[2] Date tabulated by date of registration rather than occurrence.
[3] Births registered within one year of occurrence.

[4] 1978	[8] 1984	[12] 1991
[5] 1981	[9] 1985	[13] 1993
[6] 1982	[10] 1987	[14] 1994
[7] 1984	[11] 1990	[15] 1996

Sources: UN Demographic yearbooks (1981 1982 1984 1985 1986 1987 1988a, 1988b 1989 1990 1991 1992 1993 1996 1997 1998).

Trends in the Abortion Rate

Although accurate data is not readily available for many European countries, it is possible to note from the available data that after legal abortion became an option in most Western European countries during the 1970s, the number of legally induced abortions to young women began to rise. This occurred simultaneously as the birth rate started to decline.

In Northern Europe, the proportion of young women who aborted as opposed to giving birth peaked at approximately one quarter of all pregnancies to teenage women. In Sweden, the peak occurred relatively early in 1974. In Finland and Norway it was 1980. In Denmark however, the proportion of induced abortions never rose above one fifth of all pregnancies (Kosunen 1996). Throughout the 1980s the proportion of abortions to births declined to some extent (some more than others) in all four of those countries.

In Britain the situation was quite different[1]. The abortion rate in Britain rose dramatically from 1968 to 1973 at which point it then fluctuated around 15-20 per 1000 women aged 15-19 for the duration of the mid-late 1970s (Bury 1984). Throughout the 1980s the abortion rates in Scotland, England and Wales once again had begun to rise, an increase that continued throughout the 1990s and as of 1998 it was still continuing to rise (Kane & Wellings 1999).

For those other countries in Western Europe where it is possible to acquire relatively accurate data, a similar pattern of slightly declining rates since a peak in

[1] The trend in abortions in Scotland will be examined in more detail in later sections of this chapter.

the mid 1970s has been detected (Henshaw and Morrow 1990). The Netherlands however is the exception, in that their birth and abortion rates have remained very low since the beginning of the 1970s (Kosunen 1996).

Table 1.2 below, shows the abortion rates on the basis of the latest available statistics for a number of European countries. As with the live birth rate, it appears that collectively, Britain has a rate higher than any other Western European country, although it remains lower than a number of Eastern European countries.

Table 1.2

Legal abortions per 1000 women aged 15-19 by country in 1996 (or latest available year)

Country	Rate
Bulgaria	33.7
Romania*	32.0
Hungary	29.6
Iceland	21.2
England & Wales	20.2
Scotland	18.8
Norway	18.7
Sweden	17.2
Denmark	14.4
Czech Republic	12.3
Finland	10.7
Italy*	5.1
Netherlands	4.0
Germany	3.6
Greece	1.5

General notes

* Indicates abortion data are less than 80% complete.
Year is 1996 unless noted: 1992 - the Netherlands, 1994 - England and Wales, Greece, 1995 - Bulgaria, Denmark, Germany and Italy, 1998 - Scotland.
Source is Singh & Darroch 2000 unless noted: Data for England and Wales source: Kane and Wellings (1999). Data for Scotland source: ISD Scotland (2000). Data for the Netherlands and Scotland: Abortion data are for women under 20 instead of 15-19.

Trends in the Pregnancy rate

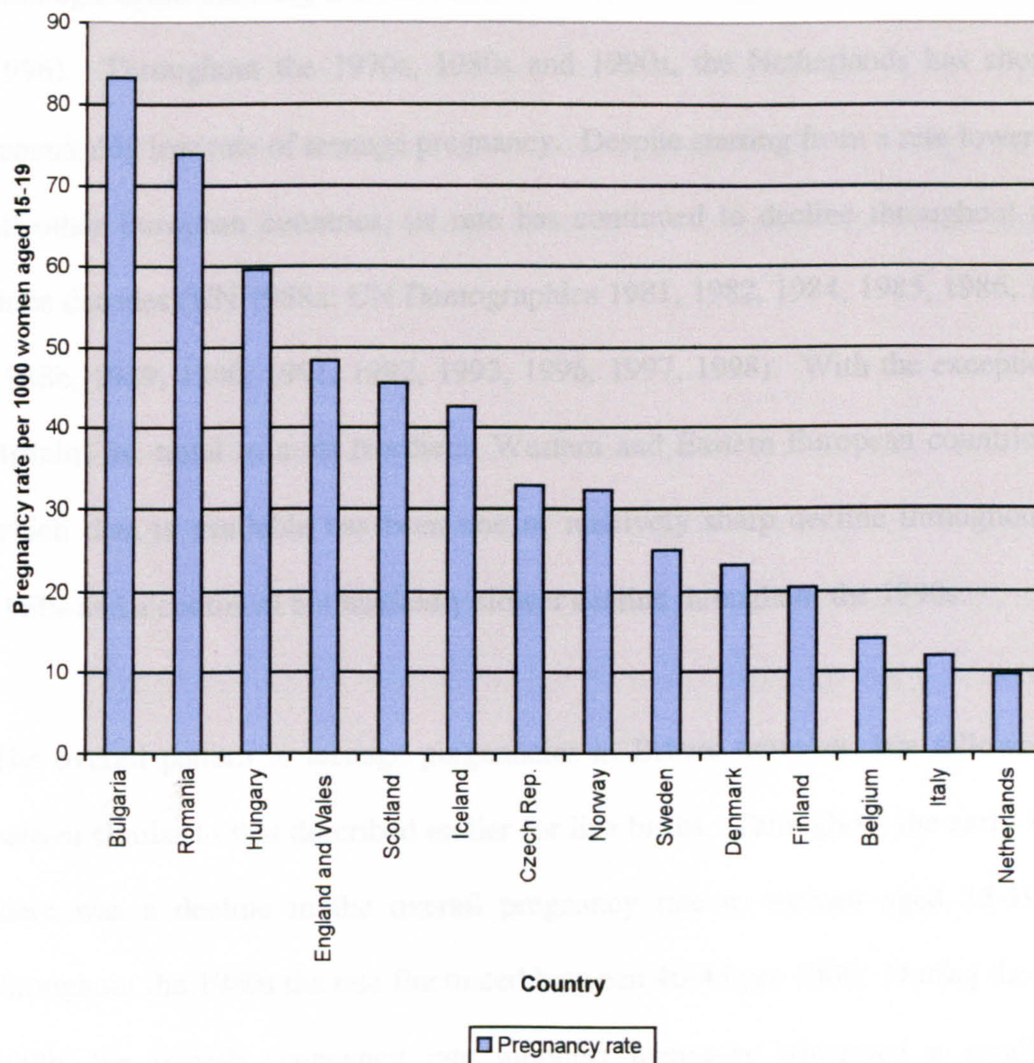
In order to gain an approximate idea of pregnancy rates in young women, proxy rates have been obtained by combining live birth and abortion rates for a selection of European countries where both data sets were available. Figure 1.1[1] below details the approximated pregnancy rates for these selected countries in 1996 (or latest available year). Of the data available, the most accurate is again for Northern European countries, Scotland, England and Wales and the Netherlands, although data is also available for a small number of Eastern European countries (such as Hungary and Czechoslovakia). Data for Italy and Romania is only 80% accurate (Singh & Darroch 2000).

Starting in the early 1970s the pregnancy rates to women aged 15-19 in Hungary, Bulgaria and Romania were considerably higher than most other European countries, although by the end of that decade the rates were declining at a very marked rate. This declining trend has continued throughout the 1990s although at a slower rate of decline than was witnessed throughout the 1980s. A similar pattern (although starting from a rate of approximately two thirds that of Hungary) has been witnessed in Czechoslovakia (UN 1988a: UN Demographics 1981, 1982, 1984, 1985, 1986, 1987, 1988b, 1989, 1990, 1991, 1992, 1993, 1996, 1997, 1998).

[1] Data for this figure can be found in Appendix i.

Figure 1.1

Approximated pregnancy rates for selected countries per 1000 women aged 15-19 in 1996 (or latest available year)



General notes

The year for both abortion and birth data is 1996 unless noted below:
1998 birth and abortion data - Scotland.
1995 birth rate - Bulgaria, Norway & Denmark.
1995 abortion rate - England and Wales and Belgium.
1993 birth and abortion data - Romania.
1992 birth and abortion data - the Netherlands.
Abortion data for Romania and Italy are only 80% accurate.
Data for Scotland and the Netherlands - birth & abortion data are for women younger than 20 not just 15-19.
Sources: Abortion data from Singh & Darroch (2000); Birth data from UN Demographic Yearbooks (1996, 1997,1998); Scottish data from ISD Scotland (2000).

Amongst Northern European countries the declining trend in teenage pregnancy began in the mid-1970s and has continued throughout the 1980s and 1990s, although again showing a slower rate of decline throughout the 1990s (Kosunen 1996). Throughout the 1970s, 1980s and 1990s, the Netherlands has shown a remarkably low rate of teenage pregnancy. Despite starting from a rate lower than all other European countries, its rate has continued to decline throughout those three decades (UN 1988a: UN Demographics 1981, 1982, 1984, 1985, 1986, 1987, 1988b, 1989, 1990, 1991, 1992, 1993, 1996, 1997, 1998). With the exception of Britain, the trend in most Northern, Western and Eastern European countries for which data is available has been one of relatively sharp decline throughout the 1980s and a continual but markedly slower decline throughout the 1990s.

The overall pattern in teenage pregnancies in Britain however, has followed the pattern similar to that described earlier for live births. Throughout the early 1970s there was a decline in the overall pregnancy rate to women aged 15-19 and throughout the 1980s the rate fluctuated between 40-45 per 1000. During the early 1990s the overall pregnancy rate amongst teenagers witnessed a small rise averaging around 45-50 per 1000 women aged 15-19 and since then the rate has slowly declined to the rates witnessed throughout the 1980s (Bury 1984; UN Demographics 1981, 1982, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1996, 1997, 1998; ISD Scotland 1997,1998, 2000).

Abortion ratio

The issue of teenage pregnancy is often misconstrued within literature as an issue

of unwanted and unplanned pregnancies. As has become apparent in recent years however, some teenage pregnancies (especially amongst 18-19 year olds) are in fact intended and where they are unplanned, it is not always the case that they are unwanted. The area of concern should therefore lie with those pregnancies that are unintended, unplanned and subsequently unwanted. When this occurs a young woman is faced with a number of options; continuing with the pregnancy and either keeping the child or placing the child up for adoption, or aborting the pregnancy.

The option to abort a pregnancy is not universal across Europe. Each country has its own laws regarding the conditions under which it is possible to obtain an abortion and variation in these laws will impact upon the abortion rate for young women in each respective country. As can be see in Table 1.3 below, throughout Europe there are four main categories under which abortion laws fall.

Definitions for the four categories have been described by Ketting (1993:4) as follows:

On request: women have a legal right to decide on the termination of pregnancy. In most cases this right only applies to the first three months of pregnancy, although there are notable exceptions (like Sweden and the Netherlands).

Rather broad: abortion is permitted for medical as well as socio-medical or social reasons. These reasons may include low income, poor housing, young or old age, and having a certain number of children.

Rather strict: only some narrowly defined circumstances justify performing an abortion. Specified grounds are often a threat to the woman's physical or mental health, foetal defects and legal indications (rape or incest).

Very strict: abortion is not allowed on any grounds or only if the pregnancy poses an immediate threat to a woman's life.

Table 1.3

European countries by current type of abortion law

1 On request		2 Rather Broad	3 Rather Strict	4 Very Strict
Norway	Czech Republic	Finland	Poland	Republic of
Sweden	Slovak Republic	Iceland	Portugal	Ireland
Denmark	Former Yugoslavia	UK (except	Spain	Northern Ireland
Netherlands	Romania	N. Ireland)	Switzerland	Malta
Belgium	Bulgaria	Luxembourg		
Germany	Albania	Hungary		
France	Greece	Cyprus		
Italy	Turkey			
Austria	Former USSR			

(Source: Ketting 1993: 4).

In the majority of European countries, laws regarding abortion fall under one of the first two categories although four countries have rather strict and three very strict laws. On the whole, the trend across Europe has been towards more liberal legislation (Kane & Wellings 1999). The move towards a more liberal level of abortion legislation in Spain, Portugal, Greece, Turkey, Romania, Albania, Belgium and the Slovak and Czech Republics occurred between the mid-1980s and 1990s (Ketting 1993).

The availability of abortion however does not always guarantee that one can be obtained, particularly in the case of young women. Across Europe the age at which a young woman can obtain an abortion and whether parental consent is required to do so, have major implications for the reality of abortion for many young women. In Austria for example, a young woman does not need parental consent from the age of 14 onwards, in Scotland, England and Wales and Switzerland the age is 16 and for Italy, France and Denmark it is 18. Due to the fact that many young women do not wish their parents to know of their pregnancy status, this places both the young women and their service providers in a difficult situation (Ketting 1993).

Since the 1970s the growing numbers of young women whose pregnancies have resulted in abortion have been in Northern and Western rather than Southern and Eastern European countries (Kosunen 1996). In addition to the laws regarding the availability of abortion, the changes in the proportion of young women across Europe who opt for abortion rather than birth are undoubtedly connected to a country's social and cultural acceptance of both abortion and childbearing in teenage years (Turner 2000).

Associated Factors

Research has further highlighted that in addition to those factors noted above, high teenage birth rates have been associated with social and economic factors (Jones et al. 1985, 1986; Selman 1998; SEU 1999; Turner 2000). In particular strong relationships exist between both higher levels of poverty and inequality, lower

levels of educational achievement and aspiration, and higher rates of pregnancy and births to young women under twenty.

The low rate of births to young women in the Netherlands, for example, has long been attributed to more open attitudes to sex and sexuality in society and the ease of access that young people have to sexual health services targeted at young people. However, Kirby (1997b) argues that other factors also play a role. In particular he notes that the Netherlands may experience a lower birth rate than Britain due to the fact that its society is more homogenous and consistently a more middle class society.

Economic Factors

The association between socio-economic background and teenage pregnancy has long been established, (Moore and Rosenthal 1993; Smith 1993; Hadley 1998) with socio-economic status, poverty and inequality all suggested to be important predictors of teenage pregnancy (Kirby 1997b). The association between deprivation, poverty and teenage pregnancy has, however, long been established as having occurred as result of pregnancy. Whereby, becoming a parent[1] at a young age has resulted in young women being unable to finish their education and therefore, being faced with a lack of employment opportunities which in turn, would mean a life reliant on welfare, resulting in a life of poverty for her and her child (Rhode & Lawson 1993).

[1] It is important to remember however that a live birth is only one potential outcome of a pregnancy; little research has thus far explored the potential negative effects on a young woman's educational continuation after an abortion.

However, while it is indisputable that large proportions of teenage mothers are faced with financial hardship, the conventional analysis of this association has been called into question in recent years as it has become more apparent, that often, poverty exists prior to pregnancy and that many young women have dropped out of education[1] prior to pregnancy, not because of it (Phoenix 1991; Kirby et al. 1994; Moore et al. 1995; Selman 1998; Turner 2000; Selman 2001 et al.).

In order to explore the relationship between poverty, deprivation and teenage pregnancy further, Kane & Wellings (1999) correlated two measures of a country's absolute wealth, Gross Domestic Product (GDP) and the United Nations Human development Index (UNHDI)[1] with teenage fertility. They found that both measures indicated strong inverse relationships with teenage motherhood, with correlation coefficients of –0.77 for economic development (GDP) and live births per 1000 women aged 15-19 (1996) and –0.62 for economic development (UNHDI) and live births per 1000 women aged 15-19 (1996).

One of the largest international studies on teenage pregnancy to date was that undertaken on behalf of the Alan Guttmacher Institute by Jones et al. (1985, 1986). This particular research explored the phenomenon of teenage pregnancy in 37 industrialised countries worldwide (with particular focus on five countries thought to be culturally similar to the USA), with the intention of highlighting relevant policy implications for the USA. Jones et al. (1985, 1986) concluded that low teenage fertility rates were found in countries where there were high levels of socio-economic modernization and where a relatively large proportion of

[1] Issues relating to educational achievement and aspiration are further explored later in this chapter.

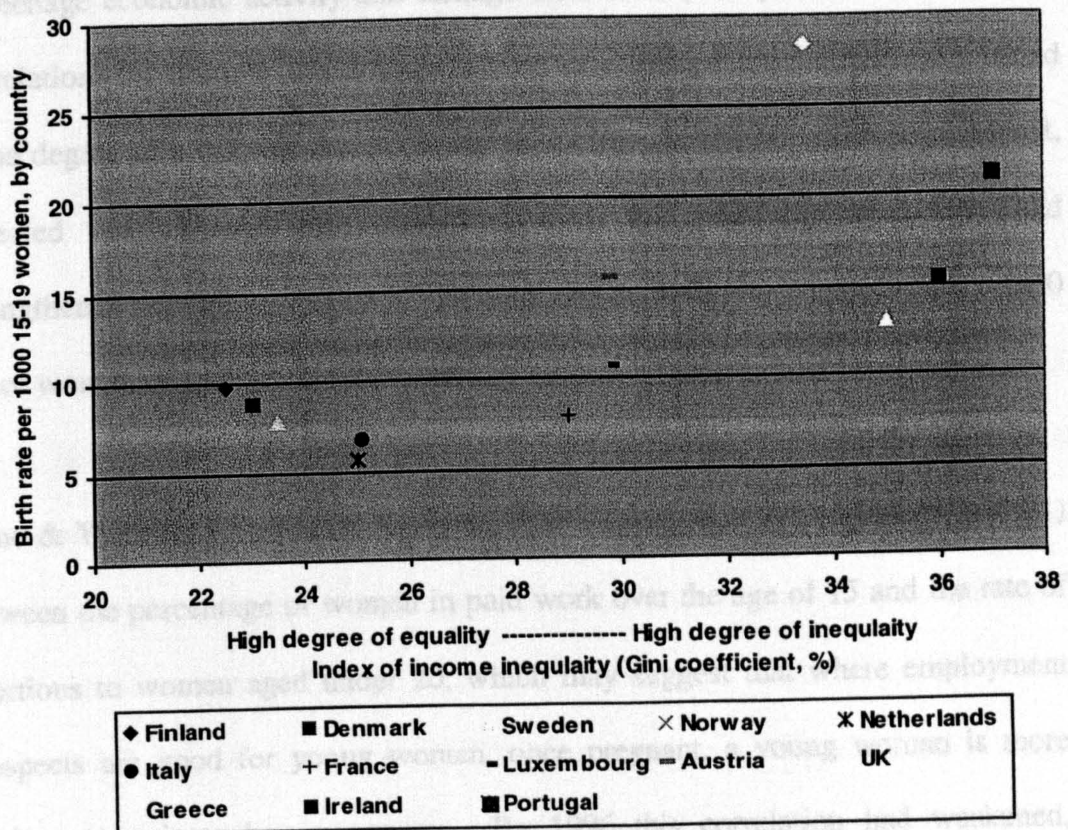
household income distributed to the low-income population (as well as those more open about sex).

Selman (1998) further explored the relationship between a country's economic development and teenage birth rates by using a measure of income distribution. He argued that using a crude measure of economic development such as GDP can provide an inaccurate picture of wealth in relation to teenage pregnancy because countries such as the USA and the UK, whilst both wealthy nations, have poor income distribution between the richest and poorest members of society (Selman 1998).

Therefore, using the gini coefficient as a measure of the percentage of all household income received by the poorest 20 percent of all households as an indication of relative poverty, Figure 1.2 below indicates that a strong positive relationship ($r_s = 0.65$) exists between countries with higher income equality and lower teenage birth rates.

[1] Since 1990, the UNHDP has incorporated national indicators of health, education and income (Kane & Wellings 1999).

Figure 1.2 – Comparison of Income inequality and teenage birth rates, by country, 1994 or latest available year.



$r_s = 0.65$

Sources: Selman 1998; UN demographic yearbook 1995.

Employment

The actual and perceived availability of employment opportunities for young people may impact upon the choices they make regarding their lives, and Kane & Wellings (1999) argue, therefore, that this may have consequences for fertility rates. Using two indicators of economic prospects: the proportion of all women over the age of 15 in paid work and the employment situation for young people aged under 25, Kane & Wellings (1999) explored the potential relationship between employment and teenage fertility rates.

They found that although considerable difference was visible across countries in

Europe, there was not a very strong correlation found between: the percentage of women in paid work over the age of 15 and teenage birth rates (0.23), nor the rates of teenage economic activity and teenage birth rates (-0.13) for 1991. Repeated correlations for 1996, by which point in time most European countries had suffered some degree of economic recession and an increase in the rate of unemployment, revealed that although the correlations were still relatively weak they had strengthened notably: $r_s = -0.40$ (15-24 employment male and female) and $r_s = 0.30$ (% of women in paid work aged 15+)[1].

Kane & Wellings (1999) did, however, find a strong positive relationship (0.71) between the percentage of women in paid work over the age of 15 and the rate of abortions to women aged under 20, which may suggest that where employment prospects are good for young women, once pregnant, a young woman is more likely to terminate her pregnancy. By 1996 this correlation had weakened, although remained significant at $r_s = 0.51$[2].

Caution must be exercised with regard to all of the above correlations, however, due to the fact that the definition of an 'unemployed' person will vary from country to country and in particular for this age group.

Education

The actual and perceived ability to continue in education beyond the age of sixteen

[1] Source for data on employment figures was European Commission 2001 and as a result of no separate figures for Scotland alone, UK figures are used for Scotland throughout; source for birth data was Singh & Darroch 2000.
[2] Source for data on employment figures was European Commission 2001; source for abortion data was Singh & Darroch 2000.

may also impact upon the choices they make regarding their lives[1]. Some potential ways in which this could impact would be where; increased opportunity in continued education, a strong normative expectation to continue in education or high unemployment rates amongst young people would encourage more young people to remain in education and hence indirectly delay parenting at a young age.

In order to explore some of these potential relationships further, noting that the average age at which compulsory schooling ends in Europe is 16, the proportion of young people aged 16-18 in education or training has been used as a measure of educational aspiration. Although there was a significant relationship found between a high proportion of young people remaining in training or education aged 16-18 and a low rate of teenage pregnancy[2] amongst 15-19 year old women in a number of European countries (r_s= 0.73) as can be seen in Figure 1.3 below, high continuation in education was not found, as one have might expected, to be significantly related to high rates of youth unemployment (aged 15-25) (r_s = 0.26) or high rates of unemployment amongst young women aged 15-24 (r_s = 0.26) across Europe as a whole[3].

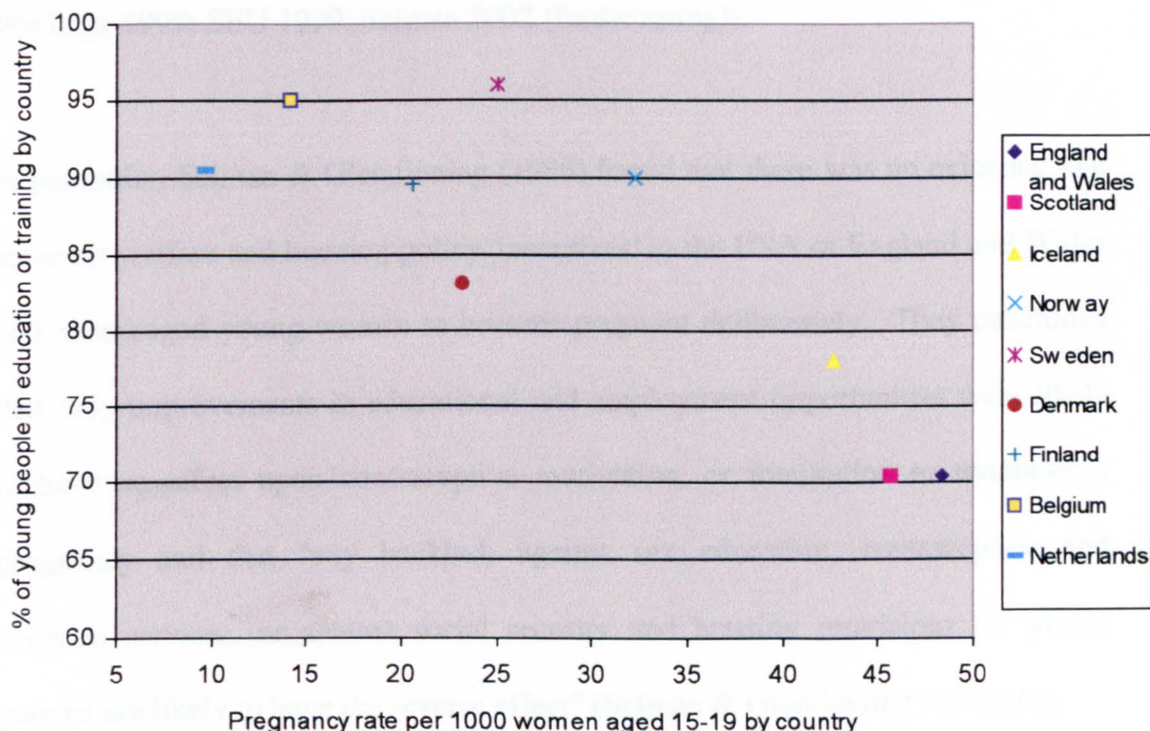
[1] The relationship between education and teenage pregnancy is discussed further in-depth in the review of literature in Chapter Two.

[2] In order to gain an approximate idea of pregnancy rates amongst young women, proxy rates have been obtained by combining live birth and abortion rates for a selection of European countries where both data sets were available.

[3] Source for data on unemployment figures was European Commission 2001. Source for % of young people in education or training data and teenage birth data as in Figure 1.3.

Figure 1.3

15-19 year old pregnancy rate and percentage of those aged 16-18 in education or training, by country in 1996 (or latest available year).



$r_s = 0.73$

General notes
Abortion data from Singh & Darroch 2000, Abortion data for Scotland from ISD Scotland 2000. Birth data from UN Demographic Yearbooks 1997,1998, Birth data for Scotland from ISD Scotland 2000. Year is 1996 for birth and abortion data unless noted: 1998 birth and abortion data – Scotland, 1995 birth rate - Denmark and Norway, 1995 abortion rate England and Wales and Belgium, 1992 birth and abortion data - Netherlands. Data for Scotland and the Netherlands - birth & abortion data are for women younger than 20. % of young people in education or training data - EUROSTAT 1998-99. Year for % of young people in education data is for 1996.
Data on Scotland and England and Wales - % education and training rates are for the UK as a whole.

Welfare Expenditure

The notion that young women become pregnant deliberately due to 'perverse welfare incentives' was a popular notion in both the USA and Britain during the Conservative eras of Reign and Thatcher respectively (Selman 2002 (forthcoming)). The suggestion that young women perceive welfare benefits as a financial incentive to conceive and continue a pregnancy to birth has, however,

been called into question by many researchers, as little evidence exists from European data to suggest that welfare provisions act as a perverse incentive to conceive (Selman & Glendinning 1996, Allen et al. 1998; Selman 1998; Kane & Wellings 1999; SEU 1999; Selman 2002 (forthcoming)).

In particular, Selman & Glendinning (1996) found that there was no evidence that apparent welfare and housing policy 'incentives' in the USA or England and Wales had encouraged young women to become pregnant deliberately. They concluded that only improvements in educational and employment opportunities were likely to have an effect upon contraceptive motivation, or motivation to terminate a pregnancy and that "any backlash against sex education, contraception and abortion services, or against social security and housing provisions for young parents are likely to have the reverse effect" (Selman & Glendinning 1996:216).

More recently Selman (2002 (forthcoming)) has argued that if the welfare incentive myth were to hold any credence, one would expect to find high rates of pregnancy and births to teenagers in countries with more generous welfare benefits such as Sweden and Finland. However, the reality is in fact the opposite, with those countries having relatively low pregnancy rates in European terms and of those who do become pregnant in the younger teenage years (under 17), abortion is by far the more likely outcome.

It is of further importance to note that in some countries, such as Scotland, England and Wales, (where the 'welfare myth' is strongest (Selman 1998; 2002 (fortcoming))), it is highly improbable that welfare benefits act as an incentive for

those aged under 16 (the group with which both England and Scottish governments are most currently concerned), because young women under the age of 16 are not entitled to any welfare benefits other than a minimal weekly child allowance which must be claimed via the young mother's own mother.

Causes of teenage pregnancy

In order to become pregnant a young woman must first be fertile, second have had sexual intercourse[1] and finally together with her partner, have failed in the use of contraception. This could be due to a failure to use contraception at all, failure to use it effectively or failure of the contraceptive itself. Therefore, in order to attempt to understand the trends in teenage pregnancy, it is first important to consider all of these factors.

Teenage fertility

Over the last century the age of menarche in most developed countries has decreased by approximately 0.2 years per decade, levelling off at twelve to thirteen years of age by the mid 1960s (Hofmann 1984). As a young woman reaches the stage of menarche and matures earlier, she therefore becomes fertile at an earlier age. Although there is often a delay between the age at which a girl reaches menarche and the age at which she becomes fertile it has been calculated that by the age of seventeen and a half, only 13.5% of women were biologically able to conceive a century ago. That figure now is believed to be 94%, as the age of

[1] Pregnancy can obviously occur through medical treatments that remove the need for sexual intercourse to have taken place, but these treatments are for infertility problems and not likely to be available or offered to teenagers. Additionally pregnancy could theoretically occur as a result of digital intercourse, where sperm having already been released from the male is then inserted into the young woman via a finger/hand. However the risks are limited due to the small amount of time that sperm can remain active once outside of the male body.

menarche has lowered on average by a total of four years over the same time period (Rauh et al. 1975). This gradually declining trend in the age of menarche is believed to be due in the main part to improved nutrition (Bury 1984).

The lowering of the age of menarche is associated with the earlier development of sexual awareness and feelings. The effect that this has had on the level of teenage pregnancy however, has been heavily contested (For example see: Bullough 1981; Cutwright 1972; Short 1978.). Rauh et al. (1975) have argued for example that it may account for as many as 50% of the increase in teenage pregnancies up to 1970.

Coital Activity

A study by the UN of coital activity across many European countries revealed that the age of first intercourse for women was in general decreasing by the mid-1980s. The proportion of women under 20 who were engaging in sexual intercourse[1] was steadily increasing compared with cohorts of previous generations (UN 1988a). For cohorts born after 1950[2] there was an increase in the proportion of women who had had first intercourse by the age of seventeen, the most noted decline of age at first intercourse therefore occurring during the late 1960s and early 1970s.

Reasons for this trend of lowered age at first sexual intercourse have been attributed to both biological (age of menarche) and social factors. For the first half

[1] Reference is made throughout this thesis to sexual intercourse and activity. This should be taken, unless otherwise noted, in every case to mean 'heterosexual'.
[2] This issue should however be viewed with caution as no data was available with regard to the age of first intercourse prior to the 1950s cohort and therefore no direct conclusions can be drawn about pre-1950s cohorts.

of this century the explanation leant towards the biological explanation. Since the age of menarche levelled off during the mid-1960s, however, the emphasis for the latter half of the century has been on social factors (Bury 1984).

Friedman and Phillips (1981) found that many young people, women in particular were engaging in sexual relations for non-sexual reasons. These included perceived enhancement of acceptance by peers, poor self-confidence, equation of sexual activity with general acceptance and often 'love'. In addition to this, research in recent years has highlighted the fact that many young women gain little if any pleasure from their first and subsequent sexual experiences (Thompson 1990) and often regret having had sexual intercourse before age 16 (Dickson et al. 1998; Wight et al. 2000).

Schofield's study in Britain found that although three quarters of young men enjoyed their first experience, only half of young women could say the same (1968). Part of this lack of pleasure is suspected to be because young women are unrealistic in what to expect, and are not prepared emotionally for what happens (Thompson 1990).

More recently Wight et al. (2000:1243) in their study of 14 and 15 year olds in Scotland found that of the 18% of young men and 15.4% of young women who reported having had sexual intercourse by age 14, a fifth of young women said they felt pressured at first (19.8%) and most recent intercourse (18.1%), compared to 7.0% and 9.1% respectively for young men. 32% of young women and 27% of

young men reported that they felt they had had sex too young and 13% of young women and 5% of young men felt that the intercourse should never have happened (Wight et al. 2000:1243).

From Wight et al.'s (2000) sample, a young man having exerted pressure on his partner was the only variable associated with regret amongst young men. For young women however, regret was associated with exerting pressure on a partner, having been pressured by a partner, having unplanned intercourse with a partner and relatively high levels of parental monitoring (Wight et al. 2000).

Data on the rate of sexual activity and age of first intercourse amongst young men and women is not readily available in many countries. Two international studies have been conducted however, one by the Alan Guttmacher Institute (Jones et al. 1985) and the other a UN report (UN 1988a). Amongst these findings was that in most developed nations the age of first intercourse was more or less the same, averaging at 17 years, with the exception of Scandinavian countries where the age of first intercourse was on average a year lower. A more recent study by Wellings et al. (1994) however, has suggested that the differences between the age of initiation for young British and Scandinavian women is disappearing.

One must be wary of these findings however, as it is quite possible that young people are not entirely truthful about their sexual experience, with young men over-exaggerating what they have done and young women underreporting. This may be especially true in countries where double standards still exist with regards to sexual behaviour and gender and this may go some way to explaining why

Scandinavian countries, who have reached a high degree of gender equality in all areas of life, apparently have a lower age of initiation (i.e. there is less stigma, especially for young women, in admitting their true age of first intercourse).

More recent smaller-scale qualitative studies such as Silver's (1998) which compared the effectiveness of sex education in England and the Netherlands found that the average age of first intercourse for both young men and women was fifteen, two to two and half years below each country's respective 'national average'.

Although some research has highlighted that a certain proportion of young women continue to have regular intercourse after their first intercourse such as is the case in Sweden (Invarsson & Lindquist 1987), for the most part, young women do not generally have a regular sex life immediately after their first intercourse. Wilkins et al. (1981) after reviewing available literature on this subject found that approximately 50% of young women who had had their first intercourse were not continuing to have sexual intercourse on a regular basis and that most sexual activity in younger years is infrequent, unplanned and sporadic.

Contraceptive use

It has been argued that at first the rise in sexual activity in European countries was not accompanied by an increased usage of contraception by teenagers and hence the pregnancy rates witnessed a rise (Bury 1984). The fall in teenage pregnancy rates among 15-19 year old women since 1970 therefore, have been attributed in part to the increased availability and greater use of contraception by teenagers

(Thompson 1976; Yarrow 1978; Hansard 1983).

Amongst younger teenagers, use of contraception at first intercourse has never been particularly high. Studies from Europe have shown that a significant proportion of young people used no effective method of contraception at first intercourse (UN 1988a). The relationship between age and likelihood of contraception being used at first intercourse has been established in that the younger the individual, the less likely they are to use any reliable method of contraception (Morrison 1985; UN 1988a).

During the mid-1980s, the world entered a phase of sexual health crisis with the discovery of a sexually transmittable virus, HIV, that was believed to be the cause of AIDS. Rigorous advertising campaigns were launched in many countries, worldwide, in an attempt to encourage effective use of condoms to halt the spread of HIV. Prior to the arrival of HIV, condoms had already been established as the preferred choice of contraception by young people at first intercourse in many countries (Kosunen 1996). This is likely to have occurred due to the relative ease of (non-medicalised) access to condoms compared to other methods of (medicalised) contraception. Additionally it may also be due to the 'unpreparedness' for sexual activity that the condom represents in comparison with 'being on the pill' prior to the commencement of sexual activity.

The fact that the use of oral contraceptives (a sign of preparedness) is more common amongst younger teens in the Netherlands and Scandinavian countries raises an interesting issue (Kosunen 1996; Silver 1998). It has been suggested that

gender equality and openness regarding sexuality in general culture play an important role here (Silver 1998). Young women in Britain for example receive many confusing messages regarding sex, most commonly from the media, where sex is used to sell everything from newspapers to cars[1] (Hadley 1998; HEA 1998). The resulting effect of these confusing messages is that young women are still made to feel that while they should be 'sexually attractive' they should also be 'sexually innocent' and that a good sexual 'reputation' is a very high priority (Lawson & Rhode 1993; Lees 1994; HEA 1998). Therefore if young women are using oral contraceptives before initiating sexual relations, they are seen to be prepared, which is often translated due to double standards as 'promiscuous' (HEA 1998).

Research has also shown that young women in Britain are often not in control of their sexual relationships as a result of a power imbalance in those relationships (Holland et al. 1993; Lawson & Rhode 1993; Lees 1994; Holland et al. 1998; Silver 1998). Often young women who are aware of the risks they take in not using condoms (STIs, HIV as well as pregnancy) will not use them because their boyfriends 'do not like them', therefore putting their boyfriends' pleasure before their safety (Silver 1998; SEU 1999). This 'dominant male' syndrome is typical of many relationships that young women have in Britain (Holland et al. 1998) and is an example of how sexual health messages fail to be internalised and illustrates that knowledge of sexual health is not always enough to alter behavioural patterns (Silver 1998).

[1] It is worth noting that such media presentations are also found in other countries. However, in the Netherlands for example, these messages are balanced with more positive media presentations of sex and sexuality, which are not present in Britain.

In contrast Papp (1997) notes that in countries with higher social and economic gender equality, there has been a move from the 'double' standard to a single-sex standard whereby women have gained more equality in sexual rights in comparison to their male counterparts. This process has occurred and is particularly strongly expressed with Nordic countries (Weinberg et al. 1995; Sprecher & Hatfield 1996; Bozon & Kontula 1998) and the Netherlands (Silver 1998).

Usage of oral contraceptives at first intercourse appears to vary greatly across Europe with the highest use occurring in Scandinavian countries and the Netherlands (UN 1988a; Jarlbro & Persson 1990; Kraft et al. 1990; Wielandt 1993; Kosunen 1996). As was the case with condom usage however, the likelihood of a young woman using oral contraceptives at the time of her first intercourse is lower, the younger the woman (Mosher & McNally 1991).

Although younger people are less likely to use any method of contraception at first intercourse, as young women grow older, their sexual relationships become less sporadic and contraceptively unprepared. The trend in contraceptive use then moves from using no protection or a barrier method (e.g. a condom) to a more reliable prescribed method (the pill) (UN 1988a; Kosunen 1996).

Having examined the trends in pregnancy, birth and abortion rates, sexual and contraceptive coital and contraceptive behaviour of teenagers across Europe and possible reasons for those trends, the remainder of this chapter examines in more detail the national data available for both Scotland and Finland.

Finnish National Trends

In this section of the chapter teenage pregnancy and associated rates for the years 1980 to 1999 will be discussed in order to compare the trends between Finland and Scotland, remembering however, that direct comparisons cannot be made as the available data represent different age groupings.

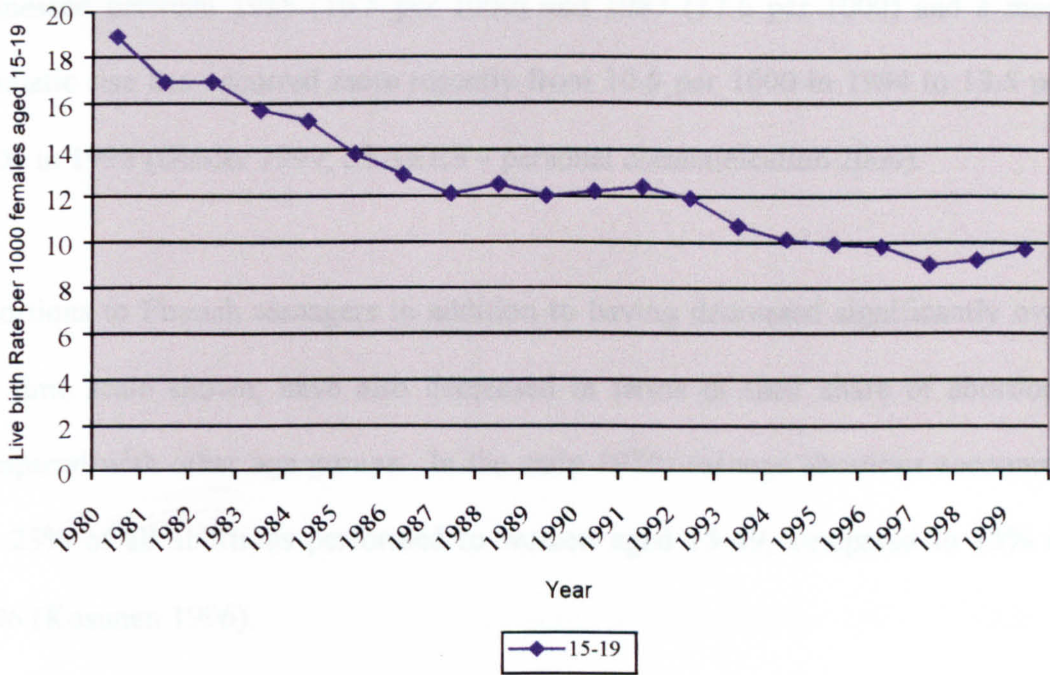
Live Birth Rate

At the point when this research began in 1996, Finland was one European country, which had a continually declining teenage (15-19 year old) birth rate from the early 1970s. As can be seen in Figure 1.4[1] below, the live birth rate for this age group steadily declined throughout the 1980s and 1990s from 18.9 per 1000 women aged 15-19 in 1980 to 9.0 per 1000 in 1997. The only temporary halt in the decline occurred between 1987 and 1990 when the rate fluctuated between a low of 11.8 per 1000 and 12.4 per 1000 (Gissler 1999). Since 1997, however, there has been a rise in the rate of live birth from 9.0 per 1000 in 1997 to 9.7 per 1000 in 1999 (STAKES – personal communication 2000).

[1] Data for this figure can be found in Appendix i.

Figure 1.4

Live birth rate per 1000 Finnish women aged 15-19, 1980-1999



Source: Gissler 1999; STAKES 2000 (Personal communication).

Abortion Rate

Prior to 1950, abortion in Finland was illegal except on medical grounds. Between 1950 and 1970 the law was liberalised to allow abortions on the grounds of medical, medical-social, ethical (rape or incest) and eugenic indications (Rehnström 1997). As the decision on whether to abort was left up to individual doctors and as many charged large fees, this in effect meant that the availability of abortion was not uniform throughout Finland and large numbers of illegal abortions continued to be performed (Hämäläinen et al. 1995).

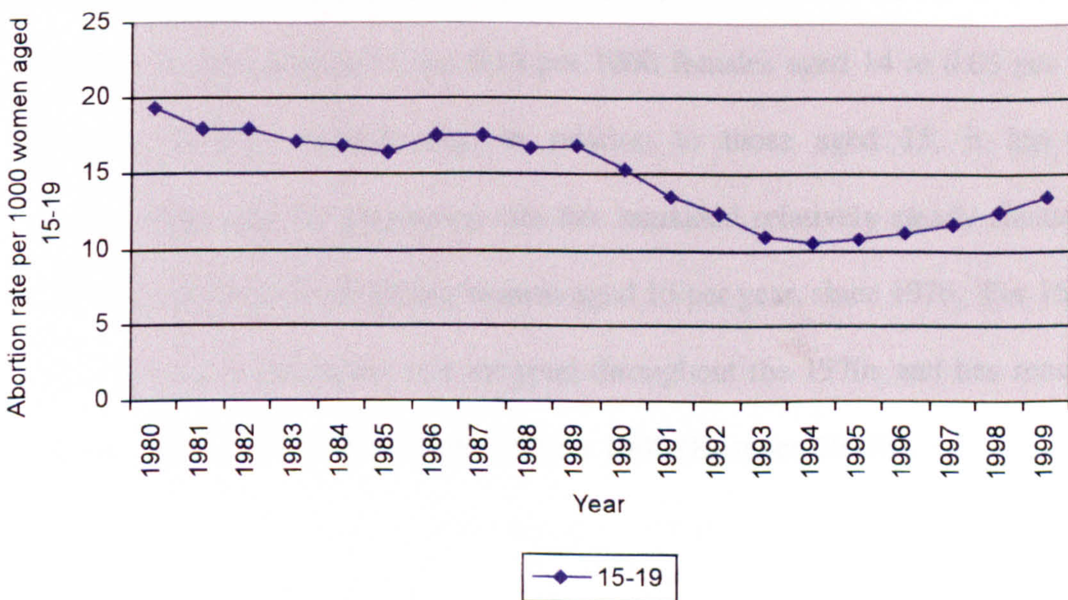
In 1970 the law was further liberalised and placed a particular priority for those aged under 17 at the time of conception. As a result, the number of legal terminations rose rapidly throughout the early 1970s. Since 1973 the abortion rate

has declined steadily for all age groups including those aged 15 to 19 (Gissler 1999). Figure 1.5[1] below shows this continually declining trend from 19.4 per 1000 females aged 15-19 in 1980 to 10.5 per 1000 in 1994. A marginal rise was witnessed between 1985 (16.5 per 1000) and 1987 (17.6 per 1000) and a more dramatic rise has occurred more recently from 10.5 per 1000 in 1994 to 13.5 per 1000 in 1999 (Gissler 1999; STAKES – personal communication 2000).

Abortions to Finnish teenagers in addition to having decreased significantly over the time scale shown, have also decreased in terms of their share of abortions compared with other age groups. In the early 1970s teenage abortions accounted for 25% of all abortions performed to women aged 15-49, compared to 15% in 1996 (Kosunen 1996).

Figure 1.5

Abortion rate per 1000 women aged 15-19 in Finland, 1980-1999.



Sources: Gissler et al. 1996; Gissler 1999; STAKES 2000 (Personal communication).

[1] Data for this figure can be found in Appendix i.

Pregnancy Rate

Teenage pregnancy has never been a source of moral panic in Finland (Rehnström 1997). Since the mid-1970s the number of pregnancies to women aged 15-19 has more than halved in size. As a whole in 1994 only 2.6% of births to women aged 15-49 were to women under the age of 20 and of those, 80% were to women aged 18-19 (Rehnström 1997:11).

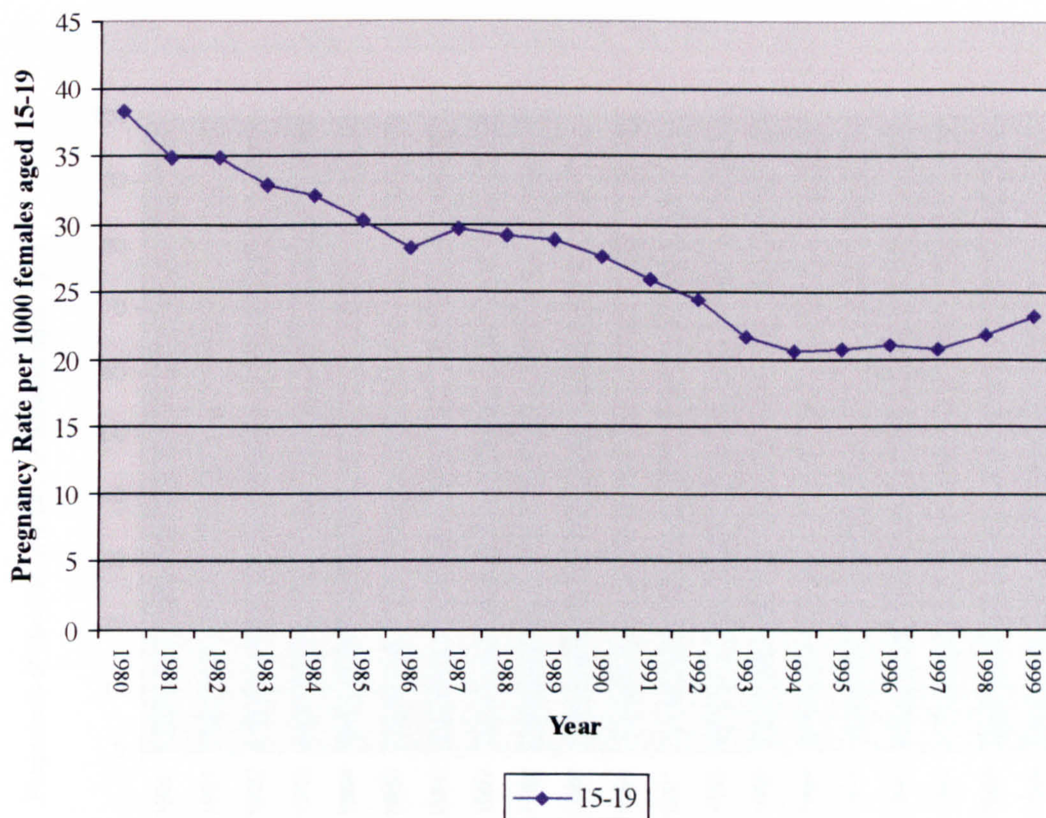
The overall decline in the teenage pregnancy rate to women aged 15-19 has been steady throughout the last two decades until 1995 (see Figure 1.6[1] below). A marginal rise was witnessed from 28.3 per 1000 in 1986 to 29.7 per 1000 in 1987. Since 1995 however, the pregnancy rate has witnessed an overall rise once again from 20.6 per 1000 in 1994 to 23.2 per 1000 in 1999 (Gissler 1999; STAKES – personal communication 2000).

As stated previously, data on those aged under-16 is not widely available in Finland. Between 1981-82 and 1989, however, the live birth rate for 14 year olds is known to have declined from 0.18 per 1000 females aged 14 to 0.03 per 1000 (Kosunen 1996). Additionally, in relation to those aged 15, it has been acknowledged that the pregnancy rate has remained relatively steady fluctuating between 3 and 5 per 1000 young woman aged 15 per year, since 1976. For 16 year olds, the overall pregnancy rate dropped throughout the 1970s and has remained since the mid-1980s at a constant of 10 per 1000 (Kosunen 1993b).

[1] Data for this figure can be found in Appendix i.

Figure 1.6

Teenage pregnancy rate per 1000 women aged 15-19, 1980-1999



Sources: Gissler et al. 1996; Gissler 1999; STAKES 2000 (Personal communication).

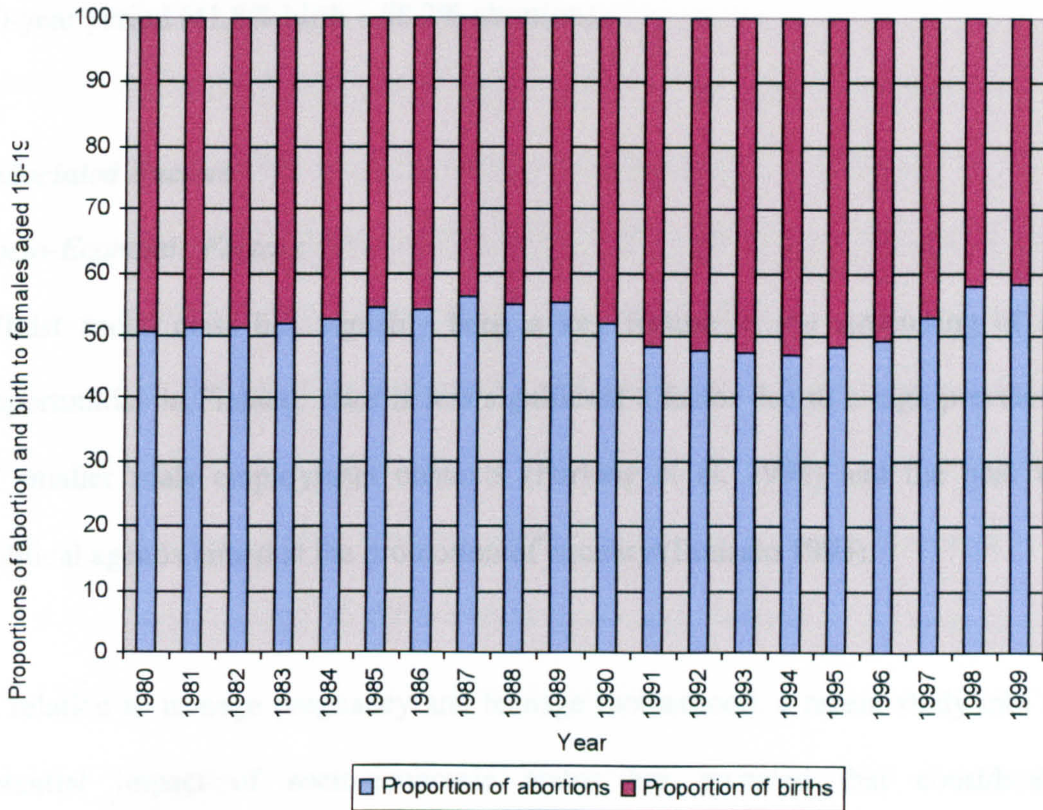
Abortion Ratio

The pattern in most Northern European countries, Finland included, with regard to abortion ratio tends to be the classic U-shape, whereby the abortion ratio is highest amongst those women over 35 and under 20. Although not much is known about the youngest age groups in Finland, it has been established that almost 100% of those aged 15 and 70-80% of those aged 16 who become pregnant, opt for an abortion rather than to give birth (Kosunen 1993b). The proportion for young women as a whole aged 15-19 can be seen in Figure 1.7[1] below.

[1] Data for this figure can be found in Appendix i.

Figure 1.7

Abortions and births as a proportion of total pregnancies to young women aged 15-19, 1980-1999.



Sources: Gissler et al. 1996; Gissler 1999; STAKES 2000 (Personal communication).

This pattern shows the beginning of an interesting change in the outcome of pregnancy amongst 15-19 year old Finnish women. Given that the proportion of those who abort is very high amongst 15 and 16 year olds (Kosunen 1993b), it is likely therefore that the majority of change is occurring amongst older teenagers. The trend from the beginning of the 1980s where the proportion of abortions was only marginally higher than the proportion of births has been one of decreasing proportions of births to abortions.

From 1991, the trend changed direction whereby it became more common for older Finnish teenagers throughout the early 1990s to give birth as opposed to aborting their pregnancy. The proportion however has now reversed quite dramatically, with the difference between the two outcomes in 1999 being the largest over the 20-year period (41.8% birth – 58.2% abortion).

Associated Factors

Socio-Economic Factors

Whilst social class has arguably been a key feature in the structuring of life opportunities in Finland, class is less significant a factor due to a high prevalence of smaller scale employment contexts (Furlong et al. 1998) and the post war political agenda aimed at the promotion of equality (Sinisalo 1993).

In relation to teenage pregnancy and teenage motherhood, a recent study into the potential impact of socio-economic status has revealed that considerable differences were found in teenage pregnancy risk in relation to a young woman's father's socio-economic status. The study revealed that young women who came from lower socio-economic backgrounds were at a higher risk of pregnancy during teenage years (Vikat et al. 2001).

Over the time period of 1987 and 1998, however, there were found to be no changes in the socio-economic differentials and the study revealed that the factors that were believed to influence teenage pregnancy risk had impacted similarly across all socio-economic groups and therefore the conclusion to this study was that the changes in socio-economic structure could not account for the levelling-off

in the reducing trend in the rate of pregnancy amongst 15-19 year olds (Vikat et al. 2001).

Employment

In relation to how the employment rate of women aged 15 and over potentially relates to the trends in births to women aged 15-19 in Finland, correlations were found to differ from that found by Kane & Wellings (1999) for Europe as a whole. In other words, over the time period 1991-1998, a correlation (although a weak one) was found between higher (rather than lower) birth rates amongst women aged 15-19 and higher economic activity of women aged 15 and over ($r_s = 0.43$)[1]. However in relation to abortion rates, Finland did fit the general pattern found by Kane & Wellings (1999), with a perfect correlation between higher rates of abortion to women aged 15-19 and higher economic activity of women aged 15 and over ($r_s = 1.0$[2]), suggesting that during times of economic prosperity, young women in Finland are more likely to view continuing a pregnancy to term as a hindrance to their potential in the labour market.

Education

The transition from school to work in Finland has for some time been a prolonged experience with a consistently high proportion (90% +) of young people remaining in some form of education beyond the age of 16 for at least two-three years, as well as the fact that university education in Finland (undertaken by approximately 50% of the cohort) can take seven years to complete (Roberts 1997).

[1] Source for data on employment figures was European Commission 2001, source for birth data was Singh & Darroch 2000.
[2] Source for data on employment figures was European Commission 2001, source for abortion data was Singh & Darroch 2000.

Although one may expect to be able to explain, at least in part, increasing rates of continuation in education as due to increased rates of youth unemployment (such as Finland has witnessed during the 1990s), the rate of continuation from the comprehensive school (11-16) to high or vocational school (16-19) has always been high in Finland, during periods of both higher and lower youth employment. This may suggest that there are other factors relating to the structure of the education system, or the normative value placed on education in Finland, which impact upon young people's willingness and ability to negotiate the transition to continued education, rather than attempt to enter the labour market directly from the lower comprehensive school.

Causes of Teenage Pregnancy

Coital Activity

The first major study of national sexual activity to be conducted in Finland took place in 1971. Although it only considered those aged 18 and above, it is possible to determine from that research the pattern of change in first intercourse and sexual activity at that point in history. The results showed that the median age of first intercourse had decreased from 20 years of age in 1930 to 18 years of age by the 1960s (Sievers et al. 1974).

A similar study was conducted in 1992 which revealed that the proportion of young women who had had first intercourse before the age of 16 had increased from 1% in 1971 to 23% in 1992. Over the same time period the proportion of young men had increased from 13% to 21% (Kosunen 1993a). The first national

study of teenage sexual activity in Finland took the format of a postal questionnaire in 1968, revealing that the proportions of young women and young men who had first had intercourse before age 15 were 4% and 6% respectively (Saviaho 1971).

The KISS[1] research study into teenage sexual behaviour began in 1986 and was repeated in 1988 and 1992. This particular study looked at a range of issues including, knowledge of sexual matters and sources of information, age of first intercourse, experience of couple and sexual relationships and contraceptive use. The first study revealed that by the 9th grade (15-16 years of age), 25% of young woman and 21% of young men had had intercourse (Kontula and Meriläinen 1988). The corresponding figures for 1988, 1990 and 1992 are shown below in Table 1.4.

Table 1.4

Proportions of young people who had experienced intercourse by age 15 in Finland.

Gender	1988*	1990**	1992*
Young men	31%	25%	19%
Young women	30%	29%	31%

Sources:
* Kiss Study (Kosunen 1993a)
** Health-behaviour in school aged children study (Pötsönen 1993)

Table 1.5 below reveals the level of sexual experience by age 15 of Finnish young

[1] KISS is the project name for a study into teenage sexual behaviour and it is an acronym from the Finnish words meaning maturation, human relationships, dating and sexual behaviour (Kosunen 1996).

men and women in 1992. The findings reveal that young women by age 15, have had on the whole marginally more types of sexual experience than young men except for masturbation. They had significantly more experience of sexual intercourse with only 19% of young men having had intercourse by age 15 compared to 31% of young women (Papp 1997).

Table 1.5

Sexual experience of Finnish schoolchildren by age 15 in 1992.

Sexual experiences	Young men%	Young women%
Kissing	69	78
Light Petting	61	67
Heavy petting	38	52
Sexual intercourse	19	30
Masturbation	59	40

Source: Papp 1997.

Contraception Use

From the first study conducted on sexual experience and young people (Leppo 1978), it was found that at first intercourse while 46% of young woman had used condoms, the remainder had relied on the withdrawal method or had used nothing at all (Leppo 1978).

Data from the KISS studies of 1986, 1988 and 1992 revealed on the whole an increase in the use of contraception by young people at first intercourse. The proportion using no method of contraception decreased in each study although more significantly between 1986 and 1988 than between 1988 and 1992 (Kosunen

1993a). The proportions who had ever-used the condom had also increased significantly between 1986 and 1992 (Kosunen 1993a). On the whole by 1992, the proportions of young people using no method of contraception had decreased in all groups of individuals, for those aged 15 the percentages had dropped from 28% (young men and young women) to 13% of young men and 20% of young women (Kosunen 1993a).

Despite the growing popularity of the condom amongst younger teenagers in Finland, it seems that as a young woman becomes older she is much more likely to adopt a more reliable method of contraception (Kosunen 1993a, 1996). Amongst older teenagers, the oral contraceptive is now the preferred method (Sihvo et al. 1995). The findings of Kosunen's study (1993b, 1996) into oral contraception use by Finnish teenagers also concluded that the increased use of oral contraceptives has perhaps reached close to 'saturation level'[1] for those in need of regular contraception.

The availability and use of emergency contraception is a factor associated with low incidence of teenage pregnancy in the Netherlands and has been suggested to be part of the reason why teenage pregnancy rates are also relatively low in Finland (Kosunen & Rimpelä 1996a). A recent study by Kosunen et al. (1999a, 1999b) using information from the National School Health Study, revealed that only 3% of those aged 15 and 1.5% of those aged 17 were unaware of emergency contraception. The proportion that had ever used emergency contraception increased according to age, ranging from 2.1% (aged 14-15) to 15.1% (aged 17)

[1] Saturation level is used within this context to mean that the contraceptive pill was being used by almost all regularly sexually active young women in need of contraception.

(Kosunen et al. 1999b). Of those who had used this method two thirds had used it only once, which Kosunen et al. (1999b) stated should alleviate fears that easy access to emergency contraception would result in it being used as a method of contraception in itself rather than as an emergency measure.

Scottish National Trends

In this section of the chapter, teenage pregnancy and associated rates for young women in Scotland from 1983-1998 will be explored. Since 1983 pregnancy, birth and abortion rates for teenagers in Scotland have been reported in the format of 13-15 year old and 16-19 year old year groupings (ISD Scotland 1997, 2000). Information prior to that year was reported in the format of a 15-19 year old year grouping and therefore it is not directly comparable to the later years and hence, has not been included.

Live Birth Rate

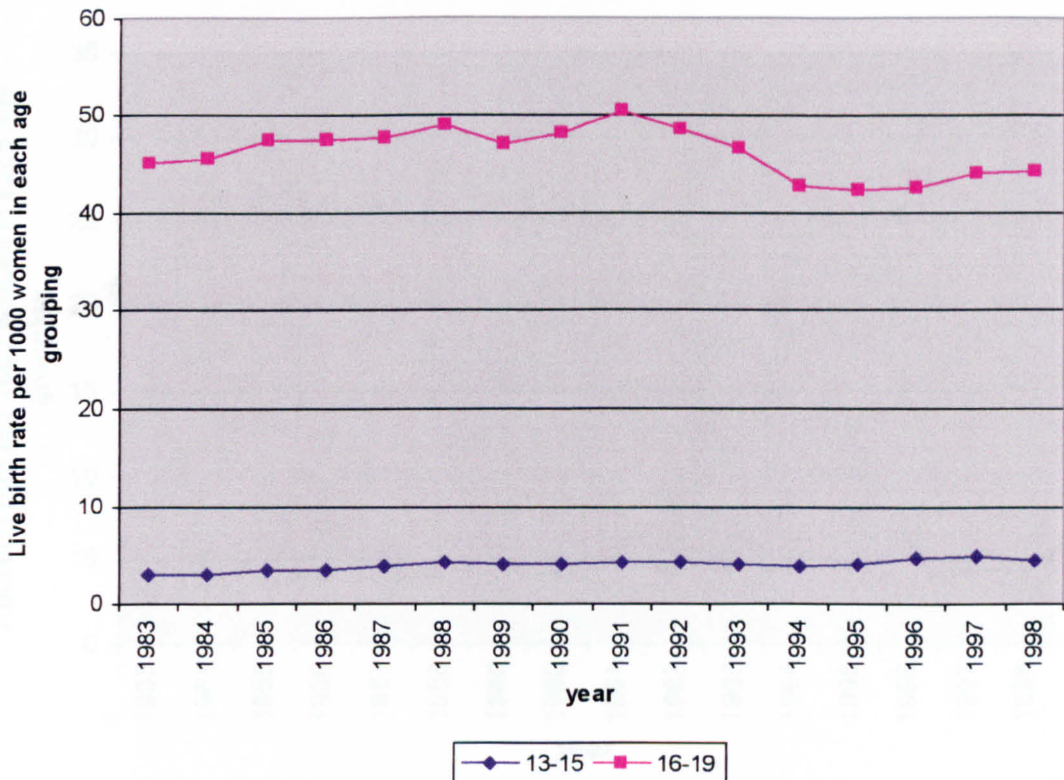
Between 1983 and 1998 the live birth rate to Scottish teenagers has changed relatively little overall. There are, however, some distinct differences in the trends between older and younger teenagers. As can be seen in Figure 1.8[1] below, since 1983, the birth rate for older teenagers rose steadily from 45.2 per 1000 to a peak of 50.4 per 1000 in 1991. Since then the trend on the whole has been one of steady decline to 42.6 per 1000 in 1996, although there was a slight rise to 44.0 per 1000 in 1997 and again in 1998 to 44.3 per 1000 (ISD Scotland 1997, 2000). Amongst younger teenagers the birth rate rose at a relatively steady rate from 3 per 1000 in 1983 to 4.9 per 1000 in 1997, with a small decline from that peak to 4.4 per 1000

[1] Data for this figure can be found in Appendix i.

in 1998 (ISD Scotland 1997, 2000). In 1998 of those births to teenagers 93.1% were to women aged 16-19.

Figure 1.8

Live Birth rates per 1000 Scottish women by age grouping, 1983 - 1998.



Source: ISD Scotland 1997, 2000.

Abortion Rate

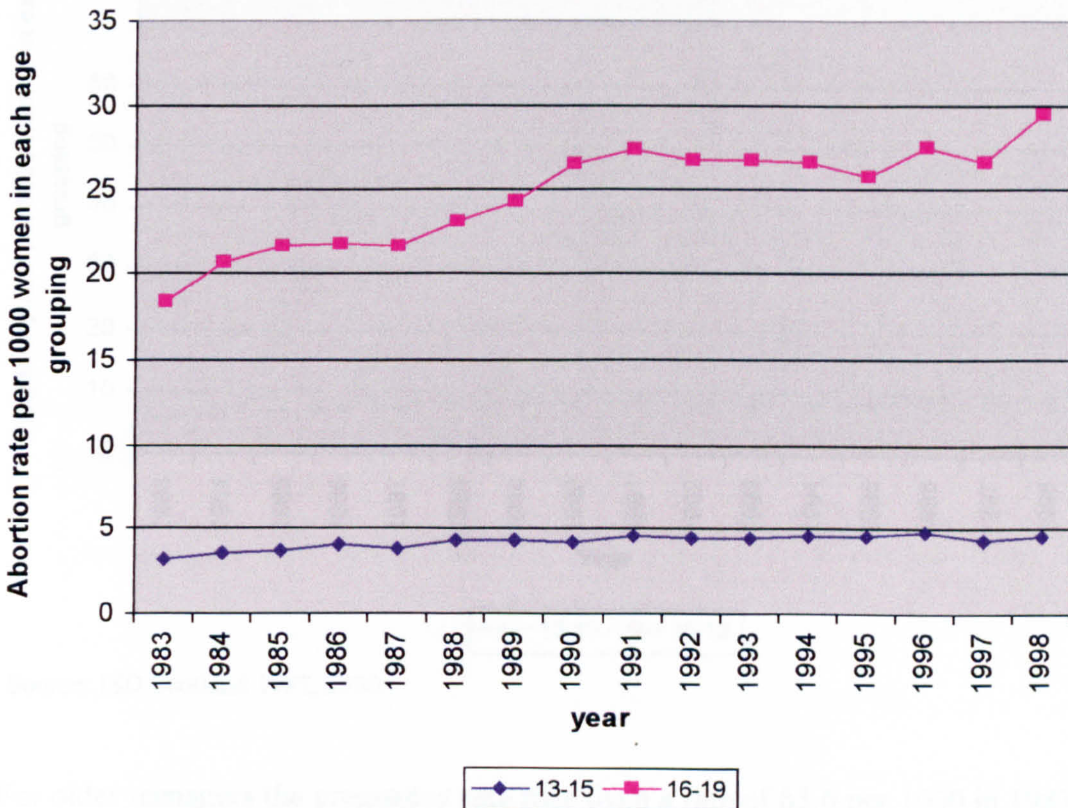
As can be seen in Figure 1.9[1] below, over the same time period there have been similarly differing trends in abortion rates between older and younger teenagers. Amongst older teenagers the abortion rate rose steadily and significantly from 18.3 per 1000 in 1983 to a peak of 29.5 per 1000 in 1998 (ISD Scotland 1997, 2000). For younger teenagers the abortion rate rose in line with the birth rate from 3.2 per

[1] Data for this figure can be found in Appendix i.

1000 in 1983 to 4.8 in 1996, before declining slightly to 4.5 in 1998 (ISD Scotland 1997, 2000).

Figure 1.9

Abortion rates per 1000 Scottish women by age grouping, 1983 - 1998.



Source: ISD Scotland 1997, 2000.

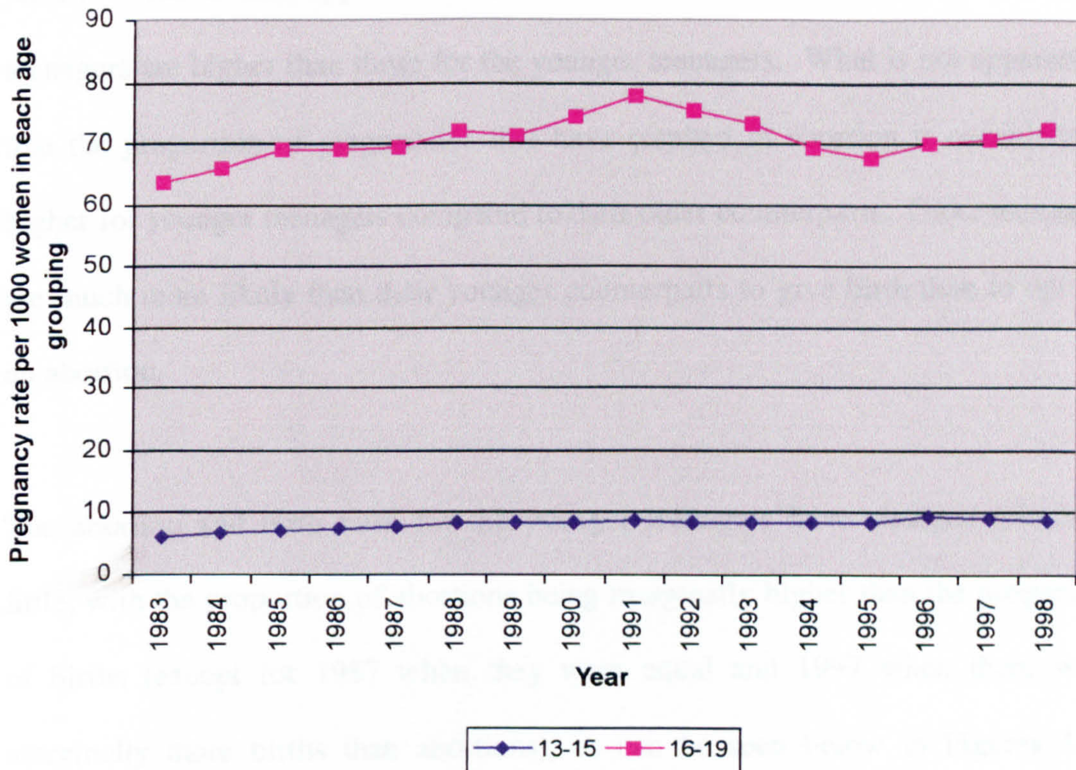
Pregnancy Rate

As can be seen in Figure 1.10[1] below, there has been very little change in the overall teenage pregnancy rates in all age groups in Scotland between 1983 and 1998. Although there has been an overall increase for both the 13-15 and the 16-19 age groups, the trends again are very different.

[1] Data for this figure can be found in Appendix i.

Figure 1.10

Teenage pregnancy rates per 1000 Scottish women by age grouping, 1983 – 1998.



Source: ISD Scotland 1997, 2000.

For older teenagers the pregnancy rate rose from a rate of 63.6 per 1000 in 1983 to a peak of 77.8 per 1000 in 1991. Since that time the rate steadily decreased to 67.6 per 1000 in 1995, although a small rise occurred again from 1995 to 1998 to a rate of 72.4 per 1000 (ISD Scotland 1997, 2000). Therefore although the rate in 1998 is higher than 1983, it has also declined from the peak of 1991.

For younger teenagers the trend in teenage pregnancy has been one of a steady increase from 6.2 per 1000 in 1983 to a peak of 9.5 per 1000 in 1996, with a small decline over the following two years to 8.9 per 1000 in 1998 (ISD Scotland 1997,

2000).

Abortion Ratio

As has been noted in Figures 1.8-1.10, the trends for older and younger teenagers differ. What is also apparent is that both the abortion and birth rate for older teenagers are higher than those for the younger teenagers. What is not apparent is that the proportion of pregnancies that have resulted in abortion is considerably higher for younger teenagers compared to their older counterparts. Older teenagers are much more likely than their younger counterparts to give birth than to opt for an abortion.

The abortion and birth rates for the younger teenagers have changed relatively little, with the proportion of abortions being marginally higher than the proportion of births (except for 1987 when they were equal and 1997 when there were marginally more births than abortions), as can be seen below in Figures 1.11 below[1]. The greatest difference occurred in 1994 when the abortion rate of 4.5 per 1000 accounted for 53.6% of all pregnancies and the birth rate of 3.0 per 1000 accounted for 46.4% of all pregnancies (ISD Scotland 1997, 2000).

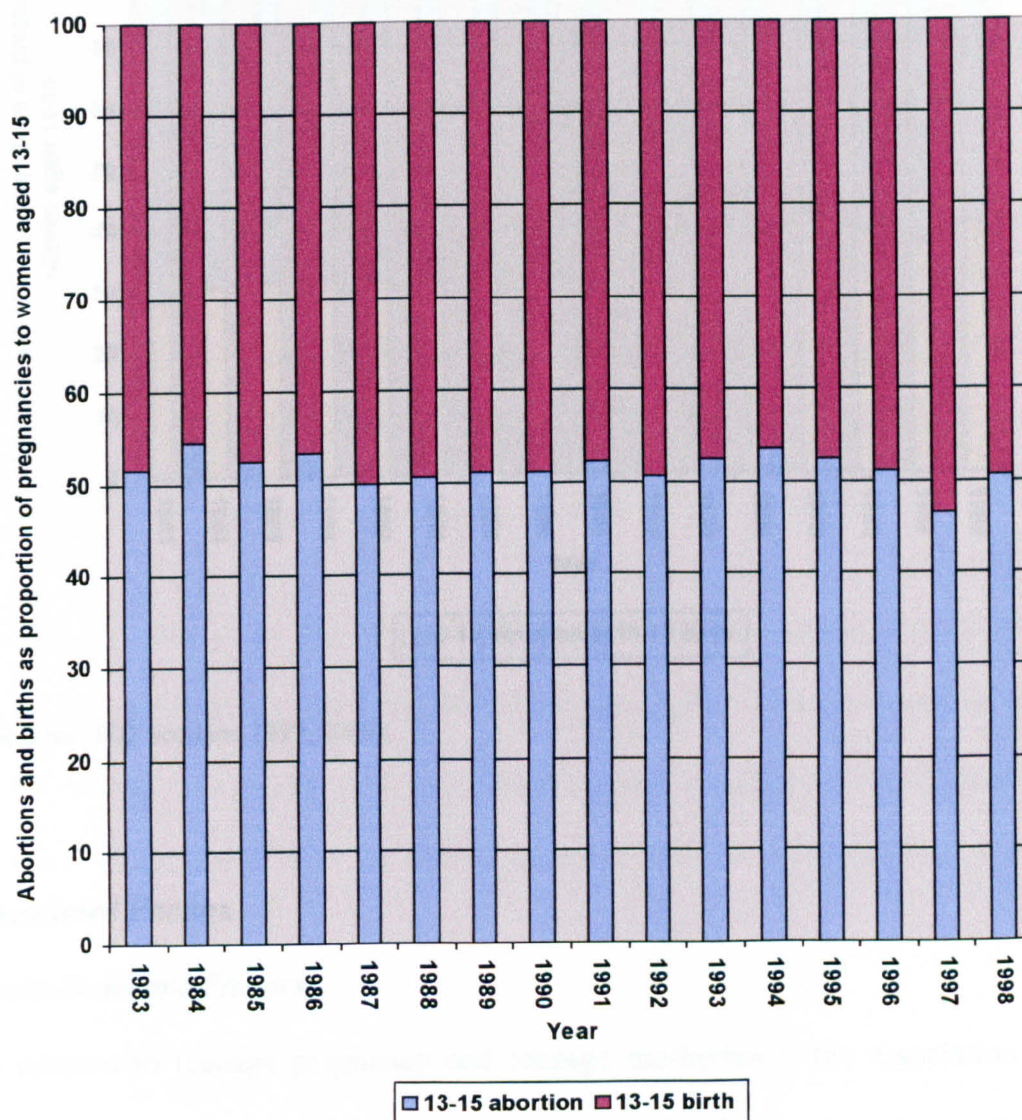
In the older age group however, as can be seen in Figure 1.12, the abortion rate has always remained lower than (although increasing in proportion to) the birth rate. Between 1983 and 1991 both the birth rate (45.2- 50.4 per 1000) and the abortion rate (18.3 – 27.4 per 1000) rose for women aged 16-19 (ISD Scotland 1997, 2000). Since the peak in 1991 both rates have witnessed steady decline (with the

[1] Data for this figure can be found in Appendix i.

exception of the slight rise in abortion in 1996[1]).

Figure 1.11

Abortions and births as a proportion of all pregnancies to women aged 13-15 in Scotland, 1983-1998.

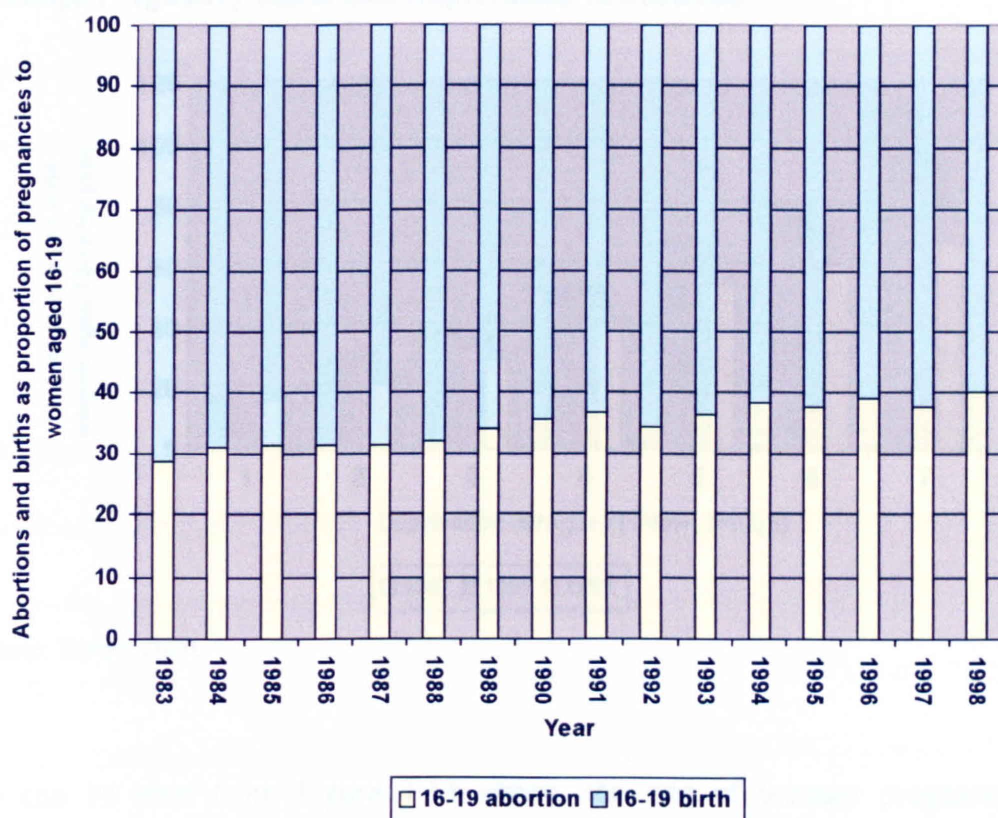


(Sources: ISD Scotland 1997, 2000).

[1] The rise in the abortion rate in 1996 has been documented to be as a result of the pill scare in 1995 (Kane & Wellings 1999).

Figure 1.12

Abortions and births as a proportion of all pregnancies to women aged 16-19 in Scotland, 1983-1998.



(Sources: ISD Scotland 1997, 2000).

Associated Factors

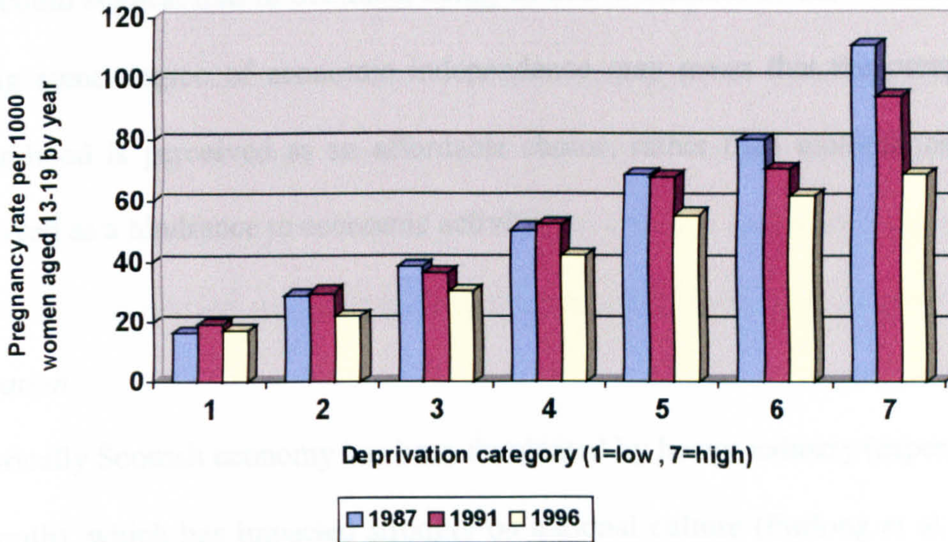
Socio-Economic Factors

In relation to teenage pregnancy and teenage motherhood, the association with poverty and deprivation has long been noted in Scotland. A study on Tayside revealed that the teenage pregnancy rate for girls in poor neighbourhoods was six times that for girls in more affluent areas and that girls in poor areas were more likely to reject abortion (Smith 1993). Figure 1.13 below shows the teenage pregnancy rates by deprivation categories (as calculated by Carstairs and Morris

(1991)).

Figure 1.13

Teenage Pregnancy Rates and Deprivation in Scotland



Source: Turner 2000.

As can be seen from Figure 1.13 above, the rate of teenage pregnancy has remained consistently lower from 1987–1996, the higher the socio-economic status of the mother. It is important to note, however, that the slight decline in pregnancy rate over that period of time has been consistent across all socio-economic groups.

Employment

In relation to how the employment rate of women aged 15 and over potentially relates to the trends in births and abortions to women aged 13-19 in Scotland, correlations were found to differ considerably from that found by Kane & Wellings (1999) for Europe as a whole. In other words, over the time period 1991-1998, whilst there was a weak correlation found between higher rates of abortion to women aged 13-19 and higher economic activity of women aged 15 and over

(r_s=0.37)[1], there was a very strong correlation found between higher birth rates amongst women aged 13-19 and higher economic activity of women aged 15 and over (r_s =0.77)[2].

This could suggest that in Scotland, being an active member of the workforce and having some degree of economic independence may mean that the prospect of motherhood is perceived as an affordable choice, rather than motherhood being perceived as a hindrance to economic activity.

Education

Historically Scottish economy has been dominated by heavy industry (especially in the south), which has impacted strongly on national culture (Furlong et al. 1998). Since the 1980s and the demise of many primary industries in Scotland, the school to work transition has become increasingly prolonged and the numbers of young people who are choosing to remain at school beyond the age of 16 or to enter some for of training post-compulsory schooling is increasing annually. However, although the proportion of young people continuing at school or in training is increasing, the rates of continuation are much lower in comparison to the rest of Europe (approximately 65-70% as opposed to 85-96% in other European countries (EUROSTAT 1998-99.)).

In Scotland, one in ten young people still enter the labour market directly from the comprehensive school at the age of 16 (Roberts 1997) according to Furlong et al.

[1] Source for data on employment figures was European Commission 2001, source for abortion data was Singh & Darroch 2000.
[2] Source for data on employment figures was European Commission 2001, source for birth data was Singh & Darroch 2000.

(1998) expectations of young people remain higher in Scotland than in Finland, that they will still make an early entrance into the labour market, even if that expectation is unrealistic.

Further to this, in relation to the previous section on employment which revealed a trend of higher birth rates amongst young women aged 13-19 when the rate of economic activity amongst women aged over 15 was high, an increase in the proportion of young people remaining in education longer and delaying their entry into the labour market, may also have an indirect effect on the rate of pregnancy to young women.

Causes of Teenage Pregnancy

Coital Activity

Between 1960 and 1990 the median age of first heterosexual intercourse dropped from 21 to 17 amongst females and from 20 to 17 amongst males. Over the same time period the proportion of teenagers reporting experience of heterosexual intercourse before turning 16 increased from around 1% to 20% (McIlwaine 1994).

Often in the literature confusion arises over what kinds of sexual activity young people have actually experienced. Table 1.6 below shows the results of the most recent work conducted in this area by Currie and Todd (1993) in the study of *Health Behaviours of Scottish School Children*, which presents data on sexual experience of Scottish School Children[1] (except Strathclyde region). From this table it can be seen that by age 15-16 at least three quarters of young people had

[1] The term 'children' is used here as that was the terminology used by the authors, it is however questionable as to whether 15 and 16 year olds should be called 'children'.

hugged and kissed on the mouth, over two thirds had experienced 'light' petting and approximately half in 'heavy' petting. Between one quarter (young men) and almost one-third (young women) had reported engaging in heterosexual intercourse (Currie & Todd 1993:12).

Table 1.6

Sexual experience of Scottish schoolchildren aged 15-16.

Sexual experience	Young men %	Young women %
Hugging	61.5	74.4
Kissing on the mouth	73.3	84.2
Light Petting (above waist)	66.3	70.8
Heavy Petting (below waist)	48.6	53
Sexual Intercourse	25.8	31.2

Source: Currie & Todd 1993.

Contraceptive Use

Free contraception was introduced to the NHS in 1975. Since that time increased contraception use has been apparent amongst Scottish teenagers. In the mid-1970s, the majority of young people were already sexually active before attending a clinic for the first time (around 90%) (Bury 1980). Since then in some areas of Scotland, young people have been more likely to seek contraception advice before starting their sexual relationships. For example by 1980 over 25% of young people attending a youth advisory service in Edinburgh did so prior to their first intercourse compared with 13% in the mid-1970s (Bury 1980).

Although sexually active teenagers are more likely to use contraception now than was the case twenty years ago, a strong determining factor in use of contraception at first intercourse has been shown to be age (McIlwaine 1994). For those over 16 years of age, some form of contraception was reported to have been used by 68% of women and 64% of men at first intercourse. In comparison, no method was reported to have been used at first intercourse by nearly 50% of young women and more than 50% of young men under the age of 16 (McIlwaine 1994).

Additionally, during the early 1980s the favoured method of contraception by young women was the pill (Jamieson et al 1983, Brook 1983, Harrison & Bury 1982). This reliance on the pill as opposed to the condom shifted the responsibility of contraceptive use in Scotland away from young men onto young women (Meredith 1983). During the late 1980s and 1990s this pattern changed with more young people choosing the condom as their preferred method of contraception. The SNAP report (McIlwaine 1994) revealed that most youngsters will now use condoms as their preferred method especially early in their sexual lives.

There is not much information at present about emergency contraception use by Scottish teenagers. The results of one study in the Lothian area of Scotland looking at the knowledge of emergency contraception - its safety, efficiency, time limits and where to obtain it - revealed that the majority (93%) of fourth year girls (aged 14-15) had heard of emergency contraception (Graham et al. 1996). Although one third of sexually active girls in the area had already made use of this method, knowledge was poor regarding correct time limits of its use. This study proposed that the high use of emergency contraception in this geographical area

could potentially be used to explain the fairly constant rate of teenage pregnancy in the area, despite increasing experience of sexual activity (Graham et al 1996).

Summary

This chapter began by exploring the European context in relation to teenage pregnancy. The trends in pregnancy and related rates across Europe since the early 1970s were presented, highlighting that although patterns of decline in these rates began at different times in different arts of Europe, Scotland, Northern Ireland, England and Wales were the only countries where there was a distinctly different pattern from any other area in Europe. In other words in most Northern and Western and some Eastern European countries, the trend in teenage pregnancy had been one of relatively sharp decline throughout the 1980s and a continual but markedly slower decline throughout the 1990s. Where as in Scotland, Northern Ireland, England and Wales, the trend had been one of decline through the 1970s and then from the 1980s and through the 1990s, a pattern of very little change.

In an attempt to explore potential factors relating to these differencing trends the chapter then presented a range of associated and causal factors relating to teenage pregnancy. These included indirect dynamics, such as economic, employment and educational factors, which may impact upon the life choices (including young parenthood) made by young people, as well as factors relating directly to the sexual and contraceptive behaviour of young people.

In relation to the associated factors there appeared to be a number of relationships in relation to the rates of births and abortions amongst young women aged 15-19.

The most significant of which in aggregate European terms being:

- Countries with stronger economic development and a more equitable distribution of household income generally had lower rates of teenage motherhood,
- Countries where there were higher rates of economic activity in the female population aged over 15, generally had higher rates of abortion amongst young women aged under 20.
- Countries with high continuation rates in education or training post-16 had considerably lower pregnancy rates to women aged 15-19, but the high continuation rates did not correlate strongly with rates of economic activity.

In relation to the causes of teenage pregnancy, this chapter has shown that throughout Europe the age of menarche has lowered consistently over the last century, levelling off at twelve to thirteen years of age by the mid 1960s and that the age of first intercourse is now more or less the same (approximately 17 years) in most European countries, with the exception of Scandinavian countries (on average 16 years). The final causal factor explored was that of contraceptive use amongst young people and whilst the research evidence shows that generally the younger the women, the less likely that contraception will be used at first intercourse, there were higher rates of contraceptive use amongst young women from northern European countries and the Netherlands.

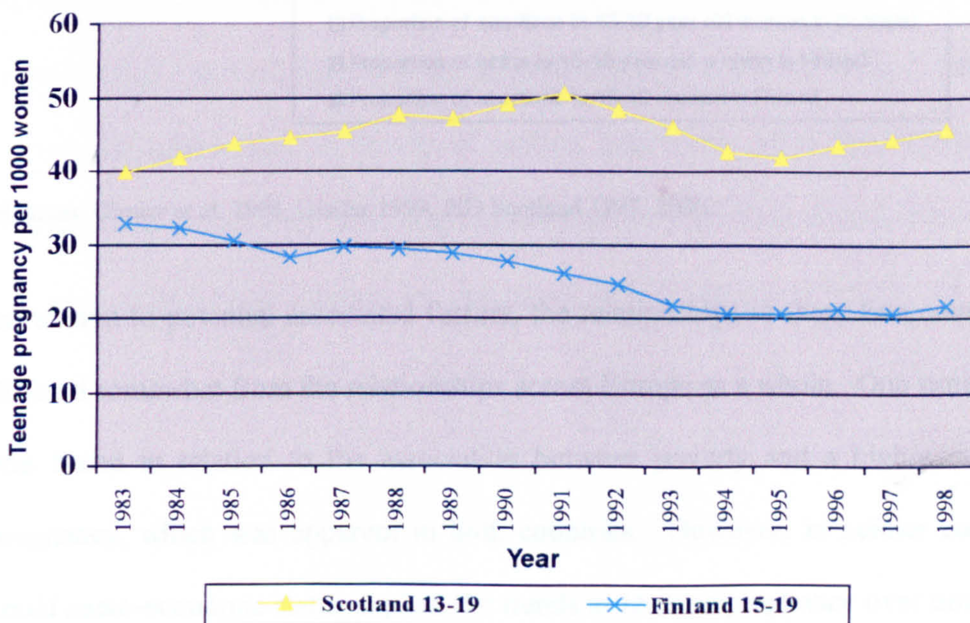
The chapter then focused on Finland and Scotland highlighting that these two countries have and continue to experience contrasting trends in teenage pregnancy and related rates. Although there are problems within the format of the two data

sets that prevent their direct comparison, an approximate idea of the differing trends is still useful[1] (see Figure 1.14[2] below). From the available data, what is apparent is that Scotland has not achieved the declining trend in teenage pregnancy that has been the case in Finland.

In addition to the difference in the direction of each country's respective trends, there is also a noted difference between the proportion of pregnancies that result in abortion as opposed to births as can be seen in Figure 1.15[3] below. In other words, more young women in Scotland opt to give birth, than is the case in Finland.

Figure 1.14

Teenage Pregnancy Rates by country, age group and year, 1983-1998

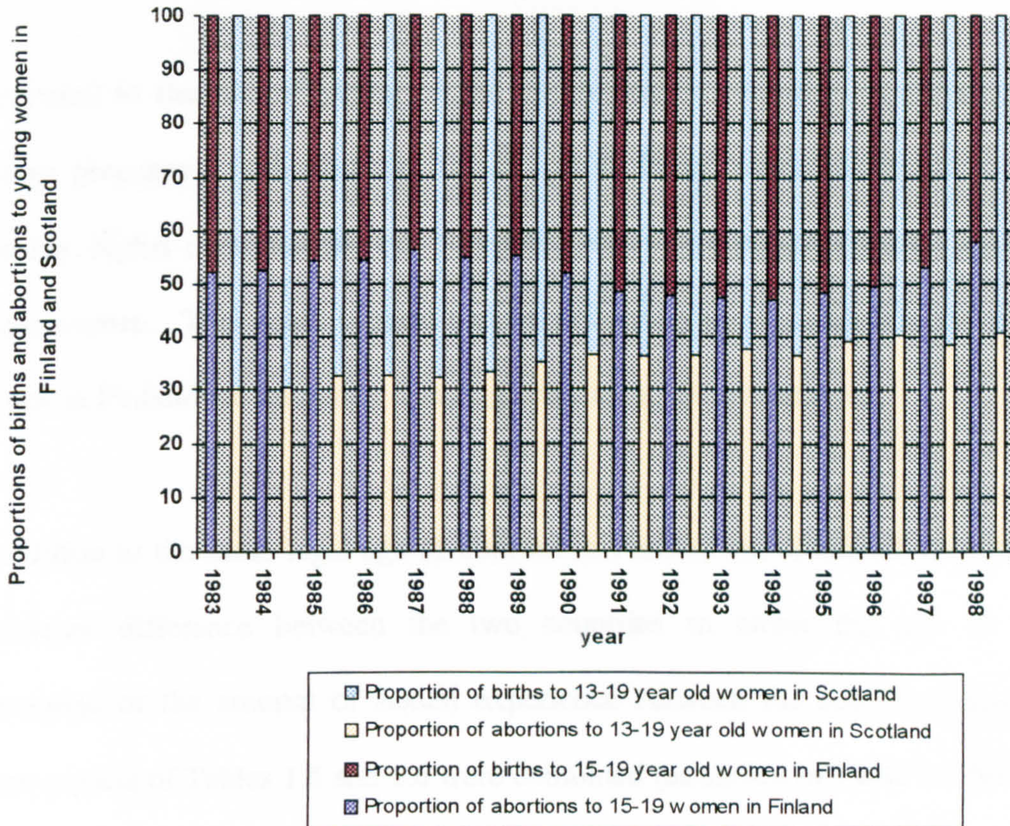


Source: ISD Scotland 1997, 2000, Gissler et al. 1996, Gissler 1999.

[1] In Figure 1.11 the 13-19 rate for pregnancy has been used for Scotland. Although it is still not directly comparable with the 15-19 Finnish rate, it offers a closer comparison.
[2] Data for this figure can be found in Appendix i.
[3] Data for this figure can be found in Appendix i.

Figure 1.15

Abortions and births as a proportion of total pregnancies by country, age group and year, 1983-1998



Sources: Gissler et al. 1996, Gissler 1999, ISD Scotland 1997, 2000.

In relation to potential associated factors, the relationships in these two countries differed somewhat from the relationships across Europe as a whole. One similarity was found in relation to the association between poverty and a higher risk of pregnancy, which was apparent in both countries. However, in neither country could socio-economic status explain the trends in teenage pregnancy over time. In relation to the employment activity of women aged 15 and over, in Finland there was only a weak correlation found between increased rates of economic activity

and higher rates of births to teenagers, whereas in Scotland this proved to a significant relationship. In contrast while only a weak relationship existed between increased rates of economic activity and higher rates of abortions to teenagers in Scotland, the opposite was found to be the case in Finland.

In relation to the rate of young people continuing in education or training and teenage pregnancy, both countries fit the pattern found across Europe in general whereby, higher continuation rates correlated with lower pregnancy rates amongst young women. This could suggest that by remaining in education longer, young women in Finland are indirectly delaying pregnancy and parenthood.

In addition to the same legal age of consent in Finland and Scotland, there is no significant difference between the two countries in either the age of first intercourse or the amount of sexual experience between the cohorts examined. When aspects of Tables 1.5 and 1.6 were combined (as shown in Table 1.7 below), no significant differences in levels of sexual behaviour were found, with the exception of the proportions of young men in Finland reporting sexual intercourse. This may however be explained by the slight difference in the make up of the cohort[1].

[1] The two cohorts being compared in Table 1.7 are slightly different and therefore should be viewed with caution. The Scottish cohort contains 15 and 16 year olds as opposed to the Finnish cohort being solely made up of 15 year olds.

Table 1.7

Sexual experiences of Scottish and Finnish young people (%) in 1992.

	Scottish* young men	Finnish** young men	Scottish* young women	Finnish** young women
Sexual experience	%	%	%	%
Kissing on the mouth	73.3	69	84.2	78
Light Petting (above waist)	66.3	62	70.8	67
Heavy Petting (below waist)	48.6	41	53	52
Sexual Intercourse	25.8	19	31.2	31

* = 15-16 years of age
** = 15 years of age

Sources: Currie & Todd 1993, Papp 1997.

What is most noted from the examination of all associated and casual factors related to teenage pregnancy, however, is the rate of contraceptive use of young people in both countries. It appears from the evidence presented so far that contraception usage especially at first intercourse is the most significant difference between the two countries as can be seen in Table 1.8 below.

Table 1.8

Use of contraception at first intercourse aged 15 (15-16 in Scotland) in 1992 (%)

Contraceptive Use	**Scottish young men %**	**Finnish young men %**	**Scottish young women %**	**Finnish young women %**
Reliable method used	45	87	52	80
Non reliable method or No methods used	55	13	48	20

Sources: McIlwaine 1994, Papp 1997.

These differences are remarkable for both young men and young woman and offer

a very plausible reason as to why there are such differences in pregnancy rates between the two countries especially in younger age groups. The fact that such a large proportion of young men in Scotland failed to use contraception at first intercourse, adds weight to the need for more consideration to be given to the sexual health needs of young men as part of the solution to decreasing the rate of unintended teenage pregnancy in Scotland[1].

The next logical step therefore is to consider why this difference in contraception use exists and whether there are significant differences in the policies at work in Scotland and Finland that may offer an explanation as to why these differences exist. The next chapter, therefore, sets out the three policy areas than have been presented for exploration within this thesis and reasons for their inclusion. This is then followed by a comprehensive review of available literature on each of the policy areas.

[1] The issue of young men's needs in the area of sexual health is discussed in Chapter Two.

Chapter Two

Teenage Pregnancy and Social Policy: A review of the literature

Introduction

The purpose of this chapter is to review the available literature focusing on the areas of policy relating to teenage pregnancy under exploration in this thesis. Having presented the various trends in teenage pregnancy and related rates as well as associated and causal factors in the previous chapter, this chapter begins by providing further explanation as to why the three particular areas of policy chosen for exploration were sex education, sexual health and education. The remainder of this chapter then concentrates on reviewing the available literature for those three policy areas.

Why sex education, sexual health and education policy?

In order to become pregnant, generally, sexual intercourse needs to have taken place and contraception to have not been used or not been used effectively or the contraceptive itself has failed. In Chapter One, the most apparent key difference between Finland and Scotland, that may go some way to explaining the differing trends in teenage pregnancy between the two countries, was that of the contraceptive use of young people.

In order to use contraception there are at least three[1] underlying factors which must be present. First, young people must have knowledge of issues relating to sex, sexuality and contraception (in particular effective use) and knowledge of where to obtain contraceptive advice and services. They must also perceive that they have 'real' access to the provisions of such services (including appropriately timed, located and confidential services) and finally they must be motivated enough to use contraception effectively in order to avoid pregnancy (and other negative results of unprotected sex) and parenthood.

Therefore in order to explore the extent to which these factors relate to the lives of young people in both countries, this thesis set out to explore three policy areas that related to these three pre-requisites namely; sex education (knowledge of sex, sexuality, contraception and available services), sexual health (access to sexual health advice and services) and education (motivation).

School-based sex education and teenage pregnancy

Set out in the previous section were a set of pre-requisites to effective contraceptive behaviour, the first of which was knowledge. School-based sex education is one means of providing that information and knowledge to a large proportion of young people. Although there are complex relationships at work between how knowledge

[1] It is important to acknowledge that there are other factors not included within this thesis that will impact upon whether or not contraception is used at all, in particular social factors such as gender equality, levels of parental control exerted over young people's (especially young women's) freedom and self-esteem levels in being able to ask or insist that their partner uses contraception; and also access to public transport for example to be able to access some services.

about sex and sexuality is internalised and translated into the choices young people make with regard to their own sexual behaviour, it is a crucial starting point (Schofield 1994).

Therefore, the next section of this chapter explores sex education. It considers what sex education is, documents the historical development of sex education in Europe, and examines the potential relationships with sexual knowledge, sexual activity, contraceptive use and teenage pregnancy. It concludes by explaining why sex education policy has been explored within this thesis.

What is sex education?

"The meaning, aims and potential effect of 'sex education' vary considerably according to the opinion of research findings, governments, educators, popular culture, media, parents and young people" (Silver 1998:5).

Unintended and unwanted pregnancy and the contraction of STIs can only be prevented if young people are fully aware of the risks involved and are proficient in how to use contraception, before they begin to have sex (Silver 1998). Internationally, researchers are united in acceptance that sex education is a continuous process, which begins when people are very young, and continues throughout the life course (Wall 1994; David & Rademakers 1996; SEF 1997; Silver 1998).

School-based sex education is an important source of information for young people, because "like it or not, children learn about sex by osmosis, from the society we live in" (Hadley 1998:8). What school-based sex education can do is bring together the information that young people learn from other (often less reliable) sources and provide a safe arena for those young people to separate the myth from reality. Sex education can be more than simply learning the mechanics of sex and the adverse effects of sexual intercourse, a view supported widely amongst the professional sexual health field (Silver 1998).

In 1975 the World Health Organisation (WHO) stressed that every person is entitled to receive information about sex and in 1984 a health and social goal for Europe became the education of children and young people in matters of sexuality, psycho-social growth and general health (WHO 1984).

Hadley has stated that "sex education should be about relationships, sexuality and sexual health, information, personal and social skills, forming positive attitudes and beliefs and sexual identity" (1998:8), a definition that is similar to that of many different organisations including the Sex Education Forum in England (SEF 1997), the British Medical Association (BMA 1997) and the Rutger Stichting Institute[1] in the Netherlands (Braeken 1994).

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[1] The Rutgers Stichting Institute was established in 1969 in the Netherlands to provide family planning advice for young people.

History of sex education in Europe

The policy debate over the previous three decades surrounding the issue of teenage pregnancy has been differently weighted across Europe, leading to the development of contrasting approaches (Kosunen 1996). In Britain, teenage sexual activity was approached from an ethical and moralistic viewpoint and led to more restrictive sex education aimed at preventing sexual activity amongst teenagers (Kosunen 1996; Silver 1998). On the other hand, throughout much of the rest of Western and Northern Europe, the Nordic countries in particular, the main issue of concern was the health consequences of early sexual activity (Davis 1989; Kosunen 1996), which led to the development of sex education aimed at promoting 'healthy sex and sexuality'. As Kosunen notes, the "European approach [except Britain] was rather to create preconditions for safer sex; to increase sex education, the availability of contraceptive methods and accessibility to birth control services" (1996:12).

On the whole the development of sex education throughout Europe has been varied, in some cases dependent on the ruling political ideology and the tolerance that ideology has of sexual activity, teenage sexual activity in particular, as well as the influence of the church within any given country (Papp 1997).

Sweden was the first country in Europe to formally introduce sex education into the school curriculum in 1956 (Persson 1993). Sex education in Finland, although not formalised in the curriculum until 1976, had however begun to be taught in some schools as early as 1944 (Papp 1997). In 1970 sex education became compulsory in

schools in France, Denmark and the Netherlands (Papp 1997) and in Portugal and Cyprus some attempts were also made to introduce sex education into schools, but without much success (Papp 1997).

By the 1980s the majority of countries in Western Europe had instigated some form of school sex education (Braeken 1988; Risor 1988; Frade & Vilar 1991; Gallard 1991; Koral 1991; Patsalides 1991). Some countries in Eastern European such as Bulgaria and Czechoslovakia then followed suit and introduced sex education into the school curriculum by the mid-1980s (Temelakiev & Vassiljev 1988; Buresova 1991).

In 1986 all Local Education Authority (LEA) schools in England and Wales (but not Scotland) were required by statute to have a policy on sex education. A LEA school's policy could be to chose not to provide sex education, but there had to be documentation of that decision (Thomson & Scott 1992). This was followed in 1993 when a statutory decision made it compulsory for schools in England and Wales to provide sex education for its pupils but also gave parents in England and Wales the right to remove their child from any non-core curriculum sex education (this included everything except biological reproduction which is taught in the biology curriculum) (Thomson 1993).

In response to these changes Thomson noted that "increasingly sex education policy [in England and Wales] is vulnerable to the whims of the wider moral and political climate and policy is made in response to political pressure rather than educational

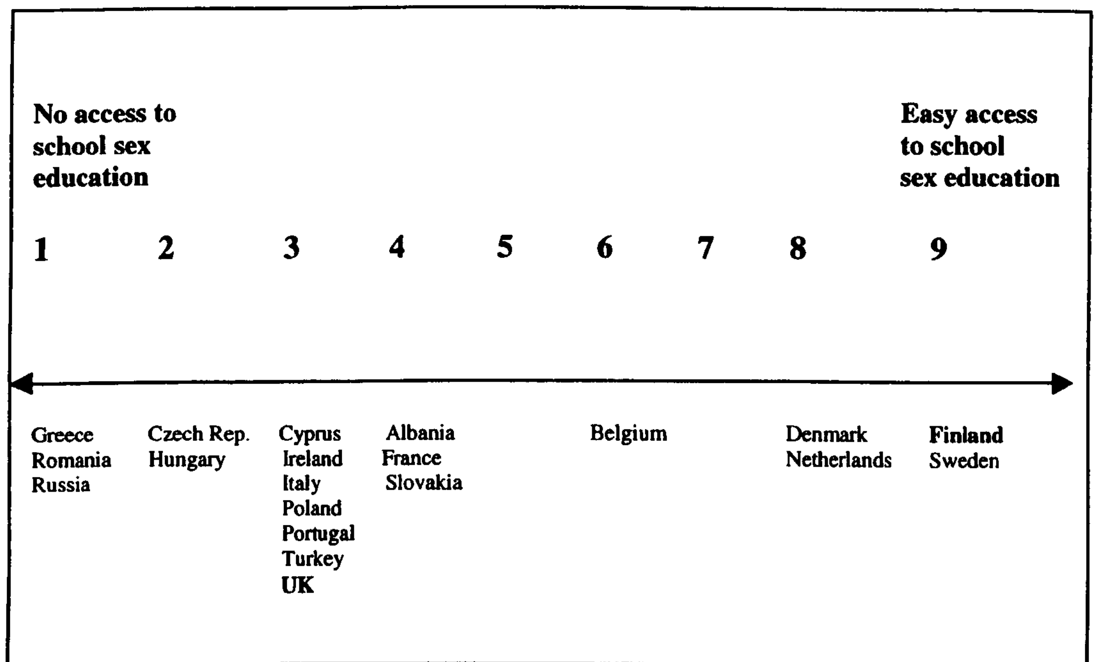
imperative" (1994:124). The influence of the anti-sex education lobby, in particular on public opinion remains strong in England and there remains much popular debate as to whether sex education if provided, should have the prevention of sexual activity as the main aim as a means to preventing pregnancy and the spread of STIs (Silver 1998).

During the early 1990s sex education was legislated into school curricula in Germany, Spain and Hungary (Baross 1994; Berbik 1994; Nieto & Ciria 1996) and around the same time, sex education was introduced into school curricula in Portugal, as part of Personal and Social Development and in Cyprus, as part of a Health Education Programme (Vilar 1994).

According to Papp (1997) sex education has never featured within school curricula in Greece, Ireland, Italy or Romania. This does not automatically mean however, that the subject is not being taught (Vilar 1994). In 1993 for example, officials in Italy reported that despite several unsuccessful debates in parliament to approve sex education, there had been increasing interest shown by schools in providing more sex education (Vilar 1994). Additionally in Scotland, whilst there has never been a requirement for sex education to be part of schools' curricula (unlike in England and Wales), the Scottish Education Office 'strongly advises' schools to now provide some form of sex education for young people (SOED 1998 personal communication).

To summarise the provision of sex education available in Europe by the mid-1990s, Figure 2.1 below presents a summary of the access young people have to school-based sex education across a number of European countries.

Figure 2.1 Access to sex education in Europe.



Source: Vilar 1994:11.

In 1993 Duarte Vilar undertook a review of the availability of sex education throughout Europe. One of the most important findings was that despite the introduction of sex education into school curricula in a large number of countries throughout Europe by the 1990s, only the Nordic countries, Belgium and the Netherlands were stated to provide adequate sex education (Vilar 1994).

Vilar (1994) further concluded that whilst the majority of countries provided their schools with some form of official guidelines to follow in their provision of sex education, it was generally geared towards the negative aspects of sexual behaviour such as pregnancy prevention, STIs and AIDS. Only Denmark, Portugal, Poland and Sweden were seen to provide guidance pointing to a positive approach to sexuality (Vilar 1994). The Netherlands, which also provides a more positive approach to sexuality in school-based sex education (Silver 1998), was not included within this grouping because there were no official instructions about the teaching of sex education at school until August 1993 (after Vilar's research (1994) was conducted).

How effective is sex education?

Within Britain some still continue to argue that the high teenage pregnancy rate is the result of sex education, accusing it of "a variety of social ills including teenage pregnancy and 'moral decay'" (Silver 1998: 9). The actual effect that sex education is perceived to have on the knowledge and behaviour of young people varies and is the central theme of continued debate in countries such as Britain and the USA. The following sections therefore, explore the available literature surrounding sex education and its relationship with variables such as knowledge and attitudes, sexual activity, contraceptive use and teenage pregnancy.

Sex education and sexual knowledge and attitudes

Ignorance about sex and sexuality places young people at risk of pregnancy, STIs and abuse. In addition a lack of knowledge about sex and sexuality would also not prepare

young people about what to expect in relationships, what it means to be a parent, or provide them with the ability to be in control of their own sexual identities and activities. Wellings et al (1996) and the SEU report (1999) both identify ignorance and misinformation as a key factors in the high teenage pregnancy in Britain and England respectively.

As an example of the ignorance amongst teenagers in England, a study of almost 4000 14 and 15 year olds surveyed by the Health Education Authority in England found that over one quarter believed that the contraceptive pill protected against STIs, a similar number believed that a steady partner also protected against STIs (HEA 1999a).

Silver (1998) defines the level of sexual knowledge as a sign of the effectiveness of sex education. Her research in the Netherlands and England found that where Dutch teenagers showed high levels of overall knowledge about sex, conception, contraception and HIV/AIDS, their English counterparts had relatively poor levels of knowledge. In turn the level of provision, content and perceived effectiveness of sex education by the two cohorts of young people, was seen to be superior in the Netherlands in comparison to England.

Goldman & Goldman (1983) argued that in countries which project more tolerant attitudes towards sex and provide objective information about sex and sexuality to young people from an early age, young people's general knowledge about sexual issues is superior. This view was also supported by the research findings of Jones et

al. (1985, 1986) and Bilsen and Visser (1994) who concluded that sex education had been found to be effective in increasing knowledge about sex and sexuality and contraception as well as encouraging more positive, liberal and tolerant attitudes to sexuality.

Sex education and increased and earlier sexual activity?

Perhaps one of the most contested and emotive debates surrounding sex education in Britain (and the USA) has been whether or not sex education actually encourages sexual activity. It is a heavily debated issue within the national British media, the most popular argument against sex education being, that it will encourage promiscuity and experimentation and the younger a person experiences such education, the younger young people will start experimenting (Thomson 1994; Silver 1998).

Whilst the research evidence explored below contradicts this argument, it remains a prevalent view in Britain. One fifth of parents and one quarter of young people surveyed in the late 1980s by Allen (1987) believed that school-based sex education encouraged earlier sexual experimentation.

Over the last two decades research has been undertaken to determine the potential merits of sex education and in particular, how it affects young people's knowledge, attitudes and behaviour. In 1993, on behalf of the World Health Organisation, Baldo et al (1993) undertook a 35-country evaluation on the provision of sex education. The main finding was that there was no evidence that the experience of sex education had

encouraged earlier or increased levels of sexual activity. Six of the studies reviewed found that after sex education had been provided there was a noted delay of first intercourse or an overall decrease in sexual activity.

Kirby et al. (1994) undertook a review of published peer reviewed studies (predominantly USA based projects). The main finding of this review was that sex education does not hasten the onset of sexual activity. Four of the studies reviewed found no increase of sexual activity as a result of the sex education and one noted a decrease in sexual activity.

In 1997, Fullerton et al. explored the educational and support strategies to tackle teenage pregnancy and reduce the adverse effects where pregnancy occurred. A key point made by this research was that "providing sex and contraceptive education within school settings does not lead to an increase in sexual activity or incidence of teenage pregnancy" (Fullerton et al. 1997:197). Additionally, "programmes which emphasise the postponement of sexual activity but omit guidance on contraceptives and where to access them are rarely effective" (Fullerton et al. 1997:197). This point has been further supported by Cheesbrough et al. (1999), who noted that despite large sums of money having been invested into abstinence projects in the USA, they generally showed no delay or reduction in sexual activity. Additionally the outcomes of a long-term abstinence-based small-group pregnancy prevention programme in the USA found that by the one year follow-up stage, there was no difference between the intervention and comparison groups of young woman with regard to the proportions

who had had first intercourse. For the groups of young men, more from the intervention group than the comparison group had had their first intercourse at the one year stage, although the proportion was not statistically significant (Lieberman et al. 2000).

In 1997, the NHS Centre for Reviews and Dissemination on behalf of the British government, undertook a review of measures to prevent and reduce the adverse effects of unintended teenage pregnancy (NHS CRD 1997). The findings of this review further support the evidence presented thus far, in that "the most reliable evidence shows that it [sex education] does not increase sexual activity or pregnancy rates" (NHS CRD 1997:1).

Wellings et al. (1995) also noted that in Britain, young people who stated that they had obtained most of their sex education from school, were less likely than those who cited parents or friends, to have had their first experience of sexual intercourse before they turned 16. Unfortunately, young people in Britain in a number of studies, report gaining most of their sexual knowledge from friends and peers rather than teachers (Currie & Todd 1993; Dean 1994; SEF 1998).

Finally, Cheesbrough et al.'s study of ways of reducing teenage conceptions in the USA, Australia, Canada, New Zealand and the UK (1999), also found that no study had shown sex education to increase sexual activity at a younger age. Some studies

did show however, that early sex education delayed the onset of sexual activity as it had encouraged young people to wait (Cheesbrough et al. 1999; Wight et al. 2000).

Sex education and contraceptive usage

Education about contraception is an important element of sex education programmes to provide young people with the relevant information that they need to use contraceptives effectively. Wellings et al. (1994) found that for those young people in Britain who recalled having had the most sex education, the higher their contraceptive use was at first intercourse.

Evidence from a variety of sources has indicated that where young people had received contraceptive education at school, the effective use of contraception was higher at first intercourse and amongst young people who had stated that they were already sexually active (Baldo et al. 1993; Kirby et al. 1994; Kirby 1997b; NHS CRD 1997; Cheesbrough et al. 1999).

Sex education and teenage pregnancy

International research has highlighted the fact that the rate of teenage pregnancy is lower in countries where there is a higher availability of sex education at school (Jones et al. 1985, 1986; David et al. 1990; Baldo et al. 1993). Jones et al. (1985) found this to be more significant where the sex education taught included a large component of education regarding the use of contraception.

Using Vilar's ranking of young people's access to sex education across Europe (1994) (see page 70), Figure 2.2[1] explores the relationship between this measure and teenage birth rates across a number of European countries. The live birth rate has been used as a suitable proxy for pregnancy (Kosunen 1996) in this analysis due to the fact that very few countries have accurate abortion data and for many there is no comparable data available. As expected there was a significant relationship found between the two variables, whereby countries which were described as providing easy access to sex education have lower rates of teenage birth. The Spearman's correlation coefficient for this relationship was $r_s = 0.71$.

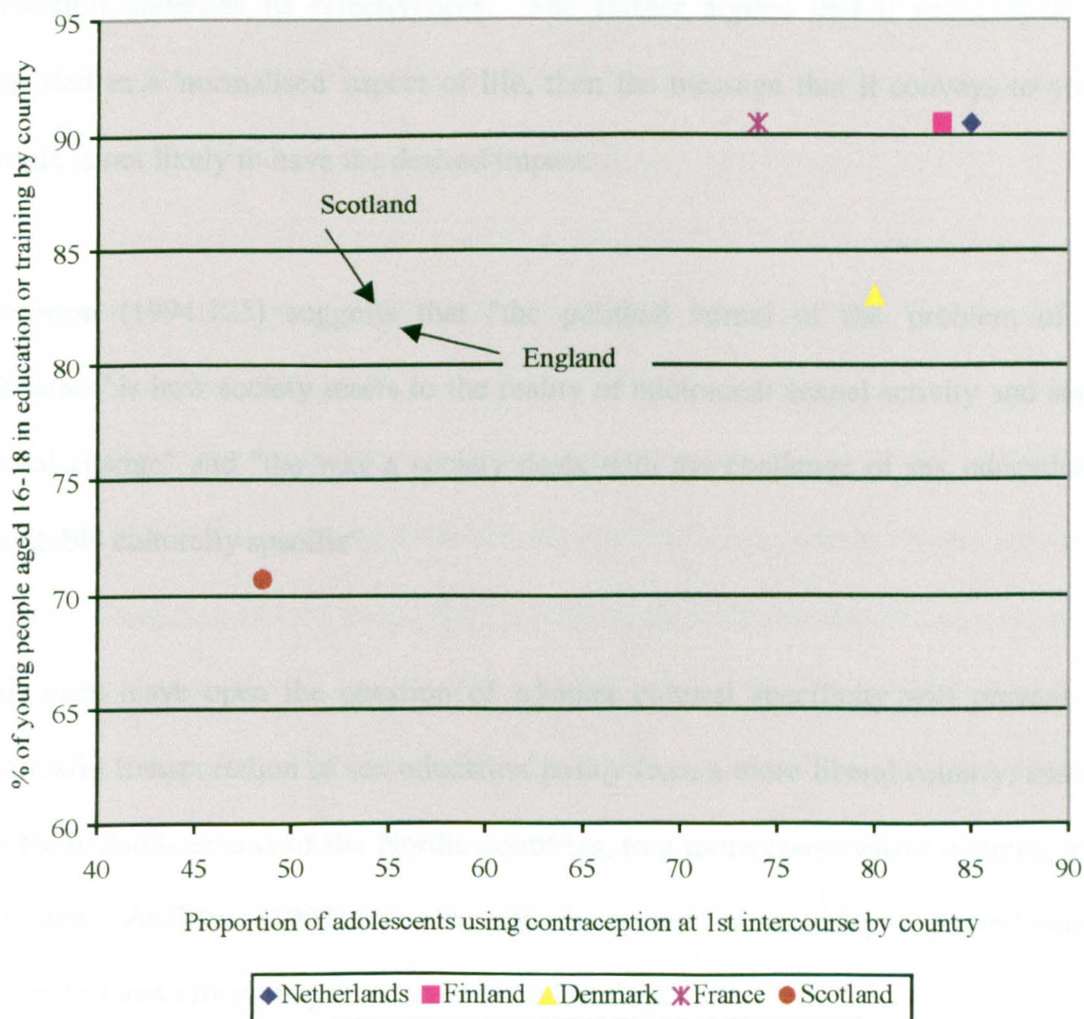
Providing effective sex education

What is it that makes some sex education programmes more effective than others? What are the key elements that make a sex education programme effective? These are important issues to consider when evaluating current sex education programmes and developing sex education programmes in the future.

[1] Data for this figure can be found in Appendix i.

Figure 2.2

Access to sex education and live birth rate per 1000 women aged 15-19 in a selection of European countries



$r_s = 0.71$

General Notes
Data on access to sex education - Vilar 1994.
Vilar (1994) only referred to the UK and so the UK access has been used to calculate both the Scottish and English and Welsh correlations.
Data on live Birth rates - UN Demographic Yearbooks 1995, 1996, 1997, 1998.
Year for birth rate is 1996 unless noted below:
1995 - Belgium, Czech Rep., France, Italy and Russia.

Socio-sexual attitudes

Silver (1998) noted in her comparison of sex education in the Netherlands and England, that a positive socio-sexual attitude and a pragmatic approach to sex education underlies its effectiveness. She further argued that if sexuality is not regarded as a 'normalised' aspect of life, then the message that it conveys to young people is not likely to have the desired impact.

Thomson (1994:125) suggests that "the political kernel of the 'problem of sex education' is how society reacts to the reality of adolescent sexual activity and socio-sexual change" and "the way a society deals with the challenge of sex education is inevitably culturally specific".

This does leave open the question of whether cultural specificity will prevent the successful transportation of sex education policy from a more liberal country, such as the Netherlands or one of the Nordic countries, to a more conservative country, such as Britain. As Silver (1998) notes the attitudes to sex and sexuality in general culture will reflect and affect the provision of sex education.

The public climate towards sex education plays a central role in how well it is accepted into schools and regarded by young people as an issue of importance (Vilar 1994). In turn if it is valued by young people this may help them better to internalise the messages presented (Silver 1998).

Curriculum location

There are two main ways of incorporating sex education into school provision. It can either permeate through the school curriculum, being taught in a variety of subjects as defined nationally or by each school, or alternatively, it can be provided as a separate subject, usually taught within the context of a subject such as Health Education or Personal and Social Education (or an equivalent).

The advantages of the permeation approach have been noted in the Netherlands whereby the inclusive approach has helped to 'normalise' the topic. As Silver (1998) noted, in the Netherlands they treat "sex education as equal to other subjects by refraining from separating and subsequently differentiating it from the experience of learning about any other topic... this in turn perpetuates the culture; young people consider sex as a normal and healthy part of human life, it is neither taboo nor sensation" (Silver 1998:33). She further argues that sex education, situated within the curriculum in this way, has come about as a direct result of the Netherlands' acceptance of the normality of teenage sex and sexuality (Silver 1998)

The 'permeation' approach however may not be successful within cultures where teenage sex and sexuality are not socially accepted to the degree that they are in the Netherlands. This becomes a likely outcome when sex education is expected to be taught within a range of subjects, and where there is a lack of general acceptance of teenage sex and sexuality. In this instance there may be a subtle disappearance of sex education from the curriculum. This is where the 'separate' approach to the provision

of sex education may be more appropriate, in that it would be visibly noticed were it not being taught.

Teaching environment

Providing a suitable teaching environment is a major key to the provision of effective sex education. As Silver states "it is widely accepted that an 'open and safe' classroom environment is necessary for effective learning" (1998:15). Staff that are both willing and capable of providing sex education are therefore key ingredients to success (HEA 1998) and teacher training on the provision of sex education is therefore an essential ingredient (Hadley 1998).

The Royal College of Obstetricians and Gynaecologists (RCOG) have suggested that all schools should have at least one member of staff who is dedicated to the provision of sex education and who has been specifically trained for that job (RCOG 1991). The Sex Education Forum has further added to this by stating that the definition of a good sex educator is one who "knows his or her stuff; doesn't get embarrassed; has a sense of humour - he or she makes it fun; doesn't ridicule or embarrass pupils; is able to control the class; is either male or female, but with male input for certain aspects of sex education" (SEF 1997:5).

In addition to a well-qualified teacher, the methods used to teach sex education are also important. According to Kirby (1995), traditional methods, such as 'talk & chalk' style lectures are largely ineffective. He has described the most effective learning

methods as 'active learning methods', which would include discussion and reflection and role playing of 'real-life' stories. Kirby states that these types of methods are more successful in helping young people to develop the skills they need in sexual negotiation as well as increasing their knowledge and developing positive attitudes and values (Kirby 1995). The notion of using a multitude of effective methods when providing sex education is supported by both the Sex Education Forum (1997) and the Health Education Authority in England (HEA 1998).

Content

In order for sex education messages to be effectively internalised by young people, the sex education should not 'scare' young people (David & Rademakers 1996). Oakley et al.'s systematic review of the effectiveness of sexual health interventions (1994, 1995) highlighted that education needs to be positive in its presentation of sex and sexuality rather being negative in either tone or content.

Sex educators should also avoid presenting a programme, the content of which is based on adult perceptions of what young people want and need to know (Sex Education Forum 1997). Sex education needs to incorporate what young people want (HEA 1998) or they are less likely to be receptive to the messages that are presented. Unfortunately, a further finding of Oakley et al's review was that "the data that exist suggest a substantial gap between what educators think is important to provide and what young people want to know" (1994:35).

The Health Education Authority suggests that sex education should have regularly reviewed and clearly stated, aims and objectives (HEA 1998). Some of the characteristics that the HEA argue represent 'sexual competence' include those listed below, and they argue that this 'sexual competence' is associated with consistent provision of sex education in school (HEA 1998). Discussion around these characteristics should therefore be represented within the content of school-based sex education.

1. Maintain friendships with both sexes,
2. Discuss problems with both sexes,
3. Communicate effectively with sexual partner/ potential partner,
4. Think about, plan and implement safer sex strategies,
5. Negotiate use of contraception,
6. Agree the status of a relationship,
7. Discuss the meaning and importance of sex in a relationship (HEA 1998:2).

Young men

"The focus of sex education has historically been teenage women because of their reproductive capacity, but it is increasingly considered that in order to maximise the effectiveness of contraception usage amongst young people, boys must not be left out of, or marginalised from, the educative process" (Silver 1998:15).

The SEU report (1999) identified boys to be half of the problem and therefore half of the solution with regard to teenage pregnancy. The policy recommendations, however, were focused on 'threatening' young men about the consequences of their actions, rather than acknowledging that they have specific needs when it comes to sex education. If boys are to be encouraged to have responsible attitudes with regard to their sexual behaviour and respectful attitudes towards their partners, they cannot continue to be marginalised in the provision sex education (Hadley 1998).

To highlight just how much need there is for young men in the UK to be able to discuss issues relating to sex, *Sex Wise*, a British government funded free-phone line receives on average 2500 daily calls, 50% of which are from 13-15 year old men (Hadley 1998).

It does not appear that young men's needs are currently being met by school-based sex education in Britain (Winter & Breckenmaker 1991; Hadley 1998; Meyrick & Swann 1998). Wood warns however, that if attempts are to be made to incorporate young men into meaningful discussion of sex education "it is necessary to acknowledge some of the powerful pressures which are prevalent during their formative years" (Wood 1998:96).

One of the largest of such pressures on young men in many countries including Britain arises through the inherent gender stereotypes that exist. In other words, there are extraordinary pressures on young men, to prove that they are just that, 'men'. Young

men and young women are both faced with gender stereotypes as they grow up and the need to conform to these stereotypes cannot fail to impact upon their sexual behaviour and their relationships (HEA 1998).

According to the HEA (1998) young men and young women are faced with similar and different stereotypes. Both young men and young women pick-up cultural stereotypes about the gender roles that they are expected to fulfil, women being passive, men, active. Young women are taught that people will make judgements about their sexual behaviour, whereas young men learn that people will make judgements about their lack of sexual behaviour. Where young women are taught to believe in 'prince charming' and invest in their relationships, young men learn to think about sex, solely in terms of their needs and desires (HEA 1998).

"Manhood and sexuality are not innate but learned and therefore able to be changed (Anderson 1997:391). The notion of masculinity however, is rarely talked about in sex education and as Wood notes, there is a real need to start to acknowledge the issue and understand what sexuality means to young men, otherwise sex education will continue to have little impact on their attitudes (Wood 1998).

Sex education is one place where young people can be encouraged to challenge gender stereotypes in a 'safe' environment and where young men can learn that 'getting a girl pregnant' is not the only way to prove that 'I am a man'.

Inter-agency collaboration

Within the context of sex education the main role of inter-agency collaboration under exploration within this part of the chapter is the role of sexual health experts in the teaching of sex education. The issue of the potential effectiveness of combining the sex education that young people receive in school with sexual health services inside or outside of the school is explored below in relation to sexual health services.

There have been questions raised as to the value of utilising sexual health or health care professionals in the teaching of sex education. Mellanby et al. (1995) had success when piloting a sex education programme with medical involvement in England. Their programme used medical professionals and peers to deliver sex education and found a relative decrease in the sexual activity of teenagers involved in comparison to the control group.

Papp (1997) in her study of sexual knowledge, moral beliefs and sexual experiences amongst young people in Finland and Estonia argued that medical professionals should be used more in sex education provisions in school, as this had been identified by young Finns as an effective style of provision.

Within Britain, the potential of the school nurse to act as a bridge between health care and education provision and potentially help teachers to provide sex education, was highlighted in government studies during the mid-1990s (Few et al. 1996; PHPU 1996), as well as having risen in profile within academic writings throughout the mid-

late 1990s (Gulland 1996; Hunt 1996; Sex Education Forum 1996; Whitmarsh 1997; Lightfoot & Bines 1998; Mayall & Storey 1998).

In particular, discussion has focused on two aspects of this potential resource. First, the school nurse's ability to form "complementary teaching partnerships" with teachers in the provision of sex education (Whitmarsh 1997:35). Second, the potential of the school nurse in providing a primary health care resource for young people in school-based clinics (discussed in relation to sexual health services).

The Sex Education Forum (1996) argue that the school nurse has the potential to act as a positive support role for teachers involved with the teaching of sex education, both in supporting the teachers themselves, as well as providing classroom sex education directly.

There are however contrasting views on the subject of the school nurse's potential as a sex educator. Whilst the Royal College of Nursing has been quoted as stating that "school nurses are willing and able to take up the challenge of providing sex education in schools" (Whitmarsh 1997:35), there is no published empirical evidence to support this claim.

Whitmarsh (1997) further notes that whilst many nurses in her study have been more than willing to undertake such a role, questions were raised however, as to their actual ability to do so. This aspect was raised as an issue of contention due to the fact that

you cannot realistically "expect a school nurse to arrive in a classroom with inherent teaching skills" (Whitmarsh 1997:41). Training was therefore seen to be a key issue if school nurses or any other 'sexual health expert' were expected to take on this 'teaching role'.

Sexual Health Services and Teenage Pregnancy

In order for young people to be sexually responsible, in addition to adequate knowledge about sex and sexuality, there are certain sexual health provisions that must be available to them, that they can access with relative ease. For example, they need access to contraceptive advice and free or low cost contraceptives. In addition where contraceptive use has failed to be effective or contraception has not been used, young women need to have access to emergency contraception and if required, free or low cost termination services.

When it comes to the provision of sexual health services for young people however, there are additional aspects to those provisions that need to be given further consideration. It is the extent to which service providers consider these additional aspects, which could prove to be a crucial piece of the 'joined-up' policy perspective.

An increasing amount of research has been undertaken both nationally and internationally in recent years, in an attempt to determine the needs and wants of young people with regard to sexual health service provision. There is a growing view

that to encourage young people to access and use sexual health services, they need to be provided in a format that is acceptable to young people, or they will not be used.

Overcoming the First Hurdle - Access

In most countries throughout Europe, sexual health services are provided through a primary care facility such as general practice in Britain and/or through specific family planning service clinics. In some countries, all or a selection of services are provided free/ low cost by the state, such as in Belgium, Finland, the Netherlands, Norway, Portugal, Sweden, Scotland and England and Wales. In others such as Austria, only private facilities are available and in countries such as Germany, there are both publicly funded and private facilities, although according to Kane & Wellings (1999) most Germans pay for private services. Finally in countries such as England and Wales, France, Greece, Iceland, Italy, Luxembourg, Scotland and Switzerland, access to services (public and/or private) varies greatly depending on where you live (Kane & Wellings 1999).

Young people often have additional needs when it comes to accessing sexual health service services, needs which may not be met by the services that are available to the general public. If young people do not or cannot access sexual health services when they need to, this will prevent them from using contraception within their sexual relationships.

Research looking at the issues of sexual health service provision internationally has documented for many years, that ease of access to services is a pre-requisite to their use by young people (Zabin et al. 1986; Peckham 1993; Fullerton et al. 1997; Liinamo et al. 1997; NHS CRD 1997; Hadley 1998). What, however, does ease of access actually mean?

Geographical location & Equality of access

One of the first elements of ease of access derives from young people being geographically able to access a service. In countries like Scotland, England and Wales, where service provision is free and widely available from a range of sources, there are still areas where a young person may have to travel a considerable distance in order to access a service. A distance that may be deemed too far by many (Hadley 1998).

Cheesbrough et al. (1999) in reviewing research on the issue of access found that young people who were already sexually active, were more likely to attend a sexual health service when those services were located in places that were geographically convenient for them.

Clements et al. (1997) conducted a study in Wessex (England) to explore the rates of teenage pregnancy by postcode area and their potential relationship with the distance a young person in that postal area would have to travel to a general practice, family planning clinic and a specialised youth clinic. The main finding of this research was

that teenage pregnancy rates were lowest in areas where young people lived within three kilometres of a 'youth' orientated service.

A further concern of many young people when they are considering accessing sexual health services however, is that they are hidden from 'parental view'. In other words, they would not use services which they knew their parents used, or where they were likely to encounter someone who knew their parents (McIlwaine 1994; Hadley 1998). The SEU (1999) therefore highlighted that for some young people, it was important that the services they used were not in their local areas, but rather that the services were far away from areas where they may be recognised. Alternatively it has been suggested that services such as school-based provisions may help to 'hide' young people when they access such a service (Zabin et al. 1986; Fullerton et al. 1997).

Suitable opening times

Young people have limited windows of opportunity when it comes to seeking advice or contraception (Hadley 1998). This occurs for two specific reasons, first, many services will only be available at times when young people are expected to be attending school (Turner 2000). Clements et al. (1997) noted that young people were more likely to use contraception if there was a contraceptive service within a 20-minute walk or a 30-minute bus ride. They highlighted that longer opening hours are critical if young people who are in school and have to rely on public transport are to be able to access sexual health services (Clements et al. 1997).

Second, sexual activity, especially amongst younger teenagers is often sporadic and unplanned and therefore young people will often be in need of immediate advice. The unplanned nature of many younger teenagers' sexual activities also means that emergency contraception plays an important role, especially for under-16s (Zabin et al. 1986).

According to Hadley (1998), young people in Britain have often reported difficulties in obtaining an appointment within the 72-hour period required for the effective use of emergency contraception. She highlighted that young people will decide whether or not to use a service, based on how easy it is to access (including location and when it is open) (Hadley 1998).

Confidentiality

One element that was continually and unanimously presented as one of the most important keys to access for young people was confidentiality. Even in countries where attitudes to teenage sexual activity are more liberal, young people still need and want confidentiality (Jones et al. 1985, 1986; Papp 1997; Fullerton 2000). The overall conclusion of researchers that have explored this issue is that for young people to access services, confidentiality is essential (Jones et al. 1985; Wulf & Lincoln 1985; Jones et al. 1986; Zabin et al. 1986; FPA 1994; Lo et al. 1994; McIlwaine 1994; Dickson et al. 1997a; Fullerton 1997; Liinamo et al. 1997: Hadley 1998; SEU 1999; Turner 2000).

In England and Wales this issue became very complicated during the early 1980s when Mrs. Victoria Gillick took her local health authority to court for prescribing the contraceptive pill to her daughter who was under the age of 16. The Gillick ruling in favour of young people's rights to access contraception under the age of 16 in 1985, paved the way for young women under 16 to be able to access a service for contraceptive advice and contraceptive supplies without the consent or knowledge of her parents (Schofield 1994). A large degree of confusion, however, still remains amongst young people and medical professionals in Scotland[1], England and Wales as to their rights and responsibilities in this area (Hadley 1998).

The extent of this confusion amongst young people is visible in the results of teenage opinion poll. A survey by the Family Planning Association in 1993 found that 66% of pregnant young women surveyed said that they had not approached a family planning clinic or their GP because they had thought it was illegal for them to do so (FPA 1993). Whilst this should not be the case, young people in England have experienced being told that they are not allowed to make an appointment without a parent present (SEU 1999).

Informal and User Friendly

In addition to concerns over confidentiality, young people in England have commented on the lack of 'friendly' reception staff and too formal an atmosphere when

[1] Despite the Gillick ruling being a case within English Law, the advice to medical professionals as a result of this ruling are provided to all medical professionals in Scotland, England and Wales by the ethical committee of the British General Medical Association.

they have attended a service (SEU 1999). Therefore an informal and friendly atmosphere instead of an intimidating one, is a further recommendation from researchers in this area (Zabin et al. 1986; Peckham 1993; Fullerton 1997; Hadley 1998; SEU 1999).

Professional attitudes to young people and their sexual activity

Young people need to feel that they are being treated with respect. The main evidence that this respect exists, has been identified by young people themselves, as service providers who are friendly, who talk to them rather than at them, who listen objectively to what they are saying, who do not judge them for their sexual activity and who are genuinely interested in what they are saying (Liinamo et al. 1997; HEA 1998; Aggleton et al. 1999). Young people have also reported that they would be more likely to access services where professionals expressed positive attitudes to sex in general (Aggleton et al. 1999).

Young people need to feel equally comfortable with the providers of a service as they are with its location and the type of service, in order that they will use it. Treating young people with respect and not judging them because they are sexually active, is likely to help foster the development of self-esteem. A lack of self-esteem amongst young women in Britain and the USA has been associated with increased likelihood of pregnancy at a younger age (Thomson 1990; Pearce 1993; Lees 1994; Hadley 1998). One area of importance that has been identified is the need for medical professionals

to be adequately trained to work and deal with young people and their needs (Liinamo et al. 1997; HEA 1998).

'Sex-speak' - youthful linguistics

A further criticism made by young people of sexual health services is that the language that professionals often use during consultations is too formal. The use of medical jargon is often confusing and not fully explained to young people (Hadley 1998). Research undertaken by Aggleton et al. (1999) found that young people would prefer professionals to use language and words that they use themselves, or to use a mixture of professional language (if explained) and less formal, more colloquial language.

In addition to the language spoken, there have also been questions raised as to the suitability of the names given to services. Clements et al. (1997) noted that the term 'family planning' is not relevant to most young people and their sexual health. Hadley (1998) notes that young people are not planning families, they are developing their sexual identities. The SEU consultations (1999) found that young people thought that family planning clinics were for married (or soon to be married) couples. Therefore regardless of whatever guise a service is provided to young people, careful consideration should be given to its name, to make sure that it is inclusive not exclusive (Clements et al. 1997).

Inclusive access for and recognition of the needs of young men

It has been argued that the appropriate use of language is even more pertinent for young men. Hadley (1998) has noted that 'family planning' alienates young men, as it is perceived as a 'female domain'. Young men also informed the Social Exclusion Unit during their consultation period that these services were further alienating because they were predominantly run as services for and by women (SEU 1999).

Service provision in this area has historically been aimed at the needs of women. When women visit their GP or family planning clinic for sexual health advice in Britain they are routinely asked about their sexual and contraceptive history and often whether they have had children or an abortion. Men on the other hand are not generally asked their contraceptive or sexual history let alone whether they have been responsible for an abortion (Nelson 1997). Having raised awareness of this issue, taking the sexual health history of male visitors is something which is being piloted within Chelsea and Westminster Healthcare NHS Trust (Nelson 1997).

An ONS survey in 1997 revealed that 61% of men believe that in practice, women should be responsible for contraception and a further 40% had never discussed contraception with friends (Nelson 1997). There is a gap in provision and if men in general are to be able to take responsibility for their own and their partner's sexual health, they need services which are targeted at them and provided for them (Hadley 1998).

Alternative service provision options

Young people's services

Young people have identified a need for services which are youth orientated and have specified a preference that these services are provided within localities that are for young people only (Liinamo et al. 1997; Aggleton et al 1999). Evidence from Europe further supports the promotion of youth clinics. In the Netherlands and in Sweden services are aimed specifically at young people (Peckham 1993). In the Netherlands there are special services targeted at young people provided by the Rutger Institute and in Sweden, there are separate systems of provision for the general population as well as for young people (Peckham 1993). Other countries such as Denmark, Finland, Germany, Norway and Switzerland all provide services specifically aimed at young people (Kane & Wellings 1999).

In England during the early 1990s there was a period of development of youth clinics which was reported to be well received and used by young people (Bloxham et al. 1999). The main expansion of such services between 1990 and 1995 was followed by the first decline in pregnancy rates in ten years (Hadley 1998). They were, however, not universally provided across the country resulting in a lack of equality of access for young people. Those most noted as likely non-attendees were "younger teenagers, young men and those living in areas of deprivation for whom the motivation to avoid pregnancy may be undermined by high levels of unemployment" (Hadley 1998:14).

Jones et al. (1995, 1986) suggested that specialised youth clinics which were fully integrated advice centres, providing young people with access to contraceptive services and counselling and linked to schools, were likely to be the most effective in helping to reduce teenage pregnancy. Their research concluded that "teenagers living in countries where contraceptive services, sex education in and out of schools, and abortion services are widely available have lower rates of adolescent pregnancy and do not have appreciably higher levels of sex experience than do teenagers in the United States" (Jones et al. 1986: 233).

This view is supported by Zabin et al. (1986), Allen (1991) and Fullerton et al (1997). Further to this, recent research on young women's views about service provision in Scotland, highlighted the desire for a clinic specifically run for young people in order that there was a provision that they could attend that they knew would not be used by their parents and/or run by medical staff who they knew personally (Turner 2000).

School-based service provision

It is widely acknowledged that knowledge about sex, is not in itself a sufficient pre-requisite for behavioural change (Rademakers 1997; Papp 1997; Silver 1998). Through international comparisons, researchers have generally concluded that the most effective sex education is found in countries where there is an official sex education policy that is linked to sexual health services offering confidential advice and provisions (Jones et al. 1985, 1986).

One of the earliest evaluated school-based programmes of sex education combined with an on-site sexual health advice and contraceptive service was in Baltimore, USA (Zabin et al.1986). The main finding of this study was that there was a delay in onset of sexual activity amongst the young women involved. There was also found to be increased contraceptive use amongst young men and women who were already sexually active and the pregnancy rates for the surrounding locale witnessed a decline. The main conclusion of the study, was that linking sex education with school-based sexual health services could be effective in increasing contraceptive efficiency and its use by young people. When the programme was discontinued however, the pregnancy rates returned to the levels that had been witnessed prior to the programme (Zabin et al. 1986).

Kirby et al. (1991, 1994, 1997) found that in the USA, using a combination of approaches was much more likely to bring about positive results than sex education alone. David et al. (1990), in a comparison between provisions in Denmark and the USA noted that teenage pregnancy rates were found to be lower in countries that provided the combination of easily accessible contraceptive services, more sex education and generally more open attitudes to sex and sexuality.

The main reviews conducted by UK researchers over the last decade, have reached the conclusion that adopting an inter-agency approach is the most effective means of encouraging safer sexual behaviour (Winter & Breckenmaker 1991; Fullerton et al. 1997; NHS CRD 1997; Hadley 1998; Meyrick & Swann 1998).

Some have argued that the school nurse is in a unique position to take on a special role within a school setting of being able to provide discrete, confidential one-to-one sex education to pupils, the confidential aspect of which cannot be guaranteed by teachers (Gulland 1996; Hunt 1996; SEF 1996). The school nurse has also been viewed as a positive resource by young people themselves as s/he is not viewed as an authoritarian figure (as teachers often are); s/he is easy to access if school-based and s/he is perceived as approachable and friendly (Hunt 1996). There have however been questions raised as to the suitability of school nurses to provide a clinic-style provision in school when they have not been specifically trained to do so (Whitmarsh 1997). Therefore, if school-based services were to be encouraged, the issue of training would be of utmost importance.

Having reviewed literature discussing the merits of school-based provision, there was a general lack of sound methodological evaluations of such a service (Oakley et al. 1995). Despite this fact there was, however, overwhelming support from researchers internationally for this style of service (Wulf & Lincoln 1985; Zabin et al. 1986; Allen 1991; Pearce 1993; Visser & Bilsen 1994; Fullerton 1997; Fullerton et al. 1997; Papp 1997; Turner 2000).

The provision of school-based clinics would also mean that a confidential resource was brought to young people instead of the young people having to go to an external service. It may solve the concern that many young people have, of being seen by

someone who knows their parents (McIlwaine 1994; SEU 1999; Turner 2000). It may also encourage more young women to access emergency contraception if the need arises rather than adopting a fatalistic approach and hoping nothing will happen (Hadley 1998). Further to this, it presents a unique opportunity for young men to gain easy access to a (sexual) health service.

It must be remembered, however, that not all young people will attend school even if they are legally required to do so. Schofield (1994) therefore notes that providing school-based clinics should not be the only option for young people and that there would be a need for services aimed at young people both within and outwith the school setting.

General acceptance of young people's sexual activity and the need for young people's services

It is widely accepted that Britain as a whole lacks 'cultural openness' about sex and sexuality and about teenage sexual activity in particular (HEA 1998). It is also widely accepted that countries which are more open with regard to sex and sexuality, including the provision of sex education and contraceptive services for young people, are the countries which have low teenage pregnancy rates (Jones et al. 1985, 1986; David et al. 1990).

Jones et al. (1985) used the following criteria to measure the level of openness of any given society:

1. Media presentations of female nudity,
2. The extent of nudity on public beaches,
3. Sales of sexually explicit literature and
4. Media advertising of condoms.

According to Jones et al.'s study (1985), the UK fits the general pattern for high teenage pregnancy with regard to its relative lack of cultural openness. Scotland escapes the extremist moralistic views of the USA, but it is well behind the more open and pragmatic approach to teenage sexual activity found in many European countries.

Education and Teenage Pregnancy

In the set of pre-requisites to effective contraceptive use outlined at the beginning of this chapter, the final pre-requisite was motivation. Young people need to have motivation to use contraception so as not to become pregnant or place themselves at risk of contracting an STI. Hadley (1998) in her review of sexual health and sex education policy in Britain, highlighted the fact that adults frequently underestimate the high level of motivation required for young people to access and use contraception effectively.

It has been widely acknowledged through international research that educational achievement is one of the strongest determinants of teenage pregnancy (Jones et al. 1985; Zabin et al. 1986; Hayes 1987; Hofferth 1987; Kirby et al. 1994; Westall 1997; Kane & Wellings 1999; SEU 1999). It would therefore seem appropriate to suggest

that educational achievements and aspirations may provide a young person with strong motivation to avoid pregnancy and parenthood.

Therefore, throughout the next section of this chapter, consideration is given to some of the literature surrounding education and its potential relationships with teenage parenthood, teenage pregnancy, contraceptive use, sexual knowledge and sexual activity, as well as the literature about why young women delay parenthood.

Educational level and achievement

Low level of educational achievement and teenage parenthood - cause or effect?

International research has highlighted throughout many industrialised nations that young women are twice as likely to become teenage mothers if they are low academic achievers (Hayes 1987; Hofferth 1987; Kirby et al. 1994; Kiernan 1995; Moore et al. 1995). Although this relationship exists, however, it has often been assumed that the low achievement occurs after the pregnancy, in other words, the young women drop out of school or fail to finish their education because they have become pregnant. What has become apparent in recent research, however, is that most often the young women who become pregnant have been suffering academic problems including low education attainment, truancy, dropping out of school or having been excluded from school, prior to pregnancy (Phoenix 1991; Kirby et al. 1994; Moore et al. 1995; Selman 1998, 2001).

Recent research consultation undertaken by the Social Exclusion Unit (SEU) in England found that young women who truant or are excluded are at a particularly high risk of pregnancy (SEU 1999). One small-scale study of 50 young women excluded from school undertaken by *Include* in response to the SEU's consultation work, found that 14% of those young women had become pregnant during their period of exclusion (1998). From examination of studies of both young men and young women in the 1958 UK birth cohort, Kiernan (1995) identified that low educational attainment was a risk factor for young parenthood.

Educational level and sexual knowledge

It has been widely accepted that having a good sexual knowledge will not automatically translate into safe heterosexual behaviour (Silver 1998). If and how that knowledge is internalised into safe behaviour has been discussed in relation to sex education, but the knowledge must first be there in order to be internalised. In relation to general levels of education, Kontula & Rimpelä (1988) found in their study of young Finns that the higher the level of their general knowledge the higher the level of their sexual knowledge.

Additionally, Turner (2000) in her research on young never pregnant women's perceptions of motherhood found that young women attending an institution of private school education as opposed to state (comprehensive) school, generally had a higher level of knowledge with regard to contraceptive/sexual issues. In particular young

women attending private school[1] were significantly more able to assess the risk of pregnancy when having sex for the first time; to know that emergency contraception should be used within 72 hours and that a young woman can become pregnant when having sex standing up and when using the withdrawal method, than those attending state school (Turner 2000).

Educational level and age at first intercourse

Research has found that an increased level of educational achievement has been significantly related to a higher age of first intercourse (Kane & Wellings 1999). In addition, for a young person who has a record of interrupted education or truancy there is an increased likelihood that they will first have intercourse at an earlier age than a young person who remains in education (Croydon Community Trust 1994 in SEU 1999; Westall 1997).

Educational level and contraceptive use

Research conducted during the 1980s in the USA found that the lower the educational level of a young person, the higher their ineffective use of contraception (Hoffman 1984; Morrison 1985). This relationship between educational level and contraceptive use, and the noted difference in contraceptive use between young people in Finland

[1] Whilst attending a private rather than a state school does not guarantee a higher level of general education, pupils attending the private school were found to be significantly more likely than those attending one of the two state schools to predict that they would go on to some form of further education (sign of educational aspiration). Additionally, the young women attending the private school appeared academically more ambitious than those attending the state school and were significantly less likely to predict that they would be mothers within four years of being interviewed (age 15-16) (Turner 2000).

and Scotland was one particular reason that lead to the exploration of education policy in both countries.

Educational level and outcome of pregnancy

There are a large number of reasons as to why a young woman may choose to abort her pregnancy. One association that has been documented is that of educational level and aspirations, in that abortion is much more common amongst high educational achievers (Kane & Wellings 1999). Whether this is due to parental pressure because they want their child to continue in education without the burden of a child (Lucey in Rattansi & Phoenix 1998; Turner 2000); because the young woman herself has educational aspirations that would be hindered by having the child (Brazzell & Acock 1988; Moore and Rosenthal 1993; Turner 2000); because being more educated, that young woman has more choices or is more aware of her choices and is more aware of how to obtain an abortion; because of a perceived lack of parental and educational support if a pregnancy was continued (Turner 2000); or because of the socio-cultural background and attitudes of significant others of the young woman being more accepting of abortion than birth (or vice versa) (Brazzell & Acock 1988; Simms 1993; Turner 2000), is unclear. The more common outcome however for higher achievers has been documented to be an abortion rather than birth (Kane & Wellings 1999).

Educational level and timing of first birth and number of children

According to Beets (1999a,b) women postponing the birth of their first child is a widespread phenomenon throughout most of the Western world, with the Netherlands

being coined "world champion [of] later parenthood" (1999a:1). Throughout most of Europe over the last two decades, starting in Northern and Western Europe before spreading to Southern and Eastern Europe, fertility rates have dropped and the ages at which women across Europe now have their first child have risen.

Beets (1999a, b) suggests that the low, declining and late fertility rates are the result of increasing levels of education amongst consecutive generations of women of childbearing age, the declining importance of having children in comparison to other life pursuits and an increasing desire amongst women to be economically active and independent. Further to this, the difficulties for women in many countries which do not provide free or low cost childcare, to combine work and motherhood as well as the desire to be financially secure prior to starting a family, provide additional explanation to the pattern of fertility rates.

The level of education, however, is believed to be one of the strongest influences on the timing of first births across Europe, "as higher education achievements tend to go hand in hand with stronger preferences for labour force participation, education may be an important factor in 'explaining' the delay of first birth" (Beets 1999a: 1).

International research indicates that a woman's educational level strongly relates to the age at which she will marry, the age at first birth and the number of children she will have, with a higher level of education equating to a higher age at marriage and first birth and fewer children overall (Westall 1997; NHS CRD 1997; Beets 1999a,b).

Continued education and teenage pregnancy

International research has indicated that in countries where there are higher levels of young people in education or training beyond the age of 16, there are lower rates of teenage pregnancy (Jones et al. 1985). There is strong evidence in England, that not being in post-16 education or training is closely associated with teenage parenthood for 16 and 17 year old women (SEU 1999). In a study of young women in England, almost half of those who were not in education or training were mothers in comparison to only 4% of young women who were mothers and in education or training (Bynner & Parsons 1999). Further analysis of this relationship revealed that approximately one third of those young women who had become mothers, became pregnant whilst they not in education, training or work (Bynner & Parsons 1999).

It is plausible to suggest given this evidence, that the longer a young woman remains in education or training, the longer she is indirectly delaying pregnancy and parenthood. It could, however, be that the delay is deliberate because a young woman has the desire to pursue a higher level of education or a career prior to parenthood. It may also be that remaining in education has offered more opportunities and choices for a young woman beyond becoming a parent at a young age.

Aspirations for the future

In addition to the relationships shown to exist in previous sections above, between educational level and contraceptive use, abortion ratio and age of first birth, previous

research has also illustrated that similar relationships exist between these variables and educational aspirations.

Educational aspirations and contraceptive use

Research conducted during the 1980s in the USA found that young people who had high educational aspirations were more consistent in their use of effective contraception. Morrison (1985) in considering the relationship between educational aspirations and current contraceptive practices also found that there was a positive association between young people who had higher educational goals and aspirations for themselves and the use of several measures of effective contraception. More recently in Norway, Pål Kraft found that the only factor that related to contraceptive efficiency in the most recent intercourse was the educational aspirations of the young person, the higher the educational aspirations, the higher the contraceptive efficiency (Kraft et al. 1991).

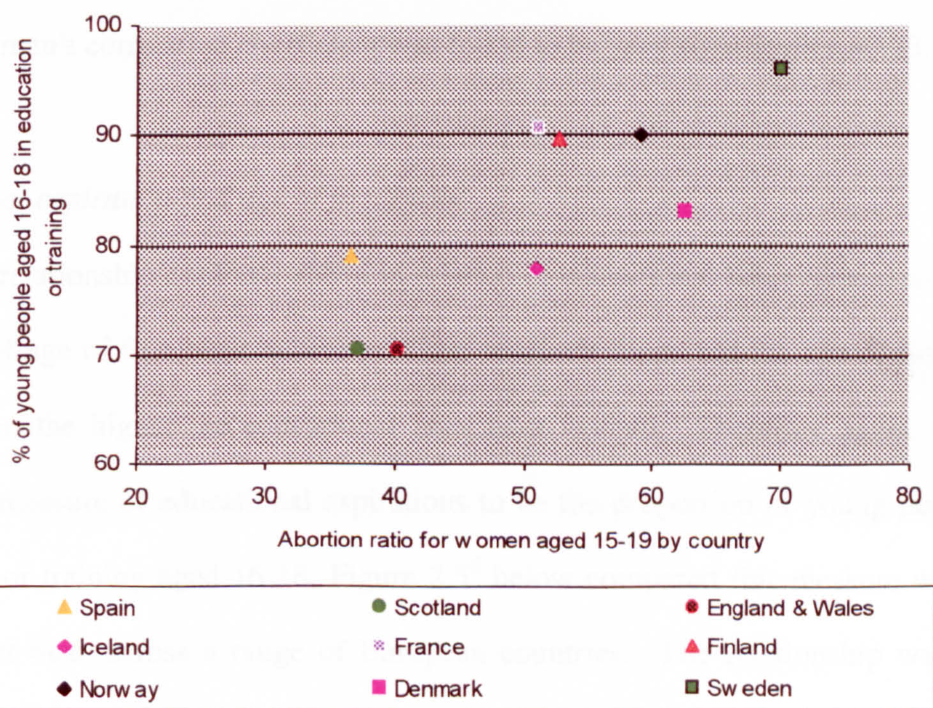
Figure 2.3[1] below, using the proportion of young people in education or training at age 16-18 as a measure of educational aspiration, explores this relationship further. In many European countries, the age of compulsory schooling ends at 16 and therefore if young people stay beyond the age of 16, this suggests voluntary continuation and a sign of aspiration. This chosen measure is rated against contraceptive use at first intercourse in five European countries.

[1] Data for this figure can be found in Appendix i.

The relationship for the data available is very significant (r_s= 0.90), however this should be viewed with caution as there are only a small number of countries included due to lack of available data. Additionally, the definition of young person varied for each country from 'young people' to specifically 15 year olds.

Figure 2.3

Proportion of adolescents using contraception at first intercourse and percentage of those aged 16-18 in education or training, by country.



r_s=0.90

General notes
Definitions of adolescents vary by country as follows:
Netherlands - 'young people' (year not stated)
Denmark - 15-16s (year not stated)
France - 'young people' (year not stated)
Finland - 15s (1992)
Scotland - 15-16s (1992)
Source of data on contraceptive use - McIlwaine 1994, Papp 1997 and SEU 1999.
Source for data on % of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.

Educational Aspiration and outcome of pregnancy

In relation to academic achievement and educational level, previous research has shown that the more common outcome for higher achievers has been abortion rather than birth (Kane & Wellings 1999) and Figure 2.4[1] below, was constructed to explore this relationship further. As with Figure 2.3, the measure of educational aspirations is taken to be the proportion of young people in education or training aged 16-18. As expected, in countries where the overall stay-on rate in education or training was higher, the outcome of pregnancy was found to favour abortion as opposed to birth. The Spearman's correlation coefficient was found to be very significant r_s=0.73.

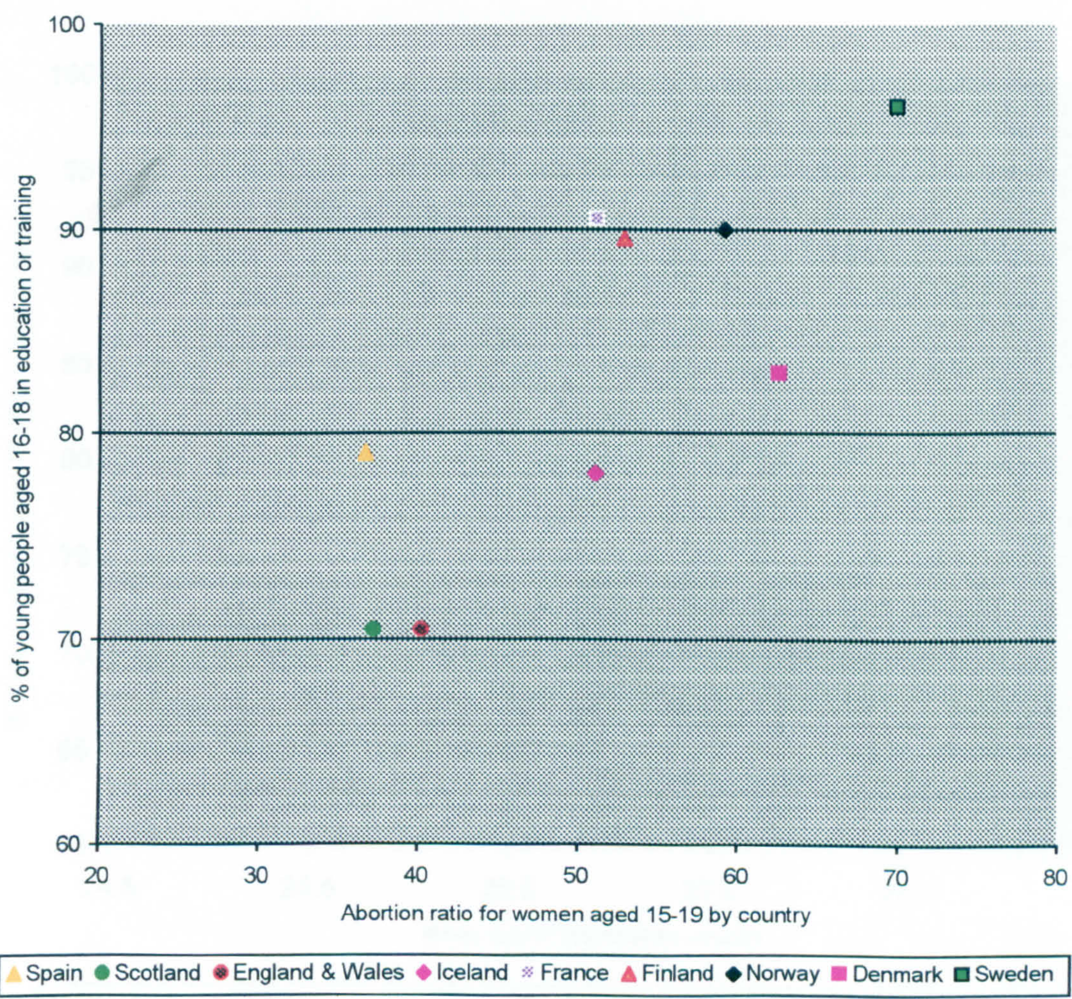
Educational aspiration and age of first birth

One final relationship explored above in relation to educational achievement and level was that of age of first birth, where previous research suggested the age of first birth was higher, the higher the educational level of a woman. Therefore again, having taken the measure of educational aspirations to be the proportion of young people in education or training aged 16-18, Figure 2.5[2] below compared this measure with the age of first birth across a range of European countries. The relationship was once again found to be significant with a Spearman's correlation coefficient of r_s= 0.74.

[1] Data for this figure can be found in Appendix i.
[2] Data for this figure can be found in Appendix i.

Figure 2.4

Abortion ratio and percentage of those aged 16-18 in education or training, by country in 1995/1996 (or latest available year).

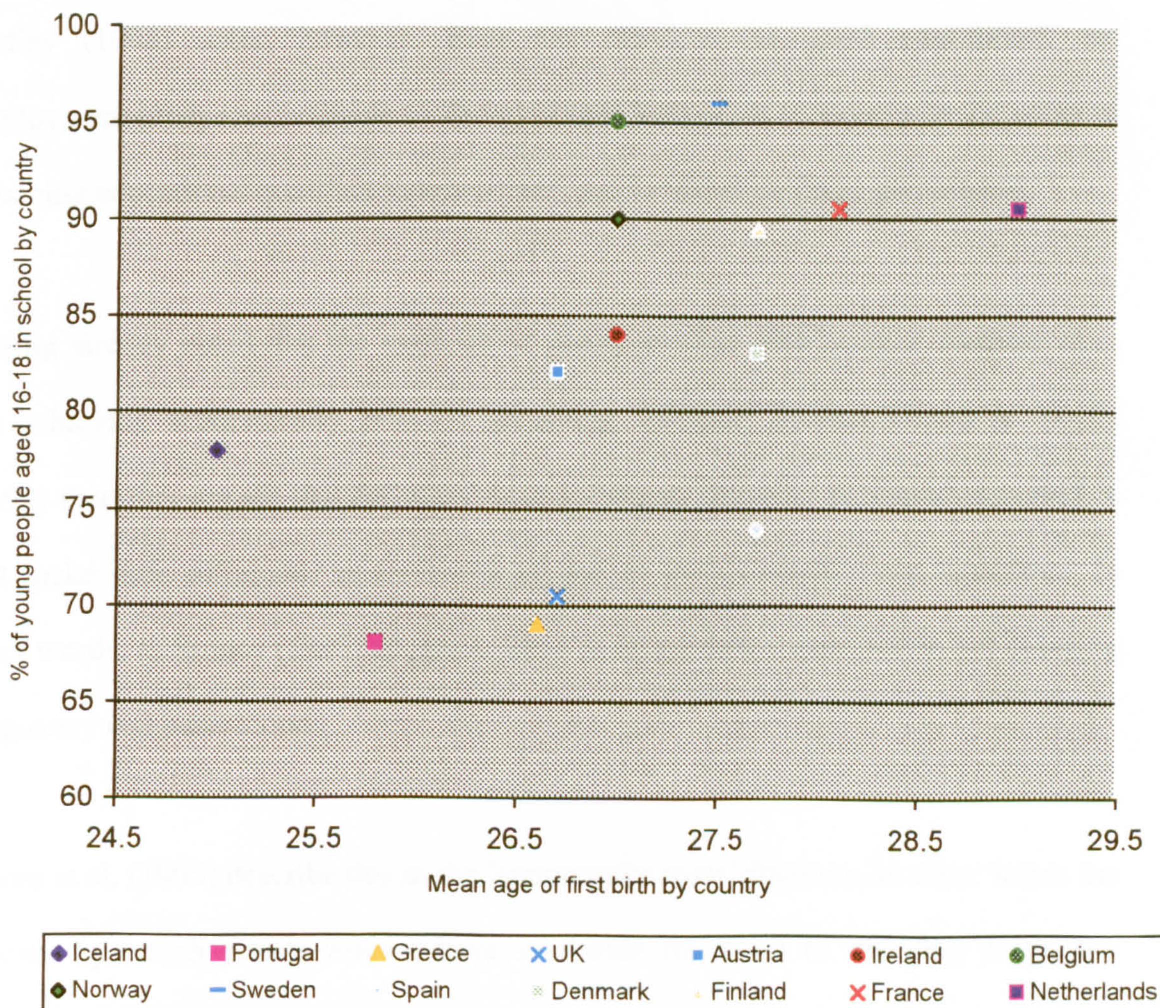


$r_s = 0.73$

General notes
Source for data on abortion ratios - Singh & Darroch 2000.
Year for abortion ratios is 1995 unless noted below:
1996 - Finland, Iceland, Norway and Sweden.
Abortion data for France and Spain are only 80% complete.
Source for data on % of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.
Data on Scotland - % education rates are for the UK as a whole, abortion ratio data is for women under 20, not just 16-19.
Data for England and Wales - % education rates are for the UK as a whole.

Figure 2.5

Mean age of first birth and percentage of those aged 16-18 in education or training, by country in 1996 (or latest available year).



r_s=0.74

<u>General notes</u>
<u>Age of first birth data</u> - Beets 1999a
Year for which first birth information is available is 1996 unless noted below:
1997 - Finland, Greece, Iceland, Netherlands, Norway, Switzerland.
1995 - France, Spain.
<u>% of young people in education data</u> - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.

'Opportunity costs' - reasons to delay pregnancy and parenthood?

"The proposition that early motherhood hinders a young woman's education and employment prospects assumes that those women who become young mothers had educational and career ambitions prior to entering motherhood" (Turner 2000:41). As Hadley (1998) notes, however, there first need to be good educational and employment prospects available to young people if they are to believe in the value of obtaining educational qualifications at school and to therefore delay parenthood.

Having already noted that the majority of young women who become mothers were not achieving academically prior to becoming mothers, Stevens-Simon & Lowly (1995) therefore argued that for many young women, delaying motherhood would in fact make little difference to their educational or future employment situation. In other words, as Simms (1993) suggests, there is no perceived sacrifice in not delaying pregnancy and parenthood.

Moore et al. (1995) describe this as the 'opportunity costs' dilemma, in other words the process by which young women have to decide the costs of delaying pregnancy against the perceived benefits of motherhood. For some young women, if they do not see themselves as having the aspiration to, or being capable of higher education or financial independence or having any solid career aspirations, but rather they see little education and an underpaid and repetitive job as their future, then Simms suggests that they may perceive that having a child potentially becomes an attractive option (Simms 1993).

This, however, suggests that there is an indication of intention to become pregnant which is not supported by research (Turner 2000; Selman 2001). What Turner (2000) has suggested is rather, that "the fewer the opportunities that a young woman has, the less motherhood is viewed as problematic" (Turner 2000:309), and that rather than the fewer opportunities being viewed as a reason to conceive, findings of her research suggest that "once pregnant, the reasons for avoiding motherhood [as opposed to abortion] may seem less significant" (Turner 2000:310).

Simms has noted, in Britain there is a need to "give girls a motive for avoiding too early pregnancy by making further education attractive (affordable) to them with the chance of a good job and independence at the end of it" (Simms1993:1750). Selman & Glendinning (1996) and Hadley (1998) both support this notion within a British context, expressing the real need for adults and educators to provide young people with reasons that they will perceive as valid, to enable them to want to stay on in education.

For young women an increase in gender equality in the labour market may be one such incentive. Research has shown that in countries where there exists a higher level of gender equality in pay and there are higher female wages, there are in turn lower rates of fertility amongst all women, younger women included (Beets 2000b, Papp 1997). Additionally Turner (2000) found that a young woman's increased enjoyment of education at the school level increased her prediction that she would be in further education in the near future.

According to Cheesbrough et al. (1999) some of the most effective teenage pregnancy reduction programmes (internationally) have been those which attempted to understand and tackle the causes of low self-esteem and low aspirations, starting at an early age. The philosophy behind those programmes is that if young people feel that their future is bleak, then they are not likely to be as receptive to and internalise safer sex messages, or to perceive any incentive to delay parenthood (Cheesbrough et al. 1999).

'Fatalism' Vs 'Being in control'

The previous paragraph introduced the notion of 'self-esteem' and this is a further issue that has been related to teenage pregnancy. Again research has shown internationally that young people in general (women in particular) who have higher educational achievements and aspirations are noted to also have higher levels of self-esteem and a feeling that they are in control of their lives instead of simply accepting 'fate' (Jones et al. 1985; Visser & Bilsen 1994; Hadley 1998; Cheesbrough et al. 1999).

In relation to teenage pregnancy, the notion of 'accepting fate' could translate to non-use of contraception with the attitude that 'if I get pregnant then that's what's meant to be' and the outcome therefore being perceived as a 'passively conceived' pregnancy[1] (Turner 2000), instead of approaching life from the perspective of 'being in control' and understanding that one has the ability to control the directions in which one's life

[1] Turner (2000) uses the term 'passively conceived' to describe a pregnancy that 'just happened', i.e. it was neither 'planned' or 'unplanned'.

may go. Jones et al. (1985) described this fatalistic approach as a response to social anomie, whereby uncertainty about one's future or the perception of a bleak future resulted in a more fatalistic approach to life and in turn lowered contraceptive motivation.

Further to this Turner (2000) found that of the two young women she interviewed who had 'passively conceived', both were noted to have had "little else to structure their lives" (Turner 2000:347). Further to this, "it was apparent that neither interviewee had enjoyed school, nor had a job, or any intention of seeking employment [and therefore] it is also possible that these pregnancies had not been avoided because the women viewed motherhood as a role which could bring them a sense of purpose" (Turner 2000:347).

Summary

This chapter has explored a range of relevant literature surrounding the issue of teenage pregnancy and its potential relationship to three particular areas of policy: sex education, sexual health and education. Each of the three areas identified are important pre-requisites to effective contraceptive use and it is therefore important to consider them in combination, as well as separate areas of policy. It is hoped that in doing so, more light will be shed on the nature of the relationships between the different policy areas and the important role that they play in the prevention of unintended teenage pregnancy, both as individual policy areas as well as jointly in relation to each other.

In order for young people to be prepared for the choices that they are to make in their lives regarding relationships and sex, in particular the effective use of contraception when they decide to begin their sexual lives, they need to first have a comprehensive understanding of sex, sexuality and how to prepare themselves emotionally and physically for a sexual relationship.

Compulsory school-based sex education is one means of providing some of that knowledge and because of its school-base, it has the potential to reach almost all young people. Within both Finland and Scotland national school health studies have been undertaken to explore the levels of sexual knowledge and attitudes of each country's respective cohorts of young people (Kontula et al. 1992; Pötsönen 1993; Liinamo et al. 1999c; Liinamo et al. 2000b: Currie & Todd 1993; Currie et al. 1998).

In addition, there have been evaluations undertaken in both countries on the effectiveness of certain types of provision and the levels of provision in schools (Hämäläinen & Keinänen-Kiukaanniemi 1991; Kontula 1997; Liinamo et al. 1998a; Liinamo et al. 1998b; Liinamo 1999a; Liinamo et al. 1999b: Bagnall & Lockerbie 1995; Wight & Scott 1994; Wight 1996; Wight et al. 1999).

So far the emphasis of research has been on the extent of provision, its content, and effectiveness in both countries. As yet there has not been a comparative exploration between the two countries of sex education policy looking at the wider remit of policy

frameworks at government, municipality/ local authority, and school levels and the potential relationships at work between the different levels. This thesis has therefore included an exploration of sex education policy in Finland and Scotland from this wider perspective.

In addition to having an adequate knowledge about sex and sexuality before becoming sexually active, young people also need to perceive that they have 'real' access to sexual health services for advice, support and contraception. In Britain, young people have frequently reported difficulties in taking responsibility for their sexual health (Hadley 1998). Many of the difficulties encountered by young people have to be addressed through social policies. The decision to include an exploration of sexual health policy in this thesis was taken in the first instance because whilst both countries had a school health service, there were apparent differences between the ways in which each country used this service. Given the increased interest as noted above, in the utilisation of school health services in teenage pregnancy prevention, this warranted further research.

Additionally as was found to be the case with sex education, there has not been a comparative study undertaken between Scotland and Finland, or any other country. Nor has there been any research published in English that has compared Finland and any other country.

Finally, in response to the evidence presented in Chapter One and in the education section within this chapter on the relationships that previous research have shown to exist between educational level and/ or aspiration and many variables including, levels of sexual knowledge, in/efficient contraceptive use, age at first intercourse, teenage pregnancy rates, outcome of pregnancy, age of first birth and motivation to delay pregnancy and parenthood, education policy was chosen as an area of focus in this thesis.

There were two main assumptions I wanted to explore within the remit of education policy. First, as the relationship (see Chapter One) between continued education rates and unemployment amongst young people under 25 was weak, I wanted to explore whether differences existed within general education policies that perhaps promoted the educational prospects of young people, women in particular. The rationale being that in doing so they may encourage continued voluntarily attendance at school, beyond the age at which compulsory schooling ends, hence providing young people with the aspiration and motivation to delay parenthood. In order to examine that assumption the decision was taken to explore in particular, policies relating to the provision of careers guidance within Finland and Scotland's education systems.

The second assumption under consideration in this thesis was whether the school leaving age and the structure of the education system in each country could potentially be indirectly affecting the rate of teenage pregnancy in each respective country. In other words, was there something about the structuring of education that required

young people to remain in education, be that legally by age or structurally by the normalised educational paths and opportunities on offer to young people at school, in both countries, hence encouraging an indirect delaying of pregnancy and parenthood. In order to examine that assumption the decision was taken to explore policies relating to both the legal age at which young people can leave compulsory schooling as well as the structure of education in both countries.

The final reason for including education policy as an area of exploration was due to the lack of focus upon this area in combination with other areas of policy that may relate to teenage pregnancy. So often research has focused on the means of acquiring knowledge about sex and sexuality (sex education policy) and/ or the means of achieving access to sexual health services (sexual health policy), only very recently (Hadley 1998; SEU 1999) has research acknowledged that the motivation to apply the knowledge and access the services, (one source of motivation potentially being education), is just as important as the other two pre-requisites to effective contraceptive use. Therefore whilst recognising educational achievement and aspiration may be only one potential source of motivation, the decision was taken to undertake a comparative exploration of education policy between Finland and Scotland.

The next chapter sets out the methodological issues of concern in this thesis as well as the methods by which the research design was achieved and the research itself was conducted.

Chapter Three

Comparative Methods and Methodology

Introduction

The rate of teenage pregnancy began to decline in both Finland and Scotland during the early 1970s. By the 1980s the rate of pregnancies to teenagers had dropped significantly in both countries. Since that time, however, whilst Finland has witnessed considerable further decline, the rate in Scotland has remained relatively unchanged for over two decades. In order to offer an explanation as to why these differing trends occurred, this research set out to explore the relationships at work between a number of specific policy areas and the rate of teenage pregnancy in both countries.

As was highlighted in Chapter One, the most noted difference between the two countries in relation to the sexual behaviour of young people was the level of effective contraceptive use. Further to this, at the beginning of Chapter Two, three of the most important pre-requisites to effective contraceptive use were highlighted as;

- Knowledge about sex, sexuality and contraception,
- Access to sexual health services
- The motivation to both access and make effective use of contraception.

Explanation as to how these three pre-requisites translated into the three policy areas under exploration was then presented within the review of the literature in Chapter Two. The aim of this chapter is to discuss the research process which led to the production of this thesis.

First, the process by which the final research design and choice of methods was achieved is documented. Detailed explanations about the natural history of the research process are often noted by their absence in the final write-up of research projects. Many problems in the design were incurred as a result of this research being of a comparative nature and the effect that the remedies to those problems had upon the final research design was considerable. I therefore considered an account of the natural history, an important process that required documenting.

Second, this chapter explores a number of current issues concerning the pursuit of comparative, cross-national social policy research. In doing so, I locate my work methodologically within those fields as a qualitative researcher.

Finally, discussion is then presented of the methodological decisions taken within my own research process including access to and the collection of the data, the use of interpreters in foreign research, as well as the process of analysis and writing up of the findings.

Natural History of the Research Process

The research project that is documented within this thesis originated from a proposal to study AIDS education in the UK. At the time of application for ESRC

funding the opportunity arose to conduct a piece of cross-national comparative research with Finland, due to contacts my principal supervisor had with the University of Tampere. Due to the fact that Finland had an incredibly low rate of HIV cases, a comparative project of each country's respective school-based AIDS education appeared at first a very plausible project.

After further exploration it became very evident that whatever the reasons behind Finland's low rate of HIV, it was not due to a superior provision of AIDS education in school. Rather than discard the opportunity to conduct a comparative project, this research took on the novel experience of a reverse approach to comparative research design, whereby the research design was developed around the two countries available for comparison.

After widening the literature review to incorporate all issues relating to teenage sexual behaviour, the decision was made to broaden the scope of this research. Having noted that there was a significant difference in the rate of teenage pregnancy between Scotland and Finland, the decision was made to pursue a research design to explore the potential reasons as to why this difference existed.

Having taken this decision, the process of narrowing the research focus and producing an effective research design began. Initially this process included reviewing the available literature on teenage pregnancy, looking for the obvious gaps in knowledge as well as airing the ideas arising from this process informally

with a group of four mothers (aged 22-25) who had conceived during their teenage years[1].

The discussion with the group of mothers was crucial to the development of the final research design as it highlighted a key point, that there was no single solution to the prevention of unintended teenage pregnancy. The mothers identified a range of issues that they perceived retrospectively as causal factors in their lack of effective contraceptive use including a combination of:

- A lack of knowledge about how contraception actually worked[2],
- A perception that pregnancy couldn't happen 'the first time',
- A lack of confidence to access their doctors for contraceptive advice and/or supplies,
- A lack of direction in their lives at the point they became pregnant.

In the six months following the discussion with the group of mothers, a number of potential ideas were raised and their feasibility thought through. Many of those ideas were not deemed to be original. Of those that were, they were either not practical, or not achievable for a number of reasons. The main recurring reasons

[1] Contact was made with this group of mothers, who all attended a self-esteem workshop group, via a personal connection my mother (a general practitioner in Glasgow) had with the individual who ran this group.
[2] One particular example of this point was made by Laura, who had conceived at the age of 16. Both she and her best friend had decided after months of going-steady, that the night of a particular party was going to be the first night they would have sex with their respective boyfriends. Both young women borrowed a couple of contraceptive pills from a packet belonging to a friend, took the pills and thought, 'well that's me on the pill'. Both Laura and her friend delivered their babies within three days of each other. Therefore, whilst both young women knew about 'contraception' neither had received any information about how different forms of contraception actually worked.

were the constraints of both time and language.

For example, despite being aware that large proportions of people, especially young people in Finland have a good command of the English language, when talking about sex, one is talking about an entirely different language altogether. In other words a very topic-specific language, which is likely to be culturally specific. It was therefore concluded that the likelihood of conceptual misinterpretation was too great for a number of the research ideas that had been raised by that point in time.

After further analysis of the literature and the discussions with the group of mothers, what suddenly became evident was that despite a wealth of research exploring issues relating to teenage pregnancy, they were generally only focused on one potential causal factor related to contraceptive use. In other words, the focus would be on teenage pregnancy and sex education or teenage pregnancy and sexual health services, very few pieces of research had actually considered exploring a range of policy areas and their potential effect on teenage pregnancy. This therefore led to the decision to explore teenage pregnancy from a number of policy areas that had been identified by previous research and the group of mothers, as important causal factors in the (in)effective use of contraception.

Studying the phenomenon of teenage pregnancy incorporates a potentially unlimited number of areas for exploration. The next stage therefore involved deciding which policies were the most relevant and feasible for comparison. To reach this decision, consideration was first given to the different levels of policy, which could impact on young people's lives.

On one level there are many influences which could affect young people including family, peer groups and school. The decision was made to concentrate on policies found at the school level because school is one institution where it is possible to reach almost all young people and because of the decision to examine policy affecting school-age teenage pregnancy (up to 16). Another research project might choose to compare the influence of peer group or family. This, however, is not the aim of this piece of research.

On a second level, young people are faced with many external settings which could have an influence on their lives, but in which they may have no direct participation. These could include local health and education authorities that can set and/ or guide school policy and community influences such as youth orientated services and social services organising sexual health services for young people, which complement efforts in school. For this reason the decision was made to examine policy at the local authority/ municipality level as well as policy relating to inter-agency collaboration between health and education services.

On a third level there exists a further set of possible influences such as the political system. For this reason the decision was taken to examine the national policy framework developed and influenced at the governmental level.

Consideration of a number of different levels of influence, in this case three, is important in order to gain an overall understanding of any influence on a young person. The immediate setting in which a young person is located is not

necessarily responsible for a certain phenomenon and therefore it is crucial to consider and examine the wider picture. As the various levels of context are sets of influences intertwined with each other, what happens at one level may have an impact or influence on what happens at other levels. As a result, this investigation included several layers of context, in order to explore more fully the effect that policy may have.

An initial prospective research design was then developed around the different levels of policy within the areas of health, education and inter-agency (collaboration between health and education), which had arisen as key policy areas from the initial review of the literature. This design was then presented during a preliminary visit to Finland, at a Public Health seminar at the School of Public Health at Tampere University.

Many of the academics present at the seminar were experts in the field of young people and sexual health in Finland and were both enthusiatisc about the project and encouraging in their advice about ways of improving the initial design. I was then invited to visit a family planning nurse and a school nurse during my stay and these visits I now believe, were crucial to the final research design.

Prior to arriving in Finland I had assumed that sex education was likely to be the most important difference between the two countries. This view had been influenced by and developed due to the overwhelming focus on sex education within the literature on teenage pregnancy and within the British media. Following discussions with the two nurses in Finland, it became apparent that whilst sex

education was a crucial element in providing young people with knowledge about sex, sexuality and contraception, this alone could not explain the difference in pregnancy rates between the two countries. The nurses highlighted the importance of their roles as service providers, in particular the ease of access that the school health service provides to young people in Finland.

Therefore after further consideration and review of each policy area outlined for exploration, some changes were made to the main policy areas. The most substantial change was to 'Inter-agency' policy. It had become apparent that there were two main areas of interest with regard to inter-agency, namely, where health professionals were utilised within a school health service or services were linked to a school and where sexual health professionals were utilised within the provision of sex education. Therefore, whilst retaining 'Education' as a distinct policy area under exploration, the other two main policy areas shifted to from 'Health' and 'Inter-agency' to 'Sexual Health' and 'Sex Education', within which the noted inter-agency issues are addressed.

Reflecting on the initial visit to Finland therefore, two very important lessons were learned. First, the recognition that the original policy areas were too broad, requiring a more specific focus and second, I had to be wary of assuming too much about what the eventual findings may be. It is important that any research framework is loose enough to accept that the underlying assumptions formulated at the start of the research may not in fact be the most important issues. This is something that is taught in every research methods class, but never really

internalised until you are faced with the reality of the rigidness of your own assumptions and bias.

The initial visit was therefore invaluable in helping to develop a research design that would test underlying assumptions whilst remaining open to new ideas. Additionally, having had the opportunity to meet and discuss my research with experts in the field of teenage sexual health in Finland, I was able to translate those meetings into contacts, which were to prove invaluable during the time I was to spend later in Finland.

This included if required, the offer of an interpreter (who worked in the same field with a social science background), who also offered to make initial contacts on my behalf to gain any access that I would require in order to conduct my research. Additionally I was provided with an office to work from and all associated facilities such as phone, postal service, a computer, email, printer, photocopier (and a never ending supply of exquisite filter coffee). Finally, I had the comforting knowledge that I would be returning for twelve weeks to a country, of whose language I spoke very little, where I knew I would not be isolated, personally or professionally.

The preliminary visit proved to be a crucial step in my research process and one that cannot be underestimated in importance for anyone considering cross-national/ comparative work, no matter how many contacts they perceive themselves to have, or how appropriate they believe their set of research questions to be to the other country/ countries involved in their research.

The 'reverse approach' to comparative research

Rather than choosing a number of countries within which to explore my research design, this research has taken the reverse approach to comparative research. Reflecting on this experience, had the choice of countries followed the design, I may have overlooked a number of important issues that made Finland one of the best choices for comparison.

For practical reasons, Scotland was an obvious choice primarily because I was located there and common sense and financial limitations made this an obvious choice. However, another important and valuable reason to consider Scotland (in relation to teenage pregnancy) as independent from the rest of the UK, as can be seen in the review of literature in Chapter Two, is that very little research on teenage pregnancy has done so. Scotland has her own legal system, education system, religion and culture, many of which are important elements when considering policy development. For this reason I believed that considering Scotland as separate from the rest of the UK would be a very enlightening angle from which to pursue a piece of research on teenage pregnancy. Additionally, my research would produce some valuable insights and policy options to present to the Scottish Executive at a time when Scotland is entering a new era of self-government.

With regard to Finland being the country of comparison, had the option of choice been open to me to compare Scotland with any other European country, the Netherlands would most likely have been my first choice, as it has lower teenage

pregnancy rates than Finland. The Netherlands, however, has already been researched to some degree in connection with England, sex education and teenage pregnancy, as was noted in Chapter Two. Additionally, as was noted in Chapter One, although the teenage birth rate in the Netherlands is just over half of that in Finland, Finland has seen more of a continual decline and percentage reduction over the last two decades than has been the case in the Netherlands. These were two key points that I would have perhaps overlooked had I simply been choosing the country with the lowest rate.

Another key reason why these two countries make a good comparison is that they have been relatively ignored in the field of comparative research in general. The review of the literature in Chapter Two revealed that although there has been a degree of research in the area of teenage pregnancy in both countries, as yet, there has not been a piece of comparative work between the two. There are, however, further issues that make Scotland and Finland a particularly good comparison.

Both Scotland and Finland are developed European countries, with similar population sizes and the proportion of each country's inhabitants who are women aged 10-19 years are also very similar (see Figure 3.1 below).

Figure 3.1

Population Statistics for Finland and Scotland (1994)

	Total population	Females aged 10-14	Females aged 15-19	Females aged 10-19 as a % of total population
Finland	5098754	161405	160375	6.31%
Scotland	5132400	158042	151443	6.03%

Source: Tilastokeskus (Statistics Finland) 1996: Scottish Abstract of Statistics 1996.

Additionally, both countries have a legal age of heterosexual consent of 16 years and it is also believed that the age at which both countries' young people first engage in heterosexual intercourse is also similar (Wallace & Vienonen 1989; Currie & Todd 1993; Papp 1997). As was shown in Chapter One, the levels of sexual experience were also noted to be very similar between young people aged 15(/16) in both countries. These are all important constants and the similarities between the two countries make the differences that do exist (such as effective contraceptive use), more notable.

Comparative Cross-National Research

In British social science research in general there has been a large increase in comparative research in recent years, especially within a British / USA and European context. The realisation that "comparisons can lead to fresh and exciting insights and a deeper understanding of issues that are of central concern in different countries" (Hantrais & Mangen 1996:3) has led comparative research into an era of significant importance and recognition.

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Despite this growing enthusiasm for comparative research, it appears that there is little consensus on many aspects of this type of research. What it should be called is an important starting point. Many names are given to this style of research: comparative, cross-national, cross-cultural, cross-societal, trans-national are to name but a few. Confusion arises when authors use these names synonymously or fail to identify why they place their research under one specific title. As a result "the vocabulary for distinguishing between the different kinds of comparative research is redundant and not very precise" (Øyen 1990:7).

Hantrais and Mangen provide the following definition whereby "a study can be said to be cross-national and comparative if one or more units in two or more societies, cultures or countries are compared in respect of the same concepts and concerning the systematic analysis of phenomena, usually with the intention of explaining them and generalising from them" (Hantrais and Mangen 1996:1). This is a very broad definition and incorporates almost all comparative research.

I prefer to define cross-national research as that which does in fact cross two or more national boundaries, as many different societies and cultures can exist within one country. I would also refer to my own work as cross-national because I see the nation as the context of my study. This research deals with government, local government, laws, policy and legally regulated institutions and therefore the nation-state is an important context (Kohn 1996: Clasen 1999). I will therefore throughout this thesis presuppose the most common sense interpretations of the words 'comparative' – to compare and 'cross-national' – across (in this case) two national boundaries.

Comparative Cross-National Social Policy

Although comparative research of all kinds has been gaining in recognition for some time, the emphasis of study has changed in recent years. Over the last twenty years there has been a shift from large scale survey research with an emphasis on descriptive, culture-free approaches (Hantrais 1999), to a new style of smaller-scale, qualitative research, more reliant on cultural sensitivity which aims subtly to draw on similarities and differences in a wide range of areas within social policy (Clasen 1999:2). Rather than examining large-scale social policy programmes across a variety of countries searching for typologies and generalisability, such as the prominent work conducted by Esping-Andersen (1990), there has been a shift in emphasis to explore through qualitative research the development, effectiveness and changes in particular social policy programmes.

As Clasen has noted, this is not to say that both styles of research are not as equally important, but for the present time at least, "the shift in research interest from the general to the more specific, from the correlational to the case study approach, can be understood as a process of catching up" (Clasen 1999:3). This new qualitative, case-study, culturally sensitive approach has much to offer the development of social policy, both nationally and globally. As Øyen states "the need for more precise, reliable comparisons has become part of a political and economic reality which is a driving force behind the demands for more cross-national comparisons most of which apply to specific problems and are fairly limited in scope" (Øyen 1990:2).

The purpose of comparative cross-national social policy can be seen as two-fold. Not only is it in itself an approach of academic enquiry, but also a means to producing policy-advice and some would argue that it is best described as a combination of both (Antal et al. 1996). A central purpose of comparative cross-national social policy is to provide not only empirical knowledge in areas of both national and foreign social policy, but also to present policy makers with choices; to provide alternative pictures of and policy solutions to issues common to many nations and also hopefully, to prevent policy makers from repeating previous mistakes and developing ineffective strategies. "In short, it can help policy makers decide what not to do as well as what to do" (Madison 1980:12).

Questions have however been raised as to how effective policies which have been devised in one national context can be 'borrowed' and applied elsewhere (Antal et al. 1996; Hantrais & Mangen 1996). One particular school of thought goes as far as to state that due to the fact that every cultural setting and context is unique, it is impossible to apply policy lessons that have been learnt outside one's own cultural context (Antal et al. 1996). Although I recognise and would argue that this is one of the central issues for consideration in comparative cross-national policy research, I do not perceive that there are no lessons to be learned from the ways in which others have dealt with common policy issues. There is, however, a need for an acute awareness of the cultural context within which the policies being explored and examined have been developed and the degree to which that culture plays in the effectiveness of certain policy solutions.

One particularly important aspect of this cultural context that researchers must immediately become aware of is that of norms and values. A policy "is a conscious contrivance, reflecting human purposiveness, and in some sense a moral act" and therefore it goes without saying that there will be "a normative element at the heart of any effort to develop some systematic, comprehensive study of public policy" (Anderson 1978:20). How to deal with this normative element is at least one area where there appears to be a large degree of agreement. It appears that in order to "unravel the subtle interactions between political culture and public policy predispositions" (Heidenheimer et al 1983:5), one must consider any normative assumptions to be key variables when undertaking the analysis of comparative policy (Antal et al. 1996).

The extent to which policies can be applied outwith the context from which they were derived will vary from policy to policy and country to country. Even where it becomes explicitly obvious that one policy cannot be 'borrowed' due to reasons of applicability, feasibility or because that policy solution does not conform to the normative values of a nation, comparative cross-national social policy still offers choice. As stated by Antal et al. "Choice between different policy objectives and different policy instruments, choice between maintaining the status quo and innovation or reform, choice between public and private responsibilities, and choice between different patterns and beneficiaries for the distribution of public resources. Indeed it is difficult to conceive of policy without invoking the notion of choice" (Antal et al. 1996:13).

Therefore even if the findings of this research do not appeal to officials at the Scottish Executive, local authorities or at the school level, on the grounds of non-conformity to normative values, they will at least present a choice, both in policy options and possible future directions in policy.

'Real' comparative research?

"Thinking without comparison is unthinkable. And, in the absence of comparison, so is all scientific thought and scientific research" (Swanson 1971:145). This quote relates appropriately to the constant debate present in many texts on comparative research as to whether or not research cross-nationally is methodologically any different from other comparative research. Virtually all social research involves comparison at some level or another (Ragin 1996) and therefore it appears appropriate to argue that there should be no great difference in methodology between different styles of research. Hantrais & Mangen appear to support that opinion by stating that cross-national research can be "descriptive, evaluative and/ or analytical and is therefore subject to many of the same problems" [as other kinds of research] (1996:4).

The situation however is not that simplistic and as Øyen concluded, there is little consensus on this matter (1990). Øyen herself has attempted to classify four different types of researcher by their beliefs on this subject under the headings of Purists, Ignorants, Totalists and Comparativists (1990:5). In summary she sees Purists as those who see absolutely no difference between sociological research in general and cross-national research, but who are aware of the methodological issues raised by conducting multi-level research. Ignorants, however, will conduct

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ignored issue of possible interview bias incurred as a result of using interpreters in foreign research[1], are specific to cross-national research.

Comparative Cross-National Qualitative Research

The shift in methods used in cross-national, comparative research already discussed, from large-scale survey research to smaller-scale case study research, reflects a more general shift in the direction of more qualitative styles of research that have been occurring within sociological and social policy research over the last twenty years. The desire to unravel the secrets of how private lives are affected by public issues has been at the core of this methodological shift. The use of qualitative methods in cross-national, comparative research however, are still very much in their infancy (Ungerson 1996).

As a result very little is written about how to approach cross-national research using qualitative methods. There are few guidelines available to the inexperienced or the experienced researcher and the reality of pursuing the use of qualitative methods in this field is very much a 'learn as you go along' process.

The decision to use qualitative methods to obtain the data for this research was taken because I wanted to examine policies that affected teenage pregnancy rates both at a documentary and practical level. A crucial element of effective workable policy is whether policy developed at government level reaches the stage of implementation at the local level. Therefore to compare only policies at one level

[1] This issue will be discussed at length at a later stage in this chapter.

for similarities and differences would not have provided the whole picture and would result in an inaccurate analysis of the situation.

I perceived that a valuable approach that would enable the study of each nation's policies for similarities and differences as well as to view the policies within each respective country from government down to school level, would be to interview those who were responsible for the development and implementation of those policies. By conducting semi-structured interviews with relevant informants from government, local authorities/ municipalities and schools, I aimed to obtain both 'content' information on the policy areas of interest, as well as reflective responses regarding the value, effectiveness and implementation of those policies. This was something I felt could only be achieved by qualitative means.

The Organisation of Cross-National Research

"It can be assumed that much research, comparative or otherwise, is guided by the principles of least resistance or invitation by opportunity. One of the central research strategies, although not much discussed, seems to be the preference given to available data and methodological tools, and the leaning towards accessible data works and easy funding" (Øyen 1990:15). This statement holds a large degree of truth. As with other aspects of methodology presented in this chapter, this is an area not often discussed and hence the following part of this chapter presents an organisational picture of my research process.

In organising a comparative cross-national research project involving two or more countries a researcher has many issues to consider, such as those of time constraint,

monetary resources, access to comparable data and collaborative relationships including both informal and formal networks (Øyen 1990). The decision on which countries to include in a piece of research is the first logical step in the organisation of a piece of comparative cross-national research. As I have already stated however, my position in the process was a reverse approach. Usually "appropriateness, research feasibility, availability of collaborators and funding are key concerns" (Kohn 1996:45), and just because my countries came before the research design made these issues of no less concern. In some senses having the countries before the design enabled me to tailor the appropriateness, feasibility, funding and contacts to a greater degree of satisfaction than perhaps would have been possible if the situation had been reversed.

The establishment of workable collaborative relationships prior to the research and sustaining those relationships during the research is another problematic area of cross-national research (Hill 1962; Sarapata 1985). Again, luck on my part played a central role to the success of the establishment and development of such relationships.

Despite the large degree of help provided by my contacts and having the basic funding to do comparative work, the combination of both was not nearly sufficient to adequately fund this research. As I was later to find to my cost, the amount of funds required to conduct comparative cross-national research is very much understated. My largest financial mistake was to underestimate the cost of the translation of my Finnish data. The Finnish language not being a mainstream European language cost on average three times the amount that French or German

would have cost to translate. As a result the process of analysing my data was seriously delayed while I attempted to raise the funds to have my data translated, funds that were not forthcoming from the ESRC[1] or my University.

Access

Access to the data is a key area of concern for any researcher. Without achieving relevant access, many projects simply would not proceed. During my access negotiations I was presented with both an expected experience in Scotland, and a pleasant surprise in Finland.

In Scotland I had not anticipated the access process to be impossible, but I had expected it to be a lengthy one. This anticipation arose from what colleagues had stated about difficulties they had had in achieving access to institutions such as schools in Britain. Gaining access to a Scottish Office official was the easiest and least time-consuming of all access negotiations in Scotland. The process took a matter of days from an initial letter to the Scottish Office Department of Education (SOED) and a reply with the name of an individual within the SOED who was happy to be interviewed by me.

The local authorities and their Directors of Education were also, on the whole, helpful from the beginning. First in allowing me to approach the schools in their area, second, by providing me with all their written policy regarding the areas under study and third by offering individuals for interviews (gaining access to

[1] Whilst I am very grateful to the ESRC for my studentship, it is somewhat ironic that the encouragement by the ESRC for students to undertake comparative research is not met with 'realistic' funds to satisfactorily complete such work.

officials in the local authorities took only one month). Some Directors of Education however, were initially a little too helpful, in that they 'suggested' the school/s that I contact. I say 'suggested' in that way because they implied that these were the only schools they would like me to write to and two authorities actually stated that one particular school was the only one I could contact.

After further investigation of these particular schools, I found out that they were all in some way 'special'. Either they had just become involved a big inter-agency collaboration project, or they were the one school in the area who was working closely with the local authority to develop a new programme of sex education. Although it was interesting to examine what improvements local authorities were trying to make and to find out about new projects, which I have done through the local authority interviews, I decided not to pursue access to these particular schools, as I wanted to examine a more 'typical' rather than 'special' school.

Gaining access to schools was the most time-consuming process, taking seven months in total. In the first instance I had to apply in writing to each local authority and ask the Director of Education for permission to approach schools to take part. In total this process took 2 months. After acquiring this permission, I then began writing to schools inviting them to take part[1]. Of the first thirty schools I wrote to, one indicated potential interest, eight replied to say that they are too busy at present and the other twenty-one did not reply. A further fifty schools were written to after I had begun my fieldwork in Finland, which covered every remaining school in all

[1] An example of this letter can be seen in Appendix iv.

three of the chosen local authorities. At this point I had to face the fact that if none of those schools replied positively then I would have to consider changing the local authorities and starting the whole process again from the beginning.

On my return from the fieldwork in Finland, I arrived to approximately a 70% response rate from the second round of applications to schools. The reason for the noted difference in response both positive and negative raised an interesting issue. I will never know why the difference in response was so dramatic, however I would speculate strongly over whether the fact that letters were sent on headed paper from a Finnish university may have helped in some way. Even although I clearly stated that I was studying at Stirling University but just happened to be researching in Finland at the time I was writing to them, it might have been perceived that I was in fact Finnish. This might perhaps therefore have fostered a feeling of obligation to provide the time for my research or to explain why they couldn't take part (but in many cases were still interested to be informed of my findings).

Of the replies that I received, almost half were inviting me to use their school in my research. After such disappointment in the early stages of attempting to obtain permission from schools, I was quite astounded by this very positive response and felt guilty having to turn so many schools down. Their letters on the whole had not simply been 'yes you can come here', but that 'we would be delighted to take part in this very worthwhile research etc.', which was very encouraging.

Compared to the process of access in Scotland, the Finnish process was a very pleasant surprise. I had anticipated difficulties in Scotland because in a sense I was

'in the know' about what to expect. On the other hand I was anticipating difficulties in Finland because I was not 'in the know' with regard to correct procedure, past experiences of other researchers and due to the obvious language barrier.

During my initial visit to Finland I became acquainted with Matti Rimpelä and Arja Liinamo, both researchers at the School of Public Health in Tampere. Part of an on-going project that they have been involved with for a number of years is the National School Health Study, a quantitative study involving a large number of schools in Finland. As a result of the contacts they already had, they offered to aid me in my access process.

The end result being that all I had to do was provide Arja with the letter I sent to Scottish schools regarding access. Arja then tailored this letter to be sent to the Finnish schools, translated the letter and then the rest of the access process was completed on my behalf. In approximately one month Arja had obtained access for me to conduct interviews in four schools, three municipalities and the Government Agency, the National Board of Education (NBE).

Research Settings and Sample

The primary data collection was conducted between March and May 1998 in Finland and between June and August 1998 in Scotland. It had been my initial intention to conduct the fieldwork in Scotland prior to my work in Finland. It became apparent however in the early stages of the access process to schools in Scotland, that this process was going to take considerably more time than I had

previously anticipated. Therefore the decision was taken to undertake the fieldwork in Finland first. In hindsight, this was a useful approach, as it helped me to view Scotland almost from an outsider's stance, having been sensitised to the Finnish system for the three months prior to my Scottish fieldwork.

During the three months I spent undertaking fieldwork in each country, I conducted research in a number of settings. In each country I gained access to four schools, one in each of three different municipalities in Finland and local authorities in Scotland and one pilot school in both countries[1].

Due to the fact that the local authorities and schools chosen in Scotland and Finland were not intended to be, nor could they be, representative of their country as a whole, in deciding on which geographical areas to focus on and which schools within those areas to approach, each municipality/ local authority and school was chosen purely on the basis that they were significantly different from each other. For example for the three local authorities in Scotland, one was an urban city-orientated local authority, one had an urban/rural mix, i.e. pockets of urban towns (one city) and villages set in a rural area and the third was a local authority with a large geographical span that incorporated a large urban city, a number of towns and a vast number of small villages.

[1] **Scotland**	**Local authority**	**School**	**Pilot school**
	Glendale	Glendale Academy	Lochend Secondary
	Arbourness	Arbourness Secondary	
	Scotallen	Scotallen Secondary	
Finland	**Municipality**	**School**	**Pilot school**
	Tehtaala	Tehtaala Peruskoulu	Koskela Peruskoulu
	Vaarama	Vaarama Peruskoulu	
	Alajoki	Alajoki Peruskoulu	

I did, however, wish to have a level of consistency between the areas and schools chosen in both countries, in a sense matching the areas by geographical type (urban/rural) and approximate size and the schools by size, location within their local authority/ municipality and similar catchment size areas.

Therefore, to ensure that the areas and schools chosen in Finland would be similar to those in Scotland, I undertook many discussions with Arja, to ensure that there was consistency between the two samples. The main difficulty in this matching process arose from the difficulty I had already encountered in accessing schools in Scotland, which meant that my fieldwork would begin in Finland rather than Scotland. Therefore, whilst I was able match the local authority areas with municipalities in Finland in advance, I had no schools to match. Therefore, I was once again faced with a reverse approach in my methods, whereby I had to decide on my Finnish school sample based on my likely school sample for Scotland.

Due to Arja's involvement in the School Health Study in Finland, however, she was able to provide detailed information about the areas and schools in which I may wish to conduct my exploration. The information on the schools was particularly important in that it enabled my desire to pick 'typical' schools in Scotland to be matched by similarly 'typical' schools in Finland.

Following these discussions with Arja the decision was taken to chose schools that varied in size[1], location within their municipality/ local authority and catchment population. As such of the schools in Finland, the pilot school, *Koskela Peruskoulu,* is an averaged sized urban-school with 400 pupils and 39 fulltime teachers, situated on the outskirts of the City of *Tehtaala*, within the municipality of *Tehtaala*. The intake for this school was from the local surrounding area lower comprehensives, few pupils came from out with the school catchment zone. *Tehtaala Peruskoulu* is an average sized school with 377 pupils and 30 fulltime, located in the centre of the City of *Tehtaala*. In addition to being a regular upper comprehensive school, this school was a language specialist school, which attracted pupils from all over the municipality and a small number from other municipalities. Therefore this school had a wide catchment area, 60% from within the school catchment zone of lower comprehensives, 40% out with the zone.

Vaarama Peruskoulu is an average sized school with 381 pupils and 36 teachers, located in the centre of the *Town of Vaarama*. The intake of pupils at this school came mainly from the local area lower comprehensives, few pupils came from out with the school catchment zone. Lastly, *Alajoki Peruskoulu* is below average-sized school with 308 pupils and 23 teachers, located in the centre of the *Town of Alajoki*. Being located in a relatively rural town, the intake of pupils at this school came mainly from the local area lower comprehensives, few pupils came from out with the school catchment zone.

[1] The size of schools in Finland did not vary very much regardless of geographical location in contrast to what was found to be the case in Scotland, an average school size in Finland would be classed as having 400 or more pupils, where as in Scotland schools would vary from under 100 to over 1000.

On my return to Scotland I then used the profiles of these schools to choose from the selection of Scottish schools that had agreed to take part in the research. Although it had become apparent that I would not be able to match the schools by school population size because the size of schools in Finland did not vary greatly, I did look for the mix of town/city location and variety in catchment size. As such, Scotallen Secondary School is a large mixed-ethnic comprehensive with 1226 pupils and 120 staff. The school is located towards the south of the City of Scotallen, near to the geographical boundary of Scotallen local authority. This school has five associated primaries, however, the school also receives a number of pupils (on average 80 per academic year) from other primaries on placement requests. This is due to the location of this school on the boundary of the local authority and also due to a large number of secondary school closures in this local authority.

Arbourness High School is the only local authority school in the town within which it is located (there is also one independent school). The school has 575 pupils and 48 members of teaching staff. The school being the only one in the town, has a catchment area of the whole town and surrounding local villages.

Lochend Secondary School was the pilot school for the Scottish schools and is a relatively small school with 130 pupils (to rise to 155 in 2001) and 19 members of teaching staff. Many teachers double or treble up on subjects to offer an almost fully comprehensive range of subjects at all levels of examination. The school is located in a small-industrialised village within the local authority of Glendale and

its intake comes from a rural catchment area. The school has four associated primaries from four local villages, including the one in which the school is located.

Finally, Glendale Academy is situated in the centre of a large city surrounded by a rural area in the local authority of Glendale. It has 1050 pupils and 80 (76 fulltime) members of teaching staff and is one of the largest schools in the local authority of Glendale. The intake of pupils in this school comes mostly from its six associated primaries, although a small number come from surrounding rural areas.

At the outset of the access process two of the three local authorities in Scotland requested confirmation that the area and school chosen for study in their area would remain confidential. Therefore all the names of the places and people (except my Finnish colleagues) have been changed to protect identity. In order to maintain this protection of identity, Appendix ii provides a flavour of each area rather than specific ingredients by which it would enable a reader to identify them.

At the level of government in both countries the individual interviewed was an Inspector of Education, with a particular remit for sex education (Scotland) and Health Education (Finland). Similarly at the level of local authority and municipality, the individual interviewed was an education official with a particular remit for sex education (Scotland) and Health and Family Education (Finland).

At the school level, in my initial letter to schools I asked specifically to interview the head teacher, the teacher/s of careers guidance (or equivalent), teacher/s of biology and as many teachers as it was possible, who were involved with the

development of and/ or teaching of sex education in that school. Figures 3.2 and 3.3 below outlines the subjects who were interviewed in each country and the names by which they will be referred to throughout this thesis.

Figure 3.2 Interviewees in Scotland

Scottish Office Education Department (SOED)
Inspector for education with an additional remit for sex education.
Reference name in thesis: **SOED official.**

Local authority
Local authority education official with an additional remit for sex/ health education.
Reference name in thesis: **(name of local authority) official.**

School level

Lochend Secondary School
Reference name in thesis:
Head teacher - male (1)
Biology teacher - male (1)
Careers Guidance teacher – male (1)
PSE teacher (including sex education) - male (1)

Glendale Academy
Reference name in thesis:
Head teacher - male (1)
Biology teachers - male (2)
Careers Guidance teacher – female (1)
PSE teacher (including sex education) - male (1), female (1)

Scotallen Secondary School
Reference name in thesis:
Head teacher - male (1)
Biology teacher - male (1)
Careers Guidance teacher –female (1)
Health education teacher (including sex education): female (1)

Arbourness high School
Reference name in thesis:
Head teacher - male (1)
Biology teachers - male (2)
Careers Guidance teachers – female (2)
PSE teacher (including sex education) - female (2)

Figure 3.3 Interviewees in Finland

	Finnish name
National Board of Education (NBE)	*Kouluhakitus*
Inspector for Education with an additional remit for Health Education.	*Koulutarkastaja*
Reference name in thesis: NBE official.	
Interview language : English, no interpreter.	
Municipality level	
Municipal officer for education	
Reference name in thesis:	
Tehtaala official: interview language, majority English – interpreter used.	
Vaarama official: interview language, majority English – interpreter used.	
Alajoki official: interview language, half English, half Finnish – interpreter used.	
School level	**Finnish name**
Koskela Peruskoulu	
Head teacher (1) - female	*koulunjohtaja*
Interview language, majority Finnish – interpreter used.	
Physical education teacher (1) - male	*liikunnanopettaja*
Interview language, all Finnish – interpreter used.	
Home economics teacher (1) - female	*kotitalousopettaja*
Interview language, majority Finnish – interpreter used.	
School nurse (1)- female	*kouluterveydenhoitaja*
Interview language, majority Finnish – interpreter used.	
Student counsellor (1) - female	*opinto-ohjaaja*
Interview language, half Finnish, half English – interpreter used.	
Biology teacher (2) – I male 1 female	*biologianopettaja*
Interview language, half Finnish, half English – interpreter used.	
Tehtaala Peruskoulu	
Head teacher (1)- female	*koulunjohtaja*
Interview language, majority English – interpreter used.	
Physical education teacher (2) : 1 male, 1 female	*liikunnanopettaja*
Interview language, majority English – interpreter used.	
Home economics teacher (1) - female	*kotitalousopettaja*
Interview language, majority English – interpreter used.	
School nurse (1)- female	*kouluterveydenhoitaja*
Interview language, majority Finnish – interpreter used.	
Student counsellor (1) - male	*opinto-ohjaaja*
Interview language, majority Finnish – interpreter used.	
Biology teacher (2) – 1 male 1 female	*biologianopettaja*
Interview language, majority English – interpreter used.	

Continued below...

Figure 3.3 continued.

School level	Finnish name
Vaarama Peruskoulu	
Head teacher (1)- male Interview language, majority English – interpreter used.	*koulunjohtaja*
Physical education teacher (2) : 1 male, 1 female Interview language, majority English – interpreter used.	*liikunnanopettaja*
Home economics teacher (1) - female Interview language, majority English – interpreter used.	*kotitalousopettaja*
School nurse (1)- female Interview language, majority Finnish – interpreter used.	*kouluterveydenhoitaja*
Student counsellor (1) - male Interview language, majority Finnish – interpreter used.	*opinto-ohjaaja*
Biology teacher (1) –1 male Interview language, majority English – interpreter used.	*biologianopettaja*
Alajoki Peruskoulu	
Head teacher (1)- male Interview language, majority Finnish – interpreter used.	*koulunjohtaja*
Physical education teacher (2) : 1 male, 1 female Interview language, majority English – interpreter used.	*liikunnanopettaja*
Home economics teacher (1) - female Interview language, majority Finnish – interpreter used.	*kotitalousopettaja*
School nurse (1)- female Interview language, majority Finnish – interpreter used.	*kouluterveydenhoitaja*
Student counsellor (1) - male Interview language, majority Finnish – interpreter used.	*opinto-ohjaaja*
Biology teacher (2) –1 male, 1 female Interview language, majority English – interpreter used.	*biologianopettaja*
English teacher – (taught option on *dating dynamics)* (1) - male Interview language, majority English – interpreter used.	*englanninopettaja*

Data Collection

During the three months spent researching in each country, the end result of my fieldwork was a selection of varied data consisting of policy documentation, national guidelines and curriculums and tape recorded semi-structured interviews with relevant individuals at the level of government, local authority and school, as described in the previous section.

During the interviews I collected systematic data on the content, aims, and objectives of existing policies, indications of changes in policy direction and reflective data on the effectiveness and practical use of those policies. Details of the subject areas and semi-structure of the interviews conducted (at each policy level) can be found in Appendix iii.

In Scotland the interviews (conducted in English) lasted between 20 and 45 minutes and all were tape recorded and later transcribed. In Finland the interviews also lasted between 20-45 minutes and were conducted in different languages depending on the language ability of the interviewee (the language used is detailed in Figure 3.3 above). In a minority of cases interviews were conducted completely in English, others were conducted half in English, half in Finnish and the remaining interviews were conducted almost entirely in either Finnish or English.

In order to ease the reading of this thesis the names referred to for the Finnish teachers will be their English equivalent. All texts that are highlighted in italics throughout the remainder of this thesis are Finnish names.

All of the interviews in Finland (except the NBE official interview) were conducted with the help of an interpreter. This process posed a number of methodological issues and as it is not often raised in relation to cross-national research, it is one of the areas I would place on my list of 'things learnt as I went along'. The following section of the chapter therefore, is devoted to discussing this experience and in doing so, I hope to add to the very small knowledge base on this subject.

The interpreter effect

Within social science literature the issue of 'language' is often raised as a methodological issue in relation to cross-national, comparative research. In most cases the reference to, or discussion of, language is made in relation to the equivalence or consistency of meaning with regard to particular concepts, most often within large-scale quantitative studies (e.g. Bulmer and Warwick 1983; Iyengar 1983).

Within other social science literature, interview bias has been discussed in some depth in relation to the effect of the race, gender and socio-economic class of the interviewer (e.g. Rhodes 1994; Schaeffer 1980; Spender 1980; Cornwell 1984). With the exception of Jentsch's work (1998), however, relatively little if anything has been written about the issue of using an interpreter in an interview situation where the interviewer herself is a cultural and linguistic stranger to the community under study.

Obeyesekere (1981) stated that "'Interpreter effect' is one of those problems swept under the carpet, when it is obvious that it is a crucial technical issue in anthropological fieldwork. I have yet to come across one sensitive, self-critical appraisal of interpreter effect by a social scientist" (1981:11). Jentsch's work (1998) is, I believe, the first that attempts to produce such an adequate appraisal. Reflecting on her use of interpreters in conducting a study of labour and management representatives in Budapest, Jentsch raised a number of issues which I will go on to discuss in relation to my own experiences.

Jentsch began by reflecting on the interview as a social process whereby the interviewer is attempting to secure a 'print' copy of the interviewee's knowledge, ideas and opinions on a particular area of interest. She argues that because the interview itself is a social interaction there will undoubtedly therefore be a risk of bias, whereby the background characteristics and the way in which the interviewer presents herself, will possibly have an effect on the interviewee and vice versa (Jentsch 1998:277).

In considering in what way these characteristics or behaviours may affect the interview process she refers to the work of Kaln & Cannell (1983) who devised a model of possible contributory factors to bias within data collection in an interview situation. The three main factors identified by Kaln & Cannell (1983) were background characteristics, psychological factors and behavioural factors. Jentsch (1998) using this model as a starting point develops it to incorporate the possible additional biases introduced into the interview situation by the interaction of a third person, the interpreter.

The main additional sources of bias that she considers are first background aspects, namely, whether the interpreter is lay or professional, the type of relationship that exists between the interpreter and the interviewee and the familiarity the interpreter has with the interviewer's research goals (Jentsch 1998:278). Second she adds to the behavioural factors outlined by Kaln & Cannell (1983) by including the effect of the interpreter not fully understanding the topic being researched and hence requiring throughout the interview to ask for clarification from both the interviewee and interviewer, and also the possible errors in translation, omissions, additions, substitutions and condensations (Jentsch 1998:279).

Before considering how these 'biases' could be said to have affected my own research, I wish to first discuss the seemingly clear-cut proposition Jentsch makes (1998) that there are four choices to be made when conducting research within a foreign country. The four broad choices being:

1) The interview is conducted in the interviewee's native language, as the interviewer is fluent in that language,

2) The interview is conducted in the interviewer's native language, as the interviewee is fluent in that language,

3) The interview is conducted in a language which is neither the native language of either participant but of which both are adequately fluent, or lastly,

4) The interview is conducted with the use of an interpreter.

(Jentsch 1998:277)

Although these may appear to be appropriate choices for conducting research in a foreign country, it was my finding that things were not as explicitly straightforward as these choices suggested. It was my experience that a combination of the first, second and last options were utilised. It had been suggested by my contacts at the School of Public Health in Tampere, that most of the respondents that I would be interviewing would have an adequate grasp of the English language to enable me to conduct most of my interviews in English. As a backup Arja Liinamo, a social science researcher connected to School of Public Health at Tampere University, herself interested in my area of work for future personal doctoral research, offered her services as an interpreter if and when it was necessary. Arja accompanied me to all interviewers except the final interview with the NBE official. Far from playing a minor role, Arja was in fact instrumental in the collection of the majority of my primary data.

Although many of my respondents did in fact speak some English, for the most part, their grasp of the language was conversational rather than terminologically specific to my research interest and therefore only a small number of interviews were conducted in English alone. For those respondents who had a relatively good grasp of the topic specific language being used, most expressed a desire to respond as far as possible, in English and used Arja for the most part, as a 'human dictionary' in order to clarify the meaning of terms being used or when they could not themselves think of the correct word in English that they wished to use. Lastly, for those respondents who did not feel competent enough to respond in English, Arja took on the main role within the interview process whilst I merely posed the questions in English before Arja translated them.

During these interviews, in an attempt to keep some level of 'rapport' between Arja and the respondent, Arja did not provide me with a literal translation of what was being said. Instead she provided a 'gloss' review, stating the main points of what was being said in order that I might adapt the semi-structured interview if I believed it to be relevant. In addition, due to the fact that my interpreter was knowledgeable in the subject under study, I felt confident and trusted in her ability to probe the respondents and pursue a line of questioning that I would have done, if I myself had not been linguistically challenged (this being an area of potential bias, I will return to it later).

Returning to the potential bias incurred as a result of using an interpreter, I will now consider the possible effect of my interpreter's characteristics. Arja, in her mid-late 30s, dressed smart but casual, with a similar educational background and research interests as myself, did not present a particularly different picture from myself, with the possible exception of age and the obvious exception of nationality.

As Jentsch (1998) suggested, I too found that Arja and I were perceived and I felt myself from the very first interview, to be part of a 'team'. Being perceived as a team by our respondents, most likely arose from the fact that we were always together, we arrived and left together and we would have most likely appeared to others to be good friends.

From my own perspective, I felt part of a team most probably because Arja had been involved in my research project for a number of months prior to the

commencement of my fieldwork in Finland. We had both made a week long visit to each other's countries and had had many discussions about the aims and objectives of my research as well as many discussions about the subject area, as it was of particular research interest to Arja as well. These discussions continued throughout the time I spent in Finland conducting my research, most often fuelled by interesting issues that had arisen from the interviews. Additionally as referred to in relation to the access process Arja played an instrumental role in my access to schools, municipalities and the NBE and was involved in all interviews except for the final interview, with the NBE official.

As a lay interpreter, Arja did not fit many of the traditional 'negative stereotypes' presented by Jentsch (1998), which may have reduced or perhaps prevented a number of areas of bias that are talked about in relation to the lay interpreter. First, a lay interpreter's job is often regarded as 'bothersome' by that individual, mainly due to the fact that it is not part of their usual job description and they have as a result other things to be getting on with. With regard to my situation, Arja volunteered to help me with my data collection. This was largely due to the fact that she herself had a research interest in this area and a desire to pursue more qualitative work in preparation for undertaking her own doctoral thesis (as opposed to the quantitative nature of the study she was at the time involved). In order that I did not encroach on her busy schedule, I provided Arja with eight weeks in which it would be possible for me to conduct this research. In doing this, Arja was free to organise the interviews at times which would suit her schedule.

Another unfavourable dynamic often related to the lay interpreter is the possibility of distortions in the data stemming from their attitude towards myself as the interviewer or towards the interviewees. As already discussed, Arja and I had developed a good working as well as social relationship, so I did not perceive the former of these dynamics to be an issue. With regard to the interviewees, a common observation of the interpreter/ interviewee relationship is that when the interpreter is familiar with the interviewee's situation they are sometimes prone to responding on their behalf, often without the interpreter even posing the question (Jentsch 1998:283). Although at the time I could not be sure whether or not this was occurring, the direct transcripts and translations do show that this was not the case. I make an assumption here that this was most likely because Arja, although previously a school nurse herself (one of the individuals that we were interviewing), was as interested in what they actually had to say as I was for the purpose of my research.

Another important issue that must be examined here is the transference and counter-transference of speech. Kline et al. (1980) talk of the reduced role of the interviewer in situations where an interpreter is being used. The problem here for the interviewer is that without an understanding of what is being said at the time it occurs, it is very difficult to remember reflections of body language that relate to that speech. The reality of this situation then is that, without an awareness of where emphasis is being placed by the interviewee, the interviewer may fail to pursue certain issues or themes that would have been of interest to the research.

In order to overcome this as much as it was possible, Arja did two things. First, she added any emphasis being expressed by the interviewee when doing her 'gloss' translations, in order that I would have some idea of the importance being placed on the response by the interviewee. Second, due to Arja's understanding of the research topic, she herself was able to recognise issues and themes of importance to me and pursued them herself without my direction. The effectiveness of her ability here was shown a number of times when I would ask her to pursue a point and she had already done so.

The following section of text below illustrates this point, when I posed the question of whether the teacher believed the school should play an important role in the teaching of sex education, the teacher answered that she personally believed it was important. I, however, wanted to know if she believed the school as a whole saw this to be the case and on posing this question for Arja to ask, she noted that she had already asked the question and provided a gloss translation of that answer. To ease reading of this text, the questions are in bold, in italics are the discussions that were in Finnish and later translated, and in regular text, the discussions that were in English.

Alison: Do you think the school should play an important role in the teaching of sex education?

Teacher: "Yes I think that it is important, but I think that young peoples must self to take information".

Teacher: I mean, adolescents should be able to seek information from other sources as well and not to think that they will get all the information they need in school. It's an important theme in school, absolutely.

Arja: Does this school see itself as playing an important role in the teaching of sex education, in your opinion?

Teacher: I don't think that it is emphasised enough. For example, the timing of the teaching, when we start teaching them sex education...it should begin earlier than in the 9th grade. Then it's more like revision. And I teach only the 9th grade. That is, other teachers bear responsibility for sex education, biology teachers, PE teachers and the school nurse in the 7th and 8th grade.

Alison: She sees it as important, but does she think the school perceives its role to be important?

Arja – Yes I have asked this... She sees that perhaps school should show its role even more important than at the moment and but she says, thinks the school sees its role as very important and it is too late to give information on the 9th grade and but also pupils have to be able to find information from other sources also.

Returning to the issue of developing 'rapport', this can be a further source of potential bias. The first possible complication could arise if such a good rapport is developed between the interpreter and the interviewee that there is no space for translation. This was overcome to some extent by the use of Arja's 'gloss' as opposed to literal translations. Although not intended for this purpose, as the interviews proceeded I became very aware that the development of rapport between Arja and the interviewee was important and because of the trust I had in her ability to probe and develop relevant lines of enquiry, I had no concern in those interviews for her to play the more central role.

Another common concern when rapport has been developed between the interpreter and the interviewee is that the interpreter is often tempted to pose

his/her own questions. In this case however, I did not perceive this to be problematic, quite the opposite. Due to the interviews being semi-structured, there was room for both Arja and myself, depending on which language was being used, to develop relevant lines of enquiry. So you could say that posing her own questions (within the subject areas) was exactly what I was hoping Arja would do. If you were to interpret 'asking her own questions', as asking irrelevant ones then that would be an issue. We had, however, spent a long time prior to the interviews and after many of them discussing which additional questions would be of use and again because of my trust in Arja's ability, the issue of irrelevancy in her probing a particular line of enquiry, did not arise.

Some final areas of potential bias presented by Jentsch (1998) are those of the interpreter's knowledge and confidence in the research area and language ability. Arja's social science academic background and personal interest in research on young people's sexual health and sex education, however, meant that she had considerable knowledge and confidence in this area. With regard to language ability, Arja had a very competent grasp of English and her topic specific language was excellent. As has already been discussed, Arja did not attempt to provide me with a literal translation during the interviews, as 'rapport' was considered of more importance and with the interviews all being tape-recorded and later transcribed and translated, I had not considered that any possible lapses in her language ability would be an issue.

In her work Jentsch (1998) also talked of the pros and cons of using a professional interpreter, balancing the benefits of this method with that of using a lay

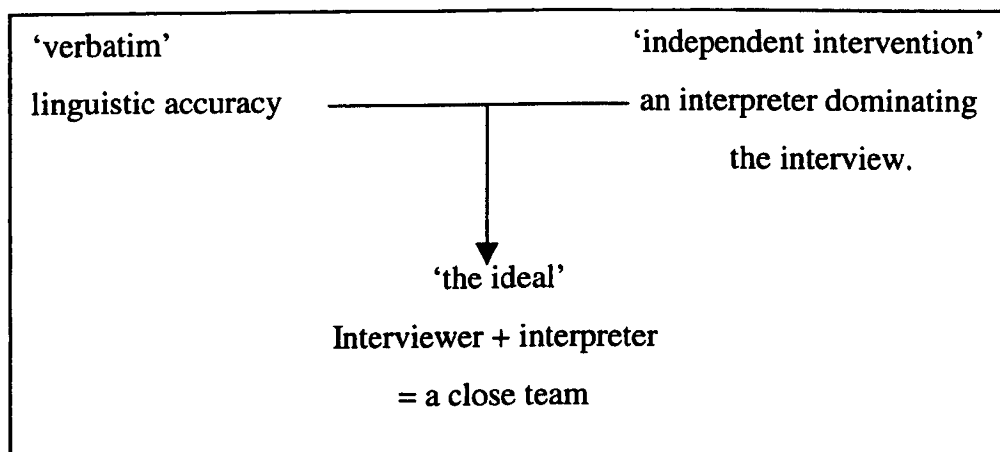
interpreter. In my situation, there was no question of employing a professional interpreter due to lack of financial resources. Through the School Health Study with which Arja was involved, I was provided with a full transcription, from the tape recording of each interview. These were, due to a lack of finance, professionally translated at a later date.

Notwithstanding the ability of a professional interpreter, I feel that the overwhelming positive aspects to my lay interpreter, resulted in better transcripts, in this case, than may well have been possible with a professional. A professional providing a literal translation on the spot would most likely in many cases have affected the rapport that both Arja and I developed with the respondents. A professional interpreter would also most probably not have had the 'insider' knowledge of the research area or understood the aims and objectives or exactly what it was that I was trying to achieve in my interviews, in the way that Arja did. Baker (1981) refers to the many different styles of interview using an interpreter and suggests that they can be placed on a continuum such as that displayed in Figure 3.1 below.

After this critique of the role that Arja played in my interview dynamics, I think it fair to say that we did in many ways produce 'the ideal' close team that Baker (1981) refers to. It is quite apparent that in my case luck played an essential role in the interview process. If I could have afforded a professional interpreter or had an interpreter been provided for me, as opposed to somebody volunteering through their own personal interest, things could have been very different.

Figure 3.1

Baker's styles of interviewing with an interpreter



(Baker 1981:392-3 in Jentsch 1998:284)

Analysis

The results of my fieldwork produced tape-recorded interviews with teachers, school nurses, local authority and municipality officials and government inspectors of education. In addition I had collected secondary statistics, a variety of documentary material including policy documentation, national guidelines and school curriculums, audit reports from local authorities, Green and White government papers, school course outlines, examples of pupil worksheets from schools, and notes from informal discussions with researchers in the field of teenage pregnancy in both countries. After arriving at this point the question still remained as to how I could analyse this material in a meaningful and methodical manner?

"The most serious and central difficulty in the use of qualitative data is that the methods of analysis are not well formulated. For quantitative data, there are clear conventions the researcher can use. But the analyst faced with a bank of qualitative

data has very few guidelines for protection against self-delusion, let alone the presentation of unreliable or invalid conclusions to scientific or policy-making audiences. How can we be sure that an "'earthy', 'undeniable', 'serendipitous' finding is not, in fact, *wrong*?" (Miles 1979:591).

Despite the growing trend of qualitative research over the last thirty years and the development of methods by which to analyse such data, the problem of the validity and confidence in findings achieved by qualitative means, has not disappeared (Miles & Huberman 1994). Many researchers have presented findings from which it is very difficult to trace back the methodological approach of their analysis, making it near to impossible to determine exactly how the final conclusions had been reached. Others have 'mystified' the whole process of qualitative analysis to the point whereby researchers, especially novices to qualitative research are left feeling very disillusioned as to how to begin and/ or complete the process of qualitative analysis. On entering libraries or bookshops one can encounter a number of texts purporting to demystify the process of qualitative analysis, but on reflection, the majority only serve to mystify it even further.

At the point at which I began deliberating as to how I would approach my data, I found myself falling very much the victim of this process of 'mystification'. Having finally gone through the process and come out somewhat unscathed at the other end, I can only hope, while acknowledging that the process was both elaborate (more so than it need have been) and personal, to do justice to explaining my process. Therefore in the following section I present some guidelines for

readers to enable a comprehensive understanding of how my results and conclusions have been reached.

I begin by acknowledging that the process of my analysis was impeded for one major reason besides my confusion surrounding the general approach. Financial constraints prevented my immediate access to the Finnish data, which resulted in the process of my comparative analysis being seriously delayed. The Finnish language is not a standard European language, as such, translation of the data cost just over £800. With all of my fieldwork costs for both countries occurring within the same financial year (£330 for Scotland) and only a sum of £440 provided annually for research costs by the ESRC, I therefore had to raise the majority of the funds to pay for the translation of my data.

The delay between the time I actually undertook the data collection in Finland and my first viewing of that data was seven months. Having the 'gloss' translations provided by my interpreter enabled me to at least begin thinking comparatively about my analysis. I did not feel comfortable however, deriving anything concrete until I had had the opportunity to view and review all of the data.

When I was in a position to analyse all of the data, the largest problem that I had to overcome was the 'fear' of qualitative analysis. I spent considerable unproductive time worrying about what I was doing instead of doing it. I had after all completed two dissertations at undergraduate and post-graduate level, both of which were qualitative in nature, a fact I had sub-consciously chosen to ignore. I therefore spent two months producing and reproducing what I thought was analysis, which

was in fact no more than reproduction and representation of the physical data. That process was, on reflection, the first stage of analysis, becoming immersed in and gaining a general feel for the data.

The second step was to acknowledge that in those reproductions my 'bias blinkers' had returned. Many researchers find that they harbour an element of personal bias with regard to their own country when conducting cross-national research. In my case at this point I realised that it was relevant to say that my bias was in relation to the other country in my research.

I have very firm views as to what I consider to be 'best practice' in approaching the negative aspects of teenage sexual health such as unintended teenage pregnancy. What I had witnessed in Finland was more along the lines of approach that I would pursue if I were in the position to influence policy decisions in Scotland. What I began to realise was that I had not addressed my biases at that point in the research process and those biases were affecting my attempts to analyse the data. This recognition was pointed out through supervision of my writings at that time. With this recognition came both desperation, wondering if I would ever be able to leave my preconceptions aside for long enough that they would not invade my analysis, but also relief in the recognition of another part of problem in doing the analysis.

The next stage of my analytical process was three-fold. The first part was to leave the data aside and try to write papers on what I considered to be the main themes of the research and to develop those themes before taking them back to the data. The second was to accept a teaching post on the advanced unit of qualitative methods at

my university. The unit involved guiding 3rd year students through the process of a small qualitative project. My reasoning for taking this post was that I had to understand qualitative analysis in order to teach it. This was an enlightening and invaluable experience and benefited my students as much as it did myself. The process of being able to help others to read between the lines of data and draw out themes from that data enabled me to return to my own data and repeat this process. Prior to this point in time I was so close to my own data I could not read between the lines. Having the opportunity to distance myself from my own work whilst learning the techniques I required to analyse it, took me a quantum leap in my analysis process.

The final stage therefore, was to return to my data with a mind freed to a certain degree of expectations and bias. I began to recognise that I had been thinking linearly and was not considering the different levels within my data. At this point I began to make use of matrices and thought-diagrams in an attempt to map out the territory of investigation and to separate out the different levels of data and finally, from those matrices, I was able to see a pattern and a story beginning to form.

A fundamental starting point in the analysis and presentation of that story, however, which then lead to the eventual structure of this thesis as it is currently presented, was the recognition not only of the different levels of data within my interview transcripts, but also the requirement of a wholly different level of analysis to reflect this. Presented within Chapters Four and Five of this thesis, are maps of the national and local policy frameworks which form the basis for the analysis of the key similarities and differences presented in Chapter Six. Within

these three chapters the interview data has been utilised primarily as a means of leading me to further sources of written documentation and for the clarification and the backing up other sources of information such as policy documentation at the national, local authority and school levels.

Due to the fact that there had been such significant changes within the various policy areas under study in both countries since the mid-1990s, I felt that it was crucial for the thesis to incorporate those changes and suggest potential outcomes arising from those changes based on the analysis of findings in Chapter Six. As such, the ways in which I have used and interpreted that interview data in Chapter Seven is very different from the preceding chapters.

Whereas in Chapters Four to Six it is primarily my voice that the reader hears and my arguments and analysis that are presented, defended and open for debate, Chapter Seven presents very much the voice of others. It could be argued that Chapter Seven presents a here'say account based on often heated emotion towards the changing policy culture occurring at that time, but it is often those voices, especially at the ground level, which have a unique insider's picture of the directions of change, their implications and whether they are likely to be successful, long before the documentation relating to those changes is formalised. Therefore Chapter Seven, although presenting information at a different level from the remainder of the thesis, has been included in order to highlight the changing nature of policy at all levels as well as present an important reference point for future research.

Therefore, after many months of agonising over how to approach the process of qualitative analysis, I am amazed at the degree to which the fear ensuing from the mystification of the process had impeded the analysis process. I had made the process much more difficult than it need have been and yet it was a very necessary process both for the analysis of the data and again for making me face the issues that were impeding a successful analysis such as personal bias. If I had been fully knowledgeable in how to proceed with the analysis I may have overlooked the degree to which my biases were affecting the analysis and hence de-validate my findings.

Writing Up

The way in which I have decided to present the key policies, issues and conclusions of my research is in short, by telling a story. As I saw the story-like pattern emerging from the analysis, I concluded that it would be one effective way of presenting the research, with each stage of the 'story' taking the reader a step further and deeper into my understanding and interpretation of the research.

The purpose of the set of chapters prior to this one has been to set the scene. Exploration of the European trends of teenage pregnancy and related rates, associated and causal factors in Chapter One, enables the reader to place both Scotland and Finland within a European context. The exploration of the literature relating to the policy areas under exploration in Chapter Two highlights both the existing knowledge on each particular policy area as well as the gaps in knowledge which this thesis aims to fill.

The next two Chapters (Four and Five) set out each policy area at both the level of national framework and local level of implementation. By mapping out and locating policies at the national and local level frameworks, attention is drawn to the similarities and differences between the two countries. This is then followed in Chapter Six with a presentation of the analysis of those similarities and differences, drawing out the main themes that have arisen from this research.

One of the greatest difficulties of policy research is that whilst some policy areas remain constant over time, development and change are equally common features. During the mid-1990s in both countries, there were the signs of change in the areas of policy under study in this thesis and therefore Chapter Seven, although at a different level of analysis, goes on to explore the direction of these changes and their potential implications bearing in mind the findings of the analysis in Chapter Six.

The conclusion to this thesis is presented in Chapter Eight. It includes a discussion of the key findings of this research and what this thesis adds to existing knowledge on the subject area followed by an exploration of the future research agenda.

Chapter Four

Teenage Pregnancy and the National Policy Framework

Introduction

The purpose of this chapter is to begin the process of mapping and locating the various policies under exploration in this thesis. Before going on to explore policy implementation at the local level in Chapter Five, this chapter will first explore the policy framework at the national level in both countries. This includes an examination of formal and informal policy, including statutory provisions as well as regulations, guidance and guidelines.

School-based Sex Education Policy

Finland

Curriculum location and time allocations

Sex education was first introduced into Finnish schools in 1944, although it was not formally included within the curriculum until 1976 (*Sukupuolikasvatustyöryhmän mietintö* 1979). Despite there being no law regarding the compulsory teaching of sex education, the National Board of Education produces curriculum guidelines which every school is obliged to follow. These guidelines stipulate what core compulsory subjects must be contained within every pupil's curriculum; how often these subjects are taught in the various grades; preferred methods of teaching each subject and the content that must be covered within each subject (Bertell 1994).

Municipalities are also expected to draft a curriculum for their area, which can act as an additional guide for schools (if they choose to use it). This curriculum outline is produced so as to take the local circumstances of a municipality into consideration.

In Finland, rather than their being taught as a separate subject called 'sex education', elements of sex education appear in three core curriculum subjects. Finnish teachers and officials referred to this as a system of provision that 'permeates' the curriculum, rather than being a subject taught separate from the main curriculum. The key subjects within which aspects of sex education are covered were outlined by the NBE official as follows:

1) Family Education in Home Economics,
2) Health Education in Physical Education,
3) The biological aspects of reproduction, abortion, contraception, STIs (including HIV) in Biology,

In addition to the class-based sex education, pupils can visit the school nurse to discuss any topic of sexual health of concern on a one-to-one discussion basis. The main topics identified above were allocated compulsory minimum time limits and these are as follows:

1) In Home Economics, 1 lesson (hour) per week would be allocated to Family Education in the 9th grade[1],

[1] Young people would be the following ages in each grade :
7th grade = 12-14
8th grade = 13-15
9th grade = 14-16

2) In Physical Education, 1 lesson per week would be allocated to health Education in the 8th grade,

3) In Biology during 7th-9th grade (12 to 16 year olds) between 3 (minimum) and 7 lessons over the three grades.

4) Pupils can go at any time to see the school nurse about any health (physical or emotional) issue of concern, including sexual health concerns. There are also one-to-one general meetings arranged with the nurse and pupils in particular grades. When and how often this occurs depends on the individual school, although most pupils will undergo a general health check in the 7th or 8th grade.

(Bertell 1994)

Teaching environment

The gender set-up of classes within which sex education was taught in Finland varied dependant on which subject the sex education was being provided within. Within Biology and Home Economics classes, the set-up was mixed-sex, the majority of Physical Education classes, however, are single sex and therefore most Health Education is taught in single-sex classes. Although not intended this way specifically for the provision of sex education, the NBE official noted that the end result has meant that most pupils are taught within a dual system of provision. She further noted that in effect, this has meant that most pupils had both a single-sexed arena to talk about more sensitive issues in single-sex classes and a mixed-sexed arena in which teachers can encourage communication between the sexes.

The training of teachers specifically to teach sex education, was not a prominent area of policy concern in Finland. Both the NBE official and head teachers

assumed that the teachers involved would have received pre-service training during their studies. Therefore, although no official policy existed regarding the pre or in-service training of staff specifically on the subject of 'sex education', when teachers received their pre-service training in Biology, Physical Education and Home Economics, they would expect to receive training on all aspects of these courses, including the aspects of sex education included within those courses.

Content

Every school in Finland is expected to cover a wide range of topics throughout the different classes at age-appropriate stages (see Appendix v for details of content). The NBE official described the overall emphasis of the content as the "promotion of healthy sex and sexuality".

Inter-agency collaboration

Policy relating to the involvement of outsiders in the teaching of sex education is informal. Due to the school-based location of the school nurse and her[1] professional training to work with and teach young people, it was the expectation at government through to school level, that she would act as an up-to-date information service for teachers. Additionally she would also be expected to take a small number of classes (usually within Biology and Health Education classes) at the request of teachers.

[1] Although there is no policy to exclude men from the position, the majority of school nurses in Finland are female and at the time of research all schools examined had a female school nurse (Personal Communication - A. Liinamo, School of Public Health, Tampere University 1998).

Scotland

Curriculum location and time allocations

In Scotland, local authorities are responsible for school sex education (Wight and Scott 1994) as they are for the provision of all education, although there is no legal obligation for schools in Scotland to teach sex education. All that is required to be covered is what is included within the Scottish syllabus (national curriculum) namely, biological reproduction, which is covered in 1st year[1] Biology. There is no other specified curriculum provision for sex education.

Although there was no official policy requiring the teaching of HIV/ AIDS education, there was encouragement from the Scottish Office that this be taught within all schools from the late 1980s. Some individual schools have set up Health Education, HIV/ AIDS education, Personal and Social Development (PSD) or Personal and Social Education (PSE) courses, this was, however, entirely at the discretion of each individual school. Sex education prior to 1993 was described as 'patchy at best' (Burtney 2000a), with the inclusion of anything beyond the biological, very much dependent on the commitment of the head teacher and senior management team.

The amount of time allocated to the teaching of biological reproduction in the Scottish syllabus is a two-three week block in the 1st year of senior school (S1). Prior to 1993 and the introduction of the 5-14 Programme (SOED 1993) there was no time specifically allocated for the provision of sex education.

[1]

1st year (S1) = 11-13	4th year (S4) = 14-16
2nd year (S2) = 12-14	5th year (S5) = 15-17
3rd year (S3) = 13-15	6th year (S6) = 16-18

The introduction of this programme meant that schools would be expected to allocate 20% of curriculum time to Environmental Studies. Whilst aspects of Personal and Social Education formed a part of Environment Studies, so did Geography, History and Science. Therefore the amount of time actually allocated to sex education could vary dramatically between schools. The 5-14 Programme only suggested broad time allocations and did not specify for each subject, only for groups of subjects.

Teaching environment

The Scottish Office of Education (SOED) official noted that the gender set-up of the classes within which sex education was taught within Scottish schools was a mixed-sexed arena. She noted that there has never been a single-sexed provision of such classes within Scotland (in the state sector), which is due in part to a belief that single-sexed sex education is seen as retrogressive (Wight & Scott 1994).

Two types of teacher training were identified by the SOED official as pre and in-service training. Pre-service training is provided when a student is undertaking studies in teacher training and in-service, once a teacher is in post. Until the introduction of a standardised pre-service training for all teachers in 1999, pre-service training would only be provided for those who undertook guidance certificates[1] as part of their pre-service training. Biology teachers, as part of their pre-service training, would also learn about how to teach the biology of sex.

[1] Guidance certificates involve training on a range of issues to enable teachers to take on a pastoral role for school pupils. Included within this certificate is training on subjects taught within PSE such as sex education, drugs and alcohol education, careers guidance and Health Education.

The more common form of training specifically on sex education has been provided in the format of in-service training. This could be organised at government, local authority or school level. It would usually be the local authority who would develop this training and offer it to schools and it would be up to the schools to arrange cover for teachers who wish to take part in such training. There had however been training developed and provided centrally, such as much training related to HIV and AIDS education during the late 1980s, early 1990s.

Content

The biological course in 1st year (S1) includes the teaching of biological reproduction from plants to animal through to humans. The focus of the human reproduction element is purely biological starting with the fertilisation of the egg, through foetal development to the birth of the baby. Some teachers would include more varied topics such as abortion, contraception and STIs (including HIV/AIDS). This, however, was considered additional and was not within the official policy, although there was a UK wide expectation that HIV and AIDS be covered from the late 1980s.

Inter-agency collaboration

No official policy exists with regard to inter-agency collaboration in the provision of sex education. Schools are, however, encouraged by their local authorities and the SOED to make use of all additional resources that are available, such as the school doctor, local family planning services or non-governmental agencies such as the FPA or the Terence Higgins Trust, where funds allow.

Sexual Health Policy

Historical development of sexual health policy in Finland

Despite the popular notion of Nordic countries having very 'liberal' attitudes to sex and sexuality in general, this has not always been the case in Finland. Finland has gone through a long process of change with regard to its attitudes to sexuality and sexual health provisions and this process is reflected in what Rimpelä et al. refer to as the change from "control policy to comprehensive family planning" (1996:28).

Prior to World War II, sex was considered to be a very private issue in Finland. Sex education was unheard of and, in the hope of keeping them from experimenting before marriage, young women were, on the whole, kept completely ignorant about sexual issues to the extent that they were not even told about menstruation (Väestöliittö 1994). At this point in time, abortion was only legal on medical grounds and many areas of society, the Lutheran church in particular, did not favour the availability of contraception to women, in fear that it would promote immorality and promiscuity (Väestöliittö 1994).

During World War II however, attitudes towards sex moved from moralistic towards pragmatic and Nordic countries as a whole began to look more favourably on abortion. Extra and pre-marital affairs increased during the war and as a result so did the number of people contracting STIs. As a result, after the war had ended, the Ministry of Education in Finland set itself the task of educating the public about sexual matters. In school the beginnings of sex education could also be seen, although at this point the education went no further than biological reproduction and textbooks showing pictures of genitals (Väestöliittö 1994).

After the war the number of illegal abortions increased dramatically. Medical concern about the effects illegal abortions could have on women's health, such as serious illness, infection or in the worst-case death, prompted the medical profession to voice their concerns to government. Despite governmental concern on this matter, however, no changes to abortion policy were made at that time. The reason for this policy decision however, was not one over concern for increased promiscuity but rather, concern over the declining population in Finland (Väestöliittö 1994).

As a result of a strong abortion lobby during the early 1960s, a new abortion law (*Laki raskauden keskeytyksistä)* was introduced in 1970. While this law did not go so far as to make abortion available on demand it did introduce two new grounds for abortion (See Appendix vi for details). First, it enabled abortions to be performed on social grounds alone with the permission of two doctors and secondly, on anyone under the age of 17 at the time of conception with the permission of only one doctor (as opposed to two doctors for women aged over 17). Prior to this time there had been no specification of age as a priority and an abortion (at any age) had required the permission of two doctors. The law was adapted in 1978 with regards to time limitations for a termination. This change meant that an abortion has to be performed before the 12th week of pregnancy (Ala-Nikkola 1992).

Shortly after the enactment of the new abortion law, the Public Health Act (*Kansanterveyslaki* 1972) formalised the role of primary care as the most important

form of national health care provision. In addition, this law made it the legal obligation of municipalities to provide sex education, contraceptives and contraceptive counselling, general health counselling and when required, easy access to safe abortion services. In addition, no limitations were placed on the age at which these services could be provided (Kosunen & Rimpelä 1996a).

In the first few years following the enactment of the Public Health Act (1972), the provision of sexual health care by the municipalities showed almost immediate results. The overall rate of abortion started to decline and substantial improvements occurred in the sexual health of the general public, without any sign of increased promiscuity or abortion being used as a method of contraception (Kosunen & Rimpelä 1996a).

One plausible reason for the continuing decline in the abortion rate (to all age groups) throughout the late 1980s and early 1990s is believed to have been the introduction of emergency contraception in 1987 (Väestöliittö 1994; Kosunen et al. 1997), the availability of which is well known amongst Finnish young women[1] (Kosunen et al. 1999b).

During the early 1990s, prompted by increased discussion of sexual health in the media, STAKES[2] undertook some preliminary research into the state of Finland's sexual health in general. Although no particular problems were highlighted, it was concluded that a long-term strategy was required in light of the changes and

[1] In a study containing just over 1/5th of all municipalities in Finland, it was revealed that only 3% of 14-15 year olds and 1.5% of 17 year olds did not know what emergency contraception was (Kosunen et al. 1999b)
[2] STAKES is the main research facility on health and welfare in Finland, based in Helsinki.

cutbacks that were occurring within health care provision in general at that time (STAKES 1997).

The strategy was named '*Family Planning 2000*'and was based around the principle of making sure that every child born in Finland is both wanted and healthy, and that people are able to chose the size of family they wish to have. The main aims of '*Family Planning 2000*' are as follows:

1. To develop services, focusing on the needs of the clients: women, men and couples,
2. To support women and couples with information and organizing peer-groups in case of miscarriage, abortion and care of infertility,
3. To assess and further develop the quality of care in family planning,
4. To promote fertility and to organize services in the prevention and treatment of infertility,
5. To make men more active in sharing responsibility in contraception and family planning,
6. To increase know-how in sexual behaviour and sexual therapy among health and social welfare personnel,
7. To establish a nationwide information network for professionals interested in family planning,
8. To stress sexuality as a positive power in life.

Source: STAKES 1997:1.

Therefore the development of a strong sexual health policy for all people in Finland was an important aim at both the governmental and local levels. Some critics have questioned why money should be allocated to such a policy when 'everything is okay' (Kosunen & Rimpelä 1996a). There was, however, a strong belief within STAKES that investing in preventative policies would in the long run be better for all individuals concerned as well as more cost effective for the government. It is also worth noting that the sexual health of all citizens, not just that of young women, is viewed as an issue for priority in Finland (STAKES 1997).

Sexual Health Policy and Young People in Finland

Looking more specifically at the sexual health of young people in Finland, the effect of the Public Health Act in 1972 had considerable implications for young people's ability to look after their sexual health. As is the case with all individuals in Finland, under this law, young people became entitled to free/ low cost contraceptive services[1]; free access to counselling and advice about sexual issues and access to abortion services if required.

As noted in the previous section, after the enactment of the 1970 Abortion Law[1] and the 1972 Public Health Act, there was a general improvement in the sexual health of people in Finland. One trend, however, stood out from the general success of these new laws; the rate of teenage abortion had not declined in line with other age groups (Kosunen & Rimpelä 1996a). The sexual relations of young

[1] The first trial of contraceptive is provided free, the length of time that this trial lasts ranges from three to nine months depending on the Municipality within which the young women is accessing the contraception (Kosunen 2000b).

people had increased during the more liberal era of the 1970s and although access to contraception and abortion had increased, young people were not fully educated about these services or how to insure their own sexual health well being. As a result, at this point, there was a large push for sexual health information and education by and for the younger generation. The topic of sex was increasingly focused on in the media and sex education became part of the school curriculum in 1976 (Kosunen & Rimpelä 1996a). Additionally from the early 1980s the Finnish government continued to focus on the sexual health of young people.

There are two main examples of this focus, the first was in 1983 when the Finnish government started to focus on attempting to reduce the rate of abortions to women under 20 and for the first time a target was set. The target was to reduce the abortion rate to women under 20 by 7% per annum from 1983 onwards.

The second was the introduction of a magazine for young people. Since 1987 the magazine *Sexteen* containing information about sex and sexuality (accompanied by a sample condom) has been sent to all Finnish young people when they turned 16. This is an important source of reliable information for Finnish young people whose readership has been associated for a number of years with a higher level of sexual knowledge (Liinamo et al. 2000b). An evaluation of the reception of the magazine conducted in 1992 (Hannonen 1993) revealed that whilst widely read by young people, most expressed a desire to have received it at age fifteen. This led to a decision to send the magazine to all fifteen and sixteen year olds in the year 2000

[1] This law enabled young women who conceived under the age of seventeen to access an abortion purely on the grounds of their age, with the permission of only one doctor.

with a view to then making it available at age fifteen only from 2001 (Liinamo 2000).

As was highlighted in Chapter Two, what is of particular interest in this research is policy relating to the reality of access that young people have to sexual health services. Therefore the next section of this chapter details policy relating to the providers of, and access to, these services that are available to young people in Finland.

Young people in Finland can access both sexual health advice (including advice regarding abortion), and contraception in a number of different locations. The main providers are municipal health centres, school health services and NGO (non-government organisation) youth clinics. Of the providers available, the municipal health centres are geared towards people of all ages. The school health services and the NGO youth clinics are, however, provided with the specific needs of young people in mind. Although many young people will use the municipal and NGO clinics to actually obtain contraceptives (Liinamo et al. 1997), they will usually arrange access (via an appointment) through the school nurse (Kosunen 2000b).

The school nurse and the school health service in general is expected to be the first point of access to all health services (including sexual health) for most people of school age; acting as a supplement to the services provided by the municipal health centres (Väestöliittö 1994). A survey of young Finns (under 18) attending a youth clinic in the City of Tampere in 1998 revealed that 58% of the clients had received information about this service from their school nurse (Kosunen 1998).

The reason that the school health service plays such an integral role in the lives of young people in Finland is because of the structure of health care provision for young people in general. Before entering the school system, the health needs of Finnish children aged up to (usually) seven are dealt with at child health clinics as part of the primary care health services[1].

When a child begins school he/she is automatically transferred to the school health care system where the role of the public school nurse is taken over by the school nurse for as long as each individual goes to school[2]. The 1972 Primary Health Care Act made it a statutory obligation that every municipality should provide its residents with school health services, to be provided on-site in school-based health clinics which was to be universal throughout all Finnish schools.

The school nurse is available in the school clinics during each school week (the amount of time will depend on the size of the school population and municipal resources for school health services). In addition to scheduled check ups in various grades, (which is determined at the individual school level), the nurse is expected to be available as and when pupils require to visit her. The system has been designed in this way in order that school nurses are expected to be the first port of call for all young people seeking any form of medical attention or advice (Kosunen

[1] In their first year of life children are expected to attend the clinic several times for regular check-ups, dropping to intervals of 6 or 12 month after the child turns one. This is in order that the public health nurse can monitor their growth and development and provide them with all relevant vaccinations (Brochures 1996).
[2] This would be until at least the age of 16. However with the average stay-on rates being high in Finnish schools, this would usually be until the age of 19.

2000b). In other words the school nurse and the school health services are set up as the main primary health care resource for young people.

Not all school nurses are able to dispense contraception within school-based clinics and when this is not the case, it is expected that the school nurse will make an appointment for the young person (usually young women) at the local municipal health centre. A number of school nurses are however allowed[1] to provide contraception on-site and this poses the added advantage of being able to deal with the often sporadic and unplanned nature of teenage (especially younger teenagers) sexual behaviour.

At the time of research there were not many NGO youth clinics in existence[2] in Finland, although they are a growing phenomenon. This is mainly in response to the recognition that young people want their own services (Liinamo et al. 1997; Kosunen 2000a, 2000b) in addition to the school health services, especially when the school health services are not available (i.e. out of school hours).

Historical development of sexual health policy in Scotland

In comparison to her European counterparts, British society as a whole has more conservative attitudes towards sex and sexuality (Jones et al. 1985). Historically, however, Britain was a pioneer in terms of sexual health policy during the late 1960s and early 1970s. The decriminalisation of both abortion and homosexuality,

[1] Being allowed to dispense contraception in the school-based clinics is at the discretion of the municipality health centre. Unfortunately there is no national data available on the number of schools where school nurses can dispense contraception. One of the four schools in this study had this system in practice.
[2] Of the three Municipalities, only *Tehtaala* had a specialised youth clinic.

as well as a number of Acts making divorce easier to obtain in the late 1960s was shortly followed by the introduction of freely available contraception to all women. The culminating effect of these changes produced a society more willing to liberalise sexual behaviour (Kane & Wellings 1999).

Beginning in the late 1960s, Britain witnessed a groundbreaking piece of legislation on abortion, which would impact upon the whole of Europe in the decades to follow. Abortion was originally made an illegal act in Britain, punishable by life imprisonment, during the 19th century. The Abortion Law Reform Association (ALRA) was set up in 1936 to fight for the right to abortion. Pressure from this organisation in particular, lead to the creation of the Liberal MP David Steel's Abortion Law Reform Bill, which eventually entered the statute books on the 27th of October 1967 and took effect from the 27th April 1968 (EFC 2000).

The Human Fertilisation and Embryology Act (1990) amended the Law set in 1967 by lowering the upper limit for an abortion from 28 to 24 weeks as a result of improved medical technology making feasible the survival of a baby born over the age of 24 weeks (EFC 2000). Other than that change, the Law governing abortion in Scotland has remained unchanged[1].

Taking the lead from Britain, the majority of other European countries followed suit during the 1970s and 1980s (VFC 2000) introducing legislation relating to both the provision of contraceptive services and abortion enabling women to have

[1] Details of the current law can be found in Appendix vii.

the right to control their fertility for the first time. Since then, however, Britain's legislation has been "superseded and rendered archaic and paternalistic by the legislative reforms made by Britain's European partners" (VFC 2000:2). These reforms have introduced laws in many countries which allow women to seek abortion without restriction, on request, during the first trimester of pregnancy. This has now left the current law in Britain (although classed as Category II (Ketting 1993)) as one of the most restrictive in Western and Northern Europe (ALRA 2000).

Various forms of contraception and birth control services have been available in Britain since the early part of the 20th century, although they were not legally sanctioned by the state until 1967. Under Section 1 of the National Health Service (Family Planning) Act in 1967 a duty was placed upon Local Health Authorities to provide contraceptive services to all who required it. This was followed in 1968 by a change in FPA policy to allow unmarried women access to contraception (which had previously only been the privilege of married women). By 1970, all health clinics were duty bound to provide contraceptive services to all women (Kane & Wellings 1999). Both pieces of legislation and policy, made no reference to the age of the individual to whom the contraceptive services could or could not be made available.

In 1974 the family planning clinics that had been run by the Family Planning Association (FPA) were taken over by the NHS and subsequently responsibility was delegated to the Local Health Authorities to provide contraceptive services and contraception free of charge. In the same year a Family Planning Circular was

issued by the Scottish Home and Health Department and similar to the Family Planning Act of 1967, no specific reference was made to the provision of contraceptive services for young women, although reference was made specifically to the unmarried. The Circular stated that "family planning services should be available to all who need them and... should be so organised as to avoid any bar to the provision of services to the unmarried" (Bury 1984: 37).

The 1980s witnessed a certain degree of stepping forwards and backwards with regard to the reproductive rights of women. The step forward was the introduction to Britain of emergency contraception in 1983 (Pappenheim 1995), the availability of which provided women with a further sexual health choice should contraception have failed, not been used effectively, or not used at all. The availability of this provision was widely publicised by organisations such as the FPA and Brook Advisory (Kane & Wellings 1999).

The step backwards came as a result of the case of Gillick v West Norfolk and Wisbech Area Health Authority and another [1984]. The basis of this case was that Mrs. Gillick objected to her daughters being provided with the contraceptive pill at the age of 15, without her knowledge or consent. The action of taking this case to court brought about the first judicial attention to the provision of the contraceptive pill to young women under the age of 16.

There were two original grounds for contention in this case based on the Sexual Offences Act 1956[1] and on the basis of those two contentions, the case was presented that if a doctor was to prescribe the contraceptive pill or provide contraceptive advice to a young woman under the age of 16 they would be "secondary participant by aiding or abetting an offence contrary to the Sexual Offences Act 1956" (Bridgeman 1996:138).

The House of Lords was left to decide whether or not it believed that providing contraception or contraceptive advice to a young woman under the age of 16 would in fact make the doctor an accomplice to the commission of the offence. After much deliberation the majority opinion was that "a doctor who gave advice on contraception would not aid or abet that offence provided that he acted in good faith, as a matter of professional responsibility, to protect the young woman against the potential adverse effects of sexually transmitted disease or unwanted pregnancy" (Bainham 1996: 38).

The Fraser guidelines (1985) (derived in part as a result of the Gillick case), provides medical doctors with a number of issues that they must consider thoroughly before providing any contraceptive advice or contraception without parental consent to a young woman under the age of 16[2]. This is now commonly

[1] First, according to Section 28 of the Sexual Offences Act 1956 "[I]t is an offence for a person to cause or encourage ... the commission of unlawful sexual intercourse with ... a girl under the age of 16 for whom he is responsible". Second, according to the Sexual Offences Act 1956, by virtue of Sections 5 and 6 which stated that "It is [an offence] for a man to have unlawful sexual intercourse with a girl under the age of thirteen" ... "It is an offence ... for a man to have unlawful sexual intercourse with a girl ... under the age of sixteen".
This law refers only to England and Wales, although is similar in content to the Scottish Law which states that having sexual intercourse with a girl under the age of 13 or above the age of 13 but under the age of 16, whether consensual or not, is a criminal offence under Section 3 and Section 4(1) respectively, of the Sexual Offence (Scotland) Act 1976.
[2] For details of the guidelines see Appendix viii.

referred to as the 'Gillick Competence Test' where by a doctor[1], on being consulted by a young woman under the age of sixteen requesting the provision of contraception, has to decide if the young woman is mentally capable of understanding the possible consequences of her sexual activity and if it is in the best interests of the young woman to provide her with contraception. If s/he believes that the answers are positive, then the doctor may provide contraception and contraceptive advice, without parental consent. If s/he does not believe that the young woman passes the 'Gillick Competence Test', the consultation will still remain confidential even if contraception is not prescribed (Hadley 1998).

Lastly with regard to the British government's concern with aspects of sexual health, the style of policy has tended to be reactive, rather than proactive. It has also tended to focus on particular individual areas of concern rather than having a more general sexual health policy objective for the nation. For example, during the late 1980s and early 1990s, policy was derived as a reactionary response to the AIDS crisis, such as the lifting of the ban to advertise condoms commercially in 1987 and the widely publicised government, HEA and other AIDS awareness campaigns (Kane & Wellings 1999).

[1] Despite the Gillick ruling being a case within English Law, the advice to medical professionals as a result of this ruling are provided to all medical professionals in Scotland, England and Wales by the ethical committee at the British General Medical Association. Therefore the 'Gillick Competence Test' is utilised by medical professionals in Scotland.

Despite the concern over the rate of teenage pregnancy in Britain over the last two decades, there was little policy derived at government level to respond to this issue until 1992. At this time *The Health of the Nation* (DoH 1992) was published. Contained within this document was the first quantitative target for lowering teenage pregnancy rates from 9.4 to 4.8 per 1000 women under 16 between the years 1989 and 2000. Although this document only pertained to England and Wales, Scotland, not having a policy such as this of its own, also took its lead from this target. Despite the setting of this target, however, policies documenting how those aims could be achieved or from where the finance with which to achieve the target would come, were notable by their absence (Ingham 1992).

Sexual Health Policy and Young People in Scotland

The resulting effect of the policy and legislation outlined in the previous section, should mean equality of access for all individuals in Scotland to free contraceptive services; free access to counselling and advice about sexual issues and access to abortion services under certain conditions. In order to assess the access that young people actually have to sexual health services, the next section identifies the framework of provision and access to sexual health services that young people have in Scotland.

Young people in Scotland can access both sexual health advice and contraception in a number of different locations. The main providers are primary care general practices and NHS family planning clinics. Additionally there are some specialist projects set up locally for young people to provide sexual health services (the

availability of such services for the localities under study will be explored in the next chapter).

Of the services available within the national framework of policy provision, the primary care general practices and NHS family planning clinics are both geared towards people of all ages, although some will provide specialist sessions for young people. Whilst young people theoretically have the same access rights to these services as others, there are many potential limitations to that access.

General practices are located so as to be within easy reach of their patient population, although in more rural areas this may not always be the case. Family planning clinics are generally located within main cities and due to their restricted numbers and location, this also limits those in the population who are able to access these services.

As is the case in Finland, all Local Education Authorities have a statutory duty to provide the schools in their area with a school health service (PHPU 1996). Although school health services in Scotland have a very long tradition dating back to 1918, the system of provision is very different from that found in Finland. The Scottish school health service was not set up or intended for use as a primary care resource for young people. The role of school health services in Scotland is purely for regular physical health and dental checkups as well as to ensure that pupils receive a variety of vaccinations such as rubella and BCG. Therefore although every school has an allocated school nurse, there is no comparable role of the school nurse in the two countries.

Finally, although abortion services are legally available to all women on certain grounds in Scotland, no specific policy exists which places young women (under 16s in particular) as a priority age group or places age by itself as grounds for abortion.

Education Policy

Statutory leaving age for compulsory schooling

The issue of continued education and teenage pregnancy rates was introduced within Chapters One and Two. It was noted that a significant relationship exists between countries with high continuation rates in education and training (post16) and lower teenage pregnancy rates. With such a considerable difference in staying-on rates between Finland and Scotland as noted in Figure 1.3 in Chapter One, an initial assumption had been that there would be a difference in the statutory age at which young people could leave school. The expected difference being that the statutory age for leaving school in Finland would be higher than in Scotland. This was not in fact found to be the case, as in Scotland and Finland the statutory age is sixteen.

Structure of the educational system in Finland

The comprehensive school (*Peruskoulu*) system in Finland was created after a series of school reforms which began in 1972[1]. Partial reform took place during the mid-1980s, which instigated the decrease in the level of central government control in the sphere of education. In 1985 the National Board of Education produced the first national curriculum guidelines. On the basis of these guidelines

schools and municipalities[2] were expected to devise their own curriculum. Therefore since the early 1970s, as is depicted in Figure 4.1 below, there have been various routes through the education system in Finland that have been open to every pupil.

The compulsory stage of education in Finland is provided at comprehensive schools between the ages of seven (in special cases at the age of six) and sixteen,[3] or until the pupil has successfully completed the nine grades of the comprehensive school. This level of schooling is divided into two sections, a six-year lower stage and a three-year upper stage, which correspond internationally to primary and lower secondary education respectively. Each municipality is obliged to provide free comprehensive schooling for every resident individual of compulsory school age[4] (Karlsson & Herranen 1998).

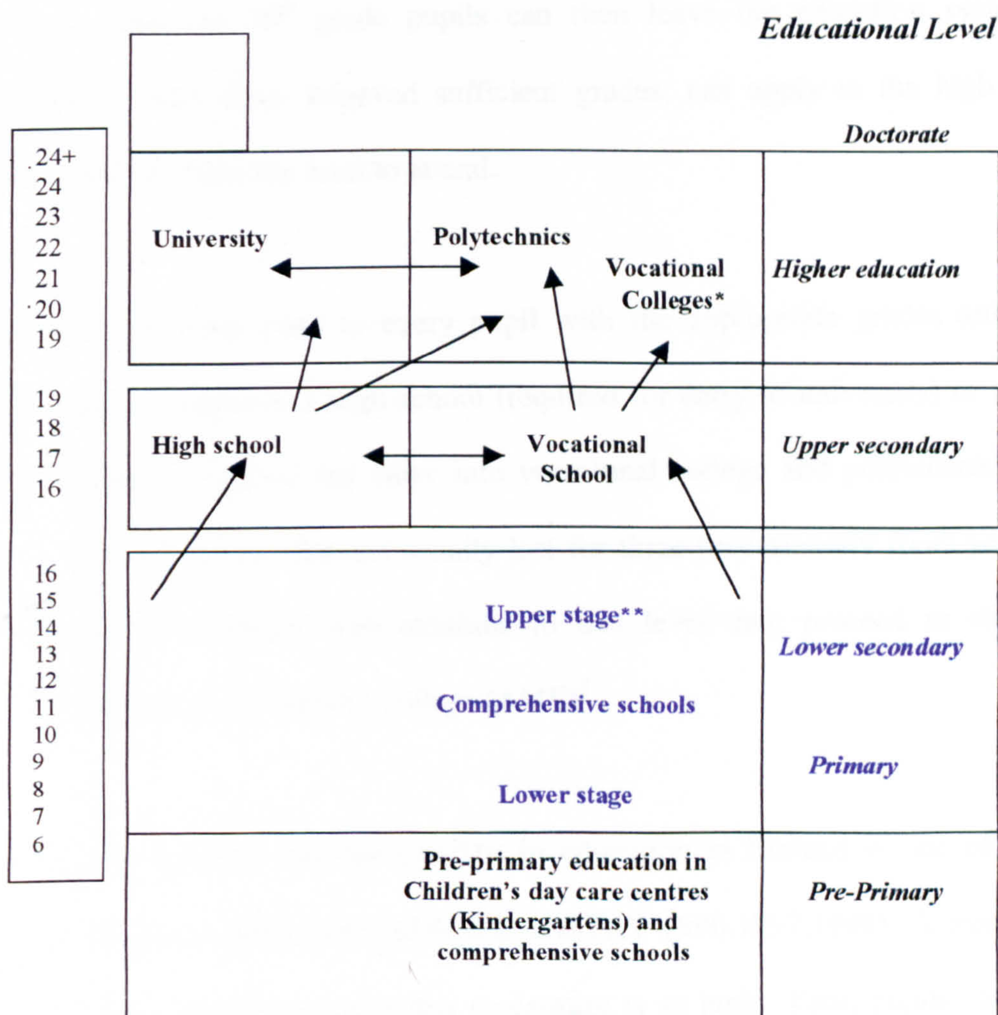
In Finland when a pupil has reached the age of 16, s/he is no longer legally obliged to continue in education. The understanding of pupils and teachers is that comprehensive education, rather than being the end of one's school education, is considered to be the beginning (Bertell 1994). The comprehensive school is intended to provide each pupil with a broad ranging education and the skills

[1] Prior to the 1970s the education system in Finland comprised of a primary education system until the age of eleven, at which point pupils were divided into two streams, those who would pursue further studies and those who would pursue vocational training.
[2] Municipalities would be expected to devise a curriculum that they would provide for all of their schools. Those schools could then follow that curriculum or adjust it to suit the needs of their pupils, as long as that curriculum remained within the national curriculum guidelines. Further reforms began in 1993, taking effect in 1994. These changes will be referred to in Chapter Seven.
[3] In 1995 approximately 581000 pupils attended one of over 4400 comprehensive level schools in Finland. Of these schools just under 93% are regular Finnish comprehensive schools, 6% are Swedish-language schools and just over 1% are private (Karlsson & Herranen 1998).
[4] Young people may obtain their education from other sources such as home tutoring. However, the majority of young people in Finland, in practice, complete nine years of schooling at the comprehensive school.

required for further study. It is considered to be the preparatory stage before the 'real' education begins. Therefore, whilst it is possible to leave school at the age of 16, it is generally recognised that gainful employment will only be obtained with further study, at least until the age of 19 (Bertell 1994).

Figure 4.1

The Regular Education System in Finland



* Most of the education at vocational colleges will be upgraded to Polytechnic level

** Sections highlighted in blue are the Compulsory schooling years.

After completing the comprehensive phase of schooling, it is possible for pupils to follow one of four paths. First, pupils can leave the education system entirely if they have successfully completed the compulsory level of schooling. Alternatively, if their grades are not good enough to continue with high school (*Lukio*) or vocational school (*Ammatttikoulu*) education, they have the option to complete an extra 10th grade. This is to enable them to increase their chance of being accepted by the institution of their choice in which to continue their education. After the 10th grade pupils can then leave the education system altogether or if they have achieved sufficient grades, can apply to the high or vocational schools that they wish to attend.

The final two options open to every pupil with the appropriate grades are to continue their education at a high school (required for entry to university) or at a vocational school (required for entry into vocational college and polytechnics)[1]. Both of these educational options usually last for three (occasionally four) years. On average 50% of those who continue to this level then proceed to either university (*Yilopisto*) or vocation college (*AMK*)[2].

The national attendance rate for over16s in education in Finland is one of the highest in Europe, annually 89.5-95% (EUROSTAT 1996,1997,1998). There are many plausible reasons as to why this percentage is so high. First, pupils cannot

[1] On the whole, the entire age group complete compulsory education and only approximately 0.04% of pupils fail to receive their comprehensive school – leaving certificate (Karlsson & Herranen 1998). In 1995, 54% of those who had successfully completed their comprehensive schooling progressed onto the high school level, 40% progressed to the vocational school level and a further 6% completed a 10th grade or entered employment (Karlsson & Herranen 1998)

[2] For the 21st Century, the Ministry of Education has also pledged within its educational policy to continue to provide vocational and upper secondary education to the entire age group. In addition, they aim to have 60-65% of that age group progress to Higher or Further education at University, Vocational College or Polytechnic (Karlsson & Herranen 1998).

attend university or vocational college unless they have completed a further three to four years of education at the secondary level.

Second, in Finland if pupils do not attend an institution of secondary, further or higher education and have never been employed (post-school), they will not be entitled to any state benefit. Up until the age of 24, in order to be eligible for benefit (if never employed post-school), an individual must be seen to be applying for further education. This positively encourages all young people aged 16-24 to be in some form of education[1].

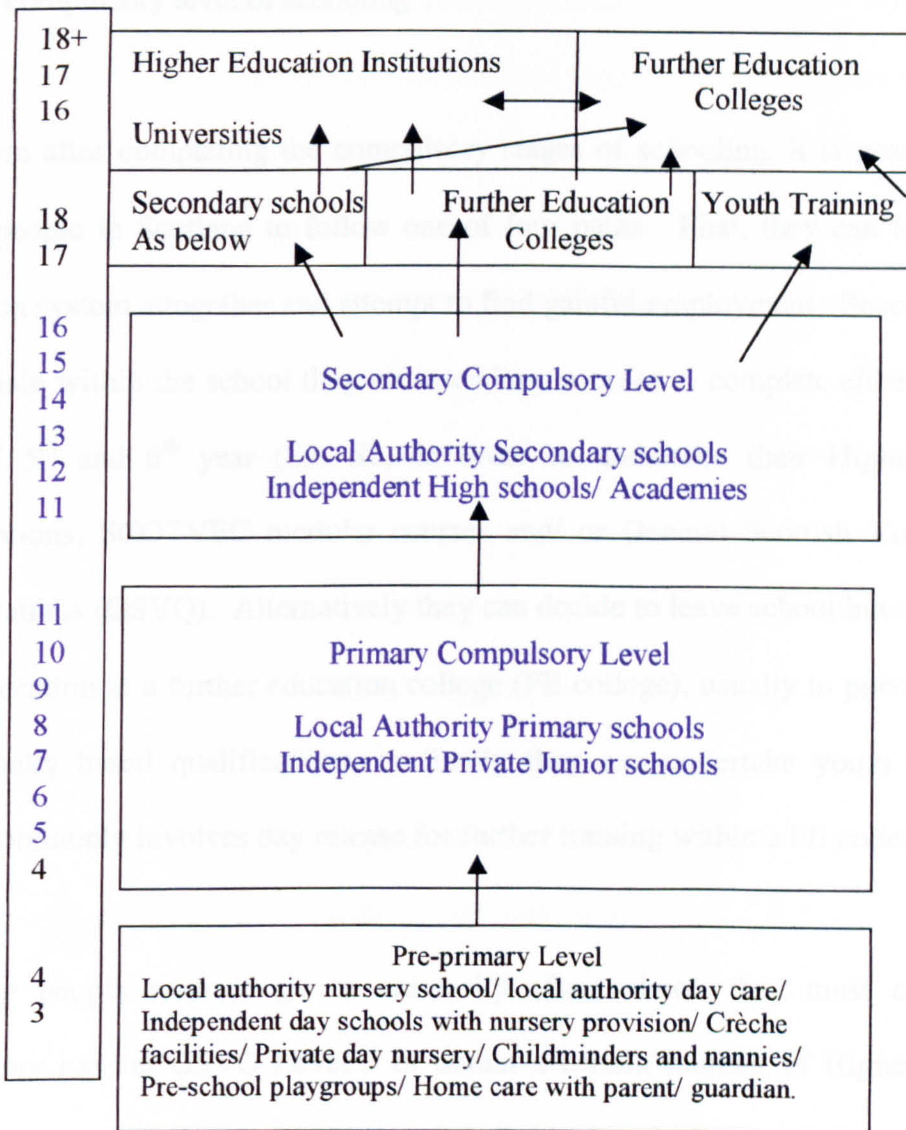
Structure of the educational system in Scotland

The Scottish education system and legislative framework supporting it has always been distinctive from the rest of the UK, with a set of Acts applicable to Scotland alone. The provision of publicly funded education[2] in Scotland is done so through a collaborative partnership between central and local government. Local authorities are legally obliged to ensure that within their local authority every young person of compulsory schooling age is in receipt of adequate and efficient school education provision. The variety of routes that a Scottish pupil can take through the Scottish education system is as depicted in Figure 4.2 below.

[1] The down side of this policy, however, is that many young people have to apply for institutions (perhaps due to insufficient grades) that are not necessarily the ones that they want to attend because they must be applying. This may account for the small degree (5%) of drop-out each year.
[2] The private education sector does not come under the responsibility or control of LEAs.

Figure 4.2

The Regular Education System in Scotland



* Sections highlighted in blue are the Compulsory schooling years.

In Scotland compulsory education is provided for the most part at state funded primary and secondary schools between the ages of five (occasionally four) and

sixteen[1]. The primary level comprises of seven years and the secondary level comprises of six years, the first four of which will usually bring a pupil to the end of their compulsory level of schooling[2].

Therefore after completing the compulsory stages of schooling, it is possible for young people in Scotland to follow one of four paths. First, they can leave the education system altogether and attempt to find gainful employment. Second, they can remain within the school they are attending in order to complete either one or both of 5th and 6th year (S5/ S6) in order to undertake their Higher-Grade examinations, SCOTVEC modular courses and/ or General Scottish Vocational Qualifications (GSVQ). Alternatively they can decide to leave school but continue their education at a further education college (FE college), usually to pursue more vocationally based qualifications, or finally they can undertake youth training which commonly involves day release for further training within a FE college.

If young people wish to go to university after school, they must obtain a satisfactory pass at GSVQ Level 3 or obtain a certain number of Higher-Grade examinations at grades specified by each individual undergraduate course. Many young people will sit and achieve the Higher-grades necessary in their 5th year and a small percentage of pupils will go to university straight from 5th year. However

[1] In addition parents have the right to choose to have their children educated at home and a very small minority do so. In cases like this the Local Education Authority has an obligation to make sure that parents are providing an equivalent level of education that would otherwise be obtained at school.

[2] In 1997 approximately 712182 pupils attended one of 2848 primary or secondary level schools in Scotland. Of these schools, just over 95% are Local Authority primary and secondary schools and just fewer than 5% are independent schools. The majority of those pupils also attended a Local Authority co-education primary or secondary school (95.7% aged 5-16) which are provided free of charge, and a minority (4.3%) attended a fee-paying independent (boarding and day) junior or senior school (British Council & SOEID 1997).

the majority of pupils who are going to go on to university will remain in school and complete a 6th year[1]. This will be either to improve their grades to obtain a university place or to undertake a higher level of exam i.e. Certificate of Sixth Year Studies, in preparation for their further studies. Pupils may also choose to enter a college of further education after completing S5 and/ or S6. As opposed to the more academic enquiry pursued at universities, FE colleges provide more vocationally based courses including SVQs[2], GSVQs[3], HNC[4], HND[5] and degree courses[6].

Unlike the Finnish system whereby state benefits can be achieved if a young person is applying for further education, in Scotland young people are not entitled to any state benefit from the ages of 16-18 (unless they can prove exceptional hardship). The only options for young people in this age group are to be in education most often remaining financially dependent upon their parent/s, to attempt to find employment to support themselves or to undertake youth training (skillseekers) which will provide them with a minimal wage.

Careers Guidance in Finland

In Finland careers guidance is taught within the broader scope of 'student counselling'. Throughout the comprehensive school the general policy for

[1] The majority of pupils will be seventeen in their 5th year and eighteen in their 6th year. However, if a pupil has begun school at the age of four rather than five it is possible that they may only be sixteen when they have completed their 5th year and therefore be eligible to enter university at the age of sixteen.
[2] Scottish Vocational Qualifications
[3] General Scottish Vocational Qualifications
[4] Higher National Certificate
[5] Higher National Diploma
[6] In 1996, 71% of young people aged 16-19 in Scotland were in some form of education or training. 67% of young people stayed on at school beyond the compulsory age of sixteen. Of those who achieved the necessary grades to continue their education beyond the school level, 45% entered some form of higher or further education and 14% entered youth training involving some education with FE colleges (British Council & SOEID 1998).

student counselling is "to support, help, and direct the students in such a manner that every student gets through his studies in the comprehensive school as well as possible and is able to make appropriate and suitable decisions concerning his schooling and career" (Bertell 1994:43).

A number of different aims are outlined in the policy for student counselling including the development of pupils' self-esteem and the promotion of gender equality. The overriding aim of student counselling in Finland, however, is to prepare every pupil for further education, choosing the right career and the realities of working life (Bertell 1994).

As pupils move through the comprehensive grades to the upper level the counselling sessions are said to become structured[1] and frequent (Bertell 1994). Pupils can expect to be provided with both guidance on a one-to-one level and within small groups. Within the group sessions work should begin by focusing on study techniques and school policies and move on to consider more specific plans for further study and career planning (Bertell 1994).

At the personal one-to-one level, work should focus on developing each individual pupil's aims for their future education and career and how best to go about achieving set goals. Pupils are entitled to personal counselling sessions with their student counsellor at the upper level. Counsellors are expected to use this opportunity in particular to help those pupils who appear to be having difficulty at school and who look less likely to be able to achieve the necessary

[1] Sessions are less frequent and structured during the lower half of the comprehensive school.

grades to continue their education beyond the comprehensive level (Bertell 1994).

The content of the student counselling sessions at the upper level is expected to comprise of specific information about and exploration of the different types of education and professions available. To do this, student counsellors are expected to develop close links with the surrounding community, in particular local education establishments and local businesses and industries. These businesses are encouraged to work with schools by visiting the pupils to present their background and what opportunities they provide for the pupils in the future.

The overall theme of student counselling at the upper level of the comprehensive school is to acquaint pupils with and prepare them for further education and working life. The NBE provides within its curriculum guidelines the ways in which this theme should be taught, the general content that must be covered and the minimum hours of student counselling to which every pupil is entitled (Bertell 1994).

Careers Guidance in Scotland

In Scottish schools careers guidance is provided within the broader scope of general guidance for pupils. This guidance provision, of which careers guidance makes up a considerable element, has been established within all local authority secondary schools since 1968. Careers guidance has been taught over the years

within a number of different remits, but it is now most commonly found within every secondary school's Personal and Social Education programme (PSE)/ Social Education programme (or equivalent) and within one-to-one guidance sessions with pupils.

What is covered within careers guidance in each of the levels of the secondary school in Scotland is entirely up to the individual school, although schools are expected to combine the content of national guidelines with their knowledge of their pupils needs. The Scottish Office Education Department (SOED) stipulates within its guidelines to secondary schools that guidance staff should be able to provide forty minutes per week for every 15 pupils (Howieson & Semple 1996).

Throughout the secondary school the need for, and aims of, careers guidance varies depending upon the particular level of schooling a pupil has reached. In second year (S2), the majority of work is expected to focus on the optional choices available to pupils for study at S3 and S4 level.

During S3 and S4 pupils can expect to be made aware of the many different kinds of careers and further and higher educational opportunities that will become available to them. Pupils at this level are also expected to spend one-to-one sessions with a careers officer who will go through their individual profile and help them to decide their goals for the future and methods of attaining those goals (Howieson & Semple 1996).

Again at the end of S4, for those remaining beyond the compulsory level, the majority of time is expected to concentrate on the choice of options for S5. If pupils then continue through S5 and S6 the majority of time in careers guidance is expected to be spent on preparation for higher and further education and guidance staff will help pupils to decide on which institutions they should apply to. Pupils are expected to make visits at this point to some of the institutions at which they are interested in continuing their education.

On the whole the aim of careers guidance in Scottish schools is to prepare pupils for working life and continuation of education and to make pupils aware of what is available to them both in terms of employment and education opportunities (Howieson & Semple 1996).

Summary

Throughout this chapter the policy framework at the national level in both countries has been mapped out for the policy areas of sex education, sexual health and education. A number of interesting issues have arisen thus far at the national level for each policy area including.

With regard to sex education, despite their being no law in either country that specifies that sex education must be taught, because the various subjects within which sex education is provided in Finland are national curriculum subjects, the provision of sex education in Finland was mandatory in the sense that there were sex education aspects in Biology, Home Economics and Physical education and the content of those subjects was prescribed at the national level. In Scotland,

however, there was no requirement for sex education to be taught as part of the Scottish Syllabus with the exception of 1st year Biological reproduction and there was no official guidance at the national level provided to local authorities or schools regarding the teaching of any non-curricular sex education.

Further to this, because sex education in Finland was provided through a number curriculum subjects, this means that in theory, young people in Finland could expect to receive both a broader content of sex education and a consistent content across schools in Finland because the content is prescribed at the national level. Without any official guidance for schools in Scotland, except for Biology, in theory young people in Scotland are unlikely to receive a consistent level or content of provision.

Again, the lack of guidance in Scotland meant that no specific awareness was noted at the national level about the issue of young men's needs in relation to sex education, whereas in Finland there was awareness at national level and the content of sex education within the Health Education classes reflected this. Further to this, the dual system of teaching environment (mixed and single-sex arenas) encouraged in Finland would have the potential to enabled gender-separate sensitive discussion, that would not be possible within the mixed-gender provision in Scotland.

In relation to the issue of access young people have to sexual health services in each country, there were a number of key issues noted at the national level. First, the general sexual health policy focus differed between the two countries, i.e. in

Finland the focus appeared to be on promoting healthy sexuality in comparison to the predominant focus on reducing teenage pregnancy in Scotland.

Second, despite the fact that young people in both countries have the right to access confidential advice and free (or low cost) contraceptives from a variety of sources in their local authorities/ municipalities, research has noted that young people generally do not perceive 'real' access to services that are visible to the public (parental) eye. It appears, therefore, that the difference in the way each country uses its school health service (and school nurse) could have implications for young people's access to a service, which can provide sexual health advice, that they are comfortable in using.

Finally, in relation to the each country's education system it appears that the emphasis within careers guidance (student counselling) on continued education in Finland and employment in Scotland, as well as, the apparent normalised expectation in Finland, that all young people should go on to continue their education for at least three years, an expectation that was not visible in Scotland, may provide some insight as to why more young people remain in school longer in Finland than in Scotland.

Before it is possible to draw any conclusions as to the effect that the similarities and differences at the national level presented in this chapter may have on the teenage pregnancy rates in both countries, it is first important to explore these policies at the local level of implementation. This exploration is therefore the focus of the next chapter.

Chapter Five

Teenage pregnancy and policy implementation at the local level

Introduction

The purpose of this chapter is to shift the focus from the national to the local policy level. Considering each policy area in turn, this chapter explores the polices that have been implemented at the local and school level in Finland and Scotland. Throughout, consideration is given to how the national framework has impacted upon the operation of local level policy.

Sex Education Policy

Having set out the national framework for the provision of sex education in Chapter Four, the first section of this chapter explores the sex education policy developed and implemented within the three local authorities/municipalities and the four[1] schools in each country.

Finland

Curriculum location and time allocations

Each of the four schools in Finland fulfilled the requirements of the permeated system of sex education provision as set out within the national curriculum for the

[1] One school in each country was a pilot school. However due to the fact that the interview schedule changed relatively little between the pilot and main stage of the fieldwork, the pilot school has been included within the data presentation in this chapter and the analysis of the data in Chapter Six. With regard to sex education policy the only addition to the interview schedule was a question about the main aims of sex education at the school level.

comprehensive school[1]. Over and above the national requirements of Biology (three or more lessons) in the 9th grade, one hour a week of Health Education in the 8th grade and one hour a week of Family Education in the 9th grade, schools were then free to allocate more provision if they thought it necessary. Table 5.1 below presents the provision of sex education in each school. The provision necessitated by the national framework is highlighted in bold.

Three out of the four schools had decided to provide on average one to two hours a week extra sex education over the three grades of the *Peruskoulu*. In addition to their extra allocations, *Tehtaala and Alajoki Peruskoulu* had also decided to host a sexual health day or week at the school, combining the resources of teachers, the school nurse and the school doctor in order to do so. Only *Koskela Peruskoulu* did not provide any notable additional provisions except for one lesson to each grade (per year) by the school nurse.

Teaching environment

The national framework provided the opportunity for sex education classes in Finland to be delivered within a dual system of provision; a system that was practised in three out of the four schools. As can be seen in Table 5.1 below, the class arrangements were mixed-sex for all Biology and Family Education classes. Only *Alajoki Peruskoulu* also had mixed-sex Health Education classes (although there was single sex provision at the lower *Peruskoulu* for Health Education). The other three schools had a single-sex provision for Health Education.

[1] See Chapter Four for an explanation of the permeated system.

Table 5.1 Sex education provision in four Finnish schools

Grade	*Koskela Peruskoulu*	*Tehtaala Peruskoulu*
7th grade (13-14)	School nurse - 1 lesson (mixed) School nurse - available 5 days per week for personal enquires	Biology - 1 lesson x 1 hr (mixed) Health education - 1 hr/week (single sex) School nurse - available 4 days per week for personal enquires School nurse - health checks with all 7th grade pupils
8th grade (14-15)	**Health education - 1 hr/week (single sex)** School nurse - health checks with all 8th grade pupils School nurse - available 5 days per week for personal enquires School nurse - 1 lesson (mixed)	**Health education - 1 hr/ week (single sex)** Biology - 1 lesson x 1 hr (mixed) Sexual health day for all 8th graders taught by teachers, school nurse & school doctor (mixed) School nurse - available 4 days per week for personal enquires
9th grade (15-16)	**Biology - 4-6 (x1 hr) lessons (mixed) Family education - 1hr/week (mixed)** School nurse - 1 lesson (mixed) School nurse - available 5 days per week for personal enquires	**Biology - 6-10 (x1 hr) lessons (mixed)** **Family education - 1 hr/week (mixed)** Health education - 1hr/week (single sex) School nurse - available 4 days per week for personal enquires

Grade	*Vaarama Peruskoulu*	*Alajoki Peruskoulu*
7th grade (13-14)	Health education - 1 hr/week (single sex) School nurse - available 3 days per week for personal enquires	Sexual health week - lectures by teachers, school nurse & school doctor (mixed) School nurse - available 2 days per week for personal enquires
8th grade (14-15)	**Health education - 1 hr/week (single sex)** School nurse - available 3 days per week for personal enquires and check-ups with all 8th grade pupils.	**Health education - 1 hr/week (mixed)** Biology - 3 (x1 hr) lessons (mixed) School nurse - available 2 days per week for personal enquires and check-ups with all 8th grade pupils. Sexual health week - lectures by teachers, school nurse & school doctor (mixed) School nurse - 1 lesson (mixed)
9th grade (15-16)	**Biology - 6-10 (x1 hr) lessons (mixed) Family education - 1 hr/week (mixed)** Health education - 1 hr/week (single sex) School nurse - available 3 days per week for personal enquires	**Biology - 6-10 (x1 hr) lessons (mixed) Family education - 1 hr/week (mixed)** Sexual health week - lectures by teachers, school nurse & school doctor (mixed) School nurse - available 2 days per week for personal enquires Health education - 1 hr/week (mixed)

A number of teachers noted the benefits of the dual-system of provision, in particular for meeting the needs of young men in sex education. The mixed classes provided an avenue for young men and women to understand and discuss each other's differences. Teachers perceived this as crucial, because an important part of practising safer-sex was communication about sex and contraception between partners. Therefore giving young people the opportunity to communicate about sex in a safe environment would hopefully increase their ability to do so in their future relationships.

Teachers of the Health Education classes which provided the single-sex arena noted that they provided a perfect opportunity for discussing more private issues if pupils wanted to, without the presence of the opposite sex. This commonly included issues such as wet dreams, pornography, eroticism and masturbation in the young men's classes and menstruation, breast development, sexual desire and masturbation in the young women's classes.

Teacher training to undertake the provision of sex education was not an issue that had warranted policy concern at the national policy level in Finland. This was reflected by the relative lack of official training undertaken by teachers at the local level. It was also not perceived by the majority of teachers or head teachers as a major area of concern. Due to the fact that there was no 'separate' subject called sex education, there had been no perceived need to train specifically on this area of provision.

During professional training, teachers would receive training on all elements of their subject and therefore, if their subject included 'sex education', training would be received on how to teach those aspects of that course. In other words, teachers of Home Economics as part of their pre-service training, would receive training on how to teach Family Education; similarly, as part of their training, teachers of Physical Education, would receive training on how to teach Health Education, including the topic sexual health.

Organised in-service training at the school level was also not a regular occurrence in any school examined in Finland. The only training undertaken by teachers working within sex education was done on their own initiative. Typical courses undertaken included one-day to one-week training courses provided by the *Mannerheim Child Welfare Organisation* or *Väestöliittö*[1]. Alternatively some teachers had undertaken research by themselves in order to ensure they were up-to-date on current issues to do with teenage sexual health. The municipality of *Alajoki*, however, had been actively involved with identifying teacher-training requirements for a number of years. Training to teach sex education, however, was not an issue that had so far arisen as an area of particular concern.

The methods employed by teachers to teach sex education across the four schools depended on two main variables; class size and the subject being taught (i.e. Biology, Family Education or Health Education). On the whole, where classes contained over 25 pupils[2] or if the subject was Biology, teachers utilised more

[1] *Väestöliittö is The Family Federation for Finland based in Helsinki: http://www.vaestoliitto.fi*

[2] Classes over 25 pupils represented a minority. Approximately 80% of classes contained under 25 pupils.

didactic methods with the additional use of visual aids (videos, transparencies and slides). For smaller classes and most other sex education subjects (including the school nurse classes in *Koskela Peruskoulu*), teachers generally employed some degree of lecturing, although the majority of work would involve smaller group work. At *Tehtaala* and *Alajoki Peruskoulu*, co-operative learning was a very popular method in particular.

Content

The most common description of the content of the sex education provisions by teachers in the four schools was the same as that provided at the National Board of Education, in other words, the content was based on the "promotion of healthy sex and sexuality". A number of the teachers noted that the permeation approach to provision enabled the content to be diverse in its coverage. This diversity was consistent across the four schools. Table 5.2 below summarises the common content within each subject across the four schools.

Some teachers noted that to an outsider it may appear that there was a degree of repetition across the different provisions, although they further noted that the angle from which the topics were taught, differed. For example, within Biology, the focus on the sexual act, reproduction and abortion was from a biological perspective, whereas the emphasis in Health Education was from a sexual health perspective and in Family Education, on the legal and social aspects.

Table 5.2 Summary of sex education content by subject provision in Finland

Biology	***Health education* (men)**	***Health education* (women)**	***Family education***
Biological maturation, Anatomy & physiology, Body functions & changes during puberty, Sexual development, Sexual desire and young people, reproduction, Sperm & egg, development of Embryo, pregnancy and Childbirth, Abortion. Reality of being a parent. Pregnancy prevention, STI prevention.	Physiology and maturation, Puberty, Masturbation (especially myths), Wet dreams, Pornography, Sexual desire, Sexual intercourse, Protecting others, protecting self, Respect & Responsibility, Connecting the sexual act & emotions, Contraception, AIDS/HIV, STIs & pregnancy, Abortion. Recognise, accept & understand difference, especially between girls and boys and different Sexual orientation.	Physiology and maturation, Puberty, Menstruation, Masturbation (especially myths), Sexual desire, Sexual relationships, Sexual intercourse, Respect and responsibility, Emotional vulnerability, Contraception, AIDS/ HIV, STIs & Pregnancy, Abortion. Media influences on young people, Sexual orientation, Alternate sexuality and sexual preferences.	Maturation, Getting to know people, Friendships, Attraction, Emotions and feelings, Dating, Falling in love, Ending relationships *nicely*, Masturbation, Sexual relationships - respect and responsibility, Risk Factors - pregnancy & STIs, Contraception, Abortion, Pregnancy & Childbirth, Looking after a baby, Parenthood, different family Stages.

School nurse

Anatomy - changes during adolescence, Physical and emotional development during puberty and teenage years, Attraction - dating - having crushes - falling in love - ending relationships *nicely*.
Making Love - when to start - listening to yourself and your own body, The right to say 'no' - pressure and force, Sex - the act.
Pornography, Eroticism and desire, Sexual fantasies and dreams, Good sexual health - protecting yourself and your partner, Contraception, Pregnancy, Abortion, Alternate sexualises, Respecting difference.

Main aims of sex education

Across the three main schools[1], response to the question of the main aims of sex education was found to differ across the subjects where it was taught, although the responses across the schools were consistent by subject. Detailed in Table 5.3 below are the main aims stated for each subject. In comparison with the content of the sex education in each subject detailed earlier, the main aims can be seen to mirror the content. On the whole the mains aims focused upon increasing knowledge and affecting upon sexual attitudes as well as fostering the attitudes of respect and responsibility (especially amongst young men). Finally, promoting the notion that sex and sexuality are a normal part of life and that sexual desire is not something confined solely to the realm of adulthood were also highlighted as important aims within the Health and Family Education classes.

Inter-agency Collaboration

Identified as an informal policy at the national level was the issue of the school nurse being used within the provision of sex education. Only *Koskela Peruskoulu* had been actively using the school nurse for class-based sex education at the time of interview. The other three school nurses had been or expected (and expressed a desire) to be involved at some point in the provision of class-based sex education. All four nurses noted however, that they were utilised as an information resource for teachers involved in providing sex education.

[1] This is excluding *Koskela Peruskoulu* as the question of main aims was introduced after the pilot stage.

Overall status of sex education at the school level

All teachers and nurses (except one male Health Education teacher[1]) perceived the provision of school-based sex education to be very important. There was recognition that perhaps parents should take more of the responsibility for this education. Because teachers noted that most did not, however, the provision of school-based sex education was very highly rated by those interviewed.

Table 5.3

Main aims of sex education in three schools in Finland

Main aims
Biology Increase knowledge of sexual reproduction and the implications of sexual intercourse. Pregnancy and STI prevention. Respect and Responsibility.
Family education De-mystifying sex and sexuality. Increase knowledge on the legalities of sex. The reality of pregnancy and parenthood. Fostering attitudes of responsibility and respect. Increase knowledge on how to protect yourself and your partner.
Health education Develop knowledge of physical and emotional development during puberty and teenage years. Understand what it means to be sexually active for you and your partner's sexual health, including pregnancy and STI prevention. Understand that sex and sexuality are a normal part of life, including masturbation, sexual desire, heterosexuality and alternate sexualities.
School nurse Promotion of healthy attitudes to sex and sexuality. Explore the positive and negative aspects of sexual activity. Know where to access advice and help. Affect on attitudes to respect and responsibility.

[1] This teacher considered family and the home a more important and appropriate venue for the teaching of sex education.

Scotland

Curriculum location and time allocations

Biological reproduction was taught within the four Scottish schools examined in this research. Unlike in Finland however, where Biology was perceived to be one area of sex education provision, this was not found to be the case in Scotland. Teachers of Biology did not consider their course on 'biological reproduction' to be 'sex education', it was purely another element of Biology. The provision of non-core curriculum sex education varied considerably across the four schools; in particular in relation to time allocation and diversity of content.

Table 5.4 below outlines the details of each school's policy regarding the provision of non-core curricular sex education provision. The compulsory provision of Biology, although not perceived as sex education is also included and highlighted in bold.

Scotallen Secondary School provided Health Education on a rotation basis from 3rd to 6th year (forty minutes per week for nine weeks). It did not however have an established programme of Social Education or PSE for any year group. Glendale Academy had a well-structured PSE programme including forty minutes per week for eight weeks per year on sex education. The original PSE programme had been introduced in 1990, but teachers noted that the provision was not well structured until the local authority provided detailed guidance in 1993.

Table 5.4 Sex education provision in four Scottish schools

	Lochend Secondary School	Glendale Academy	Scotallen Secondary School	Arbourness High School
1st year (11-13)	**Biology - 2-3 weeks (mixed)** Social education (including sex education) 40 mins/ week approx 1/5 of lessons on sex education (mixed)	**Biology - 4-6 weeks (mixed)** Since 1990 PSE (including sex education) 40 mins/ week for 8 weeks on sex education (mixed)	**Biology - 2-3 weeks (mixed)**	**Biology - 4 weeks (mixed)** PSE (including sex education) 1 lesson per week - 8-10 weeks for sex education (mixed)
2nd year (12-14)	Social education (including sex education) 40 mins/ week approx 1/5 of lessons on sex education (mixed)	Since 1990 PSE (including sex education) 40 mins/ week for 8 weeks on sex education (mixed)	Since 1990 Biology - 2 weeks ESCAPEAIDS programme	PSE (including sex education) 1 lesson per week - 7 weeks for sex education (mixed)
3rd year (13-15)	Social education (including sex education) 40 mins/ week approx 1/5 of lessons on sex education (mixed)	Since 1990 PSE (including sex education) 40 mins/ week for 8 weeks on sex education (mixed)	Health education - 40 mins / week for 9 weeks (2/9 sex education) (mixed)	PSE (including sex education) 1 lesson per week -12 weeks for sex education (mixed)
4th year (14-16)	Social education (including sex education) 40 mins/ week approx 1/5 of lessons on sex education (mixed)	Since 1990 PSE (including sex education) 40 mins/ week for 8 weeks on sex education (mixed)	Health education - 40 mins / week for 9 weeks (2/9 sex education) (mixed)	PSE (including sex education) 1 lesson per week -10 weeks for sex education (mixed)
5th year (15-17)	Social education (including sex education) 40 mins/ week approx 1/5 of lessons on sex education (mixed)	Since 1990 PSE (including sex education) 40 mins/ week for 8 weeks on sex education (mixed)	Health education - 40 mins / week for 9 weeks (2/9 sex education) (mixed)	PSE (including sex education) 1 lesson per week -10 weeks for sex education (mixed)
6th year (16-18)	Social education (including sex education) 40 mins/ week approx 1/5 of lessons on sex education (mixed)	Since 1990 PSE (including sex education) 40 mins/ week for 8 weeks on sex education (mixed)	Health education - 40 mins / week for 9 weeks (2/9 sex education) (mixed)	PSE (including sex education) 1 lesson per week -10 weeks for sex education (mixed)

The remaining two schools both had established programmes of Social Education or PSE. Lochend Secondary School provided forty minutes per week of Social Education for every year group, with approximately one fifth of the academic year allocated to sex education. Arbourness High School provided forty minutes per week of PSE. The amount of time allocated for sex education varied by year group, averaging annually at ten weeks per year group. The non-core curricular sex education provision at Arbourness High School was the most structured of the four schools and was adjusted annually to suit the needs of the young people at that school on the basis of an internal evaluation by staff and pupils.

Teaching environment

All classes within which sex education was provided in each of the four schools were mixed-sex. As was noted in Chapter Four, this style of set-up was how all education classes were structured within Scottish schools (Wight & Scott 1994).

Noting that the Biology teachers "don't teach sex education, we teach biology", they did not consider teacher training for sex education to be appropriate to them. All Biology teachers had received training to cover the biology of reproduction during their pre-service studies.

For those teaching non-core curricular sex education, the amount of training received by teachers varied across the four schools. Pre-service training had been undertaken in the form of guidance certificates by all of the guidance staff, although this was not particularly extensive with regard to how to teach sex education in particular. Additionally, not all teachers providing sex education were

guidance staff (and hence had not taken the guidance certificate). Of the four schools only the guidance staff at Arbourness High School had undertaken any substantial in-service training. This training was in the form of Health Education courses as well as training provided by the local health promotion centres in their city.

At Glendale Academy the guidance staff stated that the local authority did encourage participation in in-service training and would often send information to the school regarding the availability of courses. With the numerous changes to the Scottish syllabus and the certification of courses at secondary level over the last 15 years, however, the guidance teachers noted that undertaking training in relation to those changes was considered to be more important. As a result there had been practically no in-service training undertaken by the guidance staff at Glendale.

There was a common belief amongst all of the teachers interviewed in all four schools, that in order to provide effective sex education better training was required at pre- and in-service levels. The main constraint in relation to undertaking more training was noted to be the relative lack of importance that PSE and Social Education held in relation to curriculum subjects. Some teachers stated that until PSE and Social Education had equal status with curriculum subjects, it was unlikely that this situation would change.

The teaching methods utilised across the four schools were fairly consistent. Within the Biology classes methods were generally didactic combined with the 'Living and Growing' BBC video series (Grampian Television 1993), worksheets

and a standard Biology textbook. Within Social Education, PSE and Health Education, methods on the whole remained traditional, although small-group discussion methods were used more within the upper years (post-16) of the secondary school (4th –6th year).

Some standardised packages were used such as 'Taught not Caught' (Dixon & Mullinar 1989)[1], 'Taking Sex Seriously' (Cohen & Wilson 1994)[2] and 'Skills for Adolescence'(TACADE 1986)[3]. Teachers would generally not use a whole package, but rather would pick and choose sections that suited the work that they wanted to cover.

Content

The provision of biological reproduction taught in each of the four schools was consistent in content as set out in the Scottish Syllabus. There was a large degree of variation in content within the Social Education, PSE and Health Education provided within the four schools. One common aspect however, was that teachers talked frequently in terms of increasing young people's knowledge about sex and pregnancy prevention in particular and trying to provide young people with the skills with which to apply that knowledge to their lives and their behaviour.

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[1] ***Taught not Caught**: strategies for Sex Education* is a resource for sex education which presents a wide range of activities, issues and content in an imaginative and original manner. The resource book is widely used at secondary schools in Scotland (Forrest, Souter & Walker 1994).

[2] ***Taking Sex Seriously – Practical Sex Education Activities for Young People*** is a resource for teachers to aid in the teaching of sex education with teenagers. It includes a wide range of activities and strategies to help young people to deal responsibly with info they receive and decision-making. It covers a range of issues including, the effective use of contraception, alternatives to having sexual intercourse, STIs - prevention and treatment, issues relating to sex and the law, as well as parent workshop activities.

[3] ***Skills for Adolescence*** is a package for personal and social education, which is available to all participants of TACADE in-service training. It is suitable for S1-S2 pupils and aims to promote child centred approaches focused on the development of responsibility, self-confidence, self-discipline and service to others.

The head teacher at Glendale Academy however, was particularly wary of the current contradiction in styles of health promotion. In relation to their current education in PSE he stated that the school had recently invited some visitors to provide 'drugs education' and one set of external visitors (parents affected by the death of their child from drugs) presented the perspective of 'just say no'. The other visitors came from the perspective that 'some kids will do these things regardless' and therefore a 'harm reduction' approach was best, telling them the risks and make them aware of how they can reduce those risks. The head teacher was left wondering - "what is the best approach?"

Almost all teachers noted that young people have a lot of knowledge with regards to sex. What they were lacking was education on the relationships and emotional issues, rather than sex education per se. As can be seen from Table 5.5 below, the general focus of all of the sex education provided at these schools was increasing knowledge on the practicalities of sex such as contraception, pregnancy, abortion and STIs and to a lesser, but developing extent, focus on relationships and emotions. The guidance teacher at Lochend Secondary School added that although they tended to focus on the subjects just described, he had a policy that 'no subject is taboo' and that if pupils had the courage to ask a question, he would find the courage to answer it honestly. It is worth noting, however, that the pupils would first have to raise the questions, which would not necessarily be easy.

Notably lacking from all programmes except the PSE programme at Arbourness High School, was the presentation of positive as well as negative issues relating to

Table 5.5 Summary of the content of sex education provision in four Scottish schools

Biology - all schools	*Lochend secondary school*	*Scotallen secondary school*	*Glendale Academy*
1st year biology Biological reproduction Anatomy & physical development at different stages of life Reproductive systems of men & women How pregnancy occurs - the basic sex act - 'sperm meets egg'. Development of foetus up to birth.	**Social education - 1st-6th year** Physical development - puberty Sexual intercourse Pregnancy prevention Contraception Abortion AIDS/ HIV & STIs Relationships 'No subject is taboo'	**2nd year biology** ESCAPEAIDS programme **Health education - 3rd-6th year** Sexual intercourse Contraception AIDS/ HIV & STIs Abortion	**1st - 6th year PSE** Physical development - puberty Sexual intercourse Pregnancy prevention Contraception Abortion AIDS/ HIV & STIs Relationships

Arbourness High School

1st year PSE Growing young people, puberty, changes & developments - mental & physical. AIDS - *'Taught not caught'* Programme **2nd year PSE** Relationships and friendship groups What is sexuality? AIDS - *'Taught not caught'* Programme Risk and safety - who to trust Child abuse awareness	**3rd year PSE** Sexual relationships Heavy emphasis on contraception How to get help if you are in need - where to go. What is sexuality? Promoting healthy attitudes to sex and sexuality Teenage pregnancy rates in Scotland connecting again to contraception. *'Taking sex seriously'* programme Risk and safety - who to trust Child abuse awareness	**4th year PSE** STIs, Abortion, AIDS - *'Taught not caught'* Programme Contraception Risk and safety - who to trust Child abuse awareness **5th and 6th year PSE** Pupils choice of subjects Assertiveness training Sexuality - what it means to men and women Draw on different attitudes and beliefs for discussion.

sex and sexuality. The issue of self-pleasure[1] as part of the process of learning about your body was also lacking, even within the more 'liberal' programme at Arbourness High School.

Main Aims

As would be expected the main aims of sex education related closely to the content provided within each school. In support of the notion that teaching about biological reproduction in Biology was not viewed as a 'sex education' provision, the main aim of this course was for the pupils to pass their exams on the subject. For the non-core curricular sex education provided in each school, over and above the main aims of increasing knowledge, developing skills to help young people to apply that knowledge and make responsible decisions, and affecting upon young people's sexual attitudes, emphasis was placed on a number of alternate areas. These areas had less to do with what the young people should achieve, but rather, how the education should be presented. In other words, teachers showed concern over providing a friendly atmosphere for the pupils and to avoid preaching to them, especially about what the teachers considered to be 'right' and 'wrong'.

Inter-agency Collaboration

The use of sexual health experts[2] in the teaching of sex education varied across the four schools. All teachers acknowledged the value of sexual health experts mainly for their expertise in teaching sometimes difficult and embarrassing subjects. They

[1] Research on young women's experiences of sex and masturbation has revealed that presentation of positive as well as negative issues is particularly important; those young women who were comfortable with themselves and had learnt what pleasured them were more likely both to delay their first intercourse and to enjoy it (Thompson 1990).
[2] Sexual health experts would include individuals such as family planning nurses, school doctors, Brook advisors and other sexual health promotion workers.

were also valued for often bringing and presenting alternate view-points to the ones presented by the teachers.

As much as the teachers in each school valued these sexual health experts, their use within each school was found to be relatively limited, some more than others. The limitations arose partly from the school's lack of ability to afford their services. Additionally, teachers noted that most sexual health experts could not dedicate the amount of time that schools needed. Guidance staff at Glendale Academy in particular stated that this was a growing area of concern for them. They could not get anyone to commit to more than the occasional lesson and they certainly could not obtain a commitment time-wise to a set block of 4 or 8 weeks[1]. As a result, the use of sexual health experts had dwindled over the late 1980s and early 1990s to virtually no expert provision at Glendale. This was a major concern expressed by the guidance staff as they felt that their pupils were losing out on important alternate provision.

On the other hand, the guidance teacher and head teacher at Lochend Secondary School stated that they were quite fortunate; being located in a relatively small and close-knit community, they had found it easy to gain access to sexual health experts in particular the school doctor. There were however limitations in the school doctor's ability to provide this service consistently, as, being the main GP in the area, she would often be called away and have to cancel at the last minute. In

[1] Teachers at Glendale noted that they were comfortable providing the sex education set for years up to S2 level, but felt that for years S3 to S6, outsiders would do a better job, for example being able to answer specific questions about sexual health that the teachers did not feel they had adequate knowledge to answer. This was why they would request for an outsider to provide a block of lessons.

addition to the school doctor, this school has over the years also made use of organisations such as Tampax, the Terence Higgins Trust and drama workshops on AIDS.

Similarly Arbourness High School had managed to make use of a wide variety of sexual health experts, although this provision was mainly for those aged sixteen plus (5th and 6th year pupils). The 5th and 6th years would often be asked who they wanted to receive talks from and dependent on availability, the teachers would do their best to obtain relevant experts. The provision of these experts was closely linked to help provided from the local education authority who "worked hard" on behalf of the school to obtain the provisions they requested. Finally, Scotallen Secondary School did not utilise any sexual health experts in the provision of their Health Education programme.

Overall status of sex education at the school level

With regard to the status of sex education at the school level, all of the teachers involved in the provision of non-core curricular sex education believed that the provision of school-based sex education was very important. There was general recognition that sex education could not be guaranteed to be provided at home and therefore "schools had to do something". Many teachers did express a belief however, that sex education and PSE/ Social Education in general was not very highly valued by other teachers, especially if those teachers lost teaching time to make way for such programmes.

The inclusion of sex education and the degree to which it was provided appeared to depend heavily on commitment at senior management level. This was most apparent at Scotallen Secondary School where the current head teacher had only taken over in 1996. When he arrived there was no PSE or Social Education provision and he believed this was because the previous head teacher simply "didn't rate it". Due to his firm belief that a school like Scotallen Secondary School should have a PSE programme, he had spent the three years since his arrival at the school developing a programme that would be launched in the academic year 1998-1999.

On the whole there was a positive view presented by all teachers interviewed of the role that sex education could play, but recognition also of the limitations of each school's provision. This was most noted in the remarks of the Glendale Academy head teacher who stated that whilst he recognised the value of sex education to a degree, "in the larger scheme of things and considering how much of young people's lives is not spent in school, realistically, how much effect does it really have?". This was a repetitive question he posed during the interview.

Frequently noting his own scepticism however, he stated in his defence that he was merely being realistic. He posed a number of interesting points (see quotation below) for consideration in relation to the provision of sex education across all schools in Scotland. These points summarise well the concerns with the provision of sex education raised by other teachers across the four schools.

"I think we've got a role. As a head teacher, I get sick and tried of people passing onto schools the problems of society and... well it's just ridiculous, but there has in part got to be role. But as I say in 40 minutes a week, occasionally or a period, or block of sex education is not in my mind, going to deliver any real message. That sounds terribly pessimistic, but if I was teaching any subject, I would hardly say a period a week for 8-10 weeks is a great medium for delivery, and I think probably most schools are the same that way... My own view is that there are issues, there are wider issues which will not be addressed, it's very easy to say schools should do this, school should do that, fine, but the resources aren't there to allow it do be done without losing something else. And so until somebody is willing to come along and say well stop doing that and make sure you do 3 periods a week of PSE... they say that and we'll do it, but at the moment priorities from parents and such like in this school, it's very much to get on with the job in hand, which is more the traditional curriculum" (Head teacher - Glendale Academy).

Sexual Health Policy

From the exploration of the national framework of provision in Chapter Four it was identified that both countries had a similar basic level of sexual health service provision. In both countries, all citizens could access free contraceptive advice and free (or low cost) contraceptives in a number of locations. The implications that the different styles of provision in each country have on a young person's ability to access and utilise these services at the local level will be the focus of the next section of this chapter. In particular, attention is paid to which services are available to young people; who those services are aimed at (i.e. if they are general population or youth-orientated); how easy it is for young people to access those

services; whether the services ensure confidentiality; who the providers are, and what relevant training they have had to deal specifically with young people's needs.

Finland

Table 5.6 below provides details of the particular sexual health services that can be accessed by young people in each of the three municipalities explored in Finland. Taking first the school health service, the basic framework of this service provides every young person with a primary health care resource for as long as they attend an institution of education in Finland. For the most part, interaction within this service will be between pupils and the school nurse. A school doctor is also available within these services, but for the main part the school doctor's role is confined to the regular check-ups that the pupils receive in either the 7th or 8th grade.

The amount of time each school nurse is available to be accessed by pupils depends on the size of the school and the resources available for school health in any given municipality. Of the four schools examined only *Koskela Peruskoulu* had a fulltime nurse available on location 5 days a week. At *Tehtaala Peruskoulu* the nurse was available all day, 4 days per week, at *Vaarama Peruskoulu* all day, 3 days per week (and any time via an emergency phone number) and at *Alajoki Peruskoulu* all day, 2 days per week. Each of the school nurses worked closely with their local municipal health centre and made pupils aware (via sex education

Table 5.6 Sexual Health Services Available to Young People in Finland

Type of service	Location	Main provider	Opening hours	Municipality in which Service is available	Dedicated service for young people
School Health Service	School-based	School nurse	During school hours No. of days dependant on individual school	Tehtaala, Vaarama & Alajoki	Service for young people
School Health Service Contraception on-site	School-based	School nurse	During school hours No. of days dependant on individual school	Alajoki	Service for young people
NGO youth clinic	Central	Public health nurse	8am - 4pm Monday – Friday and Saturday.	Tehtaala	Service for young people
Municipal health centre (family planning clinic)	Various	Pubic health nurse	Monday to Saturday mainly 9-5	Tehtaala, Vaarama & Alajoki	Service for all

lessons and during visits to the school nurse) of the services on offer in the local area when she was not available.

All of the nurses interviewed had undertaken their basic nursing training before specialising in particular to work with young people (as was the case for all school nurses in Finland). All of the nurses noted however, that they were responsible for keeping their knowledge of sexual health issues affecting young people up to date, especially if they were to be involved with teaching class-based sex education[1]. Two of the nurses actively sought out training opportunities within organisation such as the Mannerheim Child Welfare organisation and Väestöliittö (which also provided training for schoolteachers). The other two nurses expressed a desire to undertake further training.

Within all school clinics a standard procedure existed for the provision of contraception; if a young woman requested contraception the nurse would first fill in a gynaecological form for the young woman. She would then make an appointment for the young woman at the local municipal health centre or NGO youth clinic (depending on availability) where the young woman would go to see the doctor and collect a prescription for her pills[2].

[1] Only the school nurse in *Koskela Peruskoulu* is actively involved in teaching class-based sex education although the other three nurses expressed an intention and desire to do so at some point.
[2] Reference to pills as the provision of contraceptive is due to the fact that the contraceptive pill and the IUD are the two most common methods of prescribed contraception used by all women in Finland (Kosunen 1996). However the IUD is usually only given to women who have already borne a child to make sure that any possible infertility is not the result of using an IUD. Therefore when a young woman in Finland goes to obtain a prescribed contraceptive it will almost always be the contraceptive pill.

Within each municipality the first trial of pills is provided free of charge. The length of time this trial lasted varied between municipalities from 3 months in *Tehtaala* and *Vaarama* to 1 year in *Alajoki*. This process would also be the same if a young woman required to access emergency contraception. In both *Tehtaala* and *Vaarama* this would cost approximately 50 Mk (6 pounds) and in *Alajoki* it is provided free of charge.

The school nurse at *Vaarama Peruskoulu* was also able to provide condoms to pupils on request. Additionally, the school nurse in *Alajoki Peruskoulu* (and all schools in that municipality) could provide contraceptive pills, including emergency contraception, within the school clinic itself. This was stated by the school nurse to be a very important additional resource because she was only available two days a week in her school and due to the rural nature of the municipality.

The role of school nurse as a whole was commented on without prompting, by most of the teachers in every school. The head teachers at both *Tehtaala Peruskoulu* and *Vaarama Peruskoulu* highlighted that not only was the school nurse a likely contributory factor to the low teenage pregnancy rates in Finland but also that the key to her success was being located within the school. In particular the head teacher at *Vaarama Peruskoulu* strongly believed that this system "would simply not work if she were placed elsewhere", for example within the local municipality health clinic. There was a strong recognition of the needs of young people within this school and one of those needs was seen to be easy access to health services when required.

All of the school nurses themselves perceived their role as a provider as very important to young people. The main reason for this was due to the recognition that many young people cannot talk to their parents about sexual issues and that for many, she would be the only person that they could talk to. Additionally the nurses all noted that because they had known their pupils for many years, they had developed good relationships with many of them. This in turn they believed, meant that young people knew that they would provide them with reliable information and advice about sexual health without 'looking down' at them for being sexually active.

One service that is available to all people in Finland is the municipality health centre family planning clinics. Whilst for most, the school health service would be the first port of call (Kosunen 2000b), the municipal family planning clinic would be the second, especially if the school nurse could not dispense contraceptives herself[1]. This service is also confidential and often the nurse who works in the school would also work in the health centre; there would therefore often be a certain level of familiarity and continuity of care. This service is however more 'visible' in its use and the opening times more restrictive for young people who attend school, both of which could be potential drawbacks.

[1] The decision as to whether a school nurse could dispense contraceptives at school is one taken at the municipal level and therefore if a given municipality allows this provision, as in *Alajoki*, then all school nurses in that municipality are allowed to provide contraception at the school clinic. Although only one of the three municipalities in this study allowed contraception to be dispensed at school, it is common practice in Finland for many municipalities to allow school nurses to provide the first trial of contraception (trial lasting 3-9 months) and then follow–up contraception is expected to be obtained from the local primary care facility (Kosunen 2000b). Within the areas studied in this thesis, the municipality which allowed this provision, was a rural municipality, the others were urban areas with more facilities available outside of school, this could therefore explain why those municipalities had chosen not to allow the school nurses in their areas to provide contraception at the school clinic.

The final service that was available to some young people, in the case of this sample only in the municipality of *Tehtaala*, was the NGO[1] youth clinic. This additional resource has the added advantages of being designed specifically for use by young people, being confidential, and open at times that are better suited to the schedules of school pupils. Similar to family planning clinics however, this service was not 'hidden' from public view. Additionally, the location of this clinic in the centre of that municipality, potentially limits use by some who live in *Tehtaala*, as geographically the municipality covers a wide area.

One further sexual health provision in Finland set out within the national framework was the provision of the magazine *Sexteen* to all 16 year olds. This magazine was highly valued by all four school nurses and was noted by two specifically to be an illustration of a very positive expression of Finnish society's general acceptance of teenage sexuality and the right of teenagers to this knowledge and was used by the school nurses to open up discussion with young people during one-to-one consultations.

Scotland

Table 5.7 below provides details of the particular sexual health services that can be accessed by young people in each of the three Scottish local authorities under exploration in this study. Of the services available, the primary care general practices and NHS family planning clinics are geared towards people of all ages. Whilst young people have the same access to these services as others, there are

[1] NGO stands for non-governmental organisation.

Table 5.7 Sexual Health Services Available to Young People in Scotland

Type of service	Location	Main provider	Opening Hours	Local Authority in which service is available	Dedicated service for young people
Primary care General Practice	Various	General practitioner	Monday – Friday various usually between 9-5. Some provide Saturday am clinics Small % provide evening clinics.	Glendale, Scotallen & Arbourness	Service for all
NHS family planning Clinics	City centre	Family planning nurses and doctors.	6 days a week Monday – Friday am and pm clinics Saturday 1-3.30.	Scotallen	Service for all Saturday clinic for young people.
	City Centre	Family planning nurses and doctors.	Monday 5-7.30PM Saturday 1-3.	Arbourness	Service for all
'Dedicated' clinics for young people run by community Family Planning services	City centre	Family planning nurses and doctors.	Various	Scotallen & Arbourness	Service for young people

many potential limitations to that access, the main one being the times at which these services are available. Except for Saturday provisions and after-school provisions[1], the times at which these services are available are likely to clash with the time at which young people are expected to be in school. Some community family planning services had sessions specifically aimed at young people although these were not available in Glendale[2]. Whilst these provisions are more tailored to young people' needs there remains the potential barrier of the geographical location of NHS family planning clinics. This type of clinic was only available in Scotallen and Arbourness and although located in the city centre, would still be difficult for many young people to access as both local authorities span a wide geographical area.

All the services mentioned so far however have one positive element (as defined by young people) in common and that is that they offer young people confidentiality. As a result of the Gillick case however, much confusion still remains especially amongst those aged under 16, as to their rights with regard to confidentiality (Hadley 1998).

Additionally, although many young people may know about their right to medical confidentiality, concern often surrounds their 'visibility' in using a service and the confidentiality of other people that may be present in or around the locale of that service. None of the services provided in Scotland are particularly 'hidden' from

[1] After school services are not guaranteed by all providers and where they are available they tend not to be provided more than once a week.
[2] These services are however more widely available throughout many of the local authorities in Scotland not under exploration in this thesis.

public view and therefore there is often a fear of being 'seen' by an individual who is acquainted with the young person's parent/s (McIlwaine 1994; Hadley 1998).

Therefore overall, there are a number of different services available to young people in Scotland. There was not however a service that encompassed all of the previously defined elements of the 'desired' service that most young people want and need to enable them to be sexually responsible.

Educational Policy

In order to place the importance of education policies into the context of teenage pregnancy prevention, one original proposition of this thesis was that, by extending the length of time in education, parenthood is being delayed indirectly. Having reviewed the relationship between continued education and teenage pregnancy in Chapter Two and having noted the significant relationship between high continuation rates in education and training and low rates of teenage pregnancy in a number of European countries in Chapter Four, this proposition has been strengthened. In order to explore this issue further, however, the structure of schooling and the influence of careers guidance will now be examined at the local policy level, as both of these policies may affect the proportion of young people in each country staying on in education beyond the age of 16[1].

[1] It is important to acknowledge that although not the focus of this thesis, there are other issues relating to the wider social context such as general standards of living, economic support for families and the state of the labour market, which may also have an affect on the proportions of young people who will remain in continued education beyond sixteen, as was discussed in Chapter One.

The national proportions of those aged 16-18 in education and training were presented in Chapters Two and Four, and Table 5.8 below show the proportions staying on in education for each school under exploration in comparison to the national education figures[1].

As can also be seen from Table 5.8, there exists a considerable difference in stay-on rates between the two countries at the school as well as the national level. Within Finland there is a high level of consistency across the four schools examined and the national rate, with 100% of pupils going on to some form of education[2].

In Scotland there is a degree of variation between the four schools of those staying on from 4th to 5th year (68-86%) and 5th to 6th year (60-80%). As a result there is variation between the schools of those staying on to 6th year as a proportion of the 4th year cohort (51-68%). In comparison to the national proportion (51%), the four schools fared from equal to 17% higher.

All of the educational routes in Finland, except for the option to complete a 10th grade, last for three years. Therefore in order to compare the percentages of those in education between Finland and Scotland, the key figures to compare are the percentage progressing from 9th grade to high or vocational school in Finland and the percentage progressing to 6th year as a proportion of the 4th year cohort in

[1] In order to aid the reading of these tables, it is worth noting that in Scotland the age of compulsory schooling (16) for most pupils would end during 4th year and for a minority 5th year. In Finland, compulsory schooling (16) for the majority would end at the end of the 9th grade.

[2] According to most student counsellors and the Director for Education at NBE in Finland, annually between 1-5% of those who take up their places in continued education will drop out within the first year and therefore the stay-on rate is never quite 100%.

Table 5.8

Summary of Finnish and Scottish stay-on rates at the school level (1996-1997)

	Koskela Peruskoulu	Tehtaala Peruskoulu	Vaarama Peruskoulu	Alajoki Peruskoulu	Finland
% progressing from 9th grade to High school or Vocational college	98%	95%	99%	99%	95%
% progressing from 9th to 10th grade	2%	5%	1%	1%	5%
% progressing in education as a proportion of 9th grade	100%	100%	100%	100%	100%
	Lochend Secondary	**Glendale Academy**	**Scotallen Secondary**	**Arbourness High**	**Scotland**
% progressing from S4 to S5	85%	86%	68%	85%	64%
% progressing from S5 to S6	80%	75%	78%	60%	80%
S6 pupils as a % of S4 cohort	68%	64%	53%	51%	51%

Scotland. The differences for those figures are substantial, with between 27-47% more Finns remaining in school-based education for at least two years beyond 16, than is the case in Scotland.

It is worth noting however, that although break-down data on percentages of students going on from 4th or 5th year to FE college from the individual Scottish schools were not available, the national rate was 4% in 1996 (British Council & SOEID 1998) and this would therefore increase the proportions of young people in education post-16 (although not school-based). The national rate would increase from 51% to 55%. Therefore the question remains, are there elements within the school structure or the careers guidance provided in those schools that could offer some plausible explanation as to why these differences exist?

Structure of the education systems in Finland and Scotland

Considering first the structure of the schooling in both countries, being a structure defined within the statute, there was very little to consider at the local level. The official structuring of each country's education system is significantly different as detailed in Chapter Four and further discussion to the importance of these differences will be explored within Chapter Six. Only two elements of the structure were referred to in either country at the local level, the first of which was the value (or lack of it) placed on vocational in comparison to academic pursuit. In Finland, for thirty years vocational and academic education have co-existed at school as well as further educational levels. Many of the student counsellors commented that there were so many opportunities to study at school post-16 and so

many different options for those three years that, "there is no reason why pupils should not continue in education".

In comparison at the school level in Scotland, until very recently, the sole focus of study at the school level has been an academic one. During the late 1980s the SCOTVEC modular courses began to enter the Scottish schools under exploration, and the numbers and styles of these modular courses have been continually developed since then. The guidance teachers and head teachers in some of the schools commented however, that even although vocational education had now become part of school level educational provision, it was still perceived by young people themselves as courses for those pupils who "cannot cope with Highers". There is therefore seen to be considerable stigma for those students who choose the more vocational studies as being "thick".

Second, the issue of structural incentives to remain in education was raised by two of the counsellors in Finland. In Finland, young people cannot receive state benefits from the age of 16 up to 24 unless they are applying twice a year for a place in an education institution. This was perceived in addition to the value of continuing education in Finland, as another main reason as to why there is an almost 100% continuation rate to vocational or high school.

In Scotland there is not a similar incentive to remain in education. A disincentive to leave school however was perceived by most guidance staff and head teachers to be the fact that state benefits are very hard to obtain if you are aged between 16-18. This, coupled with the difficulty in obtaining employment, was perceived as one of

the main reasons behind the increasing number of pupils remaining at school beyond 16 in Scotland. Additionally, beyond the age of 18 the conditions under which state benefits are available depend on an individual providing evidence that they are actively seeking work, rather than a place in education.

Careers Guidance (Student counselling)

The second area of education policy that was explored at the school level was the provision of careers guidance. The proposition in relation to teenage pregnancy was that there was perhaps something within this provision that either encouraged young people to remain in school education beyond the age of 16 and/ or placed particular emphasis on continued education rather than entering employment straight from school.

Finland

All of the Finnish schools followed the structure and content for student counselling, as set out by the national framework. As a result there was a great deal of continuity across the four schools in both structure and content. All of the schools provided each pupil with a total of 2 full courses (38 hours per course) within the three grades (grades 7-9). *Tehtaala Peruskoulu* and *Koskela Peruskoulu* chose a structure of 1 full course (1 hour per week) in both the 7th and the 9th grade. The other two schools, in *Vaarama Peruskoulu* and *Alajoki Peruskoulu* chose to provide a half course (1/2 hour per week) in 7th and 8th grade, followed by a full course in 9th grade.

Individual guidance sessions were provided to pupils primarily in the 9th grade, although if there was time individual contacts would occur at the 7th and 8th grade. Within *Alajoki Peruskoulu*, individual contact took place on a needs basis, whereby pupils could make appointments at any time, although this usually occurred in the 9th grade.

The content of each school's student counselling was also similar. Within the 7th and 8th grades the initial focus was on familiarising pupils with the structure of the *Peruskoulu* and the choices in education that would be available for them at that level of schooling. This then moved on to learning about self-esteem and study techniques such as mind-maps as well as developing the skills to work in groups.

By the 9th grade student counselling in every school focused on the decision of where each pupil would continue their studies and applying for places at those institutions. Considerable time in both group and individual guidance sessions would be spent looking at the available choices for continuing education depending on each pupil's interests and grades. In addition pupils would be given the opportunity to visit the institutions where they were considering continuing their studies. Pupils would then be given the opportunity to explore how their educational interests related to possible careers in the future.

Alajoki Peruskoulu also invited representatives from industry to visit the school and give lectures to the pupils. In particular they had developed a link with Nokia who actively tried to motivate young women into considering this more technological field.

All four student counsellors interviewed stated that the overriding emphasis of student counselling was first to make sure that every pupil had the opportunity to continue his or her education. Second, to make sure that every pupil understood that obtaining meaningful employment without at least three more years of education was a very hard thing to do. The counsellors then related those two points to the reasons as to why such a high percentage of pupils continued in education beyond the age of 16. All counsellors noted that no pupil should be without a place to study, as there were so many opportunities to study. Additionally they believed that young people were more than aware of the lack of opportunity in employment without the extra three years and therefore the majority would choose to continue their studies.

Scotland

In Scotland although careers guidance has been provided within all Scottish schools since 1968, there has not been a set structure or content defined for all schools within curriculum guidelines[1]. Therefore it was not surprising to note that none of the schools examined shared a common defined structure to their provision. Additionally there was considerable variation within the content provided across the four schools.

At both Lochend Secondary School and Arbourness High School careers guidance was provided within the remit of Social Education and PSE respectively. Both provisions were forty minutes per week and careers guidance would take

[1] There are however national programmes of work experience which all pupils are expected to undertake during S3 and additional work experience opportunities available from S4-S6.

approximately one quarter of the focus of Social Education/ PSE each year. At Lochend this work began in 2nd year (13-14) and at Arbourness in the 1st year (11-13).

At Glendale Academy there was no Social Education provision until 1990-91 at which point careers guidance became part of the PSE (Personal and Social Education) provision. Prior to that time careers guidance was provided as a separate subject beginning in the 1st year, although the amount of time per year was not specified. After it was incorporated into PSE the provision remained from 1st year and similarly to the first two schools, was provided within approximately one quarter of the total PSE allocation of forty minutes per week.

At Scotallen Secondary School there was also no PSE provision[1] and instead careers guidance was provided as a separate subject from 3rd to 6th year (14-18). Careers guidance was provided for forty minutes per week for a period of nine weeks for each year group.

Individual guidance sessions also varied across the four schools, although, despite the variations in the structuring of this provision, all pupils had the right to self-refer for guidance when required. At Lochend Secondary School there were two layers to this provision. Each year group from the 2nd year on would have two official slots a year to make an appointment with the guidance teacher as required. The guidance teacher noted, however, that as their school community was relatively small and close-knit, pupils would often have informal conversations, in

[1] The first PSE programme was introduced to Scotallen Secondary School in 1998-1999.

the hallways or the playground, rather than coming to see him in a more formal setting.

At Glendale Academy formal interviews with a careers officer were linked into school reports in 4th, 5th and 6th year. Those leaving in 4th year and 5th year were given priority and by the end of 4th year approximately 60% of pupils would have been interviewed.

At Scotallen Secondary School all 4th and 5th year pupils were interviewed by their guidance teacher and priority was given to those who were leaving and (in 5th year) to those who were considering continuing their education at university. During these interviews a careers profile was developed between the guidance teacher and the pupil. This file would then be passed on to the school's careers officer, who was available twice-weekly for self-referral by pupils.

Lastly at Arbourness High School there were no specific individual slots set aside for pupils, although all were encouraged to make appointments with the careers officer. In this school the pupils could self-refer at any stage to the careers officer or have informal discussions with any of the guidance staff.

Therefore, the structure of careers guidance provision was different in each school and although there were a number of similarities in the overall contents, what was provided at different stages of a pupil's school career varied between the schools.

The common aspects across schools were the exploration of study options for 3rd and 4th year in the first instance and then for 5th and 6th year if pupils remained in school. Additionally, all but Scotallen Secondary School utilised the Jig-Cal computer programme in 3rd year, which presented pupils with career options most suited to the details they provided about themselves.

Every school apart from Lochend Secondary School provided a career library for their pupils to encourage pupils to do their own research into careers that interested them. In the 5th and 6th years most schools hosted either career or education conventions and all schools allowed their pupils to visit open days for education institutions of their choice. Further and higher education continuation did not appear to be a particular focus of careers guidance until pupils had reached 5th and 6th year (post-16). Prior to that, careers guidance concentrated primarily on employment choices first and continuing education options second.

Having explored the variations in structure and content of each school's careers guidance provision, each of the guidance teachers went on to explain what they perceived to be the main aims of the careers guidance that they provided. This was one area where there was continuity across the four schools. Every guidance teacher stated that the main aim was to help young people achieve whatever it was that they wanted to achieve and to provide them with the skills to make the right decisions for themselves. They emphasised to me that for many pupils that did not necessarily mean pursuing further or higher education.

Summary

A number of interesting similarities and differences have been identified in this chapter in relation to each policy area. Of particular interest is how the policy implementation at the local level appears to reflect the availability of guidance (or lack of it) regarding specific policy areas at the national level.

With regard to sex education policy a key difference identified at the national level in Chapter Four was the apparent structure to the national guidance to schools in Finland that was absent in Scotland. This appears to have a notable effect on the provision of sex education in both countries, in that in Finland, where there are national guidelines regarding the content, teaching methods and time allocations of sex education (as topics within the three core curriculum subjects), all four schools had followed the guidelines set out in the national curriculum and had often provided more sex education than specifically required. Further to this, the focus, aims, methods of teaching and content of the sex education provided was also consistent across the four schools, again reflecting each school's adherence to national guidance.

In contrast to the visible effect of national guidance on local implementation of policy in Finland, in Scotland the lack of official guidance with regard to the teaching of non-curriculum sex education was reflected in the lack of consistency in time allocation, focus and content of the provision in the fours Scottish schools. The only consistency in provision was in the teaching of biological reproduction for 1st year pupils as set out in the 1st year Scottish Syllabus. This was, however,

not considered by Biology teachers to be 'sex education', rather it was a sub-section of Biology taught for the purpose of examination.

In both countries, however, there was a lack of official guidance regarding in-service teacher training and this was reflected at the local level by the inconsistency across schools in both countries in the uptake of such training. Therefore, although teachers in Finland had received in-subject training for the elements of sex education that were included within their curriculum subject, only a small number of teachers across the four schools had undertaken in-service at their own initiative.

In Scotland, the amount of teacher training undertaken by Scottish teachers varied considerably, from the majority having had very little or no training in three of the school to the teachers at Arbourness High who had all undertaken a number of courses. The teachers at Arbourness High had noted, however, that although there were no national guidelines about teacher training their local authority support for, and provision of, in-service training was good which may explain the difference in uptake of this training. It is also worth highlighting that of the four schools, the programme of PSE at Arbourness was the only one of the four to presented a more 'positive prevention' approach, its content was the most varied and annually updated based on what pupils requested that they wanted to learn and of the four schools it had the most developed non-didactic teaching methods.

Finally, in both countries there was an expectation, although no official policy regarding the use of sexual health experts in the provision of sex education. In

turn, the use of such experts was not consistent across schools in either country. In Finland, although the school nurse was expected to be involved with sex education, only one of the four nurses actively taught in the classroom. In Scotland, although there was an encouragement from the Scottish Office that schools should use whatever additional resources available to them, in practice, although sexual health experts were valued at the school level, they were often restricted in use due to the time constraints of the experts and financial restraints of the schools.

However, because of the on-site location of the school nurse within Finnish schools, even although most were not engaged in classroom teaching, they were available and actively used a knowledge resource for teachers involved in providing sex education as well as a source of sex education advice for pupils on a one-to-one level. Where as in Scotland, because the sexual health experts were external rather than school based, no such resource was available to teachers or pupils in the Scottish schools.

With regard to sexual health policy, as was highlighted in Chapter Four, despite basic similarities in the availability of sexual health services that young people could access in the local community, the key policy difference between the two countries that appeared most likely to impact on young people at the local level came in the form of the ease of access that the school nurse offered to young people in Finland in contrast to Scotland.

Most of the provision available to young people in the local community in both countries are problematic in terms of what research has revealed with regard the

particular access needs of young people. The school nurse system in Finland however provides young people with a service which is confidential, hidden from public view, free, open at times that suit young people and is run by individuals trained to work specifically with young people, which crucially means that this service, because of its location, is brought to the young people as opposed to young people having to go out into the community to seek help. Further to this because it would often be the same school nurse that would be available to a pupil throughout their time at that school, this would enable trusting relationships to develop between the nurse and pupil, also enabling nurses to be aware of each individual context in relation to advice giving.

In relation to education policy Chapter Four established that in both countries young people are able to leave education at the age of sixteen and yet annually more people choose to remain in education post-16 for at least two years in Finland than in Scotland. This was further reflected at the school level with stay on rates being 100% for the four Finnish schools, with 1-5% going on to a 10th grade (1 year) rather than high school or vocational school (2-3 years) compared to 68-86% remaining at school for one extra year and 51-68% for two years post-16 in the four Scottish schools.

In Chapter Four potential explanations for this difference in stay-on rates were suggested to be the focus and structure of careers guidance (student counselling) in each country and the extent to which continued education was presented at the school level as the normalised route for all young people.

This chapter has highlighted that the provision of careers guidance (student counselling); its focus and content did indeed vary at the school level between the two countries. Again the provision of national guidance in Finland and the lack of such guidance in Scotland appears to impact upon the consistency in structure, content, focus and time allocation found within the four Finnish schools in comparison to variations in structure, content and time allocation in the Scottish schools. What remained consistent across the Scottish schools, however, was the primary focus on future career options and employment as opposed to the primary focus on continued education in Finland. In turn the projected 'normalised' path for young people in Finland was primarily geared towards continued education whereas in Scotland, continued education (to university or college) was only projected as normalised for those pupils who had already taken the step to remain at school for their 5th – 6th year/s to undertake further study.

With regard to the potential effect of the structure of education encouraging more young people to remain in education post-16, the main difference at the local level appeared to be the greater variety of option choice and the more equal status between those choices in Finland compared to primary focus on exam based academic study in Scotland.

Having located and mapped the three policy areas at the national and local levels and identified the key similarities and differences at the different levels of policy between the two countries in Chapters Four and Five, the next chapter, therefore, presents the main analysis of these key similarities and differences. In doing so Chapter Six draws out the main themes that have arisen from this research.

Chapter Six

Similarities and Differences within National and Local Level Policy in Scotland and Finland

Introduction

Drawing on the data presented in Chapters Four and Five, this chapter compares the national framework and local level implementation of policy between Scotland and Finland. The main aims of this chapter are two-fold. First to identify the key points of comparison between the various policy areas and second, drawing upon the existing literature as explored in Chapter Two, to identify the potential connections between those policies and their effect on teenage pregnancy rates in both countries. This process of analysis however, actually raises more questions that it has been possible to answer, which raise important avenues for further research, as are discussed in Chapter Eight.

School-based Sex Education in Finland and Scotland

Key similarities and differences

Tables 6.1 and 6.2 below, set out the key similarities and differences between Finland and Scotland in relation to the national policy framework and local level implementation of policy. The following section of this chapter goes on to discuss each of the points highlighted in these Tables.

Table 6.1

Key similarities in sex education policy in Finland and Scotland

- At the school level, in all schools studied in both countries, some degree of sex education was provided for young people,
- At the national and school level both countries provided sex education in mixed-sex classes,
- At the national and local level teachers in both countries had the opportunity to undertake in-service training on sex education,
- At the school level, teachers in both countries used a combination of didactic and small-group based learning methods,
- At the school level both sets of provision have central aims to increase knowledge and effect upon attitudes and behaviour of young people,
- At the school level, in both countries, 'experts' in sexual health were perceived as a valued resource for both teachers and pupils,
- At the national and school level in both countries, the provision of sex education was perceived by teachers of sex education and government and local authority/ municipality officials as an important duty of the school.

Table 6.2 Key differences in sex education policy in Finland and Scotland

- **Guarantee of provision**
  1. In Finland, because sex education permeated through compulsory curriculum subjects, pupils were guaranteed to receive sex education in a number of subjects.
  2. In Scotland, there is no guarantee or curriculum obligation for sex education to be taught at the school level.
- **Location of provision**
  1. In Finland, sex education permeated through the curriculum being taught within Health and Family Education and Biology.
  2. In Scotland, where taught, sex education was provided as a subject separated from the main Scottish Syllabus (national curriculum).
- **Status of biology**
  1. In Finland, biological reproduction within the subject of biology was considered to be a sex education provision.
  2. In Scotland, this was not considered or found to be the case it was considered to be a section of an academic subject.
- **Time allocations for sex education provision**
  1. In Finland, 8th grade pupils were guaranteed 1 hour per week of health education and in the 9th grade, 1 hour per week of family education and a minimum of 3 lessons across the year in biology were also guaranteed.
  2. In Scotland, the amount of time allocated to sex education varied between each school, and, on average pupils would receive 40 minutes per week for 8 weeks in each year per year group.
- **Class set-up**
  1. In Finland, there was a dual system of sex education practised in 3/4 schools studied, enabled by the single-sex set-up of health education classes.
  2. In Scotland, all classes are mixed-sexed.
- **Teaching methods**
  1. In the Finnish schools studied, the use of small-group centred learning was well established.
  2. In Scottish schools studied, use of this method of learning was in its infancy at the time of interview.
- **Content of sex education**
  1. In Finland, government exercised strong directive since the mid-1970s over the content of sex education. The content itself was based on promoting of healthy attitudes to sex and sexuality and incorporated a wide range of perspectives including; biological, social, health and legal.
  2. In Scotland, there was no strong directive from government regarding content until the implementation of the 5-14 programme in 1993. The content itself was in general more limited than the provision in Finland and focused around the issue of teenage pregnancy.
- **Main aims of sex education**
  1. In addition to increasing knowledge and affecting attitudes (found in both countries), Finnish schools also had an aim of promoting sex and sexuality as normal healthy aspects of life, which was only found in one Scottish school.
- **Use of 'Experts' in sex education provision**
  1. In Finland, the school nurse was the only source of sexual health expertise used by teachers.
  2. In Scotland, sexual health experts were brought in from a number of outside agencies.
- **Overall status of sex education in schools**
  1. In Finland, sex education was viewed as an important aspect of young people's education, equal in value to other subjects.
  2. In Scotland, although perceived as an important provision in schools, sex education was not perceived as having the same status as the traditional curriculum subjects.

Curriculum location

The location of sex education at the school level in Finland and Scotland presented two different styles of provision. The provision of sex education in a range of subjects enabled a permeation approach to be adopted nationally by all schools in Finland, including those under study in this thesis. In Scotland, aspects of sex education have never been part of Scottish Syllabus subjects. Therefore to enable provision in the four schools studied, as has been found in other studies of provision in Scotland (Wight & Scott 1994; Shucksmith et al. 1994), sex education had developed as a subject separate from the main curriculum, incorporated into PSE, Social Education or Health Education.

As was discussed within Chapter Two, there are advantages and disadvantages to both styles of provision. The permeation approach enables sex education to be presented from a variety of different perspectives and within different contexts. It can also mean that more time is allocated to sex education when it is contained within a range of subjects, rather than a single subject. Additionally, if the subjects within which sex education is taught, are set within national guidelines of provision, this can help to guarantee the equality of provision to all pupils. Finally, where sex education is taught within traditional curriculum subjects, this can help to 'normalise' the subject, showing young people that it is no different from the learning experience of other subjects and this helps to present sex and sexuality as normal aspects of life (Silver 1998). All of these benefits of permeation were found to be the case within the four schools explored in Finland.

The main benefit of providing sex education as a subject separate from the traditional curriculum is that it is then easier to highlight when something, which should be taught, is not being taught. As there is no current obligation for schools in Scotland to teach sex education, and provision across Scotland has been noted to be patchy and underdeveloped in many areas (Burtney 2000a), instigating a permeation approach may result in sex education subtly disappearing from the curriculum.

Whilst the permeation approach has been effective in Finland, and has been shown to be effective in other countries such as the Netherlands (Silver 1998), consideration needs to be given to how much of that success lies in the underlying openness towards teenage sexual activity and the willingness to discuss issues relating to sex and sexuality in those two countries. As this openness has not yet been fully embraced within Scottish culture (Burtney 2000a), this may be a further reason as to why this approach has not been developed in Scotland, why it may not be a direction of policy development in the future and why it may not be appropriate to attempt it.

Time allocations

The head teacher at Glendale Academy raised an interesting question with regard to what young people can realistically be expected to learn in any subject, be it Standard Grade maths or sex education, when it is only taught in an occasional lesson, a small block of lessons or one period a week for eight weeks. In other words, it is unfair to expect young people to internalise sexual health messages

with only eight weeks of lessons a year, when pupils would not be expected to pass a Standard Grade exam after only eight weeks of provision a year.

One of the noted differences in the provision of sex education between the two countries was the amount of time allocated to the subject. As suggested in the previous section, the style of provision is likely to affect the amount of time allocated, with a permeation approach enabling more provision than a separate approach. This was found to be the case in Finland and Scotland.

As was shown in Chapters Four and Five, in Finnish schools there was a minimum provision of sex education lessons in grades 8 and 9. Within the four schools explored, most schools provided one to two hours across grades 7 to 9 in addition to what was required. Within the Scottish schools, the amount of time allocated varied across all four schools, averaging forty minutes per week, eight weeks per year.

This meant that young people in the Finnish schools were not only receiving more in terms of actual time allocation than was the case in the Scottish schools, but were also receiving it regularly throughout each grade. This meant that Finnish pupils were provided with a level of continuity of normalised sex education, which has been suggested to me more effective in helping young people to internalise the messages being taught (Silver 1998).

Teaching environment

Class set-up

In both countries, young people receive sex education within mixed-sex classes, which research has suggested is important to enable young people to develop crucial communication skills about sexual issues (Kirby 1995; HEA 1998; Silver 1998).

Research has also highlighted the need to develop an "open and safe" environment (Silver 1998:15). Part of the 'safe' environment for younger pupils will sometimes require the absence of the opposite sex to enable discussion about more intimate issues and concerns that both sexes have. In Finland, three out of the four schools explored did make use of this style of class environment. The ability to do so came as a direct result of the subjects within which sex education was taught in Finland. In the 8th grade (and some other grades) sex education was provided within the subject Health Education, which was taught in Physical Education classes. Nationally, classes are on the whole, taught as single-sex classes. This therefore meant that in three of the four Finnish schools, there was a dual style of provision offering two very different learning environments for Finnish young people. This style of single-sex provision however, was not an option utilised within the four Scottish schools explored and other research on Scottish sex education has noted similar findings (Wight & Scott 1994).

Teaching Methods

The teaching methods employed in Finland and Scotland both contained a combination of didactic, small group-discussion and active learning-based

methods. Research has shown that active learning-based techniques such as role-playing, co-operative learning as well as small-group discussion methods have more success in developing positive attitudes and increasing knowledge amongst young people (Kirby 1995).

Whilst there was evidence of schools in both countries using these more effective methods, they were substantially more developed within the Finnish schools, than was found to be the case in the Scottish schools. In Scotland the main methods used were traditional with a much less use of small-group work. The opposite was found to be the case in Finland, in particular the use of co-operative learning techniques were very popular in two of the schools. The arena within which the more traditional methods were utilised in Finland was primarily confined to the teaching of biology. According to Liinamo (2000) however, more recent research has revealed that the use of active learning-based techniques is not very common throughout Finnish schools as a whole.

Teacher training

Teacher training was not an issue of particular policy focus in either country, although for different reasons. In Finland, although teachers had not generally received specific education in how to teach sex education within their pre-service training, this was because a teacher's pre-service training would cover all aspects of the subject they would go on to teach. If there were elements of sex education in their subject then they would be covered at pre-service level, as it was merely another aspect of the overall subject. The uptake of in-service training in Finland was generally down to the individual teacher and approximately one third of

teachers interviewed had done so via courses provided by *Väestöliittö* and the *Mannerheim Child Welfare Institution.*

In Scotland, pre-service training was limited to those teachers who had undertaken guidance certificates as an extra certificate to their main education training. In-service training was more readily available and encouraged in Scotland than in Finland, although the uptake of such courses was still relatively low. Training priorities for the teachers interviewed focused on the Scottish Syllabus changes in their main subjects, and since PSE and sex education were seen as 'extra' non-core curriculum subjects, training for those subjects was not rated as highly as for curriculum subjects.

Noting that research has highlighted the importance of staff being both willing and able to provide sex education as key ingredients to the success of this provision, it was surprising that the training provision in Finland was not more substantial, as was expected. Teachers did note however, that because they did not provide a separate subject called 'sex education', but that it formed elements of their subject for which they did receive training (be that in Biology, Health Education or Family Education), there was less need to specifically train on this issue of 'sex education'. There was however a general desire amongst the teachers for up-date training and this has been noted in more recent research on sex education provision in Finland (Liinamo 2000).

Content

There were two main differences in the content of the sex education provided in Finland and Scotland. First, there was a higher degree of consistency of content across the four schools in Finland in comparison to Scotland. The consistency in content provided in Finland arose from the detailed guidelines provided by the NBE to teachers about what should be taught in each subject in every school in the country. Within Scotland, although a number of different sex education packages were available to teachers in Scotland, there were no standard content guidelines for teachers to follow, provided by either government or at local authority level until 1993.

Second, the content of what was taught in Finland was underpinned by the notion of "positive prevention" (Vilar 1994), whereas in Scotland, the provision was underpinned by the notion of "negative prevention" (Vilar 1994). In other words, the Finnish provision was based on an acceptance of teenage sexual activity and a desire to help young people develop healthy and positive attitudes to sex and sexuality, whereas in Scotland, provision was based on a desire to prevent teenagers from being sexually active and the focus was on the negative outcomes of teenage sexual activity. Previous research has suggested that the most effective sex education is that which does not aim to 'scare' young people, is positive in tone and content and addresses issues that are important to young people (Oakley et al. 1994, 1995; David & Rademakers 1996; Sex Education Forum 1997; Silver 1998), and this was a factor of difference between provision in Finland and Scotland.

The difference in prevention styles is a complex issue and relates to both the status of sex education in schools as well as the cultural attitudes to sex and sexuality in both societies. Silver (1998) suggested that the content of sex education in any given country acts as a reflection of that country's attitude towards sex and ability to discuss sex and sexuality openly. Having acknowledged that the cultural attitudes to sex and sexuality are more open in Finland than in Scotland, this potentially explains the broader content and positive promotion of healthy sexuality which was found in the sex education in Finland, and the narrow and negatively focused sex education in Scotland.

With regard to the specific content, schools in both countries covered common ground from physical maturation and puberty through to human anatomy, sexual intercourse, pregnancy, childbirth, contraception, abortion, STIs, HIV/AIDS and relationships. Of the four schools studied in Scotland only Arbourness High developed the content beyond that detailed above. Of additional interest was the point at which 'relationships' entered the provision in Scottish schools. With the exception of Arbourness High, discussion about relationships came after all the negative effects of sexual activity. When one considers that ideally relationships come before sexual activity, the order of teaching on those subjects is somewhat illogical (Oakley et al. 1994, 1995; HEA 1998).

In Finland, the order of subjects progressed from physical and emotional maturation, puberty and masturbation, to exploring friendships, relationships, attraction, dating, falling in love and having crushes before then progressing to sexual activity (including different levels of activity leading up to physical

intercourse) and all of the implications of having sex, both positive and negative. In addition to this more logical ordering of content, all of these issues were presented from at least three different perspectives, i.e. biological, health and social, due to the location of provision in a number of curriculum subjects.

The wider, positive and ordered progression of the content found in the Finnish provision, adheres to what research has previously defined as more likely to be effective sex education (Oakley et al. 1994, 1995; David & Rademakers 1996; Sex Education Forum 1997; HEA 1998; Silver 1998). The Scottish provision, whilst notably developing in a more positive direction (Arbourness High being an example of that development), still lagged some way behind the Finnish provision on a more general level.

Young men

The issue of sex education for young men has risen in profile in recent academic writings (Meyrick & Swann 1998; Silver 1998; Wood 1998; SEU 1999). In particular in Britain, concern has been raised over the point that sex education often does not meet the needs of young men and by failing to do so, half of the solution to teenage pregnancy (SEU 1999) is not being addressed.

With regard to sex education provision in the Scottish schools explored in this research, the findings concur with previous research findings in Britain - this was an issue not being fully addressed. The overriding focus on pregnancy prevention in Scottish sex education could help explain why young men's needs were not being met. Whilst men obviously play an integral part in the creation of a

pregnancy, 'pregnancy' is often perceived by young men to be a 'female issue' (Hadley 1998). Additionally the overriding negative focus (which as discussed above has been shown not to be an effective method for teaching young men or women) may aid in disengaging young men's interest in sex education from the start.

In Finland, the awareness of the need to educate young men about issues relating to sex and sexuality was acute. There were a number of ways in which teachers and school nurses were deliberate in their approach to engage young men, most notably by discussing issues such as eroticism and pornography, which were perceived as important issues to young men as they develop (Wood 1998). After engaging the young men, discussion then progressed to issues of gender and sexual equality, respect and responsibility and connecting the emotional with the physical. The ability to engage young men in a single-sex arena was perceived as particularly effective within the three schools which utilised this teaching environment.

At the end of Chapter One, the proportion of young men using reliable methods of contraception at first intercourse in Finland (aged 15) and Scotland (aged 15-16) was compared. The difference between the two was striking with no reliable methods being used by 55% of Scottish young men (McIlwaine 1994) compared to 13% of Finnish young men (Papp 1997). Whilst there is no guarantee that knowledge acquired through school-based sex education will be applied to personal behaviour, the combination of a higher level of provision, a single-sexed environment and the more engaging content of sex education for young men in Finland, may have helped those young men to better internalise the sexual health

messages presented to them. Hence this could provide explanation in part for the higher level of contraceptive use by young men in Finland and potentially the lower rate of teenage pregnancy.

Inter-agency collaboration

The use of sexual health experts in the provision of sex education was valued by teachers in both Finland and Scotland. There were however differences in both the type of expert utilised and the reasons as to why they were valued. In Finland, the only expert utilised was an internal expert - the school nurse. Due to her location on-site, the nurse in every school was utilised by teachers as a knowledge base whilst preparing to teach issues relating to sex and sexuality. Only the nurse at *Koskela Peruskoulu* was being used at the time of interview to provide class-based sex education, although all four nurses provided sexual health advice to any pupil who required help, on a one to one basis within the school clinic setting. The teachers in all the Finnish schools perceived the school nurse and her expertise as an extra bonus, complementing what teachers themselves provided for pupils in terms of sex education. In general, the nurses also perceived themselves as an extra provider of sex education.

In Scotland, some schools made use of sexual health experts such as individuals working in health promotion, or individuals from services providing resources for young people outside the school setting, such as local doctors and family planning nurses. In general, all schools noted that they would make more use of such experts if it were not for the financial limitations of both parties and the time limitations of the experts. The reason for their perceived value, was generally not

as an 'extra' as was the case in Finland - instead they were often perceived as a substitution for teachers, especially to cover issues that teachers did not feel comfortable in covering themselves.

An issue that was raised within the review of literature in Chapter Two was that of the relevant training of experts utilised by schools. In particular with regard to the popular idea of increasing the use of school nurses in Britain (Few et al. 1996; Gulland 1996; Hunt 1996; Sex Education Forum 1996; Lightfoot & Bines 1998), concern had been raised as to the suitability of nurses to undertake sex education without the relevant training either to teach or to work specifically with young people (Whitmarsh 1997).

The issue of training was something which had been effectively addressed within the Finnish system of school nurse provision. All school nurses in Finland undertook their basic training before specialising in school nursing and how to work with young people. The nurse at *Koskela Peruskoulu* who was involved in classroom teaching had also undertaken a considerable amount of in-service training, in order that she was prepared for her teaching role. The training she had undertaken was provided by the same two institutions (*Väestöliittö* and *Mannerheim*) that provide this training for schoolteachers.

The teachers in the Scottish schools could not comment on the training that the experts they had utilised had undergone to enable them to provide school-based sex education. This was not perceived as a particular area of concern by the

teachers however, as it was assumed they would have the knowledge, because of their expert status.

Main aims of sex education

Within both countries, as was expected, the main aims of sex education related to the main content of the provision. Both countries placed a large degree of emphasis on increasing knowledge, affecting young people's sexual attitudes and in Scotland, the development of 'skills' to help young people apply knowledge to behaviour.

The main difference in aims between the two countries was the presence of an explicit aim to promote sex and sexuality as a normal and healthy aspect of life in all four schools in Finland, which was present only within Arbourness High school in Scotland. Noting that Finland's culture is more open in general with regard to sex and sexuality, the positive promotion of sex and sexuality in sex education may be a direct reflection of the general culture and may therefore explain why only one of the Scottish schools explored had adopted this central aim. The existence of this additional aim was a key difference however, as research has shown that sex education is more effective when presented from positive, normalised perspective (Oakley et al. 1994,1995; Silver 1998).

Overall status of sex education at the school level

Almost all of the teachers interviewed in both countries who were involved with the teaching of sex education perceived the school's role as important, although to varying degrees. Generally the teachers in Finland were more positive about the

role that school-based sex education played in teenage pregnancy prevention than was the case in Scotland. The reason as to why it was an important provision was however the same - teachers recognised that for many young people, school was the only reliable source of sex education that they had access to.

In Finland, the provision of sex education was often suggested by the interviewees to be evidence of "good practice" in promoting good sexual health attitudes and in turn decreasing the rate of teenage pregnancy. In Scotland, although the school was seen as having a role in providing sex education, there was a noted pessimism amongst most teachers as to how effective the school could be when the school sex education was so limited and a large proportion of young people's time was not actually spent in school. These comments however, were being made within a context of Scottish school provision that was generally lower in quantity and less diverse in content and overall aims, than that which was provided in Finland.

In both countries, all interviewees from government down to the school level highlighted the role that sex education could play in helping young people to develop more healthy attitudes to sex and sexuality and in relating their knowledge to their personal behaviour. There was a degree of pessimism (more notable from the Scottish interviewees) about the actual effect sex education had on young people's behaviour.

There was a general recognition in both countries that whilst schools had a role to play, this alone would not lead to lower teenage pregnancy rates. Most interviewees noted that young people also needed access to sexual health services

and motivation to use those services and this was perceived to be of equal importance to knowledge about sex and sexuality. Interviewees in Finland however, were more positive than those in Scotland, that the services young people needed, were easy to access.

Sexual health policy

In order to aid the reader's interpretation with regard to the points of comparison discussed in the following part of this chapter, the key similarities (•) and differences (♦) found in relation to sexual health policy are summarised in Tables 6.3 and 6.4 below.

Table 6.3

Key similarities in sexual health policy between Finland and Scotland

- In both countries, primary health care facilities and family planning clinics provide sexual health services where young people can access advice and contraception.
- In both countries, these services are free (or low cost).
- In both countries there are limited but growing numbers of clinics set up for the exclusive use of young people.
- In both countries, abortion is available to young women under Category II conditions (see Chapter One for definition).
- In both countries, consultations with medical professionals remain confidential regardless of age as long as there are no explicit concerns of child abuse.

Table 6.4

Key differences in sexual health policy between Finland and Scotland

- **Strength of political commitment to the promotion of young people's sexual health.**
  1. In Finland, there has been a strong directive from government in the area of sexual health promotion including the sexual health of teenagers since the 1970s.
  2. In Scotland, the first directive from the Scottish Executive on the issue of teenage sexual health came in the form of a quantitative target, set in 1999, to reduce the rate of conception to under 16s by 20% from the base year of 1995 by the year 2010.
- **The provision of school health services.**
  1. In Finland, the school health service has been set up in such a way as to provide all young people in Finland with a primary care resource (including sexual health advice) located on-site in school.
  2. In Scotland, the school health service, although a statutory requirement for all Scottish schools, is not set up as a primary care provision, but is solely concerned with general health screenings and vaccinations.
- **Access to abortion by young women**
  1. In Finland, being under 17 at the time of conception is a specific ground for abortion with the permission of only one doctor (over 17 would require 2 doctors).
  2. In Scotland, no such age priority exists as grounds for abortion.

Sexual health and young people in Finland and Scotland

In both Finland and Scotland sexual health services were available via primary care facilities and family planning clinics, access to which was the entitlement of all citizens, young people included. Additionally, in both countries there were a number of services which had been developed specifically based around the needs of young people. The services available to young people either from the main primary care facilities and family planning clinics or the youth-orientated services were also the same in both countries. In other words, young people in Finland and Scotland had access to confidential sexual health advice, contraception and abortion services (under certain conditions) which were provided either free or at low cost.

The main difference in the provisions between the two countries relates to the extent to which young people's needs and wants were addressed by different providers, in particular with regard to young people's ease of access to the various services available - the importance of which was highlighted within the review of literature in Chapter Two. The extent of this recognition of young people's needs appears to relate to the amount of concern at government level with regard to the sexual health of young people. These two issues provide the focus for the following part of this chapter.

Strength of political commitment to the promotion of young people's sexual health

Since the 1970s the Finnish government has committed itself to promoting 'good practice' in sexual health in general and considers itself to have been "more successful than many other Western countries in promoting sexual health in its population" (Kosunen 2000a:70). In particular it has made particular efforts to aid in the promotion of young people's sexual health including:

1. Priority grounds for abortion if aged under 17 at time of conception in the 1970 Abortion Law,
2. The Public Health Act of 1972 made available the school health service and school nurse provision in every school in Finland,
3. In the early 1980s, when the government became aware that the abortion rate to teenagers was not declining in line with that of older women, a quantitative target for the reduction in the rate of abortion (not pregnancy) to teenagers by 7% per annum was set in 1983,

4. Additionally in recognition of the abortion rate, the magazine *Sexteen* was introduced and sent to the homes of all 16 year olds from 1987, changing to all 15 year olds from 2001,

5. In the early 1990s the *Family planning 2000* project was instigated to help promote sexuality as a positive power in life and to make sure that every baby born in Finland was both wanted and healthy.

In Scotland, there has not been a strong directive from government level aimed towards the promotion of healthy sexuality for all. Up until the point of devolution from Westminster (1999), the majority of sexual health directives in Scotland were heavily influenced by activities in England.

The 1980s in Britain witnessed a decade of tension around sex and sexuality resulting in policies and laws which were not conducive to the promotion of teenage sexual health rights. Mrs. Thatcher's Conservative government was "highly ambivalent about accepting the reality of teenage sexual activity and the measures needed to meet teenager's sexual health needs" (Hadley 1998:2).

The Gillick legal case in 1984 had a negative effect on young people's willingness to access contraception, and numbers attending clinics witnessed a sharp decline (Hadley 1998). Despite the case being overturned at the House of Lords in 1985, "the climate surrounding the provision of contraception appeared considerably more hostile to young people as a result of the publicity surrounding the case" (Kane & Wellings 1999:60)

The first policy to state an official concern over teenage sexual health in England and Wales was contained within the White Paper *The Health of the Nation* (1992), outlining a policy objective to reduce the rate of teenage pregnancy by 50% by the year 2000. In 1999, the Scottish Executive published the first documentation relating to the sexual health of young people in Scotland. Within this White Paper *Towards a Healthier Scotland* (1999), a quantitative target to reduce under 16 conception by 20% by the year 2010 was set.

As previous research has highlighted, countries with a high level of cultural openness about sex and sexuality, and an acceptance at government level in particular, of teenage sexual activity, have been found to have lower rates of teenage pregnancy (Jones et al. 1985.1986; David et al. 1990; Silver 1998). In Finland, there is both the cultural openness and governmental acceptance of teenage sexual activity (Väestöliittö 1994), reflected in policy and initiatives aimed at promoting teenage sexual health and sexual rights for thirty years (Kosunen 2000a 2000b). In Scotland, concern in this area only began to take off at the local level during the mid-1990s and at the government level since the end of the1990s, and culturally, there remains a lack of openness about sex and sexuality (HEA 1998; Burtney 2000a).

Sexual health services for young people

General services

As noted in Chapters Four and Five and above, young people in both Finland and Scotland are entitled to access sexual health advice and services from general primary care settings and family planning clinics. Additionally in a small number

of areas, clinics have been set up specifically for young people. All of these services, however, have a number of drawbacks (some more than others) in relation to ease of access as discussed in Chapters Two and Five. These drawbacks include limitations of geographical access, concern over visibility of a service to the public/ parental eye, non-youth orientation of a service, unsuitable opening times, perceived lack of confidentiality and the perceived attitude of some providers.

When the sexual health provisions between the two countries are closely examined, it is notable that, whilst some of these limitations may be genuine for young people in Finland (such as geographical access, non-youth orientation and unsuitable opening times) (Liinamo et al. 1997), the majority are the norm for young people in Scotland (McIlwaine 1994; Turner 2000). Noting that there are potential issues of access in both countries with the general services available, the key difference in provision therefore appears to come in the form of the school health service and on-site school nurse in Finland.

School health service

In both Finland and Scotland, there exists a statutory obligation for the provision of school health services, although, as noted in Chapters Four and Five, the intended use of this service differs between the two countries. Whereas in Scotland the service is utilised for general health screening and vaccinations of pupils, in Finland it is utilised as a primary health care resource for young people.

In Finland, the school health service both in theory and, according to all school nurses and teachers interviewed, in practice, is a policy provision which has been a key contributory factor to the reduction in teenage pregnancy and related rates in Finland over the last thirty years. This idea has been further supported by researchers of health care and teenage sexual health in Finland over the last ten years (Ala-Nikkola 1992; Hemminki 1995; Kosunen 1996; Kosunen & Rimpelä 1996a; Rehnström 1997; Kosunen 2000a, 2000b).

In relation to the needs and wants of young people in-service provisions as identified by previous research outlined in Chapter Two, there are noted to be many advantages of this style of provision for young people. First, it is a service which is aimed solely for use by young people, something which young people in Finland have highlighted as a preferred option in health (especially sexual health) care provision (Liinamo et al. 1997).

Second, school nurses in Finland were trained specifically to work with young people which increased the likelihood that third, the school nurses had the various qualities identified as important by young Finns such as being friendly, non-judgemental, approachable and objective (Liinamo et al. 1997).

Finally, this style of service satisfied the various factors identified in previous research by young people as important to encourage their likelihood of accessing a service. In other words:

- The location of the service in-school means that it is hidden from the public and parental view,
- The location also means that geographically it is easy to access,
- Additionally, the location means that the service is open at times which suit young people,
- Finally, the service is confidential.

In relation to the last point about confidentiality, the fact that a confidential resource is brought to the young people instead of the young people having to go out into the community to find such as resource is also important. A desire for a confidential service of some sort in school has been noted in research of young people needs and wants (FPA 1994; SEU 1999; Turner 2000).

In Chapter Two it was highlighted that on the whole, there is a general lack of sound methodological evaluations of school-based health provision coupled with the provision of sex education as a means to aiding pregnancy prevention amongst young people (Oakley et al. 1994, 1995). The fact that there is such a service available in every school in Finland, providing equality of access for young people, which also satisfies their identified needs and wants and is perceived by young Finns as their first port of call with regard to their sexual health needs (Kosunen 1998; 2000b), does suggest that there is merit to this style of provision in relation to aiding the reduction of teenage pregnancy.

Despite the many positive aspects that can be drawn from a service provision such as the Finnish school health service, the issue of pregnancy prevention cannot be

solved with easy access to contraceptive advice and provisions alone. There is the need for knowledge about sex and sexuality as addressed at the beginning of this chapter, but there is also a need to be motivated in order to apply the knowledge and access the services available.

Education Policy

As was discussed within Chapters Two, in addition to knowledge and access to services, the final prerequisite to effective contraceptive behaviour is motivation. As was further highlighted in Chapters One, Two and Four, there exists a significant relationship across Western and Northern European countries between high rates of continued education and lower rates of teenage pregnancy (Jones et al. 1985; Bynner & Parsons 1999; SEU 1999).

Additionally, high levels of educational achievement and aspiration were found to be strongly related to a higher age of first intercourse (Westall 1997; Kane & Wellings 1999; SEU 1999), higher and more effective use of contraception (Hoffman 1984; Morrison 1985; Kraft et al. 1991), increased likelihood of abortion if pregnancy occurred (Kane & Wellings 1999) and delayed timing of first birth (Westall 1997; NHS CRD 1997; Beets 1999a, 1999b).

The proposition under exploration from the start of this thesis has therefore been the extent to which education offers young people, women in particular, some degree of motivation to avoid pregnancy and parenthood. In Chapters Four and Five it was noted that there existed considerable differences at the national and

local level with regard to the proportions of young people remaining in education beyond the age of sixteen.

In Chapter One, an exploration of the relationship between unemployment and the likelihood of continuation in education was explored as it would appear logical that if the employment situation was not favourable for young people, this may increase the likelihood that young people would chose to remain in education for longer. There was not, however, a significant relationship between these two variables at an European level and whilst the growing numbers of young people remaining in school beyond 16 in Scotland, may in part be a result of the changing employment situation, in Finland there has always been a high continuation rate post-16 regardless of the levels of unemployment amongst its young people.

Therefore, this thesis explored a number of other potential explanations for the high stay on relate in education, including, school structure and the provision of careers guidance, in order to derive some form of explanation as to why the differences in stay-on rates exist.

In relation to the national policy framework and the local level policy, Tables 6.5 and 6.6 below highlight the key similarities (•) and differences (♦) found in relation to education policy which form the focus of this final area of discussion.

Table 6.5

Key similarities in education policy between Finland and Scotland

- Young people in both countries are legally obliged to be educated up to the age of 16 and most would attend an equivalent lower and upper comprehensive level of schooling in order to fulfil that obligation.
- In both countries this educational provision is provided by the state free of charge.
- In both countries, young people are expected to sit certified examinations of equivalent level in their final year of compulsory schooling.
- In both countries, pupils receive careers guidance (student counselling) at some point prior to the end of compulsory schooling.

Table 6.6

Key differences in education policy between Finland and Scotland

- **Age at which compulsory schooling begins.**
  1. In Finland, compulsory schooling begins at the age of 7 (occasionally 6), therefore prescribing on average 9 years of compulsory schooling.
  2. In Scotland, compulsory schooling begins at the age of 5 (occasionally 4), therefore prescribing on average 11 years of compulsory schooling.
- **Structure of careers guidance (Student counselling).**
  1. In Finland, there exists a consistent and detailed structure for student counselling across all schools, as set out within national guidelines.
  2. In Scotland, there is no equivalent set structure or defined content for careers guidance. What is taught and how often it is taught is decided at the school level.
- **Aims and Focus of careers guidance (Student counselling).**
  1. In Finland, the primary aim was to make sure every pupil had a place to continue their education post-16. The main focus therefore was on **education:** different ways of learning, value of education, education options post-16 and how educational interests related to potential careers.
  2. In Scotland, the primary aim was to make sure every pupil was able to pursue whatever it was they wanted to do when they turned 16, be that to leave school get a job, or continue at school and pursue continued education. The main focus therefore was on **career options:** options at school, potential careers, different types of employment, using careers libraries and continuing education.
- **The structure of post-16 education.**
  1. In Finland, at the end of the 9th grade, pupils have the choice to undertake a further 3 (or 4) years of continued education at either a high school (*Lukio*), or at a vocational school (*Ammattikoulu*). If grades are not sufficient to do either, pupils can attend a 10th grade to improve their options.
  2. In Scotland, at the end of 4th year, pupils have the choice to remain in the school they are attending (or change schools) to complete a 5th and a 6th years. Pupils may also choose to continue their education at a college of further education.
- **Focus of post-16 education.**
  1. In Finland, pupils in post-16 education have the choice of pursuing academic pursuits at the *Lukio*, or vocation pursuits at an *Ammattikoulu*.
  2. In Scotland, until 1990, the only option post-16 at the school level was to undertake academic pursuits. To undertake vocational education, pupils would have to attend a college of further education. Since the introduction of SCOTVEC modules and later GSVQs, pupils now have more choice at the school level to undertake either academic or vocational, or a combination of both pursuits.
- **Status of vocation education.**
  1. In Finland, vocational and academic education are both valued educational pursuits. They are viewed as different types of education.
  3. In Scotland, vocational education is still perceived to be second rate at the school level in comparison to academic pursuits. It is stigmatised as education for pupils who are not clever enough to undertake traditional academic subjects.
- **Normalised progression route for post-16**
  1. In Finland, the normalised and expected route of progression at 16 was to continue in education for at least 3 years.
  2. In Scotland, there did not appear to be any particular normalised route of progression, although there was a high uptake of Higher and Further education among those who remained at school to do 5th and 6th years.
- **Welfare incentives**
  1. In Finland, if a pupil leaves at 16 and has no job to go to, to qualify for benefit, s/he must be applying for a place in education (up to age 24).
  2. In Scotland, benefit is only available to 16-17s if they can prove exceptional hardship, and from age 18, only if they are actively seeking work.

School structure in Finland and Scotland

Differences in the structure of education systems perhaps herald the greatest contrast in education policy between Finland and Scotland. The main similarities between the two are that both systems have a national framework of provision, which includes free compulsory schooling up until the age of sixteen - made up of a primary and secondary level. Additionally, in both countries young people at age 16 (occasionally 15) would sit formal qualifications of a similar level.

The age at which the compulsory schooling begins was the first noted difference between the two systems in that young people in Finland start school on average two years later than in Scotland. This meant that even although the average number of years spent in education is similar[1] (Kane & Wellings 1999), a higher proportion of Finnish pupils would remain in education until at least the age of eighteen (usually nineteen) than was the case in Scotland.

The qualifications that can be gained at the end of the comprehensive level of schooling in Finland were not considered to be preparatory qualifications for entering the labour market, rather they were perceived as a means to accessing a place in continued education at a *Lukio* or *Ammattikoulu*. Both of these levels of schooling take on average an additional three years of study, by which point pupils would be on average nineteen years of age.

All interviewees in Finland from government through to school level acknowledged that gaining employment without a further three years of education

is very difficult. This was believed to be well known amongst young Finns and was proposed to be the main reason as to why 95-99% of pupils in the four schools examined and 95% nationally, go on to complete a further three years in education.

In Scotland, schooling begins at a younger age and therefore the compulsory aspect lasts longer in terms of actual years at school. The level of qualification that can be gained at the S4 (15-16) level is not dissimilar from the comprehensive leaving certificate in Finland. Despite this fact, considerably fewer Scottish pupils remained at school post 16, both nationally (64% S4-S5, 51% S4-S6) and in the four schools studied (68-86% S4-S5, 51-68% S4-S6), than was the case in Finland.

Explanation as to why so many Scottish pupils have chosen not to remain in school post-16 may in part have been that, until developments in assessment and certification increased the availability to undertake more vocationally based qualifications at the secondary school level (late 1980s) as discussed in Chapter Four, the only courses on offer at the S4 level and through S5 and S6 were entirely academic. Therefore, if a pupil did not want to undertake, or was not capable of undertaking the more academically based qualifications, there would be less incentive to remain in school voluntarily beyond the compulsory level.

A further structural difference between the two countries was found in relation to qualification at the national level for state benefits beyond the age of compulsory schooling. In Finland, on leaving school at sixteen, a young person who has no job

[1] Kane & Wellings (1999) did not break down the countries that make up the UK with reference to average number of years in education, and as there was no independent figure available for Scotland, Kane & Wellings' (1999) UK has been used as a proxy measure for Scotland.

to go to is classed as never-employed post-compulsory schooling. In such cases, until the age of twenty four, to qualify for state benefit that young person must be seen to be applying for a place in education. In Scotland, state benefits can only be obtained by young people aged sixteen-seventeen if they can prove exceptional hardship and from the age of eighteen upward, if they can prove that they are actively seeking work. Such measures essentially inform young people in their respective countries, what activity they are expected to be pursuing at the age of post compulsory schooling. In other words, in Finland, they are expected to be in education and in Scotland, employment.

Careers guidance (Student counselling)

In both Scotland and Finland, there has been a long tradition of providing careers guidance (student counselling) at the comprehensive school level. Despite the fact that both countries have this provision outlined within a national policy framework, substantial differences exist within the provision outlined at both the national and the school level, as were detailed within Chapters Four and Five.

The national framework within which teachers had to work at the school level in Finland was more detailed in structure than was the case in Scotland. This was reflected both by a more substantial level of provision and more consistency across schools in the content provided at each grade level, than was found in Scotland.

Additionally, guidelines for the provision of careers guidance (student counselling) in both countries encouraged teachers to promote further and higher education as an option for pupils beyond the comprehensive school. There was however,

considerably more emphasis on continuing in education as opposed to entering employment directly from school in Finland than was the case in Scotland.

As was discussed in Chapter Five, in Finland all student counsellors stated that the overriding focus of student counselling in their schools was to make sure that every pupil was aware of the educational opportunities beyond the *Peruskoulu.* The main aim of student counselling therefore was to make sure that every pupil had a place at which to continue his or her studies post-sixteen. Consideration was given to career options, in relation to what education was needed to pursue those careers in the future, but the primary focus was continued education.

In Scotland, the main focus was placed on raising pupils' awareness of the different career opportunities available to them. Although continuing in education was presented as one of those career options, it was not the primary focus of careers guidance in Scotland. The main aim of careers guidance was to make sure that every pupil had the opportunity "to pursue whatever it was they want to do when they reach sixteen".

To a degree the aim of the Scottish schools careers guidance makes the Finnish aim sound as if pupils were not given the opportunity to pursue what they wanted to, unless it was in education. This was however, not the impression that was given at the school level. Rather, continuing in education for at least three years post-sixteen, was the 'normal' thing that every pupil was expected to do.

The fact that continuing in education in Finland was normalised was a key difference between Finland and Scotland, and the fact that it occurs voluntarily in Finland, implies that young people understand the value of continuing in education and that they have both the aspiration and motivation to make use of the opportunities presented to them at age sixteen. Additionally, it means that young women in Finland have reason and incentive to delay pregnancy and parenthood.

In Scotland, continuation in education is also a voluntary choice, although, as already noted, considerably fewer pupils do so in comparison with Finland. The only point at which continuation in education (to university or college) was presented as normalised in Scotland, was for those individuals who had already chosen to continue at school to complete their 5th and 6th year level of the comprehensive school, which only accounted nationally for 64% and 51% respectively in 1997.

The extent of this process of normalisation appears to derive both from the focus and explicit aims of careers guidance (student counselling) and the structuring of pre and post-sixteen educational options in both countries. As will be discussed in the conclusion, this is a particular issue warranting further research.

Summary

Throughout this chapter a range of important issues of comparison have been raised in relation to each area of policy under study in this thesis, with tentative suggestions as to the importance that the key differences may have in relation to the teenage pregnancy rates in each country.

This chapter has indicated that young people in Finland have been provided with: knowledge about sex and sexuality in a format of sex education that previous research has identified as more likely to be effective; a health service provision that is tailored to young people's expressed needs and wants in a sexual health provision as identified by previous research; and an education system that has actively encouraged voluntary continuation for a very high proportion of young people.

What has been implemented at the local level in Finland appears to be strongly driven and supported in many areas by policy developed at the national level with guidelines for schools regarding: the location of sex education within core curriculum subjects as well as the content, teaching methods and time allocations that schools should provide; the role of the school nurse as a school-based health provider; the provision of student counselling (content, teaching methods and time allocations) and it's primary focus on continued education. In addition, the structure of the education system itself and the development of the dual system of vocational and academic schools offering wider post-16 choice at the school level are all policies developed at the national level.

Aspects of all three of these areas policy (sex education, school health service and the *Peruskoulu* style of school education) were developed and implemented during the 1970s at a time when Finland's teenage birth rate (24.2 per 1000 women aged 15-19 in 1977 (UN 1981)) was very similar to the rate in Scotland in 1996 (29.6 per 1000 women aged 15-19 (UN 1997), by 1994 and with little change to these

three policy areas over that 20 year period the teenage birth rate had steadily declined to a low of 9.0 per 1000 women aged 15-19 (Gissler et al. 1999).

In relation to Scotland, this chapter has indicated that in a number of areas of policy under exploration, in particular, the provision of sex education and careers guidance, national policy development and guidance has for the most part been absent. In turn what had been implemented in the form of sex education and careers guidance provision at the local level, varied considerably between schools in focus, content and time allocation. Therefore, without a strong directive from national policy, the development of practice at the school level has been neither uniform across Scottish schools, nor provided any level of equality of provision for young people in Scotland.

With regard to sexual health provisions in Scotland, although this research highlighted that there are a number of different provisions that young people can utilise and access for advice and contraception, none of the provisions met all of the needs and wants of young people as identified by previous research and therefore reality and equality of access for Scottish young people was also absent.

Finally, with regard to the provision of education in Scotland, focus until the 1990s in Scottish schools had been primarily on academic, examination based qualifications, effectively excluding those who were not able, or interested in undertaking academic pursuits, from continuing at the school level. Previous research has highlighted that increasing the educational choices available to young people is likely to encourage continuation at school.

Whilst the presentation of comparative analysis appears to favour Finland as the more positive, it is important to recognise that it was not the case that Scotland does not have adequate provisions. In relation to both sex education and sexual health services, the basic provisions in both countries are similar, but Finland goes one step further in providing sex education and services that are more tailored specifically to the needs of young people as well as guided by policy developed at the national level. Therefore, the basis for future development and implementation in Scotland is already in place in order to incorporate many of the policy options the Finnish case offers.

With regard to education policy, not all areas that have been highlighted in this thesis could necessarily be translated into policy options in Scotland, the main example being that of school structure. The structuring of the education system in Finland does appear central to the continuation of education rates in Finland. As noted above however, the continuation is voluntary and therefore whilst options need to be available structurally, there also needs to be the aspiration and motivation at the individual level to continue, and this cannot be derived from structure alone.

The tailored development to young people's needs in Finland, both in sex education and sexual health services derives in part from the recognition at government level of the rights and sexual health needs of young people, as well as an acceptance of teenage sexual activity. Recent developments within Scotland at government level in relation to the recognition of young people's needs and rights appear to be

moving more in the direction of acceptance of teenage sexual activity (Burtney 2000a, 2000b) and therefore the potential for tailoring future policy to young people's needs is increasing.

Additionally, there have been changes within the provision of educational options at the school level in Scotland - towards the increased availability of vocational education, which could potentially increase the desire of more young people to remain in education at school beyond the age of sixteen.

The change in direction in relation to some of the policy areas explored has not been confined solely to Scotland; there have also been changes within the various policy areas in Finland. Therefore, before going on to conclude this thesis, Chapter Seven first explores the direction of change in both countries. Particular attention is paid to the potential effect those changes could have on the rate of teenage pregnancy in Finland and Scotland, in light of the analysis presented within this chapter.

Chapter Seven

Policy change and future prospects

Introduction

As is the case with any area of policy, continuity as well as change and development are common features. The main policy areas that have been considered in this thesis have witnessed a great deal of continuity throughout the 1980s and early 1990s. The mid-1990s was however, a time of change in both Finland and Scotland and this chapter explores both the direction of those changes and their implications for the future.

Each policy area will be considered in turn, detailing the changes that have occurred within the national framework and at the local level of implementation. This is followed by discussion of the potential implications of the changes on the future rate of teenage pregnancy in both countries.

Sex education policy

Since the mid-1990s there have been a number of developments in both countries which have already been noted to have impacted upon the provision of sex education. These developments came about as a direct result of the changes in educational policy discussed in more detail later in this chapter. In order to illustrate the main changes to sex education policy in Finland and Scotland since the mid-1990s, Tables 7.1 and 7.2 summarise the key points that are developed in the following section of this chapter.

Table 7.1

Key changes to sex education policy in Finland since the mid-1990s

National level

- In 1994 the new comprehensive school curriculum enabled all schools to remove (if desired) two hours of previously compulsory subjects, Physical Education and Home Economics.

Municipality level

- In response to noted cutbacks in their schools each municipality had decided to develop a municipality-wide curriculum for their schools. In *Tehtaala* and *Vaarama* the curriculum was for health education, in *Alajoki* it was for family education.

School level

- In response to the curriculum changes, all schools studied had chosen to remove the hour a week of Health Education (in Physical Education) and all but one school had removed the hour a week of Family Education (in Home Economics) thereby removing the sex education that these subjects provided for pupils.

Table 7.2

Key changes to sex education policy in Scotland since the mid-1990s

National level

- In 1993 the 5-14 Programme was developed, enabling all schools to set aside time for the teaching of sex education.
- Clear targets for the implementation of the 5-14 programme were set and sex education became included as part of HM inspections of schools.
- In 1996 a three-year project into accreditation of pre-service teacher training began, resulting in all higher and further education training establishments providing accredited courses from 1999-2000.
- Development of future projects and initiatives at the national level are to be based on research findings of young people's needs and wants in the provision of sex education.

Local authority level

- The creation of the 5-14 programme had a knock-on effect for each local authority, whereby development at the local level was notable in the provision of guidance by each local authority to their schools about the provision of sex education.

School level

- The 5-14 programme was described at the school level as the first helpful documentation produced by the Scottish Office relating to sex education.
- Each school had revised their school sex education provision on the basis of the documentation from the Scottish Office and their local authority.
- In the case of Scotallen Secondary School, this included the development of this school's first ever PSE programme. The development of this programme was however, suggested to be more a result of the desire of the new Headteacher to have such a programme, rather than the effect of government or local authority policy.

Finland - National framework

A new style curriculum for the comprehensive school was implemented in all Finnish schools in 1994, with, it has been argued (Liinamo 2000) negative effects. In order to enable each school to develop a varied range of optional subjects, a number of subjects that were previously compulsory had to be removed to make room for these new optional developments. This change has impacted upon sex education in that two of the compulsory hours per week that were removed, were in the provision of Physical Education and Home Economics - the two subjects within which Health and Family Education were taught.

Schools were not compelled to remove these hours, they had the choice of keeping them as compulsory, making them 'optional' subjects, or removing them altogether. Schools were under an obligation to cover certain topics, which included Health and Family Education, however, it was up to each individual school to decide how to fulfil those obligations, and this did not necessarily mean keeping the two hours of previously compulsory provision.

Despite the existence of these obligations, the NBE official stated that it had already been brought to her attention that many schools had not interpreted the changes in the way that they were intended to. She said that "we are very worried about this system right now..., we have the knowledge that many schools are saying that actually Health Education is not supposed to be taught anymore".

This has raised particular concerns at government level because it was the belief that sex education combined with the "excellent" school health service that had

been responsible for the decreasing rate of teenage pregnancy in Finland. Therefore in the next framework curriculum process, (to take effect most likely from 2001), which was underway at the time of interview, they were considering that "Health Education will be one area where we must give more time because otherwise it just doesn't give enough time" (her emphasis).

Finland – local level of implementation

Prior to the curriculum changes, none of the three municipalities under exploration had provided any guidance to schools regarding the subjects within which sex education was taught, because schools had all followed government guidelines. After the changes had been made to the national curriculum, all three municipalities reviewed their schools' curricula and had noticed that there had been a substantial drop in the number of hours set aside for health or Family Education in some of their schools. As a result, they all decided to develop their own municipal curriculum framework for either Health or Family Education.

The municipalities of *Tehtaala* and *Vaarama* had decided to develop a curriculum framework for the provision of Health Education, whilst the municipality of *Alajoki* had decided to focus on Family Education. Schools were not obliged to follow this curriculum, but the municipal officers hoped that it would at least make schools review their provision, in order to make sure that they were providing enough.

In *Tehtaala* the curriculum had been devised entirely at the municipal level with consultation between the health and education sectors. In *Vaarama* and in *Alajoki*

it was being developed in co-operation with the municipal officers and the head teachers of all the local *Peruskoulu*.

At the individual school level, teachers in all four schools had noted that there had been a decrease in the provision of subjects providing sex education during the two years prior to this research.

Koskela Peruskoulu

At *Koskela Peruskoulu* when the school began to consider what optional subjects it was going to offer, it had consulted parents and teachers as to what they thought were the most important options. The second most popular choice of all options by parents was Family Education. The final decision on which subjects to incorporate was however made by the school's staff via a vote and the end result was to remove Family and Health Education as compulsory subjects.

The head teacher did not view the removal of these two previously compulsory hours with concern, due to the fact that they could rely on their school nurse. "I think the information for the pupils which is coming from the school nurse is very good, in our school. It is different in different schools, but here in our school she is very good. And because we have such a very good school nurse, the education, it is enough, I think so" (her emphasis).

The members of staff who used to teach those subjects did not share the sentiments of the head teacher that the provisions of Health and Family Education were satisfactory. All of the teachers noted that they no longer believed that school saw

its role as a provider of sex education as important because they had cut out so much of the provision.

The school nurse at *Koskela Peruskoulu* voiced further concern that she was bearing the burden of these cutbacks. Whilst she stated that she was happy to provide the education because it was important, she stated that "the school considers that it is the school nurse's duty to educate the children, as if it would be my speciality...each school makes up its curriculum and unfortunately, in our school there's now nothing" (her emphasis).

Tehtaala Peruskoulu

At *Tehtaala Peruskoulu* the head teacher was also very positive about the provisions in their school. She believed that since the changes, their sex education had become more integrated than before and whilst it had changed, it had not decreased. The teachers interviewed however, did not share the same views as their head teacher. The majority believed that the cutbacks showed that the school no longer saw its role as a provider of sex education as important. This school had removed both the extra hour a week for Family Education and Health Education. The male Physical Education teacher explained that this had happened because three years before (in 1995), when the school had created its new curriculum there was recognition that the same sex education was being taught by a number of subjects. He stated "we wanted to make... that we can co-ordinate it from Physical Education and Home Economics, so we can do better thing and then end result was nothing. So now, no-body teaches it regularly once a week".

All of the teachers who used to teach Health and Family Education expressed a desire to have the additional compulsory hour a week brought back into the curriculum. Both of the Physical Education teachers were aware that the school could easily reinstate Health Education into the curriculum, but they had chosen not too. To compensate for the reduction in compulsory hours of teaching, a number of the teachers stated that they still made time for sex education even if it means missing out something else. For example, the female Physical Education teacher noted, "If I don't teach anything else about Health Education, I have to teach that section [sexual health]".

Vaarama Peruskoulu

The view of the head teacher at *Vaarama Peruskoulu* was somewhat different from the other three schools in that he did show overt concern about the provision of sex education. He noted that they were for the most part satisfied with the old style curriculum and therefore had only developed a small element of the optional choice available to them. The extra hour of Physical Education per week had been removed, but the provision of sex education had remained the same in Family Education. Health Education was still taught but there was less time allocated to it than before.

The head teacher also referred to the work that they had been undertaking with the municipality with regard to developing the provision of Health Education. This project had come about from recognition in their school and the municipality of the increasing drug and alcohol problems in the area. They perceived that the over-reliance by some young women on emergency contraception was related to these

other problems. The head teacher hoped that the end result of this co-operative work would be an improved programme of Health Education for the 1999 curriculum.

Interestingly, noting this school's commitment to maintaining provision, the teachers were also much more satisfied with the level of provision than was found to be the case in the other three schools. On the whole teachers continued to believe that their school saw its role as a provider as important, which was reflected by their higher level of provision than they knew was the case in other schools.

Alajoki Peruskoulu

The head teacher at *Alajoki Peruskoulu* appeared to be in two minds about the provision of sex education in his school. On the one hand he noted that "some teachers have commented that pupils do not understand the subjects well and that more time is needed to increase their understanding". On the other hand he stated that "the situation is alright because there is now more sex education than before", an opinion that was not confirmed by the various teachers interviewed.

In fact at this school both the extra hour in Physical Education and Home Economics had been removed as compulsory subjects and the subjects to be removed within them were Health and Family Education. The Physical Education teachers still taught sex education but there was only time for one or two lessons a year per year group.

The Family Education course although no longer compulsory had been made into an optional subject in 1998, called '*dating dynamics*' taught by a male English teacher. This course was an option for 8th and 9th graders (14-16 year-olds), taught 2 hours per week for six weeks. It was available to both sexes, but in 1998 only young women had chosen the option and it was the teacher's understanding that because of a lack of finance this course would not be taught the following year.

This school had tried unsuccessfully to develop some co-ordination between the various subjects, "we try to take care of it... try to devise some common lines and so on, but the situation has got worse" (school nurse). The teachers responsible for Health and Family Education still believed the school had an important role to play "but here in our school – no... we could have Health Education in pupils' schedules, but the whole school don't see it so important" (male Physical Education teacher).

Implications of change

Of the four schools under exploration, all had removed their compulsory hour of Health Education in the 8th grade and only *Vaarama Peruskoulu* had retained its compulsory Family Education in the 9th grade. The removal by every school of compulsory Health Education in the 8th grade has, however, meant more than the removal of a source of knowledge - it has also meant the loss of the 'dual' aspect of provision. In other words the removal of the one class which taught issues relating to sex and sexuality in a single-sex environment. Therefore, the pupils no longer had the 'safe' arena at a younger age in which to raise sensitive issues that they may not be as comfortable discussing in a mixed arena.

Of the three head teachers, only the one at *Vaarama Peruskoulu* appeared worried about the current provision and despite the other head teachers appearing content with their provision, the majority of their teachers were not. In addition all the municipal officers and the NBE official were aware that many schools had chosen to remove Health and Family Education from their curriculums and they were not happy with this situation. Further to this, results of the latest School Health Study (Liinamo 2000) have indicated that there has been a reduction in the amount of sex education received by pupils throughout Finland, confirming that this reduction in provision is not confined to the four schools under study in this thesis.

Further to this, research has highlighted that since the changes to the curriculum, sex education in schools has generally become less co-ordinated (Kontula 1997) and the tone of teaching has been criticised for moving from the more positive promotion of healthy sexuality to one that emphasises the negatives of teenage sexual activity (Liinamo 2000), which research has shown is not an effective context in which to provide sex education (Oakley 1994, 1995; HEA 1998; Silver 1998).

Whilst sex education in Finland continues to promote co-operation between education and health sectors and "from a sexual rights perspective policy makers have made considerable progress in guaranteeing young people their right to sexual knowledge and information...there are still schools where sex education is quite inadequate. The quality of sex education varies very much according to individual municipalities and schools" (Liinamo 2000:227).

The outcome of this inequality of provision already appears to have had an effect upon teenage pregnancy rates in Finland. Most interviewees in Finland believed that it had been the combination of school health services and the variety of subjects which made up sex education that were key factors in the reduction of teenage pregnancy in Finland. The provision of both school health services and sex education had remained constant until the mid-1990s and the rate of teenage pregnancy had continued to decline until that time. In 1999 however, five years after the cutbacks began, Finland has been witness to the first rise in teenage pregnancy in over two decades. The rise is small, but noted because it is the first time that it has happened since the early 1970s and it has occurred over a period of five years from 20.7 per 1000 women aged 15-19 in 1995 to 23.5 per 1000 in 1999 (Gissler et al. 1996; Gissler 1999; STAKES 2000 – Personal communication). Whilst it would be impossible within the confines of this research to relate the effect of these cutbacks to the increase in the rate of pregnancy, there is a plausible connection warranting further research.

Scotland – National framework

There have been a number of developments within policy relating to sex education in Scotland at government, local authority and school level since the mid-1990s. One aspect that has remained constant however is that sex education remains a non-statutory area of education. In other words, there remains no obligation for schools in Scotland to provide their pupils with sex education. There has however, been strong encouragement from the Scottish Office for schools to do so over the last eight years. To enable this process of development at the school level, the

Scottish Office has developed policy and guidance in this area in order to provide local authorities and schools with advice based on "best practice".

The main formal policy developed so far has been the national advice documented within the 5-14 Environmental Studies programme (SOED 1993) which began in schools in 1993 and the new 'Higher Still' PSE provision (2000-2001). The approach of both is to help pupils establish baseline knowledge about their own body and its value and then to encourage pupils to develop the skills and knowledge needed to enable them to make informed decisions.

In addition to these guidelines, the Scottish Office has set clear targets for primary and secondary schools for this programme to be fully implemented by 1999-2000, to ensure that all pupils arriving at secondary school have obtained the same level of education in this subject (and all other subjects). To ensure this development schools' progress in this area is to now be included within formal HM school inspections.

There has been recognition of the need to improve the quality of sex education provision across schools by encouraging schools as a whole to recognise the importance of sex education, have the confidence to deliver it and be involved in self-evaluation. In supporting this process, the Scottish Office has begun to provide a range of training initiatives through grants, and Health and sex education have been given priority status. Therefore the SOED official noted that the Scottish Office Education Department perceives their role as "not just giving advice, but helping them to use it".

In addition to this in-service training, in 1998 a three-year project by the Scottish Office looking at the issue of pre-service training came to an end. The result of this project has been that all education-training establishments in Scotland have agreed to provide a particular structure of Health Education for pre-service training. This programme the official noted "will include health promotion to create the right climate within an institution and the receiving school, for the teacher to feel that this can be part of the taught curriculum". This was perceived by the Scottish Office official to be a major advance in training that will benefit the individual teacher as well as the school that he/she will work in.

In the process of continual updating of the 5-14 programme, there has been an increased awareness of "young people's right to information". The SOED official noted that this had come about as a result of a "cultural shift both within the Scottish Office and society in general". By focusing on up-to-date research on young people such as that by Currie & Todd (1993) and Currie et al. (1998) into the Health Behaviours of Scottish School Children, the Scottish Office has been made more aware of the knowledge, understanding, belief and attitudes of young people in Scotland. Information from such studies was noted to have helped the Scottish Office to commission further work on advice, training and support in the area of sex education, in order that research is used in a practical way, such as the development of the SHARE project[1].

[1] The SHARE project is a programme of teacher-led sex and relationships education has been evaluated via an RCT in 25 Scottish schools.

The SOED official further noted that development of future projects on the basis on young people's needs was crucial if they were to be effective and there was "large recognition now that giving advice is simply not enough. We must establish that the advice is meeting the needs of staff and young people". This willingness to acknowledge the findings of research which highlights young people's views, needs and wants was described by the official as a further example of "political commitment to establishing 'best practice'".

Scotland - Local level of implementation

In response to the policy development at the Scottish Office creating the 5-14 programme, all three local authorities under exploration began to look more closely at their potential role in helping schools develop the advice into practical application in their schools.

Glendale local authority

In Glendale local authority the national 5-14 guidelines lead this authority to develop their own health promotion policy. This policy contained very detailed aims and objectives with yearly targets of achievement from 1994 onwards and provided schools. This included a detailed programme for Health Education from primary 1 to senior 6 to complement the guidance the schools would have received from the Scottish Office.

According to the Glendale official, the authority made a good start towards putting the various policies into place including providing appropriate training opportunities for staff and getting provision in schools in order. All of the aims/

targets up to 1995-6 were achieved, but due to a sudden cut in funding from the Scottish Office, the whole programme of development stopped between 1996 and 1998. In 1998 in an attempt to get things back on track the local authority undertook the first audit of its kind in Scotland, to see what schools were doing with regards to providing Health Education and where schools felt that they needed help to develop those programmes. In 1998 as a result of the audit, Glendale were in the process of reviewing and updating all documentation and all support services they had. Therefore at the time of interview the official stated that this was an "interesting time" with regard to policy and Health Education.

One of the main findings of the audit had been that after 1996 things became "pretty piecemeal". Some schools had developed very impressive, coherent area group policies[1], with an agreed policy statement and agreed provision, which was found to be working well. Others had "barely reached the starting post". They had adopted the original Glendale policy but development had lain fallow since the cuts in 1996.

One of the original policy aims was to ensure that all schools were providing the same level of education by 1999-2000, as set out in Scottish Office advice. The cut in funding however meant that this was no longer considered a viable goal and schools were therefore not forced to adhere to the national guidance on this matter until a later date. The Glendale official noted that a deadline was still to be set for the future, but the authority recognised that 'best practice' in target setting would be for those targets to be both flexible and realistic.

[1] An area group is a secondary school plus all associated primaries.

The 1998 audit revealed that one of the authority's provisions deemed most useful by schools had been the detailed guidance about what to teach at each school level. The main criticism from the audit however, was that that guidance was considered to be out of date. Hence, one development within the authority at the time of interview was the updating of all documentation for schools which was being given a high priority.

Overall the Glendale official was quite positive about what they were trying to achieve within schools, however he noted that as PSE was not an attainment subject, it was difficult to get all schools to view PSE as important. As he further noted "from the kids' point of view it's perceived as being of secondary importance [because it is not assessed] ... for the best will in the world, teachers are under pressure when they are teaching it, perhaps giving the impression that it is of secondary importance, and until we get that sorted out, PSE provision is going to be second rate in a sense". With the current focus by government on attainment subjects and league tables, the official believed that whether or not schools have the additional time for PSE, schools do not perceive there to be time in terms of their other priorities. "It's back to getting your Highers – that's what seen to be important [by teachers, young people and parents]".

Scotallen local authority

Within Scotallen authority, development which began in 1996, had focused on producing a Health Education curriculum for schools in the form of a package called the 'Health Education for Living Project' (HELP). In order to make this

package easy for schools to use it was developed in relation to the 5-14 guidelines - making the two interdependent on each other. HELP was also based on the format of a previous drugs project which staff and pupils had said was good and hence the authority saw that it would be 'best practice' to develop the healthy living project in the same mould. Further to this the authority developed a committee paper which looked at the available curriculum materials and then identified the resources that teachers would be likely to find most useful and highlighted those resources to the schools in their authority.

One of the biggest developments in the area of sex education in Scotallen at the time of interview was within teacher training. Scotallen decided to produce an annual catalogue of in-services courses available to teachers which in 1998 they produced in collaboration with the health board. The aim was to provide a number of courses that would hopefully meet the needs of both health professionals and teachers.

Arbourness local authority

In Arbourness local authority policy relating to sex education had also developed from the basis of the national 5-14 guidance but further to this, from a recognition of the very high teenage pregnancy rate in this authority and a recognition that often sex education was "too little, too late, too uncomfortable".

The documentation itself is described as "a policy statement and guidelines for Health Education and health promotion in the context of PSE". The policy was

implemented in 1993 after a two-year consultation period and is based on what was considered at the time to be 'best practice' already in practice in the authority.

With regard to helping schools develop their sex and Health Education programmes, Arbourness perceived its role as of 1996 as that of a facilitator - helping schools through staff development opportunities. The authority arranged teacher-training courses to show teachers how to develop and implement PSE programmes at the school level. With regard to this teacher training, the authority had begun to provide training on the basis of funding and priority needs, with teacher training in sex education being perceived as a priority issue in 1998. As this training developed the official stated that they would "expect to see continuity and progression with regard to picking up sex education across the school to provide balance and progression".

At the school level, the introduction of the 5-14 programme was recognised by all schools to be "the first helpful documentation" produced by the Scottish Office with regard to sex education. In turn, development was noted during the mid-late 1990s in the provision of sex education within the four schools explored. Those developments however, appear so far to have been driven more by the efforts at the level of local authority than Scottish Office.

Glendale schools (Glendale Academy and Lochend Secondary school)

The two schools located in Glendale, Lochend Secondary School and Glendale Academy, both commented on the considerable help provided by their local authority back in 1993 with the provision of a very structured programme for

Health Education based on the 5-14 guidance. They further noted however, that since then progress had slowed as funding had disappeared at the local level and there had been no notable improvement at the school level since then. Despite this, the PSE teacher at Lochend Secondary School perceived the introduction of the 5-14 programme to have made a notable improvement in the equality of educational levels of young people on reaching senior 1 level.

Glendale Academy had felt that both the government and local authority guidance since the mid-1990s had had a significant impact on their PSE programme which was only three years old and not very well structured when the guidance was produced. Since the arrival of the Glendale documentation, this school had worked towards the production of its own policy which was being finalised at the time of interview.

Unlike Lochend Secondary School, Glendale Academy was still noting considerable differences between the levels of education that had been provided at their six associated primaries. They were, however, aware of the progress being made by their primaries and hoped that this would mean that within three or four years they would all be at the same level on entering S1 at Glendale Academy.

The two PSE teachers at Glendale Academy noted that the audit itself showed a level of commitment (which had previously been lacking) by the local authority to improve the situation. At the time of interview however, there remained a great deal of concern about the lack of expert help from outside the school in the teaching of sex education. As a result one thing this school had placed on their

audit form was the idea of a school-based nurse who would be able to guarantee the provision of education and advice for their pupils.

Scotallen Secondary School

The introduction of the 5-14 programme made no impact upon Scotallen Secondary School until the arrival of a new head teacher in 1995. As discussed in Chapter Five, the head at this school was aware that the provision that existed for 3rd to 6th years was limited and that there was nothing at all for 1st and 2nd years. He noted "I obviously want a PSE programme, the authority thinks you should have, your HMI, everybody, I think a school like this should have a PSE programme". He wanted in particular to develop a new programme in line with Scotallen guidelines and used their local authority advisor a great deal to make sure that their team was working to all correct documentation and guidelines.

The head teacher stated that the school overall was generally supportive of this new programme although some teachers were said to have been unhappy about cuts in their time to provide the programme but "there is commitment in there in the wider sense that we want the whole PSE programme to work, for the school, there is a big commitment to that".

Arbourness High School

Finally at Arbourness High School, the level of provision prior to 1993 was the most substantial of all four schools and had changed relatively little since then. When the authority brought out their first formal policy, the school did review a

formal plan of what they taught to make sure that it related to the Health Education advice and information form the local authority.

The main development within this school since the mid-1990s has been outside of the formalised sex education provision, in the development of a school health stall (this is discussed in relation to sexual health policy in the next section of this chapter).

Implications of change

The introduction of the 5-14 programme developed by the Scottish Office in 1993 has had the impact of chain-reaction through local authority provision down to the individual school level. Prior to 1993 only Scotallen local authority had done any particular policy development in the field of sex education - in relation to AIDS education. Since 1993 all local authorities under exploration made considerable advances in the documentation, resources and advice that they provided for their schools. In turn, the schools that appear to have benefited the most of those explored were those who had the least provision to begin with. For those with an established programme already, the local authority advice had helped to formalise and provide better structure to the provision that already existed.

While Scotallen local authority has made a significant input in the development of the new PSE programme at Scotallen Secondary School it only came about after the new head teacher decided that the school needed a programme. Had the new head teacher not come into this school the teachers involved in developing the new programme believed that it would not have been developed, regardless of what the

local authority had done to develop sex education in other schools. This raises an important reminder that without any formal obligation to provide sex education, some schools in Scotland without strong direction (pro-sex education) from senior management, may continue to have little or no provision.

Only the future will tell as to how successful these various initiatives will be and although the local authorities and schools were encouraged by recent and forthcoming developments, there was a degree of scepticism at each level as to the level of financial sustainability for many of the initiatives being developed.

Sexual Health Policy

Since the mid-1990s there have been a number of developments within the area of sexual health in both countries. In Finland the changes have come as a direct result of structural changes within the nation's health service. In Scotland the changes have come about primarily through recognition at Scottish Office and Executive and local authority levels concerning the lack of sexual health services aimed specifically at young people. The two Tables below (7.3 & 7.4) summarise the key changes in sexual health policy at the national and local level in Finland and Scotland.

Table 7.3

Key changes to sexual health policy in Finland since the mid-1990s

National level

- Changes to the funding for health care services and the de-centralisation of how that money is distributed at the local level has resulted in a shift of emphasis away from preventative health to curative health.
- Cutbacks have been made within the provision of school health services resulting in two main changes:
  1. School nurses generally will have responsibility for more than one school or area of health care provision and therefore less time to spend in any one school.
  2. The training of school nurses has begun to change from a system that trained them specifically to work with young people, to a more general broad-based training to prepare them for all types of nursing.

Municipality level

- In *Tehtaala,* cutbacks had been noticed in the amount of time school nurses had to spend in schools and the style of nurse training was moving to that of broad-based as opposed to youth-specialist.
- In *Vaarama,* cutbacks had been noticed in the amount of time school nurses had to spend in schools.
- In *Alajoki,* cutbacks had encouraged co-operation with a neighbouring municipality for the provision of school health services, this co-operation had resulted in the availability of one extra school nurse in this municipality.

School level

- At *Koskela Peruskoulu* the school nurse remained fulltime, but felt over-relied upon to provide sex education for all pupils.
- At *Tehtaala Peruskoulu* the school nurse was now responsible for an additional school.
- At *Vaarama Peruskoulu* the school nurse was now responsible for one extra school and the local health centre and when she retired, no additional nurse would take her place.
- At *Alajoki Peruskoulu* although the municipality as a whole had one extra school nurse, this school nurse now had the additional duties of working at the local health clinic.

Table 7.4

Key changes to sexual health policy in Scotland since the mid-1990s

National level

- From the mid-1990s there was an increased awareness at the national level of the need to base future sexual health provisions on the needs and wants of young people in Scotland.
- A 1996 Audit of school health service provision highlighted that the role of the school nurse could be developed in such a way as to provide a primary care style resource for young people; this idea is to be pursued further.
- The Scottish Executive produced the White Paper *Towards a Healthier Scotland*, which was endorsed by parliament in September 1999. Highlighted in this Paper is the new demonstration project *Healthy Respect*, which aims to improve the young people's sexual health, not solely reduce the rate of teenage pregnancy.
- In March 2000, the Scottish Executive hosted a deliberative seminar, the aim of which was again teenage sexual health not teenage pregnancy. The findings of this seminar include a recognition that young people's voices must be heard in processes, design, delivery and monitoring of future services for young people.

Local authority level

- In response to national developments, Glendale local authority had decided to develop an authority-wide improvement of health education at the school level, including fostering better links with community sexual health provisions to increase young people's knowledge of the services available to them outside of school.
- Scotallen local authority had decided to pursue the development of American 'full-service' schools to enable a primary care facility to be located on-site in schools, which whole communities could use, but would be confined to use by young people during school hours.
- Arbourness local authority had developed a project for young people up to the age of 21, harnessing the joint co-operation of health and education sectors to set up new initiatives within the local community for young people as well as fostering links between schools and local services.

School level

- Due to the developments at national and local authority level having only been developed in the late 1990s, the effect at the school level was minimal at the time of interview, however;
  - Scotallen Secondary School had been allocated a fulltime school nurse who would be involved within the provision of PSE and eventually it was hoped she would provide an on-site clinic for pupils.
  - Arbourness High School had developed a health stall one lunchtime a week that connected with a local youth service in town. Problems were noted with the youth service however, as it was only open one afternoon per week.

Finland – National framework

Since the early 1990s the Finnish health care system has been going through a process of de-centralisation and change. In brief the following two paragraphs describe the key changes to the Finnish system that may affect the areas of concern within this thesis.

First, prior to 1993 funding for health care services came in the form of state subsides that were distributed at the discretion of the Ministry of Health according to national plans. Since 1993, a change in the law now means that each municipality is provided with a block grant for health, social service and education[1]. This block grant, in combination with locally collected taxes, is now distributed to the various services at the discretion of the municipality. After the provision of all services defined in law as mandatory provisions[2], municipalities can use the remaining funds to support services that they deem to be most important.

How this money is distributed will depend on the attitudes of decision-makers and health care providers within each municipality. Despite the fact that at ministerial level prevention and health promotion are highly valued, the changes that have occurred have meant that experts at government level and national plans now have

[1] Additionally prior to 1993 these three areas of administration were separate sectors of provision and in practice, all services were provided independently from each other. Since 1993 municipalities have combined the provision and administration of these three sectors, providing a co-operative interagency network.

[2] Within health care provision those services include: GP-level curative services, Preventative services, GP-level hospital care, Dental care, Physiotherapy and rehabilitation, Occupational health, School Health services, Ambulance service, Environmental, work-site and food hygiene and Veterinary services (Hemminki 1995:11).

much less influence on the local level of provision. Since it has also been noted that both lay people and health professionals in Finland place more value on cure and care than preventative health care (Hemminki 1995; Rehnström 1997), there was and remains growing concern that this area of health care provision will suffer financially, unequally in comparison to other areas of health care provision (Hemminki 1995; Rehnström 1997).

Discussions with the NBE official for education revealed that this fear has already begun to manifest itself with regard to the provisions made for school health services in general and that great concern has been noted within educational sectors regarding these cutbacks. Referring to research conducted within STAKES, the NBE official stated that so far two main outcomes of these cutbacks have been noted, first, the effect upon the increased workload of school nurses and second, on their training.

First with regard to the workload, school nurses now generally have to share their time either across more schools or in alternative areas of nursing care, such as care of the elderly. The results in both instances being that school nurses now generally have less time to spend in each school than previously. The NBE official further noted that the time they do have is now mainly used to fulfil the legal obligation of school health services, i.e. the provision of individual health care for pupils. Time for the additional duties that many nurses had undertaken, such as teaching within Health Education programmes and acting as a resource of professional knowledge for teachers has now been reduced.

Second with regard to their training, according to the official prior to these changes nurses would undergo their main nursing training before specialising for example in school health care. This style of training meant that school nurses would be well qualified in dealing with the specific needs of young people (Liinamo et al.1997). What was stated to already be occurring by 1998 in some municipalities[1], was that nurses, rather than having their time spread across more schools, would have their time spread across different sectors of provision. A noted concern with this change was that future training of these nurses was not likely to be confined specifically to one field, such as school health, therefore, potentially reducing their knowledge of and ability to deal specifically with young people (Kosunen 2000a).

Local level of implementation

The changes in provision of school health services within each of the municipalities explored was found to vary in both levels and structure of provision, which reflects the expected differences that were predicted to arise as a result of the changes at the national level (Hemminki 1995; Rehnström 1997).

Tehtaala municipality

Within the municipality of *Tehtaala,* according to the official, there were differing opinions amongst the administrators as to which system of nursing would be the most productive, i.e. nurses who specialise in one field such as school health or nurses who cover a number of different fields in one geographical area. The result of the difference in opinion was that both systems were being tried out within *Tehtaala* in 1998. Some of the schools in *Tehtaala* had reported to the official that

[1] The decision as to whether nurses in a given municipality would have their time allocated to more schools or different sectors of provision is the decision of that municipality.

the new system of non-specialist nurses was causing problems for their schools as "the nurse no longer knows the school or the children so well and they don't have so much time to talk about those important things [sexual health issues] with the children".

Vaarama municipality

Within the municipality of *Vaarama* the system of specialised school nurses was still in practice, however the official reported that those nurses did not have as much time as before in each school.

Alajoki municipality

As a result of the changes at the national level, the municipality of *Alajoki* - being an area which is geographically widespread yet with a relatively small population - had decided to join forces with a neighbouring municipality to provide health care. The result of this combination had been the availability of extra resources including one additional specialist nurse to work in schools and therefore the level of provision in this area had actually improved.

Koskela Peruskoulu

At the individual school level the effect of the national changes were also stated to be having an impact in some schools. At *Koskela Peruskoulu* however, the provision of the school nurse had not changed. She was still available full time in the clinic and as a resource for sex education, both as a provider and as a professional resource for the other teachers. As detailed earlier however, in

relation to the provision of sex education the nurse believed that because her time had remained the same, the school were over-reliant on her.

Tehtaala Peruskoulu

At *Tehtaala Peruskoulu* prior to the national changes the nurse was only responsible for the one school. Since the changes, she has had to take on the responsibility of provision for a lower *Peruskoulu* in the area and spread her time across the two. She noted that this was common in the municipality of *Tehtaala* and there was "more work for school nurses, many of [the] school nurses are working also amongst other fields which they didn't do before, so there have been many cuts". Additionally the nurse noted that when she is sick and could not come in to work, no provisions would be made to cover her work, even if she is ill for a few weeks.

Vaarama Peruskoulu

At *Vaarama Peruskoulu* the nurse noted that there had been many cutbacks in health provision in Finland especially within school health care and that this trend was likely to continue. She noted that fewer nurses than before were working in the field of school health in her municipality and that when she retired in 1999, there would not be another nurse employed to replace her. The school would still receive school nurse provisions, but her work would be shared amongst the remaining school nurses in the municipality. Additionally prior to her appointment at this school she had worked in only one school, now she had to share her time across *Vaarama Peruskoulu*, a lower *Peruskoulu* in the municipality and the local health centre.

The head teacher at this school was very aware of the problems facing his school health service. He stated that he "would like to emphasise the importance of having a school nurse. In Finland the trend is not so good because of the cutbacks. However, having a school nurse is an important part of student welfare work. To have your own school nurse who knows the staff and the pupils. And everything goes well. And we have worked hard for maintaining the situation".

Alajoki Peruskoulu

Finally the situation at *Alajoki Peruskoulu* had improved and reflected the situation described by the municipality officer. The nurse in this school in addition to her school duties however, also worked at the local health clinic and encouraged pupils to visit her both within the school clinic and the local clinic. In order to encourage that link she had made arrangements for the pupils to visit the clinic as part of a school trip.

Implications of change

The effect of the structural changes to the provision of school health services was therefore noted in a number of ways. For the municipality of *Alajoki* the effect was increased municipal co-operation to increase school nurse provisions. For the other two municipalities however, the changes were generally not welcomed.

The NBE official was concerned that evaluation done by STAKES had already noted some negative effects of the cut-backs on young people themselves. She said that so far, sexual health had not been an area of concern, but increasing

problems of alcohol abuse and bullying in schools had been related to the fact that "there is less professional help available in schools to deal with these difficult situations".

As a result of these findings, members of STAKES[1] are trying to encourage on-going developmental work in school nurse in-service training, focusing on helping them to "make the best of the time available". They noted however, that this was becoming increasingly difficult when time was being cut back and priorities had to be made, none of which was helped by the fact that "complacency about our lowering rates, makes them [decision-makers] not worry...but there is a need to worry".

Scotland – National framework

As discussed in the first section of this chapter, the mid-1990s witnessed the introduction of the first official national documentation (5-14 programme) to enable curriculum time for the provision of sex education in Scottish schools. In conjunction with this there was also an increased recognition at the Scottish Office of the need to develop sexual health links outside of school - to use both within schools as teaching 'experts' and also as resources for young people in the wider local community.

The reason given by the Scottish Office for the creation and development of these types of links was because it was "the same youngsters in the school that were also potentially the customers of the local youth club, the local drop-in facility, etc".

[1] This information came as personal communication from the *Family Planning 2000* project members at STAKES in April 1998.

The Scottish Office had started to advise local authorities to develop such links and projects at the local level and their work in schools around the needs of their local communities. The results of progress in some areas that have been reported to the Scottish Office so far have been welcomed. The Scottish Office are satisfied with the progress especially that which has seen "the development of a lot of good provision where people have worked in partnership starting from the basis of young people's needs" (their emphasis).

With regard to the potential development of in-house health provisions, the official at the Scottish Office noted that while the provision of school health services in Scotland is enshrined in statute, very few school have a state-registered nurse based in their school. They were however beginning to accept, through research reported to them on young people's needs, that young people are increasingly talking about the desire for a non-teacher to be based in school to go to for advice. Within this context the notion of a school-based nurse was starting to take hold within official circles.

The SOED official highlighted that the results of the audit of the school health service in Scotland undertaken in 1996 (PHPU 1996), did raise awareness of the potential of the role of the school nurse to be developed in such as way as to be a primary care resource for young people. The audit provided guidance on 'good practice' in the provision of school health services, in particular, a change in emphasis from routine check ups at certain ages regardless of need, to a more targeted and focused service based on the needs of young people if and when they arise (PHPU 1996). The SOED official described it as moving from a system of

"screening to consultancy, based on need... including consideration of the social and mental as well as the physical".

In addition to these developments, the Scottish Executive has also acknowledged the importance of the sexual health needs of young people. In February 1999, a White Paper for Health entitled, *Towards a Healthier Scotland*, was endorsed by the Scottish Parliament in September 1999. Whilst the main sexual health policy focus of this paper remains a quantitative target to reduce teenage pregnancy (13-15 year olds) by 20% by the year 2010, there were a number of important aspects contained within this section.

The first of those aspects is the new health demonstration project, *Healthy Respect*, which has as its central aim, the improvement of teenage sexual health in general, not just the reduction of teenage pregnancy. The White Paper also highlighted additional funds that would be made available to the voluntary sector to help improve the sex education provision (outside experts) in Scottish schools (SODoH 1999).

In addition to this, in March 2000 the Scottish Executive hosted a deliberative seminar in conjunction with the Health Education Board for Scotland (HEBS). This event was set up to enable delegates of the seminar[1] to explore the issue of how "young people in Scotland can be further supported in making healthy choices about their sexuality and sexual health" (Burtney 2000a:1). The emerging agenda[2]

[1] The delegates included a number of interested parties including HM Inspectors for education, church ministers, local education authority officials, health service providers, sex education teachers and researchers.

[2] Details of the emerging agenda can be seen in Appendix ix.

produced by this deliberative group is progressive, inclusive and attempts to approach the issue of teenage sexual health from a broad perspective in the desire to see "A Scotland where sexuality is accepted" (Burtney 2000b:12).

Further to this was the recognition that the way forward must include the "constant involvement of young people's voices in processes, design, delivery, monitoring [and] recognition of the support needed to involve young people" (Burtney 2000b:14). Finally was the recognition that adults need to "trust young people to make their own decisions" (Burtney 2000b:15) and that by providing them with the right to access relevant services, they will be 'able to respond'.

The findings of this seminar and the implications they may have for future policy development were under deliberation at Ministerial level at the time of the submission of this thesis (January 2001). Noted progress thus far is that the Ministers have taken on board the need for a sexual health strategy for Scotland that takes account of the findings of this deliberative seminar[1] (Liz Burtney, HEBS, personal communication November 2000) and have requested my input in the development of the new strategy in relation to the findings of this research (Nigel Lindsay, Scottish Executive, personal communication November 2000).

Scotland - local level of implementation

The amount and type of development of services relating to young people's sexual health at the local level was found to vary across the three local authorities explored.

[1] Personal communication with Liz Burtney at HEBS 1st August 2000.

Glendale local authority

Within Glendale the local education authority had, in an attempt to achieve the goal of every school in the authority being a 'health promotion school', chosen to focus their resources on an authority-wide improvement of Health Education at the individual school level. One of the aims of the new Glendale service plan for 1999-2002 is to foster closer links between all schools and outside agencies including community education, school nurses and doctors and local providers of sexual health services for young people. The intention being to improve the provision of Health Education in schools and to improve young people's knowledge of the help that is available to them outside of school.

Scotallen local authority

After a visit by the Scotallen official to view examples of 'good practice' in the USA, this authority has decided to pursue the development similar to the American 'full-service school' for a number of their schools. The vision for this style of provision in Scotallen would be to start with eight schools in the authority in the first instance and then potentially, if successful, introduce this system in more schools. This style of school would operate twelve months a year, seven days a week, 7am-10.30pm, providing a full range of medical services for young people in a school based clinic.

The services would include general medical and dental care, psychological services, anti-natal (if required) and a full time school nurse available to deal with any issues that young people may have, including sexual health issues. The health

facilities would be available to the entire local community but would be confined to the use of young people during school hours.

The official noted that one of the reasons he personally was so keen on the American model was due to the main lesson that they have learnt from the AIDS crisis - that "access to services is critical". He explained that in relation to access in the late 1980s, many adults in the position to provide sexual health services such as contraception were "so naïve as to be stupid". Therefore in light of the success of this type of provision in the USA and the success of school based clinics in other countries, the Scotallen official believed that introducing such a system in Scotallen will "take the whole issue of teenage pregnancy a quantum leap forward".

Arbourness local authority

Lastly, Arbourness has decided to pool resources into a project for young people up to age of 21. This particular project came about through joint recognition within health and education sectors that Arbourness had particularly high teenage pregnancy rates in comparison to the rest of Scotland. Additionally it was recognised that the conception rate reflected that a certain level of unprotected sex had taken place and therefore those young people were also vulnerable to contracting an STI including HIV.

Therefore a multi-agency steering group[1] was created in 1997 and the result of their deliberations, was that the project which began in January of 1998. The main remit of the steering group was "to support and facilitate the Project worker to involve young people in discussion of how to genuinely make health facilities, particularly on sexual health issues, acceptable and accessible to the widest possible range of young people"

Prior to setting up new initiatives within the local community for young people as well as fostering links between those services and the schools in their locale, the primary aim of this project was to find out what young people needed and wanted. According to the Arbourness official the main outcomes of the Project worker's research with young people revealed that young people had requested that any service developed needed to be confidential, friendly, relaxed, anonymous and non-judgemental. Additionally young people in Arbourness had requested that a number of different facilities be available to them including those which provided free condoms, emergency contraception, contraception, someone to talk to about relationships/school/stress and a local free-phone helpline. Finally those services needed to be located near to or in school, at youth clubs or as part of a youth service and they needed to be easily accessible with free transport for rural areas, open at suitable times and have an age limitation on their use.

[1] The steering group was made up of interested parties from the education development service, health promotion (NHS Trust), community education, health promotion centre (Arbourness) and the designated project worker.

Another main finding of the review by the project worker of services already in existence was the increasing use of school nurses in Arbourness. Having noted that the young people revealed to the project worker that a school nurse, especially one who could provide confidential advice and contraception would be a favoured option in service provision, the local authority is now promoting the development of school nurse clinics. The Arbourness official noted that although this style of provision was very much in its infancy, the local authority was committed to developing this resource, which appeared to be successful where it was being used and which was a service young people have expressed a desire for.

Due to the fact the majority of the initiatives discussed above in relation to all local authorities were at the development stage at the time of interview, what was found to have been implemented at the school level was minimal. The schools were however, aware of the efforts that their local authorities were making to develop the variety of projects discussed. Some were sceptical as to whether the local authorities would in fact "produce the goods", but were also positive about what was being done. Only two of the schools, Scotallen Secondary School and Arbourness High School had already benefited from the developments that were being made.

Scotallen Secondary School

First, although the local authority was still to develop their schools in the mould of the American full-service schools, at the time of interview Scotallen Secondary School had just been guaranteed the provision of a full time nurse. The head teacher stated that the nurse, in addition to health checks, would be utilised heavily

in the development and teaching of the new PSE programme, as well as a resource for staff teaching on this course. He was unsure as to whether they would be able to utilise her in a clinic base setting straight away as there was nowhere to actually accommodate her at that time within the school. This was however, something they would be giving consideration as a school-based clinic had a great deal of appeal amongst staff at this school.

Arbourness High School

During the mid-1990s a youth enquiry service was set up very close to Arbourness High School. In order to encourage young people to make good use of this service the school liase with the community education individuals who work at the youth service in the town. The principle link has been made by the creation of a health stall every Tuesday lunchtime within the school. The stall provides pupils with leaflets and information about health-related issues including information about contraception. Although this school's nurse is not located within a school-based clinic, she does work as the dedicated nurse at the youth service providing a further link with this service.

The youth service is currently only available one afternoon a week and is also under the threat of closure due to under-use. Although it is viewed as a valued service by the local authority and the teachers at Arbourness High School, it appears that young women are still using the main hospital 30 miles away for emergency contraception.

The teachers noted their confusion over this under-use. Comments by young people to the project worker in Arbourness however have revealed that services like the youth service, whilst useful, were not considered to be open often enough. For example if unprotected sex occurred any time between Wednesday night and Saturday night, the youth service would be of no use for emergency contraception, as it would not be open until the following Wednesday, more than 72 hours after the event having taken place[1].

Implications of change

The first change that has occurred in relation to young people and sexual health in Scotland, has been the increased recognition at all levels of policy development and implementation of the need to listen to young people and acknowledge their needs and wants. This recognition was particularly noted within the interviews at the Scottish Office and local authorities and was also prevalent within documentation on the issue produced from the deliberative seminar in March 2000.

The actual projects being proposed for development at the Scottish Office and local authority level, appear in light of the discussions in Chapter Six, to be crucial steps forward towards meeting the needs of young people in relation to sexual health provisions. There was however, scepticism voiced at the different levels with regard to those developments. The local authorities were sceptical about the commitment at government level and the schools were sceptical of the commitment of both the government and their local authorities.

[1] 72 hours being the maximum time within which to take emergency contraception after un-protected sex has taken place.

In particular the concern at both levels was one of continued financial commitment. For example the Glendale official noted that since Labour came into power the Scottish Office have been making a very big deal about sex education and sexual health but as yet they "have not really seen the funding... that we might have expected from the initiatives that have been flying out of the Scottish Office...the initiatives sound great...[but] I'm not quite sure if this government is going to put its money where it's mouth is".

This research has only considered three of the thirty-two authorities in Scotland and whilst similar development may be occurring throughout the country, similarly it may not. Additionally, while the projects being undertaken in the three authorities explored are all steps in the same direction, they are diverse in their approaches, showing that there remains no uniform development.

Therefore there remains an issue of concern in that the lack of any formal obligation for authorities to devote resources to such developments may mean that some will not. The potential outcome therefore being that whilst provision in some areas may be substantial, it may be non-existent in others. Therefore the development of sexual health services for young people may end up mirroring the development of sex education in Scotland whereby the provision is piece-meal. A potential result being, an inequality of access to sexual health services for young people in Scotland.

Education Policy

Within both countries there were changes within education policy during the mid-1990s, which have the potential to affect on teenage pregnancy. In particular, the process of de-centralisation and curriculum changes has already affected the provision of sex education as discussed earlier in the chapter. Additionally, however, some of the changes have the potential to affect young people's motivation to remain in school and therefore indirectly affect teenage pregnancy rates. A summary of the key changes in education policy since the mid-1990s can be seen in Tables 7.5 and 7.6 below.

Table 7.5

Key changes to Finnish education policy since the mid-1990s

National level

- A process of de-centralisation and de-regulation of education, which began in the early 1990s, brought about the most noted key change in relation to this thesis in 1994 – changes to the national curriculum for the comprehensive school. The key effect of this chance was the ability of schools to now remove two hours of previously compulsory subjects within which a large proportion of sex education had been provided.

Municipality and school level

- The resulting effect of this change at the municipal and school level have been noted in Table 7.1

Table 7.6

Key changes to Scottish education policy since the mid-1990s

National level

- The introduction of the 5-14 programme provided the first curriculum development at the primary level that linked to secondary level provision – encouraging a continuity of education between the primary and secondary levels.

- Changes to assessment and certification have resulted in qualifications at the school level moving from an entirely academic, exam-based system to one which involves a mixture of course-work assessment and exams, as well as an increased availability to undertake vocational qualifications at the school level.

School level

- o Schools had noticed a general improvement in the equality of educational level of pupils on reaching secondary level – therefore reducing the need to repeat education at the S1 level and risk dis-engagement through boredom or an inability to catch-up.

- o In all schools, teachers accredited a growing annual proportion of young people remaining at school beyond compulsory level, to the increasing availability of vocational qualifications at the school level.

- o Additionally some guidance teachers noted that GSVQs were providing young people, women in particular, with increased confidence and status.

Finland - National framework

From the creation of the *Peruskoulu* in the early 1970s with its system of strong centralised control regarding curriculum, examination and governance, there was little notable structural change until the mid-1990s. However, the seed of reform had been sown during the late-1980s with encouragement from the Ministry of Education of the development of closer partnerships between municipal education bodies and their schools. The aim of this subtle change was to lay the foundations for the process of decreasing the level of central governmental control in the sphere of education in the 1990s.

This first change was seen as the beginning of the process of de-centralisation and de-regulation of education that would occur during the 1990s in Finland (Lindblad & Lundahl 1999) and was part of a common trend across many European countries at that time (Hirvenoja 1999). The economic recession that Finland suffered during the early 1990s gave momentum to the process of de-centralisation, as it was deemed easier to make the necessary cutbacks in education if control was held at the local level (Hirvenoja 1999).

The most notable changes occurred in 1994, at which time Finland moved from what Green et al. refer to as a "centralised system with some element of devolution and choice" to a system of "localised control with national 'steering' and partial school autonomy" (1999: 74-5). In conjunction with this change, the control of the school curriculum was devolved to the individual school level. Therefore instead of a centrally prescribed curriculum with a small optional element of choice to be

developed at the school level, the entire curriculum was now developed at the school level with minimal guidelines provided by the NBE.

These guidelines still prescribed a compulsory element that had to be taught within each school, but the overall control of how these elements were to be taught was devolved to each individual school. In order to enable this change, a proportion of what had been compulsory hours of teaching in certain subjects were removed to make way for schools to develop a wider optional element for their pupils[1].

The culmination of these two changes means that in order to keep their allocated pupils from moving to other schools and also to attract new pupils, schools are under pressure to develop a wider and more varied 'optional' element to their curriculum. Schools could in theory keep the previously compulsory subjects as either options or compulsory subjects within the new curriculum. Schools however, were actively encouraged instead to develop their strong subjects and in a sense become 'specialists' in a particular area, such as language, music or arts (Sarjala 1996).

Finland - Local level of implementation

Since these changes were implemented during the 1990s each municipal area has remained responsible for making sure that the school system works at the local level. In the past, municipalities played little role in the development of each of its schools' curriculums, as they were for the most part prescribed at the national level. Since curriculum development primarily became the responsibility of each

[1] Of particular interest to this research were the removal of one hour per week of physical education and one hour a week of home economics, as was discussed earlier in this chapter.

school, the municipal role in this area increased at the initial development stage. Each municipality was encouraged to provide a skeleton framework of curriculum provision for their local area. Schools were then encouraged (although not prescribed) to use this framework as they developed their own curriculums.

Developing this closer bond of co-operation between schools and their municipal body, was part of an overall NBE plan to encourage the view that "the educational services in a given municipality as a whole so that the strong points of different schools can be made use of in diversifying the curricula of different schools" (Bertell 1994:18). At the local level however, rather than providing an overall curriculum framework for schools as standard, only *Alajoki* provided a common curriculum for its schools, whilst the municipalities of *Tehtaala* and *Vaarama* opted to place no framework restrictions on schools.

Although not necessarily providing an overall curriculum framework, all three municipalities did provide curriculum frameworks for specific subject areas, as was discussed earlier in the chapter, when it became apparent that some schools in their municipality were not providing enough of a particular subject.

At the school level, as was discussed earlier, the effect of the changes to the curriculum impacted upon the provision of sex education. Hours that had previously been compulsory were removed from all schools except for the provision of Family Education at *Vaarama Peruskoulu*. Some subjects remained as optional courses, however for the most part, schools had decided to develop

their option element for subjects such as internationalism, IT, specialist languages and sport.

Implications of change

With regard to the implications of the changes discussed, the most important in relation to this thesis is the effect that these changes have had on the provision of sex education. The reduction of national guidance and the increase in responsibility at the local and school level has been said to have weakened the provision of sex education in schools in Finland (Liinamo 2000). This has been confirmed through follow-up studies of the provision of the previously compulsory subjects from the school year 1995-1996 to 1997-1998. This study found that whilst approximately 25% of schools had maintained their level of provision and 31% had increased their provision, 44% of schools had decreased levels of sex education provision (Liinamo et al. 2000a).

Scotland – National framework

In Scotland, the process of changing the curriculum actually began in the late 1980s with the first submission by the Scottish Consultative Council on the Curriculum (SCCC) to the Secretary of State, of new guidelines for secondary schools in 1987. The implementation of this reform however, did not take place until the early 1990s.

The first major change was to the curriculum for those at the primary and lower secondary level (aged 5-14), which came about from the recognition that there needed to be a more efficient connection between primary and secondary

education. Secondary schools routinely take pupils from a number of different primaries, including their own associated primaries[1]. Therefore it would often be the case that pupils coming from a range of different primaries on reaching S1 level of the secondary school would not all be at the same educational level as each other because there was no common curriculum within primaries. In an attempt to create a 'bridge' between the two levels of education, the Scottish Office Education Department launched the 5-14 programme. The initial documentation came in the form of working papers before the finalised guidelines were disseminated to schools, which took effect in 1993. Building from core subjects already taught in the majority of primaries, the 5-14 guidelines provided each school with guidance on developing a common curriculum aimed at the "breadth, balance, coherence, continuity and progression" (SCCC 1998:18) of education through the seven levels of primary and the first two levels of secondary education.

Changes to the level of secondary education from S3 through to S6 were then developed to link in with the new 5-14 programme, broadening the five main areas covered at the primary level to eight[2]. Those guidelines also suggested to schools the minimum amounts of time that should be allocated to the various core areas[3].

[1] On average schools in Scotland have between 3-6 associated primaries, whereby pupils from those primaries, unless requested to be placed elsewhere by their parents, would automatically follow through to their associated secondary.

[2] The 5 primary core areas incorporated English, Mathematics, Environmental Studies, Expressive Arts and Religious and Moral education. The 8 secondary core areas incorporated Language and Communication, Mathematical studies and applications, Scientific studies and applications, Social and Environmental studies, Technological activities and applications, Creative and Aesthetic activities, Physical education and Religious and Moral education.

[3] The introduction of the 5-14 programme and further developments in the S3-S6 curriculum will be discussed in more detail later in the chapter, as these guidelines were in effect the first official documentation from government that allocated specific time in the curriculum within which sex education could be taught in Scottish schools.

With regard to assessment and certification procedures for Scottish pupils, there have been numerous changes over the last fifteen years. Some have come as a direct result of the changes made to the curriculum and others preceded that change and in part instigated the changes to the curriculum in 1993.

Prior to the end of the 1980s the qualifications available to pupils were entirely exam-based (Ordinary grades at S4 and Higher grades at S5 and6). In 1989-1990 these qualifications changed to Standard grades (S4) and Revised Higher grades (S5 & S6) respectively. Both were based on the notion of positive assessment, incorporating elements of assessed course-work in addition to formalised examinations.

As discussed in Chapter Four a new system of vocational qualifications was introduced at the beginning of the 1990s which pupils were able to take instead of or in combination with their Standard grades. These were called Scottish Vocational Qualifications (SVQs). Pupils would have the option to choose a range of subjects from a catalogue of modules set by the Scottish Qualifications Authority (SQA) and if successfully completed would provide accreditation towards a 'non-advanced' vocational qualification (national certificate).

For those pupils who opted for the more vocationally based qualifications, a new system was then introduced at the upper secondary level (S5-6), enabling continuity of study with a wide range of short and modular courses (SCOTVEC modules). The introduction of these courses is probably one of the most notable

changes within upper secondary educational policy in recent years, providing the first alternative qualification to academically orientated examinations.

1999 witnessed further change to the assessment and certification system of the upper secondary level. As of August 1999, all schools were expected to move from the Revised Higher grade examinations introduced at the beginning of that decade to the new Higher-Still examination, a system that is even more course-work based than the previous Revised Higher. Eventually it is expected that in the future the five different levels of Higher-Still will replace Standard Grades, Revised Highers and Sixth Year Studies, offering further continuity of education from S3-S6.

In addition a new vocational qualification, General Scottish Vocational Qualification (GSVQ), has been introduced to take over from the SCOTVEC models. This qualification is more broadly based, aimed at those aged 16-19 and can be taken in both secondary schools as well as further education colleges.

Scotland - Local level of implementation

At the individual school level, all four schools explored in Scotland had devised and developed their own curriculums at the school level based on the new 5-14 programme and S3-S6 guidelines that were intended to tie in with what was introduced within the 5-14 programme. Schools had begun to notice (some more than others), a greater degree of equality in the educational levels of pupils upon reaching the secondary school. In some cases this was enabling the progression of pupils from S1 to S2 level to take place without the need to repeat education that

should have been provided at the primary stage - which was noted to effect upon S1 level pupils' level of interest in their courses.

With regard to the changes in assessment and certification, teachers at all of the schools had noted that more pupils were staying on at school than had been the case in previous years. All schools acknowledged that the lack of job opportunities at age sixteen was a likely contributory factor to this increase in staying-on. Some credit for this increased continuation however, was placed upon the increased availability of vocation education at the school level. There was an increasing sense amongst careers guidance teachers that pupils were staying on not only to gain better qualifications but also because they "perceived that there was something for them to gain by staying". In other words, increased opportunity at the school level had increased motivation and aspirations to remain in school for longer.

Although vocational qualifications were still not believed to be perceived by pupils as on the same 'level' as Higher grades, guidance teachers were noting that those who stayed on to achieve GSVQs, gained more than the qualification. As the careers teacher at Glendale Academy noted, "those who've done it have gained a lot in terms of their confidence and their ability to handle different situations… it is the sort of thing that has been excellent in giving status, in particular to girls, who may have otherwise drifted away...".

In three of the four schools careers guidance teachers noted that the increased availability of vocational qualifications were being viewed as a main reason as to

why the stay-on rates were on the increase amongst those who would otherwise have left school at sixteen. There was also a desire amongst careers guidance teachers to encourage the normalisation of these qualifications as valid educational choices for young people to encourage their up-take further.

Implications of change

The implications of the change within education policy in Scotland, as was the case in Finland, have already impacted directly on the provision of sex education as was discussed earlier. There are however, also implications for some of these changes to have an indirect effect upon teenage pregnancy rates in Scotland, in relation to increased motivation to remain in education.

The new curriculum guidelines have now created a system whereby greater continuity in education has been encouraged between primary and secondary schools. This system has the potential to make sure that all pupils are at the same standard of education when they reach secondary school. Some schools were already noting that this had meant that pupils had appeared more interested in learning, because they were not having to repeat education they had already done at primary, or having to catch up education that they had not covered.

The changes in methods of assessment and certification have also meant that since the 1990s pupils are now no longer assessed purely on the basis of how they perform on one examination day. Instead there has been a gradual move towards more and more continual assessment in conjunction with formal examinations.

The introduction of more vocationally based qualifications at the school level has been suggested by careers guidance teachers as part explanation as to why more young people are remaining in education for longer. It is unlikely that any significant impact on stay-on rates will be noted for a period of time. The implication from the schoolteachers however, was that this may well prove to be the case. The combination of the development of and increased availability to pursue more vocationally based qualifications as an alternative to more academic pursuits could prove to be a key factor in encouraging more young people to stay on in education beyond the age of sixteen, than has been the case until now.

In the longer term, this may aid the 'normalising' of continuation in education for young people in Scotland, which was so noted in Finland. The indirect implication therefore being that increased opportunity at the school level and increased motivation to achieve, may provide more young people in Scotland with the incentive to delay pregnancy and parenthood at a relatively young age.

Summary

As can be seen from the discussion within this chapter, there have been a number of interesting developments in all three areas of policy since the mid-1990s. Whilst it is too early to predict what the eventual outcomes of the various developments may be, of interest at this point in time is the apparent direction of change.

The changes within education, school health and sex education that have arisen from the de-centralisation within the sectors of health and education in Finland,

have the potential to negatively effect upon the rate of teenage pregnancy in Finland. Two main areas drawn out from the analysis in Chapter Six as potential key policy differences were those of the combined provision of health services and sex education at the school level in Finland.

Additionally, there was common agreement amongst those interviewed as well as researchers in the field of teenage sexual health in Finland (Kosunen 2000a, 2000b; Liinamo 2000), that these two provisions had been crucial components of the successful reduction of teenage pregnancy in Finland. It would therefore appear that the recent policy changes might continue to have the undesired effect upon the Finnish teenage pregnancy rate that has developed during the latter years of the 1990s.

From the discussion within this chapter, it appears that changes within education, sexual health and sex education policy in Scotland, are moving in the opposite direction to that in Finland. With regard to education policy, the provision of more vocational and course-work based qualifications may well prove to be a strong motivational aspect that encourages a higher stay-on rate in education at the school level and potentially encourage the 'normalisation' of continued education found in Finland.

An acute awareness of young people's needs and wants has formed the basis of development in the area of sexual health services for young people in Scotland. Similarly, the development of sex education guidance based on young people's needs at Scottish Office and local authority level, as well as developments in pre

and in-service teacher training and attempts to raise the profile of PSE and sex education within schools, are all important changes which will hopefully lead to a greater level of provision and equality of provision across Scottish schools.

The next chapter presents the concluding part of this thesis addressing a number of important issues. First, a number of potential policy options that could aid in the reduction of teenage pregnancy in Scotland are discussed, second there is a final discussion drawing together the key themes that have arisen from this research, which highlight what the findings of this research add to the existing literature on social policy and teenage pregnancy. The chapter then concludes by considering the future research agenda drawing from issues which have been raised within this thesis.

Chapter Eight

Conclusions, Policy Issues and the Future Research Agenda

Introduction

The purpose of this thesis has been to explore a range of policies relating to teenage pregnancy in Finland and Scotland in an attempt to highlight policy explanations for the noted difference in teenage pregnancy trends between the two countries. It has mapped and located those policies within their national framework and at the local level of implementation before drawing attention through comparative analysis, to the main similarities and differences in policy between the two countries.

The data analysed in this research is not representative of all schools or authorities in either country. The data does, however, raise some important issues in relation to a number of social policies and their connection to the rate of teenage pregnancy in Finland and Scotland. The effects that these policies appear to have had are multifaceted and inter-related. As a result, the conclusions presented within this chapter, are drawn cautiously and further research directions are identified later in this chapter.

The overall aims of this thesis have been: to explore three policy areas relating teenage pregnancy in Finland and Scotland with a view to highlighting potential policy options that could aid in the reduction of teenage pregnancy in Scotland; to add to the existing knowledge base on policy relating to teenage pregnancy, and

finally to consider areas for future research. Consequently, the remainder of this chapter has been divided into three parts, the first of which discusses the potential policy options derived from the analysis of the key similarities and differences between Finnish and Scotland policy, which could aid in the reduction of teenage pregnancy in Scotland.

Reducing the rate of unintended teenage pregnancy in Scotland: Potential Policy Options

Having explored, analysed and discussed the key policy similarities and differences between Finland and Scotland, there are a number of potentially important individual aspects of policy raised, the following highlights those policy options, which stand out as the key findings of this research.

One of the most striking policy differences between the two countries was in their different use of school-based health services and in particular the role played by the school nurse. As highlighted in Chapter two, young people have a range of issues with regard to accessing sexual health services, in particular those services which have been set up for use by whole populations. Issue of concern include, the visibility of a service, confidentiality, appropriate opening times and the perceived attitudes of the service providers, from the receptionist through to the doctor or nurse that they see. The school nurse system in Finland provided a service-model that actually met all of the additional needs and requirements of young people in relation to service access as defined by previous research.

Further to this, the fact that the school nurse was trained specifically to work with young people and would often remain in the same school for many years meant that a relationship could develop between pupils and the nurse over time, enabling an individual context in any advice-giving process.

The fact that the school health service is intended to be the first port of call for young people in Finland when they have any health concerns also means that barriers to accessing health care in general are broken down from an early age and therefore, when a young person needs sexual health advice, concerns about accessing this health service are likely to be have been reduced.

As an intended first port of call for young people with health concerns, this style of service could also be argued to be actively encouraging young people to take individual responsibility for their health, to know that when they are ill or something is not right with their physical or mental health that there is help available. In other words, if an individual has become familiarised with taking responsibility for themselves and their health, the less likely they are to not ask for help when required, or to 'bury their head in the sand' when they know they require help.

In Scotland and Britain as a whole, young people generally do not access health care by themselves. If a child or young person were ill they would usually be accompanied by a parent/ adult to see their family doctor. In this sense young people in Scotland are not encouraged, as in Finland, to be active in accessing health care by themselves. Although every school has a statutory obligation to

provide a school health service only a very few schools across Scotland have set up a system of on-site clinics in the way that every school in Finland provides. There is no service available to children or young people in Scotland that they have ownership of, which is something that research has increasingly shown is an important determinately factor in young people actively accessing a service (Zabin et al. 1986; Peckham 1993; Fullerton et al. 1997; Liinamo et al. 1997; NHS CRD 1997; Hadley 1998).

The fact that a statutory school health service already exists in Scotland does, however, mean that the foundations for developing such a service already exist. Developing such a system would not only potentially aid in the promotion of sexual health amongst young people but as a generic health service, would also be able to deal with all holistic health issues of concern to young people including diet, self-esteem, smoking, alcohol, bereavement, drugs, bullying and so on.

Despite the cost of developing such a service in the first instance, in relation to lower curative health care costs in general as well as costs specific to sexual health including, the cost of abortions, STI treatments (and longer term infertility complications and costs), as well as costs associated with unintended motherhood, would mean potentially large financial savings in the longer-term.

Perhaps of greatest importance is that it would mean that all young people across Scotland would have equality of access to a health care facility, regardless of whether they lived half a mile or fifty miles from their nearest clinic or service provider.

The second key finding of this thesis is in relation to the provision of sex education and is two-fold. First, the fact that sex education in Finland was incorporated into a number of core curriculum subjects set out at the national level has a number of important implications including:

- Helping to both promote sex education as of equal status to other subjects and to normalise the subject matter,
- Providing young people with a variety of perspectives on issues relating to sex and sexuality,
- Providing regular provision of sex education across each grade of the *Peruskoulu*, rather than as a one-off or small block of lessons,
- Consistency in content, teaching methods and focus across all schools.

The second important factor is how Finnish sex education has been provided with an acute awareness of young men's sex educational needs. The English SEU report (1999) highlights that young men are half of the problem of teenage pregnancy and therefore must be half of the solution, however, young men have specific needs, which are often not addressed by sex education. When it comes to what young men want to know about sex, their agenda often varies considerably from the agenda of what adults think they should know. What recent work with young men has revealed, however, is that if you begin with the agenda of young men, which is often wanting knowledge about masturbation and pornography, and

deal effectively with that agenda, you will eventually get around to the 'adult' agenda of respect, responsibility and safer sex (Selman et al. 2001; Kell 2001)[1] .

In Finland, through the provision of health education as a single-sexed environment (in most schools), teachers have been able to address the agendas of both young men and women separately, providing a platform for discussion about their interests and concerns. If sex education is to be effective in impacting upon young people, especially young men, future development of sex education must take these issues into consideration. Young people are often curious about sex, what it is, what it's like, how to be good at it, and unless these points are addressed first, there is the risk that young people will disengage from what is being taught and an opportunity to eventually reach discussion of the 'adult' agenda, will be lost.

Finally, the third key finding of this research is in relation to education policy. What was most striking about the education system in Finland was the overriding normalised expectation portrayed at both the national and school level that young people would continued their studies for at least three years post compulsory schooling, which was reflected both in the national stay on rates and those of the four schools explored. The fact that high stay on rates at the school level is strongly correlated with lower rates of teenage pregnancy is important and suggests that by continuing in education for longer, young people in Finland are indirectly delaying parenthood.

[1] Personal communication with Chris Kell, Boys and young men's development worker, Northumberland Health Authority.

There are a number of potential reasons as to why the stay-on rates are so high in Finland, but the fact that there was no significant relationship found between the rate of unemployment and staying on at school, lead to a focus on the structure of schooling and the potential influence of careers guidance (student counselling). The findings of this research appear to suggest that the over-riding focus within student counselling on continued education as opposed to careers pursuits at the *Peruskoulu* level, may explain in part the expectation of continued education is normalised.

In addition, the fact that vocational education does have along history in Finland and is a valued form of education offering a great range of choice beyond purely academic study, in comparison to Scotland, where vocational education is still in the early phase of development and not as highly valued by young people, may add further explanation as to why the stay-on rates are considerably higher in Finland, than Scotland.

A final important factor, however, is likely to be related to the access that young people in Finland do/ do not have to welfare benefit when they leave school. Unlike Scotland, where a person must be seen to be actively seeking work to obtain benefits, in Finland, the fact that young people (who have never been employed post-school) must be actively seeking a place in education, is telling young people in Finland that the expected normalised route for them at that stage in their life is continued education.

Teenage pregnancy and social policy: revisiting the literature

Sex education policy

The question of how effective school-based sex education is in helping to reduce the rate of teenage pregnancy has been and remains an issue for debate. Whilst it has been generally acknowledged that sex education can help increase knowledge on issues relating to sex and sexuality (Goldman & Goldman 1983; Jones et al. 1985, 1986; Bilsen & Visser 1994), what remains contested is the relationship between the acquisition of that knowledge and its effect on personal behaviour (Allen 1987; Thomson 1994; Silver 1998).

Despite the debates surrounding this issue, as can be seen from the discussion within Chapter Two, there does exist a range of evidence to support the view that the effectiveness of sex education is dependent on a number of factors and that the provision of sex education which incorporates those factors has been related to safer sexual behaviour amongst young people.

In relation to the factors associated with effective sex education, previous research has illustrated that the public climate towards sex education plays a key role in the level of acceptance of that provision in schools (Vilar 1994). In countries which are generally supportive of pragmatic sex education such as the Netherlands, sex and sexuality are presented as 'normalised' aspects of life, which Silver (1998) suggests underlies the effectiveness of sex education. Further to this, research has identified two key components of sex education that are more successful in helping young people to internalise the messages that they are receiving. First, presenting sex education from a positive 'sexual health' perspective rather than focusing

solely on the potential negative outcomes of teenage sexual activity (Oakley et al. 1994, 1995; David & Rademakers 1996). Second, providing sex education that is based on what young people want to know, rather than on adult's perceptions of what they need to hear (Oakley et al. 1994, 1995; Sex Education Forum 1997; HEA 1998).

In relation to this research, whilst Scottish provision appears to moving towards a more pragmatic and normalised approach, based upon what young people in Scotland have stated that they want to know (Burtney 2000b), sex education had not been an issue of national policy focus until the mid-1990s. Rather, it appeared to have developed in a piecemeal fashion and was generally focused on biological reproduction and the negative aspects of sexual behaviour. The provision in Finland, however, presented a picture more in line with that of effective provision. Sex education at school had been a focus of national policy for two and a half decades and had developed from a narrow biological focus in the 1970s to sex education that aimed to promote good practice in sexual health. Sex education in Finland did not aim "to forbid sexual activity, but to reduce health risks involved and emphasise responsible behaviour" (Väestöliittö 1994:27). Therefore the findings of this research support the suppositions of existing literature discussed above, with regard to these specific factors relating to effective provision.

With regard to how sex education is provided in schools, existing literature has illustrated that utilising a permeated approach, whereby sex education is located within a range of curriculum subjects can help to normalise the topic, provide a wider range of perspectives on similar issues, provide higher levels of provision

and help promote sex education as of equal importance to other subjects (Silver 1998). Additionally, for sex education to be most effective previous research has highlighted that provision needs to be situated within a suitable teaching environment (Sex Education Forum 1997; Hadley 1998; HEA 1998; Silver 1998). Three key elements of that environment have been identified as; provision being taught by staff who are both able and willing (RCOG 1991; Sex Education Forum 1997; HEA 1998), the use of active-learning based methods such as role-play and small group discussion (Kirby 1995; Sex Education Forum 1997; HEA 1998) and the provision of an "open and safe" classroom environment (Silver 1998) which can be aided by the use of both single and mixed-sex arenas.

In relation to this research, the provision found within the four schools in Scotland did not generally incorporate many of the 'effective' factors presented above. As sex education in Scotland does not form part of the Scottish Syllabus (national curriculum), a separate subject approach had been utilised in all four schools rather than a permeation approach. In turn, teachers were aware that the separated provision was not viewed by pupils as of equal status to curriculum subjects. One of the main reasons given by teachers for not having undertaken much in-service training on sex education was because it was more important that they received training about the curriculum changes to their 'main' subjects.

In relation to the development of an effective environment, although there did appear more opportunity for in-service training in Scotland than in Finland, for the reason noted above, the uptake of such training had not been high. There was also no substantial pre-service training available to teachers in Scotland, suggesting that

this factor, relating to the provision of effective sex education was missing from the schools explored. In relation to teaching methods, although active-learning techniques were beginning to be utilised, the most common methods remained traditional 'chalk & talk' style lecturing. Finally, only a mixed-sex arena was available to pupils at the four schools explored.

In Finland, all schools explored (and all schools nationwide) utilised a permeation approach providing sex education within Health Education, Family Education and Biology. This had, according to those interviewed, helped to normalise the topic, provided a range of different viewpoints, enabled a high level of provision, and presented sex education as a topic of equal value to other subjects.

With regard to the teaching environment, the most interesting finding in Finland had been that teacher training was not an issue of policy importance at the national or school level. Although there were opportunities for teachers to undertake training on sex education, it was down to the individual teacher to organise his/ her own training and only one third of teachers interviewed had done so. With regard to effective teaching methods, all four schools explored did utilise methods which have been suggested to be more effective and finally, in three out of the four schools explored, both single and mixed-class arenas had been utilised (which was common throughout Finland), therefore providing an opportunity for different levels of discussion for pupils.

Therefore, although the findings of previous research do suggest that there are elements that can make for a more effective teaching environment, the lower extent

than would be expected of teacher training in Finland and the fact that although the learning methods utilised in the four schools were of the more effective style, recent research has illustrated that these schools may have been the exception rather than the norm in Finland (Liinamo 2000), perhaps suggests that other elements related to effective provision are more important.

Existing literature has suggested that some of those additional elements include; sex education programmes with content that is positive in its presentation of sex and sexuality and goes beyond discussion of biological reproduction (Oakley et al. 1994, 1995; Sex Education Forum 1997; HEA 1998), programmes which provide sex education aimed at young men's issues in relation to sex and sexuality (Winter & Breckenmaker 1991; Hadley 1998; HEA 1998; Meyrick & Swann 1998; Silver 1998; Wood 1998) and the use of trained sexual health experts in the provision of sex education (Mellanby et al. 1995; Few et al. 1996; Sex Education Forum 1996; Papp 1997; Mayall & Storey 1998).

In relation to these factors, this research found that in the Scottish schools with the exception of Arbourness High School, the focus of the content was generally on the potential negative outcomes of teenage sexual activity, before any discussion on relationships (if provided at all). The focus of the content was around biological reproduction and pregnancy prevention, which as discussed in Chapter Two, is not the best approach for engaging young men. Finally, whilst teachers valued sexual health experts, use of them was limited due to financial constraints of both parties and time constraints of the experts.

In relation to Finland, this research found that the content of provision was wider in focus and number of perspectives (social, health, biological, ethical), and focused on positive as well as negative outcomes of teenage sexual activity, which was consistent across the four schools. There was an overt awareness of the need to provide sex education that would engage young men and help to raise their awareness of sexual health, respect and responsibility. Finally, whilst the only sexual health expert that was utilised in the Finnish schools was the school nurse, due to her location in school, gaining access to her was considerably easier than accessing sexual health experts in Scotland. Whilst only one nurse interviewed actively taught sex education in the classroom, all four nurses were available to pupils on a one to one basis if they needed advice and they also provided information to teachers who were involved in providing sex education.

It would therefore appear that the findings of this research add weight to the existing knowledge in respect to programme content, young men's needs in sex education and the availability and use of sexual health experts, all being factors of importance with regard to the provision of more effective sex education. The use of the school nurse in Finland as an additional educational resource, trained to work specifically with young people, adds further weight to current discussions about the suitability of such individuals to provide this resource at the school level (Hunt 1996; Whitmarsh 1997), when they have been appropriately trained to do so.

As noted in Chapter Two, the provision of effective sex education has been related to a number of positive outcomes in personal behaviour. This included evidence that the provision of effective sex education does not hasten teenage sexual activity

and in some studies there was found to be a delay in first intercourse (Baldo et al. 1993; Kirby et al. 1994; Fullerton 1997; NHS CRD 1997; Cheesbrough et al. 1999) and increases effective contraceptive usage (Baldo et al. 1993; Kirby et al. 1994; Wellings et al. 1994; Kirby 1997b; Fullerton 1997; NHS CRD 1997; Cheesbrough et al. 1999). Countries with lower teenage pregnancy rates generally have more sex education at the school level (Jones et al. 1985, 1986; David et al. 1990; Baldo et al. 1993) and countries described as providing easy access to sex education (Vilar 1994), in turn were found to have significantly lower birth rates to teenagers.

In relation to previous research findings on the range of factors which culminate to produce more effective sex education, this research has shown that the sex education provisions found within the Finnish schools could be classed on the whole, as more effective than the provisions found within the Scottish schools. This therefore, adds weight to the relationship between the availability of effective sex education and lower rates of teenage pregnancy and in part, adds explanation as to why there has been a noted difference in pregnancy rates amongst teenagers in Finland and Scotland.

The developments in sex education policy during the mid-1990s however, as discussed in Chapter Seven, highlighted a direction of change in sex education policy in both countries. In light of the evidence of previous research and the analysis of the findings of this research, if these patterns of change continue in their current direction, the future may witness a decrease in the effectiveness of Finnish sex education and an increase in the effectiveness of the Scottish provision.

In turn, this change in effectiveness may manifest itself within the rate of teenage pregnancy in each country.

Sexual Health Policy

In order for young people to take responsibility for their sexual health, in addition to adequate knowledge about sex and sexuality, they also require access to advice and contraceptive services to enable them to respond. Chapter Two presented a range of evidence from previous research illustrating that when accessing sexual health services, young people have a number of additional requirements of services, which if not met, act as potential barriers to their accessibility and use.

These additional requirements included; the suitable geographical location of a service and equality of access (Zabin et al. 1986; McIlwaine 1994; Clements et al. 1997; Fullerton et al. 1997; Hadley 1998; Cheesbrough et al. 1999; SEU 1999), suitable opening times (Zabin et al. 1986; Clements et al. 1997; Hadley 1998; Turner 2000), confidential services (Jones et al. 1985; Wulf & Lincoln 1985; Jones et al. 1986; Zabin et al. 1986; FPA 1994; Lo et al. 1994; McIlwaine 1994; Dickson et al. 1997; Fullerton 1997; Liinamo et al. 1997: Hadley 1998; SEU 1999; Turner 2000), informal and user-friendly services (Zabin et al. 1986; Peckham 1993; Fullerton 1997; Hadley 1998; SEU 1999), services provided by professionals trained to work with young people who held positive attitudes towards young people and their sexual health and who used terminology that young people could understand (Liinamo et al. 1997; HEA 1998; Aggleton et al. 1999; SEU 1999) and services which were inclusive and recognised the needs of young men (Nelson 1997; Hadley 1998; SEU 1999).

Further to this, previous research has illustrated that young people would prefer services that are aimed at young people, (Peckham 1993; Liinamo et al. 1997; Aggleton et al. 1999; Turner 2000), preferably located near to or in school and/or youth settings (Zabin et al. 1986; Allen 1991; Peckham 1993; Fullerton et al. 1997; Liinamo et al. 1997) and that are exclusively for the use of young people (Liinamo et al. 1997; Turner 2000).

The findings of this research revealed in Chapters Four and Five, that the basic health and sexual health services available to young people in Finland and Scotland were very similar. In both countries young people had access to primary health care facilities, family planning clinics and a small number of clinics set up for the exclusive use of young people. Previous research discussed in Chapter Two, however, highlighted that these types of services all had potential barriers to access, such as, the issues of geographical location, the visibility of the services to the public (parental) eye, concern over confidentiality and unsuitable opening times.

The main difference in access and service provision for young people that this research identified however was the school health service. As noted in Chapters Four and Five, although both countries have a statutory provision of school health services, the service in Finland was set up as a primary care resource for young people whereas in Scotland, it was set up as a health screening service not intended for primary care use. In relation to what previous research has identified as key factors in relation to young people's ability and willingness to access services, the

school health service in Finland was shown in Chapter Six, to fit all of the requirements identified by young people in general and in Finland (Liinamo et al. 1997) as necessary for their needs.

Although previous research has identified that there is a lack of sound methodological evaluation of the effectiveness of school-based provision (Oakley et al. 1994, 1995), those interviewed in Finland for this research, believed that the school health service in combination with the provision of permeated sex education had played a central role in the reduction of teenage pregnancy in Finland over the last thirty years. This is a viewpoint supported unanimously by researchers in the field of teenage sexual health and general health care in Finland (Hemminki 1995; Kosunen 1996; Kosunen & Rimpelä 1996a; Rehnström 1997; Kosunen 2000a, 2000b).

Whilst evaluating the effectiveness of a school-based health provision has not been an aim of this research, the findings of this research have highlighted that in relation to the factors that are more likely to enable young people to access sexual health services, the provision of the school health service in Finland is a key difference between the provisions available to Finnish and Scottish young people.

Further in relation to sexual health policy, previous research has illustrated that in countries where there is a general acceptance of teenage sexual activity and young people's sexual health rights, there are also generally lower rates of teenage pregnancy and related rates (Jones et al. 1985, 1986; David et al. 1990).

This research has illustrated that until the late 1990s, there was no visible direct policy commitment to the promotion of teenage sexual health in Scotland. Despite the setting of the 1992 target to reduce teenage pregnancy set by the British government (DoH 1992), there was little policy development to enable or encourage this target to be met (Ingham 1992).

Additionally, this research indicated that in Finland, since the early 1970s, there has been a visible pragmatic commitment to helping young people take responsibility for their sexual health. In addition to the development of the school health service as discussed above, in response to the teenage abortion rate in the 1980s, the Ministry of Health and Welfare developed the magazine *Sexteen*, which was sent out to the homes of every sixteen year old in the country. Although a target for reduction was set, unlike in Britain, the target was to reduce the rate of teenage abortion not teenage pregnancy, therefore implying an acceptance that it is not teenage pregnancy that is the issue of concern, but rather those pregnancies which resulted in abortion and therefore should have been prevented.

The findings of this research therefore appear to suggest that the level of government commitment to promoting the sexual health rights of young people and in turn the level of provision for young people developed at the national and the local level, act as a reflection of the level of that acceptance. This research therefore adds weight to the suggestion from previous research, that for effective sexual health policy to be developed, there first needs to be an acceptance of teenage sexual activity. Without that acceptance, the will to develop policy that

enables young people to take responsibility when they have sex, will be missing as well (Silver 1998).

In Finland, the issue of concern has not been that young people are having sex, but rather that, the use of abortion shows that not all young people are taking adequate responsibility when they have sex (Väestöliittö 1994). In Britain teenage pregnancy has been presented as an issue of concern for many reasons, including the costs of welfare (Selman 2001), as evidence of the breakdown of the traditional family (Selman 2001) and the loss of childhood innocence (Turner 2000). Policy therefore, has developed from a desire to prevent teenage pregnancy by preventing the teenage sexual activity rather than by accepting it and promoting the responsibility that comes with that activity (Silver 1998).

As discussed within Chapter Seven however, there have been interesting developments in sexual health policy since the mid 1990s in both countries. Within Finland, there has been a move towards de-centralisation of budgets and responsibility for policy development and implementation. Therefore even although there remains a strong belief in prevention and sexual health promotion at the national level, with the downshift in control, there is less control at the national level over how health budgets should be spent.

The findings of this research have illustrated that the cutbacks in funding for school health services have already been stated to have resulted in some instances in reduced time for school nurses to work in schools and also in the training of school nurses moving from the specific youth-orientated training to general broad-

based training. This research further shows that concern has already been voiced at national and local level that a degree of complacency has set in amongst those responsible for budget prioritisation, that teenage abortion is no longer an issue of concern in Finland, and that without a return to previous levels of provision, there is a risk that the abortion rate may begin to rise, a concern that has already materialised (although not yet significantly).

In Scotland, the development of sexual health policy since the mid-late 1990s, as with sex education policy, has been considerable. Although policy relating to education, health and sex education in Scotland has always been separate from the rest of Britain, the creation of the Scottish parliament has provided a platform for change that is distinct and physically distant from Westminster and British policy, a key example being the repeal of Section 2a[1] in Scotland, but not the equivalent Section 28 in England.

The recent and current developments in sexual health policy in Scotland appear to be moving in a direction that accepts teenage sexual activity, which, as previous research has shown is a central underlying factor in the success of sexual health policy for young people (Silver 1998). Within Chapter Seven analysis of those interviewed on the subject of current and future developments, gave the impression that there is a keen desire at the national and local level to develop policy that is based on the needs and wants of young people in Scotland. There also appeared to

[1] In June 2000, Section 2a, which prohibited the 'promotion of homosexuality' by local authorities, was repealed in Scotland. This is a good example of where Scotland and England have parted company in official opinion. While the House of Lords in England have twice voted to keep the Clause, Scottish MSPs voted overwhelmingly (99-17) in favour of its repeal. This was the first major piece of legislation since devolution that differed from Westminster.

be a growing understanding that basing provision on what young people have expressed that they need and want is crucial to the effectiveness of future policy development and implementation.

Further to this, recent discussion with an official of the Scottish Executive responsible for developing the future policy strategy on teenage sexual health in Scotland (Nigel Lindsay – Personal communication November 2000) revealed that attention is being paid to examples of good practice in Europe, where teenage pregnancy rates are lower than Scotland, rather than focusing on the USA, where rates are higher, as the British government continues to do[1].

As was discussed in relation to the changes in sex education policy, the outcomes of the changes in direction of sexual health policy also remain to be seen. Analysis of the findings of this research prior to those changes and the evidence of previous research findings in relation to sexual health policy and young people do suggest, however, that the current policy developments in both countries (if continued in line with the developments discussed in Chapter Seven) have the potential to impact upon the rate of teenage pregnancy, negatively in Finland and positively in Scotland.

Education policy

Previous research as discussed in Chapter Two, highlighted that a variety of relationships exists between education and teenage pregnancy. This included

[1] A noted example of this point being that after the Deliberative Seminar in March 2000, referred to in Chapter Seven, at which findings of this research were presented to various delegates including members of the Scottish Executive, a fact finding trip was made to Finland by members of the Executive to explore provision for young people.

associations between higher levels of education and; higher levels of sexual knowledge (Kontula & Rimpelä 1988, Turner 2000), higher age of first intercourse (Kane& Wellings 1999), more effective contraceptive efficiency (Hoffman 1984; Morrison 1985; Kraft et al. 1991), abortion as the more common outcome of pregnancy (Kane & Wellings 1999) and a higher age of first birth and smaller number of children over a woman's fertile life course (NHS CRD 1997; Westall 1997; Beets 1999a, 1999b).

As was illustrated in Chapters Two and Four, in countries where there was a high level of continuation of education or training for those aged sixteen to eighteen, there were found to be; significantly lower rates of teenage pregnancy, significantly higher rates of contraceptive use amongst young people at first intercourse, significantly higher proportions of abortion to birth as an outcome of pregnancy and significantly higher age of first birth.

A number of researchers have supported the hypothesis that the availability of good educational and employment prospects beyond the compulsory school level are required to enable and encourage young people to have the motivation required to continue their education (Simms 1993; Selman & Glendinning 1996; Hadley 1998) and in turn to delay pregnancy and parenthood.

This research therefore set out to explore further the relationship between educational policy and teenage pregnancy. In particular, having noted the considerable difference that existed between the stay-on rates at the school level

between Finland and Scotland, Chapters Four and Five went on to explore whether there were differences in school structure and/or careers guidance that actively required or encouraged young people to remain in education for longer.

The overall key difference between the two countries was found to be the level of normalisation of continued education. In both countries, continuing in education beyond the age of sixteen was voluntary and yet in Finland, young people were expected to, encouraged to and most did continue their education for at least three years after the compulsory level. In Scotland, the only point at which continued education was presented as normalised, was for those young people who had already taken the decision to continue to S5 and S6, the normalised route thereafter being to university or college.

The findings of this research imply that there are a number of factors that have encouraged this normalisation in Finland including; the structure of post-sixteen education, the strong emphasis on continued education as a valued commodity during student counselling at the *Peruskoulu* level and the requirement for young people aged sixteen to twenty-four, who have never been employed since leaving the *Peruskoulu*, to be applying for a place in continued education in order to obtain welfare benefit.

The findings of this research further imply that the relative lack of normalisation of continued in education in Scotland, has resulted from a range of factors including; the pre-1990s focus on academic (examination-based) pursuits at the pre and post-sixteen level, the perception that vocational options are second rate to academic

qualifications, the principal emphasis in careers guidance on career pursuits with a lesser focus on continued education, the welfare incentive from age eighteen plus being that of applying for employment rather than a place in continued education and finally, the lack of focus at the comprehensive level on continued education as the 'normal thing' for young people to do.

Whilst there were changes to education policy in both countries during the 1990s, of significance, in relation to continued education, were the changes that occurred in Scotland[1]. In particular, the increasing availability of mixed examination and coursework-based qualifications of academic and vocational variety is opening up a wider choice for young people at the school level in Scotland. Teachers interviewed for this research, had already begun to note amongst their pupils, an increasing desire to and perception of the value to remain in school for longer. The teachers believed this partially explained the annual growth in young people remaining at school for longer.

Previous research has identified that the longer young people remain in education, the less likely they are to enter parenthood at a younger age (Jones et al. 1985, 1986; Bynner & Parsons 1999; SEU 1999). In other words, by remaining in education, pregnancy and parenthood are being delayed indirectly. The findings of this research have illustrated that there exists a considerable difference in the proportions of young people who remain in education in Finland (and other European countries with low pregnancy rates) and Scotland. The fact that the continuation is voluntary is of importance, as whilst the structuring of an

[1] The impact of the changes to education policy in Finland as discussed in Chapter Seven, were noted in relation to the effect that they have had on the provision of sex education.

educational provision will play a role in young people's continuation, there must also be a degree of motivation present, for young people to voluntarily undertake something that is not compulsory. The findings of this research were such that it is not possible to separate at a policy level, the potential effect that school structure and the potential influence of careers guidance (student counselling) may have had on young people in Finland and Scotland. There were, however, noted differences in both areas of policy which warrant further research as will be explored in the final section of this chapter.

Future research agenda

In relation to research on sex education, there have a number of projects through the late 1990s in Scotland (e.g. the SHARE project[1]) and in England (e.g. APAUSE[2]) that have explored the merits of different styles of providing sex education in schools. It would be beneficial for a future sex education pilot to evaluate a programme that permeates the curriculum rather than another separate approach.

The findings of this research have highlighted the potential importance of sex education programmes that provide a dual-arena for the teaching of sex education, i.e. providing pupils with a mixed-sex as well as a single-sex environment, that place a particular focus on engaging young men and that utilises more active learning-based methods. Whilst previous research has indicated that these are all important aspects in the provision of more effective sex education, further research is required in these areas, before any firm conclusions can be drawn. This could be

[1] See Wight et al. 2000
[2] See Rees et al. 2000

achieved by undertaking randomised control studies exploring the potential of each aspect as well as one that combines all three.

One further issue that was raised within this research, was the effect that one individual in a position of power (e.g. the head teacher at Scotallen Secondary School) can have on the provision of sex education at the school level, as these individuals are effectively the gatekeepers in relation to sex education provision. What warrants further research, especially in light of the fact that the provision of sex education remains an area outwith statutory provision in Scotland, is the attitude of head teachers and senior management teams within all Scottish schools.

One method of undertaking such research would be to develop and adapt the audit undertaken in Glendale local authority (which all schools were required to participate in) for all local authorities in Scotland. This would achieve three objectives; first it would provide a picture of the level of sex education provision in all Scottish schools, second, it would enable the opinions of head teachers and senior management teams towards the provision of sex education to be sought and third, this would allow an analysis of how those opinions related to the actual provision of sex education in schools to be determined.

One issue that warrants particular attention in relation to sexual health is the attitude of sexual health providers towards the sexual health of young men. As was identified within the review of the literature in Chapter Two, there is a lack of understanding and appreciation of young men's needs in both the provision of sex education and sexual health services. As was further highlighted throughout this

thesis, in Finland there was an acute awareness of young men's needs in both sex education and sexual health service provision. Whilst this was addressed through interviews with the teachers and the school nurses, in order to develop understanding on this issue further, future research should focus on the level of understanding and appreciation of young men's needs and in turn provision geared at young men within sexual health services at the local level outwith school.

Further in relation to sexual health services, it was noted in Chapter Five that variations existed across municipalities as to whether school nurses could provide contraception within the school-clinic. It would therefore be of value to explore whether any significant relationship exists between the rate of teenage pregnancy and whether or not school nurses are able to provide contraception on-site, as this would potentially provide evidence of the importance of the school nurse's role in reducing and maintaining low teenage pregnancy rates in Finland.

One method of carrying out such a project would be to undertake a large-scale short questionnaire of school nurses' contraceptive dispensing capabilities in Finland and then map the results by municipality for differences in pregnancy rates.

An exploration into the different types of sexual health provisions available to young people (and their opinions of such provision) in other developed countries would potentially be another area warranting further research. In particular, exploring the availability of sexual health services for young people in a range of countries with varying rates of teenage pregnancy would offer more scope to

highlight exactly what types of services encourage the greatest level of use by young people.

After the initial analysis of the data on education policy it became apparent that whilst there were noted differences within the school structure and the emphasis placed on continued education in careers guidance (student counselling), there are potentially many other factors which could also have an effect upon the proportion of young people who chose to continue their education beyond the age of sixteen and the extent to which that continued education was perceived as the normal thing for young people to do. This may include, the wider social context within young people live, such as general standards of living, economic support for families, the state of the labour market and the level of parental education.

Therefore future research in this area is both necessary and important and should incorporate a qualitative exploration of young people's views as to their future educational aspirations and the factors they perceive as aiding or preventing them from continuing in (or wanting to continue in) education.

An issue that has become more apparent towards the final stages of writing up this thesis is the role that the self-esteem of young people may play both in their motivation to remain in education as well as the more acknowledged effect on sexual behaviour (Thomson 1990; Pearce 1993; Lees 1994; Hadley 1998). Therefore in order to develop a greater understanding of why young people choose to remain in education (or not) beyond sixteen, another area of future research would be to focus on the issue of self-esteem. Of particular value would be an

evaluation of a range of programmes that have been developed to raise young people's self-esteem both within schools and the local communities in which young people live. Valuable outcome measures could be tested through the use of pre and post self-esteem profiles as well as exploring young people's aspirations through in-depth discussion regarding their choices in life and their understanding of self and 'fate' in relation to those choices.

Further in relation to education policy, the relationship between a higher rate of continued education and a lower rate of teenage pregnancy has been established in this thesis. Therefore an area of particular interest for further research would be to explore the 5% of young people in Finland who annually do not progress on to (or drop out quickly from) High school, Vocational school or a tenth grade. Further research would need to explore who these young people are and of particular interest would be to determine if these individuals are more heavily represented within the small proportion of young people in Finland who are young parents.

Final thoughts

As was highlighted within Chapter Three, the purpose of exploring policy development and implementation comparatively is to provide policy developers with a variety of choices and strategies. As Kuronen notes "implicitly or explicitly, the practical and political aim of comparative research, especially in social policy is to find models of policies or provision in one country, to learn from the experience and develop the system in another" (1999:303)

Further illustrated was the fact that 'policy borrowing' can be potentially ineffective for a number of reasons, the most important being a lack of attention paid to the culture from which suggested policy solutions are being drawn. Throughout this thesis, the issue of attitudes towards teenage sexual activity was raised in relation to policy development in sex education and sexual health services for young people. If Scottish officials are to entertain many of the policy solutions presented within the Finnish system, such as a permeated, broader based sex education provision for all schools and a school health service that could provide sexual health advice when required, then policy development must derive from an accepting stance (Silver 1998).

For the implementation of such policies then to be effective at the school level, it will require an acceptance of teenage sexual activity at a wider level throughout Scottish society and its institutions. In particular, to facilitate this process of increasing the acceptance of teenage sexual activity, the attitudes of those who are in the position to develop and implement policy, such as head teachers in schools, are crucial.

As pointed out in Chapter Seven, it does appear that there is a growing acceptance of young people's sexual health rights, teenage sexual activity and the need to listen to what young people say they require in service provision, not only at the level of the Scottish Executive and Scottish Office Education Department, but also within the local authorities and the schools explored. It is, however, important to remember that the sample interviewed for this research was limited and the officials interviewed all had a particular remit for sex education/ health education

and would therefore be expected to be more pragmatic about and accepting of teenage sexual activity. At a wider institutional level, however, the findings of the Deliberative Seminar[1] referred to in Chapter Seven also appear to support a growing acceptance of teenage sexual activity and young people's sexual health rights, as the delegates at this seminar were from a range of backgrounds including Scottish Executive and local authority officials, teachers, researchers, members of health promotion and church ministers.

What needs to be developed further however, is an understanding that whilst acceptance needs to underlie policy development, there also needs to be co-operation between the agencies of health and education and at the different levels of policy development and implementation. The reduction of unintended teenage pregnancy cannot be achieved by focusing on one particular area of policy in isolation or independently of other developments. The recent SEU report (1999) has placed a great deal of emphasis on 'joined-up' policy, thinking and action to pursue the reduction of teenage pregnancy in England, however, the focus is only in relation to the issue of teenage pregnancy. What needs to be considered from a wider perspective is not just the future policy approach but also its focus.

Whilst teenage pregnancy has been the primary focus for the English government with the development of the *Teenage Pregnancy Strategy*, there is a risk that by focusing on pregnancy alone, rather than a more holistic promotion of good sexual health, the strategy may fail to impact on a large proportion of young people, specifically young men, who often perceive 'pregnancy' as a female issue not

[1] For further details on the findings of this seminar, see Appendix ix.

relevant to their lives (Hadley 1998). Further to this from a political point of view, use of the phrases 'teenage pregnancy' and 'sexual health' does not simply highlight two different policy foci; there is also underlying meaning to both (Silver 2001: personal communication). Within the British policy context, 'teenage pregnancy' has continually been used to portray a negative situation. An example of this overtone is noted in the foreword to the SEU report (1999) where the British Prime Minister, Tony Blair, states "Britain has the *worst* record on teenage pregnancies in Europe. It is not a record in which *we can take any pride*... Our *failure* to tackle this problem has cost... As a country, we can't afford to continue to ignore this *shameful record*" (SEU 1999:4). 'Sexual health' (although use is also made in terms of illness) can be more positive terminology. If used in the correct context, 'sexual health' can portray to young people both an acceptance of their sex and sexuality, and their right to be healthy in that sphere of life. As was found to be the case in Finland, both at the national and local level the overall focus of policy was on the positive promotion of healthy sex and sexuality and never a focus on the negative.

The pursuit at the outset of a 'sexual health strategy' rather than a 'teenage pregnancy strategy'[1] by the Scottish Executive is an important first step down a policy road that is more likely to impact upon the lives of young people in Scotland for two key reasons. First, the focus on broader 'sexual health' portrays an inclusiveness of all young people not just young women. Second, it provides a platform from which to promote 'good practice' in sexual health, whereby young people can learn that sex is a normal healthy aspect of life and that in appreciating

the value of their own sexual health, they can develop an understanding appropriate to their lives about respect, responsibility and safer sex.

The findings of this research have opened up as many new questions as it has tried to answer. Due to the exploratory nature of the research, the conclusions that have been drawn are tentative ones, although they do point to a number of important policy differences and illustrate the need for a more pragmatic approach the issue of reducing the rate of unintended pregnancy amongst teenagers in Scotland. Hopefully recent and future developments in sex education, sexual health and education policy in Scotland will translate into a reduction in unintended and unwanted teenage pregnancy. This would then go some way towards achieving the Scottish Executive's desire to see a Scotland where sexuality is accepted in a cultural context which supports sustainable improvements in the sexual health of Scottish young people (Burtney 2000[a]).

[1] The English government have now launched their sexual health strategy, but because of the pre-existence of the teenage pregnancy strategy, the sexual health strategy contains very little emphasis on young people or the issue of unintended pregnancy.

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Appendix i

a. Data for Figure 0.1

Country	Birth rate	Abortion rate
USA	54.4	29.2
Bulgaria	49.6	33.7
Hungary	29.9	29.6
England and Wales	29.8	18.6
Scotland	27.2	18.8
Iceland	21.5	21.2
Norway	13.6	18.7
Sweden	7.8	17.2
Denmark	8.8	14.4
Finland	9.8	10.7
Belgium	9.1	5.0
The Netherlands	5.6	4.0

General notes
Year for birth and abortion data is 1996 unless noted below:
1998 Birth and Abortion data for Scotland.
1995 Birth data for Bulgaria, Norway and Denmark
1995 Abortion data for England and Wales and Belgium
1992 Birth and Abortion data for the Netherlands
Data for Scotland and the Netherlands - birth & abortion data are for women younger than 20 not just 15-19.
Sources: Abortion data from ISD Scotland 2000; Singh & Darroch 2000.
Birth data from UN Demographic Yearbooks 1997,1998,1999; ISD Scotland 2000.

b. Data for Figure 1.1

Country	Pregnancy rate
Bulgaria	83.3
Romania	74.0
Hungary	59.6
England and Wales	48.4
Scotland	45.6
Iceland	42.7
Czech Rep.	32.9
Norway	32.3
Sweden	25.0
Denmark	23.2
Finland	20.5
Belgium	14.1
Italy	12.0
Netherlands	9.6

General notes
The year for both abortion and birth data is 1996 unless noted below:
1998 birth and abortion data - Scotland.
1995 birth rate - Bulgaria, Norway & Denmark.
1995 abortion rate - England and Wales and Belgium.
1993 birth and abortion data - Romania.
1992 birth and abortion data - the Netherlands.
Abortion data for Romania and Italy are only 80% accurate.
Data for Scotland and the Netherlands - birth & abortion data are for women younger than 20 not just 15-19.
Sources: Abortion data from Singh & Darroch (2000); Birth data from UN Demographic Yearbooks (1996, 1997,1998); Scottish data from ISD Scotland (2000).

c. Data from Figures 1.2 – 1.5

Finnish rates	Live birth rate (% of births – total pregnancies)		Abortion rate (% of abortions - total pregnancies)		Pregnancy rate
1980	18.9	(49.3)	19.4	(50.7)	38.3
1981	16.9	(48.6)	17.9	(51.4)	34.8
1982	16.9	(48.6)	17.9	(51.4)	34.8
1983	15.7	(47.9)	17.1	(52.1)	32.8
1984	15.2	(47.4)	16.9	(52.6)	32.1
1985	13.8	(45.5)	16.5	(54.5)	30.3
1986	12.9	(45.6)	17.5	(54.4)	28.3
1987	12.1	(43.7)	17.6	(56.3)	29.7
1988	12.5	(45.1)	16.7	(54.9)	29.2
1989	12.0	(44.7)	16.8	(55.3)	28.8
1990	12.2	(48.1)	15.4	(51.9)	27.6
1991	12.4	(51.5)	13.6	(48.5)	26.0
1992	11.9	(52.2)	12.5	(47.8)	24.4
1993	10.7	(52.5)	10.9	(47.5)	21.6
1994	10.1	(52.9)	10.5	(47.1)	20.6
1995	9.9	(51.6)	10.8	(48.4)	20.7
1996	9.8	(50.5)	11.2	(49.5)	21.0
1997	9.0	(46.9)	11.7	(53.1)	20.7
1998	9.2	(42.2)	12.6	(57.8)	21.8
1999	9.7	(41.8)	13.5	(58.2)	23.2

d. Data for Figure 1.6 – 1.8

Scottish rates

	Live birth rate		Abortion rate		Pregnancy rate	
	13-15	16-19	13-15	16-19	13-15	16-19
1983	3.0	45.2	3.2	18.3	12.1	63.6
1984	3.0	45.6	3.6	20.6	13.6	66.1
1985	3.4	47.5	3.7	21.6	14.3	69.0
1986	3.5	47.4	4.0	21.7	14.6	69.1
1987	3.8	47.7	3.8	21.6	14.7	69.3
1988	4.2	48.9	4.3	23.1	15.9	71.9
1989	4.1	47.1	4.3	24.3	16.6	71.3
1990	4.0	48.1	4.2	26.5	17.9	74.6
1991	4.2	50.4	4.6	27.4	18.4	77.8
1992	4.3	48.5	4.4	26.8	17.7	75.3
1993	4.0	46.7	4.4	26.8	17.3	73.5
1994	3.9	42.8	4.5	26.6	16.9	69.4
1995	4.1	42.4	4.5	25.8	16.3	67.6
1996	4.6	42.6	4.8	27.5	17.5	70.1
1997	4.9	44.0	4.3	26.6	17.1	70.6
1998	4.4	44.3	4.5	29.5	18.8	72.4

e. Data for Figures 1.9 – 1.10

Scottish rates

	Abortion as % of total pregnancies		Births as % of total pregnancies	
	13-15	16-19	13-5	16-19
1983	51.6	28.7	48.4	71.3
1984	54.5	31.1	45.5	68.9
1985	52.6	31.3	47.4	68.7
1986	53.3	31.4	46.7	68.6
1987	50.0	31.2	50.0	68.8
1988	50.6	32.1	49.4	67.9
1989	51.2	34.1	48.8	65.9
1990	51.1	35.6	48.9	64.4
1991	52.3	36.7	47.7	63.3
1992	50.6	34.4	49.4	65.6
1993	52.4	36.5	47.6	63.5
1994	53.6	38.3	46.4	61.7
1995	52.5	37.8	47.5	62.2
1996	51.1	39.2	48.9	60.8
1997	46.7	37.7	53.3	62.3
1998	50.7	40.0	49.3	60.0

f. Data from Figure 2.2

Country	Live birth rate per 15-19 year old women in 1996 (or latest Available year)
Russia	45.6
Romania	40.5
Hungary	29.9
Czech Rep.	20.6
England & Wales	29.6
Scotland	29.8
Ireland	21.5
Italy	6.8
Slovakia	32.3
France	10
Belgium	9.1
Denmark	8.8
Netherlands	5.6
Sweden	7.8
Finland	9.8

General Notes

Data on live Birth rates - UN Demographic Yearbooks 1995, 1996, 1997, 1998.
Year for birth rate is 1996 unless noted below:
1995 - Belgium, Czech Rep., France, Italy and Russia.

g. Data for Figure 2.3

Country	Proportion of adolescents using contraception at 1st intercourse by country				
	Netherlands	Finland	Denmark	France	Scotland
	85	83.5	80	74	48.5
Netherlands	90.5				
Finland		90.5			
Denmark			83		
France				90.5	
Scotland					70.7

Percentage of young people aged 16-18 in education or training

General notes
Definitions of adolescents vary by country as follows:
Netherlands - 'young people' (year not stated)
Denmark - 15-16s (year not stated)
France - 'young people' (year not stated)
Finland - 15s (1992)
Scotland - 15-16s (1992)
Source of data on contraceptive use - McIlwaine 1994, Papp 1997 and SEU 1999.
Source for data on % of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.

h. Data for Figure 2.4

Abortion ratio for women aged 15-19 by country

	Spain	Scotland	E & W	Iceland	France	Finland	Norway	Denmark	Sweden
	36.7	37.2	40.2	51.1	51.2	52.9	59.2	62.6	69.9
Spain	79								
Scotland		70.5							
England & Wales			70.5						
Iceland				78.0					
France					90.5				
Finland						89.5			
Norway							90.0		
Denmark								83.0	
Sweden									96.0

Percentage of young people aged 16-18 in education or training

General notes
Source for data on abortion ratios - Singh & Darroch 2000.
Year for abortion ratios is 1995 unless noted below:
1996 - Finland, Iceland, Norway and Sweden.
Abortion data for France and Spain are only 80% complete.
Source for data on % of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.
Data on Scotland - % education rates are for the UK as a whole, abortion ratio data is for women under 20, not just 16-19.
Data for England and Wales - % education rates are for the UK as a whole.

i. Data on Figure 2.5

Country **Mean age of first birth by country**

	Iceland	Portugal	Greece	UK	Austria	Ireland	Belgium	Norway	Sweden	Spain	Denmark	Finland	France	Netherlands
	25	25.8	26.6	26.7	26.7	27	27	27	27.5	27.7	27.7	27.7	28.1	29
Iceland	78													
Portugal		68												
Greece			69											
UK				70.5										
Austria					82									
Ireland						84								
Belgium							95							
Norway								90						
Sweden									96					
Spain										74				
Denmark											83			
Finland												89.5		
France													90.5	
Netherlands														90.5

Percentage of young people aged 16-18 in education or training

General notes
Age of first birth data - Beets 1999a
Year for which first birth information is available is 1996 unless noted below:
1997 - Finland, Greece, Iceland, Netherlands, Norway, Switzerland.
1995 - France, Spain.
% of young people in education data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.

j. Data for Figure 4.1

Pregnancy rate per 1000 women aged 15-19 by country

	E & W	Scotland	Iceland	Norway	Sweden	Denmark	Finland	Belgium	Neth.
	48.4	45.6	42.7	32.3	25	23.2	20.5	14.1	9.6
England and Wales	70.5								
Scotland		70.5							
Iceland			78						
Norway				90					
Sweden					96				
Denmark						83			
Finland							89.5		
Belgium								95	
Netherlands									90.5

Percentage of young people aged 16-18 in education or training

General notes
Abortion data from Singh & Darroch 2000.
Abortion data for Scotland from ISD Scotland 2000.
Birth data from UN Demographic Yearbooks 1997,1998.
Birth data for Scotland from ISD Scotland 2000.
Year is 1996 for birth and abortion data unless noted below:
1998 birth and abortion data - Scotland.
1995 birth rate - Denmark and Norway.
1995 abortion rate - England and Wales and Belgium.
1992 birth and abortion data - Netherlands.
Data for Scotland and the Netherlands - birth & abortion data are for women younger than 20.
% of young people in education or training data - EUROSTAT 1998-99
Year for % of young people in education data is for 1996.
Data on Scotland and England and Wales - % education and training rates are for the UK as a whole.

Appendix ii

Details of case-study areas

The three areas detailed for each country were matched roughly by geographical size, population density and the location of the schools within each area were also matched for similarity of location (i.e. in main city or town of each local authority /municipality) wherever possible. The areas that are 'twinned' are highlighted in brackets.

Finland

Tehtaala Municipality *(Scotallen local authority)*

The municipality of *Tehtaala* is located in Southern Finland and its parameters span around the *City of Tehtaala.* On the whole *Tehtaala* can be described as an urban municipality with a high density population. The two schools explored in this municipality were *Koskela Peruskoulu,* located on the outskirts of the *City of Tehtaala*, and *Tehtaala Peruskoulu,* located in the centre of the *City of Tehtaala.*

Vaarama Municipality *(Arbourness local authority)*

The municipality of *Vaarama* is located in Eastern Finland and has the *Town of Vaarama* at its centre. The municipality as a whole can be described as urban/rural. I.e. pockets of urban towns set in a rural area. The majority of the population in this municipality is concentrated within the towns, with a low population density throughout the remainder of the municipality. The school

explored within this municipality was *Vaarama Peruskoulu* which is located in the centre of the *Town of Vaarama.*

***Alajoki Municipality** (Glendale local authority)*

The municipality of *Alajoki* is located in Central Finland and has the *Town of Alajoki* at its centre. Similar to the municipality of *Vaarama,* this municipality as a whole can be described as urban/rural. The *Town of Alajoki* was itself an urban town set in a very large rural area. The majority of the population in this municipality was concentrated within the *Town of Alajoki,* with a low population density throughout the remainder of the municipality. The school explored within this municipality was *Alajoki Peruskoulu* which is located in the centre of the *Town of Alajoki.*

<u>Scotland</u>

Glendale local authority (*Alajoki Municipality*)

Glendale local authority spans a large geographical area in Scotland and incorporates a large urban city, a number of towns and a vast number of small villages. The population of Glendale local authority is concentrated within the city and towns, and the remaining population is widespread across the authority. Therefore the authority comprises of areas of both dense and sparse population. The two schools that were explored within this local authority were Lochend Secondary School (pilot school), which is located in a small-industrialised village within the local authority of Glendale; and Glendale Academy which is situated in the centre of a large city surrounded by a rural area in the local authority of Glendale.

Scotallen local authority *(Tehtaala Municipality)*

Scotallen is a city-orientated local authority, similar to *Tehtaala* in Finland; the local authority is based around one main City – Scotallen. On the whole Scotallen can be described as an urban local authority with a high-density population. The school explored within this local authority was Scotallen Secondary School which is located towards the south of the City of Scotallen, near to the geographical boundary of Scotallen local authority.

Arbourness local authority *(Vaarama Municipality)*

The local authority of Arbourness, similar to *Vaarama,* spans a large geographical area. The local authority as a whole can be described as urban/rural. I.e. pockets of urban towns (one city) and villages set in a rural area. The majority of the population in this municipality is concentrated within the city and towns, with a low population density throughout the remainder of the local authority. The school explored within this local authority was Arbourness High School which is located within the small town of Arbourness.

Appendix iii

Interview schedules

Government Level

Example areas and topics presented below were for Finland, similar questions were asked of the SOED official, with questions tailored to Scotland.

Sex education

Defined law/ policy on sex education
Defined curriculum location and time allocations of sex education
Government role and municipal role in helping schools design sex education
Importance of sex education – government perception.
Defined content of sex education
Government guidelines for schools
Teacher training specified at government level for teaching sex education
Inter-agency collaboration
Main objectives of sex education – government perception

Sexual health

History of school health service
Information on role of school nurse
Likely/ known effect of recent cut-backs in school health service
Value of school nurse
Government encouragement of youth clinics
Confidentiality laws
Guidelines for pregnant teenagers – re: continued education.

Education

Information on careers guidance
Explanations for high stay-on rates at school level
History of comprehensive school structure

Overall

Potential explanations as to why Finland has been so successful in decreasing its teenage pregnancy rates.

Municipality/ local authority level

As with government areas of interest detailed above, example areas and topics presented below were for Finland, similar questions were asked of the local authority officials, with questions tailored to Scotland.

Sex education

Defined law/ policy on sex education
Defined curriculum location and time allocations of sex education
Government role and municipal role in helping schools design sex education
Importance of sex education – municipal perception.
Defined content of sex education
Municipal/ government guidelines on sex education for schools
Municipal/ government guidelines on evaluating sex education for schools
Teacher training specified at municipal/ government level for teaching sex education
Inter-agency collaboration
Main objectives of sex education – municipal perception

Sexual health

Information on role of school nurse
Likely/ known effect of recent cut-backs in school health service
Value of school nurse
Availability of municipal youth clinics
Confidentiality laws
Guidelines for pregnant teenagers in municipality – re: continued education.

Education

Information on careers guidance
Explanations for high stay-on rates at school level
History of comprehensive school structure
Curriculum changes in 1994

Overall

Potential explanations as to why Finland has been so successful in decreasing its teenage pregnancy rates.

School level

As with the other policy levels of interest detailed above, example areas and topics presented below were for Finland, similar questions were asked of the teachers in Scotland, with questions tailored to Scotland. No school nurses were interviewed in Scotland however, as no school studied had the use of a school-based nurse.

Head teacher
Question areas covering the topics of:
Background information on school
Sex education
School health service
Careers guidance
(questions topics – similar to those asked of individual teachers and school nurse)

Teachers (adjusted by subject)
School policy on provision of sex education
Government/ municipal guidelines
Curriculum and grade level allocation and time allocations
Class sizes
Teaching methods
Importance of school role as sex educator
Differences between sex education for girls and boys
Content of sex education
Teacher training
Involvement of sexual health experts to teach class-based sex education
Feelings on teaching sex education
Changes to curriculum – potential/ known effects on sex education provision
Future of sex education at school – what if anything should change.
Confidentiality between staff and pupils.

School Nurse

Sex education
School policy on provision of sex education
Curriculum and grade level allocation and time allocations
Class sizes
Teaching methods
Importance of school role as sex educator
Differences between sex education for girls and boys
Content of sex education
Teacher training for school nurses
Involvement of school nurse in class-teaching
Confidentiality between staff and pupils and school nurse
Feelings on teaching sex education

School health service
Time availability of school nurse
Connections to local health centres
Methods of obtaining contraception
Contraceptive costs and availability
Emergency contraception
Youth clinics (visits by pupils)
Young men and contraception
History of school nursing
Cutbacks – potential/ known effects

Appendix iv

Letter of application for access to Scottish schools

University logo and contact details

Dear ....(head teacher)

My name is Alison Hosie and I am currently in my 2nd year PhD at Stirling University studying "The effect of social policies on teenage pregnancy in Scotland and Finland". I am undertaking research in your local authority and your Director of Education has granted me permission to contact you, to enquire if you would be willing to take part in my research.

The reasons behind my choice of topic are that at the present moment in time, Scotland has one of the highest teenage pregnancy rates in Western Europe. A large amount of research has already been conducted into different types of sex education programmes and the attitudes and knowledge of Scotland's young people. What has been neglected to a great extent though, is the effect that different social policies may have on the teenage pregnancy rate in this country.

It is therefore my intention to examine various policies including sex education, sexual health and general education policies, at the levels of government, local authority and schools in Scotland and compare them with Finland (a country which has had considerable success in curbing the negative effects of teenage sexual behaviour).

In order to do so I intend to take a case-study approach and examine 3 schools in 3 local authorities in each country, matching them by geography and demographics. If you were to allow me to include your school in this research, it would be my intention to obtain a copy of your school's policies (if possible) regarding sex education, the health of school children and careers guidance. I would also like to interview yourself, teacher/s of careers guidance and as many teachers as possible involved with the development and/or teaching of sex education in your school. It is not my intention in any way to interview or questionnaire pupils at your school.

If you were agreeable to my visiting your school, it would be my intention to undertake the interviews during the month of June, after the completion of the SCE examinations. If you would like to take part in this research, or you require further information before making a decision, please contact me at the above address.

I look forward to hearing from you.

Yours sincerely

Alison Hosie

Appendix v

Core content of sex education in Finnish Schools

School age	School mates and early friendships.

Puberty	Physical, psychological and social changes of beginning adulthood:
	* Changes of outer appearance
	* Menstruation
	* Wet dreams
	* Masturbation
	* Growing interest in the opposite (or same) sex
	    * Dating, experimentation (age, legislation)
	    * Sexual relations, responsibilities
	    * Pulp literature and porn
	    * Friendships
	    * Affection
	    * Trust
	    * Constraints of expectations
	    * Fears
	* Declaration of independence, breaking away from parents
	* Being part of a gang
	* Opposition of established morals and values
	* Mass delusion

Intercourse	* The act itself, the first time * Mutual consent, forcing oneself, rape * Virginity, possible pregnancy
Contraception	* Contraceptive measures, family planning, childlessness * Prevention of STDs
Pregnancy and childbirth	* Fertilisation and inception of pregnancy * Development of the foetus * The various stages of labour
Abortion	* Legislation * Ethics involved * Clinical aspects of abortion
STDs including AIDS	* Ways of becoming infected * Cures, or in the case AIDS no cures * Legislation
Sexual Orientation	* Heterosexuality, homosexuality * Other sexual preferences

(NBE 1998)

Appendix vi

Finnish Abortion Law

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

1) Pregnancy or childbirth would risk her life or health
2) Childbirth and child care would be a considerable strain on her and her family economically and socially
3) She is made pregnant against her will
4) She was not yet 17 years of age or was over 40 at the moment of conception or already had four children
5) There is a reason to expect the child to be mentally defective or to have difficult illness or physical defect
6) Illness, disturbed psychological functioning, or a comparable factor of one or both parents limits their capacity to take care of the child.

Source: Abortion Law 24.3.1970/239 Finland

Source of translation: Kosunen 2000:77.

Appendix vii

Scottish Abortion Law

Abortion is only legal if it is carried out by a doctor in approved premises and two doctors certify:

a) that the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated,

b) the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman,

c) the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman,

d) the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman,

e) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(HMSO 2/96 (118088))

Appendix viii

The Fraser Guidelines (1985)

The Fraser guidelines (1985) (derived partly from the Gillick case), provides medical doctors with a list that they must consider thoroughly before providing any contraceptive advice or contraception without parental consent to a young woman under the age of 16. The guidelines are as follows:

1. The young person will understand the doctor's advice,
2. The doctor cannot persuade the young person to inform his or her parents or allow the doctor to inform his or her parents that he or she is seeking contraceptive advice,
3. The young person is very likely to begin or to continue having intercourse with or without contraceptive treatment,
4. Unless he or she receives contraceptive treatment, the young person's physical or mental health are likely to suffer,
5. The young person's best interests require the doctor to give contraceptive advice, treatment or both without parental consent.

Source: Thomson 1996:108.

Appendix ix

The emerging agenda

- Acknowledgement and addressing of differences
- Gay sexuality
- Learning disabilities
- Ethnic minorities and other "absent" groups
- Stretching back into childhood
- Sexual orientations
- Voluntary and community involvement
- Social inclusion partnerships and social justice
- Life affirming approaches
- Role of socialisation of young people – gender and power imbalances
- Dissonance... lack of openness, inhibition
- Using original aims – inviting consensus building
- Parents and parental involvement
- Where/how will leadership develop
- Hearing and valuing the voices of up
- Supporting and developing the role of teachers
- Addressing inequality and variability
- Creating safe, accessible for a for dialogues about relationships and health
- How best to consult young people
- Public health model vocational school holistic/ integral
- Emotional and social
- Positive indicators
- An "NHS" or a "quality" model?
- Presumed models and community values
- From problematised → contextual approach
- Testing the "taken for granted" assumptions
- Generic → local response
- How and when do we involve young people?
- Diversity and validity
- New technology
- Role of parents
- Co-ordinated, flexible, accessible basis for services strategy
- Leadership...?

Deliberative Seminar – Teenage Sexuality in Scotland 6/7 March 2000 "*initial reflections*".