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).

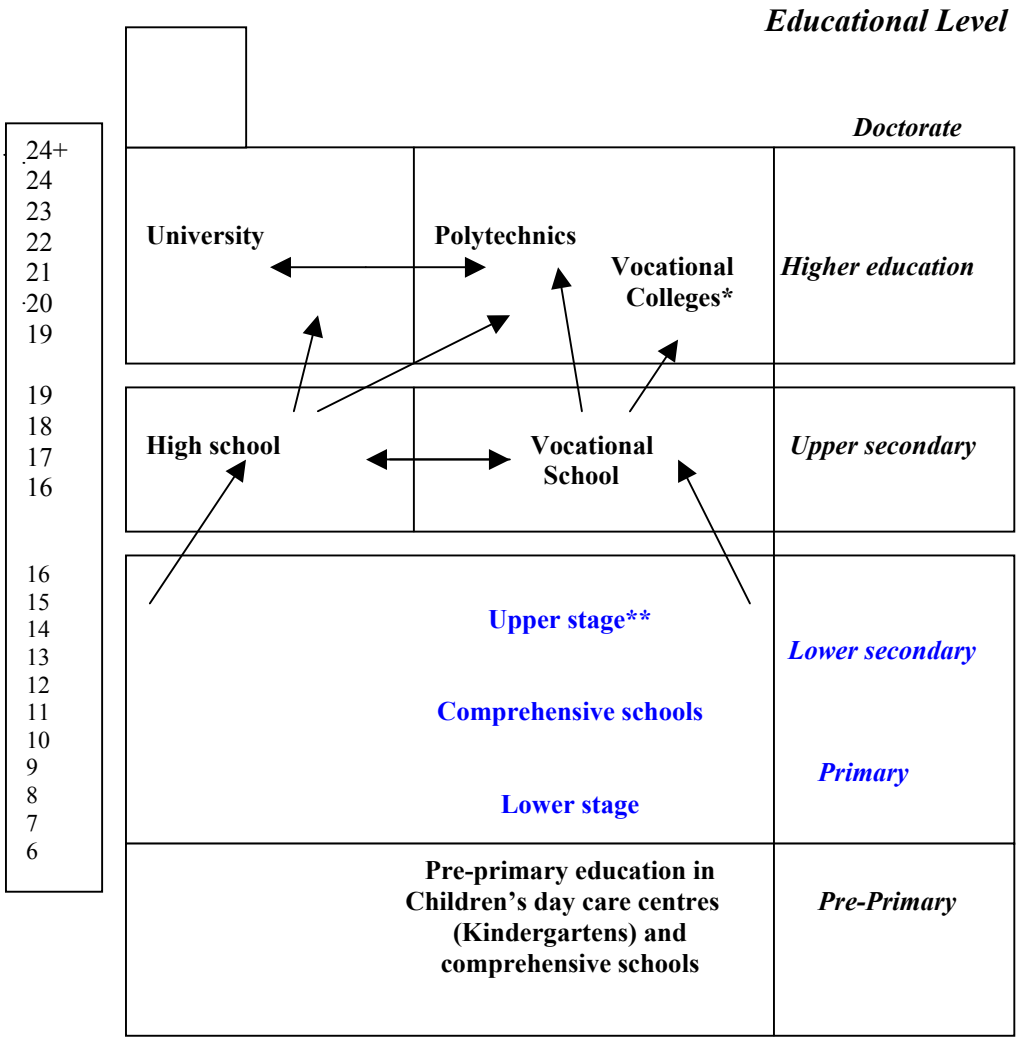
In Finland when a pupil has reached the age of 16, s/he is no longer legally obliged to continue in education. The understanding of pupils and teachers is that comprehensive education, rather than being the end of one's school education, is considered to be the beginning (Bertell 1994). The comprehensive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

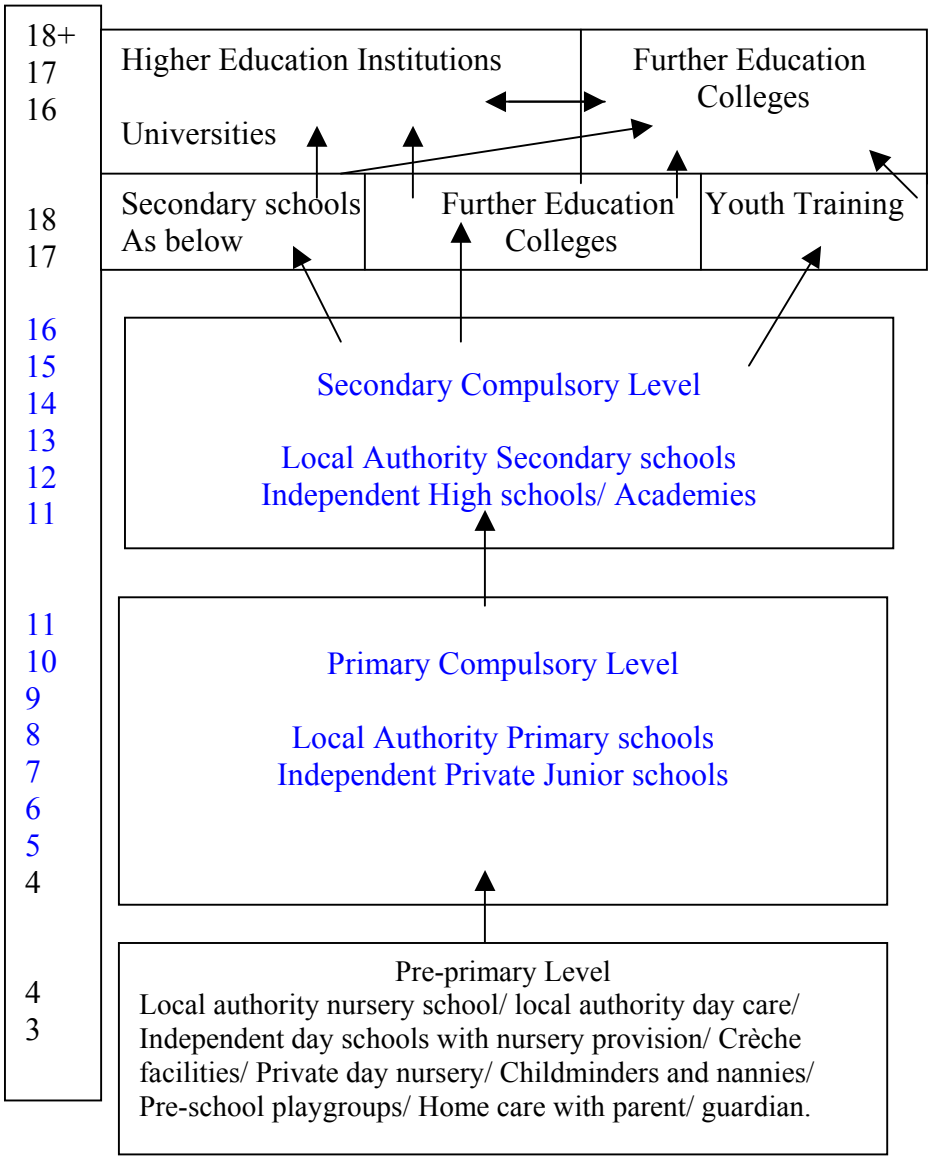
Structure of the educational system in Scotland

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.