European Population Conference 2001
Helsinki, Finland 7-9 June 2001

Theme A: Fertility, contraception and reproductive health

Overcoming the first hurdle: young people and access to sexual health services in Scotland, England, Finland and the Netherlands*.

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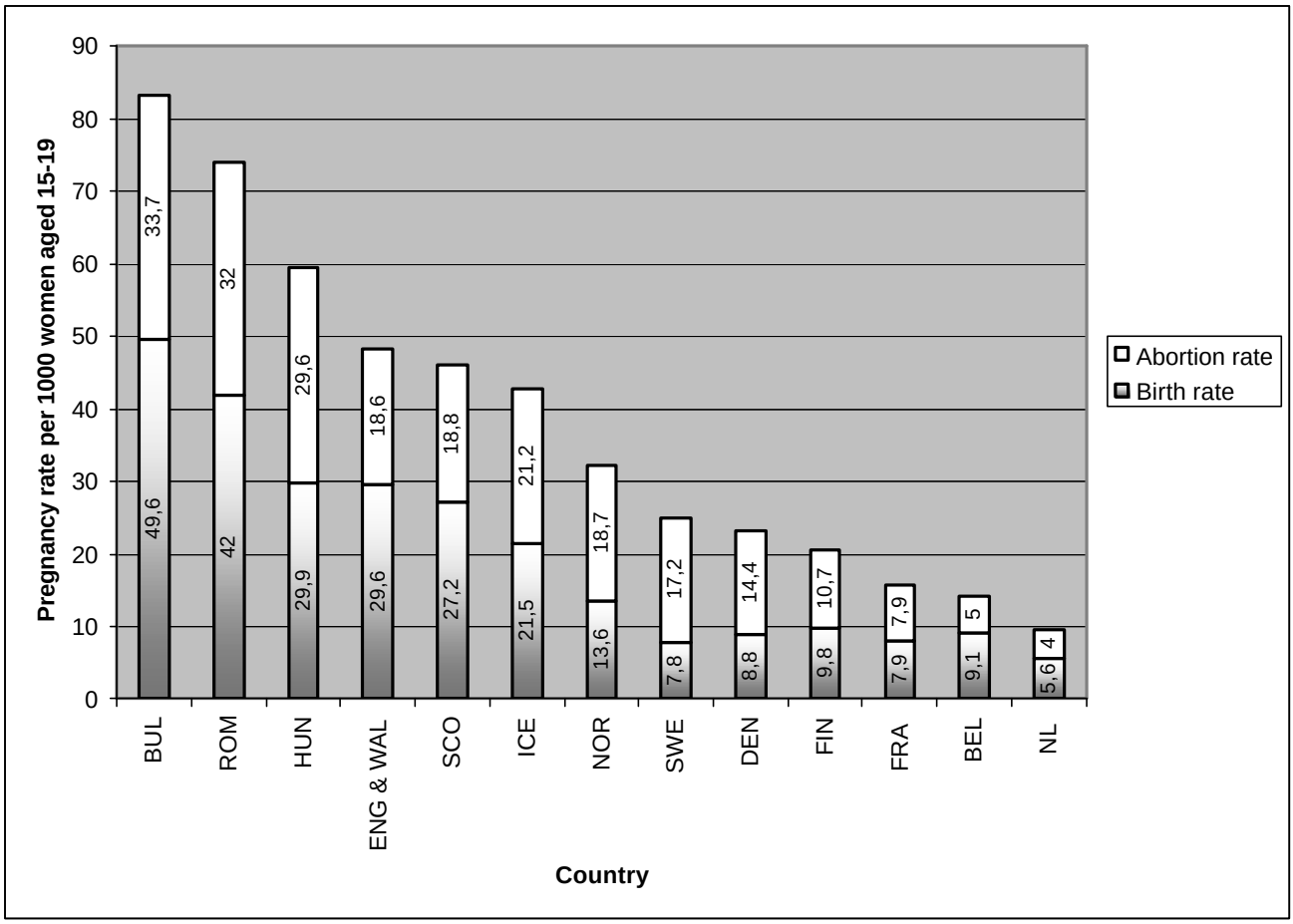
Background and purpose of the research

Overhead – *Teenage pregnancy rates in Europe*



* This paper is a piece of work in progress and is being prepared for publication elsewhere and therefore the authors would appreciate being contacted if reference is being made to this piece of work.

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Scotland and England currently have two of the highest teenage pregnancy rates in Europe with the exception of some Central East European countries and this has and continues to raise concern within the Scottish and English governments.
When concern is raised, government officials and interested parties often ask why our teenage pregnancy rates are so high, and the simple answer is because young people have sex. And they either do so without contraception, they do not use contraception effectively, or the contraception itself has failed. Regardless of all other factors as to why young people have sex, effective contraceptive use is fundamental if unintended pregnancy and STIs are to be prevented. In turn, the ease of access that young people have to sexual health services, as they become sexually active, will play an important role in determining contraceptive use.

In order that young people can be responsible for their sexual health, one pre-requisite to enable them to respond, is access to sexual health services. In many European countries, young people can access sexual health services through a variety of providers, however, young people's needs are often not met by provisions that have been set up for use by whole populations. Young people have many additional needs when it comes to accessing sexual health services, needs, which may or may not be met by the range of services available to them. Research exploring the issue of sexual health service provisions internationally has documented that the ease of access to services is crucial to their use by young people.

This paper explores the issue of access in four different countries, Scotland, England, Finland and the Netherlands, and aims to identify potential lessons that can be learned from the experience of Finland and the Netherlands, whose young people repeatedly report high use of contraception at first and subsequent intercourse and have lower rates of teenage pregnancy, than do their counterparts in Scotland and England.

Data and methods which were used
The presentation builds on work conducted for 2 recently completed and 3 current pieces of research on teenage pregnancy, which are highlighted on Overhead 2.

Overhead 2 – *Titles of research*

Recent
Hosie A, 2001, ***A Comparative Exploration of Social Policy Relating to Teenage Pregnancy in Finland and Scotland***, Stirling: Stirling University, unpublished Doctoral Thesis.

Hosie A, 2001 (forthcoming), ***Young People's Sexual Health Promotion and Social Policy in Selected European Countries,*** Evidence into Action series, Edinburgh: HEBS.

Current
Silver C, 2002 (work in progress), ***Towards an historico-cultural understanding of teenage pregnancy in the Netherlands and England,*** Surrey: University of Surrey, Doctoral thesis.

Silver C, 2001 (forthcoming), ***Contraception, Advice and Information Services & Support for Teenage Parents - Pilot Consultation with Young People***: West Sussex Health Authority.

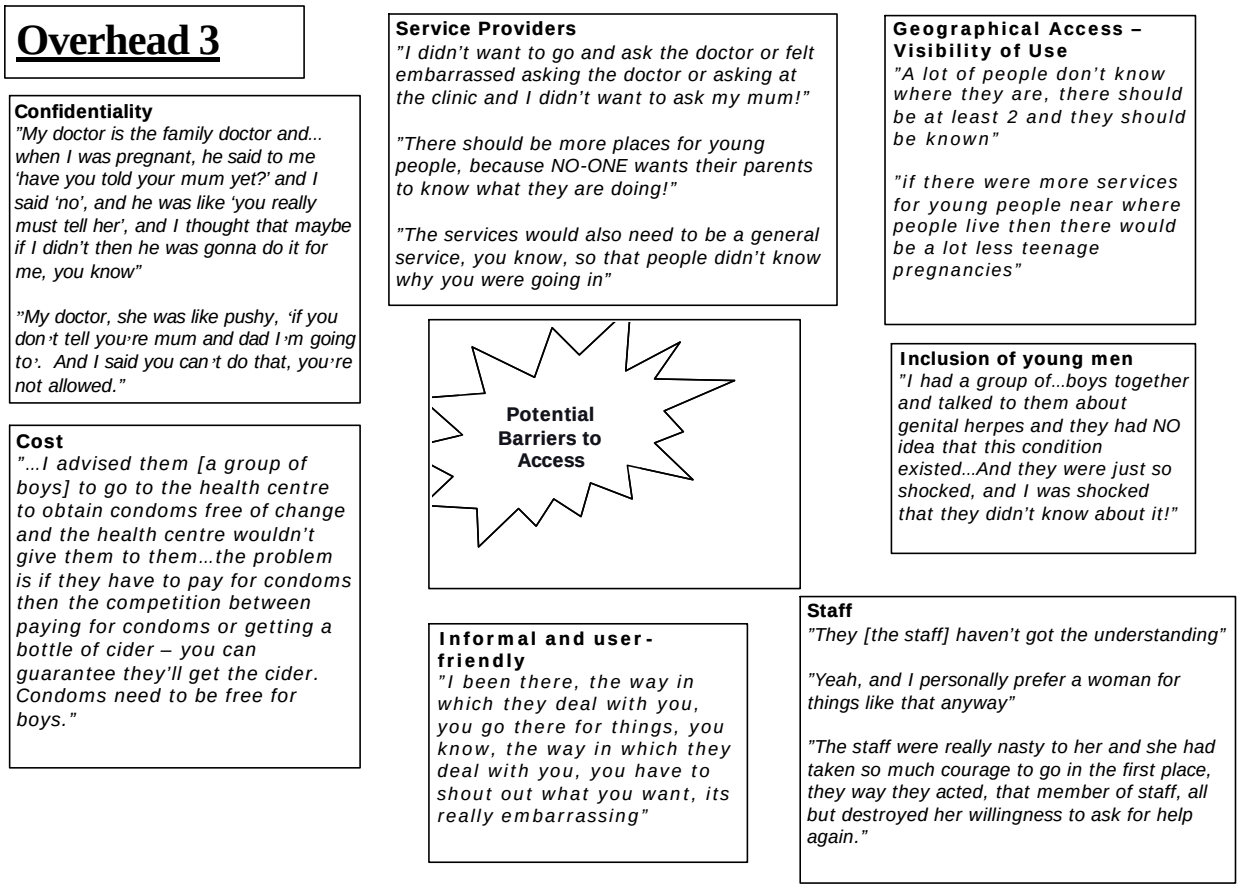
Selman P, Speak S and Hosie A, (work in progress), ***Evaluation of the DfEE Standards Fund Grant: Teenage pregnancy***, London: The Stationary Office.

Data from the four countries is combined to present a picture of sexual health service provisions in the four countries. The extent to which those provisions meet the needs of young people will be discussed. However, because access to sexual health services was not the focus of any one of these studies but rather an aspect, which has or is arsing within all five, there are limitations to the data we present today. For some of the proposed potential barriers to access, there is a lack of comparable data, for all four countries. However, the aim of this paper is not to answer any definitive questions, rather the issue of young people's access was something that through discussions, appeared to rise time and again as something that needed to be explored further. Therefore the aim of this presentation is more to explore the issue of young people's access to sexual health services and raise issues for further research.

Data presentation

In order to explore this issue, we will first look at the potential barriers that young people face, real or imagined, as defined by previous research in accessing sexual health services. This will be followed by an exploration of the types of services available to young people in each respective country, and a discussion as to how the level of access in each country may relate to the respective teenage pregnancy rates in each country.

Overhead 3 – *Potential barriers to access – real or imagined*



On this overhead a number of key potential barriers to accessing sexual health services raised by our current research with young people in England have been highlighted. The level to which these are real barriers as opposed to perceived barriers will depend very much on the social and cultural context, which we go on to look at in a few minutes.

Confidentiality

- The issue of confidentiality is unanimously presented as one of *the* most important keys to access for young people: if young people are to ask for help then Confidentiality is essential.

Service providers

- Generally, young people do not want parents to know they are sexually active (McIlwaine 1994), therefore they may chose not to access services where they may be known or which are visible to their parents.
- Research has shown that services, which are not 'sexual health' but 'youth orientated', may help to hide the nature of the visit and encourage their use by young people.
- Well-resourced School-based services may help to hide young people's use of a service as well as be easy to physically access for young men and women. (Zabin et al. 1986; Fullerton et al. 1997; Hosie 2001).

Geographical access – visibility of use

- Young people who are sexually active are more likely to attend a service if it is geographically convenient (Cheesbrough et al. 1999).
- Teenage pregnancy rates in England have been found to be lower in areas where young people live within 3kms of a 'youth' clinic (Clements et al. 1997).

Inclusion of young men

- Historically sexual health services have been developed with the needs of women in mind, for example in the UK, doctors are reimbursed for family planning consultations with women but not men (Nelson 1997).
- Young men often perceive services as predominantly run as services for and by women (SEU 1999).

Staff

- If young people are to use sexual health services then they need to be treated with respect, and this has been identified by young people as service providers who:
- Are friendly, talk to young people not at them, listen objectively, do not judge and are genuinely interested in what young people are saying (Liinamo et al. 1997; HEA 1998; Aggleton et al. 1999).
- One bad experience is enough to put a young person off trying to access any services, and by word of mouth, one bad experience will often mean that young people will learn not to use certain services.

Informal and user friendly

- Access to a service starts with the reception staff, therefore an informal and friendly atmosphere, rather than an intimidating one is recommended by research in this area (Zabin et al. 1986; Peckham 1993; Fullerton 1997; SEU 1999).

Cost

- Cost can be a potential barrier to accessing contraception.
- With little disposable income of their own, when young people have to make the choice between buying condoms/ oral contraceptives, or other things, contraception may be lower priority.

Opening times

- Young people have limited windows of opportunity to seek advice: Services are often only available

when young people are meant to be in school (Turner 2000) and often require a bus ride (Clements 1997 et al.)
- Sexual activity especially amongst younger teenagers is often sporadic and unplanned, and therefore often requiring immediate advice.
- Longer opening times are critical.

In each of the four countries young people can access sexual health services from a primary health care resource.
- The Netherlands – Family Doctor
- Finland – Primary health care centre
- Scotland & England – General practitioner (GP)

In all four countries there is also an organisation or network of provision for youth specific clinics,
- The Netherlands – Rutgers Stichting Institute
- Finland – Non-Governmental Organisation
- Scotland & England – Brook Advisory Service

In Finland, all young people also have access to a universally provided school health service, with on-site school nurse provision.

And in Scotland and England although there is a universal school health service, very few schools have an on-site facility, the services are generally used for large vaccination programmes.

In Scotland and England, young people also have access to
- Family Planning Clinics,
- Specific sessions organized by FPCs and/or GPs
- Voluntary and Private Organisations with youth specific sessions.

Overhead 4 – *Sexual Health Service provisions by country*

Sexual Health Service Provisions by Country				
	PRIMARY HEALTH CARE	**YOUTH-SPECIFIC CLINICS**	**SCHOOL HEALTH SERVICE**	**OTHER**
Scotland	• General Practitioner	• Brook Advisory Centre	• Universal school health service • Limited on-site provision	• Family Planning Clinics • Specific sessions provided by FPCs and/or GPs • Voluntary & Private organisations with youth specific sessions
England	• General Practitioner	• Brook Advisory Centre	• Universal school health service • Limited on-site provision	• Family Planning Clinics • Specific sessions provided by FPCs and/or GPs • Voluntary & Private organisations with youth specific sessions
The Netherlands	• Family Doctor	• Rutgers Stichting		
Finland	• Primary Health Care Centre	• Non-governmental Organisations	• Universal school health service • Universal on-site provision	

Potential problems	Opening times Visibility of Use Inclusion of young men Staff Formal – user-friendlyness Perceived/ real lack of confidentiality (England & Scotland)	Non-universal provision, access dependent on geographical location Visibility of Use	Where on-site facility isavailable, potentially all barriers are overcome. Key barrier would be non-attendance at school.	• FPCs: ▪ Limited by geographical location, ▪ Visibility of use, ▪ Opening times, ▪ Misconceptions of target group – ▪ young people are not 'planning ▪ families', ▪ Formal, non-user friendly for ▪ young people, ▪ Staff ▪ Perceived/ real lack of confidentiality • Youth sessions held in FPCs or GPs: ▪ All barriers associated with type of service. • Voluntary: ▪ Limited by geographical location ▪ Opening times, ▪ Unless 'youth' not 'youth sexual health' – ▪ visibility of use. • Private: ▪ Opening times, visibility of use, staff, cost, ▪ Perceived/ real lack of confidentiality.

Potential problems with services

There are some standard barriers across all four countries, such as the geographical locations of the youth specific clinics in each country generally being confined to larger cities and the opening times of general primary care provisions. However, the extent to which the remaining barriers noted underneath each style of provision will be real for young people in each country, will also relate to the degree to which teenage sexual activity is acknowledged and accepted in any given country. For example, since the 1960s the Dutch have been very pragmatic in their acceptance of teenage sexual activity and the level of communication that has developed between parents and their children over sexual issues, has meant that the visibility of being seen accessing a sexual health service is not as much of an issue as it is Scotland or England.

In Finland, the availability of a universal system of on-site school nurses has meant that young people have access to a service, which is hidden from public view, is open when it suits young people, is staffed by nurses trained to work with young people, is informal and is confidential. The only real barrier would be for young people who for whatever reason, did not attend school.

The provisions in Scotland and England are interesting. It does in fact appear that in both countries, there are considerably more types of services available to young people than in either Finland or the Netherlands, however, young people in both Scotland and England appear to face more real barriers to those provisions than is the case in Finland and the Netherlands.

A major issue of concern for young people in Scotland and England is confidentially, and this goes beyond concern over whether parents will be informed by doctors, which should not be the case, but does reportedly still happen. Young people have also voiced concern about being seen by their parents or people that know their parents and therefore their parents finding out. This is particularly noted in more rural areas where everybody does tend to know everybody, and often leaves young people with no choice of service.

Additionally, although young people in Scotland and England can access services in FPCs, and youth services run by FPCs or their GPs, the barriers remain the same because of the service being located within a primary care facility. Finally, although there is a statutory obligation for all schools to provide a school health service in England and Scotland, this service is generally for large vaccination programmes or standard health checks at certain ages. Very few schools in either country have a dedicated on-site provision such as is found in Finland.

Concluding words

Finally, whilst there are many other important factors that will affect contraceptive use amongst young people, such as having adequate knowledge about sex and sexuality and the motivation and confidence to apply that knowledge, access services and use contraception, if young people are expected to take responsibility for their sexual health then the issues of access need to be addressed. Whilst we are not arguing that provisions in Finland or the Netherlands are perfect by any means, indeed there have, for example, been cutbacks in school health service provisions in Finland in recent years and in turn the pregnancy rates to 15-19 year old women have risen consecutively for the last 5 years since those cutbacks began. However, there is a lot that the Scottish and English governments could learn from further exploration of systems such as the school nurse provision in Finland, as well as recognising that the social attitudes towards teenage sexual activity which have been renowned in Britain for being very negative, also

need to be addressed, if young people are to feel comfortable in accessing the help they so obviously require.

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