Teenage Sexual and Reproductive Behavior in Developed Countries

Country Report For Sweden

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Background

Sweden in Brief

Sweden has a population of 8,9 million people, 83% living in urban and 17% in rural areas. Nearly half of the population is concentrated in and around the three largest cities: Stockholm, Gothenburg and Malmö. The metropolitan areas around these cities and some southern coast areas have a population density of more than 60 per square mile, while other parts of southern Sweden have between 25 and 60 people per square mile. Only 10% of the inhabitants are living in the northern half of Sweden, mainly concentrated to the coastal region whereas wide areas in the inland are extremely sparsely populated

Life expectancy at birth is 82 years for women, 77 for men. The annual number of births in the 1990s has varied between 90,000 and 120,000, reflected in a decline in total fertility rate from 2.1 in 1991 to 1.5 children per women in 1999. In the 1990s the annual number of deaths varied between 92,000 and 95,000.

Swedish Gross Domestic Product is $24,730 per capita. Public responsibility for social and health services for the entire population on equal conditions has been a long-standing priority. The county councils are responsible for financing and operating health and medical care, levying taxes for the required resources. Health insurance coverage is universal and people across all income levels use public health services. Social welfare includes general child allowances until the child's 16th birthday, and 15 months paid parental leave for either of the parents. Reducing economic disparity is a generally agreed upon goal and only 4% of Swedish children live in families below the median income.

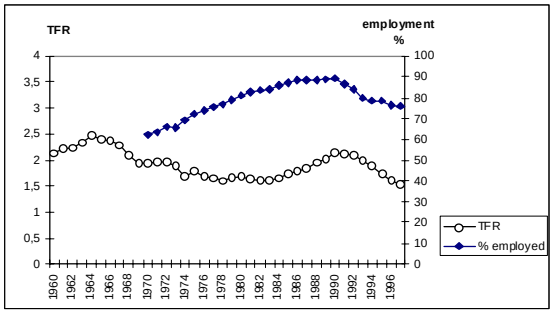
Nine years of schooling are compulsory for all children from the age of 6 or 7. About 98% go on to the upper secondary school, which offers both vocational and academic programs. Schools are run by municipalities and provide free instructions, books and lunches. Private schools and collages are few, but increasing in number and generally receive governmental grants. There are about forty institutions of higher education in Sweden, operated mainly by the State and providing free tuition. About half of the students are women. More than one fourth of adult Swedes have a higher education.

Part I. Levels and Trends in Adolescent Sexual and Reproductive Behavior

Birthrates in Sweden

During the 1970s, there was a decline in births in Sweden as in most northern European countries. Large numbers of Swedish women were entering the labor market.[1]

Figure 1. Changes in total fertility rate and percentage of women gainfully employed 1960-1997 in Sweden, women 15-44 years, Table A1 in Appendix A



Women's age for the first pregnancy was postponed. In 1974, the mean age of a mother with her first child was 24.4, in 1983 it was 25.3 and in 1995, 27.3. The birthrate among teenagers also declined. In the mid 1970s, about 8% of all births were among women under 20. In the mid 1980s, 3% and in 1996, 2% of the newborns had a teenage mother.

Starting in 1985 the birthrate increased in Sweden, although higher percentages of women were gainfully employed than ever before (Figure 1). Second only to Iceland, Sweden had the highest total fertility rate, namely 2.1 in Europe in 1991; higher even than Ireland. This increase in childbearing was seen throughout Scandinavia, although it was most pronounced in Sweden. In contrast, the birthrate continued to decrease in the other countries of northwestern Europe. In southern Europe (western part), the birthrate began declining later in the 1980s, and continues to decline.[2]

The increase in births in Scandinavia in the 1980s was probably due to the fact that women have been able to combine gainful employment with family responsibilities. In the 1970s, a series of public policy reforms were enacted to enable parents to combine family and work life. Parental-leave was prolonged and could, for the first time, be shared by both parents. At the same time, the system of childcare was expanded, making it easier for mothers of young children to work outside the home.

For a long time, Sweden was also spared high general rates of unemployment. At the beginning of the 1990s, however, Sweden underwent an economic crisis, and unemployment rose to levels unseen in Sweden since the 1930s. In 1991, the total fertility rate had reached its highest level of 2.1, only to begin declining continuously to 1.6 in 1997. The greatest drop is found among women 20–29-years-old, while the birthrate among older women was less influenced (Figure 2, page 8). Swedish women avoid getting pregnant when they cannot find work on the labor market. Concern about the future and worsened finances have resulted in postponing pregnancy. The shorter education women had, the greater the decrease in fertility. This is discussed further below under 'Socioeconomic status and reproductive behavior.'

Teenage Fertility

In the decades up to 1970, the pregnancy rate among teenagers was stable: 40 to 50 births and less than 10 abortions per 1000 women aged 15–19. Illegal abortions were not recorded, but estimated to have been rather frequent, especially among young women.

Figure 2. Changes in birthrate (per 1000) in different age groups between 1979-1999, Sweden, Table A2 in Appendix A

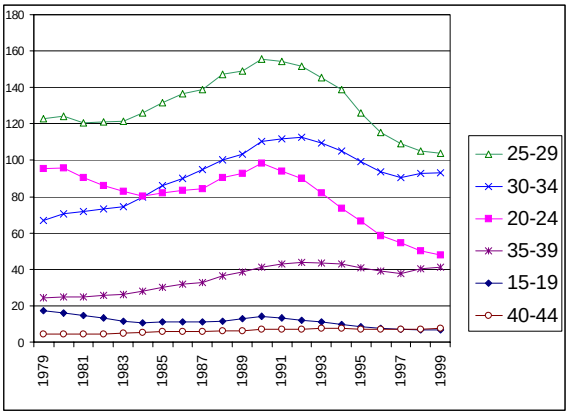


Figure 3. Changes in birthrate (per 1000) and abortion rate (per 1000) between 1969-1998 among 15-19-year-old women in Sweden, Table A3 in Appendix A

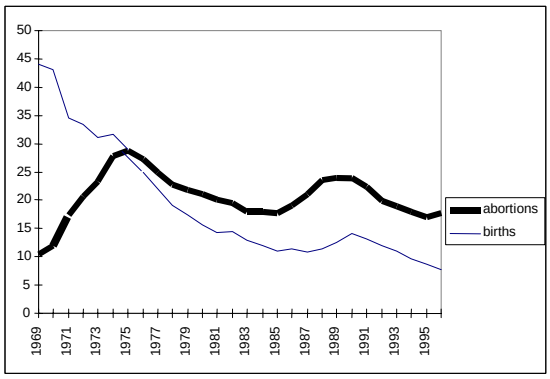
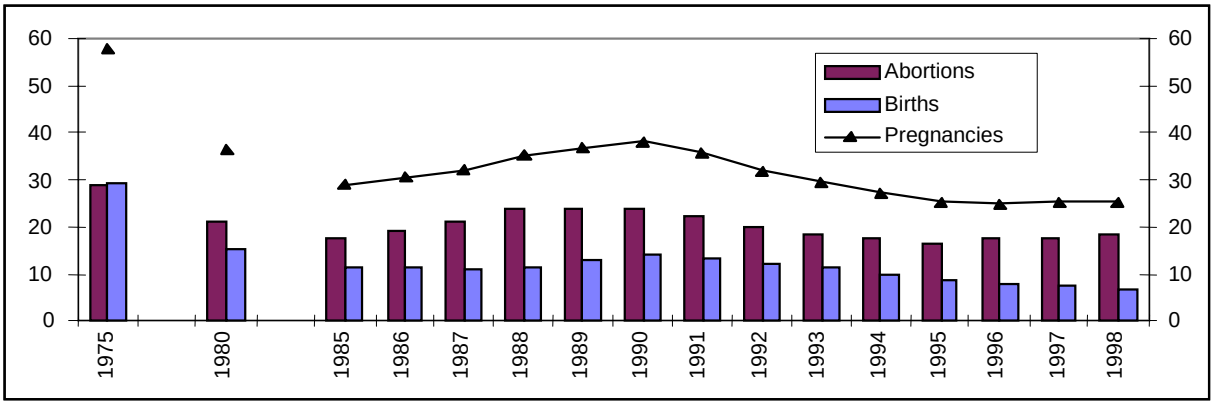


Figure 4. Changes in pregnancy rate (per 1000) birthrate (per 1000) and abortion rate (per 1000) between 1975-1998 among 15-19-year-old women in Sweden



In the beginning of the 1970s it became easier for young women to obtain a legal abortion. The abortion rate among teenagers increased rapidly, and the births declined nearly as fast (Figure 3, Table A3 in Appendix A). From 1970 to 1975, the birthrate decreased from 43 to 30 per thousand, while the abortion rate increased from 12 to 30.[3]

In 1975, the abortion rate started to decline. The new Abortion Act, approved by parliament in 1974, made abortion free on request. In connection with the legalization of abortion, a long-term public health program on sexuality and human relations was initiated. Government funds were provided to institutions and NGO's for education projects on sexuality, birth control and gender issues. In addition, contraceptive services provided by trained midwives were soon accessible at public health centers all over the country. The idea behind these efforts was to prevent unwanted pregnancies by means of contraception in the first place and abortion as a last resort. By legalizing abortion, society had an obligation to make contraceptives equally accessible.

Many activities were directed toward teenagers with the aim of reducing the increasing number of teenage abortions. Special youth clinics offered various counseling programs, including contraceptive services. One of the lasting effects of these activities was a more open, relaxed attitude in society toward teenage sexuality. A sharp decline in the pregnancy rate among teenagers from 1975 was seen as an effect of the preventive program; both the abortion rate and the birthrate declined. In a period of ten years, 1975 to 1985, the pregnancy rate had dropped by half; the birthrate declined from 30 to 11 per thousand and the abortion rate from 30 to 18 per thousand (Figures 3 and 4).

A period with increasing fertility in the late 1980s was also seen among teenagers, though

much less pronounced than among older groups. Since 1991, the birthrate has declined in all age groups, including teenagers.[4]

The percentage of teenage pregnancies that lead to childbirth has continuously decreased (Figure 4). In 1998, only 13% of pregnant teenagers, 15–17-years-old and 36% of those 18–19-years-old, chose to give birth. Since 1995, the teenage pregnancy rate has not changed; the birthrate is still decreasing and the abortion rate has increased among the younger teenagers, 15–17-years-old.[5]

Teenage Mothers and Disadvantage

Births among teenagers 15–19-years-old are becoming increasingly uncommon. In 1998, 6.7 per thousand gave birth compared to 43 per thousand 1970. Among women 15–17, the birth-rate is only 2.9 per thousand. Among teenagers today it is unusual and deviant to get pregnant and to choose to have a baby, especially if you are a younger teenager. In Sweden younger teenage mothers can therefore be expected to differ from other mothers, at a group level. Most studies on teenage pregnancy focus on abortion while teenagers who decide to be mothers are seen as a part of all "normal" mothers.

A national survey from 1990 on sexual behavior among adolescents born in 1973 showed that teenage pregnancy is practically always unplanned, at least on a conscious level. It is also seen as unwanted by parents, peers, health providers and the society at large. At increased risk for becoming pregnant in their teens are girls with early physical maturity, early sexual experiences, and low socio-economic status. Pregnant teenagers are more often than others from broken homes and school dropouts. A teenage pregnancy, therefore, can be recognized as an indication of girl-specific psychosocial problems.[6]

The long-term socioeconomic consequences of teenage childbearing were studied among all Swedish women born from 1941–1970, who had their first infant from 1954 to 1989 under the age of 29. This longitudinal study included 140,000 teenage mothers[7] and they were compared to mothers aged 20–24 at first birth. Teenage childbearing was more common among girls whose parents were blue-collar workers or were not gainfully employed. Teenage mothers, especially mothers in their lower teens, were later in life to be at increased risk of less favorable socio-economic conditions. They are at increased risk of attaining lower educational levels (odds ratio ranged from 1.7–1.9 in different age groups), to be single (1.5–2.3), to have many children (2.6–6.0), to receive disability pensions (1.6–1.9) and to be dependent on social welfare (1.9–2.6).

The effect of young maternal age at first birth on one's later socio-economic situation was almost of the same magnitude among women from white-collar and blue-collar backgrounds. Risks of disadvantageous social outcomes were evident in all birth cohorts, but risks were generally larger in the youngest birth cohort (born 1961–1970). An explanation could be that a negative effect of teenage childbearing to some extent levels off with time after childbirth (since for instance disability pension and welfare dependence were measured for all cohorts in 1994). An alternative hypothesis could be that, as teenage childbearing was less common in the youngest birth cohorts, teenage mothers born in the 1960s comprise a more vulnerable group of women than women born in the 1940s and 1950s.

Long term adverse health consequences for teenage mothers were studied among all Swedish women born in 1950–1964 (n=460,434), who had their first infant before the age of 30.[8] The women were followed up regarding mortality and causes of death from 1990 to 1995. Irrespective of whether coming from a white-collar or blue-collar background, teenage mothers faced an increased risk of premature death compared to mothers aged 20–29 at first birth. Mothers aged 17 or under at first birth had a 70% increase in risk for premature death and those aged 18–19 had a 50% increase in risk. Increased risk for premature death was most evident for deaths from cervical cancer, ischemic heart disease, suicide and inflicted violence. Although, there were few deaths caused by inflicted violence during the five years of the study (seven teenage child bearers and five older mothers), the teenage child bearers face a ten-fold increase in risk for death caused by inflicted violence. This indicates that teenage child bearers are exposed to a more violent environment—violent men—than older child bearers.

The only Swedish study on fathers to children born to teenage mothers was conducted in 1997 in Stockholm and contributes to the understanding of the findings of premature death among teen

mothers.[9] During this study, 350 children were born to teenage mothers, but only 50% of the fathers were included in the study. A large group of teenagers did not have any contact with their partners. Furthermore, only Swedish speaking persons and fathers attending or visiting at the postpartum ward were recruited. Fathers to children born to teenage mothers were compared to fathers of children born to women who had their first child at the age of 25–29. Like the fathers to children born to teenage mothers, these fathers were also attending the postpartum ward. To be a teenage father is probably even more unusual than to be a teenage mother, since the findings showed that only about 20% of fathers to children born to teenage mothers were teenagers themselves, and 72% were between 20–29-years-old. Fathers to children born to teenage mothers were more often immigrants or had immigrant parents. However, fathers who actually were teenagers themselves were more commonly native Swedes than the older fathers. The fathers to children born to teenage mothers had significantly lower education (not explained by age difference), were more likely to be unemployed or on sick-leave, and to come from a single-parent home. They were more likely to smoke and to have used narcotics. The most remarkable finding was the large share among fathers to children born to teenage mothers that were involved in serious criminality. The offences were also more serious and violent and 13% were sentenced to imprisonment.

Socioeconomic Status and Reproductive Behavior

Fluctuation in birthrates has been large in the last decades. The variation is due to change in timing of childbirth between generations and not due so much to how many children women end up having. The total fertility rate has been around 2 children for all generations in the last century. The rise in fertility in the 1980s was by and large due to the fact that there were shorter intervals between the first and second child, and as a result the trend of postponing the first birth leveled off. In addition, more women than before had a third child. The Swedish economy was prosperous, and the economic boom was accompanied by a baby boom. Abortion rates also increased, parallel to births, thus a fertility boom followed the period of prosperity. People expected an even better economic situation for themselves in the future. The social benefits for parents improved. For instance, the compensation for income during parental leave was improved. Altogether, it was a period of optimism regarding future possibilities for supporting a family and for combining family life with a work career.

In 1991, Sweden rapidly ran into a depression that lasted until 1998. Unemployment and threat of unemployment rose. Economic benefits addressed to families and children were reduced, public services like schools, children's leisure activities, etc. received less economic support. The birthrate decreased substantially, and even the abortion rate decreased. Unlike during the economic boom when the baby boom affected all socioeconomic strata, the recession did not affect the birthrate evenly.[10] The lower the education, the larger the decline in the birthrate. Among highly (university) educated women, the birthrate did not change at all. In the 1980s, women with university education were already having their first child later in life, after their educational period, and that pattern continued into the 1990s. Those with very low income, under $5000, had the lowest birthrate of all (controlled for age). This low-income group consists of persons who have no stable connection to the labor market either due to unemployment or studies and who lack "insurance-income" from earlier employment. There were also interesting socio-geographic differences in the changes in birthrates during the 1990s. In municipalities where the employment rate decreased, the birthrate decreased substantially, while municipalities with no change of employment rate, regardless of low or high level of employment, had little or no change in the birthrate.

The timing of childbirth is strongly connected to the economic situation in Swedish society. The "norm" in Sweden among both women and men is to have a job and an income of your own before raising a family. The benefits during parental leave also encourage parents to have a fair income before becoming a parent, since it is based on income before parental leave (80–90% of income during the prior 9–12 months up to a certain income level, at present about $2,200 a month). Therefore, in a Swedish context, it is rational that women with no income, and women in areas with

increasing unemployment, postpone their childbearing. The postponement of childbearing was noted among young women, while older women had their first child regardless of their economic situation. Unemployment or threat of unemployment affects younger people more than older and young women also have more years ahead of them to have children. It seems that young Swedes with a low income believe that they are able to improve their economic situation in the future, and that it is worthwhile to postpone starting a family. Since 1998, the economy in Sweden has improved. Unemployment is decreasing rapidly. We do not yet know how this will influence the fertility rate.

Socioeconomic, Ethnic and Demographic Differences

Immigrant Status and Fertility

The birthrate is higher in all age groups among citizens from all other countries (grouped together) than among Swedish citizens (Table 1). The birthrate is considerably higher among immigrants from Turkey. The largest immigrant group in Sweden is Finnish citizens (Table 2). Observe that the figures in the table show differences according to citizenship and not country of birth.[11]

Birthrates among those born in the same country are different depending on whether the person is a Swedish citizen or not. The highest fertility rate is found among those with foreign citizenship. This poses the question of what is meant by immigrant status. Is it to be born outside of Sweden, or not being a Swedish citizen?

In order to be classified as an immigrant, one must stay in Sweden for more than one year. To become a Swedish citizen, one must apply for it. In order to be eligible to apply, one must be older than 18 and have lived in Sweden for at least 5 years. Children of naturalized immigrants automatically become Swedish citizens. Immigrants from Nordic countries need only live in Sweden for 2 years. If the mother is a Swedish citizen, a newborn child automatically acquires Swedish citizenship, even when the father has foreign citizenship.

Whether or not a person who is born abroad becomes naturalized as a Swedish citizen differs among the immigrant groups (Table A8 in Appendix A). The birthrates are very different depending on the immigrant's country of origin. Differences in birthrates between countries also reflect differences in educational background, purpose of immigration, length of stay in Sweden and the degree of employment, integration or discrimination in the Swedish society. For instance, most of the Turkish immigrants came to

Table 1. Age-specific fertility rates in 1995 by mother's citizenship

	15-19*	20-24	25-29	30-34	35-39
Sweden	6.9	59.5	121.9	97.7	38.9
Other countries which are	29.6	138.4	152.1	107.0	55.1
Finland	17.6	88.1	117.4	88.1	40.4
Greece	21.1	95.5	82.3	55.6	33.1
Turkey	34.3	192.4	169.5	108.5	57.6

*Age group 15-19 includes all births under age 20, divided by the population 15-19 year olds (few are under 15).

Table 2. Population (women) and citizenship in Sweden, 1995

	15-19	20-24	25-29	30-34	35-39
Sweden	248,384	285,867	306,914	302,234	287,357
Other countries which are	16,017	21,540	29,515	30,248	26,558
Finland	5,828	5,415	6,558	7,222	9,610
Greece		188	223	236	143
Turkey		1,175	1,011	1,102	797

Sweden from the late 1970s until the end of the 1980s. In the late 1970s, the total fertility rate among Turkish women in Sweden was very high, up to 6.2 children per woman. Since then it has decreased steadily. In the 1990s it was around 2.9. The Turkish women living in Sweden are adopting the fertility behavior of native Swedes.

There is no routine registration of socio-economic or immigrant status in statistics regarding abortions. We therefore cannot present any tables with surveillance data in this area. Studies from a catchment area of one of the large hospitals in Stockholm have shown that immigrants have substantially higher abortion rates. Whether this is the case for teenagers remains to be investigated.

Marriage, Family Status and Births

Fifty-three percent of children born in Sweden in 1995 were born to unwed mothers (all ages). Since at least 1986, this percentage has been around 50. Most unwed mothers are cohabiting with the child's father. Table 3 illustrates that many mothers will marry later, following the first child. Family formation in Sweden today often begins when a cohabiting couple decide to have a child, while marriage comes later.[12]

Table 3. Live births by mother's age and family status, percentage within age groups, Sweden, 1995, age at the event

Age	Married	Cohabiting	Single	Total
15-19	18	33	49	100
20-24	30	46	24	100
25-29	46	40	14	100
30-34	56	33	11	100
35-39	59	29	12	100
40-44	61	24	15	100

*The term *currently cohabiting* does not include married persons. The term *married* denotes married persons only.

Forty-nine percent of mothers in the age group 15–19 are single mothers, a proportion that is higher than that of any other age group. Furthermore, only 18% are married, which is lower than for any other age group. Yet, this group (15–19) has the highest birthrate among those married (Table 4). This is because marriage is unusual among teenagers, only 0.5% were married in 1995 (Table 5). Among those few that do marry as teens, expecting a baby is a common reason for marriage. However, most teenagers (82%) do not marry, even when they are expecting a baby. We do not have data on the proportion of births conceived before marriage, but this is probably the case for most of the births in early marriages since teenagers usually do not marry otherwise. The legal age of marriage for women is 18.

Abortion statistics do not include marital status nor is marital status used in contemporary studies as a determinant of psychosocial problems in the family or of significance for the abortion decision.

Table 4. Birthrates among married and unmarried women in different age groups, number of births in different age groups (married and unmarried together)

Age	Married	Unmarried	Number of births
15-19	247.2*	6.5*	2,135
20-24	232.5	49.5	19,006
25-29	192.2	96.3	38,707
30-34	110.9	86.1	30,091

*All births under 20 divided by mean population 15-19, by marital status

Table 5. Number of women per thousand according to marital status and age, Sweden, 1995

Age	Unmarried	Married	Widowed	Divorced
15–19	995	5	0	0
20–24	918	75	0	6
25–29	678	286	1	35
30–34	450	475	2	73
35–39	301	582	5	112

Birth and Abortion Rates in Rural and Urban Areas

There are very small differences in birthrates between urban and rural areas in Sweden (except for the very few who live in the inner part of northern Sweden). Twenty percent of Sweden's population lives in Stockholm County. There are two other large cities in Sweden, Gothenburg and Malmo. The remaining part of Sweden is characterized by a mixture of small towns and rural areas. The birthrates in these areas are close to those of urban areas.

Only in remote areas in northern Sweden, with few inhabitants, is there a higher birthrate at younger ages and a lower birthrate at older ages, which means that childbearing occurs at a younger age.

In contrast, there are differences in abortion rates between rural and urban areas.[13] The areas of the three big cities Stockholm, Malmo and Gothenburg have higher rates of abortion then all other counties in Sweden, both for teenagers (up to 19) and for all women 15–44 (Table 6).

In 1998, Blekinge and Jonkoping had the lowest abortion rate among teenagers of all counties. Jonkoping is known for being an area where many take part in the Nonconformist Church.

Table 6. Induced abortions among teenagers (under 19 years) per 1000 women by county or municipality of residence, 1998

County	Rate
Stockholm Municipality	27.5
Stockholm County, exclusive of Stockholm Municipality	22.6
Malmo Municipality	23.9
Gothenburg Municipality	24.5
Blekinge County	11.1
Jonkoping County	10.5

Sexual Activity and Contraceptive Use

Age at First Intercourse

The National Swedish Survey in 1996 on sexual behavior[14] recorded sexual activities of 2,810 women and men aged 18–74. The age distribution at first intercourse in seven age groups from 18–49 is reported in Appendix A, Table A9. A cumulative percentage distribution is also displayed in Figure A5, Appendix A.

Women aged 45–49 at the time of the survey in 1996, seem to be the only cohort among women that differs—having their first intercourse later than the others. By the age of 20 almost 90% of women of all age cohorts have had their first intercourse.

The median age at first intercourse, processed from the national survey,[15] for the youngest group, aged 18–24, was 16.5 for women and 16.8 for men. For the older generations, now over 50, the median age was 18–19 for women and 17–18 for men. In generations under 50, the age at first intercourse seems to have stabilized between 16 and 17, with a slightly lower age for women than for men (Table 7).

The age pattern for first intercourse among adolescents today found in the national survey is confirmed in several minor studies. In a survey of

Table 7. Age (median) at first intercourse, women and men in five age groups

Age	n	Women	Men
18–24	412	16.5	16.8
24–34	626	16.1	16.9
35–49	819	16.4	16.6
50–65	605	17.7	17.1
66–74	192	19.0	18.0

sexual behavior among 17-year-old students in upper secondary schools[16] in 1990, just over 50% of the participants had experienced intercourse. A study, in 1999, explored sexual behavior of 333 (98% response rate) female high school and university students in Uppsala. The median age at first intercourse was 17.6 (range 13–27 years).[17] In a survey in 1999, among 1,000 female clients aged 14–24-years-old, who came to the RFSU clinic for contraceptive and/or STD counseling, 99% had had their first intercourse. The median age was 16 (range 9–22 years).[18]

Some studies report differences related to social class. In 1990, about 70% of girls in vocational training in upper secondary school compared to 54% of girls in theoretical lines had experienced intercourse by age 17. Of the boys in vocational training, 60% had this experience while 40% of boys in theoretical programs had had intercourse by 17. The findings also suggested that living together with both biological parents was related to later sexual debut.[19]

In a survey in 1999 in two towns, Uppsala and Västerås, 408 pupils (82% of a randomized sample) in first grade of upper secondary school answered a questionnaire on sexual behavior. Female and male students from theoretical as well as practical programs participated. In the whole group, 46% had experienced sexual intercourse and the median age for first intercourse was 15, range 11–18. Fifty-nine percent of students within vocational programs had experienced intercourse, compared to 37% of those in college-preparatory studies.[20]

In a study from 1999 in a multi-ethnic suburb of Stockholm, 49% of the 17-year-old respondents had at least one immigrant parent. In the study 59% of the boys and 50% of the girls had experienced intercourse.[21] This is different from other studies in the 1990s, where the age of sexual debut is lower for girls than for boys (see above).

In the multi-ethnic area, 66% of the sexually experienced girls had had their first intercourse with a stable partner, compared to 46% among the boys. Of the girls, 23% and of boys, 37% had had their first intercourse with a casual partner or with someone they did not know at all. The others said it had been with "just a friend".

A study from Umeå, a city in Northern Sweden explores sexual behavior of women in the 19, 21, 23 and 25-year-old age cohorts of Ålidhem community center. The median age at sexual debut was 17 (range 12–23) and the mean age was 16. Of the sexually experienced women, 19% had coitus before the age of 16.[22]

As expected the age of first intercourse is lower in studies of selected groups, e.g. inquiries among clients to clinics for contraceptive and/or STD counseling. For instance, the majority of the clients visiting youth clinics have had their first intercourse. The reason for calling is that they already are sexual active.[23]

Number of Sexual Partners

From the national survey on sexual behavior in 1996,[24] the number of partners in the past year for women and men is shown in Figure 5. Only respondents with one or with more than three partners are shown in the diagram. For complete figures see Table A11 in Appendix A.

Except for the teens, men seem to have more partners than women. About 50% of both women and men under 20 had only one partner last year. In the age group 20–24, 65% of women and 50% of men had one partner. Over the age of 30, 80% and 70% respectively had one partner.

In the previous mentioned study of women from Umeå[25] the reported number of lifetime sex partners ranged from 0–30, with a median of 4 partners. The number of partners increased with age, and women with an early sexual debut had twice as many lifetime sex partners as women with a late debut.

Among high school and university students in Uppsala in 1999, the number of partners in the last 12 months was one (range 0–13 partners).[26] The median number of partners for young women in the RFSU study in 1999 was 7 partners (range 1-80).

Frequency of Intercourse

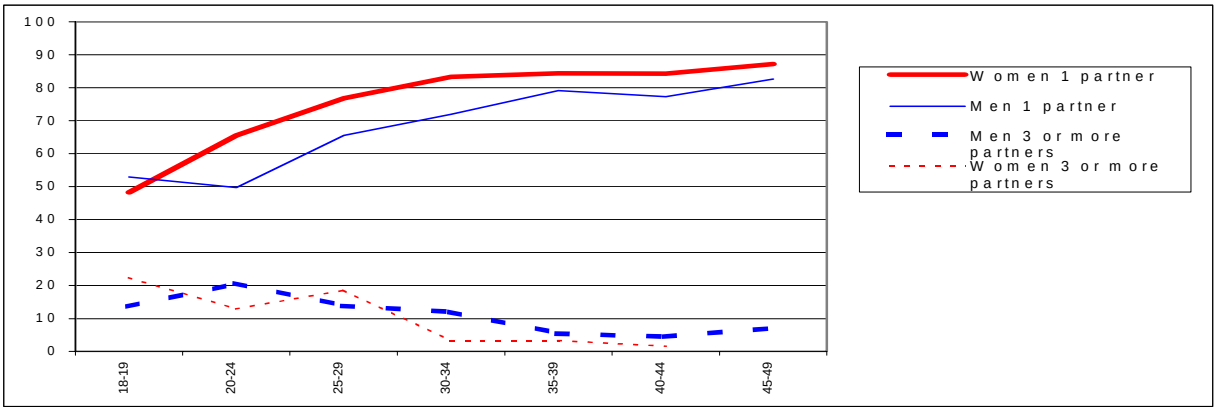
Figures on frequency of intercourse from the Swedish National Survey in 1996 are shown in Table A12 in Appendix A. Among those who had had intercourse in the last month, the most common frequency for all age groups was 2–4 times a week. In the age group 18–19, women report higher frequency of intercourse than men do. No gender differences are noted in the 20–24 age group.

Contraceptive Use

The national survey on sexual behavior in 1996 includes women and men from age 18–74. Contraceptive use at the latest intercourse, but not at the first is reported. As background for more limited studies on contraceptive practice, an extract from the national survey on contraceptive use in three age groups is presented in Table 8 (see also Appendix A, Table A13).[27]

Less than 10% of couples under the age of 25 did not use any contraceptive method. Condoms

Figure 5. Percentage distribution according to number of sexual partners in the past year by respondents' age at the survey, Sweden 1996



and the pill are most popular, used by nearly 80% in the two youngest groups. Non-technical methods like withdrawal and rhythm were practiced in around 10% of youths under 25. Condom use is most frequent in the youngest group, and pill use is most frequent among those 20 to 24.

Contraceptive use was explored in a study on sexual behavior among 1,000 women aged 14 to 24, visiting RFSUs clinic for advice on contraception and STDs.[28] Their contraceptive choices at first and latest intercourse are shown in Table 9.

Few women had started taking oral contraceptives before their sexual debut. The majority had relied on male methods at the first intercourse, when condom and withdrawal were used by 80%. Later on, however, many women wanted a method of their own. About 60% used oral contraceptives at the most recent intercourse.

In the survey of sexual behavior of 17-year-old students in upper secondary schools in 1990,[29] contraception was used at first intercourse by 68% of girls and 60% of boys. Condom was the most common choice. At the latest intercourse 81% of girls and 69% of boys used contraception, the majority relied on the pill. The same study also reported a lower use of contraception in a group of school dropouts than in the sample of upper secondary school students. The prevalence was lower both at first (57% for girls and 38% for boys), and at the most recent intercourse (69% for girls and 55% for boys). The social background in the drop-out-group also differed from the students' in that fewer lived with their parents. Young women in this group had experienced a higher rate of pregnancy and of abortion than had school-going girls.

Contraceptive use was recorded in the previous mentioned study in 1999 among girls and boys in the first grade of upper secondary school in Uppsala and Västerås.[30] At first intercourse, three-quarters of the youths had used contraceptives, of which 66% used condoms and 10%, oral hormonal pills. About 10% practiced interrupted coitus and 13% didn't use any contraceptive method.

Differences in contraceptive use between 1989 and 1999 were explored in a study of female high school or university students.[31] In the survey in 1989, the study population was nearly 350,000

Table 8. Contraceptive choices at latest intercourse among sexually active women and men, aged 18 to 29

Contraceptive method	18–19		20–24		25–29	
	n	%	n	%	n	%
No method	9	9.3	23	8.2	34	11.9
Condom	28	28.9	45	16.0	50	17.5
Oral contraceptives	46	47.4	162	57.4	92	32.2
IUD	1	1.0	10	3.5	34	11.9
Withdrawal/cap/rhythm	12	12.4	26	9.2	43	15.0
Pregnant/want to be	1	1.0	16	5.7	33	11.5
	97	100	282	100	286	100

Table 9. Percentage of women, aged 14 to 24, according to choice of contraception at first and latest intercourse, n = 1,000

Contraceptive method	First intercourse	Latest intercourse
No method	13.3	9.2
Condom	63.4	12.7
Oral contraceptive pill	4.2	61.0
Both condom and pill	2.7	3.9
Other (Injectibles, IUD)	0.0	0.7
Withdrawal	16.3	12.4
Rhythm	0.4	0.8
	100.3	100.7

Table 10. Choice of contraceptive method at first and latest intercourse among female university students in 1989 and 1999

	1989 (n=345,275)		1999 (n=333)	
Contraceptive measures	First intercourse	Latest intercourse	First intercourse	Latest intercourse
No technical contraceptives*	40	12	16	9
Condom	40	24	73	21
Oral contraceptives	19	59	6	64
Condom and pill	0	0	4	5
No answer	1	5	1	1
	100	100	100	100

* Includes withdrawal, rhythm and "no method"

women with a median age of 22.9. In 1999, questionnaires with similar questions were handed out to 345 consecutive female clients to the health clinic for university students in Uppsala. Of these, 333 students participated and filled out the form. Contraceptive practice at first and latest intercourse in the two studies is shown in Table 10.

The difference in 1999 compared to ten years earlier is an increase of contraceptive use at first intercourse. In 1989, about 60% used either condom or contraceptive pills at the first and 80% at the most recent intercourse. Ten years later, contraception was practiced by 80% at the first intercourse and by 90% at the latest intercourse. Condoms were the choice for 73% at the first intercourse, while the pill was most frequent at latest intercourse.

To sum up, studies of contraceptive prevalence among adolescents up to the 1990s have shown that between 50 and 60% of adolescents used contraceptives at first intercourse. Quite a few independent studies suggest increased use of contraceptives in the 1990s, especially at first intercourse. A higher use of contraception at the latest, compared to the first sexual intercourse, is reported both in studies from recent and previous decades. In the late 1990s, contraceptive prevalence rates between 70% and 85% at the most recent intercourse, have been reported. Condom is the most common method at first intercourse, the pill is the predominant choice at the latest. Emergency contraception, available since 1993 is well known among teenagers and quite a few have also used it after unprotected sex.

Part II. Societal Attitudes about Sexuality

Attitudes and Norms about Sexuality and Sexual Behavior

A notably open attitude to sexual matters is a feature of Swedish society. Sexuality and personal relationships are regularly discussed in radio and television programs as well as in newspapers, magazines and books. All children receive sex education in school.

Popular support for this open approach is strong. This is partly because sexuality is perceived as positive, a source of pleasure and togetherness, so that talking about it is both proper and important. Moreover, openness is needed to acquire knowledge and knowledge in turn is seen as the best means of handling sexuality in a responsible way. This strong belief in knowledge goes back to the days of pioneers and popular movements in the early 1900s and creates the foundation for today's fruitful cooperation between NGOs and public institutions, such as the National Board of Education and the National Institute of Public Health.

Monogamy is the norm for sexual relations, but it is common and accepted to have several life-time partners. Abstinence before marriage is not an issue, rather, premarital sexual activity is expected and socially accepted. Love and sexuality are supposed to go together, and young people having sex is seen as sound and proper, as long as they are in love. In most Swedish families today it is customary to allow the boyfriend or girlfriend to sleep overnight. The fact that adolescents also have a sexual life calls for policy initiatives in areas of health, school and social welfare.

There are in society different degrees of openness. The tendency for Swedes to be frank about sexuality does not apply to *every* aspect. It is mainly the biological side of sexuality that is talked about openly. The explicit presentation of facts about the appearance and functions of the genital organs, psychosexual development, sexual intercourse, masturbation, pregnancy, infertility, contraceptives and STDs has a long tradition. Recently there has also been more open talk about negative aspects of sexuality: sexual assault, rape and prostitution.

Homosexuality is nowadays often openly discussed. It is unusual, on the other hand, to talk about one's own sexuality, emotions, experiences and desires—such matters are felt to be too private for that.

Another clear tendency today is the stronger focus on sexuality in the media: in newspapers, magazines, TV talk shows, etc. Cable television, videos and the Internet have also made pornography available in principle to everyone. This commercial exploitation of sexuality is a consequence of openness that many regard as negative. In other words, openness is debated. There is concern that young people are being influenced and pushed into having intercourse and participating in advanced forms of sexual behavior. Others argue that young Swedish people are sufficiently well-informed and self-confident to act independently, that the concern is largely unwarranted and that such abuses as do occur have other causes.

Historical Background

Swedish norms and attitudes to sexuality should be seen in their historical context. There has been a long tradition of premarital sexual relationships. In the mid 19th century it was common in some areas for men and women to cohabitate—and even have children—before getting married. The custom varied, but this example shows that even in earlier times people accepted premarital sex.

Pioneers

Sex education in school has been provided for a long time. In the 1890s, Karolina Widerström, the first female doctor in Sweden and an active feminist, advocated sex education for girls as well as boys. She, herself lectured for last year schoolgirls about "sexual hygiene". As early as in 1901 sex education was introduced in some schools. It was, however, restricted only to girls. It was considered that sex education protected girls, but was dangerous for boys; for the latter it was better to let sleeping dogs lie.[32]

Another pioneer, Hinke Berggren, from the labor movement caused alarm in society by showing a condom in public and arguing that contraception was a way out of poverty. As a result, a law was passed in 1911, prohibiting public information and the sale of contraceptives.[33]

The 1920's was a time of convulsive social change. With urbanization and industrialization followed less social control of sexuality and the views on sexual life became more open and permissive. The openness also had undesirable consequences. Venereal diseases increased, children born outside marriage were abandoned and lived unattended on the streets. To avoid shame or poverty women resorted to dangerous back-street abortions. The society took no responsibility to counteract the negative effects of "free" sexuality.[34] Instead, it was pioneers in women's labor and other popular movements, involving doctors, school teachers and individuals who continued to campaign for sex education and responsible behavior.

One significant pioneer was Elise Ottesen-Jensen who traveled around the country, talking to people and introducing contraceptives as means for women to enjoy sex without fear. She was one of the founders and the first chair of the Swedish Association of Sexuality Education, RFSU, instituted in 1933.[35] This association has from the beginning focused on sex education, putting the question of birth control and prevention of diseases in a broader context of sexuality, equality and social justice. This broad humanitarian approach, which has been a sign of Swedish sex education ever since, was formulated by Elise Ottesen Jensen in the following way: "I dream of the day when all children are born welcome, when men and women are equal and when sexuality is an expression of intimacy, tenderness and pleasure."

Sexual Policy and Social Welfare in the 1930s

In the 1930s, in times of unemployment and economic depression, concern over the falling birthrate triggered a broad social welfare program. Maternal and child health care, maternity allowances and better housing for young people were among the reforms introduced to encourage people to have many children. In addition, general sex education in school was proposed, reasoning that knowledge promotes responsible behavior and prevents sexual diseases and unwanted pregnancies. Sexual life should be restricted within marriage and young people should be able to marry and have children. Consequently, even young people had to be informed and allowed a sexual life.[36]

However, there was also resistance to this approach. When sex education was recommended in the school curriculum in 1942, the National Board of Education prepared a very strict curriculum condemning sexual relationships before marriage. After opposition, especially from female elementary school teachers, new guidelines for teachers with a more modest recommendation on abstinence for young people was issued in 1945, and in 1955, sex education became compulsory in elementary schools.[37]

In the 1930s, other notable reforms on sexuality were introduced. The ban on information about contraceptives was lifted in 1938, accompanied by a law permitting abortion under certain circumstances, for instance if the woman was sick, had an inheritable disorder or had been subject to rape or incest.[38]

In 1944, moreover, homosexual contacts ceased to be a criminal offence. Previously, homosexuality had been regarded as a sin and a crime, which could lead to a prison sentence of up to two years of hard labor. The law was repealed because of a growing tendency to interpret homosexuality as an illness or a behavioral disorder. In the 1960s and '70s, this view was challenged and in 1979 homosexuality was deleted from the National Board of Health & Social Welfare's list of classified diseases.

Sexual and Reproductive Freedom

The 1960s were a turning point in many respects. It was a time of rapid economic development, lots of opportunities for education and well-paid jobs

for young people, women as well as men. Oral contraceptives became available, which meant a new sexual freedom. It became increasingly common for young people to live together without marriage and without the intention of forming a family.[39]

In practice, access to legal abortion was very restricted; for a young, healthy woman it was seldom approved. Many young, single and abandoned women resorted to illegal abortion, and in the early years illegal abortions far outnumbered legal ones, especially among young women. In the mid 1960s, the government appointed a committee to prepare a more liberal abortion law. Eventually, the interpretation of the abortion law became more lenient and an application could be approved just because a woman claimed that she was too young to be a mother. Consequently illegal abortions became appreciably less frequent, while the number of legal abortions among teenagers increased.[40]

RFSU was active in the promotion of sex education and efforts to prevent abortion, influencing politicians and government from the grass roots level. Initiatives from RFSU led to collaboration with the National Board of Health and Welfare in training of midwives as providers of contraceptive services (see part III, page 29).

In 1974, a new Abortion Act, which is still in force, gave every woman the right to have an abortion under the National Health Service up to the end of the 18th week of pregnancy. Thus, it is now the woman who chooses whether or not to terminate a pregnancy; previously it had been representatives of society—doctors, social workers or central administrative bodies—that had decided what was best for her. Today, abortion on request is generally supported in the population. All the political parties stand by the present form of the Abortion Act. Opponents of abortion are represented by small groups, inspired as a rule by similar movements in the United States.[41]

RFSU was also very active in calling for a revision of the governmental guidelines for sex education in school. A governmental committee, appointed in the 1960s to reform sexuality education presented their proposal in 1974, which resulted in a new curriculum labeled Sexuality and Interpersonal Relations.[42] In the years that followed there has been a shift away from focus on sexuality as a value in its own right to prevention of sexually transmitted diseases (like in the early 1900s) and other negative consequences such as sexual abuse and violence.[43]

Gender Equality

Another force behind sexual policy in recent years has been the drive for equality. Already in the 1970s many reforms were implemented with the aim to increase equality between men and women and make it possible to combine work and children. New laws on marriage and divorce made less difference between marriage and informal cohabitation. Both parents should provide economically for the child and paid parental leave after childbirth could be shared between the mother and the father. The public day care facilities were expanded to allow mothers of small children to continue their professional work.[44]

Through access to contraceptive services and safe abortion as a back up, a woman could decide when and with whom to have children. To become pregnant was a deliberate decision and there was no longer a stigma on single parents. Also, young men were supposed to make their own decisions about becoming a father. The message to boys was that he could not rely on the girl, but had to protect himself if he wanted to avoid becoming a father. A man can neither force a woman to give birth nor to have an abortion if she so decides. And the man has economic and other responsibilities as a father, even if he did not approve of her choice.[45]

Most young people, even if they live together in stable relationships, are highly motivated to use contraceptives to avoid pregnancy. In the case of an unplanned pregnancy they may choose an abortion because they do not feel mature enough to be come parents. The notion, often repeated in health education in the 1970s, “A child has the right to be wanted,” has become generally adopted by young people.

Areas of Attention

• *Prevention of STDs.* Improved health and greater equality have been the goals of Swedish sexual policy for a long time. Prevention of STDs has always been, and is still, a high priority in public health education programs. Gonorrhea, which was common among young people in the 1970s, has nearly vanished, partly due to focused health education including intense condom campaigns,

and partly because of early detection, partner notification, free treatment and follow-up. Since the late 1970s, other STDs like chlamydia and herpes became the main target for STD prevention and education. The HIV epidemic has been contained and very few young Swedes have acquired HIV. In order to safeguard the favorable trend and reduce the frequency of other STDs, a continuation of the preventive efforts is seen as highly important.

Today, chlamydia, which since 1988 has been registered and under the same surveillance as gonorrhea and other STDs including HIV, is the most commonly reported STD. In the 1990s, the incidence of chlamydia was around 15,000 cases each year; in recent years less than 300 cases of gonorrhea and about 250 new cases of HIV have been reported.[46]

The incidence of chlamydia decreased in the early 1990s, but has recently increased, mainly in teenagers and young adults. The 16,000 cases in the whole country in 1998 were 9% more than those reported in 1997, but half as many as in 1989. More effective methods for testing and more testing of young men are among the explanations of the further increase.

• *Teenage pregnancies*. Pregnancy rates, which include live births and abortions (for women under 20), have fallen markedly over the past decades. At the same time, the proportion of pregnancies terminated by abortion has also increased, especially among younger teenagers. In 1998, 16 pregnancies occurred in 1,000 women aged 15–17, and 87% of these pregnancies were terminated by abortion. In the age group 18–19 years, there are 35 pregnancies per 1,000 women and 64% of all pregnancies were aborted. The corresponding figures among women aged 20–24 were 80 pregnancies per 1,000 women and 25% of all pregnancies ended in abortion.[47]

The decreasing pregnancy rate among teenagers is considered as a favorable development from a health point of view, but teenage mothers per se are not seen as a problem. A sexually active adolescent is supposed to use contraceptives and in case of a pregnancy it is up to the young woman and her partner to decide if they want to have the baby or have an abortion. Abortions, performed in public health care, are legal and safe. Young women who choose to keep the baby are entitled to social and economic support, including the continuation of school education. There are usually some options for childcare if the mother wants to go to school after childbirth. Parental leave during the first year can be shared by the father to allow the mother to go back to school. She can also study part time or in the form of distance learning. Day-care is available when the baby is a year old, and in many cases relatives and grandparents take care of the child.

Having the child adopted—a common solution for unmarried young mothers as recently as the 1960s-is a practice that has ceased. There has also been a radical change in attitudes toward single mothers. No one now looks down on a woman who chooses to go it alone with a child or to live with a man without formal marriage. To be a single mother is no longer a social disgrace. Many women, as well as some men, live singly with their children, either after a divorce or without ever having had an established relationship. It is also possible for a single person to adopt a child.

• *Love, sex and fidelity*. A comparative study on attitudes toward sexuality in various countries examined views on premarital and extramarital sex. In Sweden, only 4% of adults disapproved of premarital sex and a majority, 68%, disapproved of extramarital sex.[48] Today, however, the notion of premarital sex has little relevance, especially among adolescents. Young people tend to accept casual sex without the intention of a lifelong relationship, but reject sex outside of a stable relationship.[49] Most people of all ages agree to sexual intercourse only if you are in love. There are, however, some differences between women and men. In practice men have more experiences of sex without love, while women more often, both in theory and practice, follow the norm.[50]

Weinberg et al. examined gender differences in sexual attitudes and behavior between American and Swedish University students.[51] In Sweden, the students had more accepting attitudes toward sex and more similar sexual standards for women and men than did American students. The American male students reported the most sexual experiences (age of intercourse, number of partners etc.), the Swedish men had the least, with women of both countries in the middle.

In 1987, adolescents aged 16–24 were asked to respond to the statement: “Sexual intercourse is appropriate only in a stable relationship.” Thirty-five percent of females and 30% of men agreed

totally, while 15% women and 18% men totally disagreed. Ten years later, in 1997, only 18% of young women and 15% of young men agreed with this statement. The liberal view was supported by 18% of female adolescents, slightly more than in 1987, but by as much as 33% of the young men. An HIV/AIDS study comparing attitudes in 1987 and 1997 also asked about “sex without being in love”.[52]

Love is seen as a justification both for sex and for living together and, even among young people, the norm is to love and have sex with a stable partner. The duration of the relationship is not so important; couples who are no longer in love can break up and find a new partner. This pattern has been called ”serial monogamy” and is increasingly common not only among young people, but also among adults.

Thus, heterosexual, monogamous, stable relationships are the norm among women as well as men. However, it is a rather common experience among both women and men to have a sexual relationship outside a stable relationship. According to a Swedish survey in 1996, 15% of women 18–24 and nearly 30% of the men in that age group had that experience. The majority was sex with a casual partner, but quite a few have also had a period of parallel sexual relations.[53]

• *Abuse, violence, harassment*. The matters that currently are defined as problems in Sweden are, above all, acts of violence and insufficient equality. The social authorities, the health care sector, voluntary organizations and the public debate focus attention on incest, sexual assault, rape and prostitution. In recent years there have also been attempts to tackle sexual harassment, for example the harassment of women at work and the exposure of young girls to negative sexual epithets from their peers in school. The "peace for women" law, from 1998, is intended to be a more effective and concerted instrument for preventing sexual assault and repetitive harassment.[54] In 1999, purchasing "sexual services" was made a criminal offence, but the sale of such services (prostitution) is not prohibited.

Attention has also been drawn to the conflicts that some young women with an immigrant background experience. For them, breaking the norm of premarital virginity entails major personal risks at the same time as the norm has no meaning for their Swedish female peers or for young men. There are conflicting messages from school teachers and service providers concerning the Swedish policy of respect of other cultures and the norm of gender equality and personal freedom.

The question of female genital mutilation, prohibited by Swedish law, has arisen in recent years in communities with immigrants from countries where it is customary. Many young circumcised women have physical complaints as well as problems in their relationships with other girls and boys. Training has been provided for maternal health care personnel to enable them to treat, support and inform pregnant women and their partners. Likewise midwives at youth clinics are trained to meet the needs of female and male adolescents coming from countries where FGM is practiced. A recent study identifies the youth clinics in immigrant areas as sites where young women come for advice and support on FGM.[55]

With regard to pornography and the growing sexualization of media, opinions differ as to whether, for example, the effect on youth is negative. Pornography involving violence or children has been illegal for many years. No further prohibitions are being considered at the present. What many people see as important instead is ensuring that young people have opportunities to discuss, for instance in school, the media's representation of sexuality and gender roles.

• *Homosexuality*. Homosexuals have been highlighted in a new way in recent years. In 1994 the Parliament passed the Law on Registered Partnership. Registration grants the homosexual couple the same legal status as a married couple, except in relation to adoption of a child. A ban was recently imposed on discriminating against people in the labor market on account of their sexual orientation. An ombudsman for homosexuals has been appointed. Thus, the official line is that homosexuality as such is neither negative nor a problem; the problem lies instead in the social environment.

The process of coming out as a homosexual is still difficult, especially outside larger cities. Moreover, many homosexuals experience violence and harassment on account of their sexual orientation. Neither do homosexuals have quite the same legal status as heterosexuals. Two laws that are being considered at present concern

the right of homosexuals to adopt children and an extension of the law protecting ethnic defamation to include homosexuals.

According to Widmer,[56] 56% of adults in Sweden have the opinion that homosexuality is always wrong. The attitudes, however, have changed over time and differ according to age, sex and social class. Women are generally more tolerant than men. The most rapid changes toward a more liberal view are seen among young people in recent years.

The Swedish National Survey on Sexual Behavior in 1996 explored attitudes toward homosexuality in the participants' family when they were young. It seems that homosexuality used to be seen as more threatening for young boys than for girls. Among women and men over 50, virtually none had met a positive attitude to homosexuality from their parents. Ten percent reported their parent's views as neutral and 40% as negative. Among 50%, the reaction had been silence. Women and men under 34 had different recollections; over 50% reported positive or neutral parental views, while 30% were negative and less than 20% silent.[57] A national survey in 1999 showed great variations in attitudes to homosexuality, with the most positive views among young people and females. Sixteen percent of the women and 35% of the men expressed negative attitudes toward homosexuals.[58]

In the 1990s, there has been a notable change in attitudes to homo- and bisexuality among adolescents. In 1997, 58% of girls 16–17-year-olds and 38% of boys agreed with the statement that there is nothing abnormal about being homosexual, while the corresponding figures ten years earlier, in 1987, were 20% for girls and 11% for boys.[59] A likewise more open attitude is reported from a project called Q 90–98, investigating attitudes and behavior of girls and boys in grade 9 (aged 16 to 17) every second year since 1990. It was more common, especially among girls, in 1998 than in 1990 to consider one's own sexual orientation. A higher proportion had also felt attraction for both a person of the same and of the opposite sex.[60]

These trends are seen as part of a more open attitude in general. The most recent results could partly be an effect of the movie "Fucking Åmål" about two girls who fall in love with each other and stand up for their feelings against both parents and peers. This film came out in 1998 and became very popular, particularly among teenagers.

• *Youth policy*. Since the 1970s, Swedish youth policies applied a more holistic view of young people, with a focus on equality and independence. Not until the 1990s did the special needs of youths get a more official recognition in that a separate governmental agency for youth, the National Board of Youth Affairs was established in 1994. The goal of this Board is to promote a healthy environment for young people to grow up in. In a period of economic stagnation and increasing unemployment among youth, the youth policy of today focuses on integration and influence. The young generation must be given the chance of influencing both their own living conditions and the entire social system. Several projects have been initiated and funded, mainly in three areas, work, economy and living conditions.[61]

Better housing and the possibility for young people to settle down is an area of concern. Today, the majority of youth aged 18–19 (close to 70% female and 80% male) still live in their parental home, while 17% of women and 34% of men aged 20–24 stay with their parents. In both groups it is more common for young men than women to live with their parents. Women aged 20–25 more often leave their parents to live with a partner than do young men (Table A14, Appendix A).

In contrast to the public discussions in the 1970s, issues of sexuality, reproduction and interpersonal relations are not in the forefront any longer.[62] To support young people to be able to earn their living and have a place to live are among the priorities, but the decision on how and with whom to live and when to start a family is left to the individual. The previously strong attention on responsible sexuality may not be required any longer, since openness and an affirmative view on youth sexuality are a common ground in the society.

Young people's Socialization about Sexuality, Sexual Behavior and Sexual Responsibility

Sex education has been compulsory in Swedish schools since 1955 and it is given to all children and adolescents of both sexes beginning in preschool. Parents, however, are the first to answer children's questions, usually giving honest answers when asked "where do I come from".

There is openness on such matters and a number of books for small children on sexuality and childbirth are available.

Sex Education in School

Both the form and the content of sex education has changed a great deal over time. By today's standards, the approach in the 1950s was moralizing, restrictive and traditional in its treatment of the two sexes; it advocated sexual abstention during adolescence.

Following the recommendations from a governmental subcommittee on sex education in school, the subject was revised and re-named Sexuality and Interpersonal Relations.[63] Since then, the goal has been to convey an affirmative view of youth sexuality and a striving for gender equality, e.g. through discussions on gender roles. Abstention is no longer called for.[64]

National guidelines and curriculum gave detailed instructions on how the subject Sexuality and Interpersonal Relations should be taught. As a multidisciplinary matter, sex education should be included in such subjects as biology, civics and religion. It was to be taught by the regular teaching staff both in the nine-year compulsory school system (“basic school”) and in the subsequent three-year school program ("upper secondary school").

Four goals were formulated in the teachers’ manual from 1977:[65]

1. Provision of basic facts on physiological, psychological, ethical and social aspects on sexuality as tools for promoting a responsible behavior and enhance sexual life as a source of joy and happiness.
2. Knowledge and understanding of norms and values.
3. Present sexuality as an integrated part of human life to be understood in a social and psychological context.
4. Convey insight on the complexity of sexuality as grounds for personal decisions in matters related to sexuality and interpersonal relations.

In presenting this curriculum, an interactive approach was recommended. Students were invited to take part in planning for sex education. It is considered that, to be effective, information about birth control and STDs must relate to the young pupils' own situation and experiences. The message is that safer sexual behavior is deemed to depend on a sense of responsibility, integrity and self-awareness, qualities that are promoted by talking with youth rather than by providing technical information. The curriculum gave detailed instructions and examples of content and structures of lectures.

The education includes basic facts about anatomy, physiology, reproduction, contraceptive methods and STDs, together with opportunities to discuss love, sexuality, personal relations and gender roles. Girls and boys are taught together as a rule but, more and more often, also separately.

The dialogue and the interaction have been more vivid in lower grades. At the senior level of compulsory school, grades 7 to 9 (14–16-years-old), the subject has mainly been taught by the biology teacher and in medium level, 4th to 6th grade (11–13-years-old) by the class teacher and, to some extent, in collaboration with the school health service.

In reality, this strict curriculum gave the schools rather limited possibilities to adjust the education according to needs and expectations of the pupils. Although the syllabi were comprehensive, the quality of education was dependent on the individual teacher. A minimum of education, however, and a rather useful factual knowledge reached school children in all grades.

Reforms of the School System

In the early 1990s, the Swedish school system was profoundly reformed in that responsibilities, management and administration were decentralized. It was a shift from central regulations to goal- and result oriented steering of education.

The government issues general guidelines and curricula for the whole school system. The National Agency for Education is the central authority for evaluation, supervision and follow-up. The national curriculum contains the overriding goals and guidelines of compulsory nine-year schools and the three-year gymnasium program. Since 1998, this expanded also to include the pre-school for five to six years old. Curricula from 1994 (Lpo 94 and Lpf 94) reflect the new policy, allowing great freedom and putting the responsibilities to headmasters in each school.[66]

Within this framework, each individual municipality is free to decide how its schools should be

run. An educational plan must be produced and the headmaster of each school has the task of drawing up a local working plan based on the national objectives and curricula. This should take place in consultation with teachers and other staff. Pupils are also supposed to take part in the process of planning and implementation of the teaching objectives.

This new policy has changed the conditions for sexuality education. According to the new curricula from 1994, the concept "sexuality and interpersonal relations" is not defined as a core subject, but as an overarching topic, similar to such areas as environment, traffic, gender equality and prevention of smoking, alcohol and drugs. These areas have no specific syllabus; it is up to the headmaster to decide the content and the range of sexuality education, like for other overreaching areas.

There are no specific goals for sexuality education, like for other areas, such as improved gender equality, development of the pupils' self-confidence, empathy and independence or other dimensions of social competence. Depending on the interest among the headmaster and teachers, these goals can also embrace sexuality education.

Instead of detailed instructions from the central authorities, such as the teacher's manual in 1977, the Agency for Education issues so called "reference materials" in various subjects. Such material on sex education was published in 1995.[67] It focuses on feelings and sexuality, with the teaching emphasis on dialogue rather than lecturing. The views on methods and dialogue are the same as in the 1977 guidelines. The common values in the Swedish society are adopted practically unchanged in the goal and result oriented school as in the central guidelines from the 1970s.

The present syllabi for specific subjects came into force in 1995. Only the subject biology, with knowledge on biological sexual functions, contraceptive methods and STDs can be directly related to sexuality education. Some other subjects, such as democracy, ethics and social competence, may be interpreted by the teacher as sexuality and interpersonal relations.

Sexuality Education in Late 1990s

When providing sex education in the 1990s, each school decides how the teaching will be done and what it should cover. In compulsory school, the class teacher can choose to include sexuality and interpersonal relations in various subjects. The role of the school health staff differs.

According to a national survey in 1997,[68] about 10% of the schools in the whole country relied on school health personnel for sex education, while a study from Stockholm county reported that the school health service was much more involved; in the medium level of basic schools, the school nurse was responsible to the same extent as the class teacher, and in the senior level, was nearly as important as the biology teacher.[69]

In the three years of upper secondary school the pupils (17–19-years-old) can choose between 16 national programs. Sexuality and interpersonal relations are not among these programs, but could be part of some of them. Where sex education is taught the emphasis is mainly on social and psychological aspects including relationships and equality. A factual account of homosexuality is also to be included. Pupils may undertake special projects and study some issues in more detail. Topical issues that pupils learn about through newspapers, television and other media are discussed.

In the senior level of compulsory school, grades 7 to 9, like in upper secondary school the teaching may also be supplemented with visits by representatives from NGOs such as RFSU (Swedish Association for Sexuality Education) and RFSL (Swedish Federation for Gay & Lesbian Rights).

Most school classes in 8th or 9th grade (15–16 years of age) visit the local youth clinic to learn about their services and discuss contraceptives, abortion and STDs. If facilities are too small to invite all pupils, a midwife from the youth clinic or, in the case where there is no youth clinic, health staff in public health, pay a visit to the school. The purpose of the visits is for the health staff to present themselves and tell the students where to go for services. Some youth clinics invite girls from the 6th grade to sessions to talk about puberty and menstruation. The role of the youth clinics is to provide support and services to young people and to meet them on their own conditions. With a few exceptions, parents are not invited to youth clinics, neither for information sessions nor individual talks.

Depending on the motivation of the headmaster and the teachers, there are great variations from

one school to another. Some schools arrange Sexuality and Living Together as a block that consists of one or more themes and lasts for several days. Value-clarifications, role-play and talks about relationships are used with a view to strengthening the pupils' self-esteem and help them build an identity.

Recurrent talks can be exemplified by a project in Malmö (Sweden's third largest city). For ten years now young adults have been engaged to lead the talks and they visit all the senior-level compulsory schools in Malmö as well as, more recently, the upper secondary schools. The leaders are handpicked for regular employment and undergo training as well as continuous guidance. The talks, which are held in three two-hour sessions separated by fairly short intervals, focus on discussing love, friendship, sexuality, equality and ethics.

A survey in 1997 on behalf of the National Institute of Public Health[70] shows that the coverage and content of sexuality education varies from school to school. A one-sided biological perspective on the senior level of compulsory school is rather common, in spite of the general guidelines. In 79 percent of the schools the biology teachers are responsible for sex education. The topic was taught in biology in 90% of the schools, while 40% brought it up also in civics and religion.

A complementary study from Stockholm County[71] showed that sex education was more varied in the Stockholm County than reported in the national survey. Few schools, only 18% in the Stockholm County, have a special plan for Sexuality and Living together. Nevertheless, many innovative sex education projects have been carried out and most teachers in the Stockholm County have attended courses on sexuality and interpersonal relations, arranged by LAFA (Stockholm County AIDS Prevention Program, see below pages 26, 27 and Part III page 29). In Stockholm County, 90% of the senior level schools are handing out condoms during lectures about contraceptives and STD protection. Homosexuality is dealt with in nearly all schools. Group discussions, theatre, role-playing and visits to youth clinics are also more common compared to the national figures. In contrast to the result from the national survey it was shown that schools in Stockholm municipalities with more than 50% of the pupils coming from other ethnic background provided a more extended and varied sex education.

In a report from Tenasta/Rinkeby, an area with high percentage of immigrants, it was confirmed that sex education was given special attention in the schools. The need is obvious and the subject is integrated in many subjects.[72]

Review of the Present Situation

In late 1999, the National Agency for Education commissioned a review of sexuality education in 80 schools, 51 of them covering grades 6 to 9 of compulsory school, and 29 in upper secondary schools. Each school was visited over a few days by educational inspectors who observed classes, and interviewed headmasters, teachers and pupils.[73] The most notable impression of the review is the variations in terms of the goals, organization, and content of the education between as well as within schools.

Few schools have written plans and guidelines for sexuality education. Sometimes the head master, sometimes one single interested teacher is the main coordinator. The result is often uncertainty and frustration about the intentions or content of the education.

The following indicators of the content and quality of teaching were used in the evaluation:

- gender equality perspective
- a predominantly risk approach and/or affirmative approach and promotion of a healthy lifestyle
- one-way communication versus dialogue and the degree of pupils' influence over content and methods
- balance between factual knowledge and opportunity for reflection and exchange of opinions, values and feelings.

Less than 10% of the compulsory schools had a varied program for sex education for all pupils with well-defined goals. Usually more than one teacher was involved in the teaching. The younger the pupils, the more integrated and interactive the teaching, starting from the pupils' questions and experiences. In half of the basic schools, similar high quality education is offered, but only by some teachers. Therefore, not all pupils have access to the same standards of education. Finally, just over 40% of the schools offer sex education only in biology class with a focus on biology, risk behavior and prevention of diseases.

The same variations were present in upper secondary schools, where 20% had a broad program on sexuality and interpersonal relations for all pupils, related to the basic values of democracy, gender equality etc. In 40% of the schools, high quality sex education was one of several optional programs, so only some of the pupils had access to this type of sex education. In 38% of the upper secondary schools, the pupils had practically no sexuality education except one single day with workshops and exhibitions or a visit to a youth clinic.

The Pupils' View

The pupils' view on sex education differed. Those who had a rather conventional education thought that it was enough, we "already know everything from 'Veckorevyn' " (a commercial magazine with rating-lists, advises on sexual practices, etc.). On the other hand, those who have got a more varied and interactive education are satisfied or want more. Most valued was talking in small groups and for the girls to learn what the boys are thinking and vice versa. Visits by homosexuals who tell about their lives are also appreciated. The pupils had many ideas on content and structure of sex education and appreciated when the teachers listened to their suggestions. Among their proposals were both medical issues and cultural and ethical aspects of sexuality. A common view was that the issues must be taken seriously and be adapted to the pupils' age and experiences. For instance, the pupils in upper secondary rated the values clarification exercises as too childish—they would prefer more time to talk with their peers and their ordinary teachers on feelings, sexuality and relations.

Other studies on pupils' view on sex education in schools is scarce, but interviews indicate that what they want is a dialogue and discussion instead of lectures. They have already learned about facts, earlier or from newspapers and other media. What they are looking for is a chance of processing all this information, seeing it in the context of their own lives and discussing their personal opinions with others.[74]

Thus, school is an important provider not only of information, but also of standards for children and adolescents. All children in Sweden attend school for nine years and most of them for twelve years. The media, with a markedly frank attitude to sexuality, also sets standards. Facts and values are disseminated via newspapers, magazines, films, television and the Internet. Commercial magazines for youth contain articles and answer questions about sexuality. Public-service television also has programs for youth in which sexuality and gender roles, for example, are discussed.

Interventions on Sexual Behavior and the Socialization of Adolescents About Sex

Public health services, including information/education and preventive measures, are a responsibility for the county councils. Many county councils have a Health Promotion Unit with tasks that include preventive work and IEC (Information, Education and Communication) on sexuality, gender equality and fertility regulation. Specialized units for HIV/AIDS prevention, providing information/education on risk behavior and safe sex are also common.

Many municipalities have also set up health promotion units and appointed "health planners" who work on behalf of the local politicians. Activities at the community level are arranged in cooperation with municipal health, school and social authorities. Cooperation with the county health unit is also required, e.g. to support youth clinics and provide training of professional groups. County councils and municipalities also cooperate with NGOs at all levels (see below).

Stockholm County AIDS Prevention Program (LAFA) is the central unit for health promotion in the field of sexuality, including prevention of HIV/STDs and unwanted pregnancies (see below). LAFA arranges seminars at local youth clinics and promotes initiatives in primary care, for instance on services and counseling for various professional groups.

It was in the mid 1970s that matters related to sexuality and personal relationships began to be integrated with the family planning program in public health. Midwives working at maternal clinics were trained as counselors and, gradually, contraceptive services provided by midwives became accessible at public health centers all over the country. Health education activities to prevent unwanted pregnancies were initiated in many counties, using the experiences from a pilot project on Sexuality and Living Together, undertaken on the island of Gotland (see Part III,

page 29). These projects included education and training of personnel from the school, health and social sector, with an aim to reach young people through the professionals. In the health sector, midwives became actively involved, providing not only contraceptive services but also education and counseling on sexuality, gender and interpersonal relations in public health, not least as part of various types of youth friendly services.

In the late 1970s and throughout the 80s virtually every county council arranged regular courses in sexuality and personal relationships for professional staff in schools, public health care, etc. This is still being done in some places but on a much smaller scale. The preventive work has been decentralized in the second half of the 1990s. The argument was that local needs could not be adequately met by highly centralized activities. Many municipalities, however, have cut staff training grants because of financial constraints, resulting in less training opportunities for school and social welfare personnel.

At the national level, since 1992, it is the National Institute for Public Health that is responsible for health promotion work in the field of sexuality and health. This is done by coordinating inputs, supporting projects, personnel training, information campaigns and the production of information material. In 1995, the National AIDS Advisory Committee affiliated with the Institute produced a national policy for the prevention of HIV-infections and other STDs.[75]

The National Institute of Public Health issues two free publications: Hiv-aktuellt (HIV News) and Glöd (Glow). The latter is issued quarterly in an edition of 180,000, which makes it Sweden's largest periodical for youth. It is produced in consultation with an editorial body that includes young people and features such subjects as love, identity, sexuality, sport and alcohol. The journal is distributed free of charge through schools, youth clinics and leisure centers. Since 1999 it has also been available on the Internet.[76]

Teenagers can find heaps of material on sexuality in girls' magazines, commercial publications, the Internet, popular music, books and cartoons, movies, etc. Books with candid information for children from an early age are available on the market. Some novels for adolescents on love, sexuality and existential issues have been best sellers for years. On the public service channel of Swedish Television, a popular weekly program for young teenagers, called Bullen (the Bun), on sexuality, love and relations has been broadcast for the past 13 years. It contains music, interviews, life histories and short documentaries produced by young girls and boys. Questions are answered and a vivid dialogue with youth and young adults goes on in the studio.

Another intervention is a monthly magazine called Kamratposten (a peer journal) for schoolchildren between 8–13 with lots of information on love and being together, letters from the readers, cartoons on most subjects from birth to death, such as relations to parents, divorced single mothers, love, friendship, growing up, puberty, etc. The journal has been distributed at a low cost to young schoolchildren for many years. The content has adapted to new trends and it attracts the children today as much as their parents 20 to 30 years ago.

RFSU introduced an interactive site on the Internet in 1997 for questions on sexuality, contraception and STDs. Since then, the number of visitors to this website has successively increased; 1,000 in 1997; 2,008 in 1998; 4,097 in 1999 and an estimated 8,000–9,000 in 2000.[77]

"Ungdomsbarometern" (The youth barometer), an annual national poll on various youth issues, usually includes some questions on sexuality and living together. Of nearly 5,000 youths aged 16 to 25, 67% got their main and best information on sexuality, contraceptives and STDs from school. After that came the media, such as newspapers, radio, TV, and next were service providers. Parents were last on the list for factual information, and fathers were virtually invisible.

Asked whom they trust and want to talk to about sexuality and being together, 60% gave peers as their first choice, followed by their partner, and health personnel e.g. at youth clinics. Then comes their mother, both for girls and boys, and their father, mainly for boys.

When it comes to serious issues, e.g. pregnancy and abortion, young people tend to turn to their mothers. In a study of male partners to teenage mothers practically all of these expecting fathers had talked with their own mother to discuss the pregnancy. Only when they received their mothers' approval, did they decide to keep the baby.[78]

LAFA, which is Stockholm County Council's unit for promoting sexual health and preventing

HIV/STDs as well as unwanted pregnancies, targets youth, men who have sex with other men, immigrants and refugees. The unit provides the counties' urban districts and municipalities with analyses, material and research reports. It also regularly offers a number of courses on sexuality and personal relationships for professionals from municipalities in the county.

LAFA's work for youth is aimed at personnel in schools, leisure centers, social services, youth clinics, health and medical care, religious institutions, military units, sports clubs, etc. Much work is done on developing methods, including the production of a methodological handbook, *Röda tråden* (The main thread)[79] about different teaching methods for sexuality and relationships. A booklet that presents the female genital organs, *En hemlighet?* (A secret?), in words and pictures has attracted a lot of attention; the affirmative presentation is intended to promote women's self-esteem and ability to enjoy and control their sexuality.[80]

The youth clinics, of which there are about 200 in Sweden, are run by municipalities or county councils as part of their health-promotion work. Besides providing counseling and individual talks for youth (see Part III), the personnel are engaged in out-reach to schools and youth centers. Efforts to reach young men as well as women have been stepped up in recent years.

Health-promotion work for youth is accordingly undertaken in the first place in primary care, organized by the county council and municipal health units. Information about sexuality and living together is also provided by two NGOs, RFSU and RFSL, often in cooperation with or supported financially by national and local authorities.

RFSU was founded more than sixty years ago and has been advocating and lobbying for sexual and reproductive rights for many years. RFSU has a wealth of experience in sex education and prevention, is open for everyone but runs special activities for youth. It covers Sweden through ten regional sections that train information workers who are active in schools, leisure centers and other places where young people meet. It also provides sex information together with organizations for young immigrants and youth with functional disorders. In Stockholm RFSU runs a clinic with drop-in for youth as well as special clinical hours for young men. Methods for counseling and services are developed and tested at the clinic. The results are communicated throughout Sweden and other countries through RFSU's training programs and publications.

RFSL established in the 1950s, is an organization for homo- and bi-sexual men and women. It has local associations throughout Sweden. The Federation has a broad program that, since the advent of the HIV epidemic, includes major efforts for HIV prevention. The work for youth includes informing young people about homosexuality, mainly by having trained personnel visit schools, as well as support for young homo- and bisexuals in the form of special activities and groups. A local section for youth, RFSL Youth, was formed in 1999. One goal is to put homo-, bi- and heterosexuals on an equal footing. Ending discrimination and prejudice is seen as important also for prevention, in that people with positive self-esteem are more prone to protect themselves and others.

RFSU, RFSL and the National Institute of Public Health have worked jointly since 1989 on various summer campaigns for HIV prevention, with youth as the primary target. The Institute provides financial support and information materials, while trained information workers from the two NGOs engage in outreach activities—dialogues and condom hand-outs on bathing beaches, restaurants, discos, rock concerts, shopping centers and camping sites. The campaigns aim to improve knowledge and increase the use of condoms.

In conclusion, young people are a priority group for preventive work in Sweden. All young women and men receive sex education, mainly in school but also via other channels such as newspapers, poster campaigns and outreach activities. The preventive work is characterized by a positive view of sexuality and confidence in the ability of young people, through knowledge and talks, to take responsibility and make their own decisions. A prominent feature of preventive work in Sweden is that general measures, publicly financed, are implemented locally in cooperation between county councils, municipalities and NGOs. Outreach activities and no-fee youth clinics with hours that suit young people are evidence of the ambition to be available and side with young people on their own terms.

Part III. Reproductive Health Services for Adolescents

Reproductive Health Care in Sweden

Public health services for pregnant women and pre-school children have for many decades been the backbone of the Swedish primary health care system. In addition to antenatal care, provided at maternal health centers (MHC), other reproductive health services such as contraceptive services, and testing, prevention and treatment of sexually transmitted diseases (STDs), have been integrated in the program. The services are easily accessible, free of charge and provided by well-trained staff of midwives and obstetricians.

Contraceptive services are offered to men and women without restrictions in terms of age or marital status. For adolescents, contraceptive services and information on STDs are also offered at a growing number of youth clinics. Most of these clinics are located in the local community, publicly financed and staffed by doctors and midwives in public health. A few youth clinics are run by NGOs.

The availability of reproductive health services in primary health care and the promotion of youth clinics as a complement to general public services reflect society's recognition of its obligation to offer sex education and contraceptive services to young people.

The following description of reproductive health services for adolescents will deal with general health services and the services at the youth clinics, specially designed for adolescents. Public and private sector intervention projects will be described.

Swedish Policy for Provision of Primary Health Care

The goal of the Swedish public health system is to provide health services for the entire population on equal conditions. The county councils are responsible for financing and operating health and medical services, e.g. levying taxes for the required resources.

Primary health care is provided at public health centers. The services offered are prevention, health education, and treatment of diseases and injuries that do not require hospitalization. In addition to family doctors and general practitioners, primary care is provided by district nurse clinics, maternal and child health units and private doctors.

The patients' fees for outpatient care, by both private and public health doctors and nurses, are set by the county councils. The fees vary between 60 and 270 SEK ($8 to 40) for consultation and treatment, the highest for specialists in private practice. Maternal and child health care, including contraceptive services, is free of charge. Health and medical services for children up to the age of 16 are also free.[81]

Reproductive Health Services

Maternal health care (MHC), introduced in the 1930s, started as medical check-ups and social support to expectant mothers. The service providers were obstetricians, general practitioners and midwives. Information on family planning, in those days condoms and diaphragms, was offered not only to women after childbirth, but also to women who had never been pregnant. Very few young and unmarried women, however, dared to ask for these services.[82]

The introduction of oral contraceptives and IUDs in the 1960s placed new demands on the health care system. Eventually efforts were made to provide contraceptive services for women. After an initiative from RFSU (Swedish Association for Sexuality Education), the National Board of Health and Social Welfare in cooperation with

RFSU and the Swedish Association for midwives arranged postgraduate training for midwives who were already practicing antenatal care. After additional in-service training, the midwives were entitled to provide services including contraceptives, prescription of oral contraceptives and insertion of IUDs.[83]

In the 1980s, information on sexually transmitted diseases (STDs), including HIV, also became part of the preventive work of the maternal health clinics. Today, MHC is the dominant provider of integrated sexual and reproductive health services in the Swedish primary health sector.[84]

Today, the maternity clinics are staffed by midwives and doctors, mainly specialists in obstetrics and gynecology. The midwives are responsible for basic obstetric care, while the obstetrician acts as a consultant in case of risk-pregnancies or complications. Midwives provide reproductive health services, including antenatal care and postpartum care; preparation for child birth and promotion of breast feeding; contraceptive services and abortion counseling; testing, counseling and referral for treatment of STDs and HIV; and early detection of cervical cancer. Thus, all types of sexual and reproductive health services are accessible in public health. Only delivery care and surgical or medical management of induced abortion are not provided at the primary health level. The public health system is also responsible for reproductive health services to groups or individuals in need of special attention, such as immigrants, disabled people or young mothers.[85]

Maternal health care in public health is valued in the population; practically all pregnant women attend the antenatal program and many of the fathers take part in group sessions for parenthood preparation. There are no private clinics for delivery care. Contraceptive services are provided, free of charge, both by midwives in public health and by private practitioners. Midwives account for 80% of the services. Most adolescents use public health services, either at the health centers or at youth clinics.

Health Services for Adolescents

Health care for children and adolescents is provided free of charge at the primary health level. The following public units offer health and medical services for children and adolescents: 1) Child Health Services, including advice on breast feeding and nutrition, immunization and medical treatment for all children before school-age, 2) school health care in public education up to grade nine and to some extent also in upper secondary school, for counseling, health and medical care, education on sexuality and hygiene, including information on contraceptives, 3) child psychiatry units for consultation, observation and psychotherapy of children and youth up to 18, 4) reproductive health services, including counseling, antenatal care and contraceptive services at the maternal health clinics, 5) family doctors, pediatricians or private doctors for control and treatment of diseases such as diabetes or asthma and 6) youth clinics offering services and counseling for all kinds of health, social, and psychological problems, with the focus on sexual and reproductive health and rights.

Reproductive health services for adolescents are accessible in three settings.

• *Contraceptive services in public health*. Primary health services are equally accessible all over the country. Young people can turn to the local health center for reproductive health services such as pregnancy tests, antenatal care, abortion counseling or information and services on contraception, and for testing, contact tracing and treatment of STDs. Access to services for contraception or abortion is unrestricted in terms of age or marital status. Services are free of charge and confidentiality is ensured. Staff are under no obligation to inform parents of teenagers who seek consultation for pregnancy or birth control. The services are provided by general practitioners or female midwives. Practically all visitors for contraception are girls, while both girls and boys come for STD services. Young people are usually offered consultations in other settings or at other hours than the pregnant women visiting MHC for antenatal care.[86]

• *Integrated services for contraception and STDs*. Integrated services are also accessible in public health. Many counties have special projects directed to adolescents for STD prevention, including testing for HIV. These services are often integrated with information and education on sexuality, relationships and birth control. Joint programs and clinics for prevention of unwanted pregnancies and STDs are staffed by venereologists, gynecologists, midwives and social workers.

Outreach information and education in cooperation with the school and social sector are part of the activities.[87]

• *Youth clinics*. About 200 youth clinics are located over the country offering various types of counseling and health services. The youth clinics are staffed by midwives, social workers and doctors and mainly situated in main cities and towns, while there are very few in less urbanized or rural areas. Where available, the youth clinics, are the most popular sites for young girls and boys to go for advice or services on contraceptives and STDs. In areas without special youth clinics, youth friendly services are provided as part of the regular maternal health services in primary health care.

The youth clinics will be described here in detail as an example of reproductive health services for adolescents.

Youth Clinics, a Swedish Concept for Sexual and Reproductive Health Services

The first youth clinic, which offered medical and health services in a youth-friendly "open house" setting, started in 1970 in a middle-sized town with heavy industry and few opportunities for young women. It was followed by similar initiatives in other parts of the country and in the next ten years about 70 youth centers were established. The clinics had different schemes, adjusted to local needs among youth. Three main types were 1) clinics offering comprehensive health and social services, 2) clinics mainly providing contraceptive services and 3) clinics that focused primarily on abuse of drugs and alcohol among adolescents.[88]

HIV information to youth increased up in the late 1980s when the county councils received increased grants for HIV/AIDS prevention. At that time, a number of youth clinics focusing on STD prevention were opened in various parts of Sweden. Today, there are about 200 youth clinics in the country and practically all of them offer counseling on sexuality, interpersonal relations, information on safer sex and contraceptive services. The upper age limit varies with the general focus of the clinic; it is usually between 23 and 25 years.

Most youth clinics are run by the public sector, with county councils providing the major funding and responsibility often being shared between the county council and a municipality. Stockholm now has about 40 municipal youth clinics in the central area as well as in almost every suburb. The Stockholm School Administration is the principal administrator of youth clinics that are open to pupils from schools in the metropolitan area. There are also youth clinics affiliated with the Church of Sweden and the City Mission. The Stockholm clinic of the Swedish Association for Sexuality Education (RFSU) has a general section for both boys and girls as well as a section for young men.

All youth clinics are attached to the Swedish Society for Youth Centers (FSUM), which defines a youth center as "a forum where help can be given based on a holistic view of young people and their different needs of not only a medical but also a social as well as a psychological kind". The objective is "To prevent physical and mental ill-health; strengthen young people in coping with their sexuality and respecting themselves; and preventing unwanted pregnancies and sexually transmitted diseases".[89]

Attendance and utilization of services vary a lot from clinic to clinic and within regions. Statistics from FSUM, collected from 168 clinics, report 312,400 visits in 1998. Of these 74% were to midwives, 11% to social workers, 5% to gynecologists, 3% to general practitioners, leaving 7% to others, such as psychologists, public health nurses, pediatricians, etc.[90]

From the youth clinic in Falun, the principal city in the county Dalarna, it was reported that 95% of female and 18% of male adolescents, born in 1976 had visited the youth clinic for individual counseling at least once when they were 17 to 20 years of age.[91]

The staff at youth clinics apply the same confidentiality rules as all medical and health personnel. If a young adolescent asks for contraceptives or a pregnancy test, the midwife is not allowed to contact the parents or anyone else, even if the girl is under 15, which legally is the eligible age for intercourse. The midwife may encourage a young girl to talk to her mother in case of a pregnancy, but she cannot contact anyone without the permission from the girl.

• *Operation of youth clinics*. The youth clinics are usually located in separate premises with a youth-friendly interior. They are run as a sort of 'open house' and keep hours that fit young people's ability to visit or phone in, that is, afternoons,

evenings and during school holidays. Traditionally, those who use the youth clinics, especially for contraceptive counseling, are mostly girls. Boys account for 7–15% of visits, usually for STD testing or information.

There are variations in terms of operating hours and number of staff, but most clinics have the same functions and modes of operation.[92]

The most frequent reasons why young people visit a youth clinic are:

- questions about contraceptives, including drop-ins to obtain condoms free of charge;
- testing for pregnancy, chlamydia or HIV
- emergency contraceptives
- psychosomatic problems
- depression
- problems with parents
- problems in school, peer relations, mobbing, etc.

Most of the regular work is done by nurses/midwives, social workers/psychologists and doctors. The latter, including general practitioners, pediatricians, gynecologists, venereologists, are usually available for an hour or two per week for examinations, treatment and supervising the nurses/midwives.

Contraceptive services are mainly provided by midwives under the professional guidance of gynecologists or general practitioners. Midwives and social workers convey information and services for STD prevention. Most clinics try to employ men as counselors to provide information and education to boys.

The tasks of midwives at youth clinics include the following:

- individual guidance for girls and boys on contraceptives and STDs;
- testing for STDs, including HIV;
- talks in connection with results of pregnancy tests;
- abortion counseling or referral to maternal health clinic;
- talks about sexuality, the body, alcohol, and relationships in general and with peers, parents, etc.;
- assessing the need to refer to or consult a doctor, social worker or psychologist.

Social workers provide individual counseling sessions about:

- personal matters, including counseling and support for psychosocial problems;
- counseling and support when pregnancy tests are positive;
- information/education on risk behavior, partner notification and special counseling in connection with HIV testing.

In addition to personal medical services and counseling, the staff handles other matters as a team:

- education in sexuality and personal relationships, both by visiting schools and receiving school classes at the clinic;
- cooperation with professionals in schools and local social services;
- group activities in schools or recreational centers, arranging conversation groups for young women or men with particular needs, e.g. parenthood education for young expectant parents.

• *Outreach activities.* Outreach activities and developing contacts and cooperation with personnel in local schools, social services and recreation centers are important features of the work of the youth clinics.

One aim of the outreach activities is to attract those who do not come to the clinic by 'marketing' the clinic and its staff: "here we are, these are the things we can help you with, you're very welcome".

By visiting schools and participating in sex-education sessions, the staff of the youth clinic make valuable contacts with young people-including young men. These visits also complement regular sex education.

Youth clinics regularly arrange study visits for grade nine and high school (15–16-year-old) students. The female staff talk to the girls and male counselors to the boys. The visitors are invited to ask questions and the midwife talks about contraceptives and protection against STDs and about the tests and services offered.

Some youth clinics invite girls in grade six (13 years of age) for information on puberty and menstruation. This is particularly the case in areas where a majority of the young people are from immigrant families and where many of the girls evidently lack knowledge of these matters.

• *Evaluation of youth clinics.* A survey covering 9,000 youths, carried out at 70 youth clinics over a two-month period in 1990, showed that 93% of the visitors were female and that the same

proportion had had their first intercourse. Mean age at first coitus was 15.[93]

Asked how they had obtained their first information about the youth clinics, almost 50% said from a peer. Other sources were the health nurse in school (16%), a leaflet or a newspaper (15%), a study visit to the clinic (10%), mother (9%), a teacher (9%), hospital staff (5%) or sibling (3%). None had gotten the information from their father.

A recurrent problem is how to reach boys and get them to visit the youth clinics. Studies, including a look at two clinics in the Stockholm area, have shown that the broader the range of competence a clinic's staff can offer, the easier it is for boys to bring their needs.[94]

The things that young people themselves like about youth clinics have been studied with interviews and other techniques.[95] They include:

- availability, being helped quickly with what one needs help for;
- feeling free to talk about everything—that no problem is too insignificant
- being seen, being taken seriously
- professional confidentiality; grown-ups who care and are interested in young people
- being given as much time as one needs
- coming to a pleasant atmosphere
- counselors who give clear advice and keep their promises

To sum up, both qualitative and quantitative studies show that the youth clinics have gained the confidence of young people. The fact that the staff are bound by rules of confidentiality undoubtedly contributes to the clinics' popularity among young people. Many of those interviewed talk about the youth clinics and the staff as a major factor in their lives; not just for questions and worries about contraceptives and STDs but also about issues of sexuality, love and relationships with parents and peers. The youth clinics perform the functions of explaining, calming, and hopefully, making young people feel more self-confident and raising their self-esteem.

Finally, here are some quotes from young people on what the youth clinics mean to them[96]:

> "If the youth clinic were to close for the summer, I'd never go to the maternity clinic. Without any warning, you may meet mummy there with my little sister, or an aunt or a neighbor. And you really don't want that to happen. My parents do in fact know I come here but it would still be so awful to hear: 'well, well, and what brings you here?" "I ... no ... I'm just checking whether I'm pregnant" (Nina, 16).
>
> "And then they're so understanding, they don't think ... a stupid little teenager-things like that just happen, you'll soon grow. They take me seriously, they listen properly. They don't treat me like a child and I think that's really good" (Anna, 21).
>
> "You're too young, mummy says. Then it's really wonderful to be allowed to spill it all out here and get straight answers without anyone thinking you're too young" (Linda, 19).
>
> "They know at once who it is when I phone. We have talked a lot over the years. I've phoned and asked for advice about many things. So it's not just a matter of checking what's obligatory once a year; I've been able to phone and ask about many other matters" (Hanna, 24).
>
> "I've talked a great deal with my parents but some things can't be talked about. I think it's more comfortable to talk with someone who takes an active part, isn't partial, someone outside. It's *me* who goes there, it's *me* who gets support" (Nina, 16).

• *Access to services and choice of method*. Practically all adolescents in Sweden today have access to quality contraceptive services. Even in places where there are no special clinics for young people, the methods and procedures that have been developed at the youth clinics are applied in counseling at health centers and maternity health clinics.

Although the most common choices for adolescents are condoms or some type of oral contraceptives, a number of contraceptive methods are available at youth centers as well as at other family planning clinics. These include:

<u>Barrier methods</u>

- male condom
- diaphragm + spermicides

<u>Hormonal contraception</u>

- combined oral contraceptive pill
- mini-pill, progestagen-only pill
- emergency contraceptives, Yuzpe method
- injectables, Depo Provera (DMPA), for administration every three months

- subdermal implants, Norplant with levonorgestrel, for five years protection

Intrauterine device, IUD

- copper-bearing IUDs, Nova-T and TCu 380A
- hormone–releasing IUD (levonorgestrel)

Services may also include information on traditional methods, such as withdrawal, breast-feeding, safe periods and periodic abstinence.

Contraceptive services are free of charge. Oral contraceptives and injectables must be prescribed by a physician or a midwife. They are delivered at pharmacies and subsidized like other pharmaceutical drugs. Emergency pills can be bought without prescription. Oral contraceptives for thirteen months cost about 280 SEK ($34 US). In many counties, however, the price for the pill is reduced for young women, who may have to pay around $10 US for a 12 month supply. Condoms are easily available at supermarkets, gas stations or pharmacies at market price, i.e. a dozen for 60 SEK ($8 US). To some extent condoms are provided free during consultations at school health or youth clinics.

When it comes to contraceptives to young women, the policy among service providers in Sweden was expressed at a Nordic workshop as follows[97]:

> "Sexually active young women require high contraceptive efficacy as their fertility is considerable, and a large proportion of pregnancies in this age group lead to abortion. Methods used in this age category should, furthermore, be rapidly reversible and carry no threat to future fertility ... The method primarily recommended for young sexually active women is often a combined oral contraceptive. Mini-pills are, however considerably less effective in this age group because of their markedly lower hormone dose. The pills have furthermore to be taken with great regularity…"

Individual counseling and services for a number of contraceptive methods are provided at youth clinics and at health centers. However, some of the methods are less suitable for young women and seldom prescribed. The aim of individual counseling is to enhance a free and informed choice of method. The role of the midwife is to give information and investigate any medical contraindications and to share her experiences about which methods are most suitable in relation to age and life situation.

The most common choice among young people are condoms and combined contraceptive pills. Due to risk of infection, IUD is not recommended as a first choice for young women who have never been pregnant. Norplant is seldom recommended or asked for. If the youth center does not have the equipment and/or trained gynecologist to insert an IUD or Norplant, the girl can be referred to other units. Injectable, Depo-Provera, is not a popular method among teens, because of side effects such as gaining weight, acne and amenorrhoea. It may be recommended for mentally retarded girls, who have difficulties remembering to take the pills. When the choice is condoms or oral contraceptives, the midwife also gives information on emergency contraceptives. Packages of post-coital pills can be provided on demand or bought over the counter in pharmacies.

Depending on life-style, self-esteem and the particular sexual relation, adolescents face several problems in relation to the choice and use of contraceptives. They are always offered a follow-up visit after a period of practicing the chosen method. Then they can ask about side effects, talk about concerns regarding their own and their partner's health, and talk about how to protect one's self against both pregnancy and STDs.

STD prevention includes not only education about and provision of condoms, but also screening and testing, contact tracing and free treatment in the case of a positive test. Young women and men are aware of the importance of contact tracing and are willing to give notice, so that their partner can have a check up and be treated as soon as possible.

Many adolescents come to youth clinics to be tested for chlamydia as well as HIV 'just to be on the safe side.' If their partner has been abroad or had a sexual relationship with someone else, it rings a bell. Thus, rather than being a sign of risky behavior, repeated testing may indicate a responsible attitude toward their sexuality.

Young people asking for advice are met by the staff with respect. The health and social personnel are ready to talk with them about what they choose to bring up. They appreciate that young women and men, if they fail in protecting themselves, take responsibility by asking for emergency

pills or a chlamydia test.

Two examples from a Swedish youth clinic, told by the midwife[98]:

> "When a 16-year-old girl comes to me for a safe contraceptive, my role is to guide her to find a method she can trust. I give information on different contraceptives. If she chooses the pill, I give her a prescription and tell her how to use the pill and how to act in case of side effects. I can offer a gynecological examination if she wants a check-up. If she has had intercourse without a condom, I offer her a test for chlamydia and I may also talk about the importance of condoms for protection against STD transmission."
>
> "In short, I support her with service and my professional knowledge. I do not question the fact that she is sexually active, but appreciate that she wants to take responsibility for her sexuality."
>
> "A young couple, a girl of 17 with her 20-year-old boyfriend, come to the clinic and ask for STD tests. They have had a relation for two months and do not want to use the condom any longer, so she is considering the pill for protection against pregnancy. I provide the services they ask for. Then I invite each of them for individual counseling, to give them the opportunity to talk in privacy about questions they may have, e.g. fear of STDs or side-effects of the pill. Although most visitors to the youth clinic are girls, some are couples who want to talk about their relationship."

How to Offer and Motivate Youth to Use Services

Information and education about sexuality and relationships, and where to go for services are provided to adolescents in many ways, in the first place through schools. In addition to regular sex education, school health care offers individual counseling and referrals to a doctor or youth clinic. Information about clinics and when they are open is posted on notice boards.

Information, Education, and Health Promotion

Health education for young people about sexuality and personal relationships is arranged at various levels as described previously.

Folkhälsoinstitutet, FHI (National Institute for Public Health) in its program 'Sexuality and Health' produces information material, develops methods for health promotion and initiates research projects. The national survey on sexual behavior in 1996 was conducted and financed by FHI, and a public health policy for combating STDs and HIV/AIDS has been formulated.[99] Recently the Institute issued two publications to be used by professionals working with IEC (Information, Education and Communication) on sexuality, health and gender equality. One is a book commenting on and illustrating some of the abundant material from the national survey on sexual behavior, the other is a review of recent Swedish studies on youth and sexuality.[100]

Public information, education and communication on health issues are among the responsibilities of primary health care. Most counties have special programs for promotion of sexual health among adolescents, including outreach activities, campaigns and exhibitions in schools and youth clubs. LAFA, the Stockholm County Council AIDS prevention program, is such a unit. Among a number of IEC materials from LAFA is a manual for promotion of sexual and reproductive health. This handbook has been developed, tested and applied in an extensive program for education and training of health, school and social service personnel at the community level.[101]

RFSU (the Swedish Association for Sexuality Education) is a non-profit organization, partly financed by RFSU's company that sells and distributes condoms. This NGO has a broad agenda for public sex education, including campaigns for safer sex and condom use.

A common characteristic of all the information programs and projects in schools, health care and the social and recreational sector is that the information about sexuality and personal relationships is invariably combined with practical advice and instructions about where (in this case) adolescents can obtain services for contraceptives and STDs.

Content of Messages Directed to Adolescents

The content and aims of the educational work have been previously described. The common ground is an emphasis on education, reflected in the fact that there has been sexuality education in public school for more than 40 years. Like in the

school system, the aim for popular information/education is to increase knowledge and understanding of the health aspects of sexuality while maintaining an open-minded, respectful and positive attitude towards sexuality.

An example of public information activities is the summer campaigns that RFSU has run for many years. The outreach work is done mainly by RFSU's local branches and their peer-educated volunteers.

The idea is to get in touch with people during the summer, when they have more free time and are receptive to new sexual contacts, and start talking about sexuality and human relationships. The campaigns, based on 'Love Power' as the overall concept, are designed by an advertising bureau in collaboration with the National Institute for Public Health. RFSU and RFSL (Swedish Federation for Gay & Lesbian Rights) are in a position to influence the content and design.

The aim is to talk about sexuality, relationships and prevention in a way that brings about a 'good dialogue'. Various types of 'icebreakers' (picture postcards, key rings, condoms) are used to initiate the encounters. There are also informative handouts about emergency contraception, STDs, abortion, etc. The message, in connection with contraceptives as well as the concept 'safer sex', is to affirm sexuality and at the same time underscore responsible behavior: "Desire and sexuality are OK as long as you go along on your own terms."

Policies and Intervention Programs

This section describes interventions and health promotion projects in relation to youth sexuality and reproduction. Some of them are nation-wide, initiated at a governmental level, others are part of the responsibilities of the health, school or social sector and some are initiated by networks and NGOs on a grass roots level.

A National Program for the Prevention of Unwanted Pregnancies

An example of a significant and successful social initiative in the sphere of reproductive health is the abortion prevention program launched in connection with liberalization of abortion.

In the early 1970s, abortion was a heated issue in the public debate in Sweden. New legislation on abortion was under preparation and radical groups called for women's right to abortion. Rapidly increasing abortion rates, particularly among teenagers, were used as arguments by the opponents to liberalization.

In 1974, after years of public debate, preparations and considerations, Parliament approved a new Abortion Act, which gave women the right to choose an abortion up to the end of the 18th week of pregnancy. The Act was combined with a law making contraceptive services free of charge and subsidizing the price of contraceptives, the idea being that in legalizing abortion, society also had an obligation to make contraceptives equally accessible. Contraceptives should be the primary means of fertility regulation, with legal abortion as a last resort.

Prior to the change in legislation, a number of preventive efforts were launched. Information and education were seen as the main instrument to bring about responsible behavior and to enhance an open and positive attitude to sexuality. The National Board of Health and Welfare received government funds for a health education program on sexuality and interpersonal relations, with the goal of preventing unwanted pregnancies. Special funds were also allocated to assist women, youth and immigrant organizations in providing information on sexuality and birth control.[102]

A key component of the efforts to prevent abortion was a community-based three-year project on Gotland, one of the big islands in the Baltic. Methods for communication and information were developed and tested, the abortion issue was approached in the context of sexuality, gender roles and interpersonal relations. Training and education were fundamental, including courses for all categories of social, school and health personnel. The goal was to tackle the problem of unwanted pregnancies and reach the public through the professionals.[103]

Exchange of experience and cooperation across professional borders were encouraged. When working with teenagers, the aim was to convey a positive attitude to sexuality. Similar projects were initiated in other counties in Sweden in the period of 1977 to 1980. One of the lasting effects of these activities was a more open, relaxed attitude in society toward teenage sexuality, as well as a general decline in teenage fertility for ten years, from 1975 up to 1985 (see Part I, page 7).

Parallel to the education program on sexuality and interpersonal relations, contraceptive services

were expanded throughout the country as part of the maternal health services, with midwives as service providers. Government subsidies also aided the establishment of a number of youth clinics that provided information and counseling for young people. Thus, prevention of unwanted pregnancies by sex education and contraceptive services became an integral part of the public health system.[104]

In 1980, a government subcommittee was appointed to assess the outcome of the 1974 law on abortion and the associated prevention program. The committee reviewed the abortion trends and confirmed that the overall abortion rates had not increased and that illegal abortions had stopped entirely. Abortions were now performed at an earlier stage, which meant fewer risks and complications for women and less stress for medical personnel. The report stated that women were not using abortion as a means of family planning and that abortion prevention efforts had resulted in a sizeable reduction in the number of abortions performed on teenagers.[105]

• *Interaction between NGO and government.* The origins of the preventive program in the 1970s demonstrates the role an NGO can play to bring about social change. The Swedish Association for Sexuality Education (RFSU), founded in 1933, has a long tradition of popular education on sexuality, reproduction and gender issues. RFSU has also been instrumental in a number of reforms, such as sex education in school and the provision of contraceptive services.

In the 1970s, RFSU was active in lobbying for women's right to contraceptive services as well as abortion on demand. One of the proposals from RFSU, to improve the quality and access to contraceptive services for young women, was that public health midwives should act as service providers. This initiative led to a training program for all midwives working in antenatal care, carried out in collaboration between the National Board of Health and Welfare and RFSU.[106]

This was the start of a process to place the main responsibility for contraceptive services on primary maternal health care. RFSU also started one of the first youth clinics in the country, staffed by midwives. Over the years this clinic has developed strategies and methods for reproductive health services for adolescents. At the same time, the application of these ideas throughout the health system called for cooperation with the health authorities. Only then could sustainable services be secured for the entire youth population.

Integrated Services for Sexual and Reproductive Health

In the late 1980s, a project to coordinate resources from venereological and obstetric disciplines in Stockholm was carried out by the AIDS Prevention Unit of Stockholm County Council (LAFA). Clinics for education and counseling on sexuality and interpersonal relations were set up in four district hospitals, staffed by gynecologists, venereologists, midwives, social workers, nurses and secretarial staff.

This was a response to a recent increase in the frequency of STDs in the county, in particular chlamydia among young adolescents and a rising rate of abortions, above all among 25–30-year-olds, but also among teenagers. The project therefore focused mainly on youth and aimed to use education and easily available services to reduce both the number of teenage abortions and the incidence of venereal disease.

The first clinic, which served as a model for the others, was opened in 1988. Since 1992, Stockholm County Council allocates about 8 million SEK a year for what are now five clinics. The education of personnel from other social sectors, undertaken at the clinics, has been an important part of the project; over the years, it has covered a very large proportion of the staff in local health care and schools. Cooperation has been strengthened between disciplines and social sectors involved in work with youth.

Since the clinics were established, the statistics show that the incidence of abortions as well as STDs has declined in the Stockholm area. Although various interim reports and project assessments have shown improvements in the quality of care and an increased attendance at the clinics, it is not possible to determine to what extent the favorable health indicators are related to the preventive efforts. The reports are intended to spread experience to others who are working on sexuality and health.[107]

Enhancing Access to Contraceptives by Reduced Price

The number of teenage abortions in Sweden increased in the late 1980s after a decade in which

the pregnancy rate for the under-20s had fallen. This was accompanied by a decreased use of the pill that was attributed in part to a higher cost in connection with changes in the public health insurance system. The price of a three-month prescription of contraceptive pills had become equal to a whole year's supply prior to reforms. Several youth clinics reported a rising number of teenage abortions occasioned by discontinuation of the pill. The reason given for discontinuation was, in many cases, the cost. Trials with free or subsidized pills for young women were carried out in various parts of the country. A number of youth clinics took an active part in these projects with a view to increasing the use of contraceptives to prevent unwanted pregnancies.

The trials were assessed by the Epidemiology Center of the National Board of Health and Welfare.[108] A comparison of the abortion trend in 'subsidized' districts with that in control districts showed a decreased frequency of abortions in all but one of the 'subsidized' districts, though in almost half of these cases the changes were small. The differences within the group of subsidized districts suggest that the best effects were achieved when the subsidy was combined with other preventive measures. It was concluded that the increased cost of the pill is one, but not the only, reason why use of the pill had decreased among young Swedish women.

RFSU Clinic for Young Men

Most health clinics dealing with sexuality, including youth clinics, are clearly female dominated. It seems to be totally self-evident that, for counseling or medical examination, young women have the right to meet a person of the same sex, while a young man seeking information for the first time about his genitals and sexuality is expected to accept a female school nurse or a midwife at a youth center.

Since the young men who visited the clinic run by the Swedish Association for Sex Education (RFSU) were likewise treated by female counselors, the idea took shape to establish a specialized clinic for young men, a kind of targeted youth clinic. It was felt that teenage boys and young men would find it easier to seek help on sexual matters and complaints if they had a clinic of their own, with male personnel to turn to.

The RFSU Clinic for young men started in 1990 with the aim of providing better care for men who had already visited the clinic, and to make the clinic an obvious alternative for young males.

Since it was known that young men's questions often concern STDs and (usually quite normal) bodily variations, it was regarded as important that a high level of medical expertise be available. As the goal has consistently been to provide advice on all matters concerned with sexuality, considerable weight was placed on collaboration with the RFSU Clinic´s resources for sexual counseling.

Ever since the clinic first opened, there has been a need for longer hours. It started with two hours of venereological treatment and four hours of nursing. Today, it is open for seven hours per week. The clinic´s staff consists of two registered nurses (15 hours) and one venereologist (5–6 hours), all male, and one assistant nurse and one receptionist, both female. Clinic hours for young men are Monday afternoons between 12.30 and 19.30. Visits are made by appointment and drop in. The clinic also has an open telephone line for one hour each Monday.

At the outset in 1990, young men made up about 7–8% of those who visited RFSU's clinic (including both the general and young men's sessions); in 1999, the figure is 30%.

The reason that the clinic is so attractive is that counseling is offered from a male perspective. If clinics with male counselors are available, young men will come.

After nearly ten years of experience, it is obvious that all preventive work in the sexual arena is based on good information. If they are to be involved, boys and young men in preventive work have to recognize themselves in the message. In the case of young men, this can most simply be achieved by providing explicit anatomic and physiological knowledge that offers answers to the questions they are harboring.[109]

• *Results from two Investigations among male visitors at the RFSU Clinic*. Two surveys were carried through in 1996: 1) questionnaires filled out by 299 male visitors before and after the consultation/examination, and 2) reviews of case records on 969 men, with forms filled by the consulted doctor/nurse.

- the average age of visitors in the first study

was 24, in the second 22;
- 76% of visitors were under 26
- half of the visitors stated their visit was for a medical difficulty/complaint
- a third did not know where they would have gone if they had not come to the clinic; 5% stated they would not have gone anywhere at all
- a quarter of those reporting "no symptoms" had a disease diagnosed at the medical examination
- 11% of the chlamydia tests (602 cases) were positive
- virtually all visitors reported heterosexual relations
- about half of the men had had sexual intercourse during the week prior to their visit; 22 had not made their sexual debut
- less than 20% of respondents stated that they always used condom; 47% reported having used a condom for the first intercourse with their latest partner.

Introduction of Emergency Contraceptives

Since 1990 the RFSU clinic, with full support from the board of RFSU, has been active in advocating emergency contraception. Postcoital intake of one dose of contraceptive pills is a safe and effective back up to other contraceptives, but it took a long time for the method to be accepted by the medical profession and for the formula to be officially registered as a contraceptive method.[110]

RFSU has led the campaign in Sweden, on several fronts, by spreading information to professionals and the public. In March 1991, RFSU arranged a groundbreaking seminar and subsequently printed a brochure for national distribution.

The staff at the RFSU clinic took every opportunity to inform the media and approached the Medical Products Agency (MPA)—the Swedish equivalent of the U.S. Food and Drug Administration (FDA)—to get them to consider the registration of emergency contraception. RFSU also wrote to the pharmaceutical companies and asked them to apply to the MPA to get the oral hormonal pills registered as PCC (Post Coital Contraception).

The midwife at the clinic informed midwives at a national conference held by the Association for Swedish Youth Clinics and was also invited to lecture at a seminar on adolescents, pregnancy and abortion, held by the Save the Children Fund.

An RFSU gynecologist wrote an article for the Journal of the Swedish Medical Association. He also held a number of lectures for both physicians and midwives, including at a national meeting for midwives and gynecologists in April 1993. On this occasion, emergency contraception was officially recommended by MPA. The national recommendations are for the intake of hormonal pills (the Yuzpe method) and postcoital IUD insertion within five days of unprotected intercourse.

The contacts with the media have been of great importance for spreading the information. The emergency method has been presented as front-page news in the largest Swedish morning papers and has also been mentioned in the evening news on television. Several newspaper articles have presented the method of postcoital contraception in a positive way.

Since December 1993, the National Institute of Public Health has taken over from RFSU the printing and distribution of the brochure, which is now distributed to public health and youth clinics over the country.

In 1993, when the method was officially recommended, one problem remained. According to MPA, midwives were not allowed to prescribe emergency pills, even though they are authorized to prescribe hormonal contraceptives. RFSU, the Association of Swedish Midwives and the National Institute of Public Health requested the MPA to investigate the reason for the decision. They expressed their concern about the method's availability being limited, if midwives were not entitled to prescribe and provide it. Was it just an oversight by the official authority, fear of "misuse" of the method or a doubt that midwives could handle it?

There have been concerns in the public debate and among some service providers that frequent use of the "day-after pill" could encourage promiscuity. The ongoing international misinformation on emergency contraceptives as equivalent to abortion has been echoed in some anti-choice campaigns. As late as in June 1999, the leading Swedish daily newspaper had an informative and correct article on the new gestagen-only-pill for PCC. The headline on the front-page, however, said: "No side effects of the new abortion pill".

• *The situation today*. The official recommendation of PCC by MPA in 1993 was followed in May 1995 by the permission for midwives to prescribe the pills, registered for emergency contraception. The information and official recommendation have been well received by gynecologists and midwives as a new complementary method to prevent unwanted pregnancies.

RFSU's work to promote the use of PCC has continued. Women and service providers need information on how and when to use the method and where it can easily be obtained. In June 1999, RFSU initiated a hearing to present a new preparation of emergency contraceptive pills, with only gestagen. In early 2000 this levonorgestrel method was registered in Sweden for PCC. RFSU advocates that this method is highly reliable and without side effects and should be easily available. Finally in April 2001, MPA approved emergency contraceptive pills to be sold without prescription over the counter in pharmacies.

• *In conclusion*. Today, every clinic with youth friendly services offers emergency contraception as a back up if regular contraceptives such as condoms or the pill fail. There is no risk of "misuse" in the sense of women using PCC instead of other contraceptives. Rather, a consultation for PCC in an emergency situation is an opportunity to provide services about other methods.

Part IV. Public Policy and Programs for Disadvantaged Groups

The economic situation in Sweden has changed from a boom in the 1980s with high employment and generous social welfare benefits to a period of economic stagnation and rapidly growing unemployment. A realignment program in the early 1990s, aimed at restoring the Swedish economy, included drastic savings in the public sector and cuts in almost every area of the welfare system, e.g. reduced levels in the sickness and social insurance schemes. In recent years unemployment has been decreasing, rapidly but unevenly. Not until the year 2000 was a reduction of unemployment also seen among young people. Child allowances and income-related benefits for parents have almost been restored to their earlier levels.[111]

As mentioned previously (Part I, page 7), one effect of the economic crisis in the 1990s has been a decreased birthrate, mainly due to a postponement of childbearing among women under 30.[112] Women with very low income and no stable links with the labor market, due either to unemployment or to studies, have the lowest birthrate of all.

Those affected most negatively in the present economic situation are above all people without a foothold in the labor market; immigrants who do not speak Swedish; young people with a low education and, among them, single mothers in particular.

In this section, we will focus on young people in these circumstances and on society's efforts and initiatives to encourage and support disadvantaged subgroups.

Economically, Socially or Culturally Disadvantaged Adolescents

In the 1990s it became less feasible for young people to earn a living and settle into a home of their own. More women and men than before in the younger generation are financially dependent on their parents or have to rely on social cash benefits.

Income and Welfare

In 1995, one third of young women and men under 20 had no income from paid work, whereas in the age group 20 to 24 over 90% had at least some income (from work, self-employment or capital) (Table 11). Practically all employed people under 20 are in the lowest income group, with less than SEK 100,000 (US$ 11,000) a year.

Table 11. Income, women and men, ages 16 – 19, and 20 – 24, percent age distribution, Sweden 1995

	16 – 19 years			20 – 24 years		
Income level	Women (197,028)	Men (207, 130)	Total (404,158)	Women (284,543)	Men (295,628)	Total (580,171)
No income	32.5	34.0	33.3	6.9	7.9	7.4
Low (< 99,900/year)	66.9	64.4	65.5	53.2	45.9	49.4
Medium (100,000 – 159,000/year)	0.7	1.3	1.0	33.0	25.6	29.1
High (> 160,000/year)	0.0	0.3	0.1	7.0	20.8	14.0

Table 12. Type of income, youth, 18 – 24 years, percent, Sweden 1990, 1994-97

Type of income	1990	1994	1995	1996	1997
From paid work only	41.1	15.8	18.3	19.9	19.3
Work + social income*	53.1	62.1	61.6	58.5	59.0
Social income* only	3.8	18.9	16.9	18.1	17.9
No income	2.0	3.2	3.2	3.6	3.7

*Includes study benefits, parental leave, sick leave, unemployment compensation, rehabilitation, student allowances etc.

Table 13. Percentage of people receiving social benefits, three age groups, Sweden, every second year 1990 – 98

Age group	1990	1992	1994	1996	1998
18 – 19 years	8	12	14	13	12
20 – 24 years	10	12	17	18	18
25 – 29 years	10	11	12	11	10

Table 14. Percentage of under 25s living with parents, trends in the 1990s

Age group	1990	1994	1996
16 – 17 years	97	98	98
18 – 19 years	79	85	86
20 – 24 years	30	36	37
25 – 29 years	6	9	10

Most people between 20 and 24 are in the lowest or medium group, although men generally have somewhat higher incomes than women. Only 7% of women, but 20% of men, are in the highest group, i.e. earn more than SEK 160,000 (US$ 19,000) a year.[113]

Most young people have to supplement their earned income with study allowances, social cash benefits, etc. From 1990 to 1994, the proportion of young people aged 18 to 24 relying on social benefits rose and those with earned income dropped from 41 to 16% (Table 12). From 1995 to 1997 the proportion with an earned income tended to rise, but dependence on social benefits, partial or complete, hardly changed.[114]

During the 1990s, a growing proportion of the under 25s had at some time had social cash benefits either as their only income or as a complement. The increase was most marked up to 1994 (Table 13). Dependence on social welfare has stabilized or declined slightly in recent years, reflecting better employment opportunities even for young people.[115]

Housing

Swedish young people have traditionally left the parental home at a young age. The move usually takes place between the ages of 18 and 21. Women usually leave home earlier than men. In the 1990s many young people have had to postpone their decision to leave home, partly because they cannot afford to pay the rent, partly because there are no accommodations to find. More young people live at home today than at the beginning of the decade.[116]

Most school children up to age 18 live in their parental home. Of those aged 18–19, a high proportion, higher in recent years, also stay with their parents. Those in their early 20s who used to move to a dwelling of their own, nowadays more often live with their parents (Table 14). The reasons for this trend include reduced social benefits and uncertainty about employment.[117]

Unemployment

The proportion of youth in the labor force (includes employed or unemployed seeking employment) decreased markedly in the mid-1990s (Figure 6, Table 15, page 43). Moreover, unemployment increased among those who had had a foothold in the labor market. From 1990 to 1998 women and men between 20 and 24 reduced their labor force participation from over 80 to 63%.[118] Single mothers, young single mothers in particular, are identified as having suffered notably in the present situation of unemployment and strained economic means.[119] Labor force participation among single mothers between 20 and 24 (with children under 7) dropped more markedly than in the whole age group (Table 15). Their participation is higher than that of youth between 16 and 19, but showed the same downward

Figure 6. Labor force participation, percent, youth 16-19 and 20-24, 1987 to 1998, single mothers 20-24, 1989 to 1999

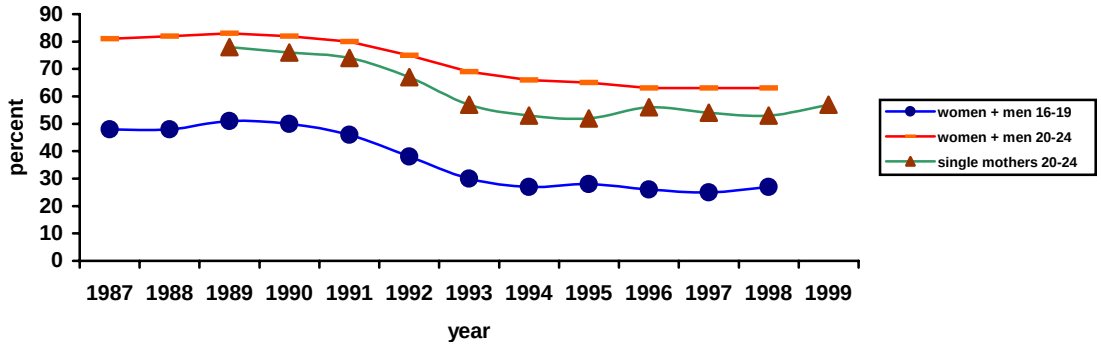


Figure 7. Unemployment as a percentage of labor force participants

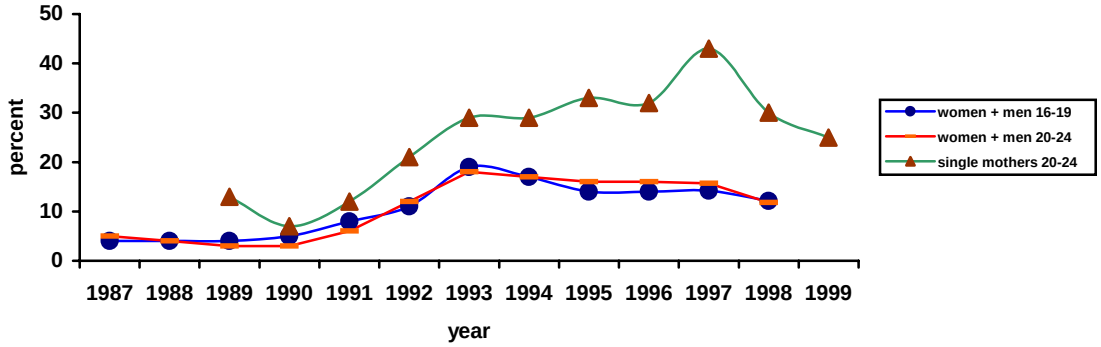


Table 15. Labor force participation, percent, youths 16-19 and 20-24, 1987 to 1998, single mothers 20-24, 1989 to 1999

Year	Women+men 16-19	Women+men 20-24	Single mothers 20-24
1987	47.7	80.7	-
1988	48.1	82.1	-
1989	50.5	83.0	78
1990	50.2	82.3	76
1991	45.5	79.6	74
1992	38.0	74.6	67
1993	29.7	68.5	57
1994	27.3	65.8	53
1995	28.3	65.3	52
1996	25.9	63.2	56
1997	24.6	63.0	54
1998	26.6	62.7	53
1999	-	-	57

Table 16. Unemployment as a percentage of labor force participants, youths 16-19 and 20–24, 1987 to 1998, single mothers 20–24, 1989 to 1999

Year	Women+men 16-19	Women+men 20-24	Single mothers 20-24
1987	4.1	4.8	-
1988	3.5	3.6	-
1989	3.5	3.0	13
1990	5.0	3.1	7
1991	7.6	6.1	12
1992	11.3	11.5	21
1993	19.4	18.1	29
1994	16.6	16.8	29
1995	14.0	15.7	33
1996	14.3	16.1	33
1997	14.2	15.7	41
1998	12.1	11.8	29
1999	-	-	25

trend in the early 1990s, followed by a slight increase in the late 1990s (Figure 6).

The increase in unemployment among those with a job in the early 1990s was more rapid among young single mothers than for young people in general (Figure 7, Table 16).

Since the mid 1990s the general unemployment rate among youth has been unchanged or tended to fall.[120] The unemployment rate for single mothers aged 20 to 24 peaked in 1997, followed by a fall in the next two years (Figure 7).[121] The situation for teenage mothers will be further discussed after a description of social welfare with reference to young people.

General Social Welfare with Regard to Children and Young People

The Swedish social welfare system is of special importance for children and youth in three areas: education, the health sector and the social welfare system, including parental insurance.

The Swedish School System

• *Compulsory basic school*. The Swedish school system comprises the nine-year compulsory basic school for all children between the ages of seven and sixteen years. The municipal authorities are responsible for organizing and planning the content of school education, subject to the compulsory school curriculum adopted by the Government. Since 1998, the curriculum also includes pre-school education and leisure time activities. The local school authorities are required to organize preparatory school activities for all children from the year of their sixth birthday until school entrance and open centers for pupils after school hours.[122]

• *Voluntary schools*. Voluntary schools comprise upper secondary school, municipal adult education and education for mentally handicapped adults.

Tuition in schools is free. Neither pupils nor their parents usually incur any costs for teaching materials, school meals, health care, school transport, etc.

• *Upper secondary school*. Almost all pupils attending compulsory basic school continue directly to upper secondary school, and almost all complete their upper secondary schooling within the three years. Upper secondary school is organized into three-year national programs or individual programs which are intended to provide a broad-based education. In 1996/97, 56% of adolescents applied for vocational training programs and 44% for programs preparing for higher education.[123]

Upper secondary school for the mentally handicapped provides vocational education in national, specially designed or individual programs in a similar way to the regular upper secondary school. The programs in the upper secondary school for the mentally handicapped are of four years duration.

Although only nine years at school are compulsory, twelve years of basic education is nowadays the norm: 93% of those aged 16 to 19 are attending upper secondary school.

• *Adult education*. Young persons are entitled to enter upper secondary school up to the age of 20. Above that age they can choose between various forms of municipal adult education. This comprises regular adult education (komvux) and education for the mentally handicapped (särvux).
• *Swedish for immigrants*. Swedish for immigrants (sfi) is intended to confer knowledge of the Swedish language and of Swedish society. The municipality has an obligation to offer sfi to all newly arrived adult immigrants.
• *University and colleges*. In the 1990s, society gave high priority to an expansion of universities. University tuition is free of charge. There are universities and colleges at more than 20 centers around the country. Almost a quarter of pupils goes on to higher education within three years of leaving upper secondary school. More women than men attend universities.[124]

The proportion of adolescents attending universities has risen continuously in the 1990s. Behind this is the present difficult labor market situation; many adolescents choose to study instead of looking for a job. They are also aware that graduation from upper secondary school is no longer enough to qualify for employment.[125]

The recruitment to higher education is still socially skewed, especially for university programs that require higher credits/marks for admission. Already in upper secondary school a higher proportion of middle and upper class students apply for collage-preparatory studies even when they have rather bad marks. At the same time, pupils from blue-collar families choose the vocational programs even when they have good marks.[126]
• *Study allowances*. Between the ages of 16–20 the financial support for those in upper secondary school or equivalent education is SEK 750 (88$) a month, which matches the general child allowance to all children up to the age of 16. From the age of 20, study support and study loan can be obtained for studies at the university level or equivalent education up to a monthly maximum of SEK 1,973 ($230) as support and SEK 5,125 ($600) as a loan. The amounts depend on the length of the term and the student's financial situation. Study loans are paid back after studies are completed at the rate of 4% of annual income.[127]

The high and rising rate of unemployment among young people has placed demands on the school system. Among the myriad of programs to reduce unemployment among adolescents, the municipal youth program can be mentioned.

Since 1995 the municipalities, after obtaining special agreements with the county employment board, have assumed the responsibility for youth at risk of unemployment. The municipalities arrange full-time practical work, education programs or other activities for unemployed young people up to the age of 20, including drop-outs from upper secondary school. In these programs young people acquire work experience, on-the-job training and social education. These measures have reached most unemployed teenagers. In practice this means that the majority of Swedes up to age of 20 either study in upper secondary school or are engaged in other activities.[128]

Public Health Services

Public health services for children, adolescents and pregnant women have been described in Part III. Preventive health care for all citizens is free of charge. All children and young people up to 19 also receive free dental and medical care, including treatment of diseases and injuries. Medical care for citizens over the age of 16 is covered by the health insurance system. After being reduced in the mid-1990s, compensation in sickness insurance and the parental insurance schemes were increased in 1998 to 80% of income.

Practically all pregnant women attend antenatal care programs at public maternal health centers. Besides regular visits to doctors and midwives, the maternal health service includes a program for parenthood education. Expectant parents are invited to group sessions led by a midwife. Practically all parents expecting their first child attend 5 to 8 group sessions for exchanges with other couples on pregnancy and childbirth and preparation for parenthood.[129]

If parents do not attend, it is the responsibility of the service provider (the midwife at the maternal health center) to offer equivalent support according to identified needs. This may, for instance, involve offering group sessions for teenage mothers or preparation for parenthood with ethnic groups or using an interpreter. For immigrants who don't speak Swedish, interpreters should be available in maternal and health care and at youth clinics.

Social Welfare

The goal of Swedish welfare policy is "economic security for everyone". The system used to be family-based, built on the income of the husband/father. In recent decades the approach has been individual-based, reflecting the growing proportion of women in the labor force and the norm of two incomes in a family.[130]

• *Support for families and children*. A general child allowance is paid monthly to the mother until the child is 16 (20 if the child is receiving an education). The amount, SEK 750 ($88), is tax-free and independent of the parents' income. The child supplement was reduced in 1996 from SEK 750 to SEK 640 ($88 to $75) a month, but was restored to its previous level in 1998.

In 1974, a parental insurance system with cash benefits replaced the previous maternal allowances. At that time, parental leave totaled 180 days at 90% of earned income. The parents could share the period with cash benefit. Parents also got the right to stay at home to care for a sick child, maximum of 60 days per child and year, with the same compensation (90%) as in sickness insurance. Since then the duration of paid parental leave has been extended.

In the 1990s the replacement rate was reduced and then increased again. In 1998, when some of the reduction was restored, paid parental leave totaled 390 days at 80% wage-replacement plus 90 days with the minimum payment (SEK 60, less than US$10 a day).

In 1995 it was decided that at least one of the months with cash benefits must be used by the father, the so-called "daddy-month." The cash benefit is based on income six months before the birth of the child. Persons outside the labor market get the minimum payment of SEK 60.[131]

The municipal authorities must provide a sufficient number of places for pre-school children in day care institutions or in family homes. Children whose parents are actively employed or studying are given priority for a place either in public day care institutions or in family day care. For school children up to 10 (13 in some municipalities) there are day-care options in special youth centers open after school hours. They are often located close to school and administered by the school authorities.

The social authorities are responsible for intervening to support children and young people in the event of risks to them due to adverse circumstances. If the parents are separated, a maintenance allowance has to be paid by the parent not living with the child (usually the father). If the sum, fixed at the separation by law court, is not paid as agreed, it is paid in advance by the public authorities, i.e. social services.[132]

Housing benefits are allocated to families and individuals based on income; additional criteria are the number of children and the size of the rent. The rules for receiving housing allowances are more favorable for families with children. The highest level of monthly housing benefits is paid to single parents with children, followed by married or cohabiting couples with children. The lowest allowances go to single people and to couples without children.[133]

• *Unemployment*. Like other parts of the welfare system, unemployment insurance is linked to a person's working life. Since 1998 the replacement rate during unemployment is 80% of earned income, payable only to people enrolled in the insurance system for at least two years. Other conditions are a minimum of employment periods and work-seeking activities in the past six months. Thus, the chances of obtaining compensation in the social insurance system depend on current income, so young people who leave school and have never joined the labor market cannot qualify for unemployment insurance benefits, sick leave benefits or parental allowances.

Temporary unemployment–alternation between job searches, studies and temporary employment—has long been a part of young people's lives. In the 1990s, however, the nature of unemployment has changed. Not only have considerably more young people than before ever been without jobs or never joined the labor force; there are also many young people who have experienced long-term unemployment. Unemployment is highest among young people with little education, but it also increased among those with higher education. Graduation from upper secondary school no longer guarantees a job or an advantage over students who only completed compulsory school.[134]

To sum up, young people, in spite of spending a long time in school and having a good education, have limited opportunities of gainful employment and are consequently excluded from many of the social welfare schemes. Many of them have few

opportunities after school and those with an immigrant background are in an even worse position in the labor market. As mentioned earlier (Figure 6, page 43), single mothers, young single mothers in particular, are another group with less chance of gaining a foothold in the labor market.

Single Mothers

Historically, the economic status of single parents in Sweden (chiefly women) has been fairly good, mainly because of their high participation in the labor force. Unlike the case in many other countries, there are no special benefits for single mothers. All parents are supposed to have a paid job that enables them to provide for themselves and share the costs of children with the other parent, whether they live together or apart. Support from society includes general social benefits, such as child and housing allowances. Other cash benefits, e.g. in the parental and sickness insurance schemes, are income-related, which encourages young women to participate in the labor market. Around 75% of single mothers are gainfully employed, which is the main reason why not more than 4% of single mothers of all ages are below the poverty line, defined as having less than half of the median income. This proportion is internationally low. In the US, for instance, 40% of single mothers with children live below the poverty line.[135]

But the group of single mothers is not homogeneous in these respects. Young mothers with a low education are most vulnerable, especially in times of economic depression. The unemployment rate among teenage mothers is high and their dependence on social security growing.

Teenage Mothers, a Disadvantaged Group?

Teenage pregnancies are few, but are not evenly distributed. A survey of 17-year-old girls and boys in 1990 showed that unwanted pregnancies are more common among girls with early physical maturity, early sexual experiences and low socio-economic status. Students in vocational training were compared with those in theoretical programs. The pregnancy or, rather, the abortion rate, was higher among girls with socio-economic problems and among girls who drop out of school (see part I).[136]

A study of attendance at a youth clinic showed that low age at first intercourse is associated with negative health consequences. There was a higher risk of STDs and a higher risk of pregnancy and abortion among females whose coital debut had occurred before the age of 15.[137]

Since most unwanted pregnancies among teenagers lead to abortion, the focus in reproductive health care is on the abortion decision, while teenage mothers are considered a part of the population of mothers, although in the youngest group. Still, teenage mothers do constitute a selected group with specific background characteristics and a need of special attention.

The international literature contains strong evidence of socioeconomic hardship and marginalization of teen mothers. The social support and the acceptance of single mothers make the situation easier for young mothers in Sweden. The specific problems for teenage mothers in the 1990s were explored in a qualitative study in a Stockholm suburb.[138] Above all, young mothers had the feeling of being an exception to the rule. The behavior expected of a young, sexually active girl is to use contraceptives and in the event of an unwanted pregnancy, to have an abortion, which is offered promptly by the public health service providers.

The practical consequences for young mothers included disruption of education, financial dependence on boyfriend, parents and social security and problems with a job and housing. The social support system was felt to compensate for many of these obstacles; returning to school and getting on with studies after the parental leave was rated as most problematic. The emotional gains were better relations with their own mother and the rewarding relationship with the baby, while conflicts with the partner and loss of friends were drawbacks. A common experience among young mothers is loss of contact with friends of the same age but in a different life situation. At the same time they have difficulties in establishing contact with other—often older and well-established—parents of small children.

Of all the children born in 1997, 82% had parents who were either married (46%) or living together without formal marriage. Of mothers under 25 who gave birth, 71% lived together with the father, but only 28% were married. If both parents were under 25, more than a third of the mothers were single and lived alone, compared to 18% among mothers in general.[139]

In Sweden, family conflicts and an increased divorce rate are common after the birth of the first child, and more frequent among young couples. The risk of separation in connection with the birth of a child is highest among couples where the relation is of short duration, if the mother is young and the income low.[140] Studies suggest that every second teenage mother is abandoned by the father before the birth, and more than half of the fathers who do stay have left the family within three years.[141]

Interventions to Assist Disadvantaged Youth, Focusing on Sexual and Reproductive Behavior

As mentioned before, the Swedish social security system generally covers the entire population and is supposed to provide support and protection for people with special needs. Protection of children and young people is a priority in the social support system. Identified health or social problems should be taken care of within the system.

In recent years, some issues related to adolescent sexual and reproductive life have been the focus of the public debate. Subgroups of youth have been identified as disadvantaged, for instance:

- some, but not all young mothers;
- some, but not all second generation immigrants;
- young homosexual and lesbian youth;
- schoolgirls as targets for sexual harassment and abuse.

The following examples illustrate initiatives and interventions at different levels in society.

Governmental Level

• *Ministry of Health and Social Affairs: single parents-a vulnerable group*. In the mid-1990s, the Ministry of Health and Social Affairs conducted a project, Social Welfare in Transition, to investigate the consequences of the reorganization of social welfare in connection with the economic recession. Single mothers were identified as a group suffering more than others from unemployment and the cuts in social security programs.[142] Moreover, according to a governmental committee, Welfare at Crossroads, the improved economy of the late 1990s, has not markedly benefited this group. These reports will serve as source material for policy and development work, e.g. within the school and educational sector, the labor market and the National Board of Youth Affairs.

• *Minister for Equal Affairs: violence against women*. In 1998, the Swedish government proposed new legislation and measures for more effective work within the police, the prosecution and the social services to combat violence against women. The Peace for Women Bill was approved by the Parliament and came into force in July 1998.[143] The prohibition on the purchase of sexual services became effective six months later. In relation to this new legislation, a number of initiatives were taken at the central level, including the Minister for Equality Affairs, the Minister of Justice and the Minister for Health and Social Affairs. Special attention was paid to sexual abuse and exploitation of minors, gang rape of young girls and sexual mobbing.

In 2000, the Government appointed a National Advisory Board for surveillance of violence against women with the Minister for Equality Affairs as coordinator. The Board will review relevant research, disseminate information and initiate actions to counteract violence, discrimination and abuse. A key issue is action to improve gender equality among school children and prevent sexual mobbing and harassment of girls. Members of the Board are representatives from NGOs (e.g. youth organizations) and popular movements from the central labor unions and from the school, health and social sector.

Central Authorities

• *Equal Opportunities Ombudsman*

Dare to break the pattern — A project against sexual mobbing in school. The public debate on sexual exploitation, abuse and violence has been heated in recent years. Reports from schools have been frequent on sexual harassment and pupils using sexist language. Especially girls have become targets for sexual mobbing and humiliating treatment. In 1996, in response to these reports the Equal Opportunities Ombudsman initiated school projects to counteract sexual mobbing. Methods for changing attitudes were tested in pilot projects at two schools, one in Botkyrka, a Stockholm suburb, the other in Linköping, a university city in the south of Sweden. The project was financed by the Government, the county council of Östergötland, and the municipalities of Botkyrka and Linköping.

In the first phase of the project, teachers and other school personnel took part in a three-day workshop with the pupils. The students as well as the teachers assessed the project very favorably, but from follow-up interviews one year later it was evident that the improved atmosphere had not been sustainable. The pupils were disappointed, since the teachers had not continued with the dialogues and had not followed the agreed plan for equal opportunities. As a result, a new phase of the project was initiated with courses for teams of staff from each school to achieve a better adult understanding of the issue of gender equality. Three-day courses have been held in methods for communication and dialogue on matters like human rights, equal opportunities and sexual relationships. The results have been presented in a manual from the Equal Opportunities Ombudsman on how to counteract sexual mobbing in school.[144]

• *National Institute for Public Health: Report on youth sexuality*. One of the initiatives taken to counteract gender inequality and sexual mobbing in schools was to explore attitudes to sexuality and sexual behavior among youth. On behalf of the government, in March 1999 the Institute for Public Health started to map what was known about youth attitudes to sexuality and whether they had changed over time.

Besides having to do with society's responsibility for giving adolescents counseling and support in questions dealing with sexuality and interpersonal relationships, the initiative was stimulated by a number of rapes among adolescents. The government needed to determine whether the rapes mirrored changed attitudes among adolescents rather than being unconnected incidents.

The report reviewed recent studies on adolescent sexual knowledge, attitudes and behavior.[145] A number of recent studies did show changes in behavior over time, but they were less sensational than had been expected. Results from these studies are discussed in Part II.

• *National Board of Youth Affairs*. Since 1994, the National Board of Youth Affairs has worked across sectors and suggested measures to improve the living conditions of young people and enhance their influence over social developments. The Board allocates state aid to non-governmental youth organizations and initiates and revives youth activities in municipalities all over the country.[146]

• *Support to Network for Young Parents*. Among the projects with financial support from the Youth Board is a Network for Young Parents. The network is for parents up to the age of 25 for support and exchange of experiences. The support group was started because teenage parenthood, and even having the first baby in the early 20s, tends to be questioned by society at large. The network issues a magazine four times a year for contacts and interaction with young parents. Other activities are a scheme for social support during pregnancy and delivery, phone services to reach contact persons for support and advice, local groups for expectant parents and summer camps for young parents with children under three. The network also acts politically, e.g. is lobbying for better parental insurance for youths who have not yet entered the labor market, arguing that they will be gainfully employed in the future and make a contribution to the national economy.[147]

• *Maternal health and social services*. Maternal Health Care is responsible for providing reproductive health services for all, including antenatal care, contraceptive services and abortion counseling. In all their activities public health services have to pay special attention to disadvantaged groups and provide adequate services according to need. Some examples of projects for support to disadvantaged youth are as follows:

• *Support program for teen mothers*. In Järfalla, a suburb northwest of Stockholm, a support project for young mothers is run jointly by the social service and maternal health care. All expectant teenage mothers attending antenatal care are referred to a social worker for economic and social support. Although young mothers seldom join parents' groups for preparation for childbirth, the social workers identified their need for a social network. So they started a "young mother group" led jointly by the midwife and social worker. After a while these group sessions were developed into a more permanent open-house activity, where young mothers could go during pregnancy and after childbirth to meet other young parents. The staff was expanded with child health personnel at certain hours. Courses, study circles and free activities for young parents and their children are part of the program.

• *A youth center for drug addicts*. A youth center in Stockholm called "Maria Youth" is open for girls and boys with problems with drugs and alcohol. It is organized as a youth clinic staffed with pediatrician, gynecologist, child psychologists, social workers and midwives. Among the young people attending the clinic, abuse of alcohol and drugs is often combined with a history of sexual exploitation, rape or violation of their integrity. Among addicted boys, sexual abuse is a common but hidden problem, since they are less willing to talk than are the girls. Young pregnant girls come for abortion counseling or for antenatal care if they want to give birth. They are frequent visitors to the midwife and social worker. They are eager for help to stop using alcohol or drugs and to be able and allowed to take care of the baby. Information, education and testing for HIV and other STDs are offered at the clinic. Those in need of long-term social and psychological support are referred to psychotherapy or rehabilitation programs for alcohol or drug addiction. A recent survey explores the living conditions among youth visiting "Maria Youth" and evaluates the support program.

• *Female genital mutilation*. In the 1990s, the issue of female genital mutilation (FGM) has come to the front in maternal and child health care. The National Board for Health and Welfare has produced an information package on legal, cultural and medical aspects of FGM. In Gothenburg, where many immigrants from Somalia are living, a model has been developed for information and health services on FGM.[148]

Young women and men from Somalia living in a Stockholm suburb have been interviewed on their views and experiences of FGM.[149] The girls told about both physical and psychological difficulties and practically all of the young boys rejected the custom as old-fashioned and dangerous. An enquiry to all youth clinics in the country showed that girls had visited one third of them with problems from FGM. In a few places the youth clinic staff or school health personnel had tried to tackle the problem. In one small town in southern Sweden the school nurse had collected a group of Somalian girls and talked with them about their problems. They were informed and felt relieved that Swedish law forbids FGM. They also agreed to their parents being invited to the school, which led to a series of talks with women and men in the older generation. These initiatives are encouraged and will be replicated in other areas and taken up in the regular school and public health programs.

Civil Society

• *Kvinnoforum (Foundation for Women's Forum) Xist — a multi-activity house for school drop outs.* Xist is an NGO project run by the Foundation for Women's Forum with financial support from the municipality of Stockholm. It is organized as an open house for girls and young women aged 13 to 25. The goal is to strengthen girls' possibilities in their private lives, their working lives and in society as a whole.

The approach includes:

- focusing on the girls' own strengths and possibilities and seeing their different ethnic backgrounds as a resource;
- building a network to gather and spread ideas, experience and knowledge with the aim of shedding light upon young girls as a population group;
- letting the girls take an active part in all the different activities, from running the Xist 'cafe' to representing Xist externally e.g. at conferences and debates about girls' living conditions.

The activities include:

- Xist individual high-school program. This program focuses on girls who, for various reasons, have difficulty in coping in the municipal school system. They are given the opportunity to study at an individual level, but also to belong to a group. They may work with creative subjects like photography, theatre and music. The subject 'livskunskap' (life skill training) is studied together in groups.
- open house for young parents. Once a week, young mothers (to be) gather together with an instructor. They talk about the role of the parent, about the development of the child, about games, songs, diapers and they support each other in parenthood.

Voluntary Organizations

• *Swedish Association for Sexuality Education, RFSU: RFSU project on sexuality education for adolescents in upper secondary school with an immigrant background*. In cooperation with a school in central Stockholm, RFSU runs a project

for upper secondary school pupils at risk of becoming dropouts. The activities in 1997/98 focused on students in the individual programs, who are known to be at risk of unwanted pregnancies and STDs. With a high frequency of non-attendance, they also miss the ordinary sexuality education in school. A majority of the pupils had an immigrant background. The main topics were information, education and communication on sexuality and interpersonal relations. After the project period, the school has continued to offer extra sexuality education for pupils within the individual programs.

• *RFSU support projects for young disabled people*. RFSU has a long-standing cooperation with HSO (an "umbrella" organization for almost every handicap organization in Sweden), resulting in 1999 in an association with the aim to develop information and education within the field of sexuality and disabled persons. As early as 1990, HSO and RFSU arranged a summer camp for women confined to wheelchairs because of spinal injuries; one of the topics was sexuality and the possibility to have children.

• *Swedish Federation for Gay and Lesbian Rights, RFSL*. RFSL coordinates Line 59, a hotline for young people with questions about homosexuality. The project is run in cooperation with and gets financial support from the National Institute for Public Health, FHI and Stockholm County AIDS Prevention Program, LAFA. RFSL has also arranged summer camps for young men. Over time RFSL has organized special groups for Spanish speaking and Persian speaking homosexuals.

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Appendix A

Table A1
Changes in total fertility rate and percentage of women gainfully employed 1960-1997, in Sweden. Women 15-44 years old, (figure 1 in the text).

Table A2
Changes in birthrate (/1000) in different age groups between 1979-1999, (figure 2 in the text).

Table A3
Changes in birth rate (per 1000) and abortion rate (per 1000) between 1969-1998 among 15-19 years old women in Sweden, (figure 3 in the text).

Table A4
Number of live births. Sweden 1975-1998. Women up to 14 and 15-24 years. Figure A1 in Appendix A.

Table A5
Number of abortions. Sweden 1975-1998. Women 15-24 years. Figure A2 in Appendix A.

Table A6
Number of live births/1000. Sweden 1975-1998. Women up to 14 and 15-24 years. Figure A3 in Appendix A.

Table A7
Abortion rate and birth rate (/1000) among teenagers 15-19. Sweden 1985-96. Figure A4 in Appendix A.

Table A8
Foreign-born persons or aliens by country of birth or citizenship in Sweden 1995.

Table A9
Age at first intercourse by age and gender.

Table A10
Percentage distribution when respondents had their first birth.

Table A11
Number of sexual partners in the past year by gender and age.

Table A12
Frequency of intercourse in the past month by age and gender.

Table A13
Contraceptive method at last intercourse by age and gender.

Table A14
Socio-economic factors, such as cohabitation status, education, geographic area, ethnicity, immigrant status and employment by age and gender.

Figure A1. Number of live births. Sweden 1975-1998. Women up to 14 and 15-24 years. Table A4 in Appendix A.

Figure A2. Number of abortions. Sweden 1975-1998. Women 15-24 years. Table A5 in Appendix A.

Figure A3. Number of live births/1000. Sweden 1975-1998. Women up to 14 and 15-24 years. Table A6 Appendix A.

Figure A4. Abortion rate and birth rate (/1000) among teenagers 15-19. Sweden 1985-96. Table A7 in Appendix A.

Figure A5. Distribution according to the age at first intercourse by respondents age.

Table A1. Changes in total fertility rate and percentage of women gainfully employed 1960-1997 in Sweden, women 15-44 years. Official Statistics Sweden

Year	Total fertility rate	Gainfully employed
1960	2,13	
1961	2,22	
1962	2,23	
1963	2,33	
1964	2,47	
1965	2,41	
1966	2,37	
1967	2,28	
1968	2,09	
1969	1,94	
1970	1,94	62,3
1971	1,98	63,7
1972	1,98	65,9
1973	1,88	65,6
1974	1,69	68,9
1975	1,78	72,3
1976	1,69	73,7
1977	1,65	75,4
1978	1,6	77,0
1979	1,66	79,1
1980	1,68	81,0
1981	1,63	82,9
1982	1,62	83,5
1983	1,61	84,3
1984	1,65	85,7
1985	1,73	87,1
1986	1,79	88,2
1987	1,84	88,5
1988	1,95	88,6
1989	2,02	89,0
1990	2,14	89,1
1991	2,12	86,9
1992	2,09	84,0
1993	2,00	80,0
1994	1,89	78,7
1995	1,74	78,6
1996	1,61	76,3
1997	1,53	76,1

Table A2. Changes in birthrate (/1000) in different age groups between 1979-1999 in Sweden. (figure 2 in the text). Age refers to age at the event. Official Statistics in Sweden

	15-19	20-24	25-29	30-34	35-39	40-44
1979	17,3	95,5	122,7	67,1	24,4	4,3
1980	15,8	95,6	124,2	70,7	24,9	4,3
1981	14,5	90,3	120,6	71,7	24,8	4,4
1982	13,2	86,1	120,9	73	25,5	4,6
1983	11,7	83,0	121,5	74,7	26,1	4,7
1984	10,7	80,3	125,8	79,9	28,1	5,4
1985	11,0	81,8	131,8	85,9	30,3	5,6
1986	11,3	83,4	136,4	89,8	31,9	5,7
1987	10,9	84,3	138,7	95,0	32,7	5,8
1988	11,4	90,5	147,2	100,4	36,3	6,0
1989	12,7	92,8	149,0	103,4	38,7	6,4
1990	14,1	98,6	155,6	110,3	41,4	7,0
1991	13,1	94,0	154,1	111,9	42,8	7,2
1992	11,8	90,2	151,5	112,7	44,1	7,3
1993	11,0	82,1	145,5	109,7	43,3	7,5
1994	9,6	73,8	138,7	105,0	43,1	7,4
1995	8,6	66,3	125,7	99,1	40,6	7,1
1996	7,7	58,5	115,4	93,4	38,9	7,1
1997	7,2	54,6	108,9	90,6	37,7	7,1
1998	6,5	50,1	105,3	92,7	40,3	7,3
1999	6,8	48,1	103,6	93,0	41,4	7,5

Table A3. Changes in birth rate (per 1000) and abortion rate (per 1000) between 1969-1998 among 15-19 years old women in Sweden (Figure 3 in the text)

Sources: Births: Official Statistics of Sweden. Population statistics 1996, Part 4. SCB 1997; Abortions: Official Statistics of Sweden. Aborter 1998. National Board of Health and Welfare, Statistics-Health and Diseases, 1999:11

Year	Births per 1000 women	Abortions per 1000 women
1969	44.0	10.5
1970	43.0	12.0
1971	34.6	17.4
1972	33.4	20.6
1973	31.1	23.4
1974	31.7	27.8
1975	28.9	29.8
1976	25.0	27.3
1977	22.1	26.2
1978	19.2	23.8
1979	17.3	22.3
1980	15.5	21.8
1981	14.3	20.7
1982	14.5	19.4
1983	13.0	17.9
1984	12.0	18.0
1985	11.1	18.2
1986	11.4	19.7
1987	10.9	21.6
1988	11.4	24,4
1989	12.6	24.8
1990	14.1	24.6
1991	13.2	22.9
1992	12.0	20,4
1993	11.0	19.0
1994	9.6	17.9
1995	8.6	17.0
1996	7.8	17.8
1997	7.4	17.8
1998	6.7	18.5

Table A4. Number of live births. Sweden 1975-1998. Women up to 14 and 15-24 years. (Age refers to the age at the end of the year and not at the event. Population at the end of the year.) Statistics Sweden, data file. (Figure A1.)

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
-14	7	3	4	5	6	8	4	5	1	1	2	8	2	4	1
15	36	31	40	32	27	32	27	18	17	13	14	16	16	13	12
16	239	164	156	114	115	104	91	88	73	43	49	61	56	76	89
17	736	611	501	428	428	384	385	329	242	193	209	206	242	237	273
18	1649	1396	1169	1037	934	878	846	762	643	556	558	555	485	546	637
19	2910	2501	2241	1961	1857	1726	1610	1494	1460	1304	1283	1337	1235	1237	1438
20	4040	3877	3505	3099	2834	2796	2528	2583	2292	2314	2385	2324	2338	2374	2375
21	4984	4722	4587	4170	3873	3749	3580	3281	3232	3220	3427	3488	3335	3603	3540
22	6184	5520	5397	5006	4898	4743	4335	4193	3992	4072	4215	4715	4753	4956	5055
23	6994	6276	5984	5853	5647	5774	5421	5011	4878	4649	4944	5366	5973	6283	6179
24	7298	7005	6861	6264	6610	6553	6283	5792	5675	5572	5815	6005	6296	7328	7565

	1990	1991	1992	1993	1994	1995	1996	1997	1998
-14	3	5	5	3	2	2	3	2	1
15	24	15	17	14	12	20	12	11	14
16	85	89	81	58	49	61	58	62	46
17	294	244	257	219	198	169	170	180	143
18	720	675	571	497	406	387	370	334	332
19	1562	1427	1229	1156	1004	849	736	637	610
20	2642	2506	2262	1999	1771	1516	1311	1169	1025
21	3611	3526	3352	3144	2601	2419	2120	1721	1579
22	5030	4463	4473	4114	3676	3276	2845	2578	2167
23	6699	6012	5513	5188	4729	4287	3542	3340	3000
24	7839	7596	7008	6141	5754	5175	4585	4107	3824

Table A5. Number of abortions. Sweden 1975-1998. Women 15-24 years. (Age of abortions refers to the age at the event.) The National board of Health and Welfare, data file. (Figure A2)

	Age									
Year	15	16	17	18	19	20	21	22	23	24
75	813	1499	1741	1747	1671	1656	1532	1465	1424	1363
76	874	1380	1689	1798	1905	1761	1665	1517	1497	1423
77	735	1146	1473	1552	1597	1588	1480	1370	1323	1317
78	631	1003	1284	1465	1585	1511	1479	1418	1353	1227
79	634	969	1186	1414	1647	1592	1585	1510	1466	1352
80										
81										
82										
83	370	720	1075	1436	1567	1528	1511	1356	1339	1303
84	374	697	1055	1377	1550	1606	1549	1495	1386	1285
85	349	673	974	1434	1562	1739	1672	1552	1506	1262
86	400	777	1047	1364	1744	1895	1936	1754	1687	1479
87	464	856	1147	1491	1817	1985	1931	1991	1761	1656
88	533	1040	1395	1645	1835	2093	2181	2015	2096	1863
89	544	1055	1440	1722	1889	2057	2124	2143	2136	2052
90	521	1008	1381	1723	1954	1931	1978	1995	1978	1940
91	438	915	1186	1584	1871	1850	1803	1845	1824	1928
92	398	734	1094	1364	1608	1799	1790	1674	1708	1797
93	324	665	938	1268	1482	1775	1774	1741	1658	1585
94	350	626	869	1091	1414	1506	1692	1677	1636	1519
95	359	658	780	993	1277	1482	1485	1593	1500	1487
96	370	725	928	1016	1186	1433	1576	1615	1536	1560
97	351	672	904	1122	1191	1322	1418	1556	1468	1492
98prel	404	682	954	1121	1213	1328	1277	1384	1431	1466

Table A6. Number of live births/1000. Sweden 1975-1998. Women up to 14 and 15-24 years. (Age at refers to the age at the end of the year and not at the event, both for the numerator and denominator.) Statistics Sweden, data file. (Figure A3).

	1975	**1976**	**1977**	**1978**	**1979**	**1980**	**1981**	**1982**	**1983**	**1984**	**1985**	**1986**	**1987**	**1988**	**1989**
14	0,136	0,057	0,072	0,083	0,100	0,133	0,068	0,090	0,019	0,019	0,036	0,145	0,037	0,073	0,019
15	0,713	0,603	0,757	0,578	0,447	0,532	0,450	0,304	0,305	0,247	0,26	0,288	0,290	0,239	0,218
16	4,658	3,239	3,022	2,154	2,073	1,718	1,510	1,467	1,233	0,772	0,931	1,131	1,005	1,373	1,626
17	14,23	11,85	9,841	8,257	8,056	6,901	6,352	5,455	4,028	3,256	3,745	3,905	4,479	4,243	4,909
18	31,02	26,82	22,51	20,25	17,89	16,42	15,16	12,54	10,65	9,237	9,391	9,911	9,154	10,05	11,32
19	54,59	46,58	42,63	37,41	35,89	32,69	29,91	26,67	23,96	21,51	21,22	22,37	21,9	23,17	26,14
20	75,02	71,97	64,57	58,38	53,53	53,49	47,65	47,82	40,79	37,8	39,17	38,25	38,89	41,75	43,88
21	93,63	86,85	84,05	76,07	72,26	70,2	68,13	61,71	59,69	57,08	55,73	56,97	54,58	59,52	61,49
22	111,3	102,7	98,25	90,88	88,52	87,87	80,99	79,58	74,95	74,94	74,38	76,24	77,25	80,52	82,56
23	124,8	112,0	110,2	105,8	101,8	103,7	100,1	93,42	92,4	87,04	90,55	94,12	96,02	101,3	99,27
24	129,2	124,2	121,4	114,5	118,6	117,6	112,6	106,8	105,7	105,2	108,4	109,4	109,7	116,9	120,5

	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
14	0,020	0,033	0,032	0,019	0,012	0,011	0,017	0,011	0,006
15	0,225	0,142	0,163	0,135	0,115	0,188	0,109	0,094	0,115
16	0,309	0,324	0,295	0,212	0,179	0,225	0,216	0,232	0,170
17	5,354	4,410	4,896	4,394	4,049	3,533	3,437	3,587	2,917
18	12,87	12,24	10,28	9,406	8,063	7,882	7,711	6,725	6,575
19	27,49	25,32	22,15	20,63	18,77	16,74	14,92	13,23	12,26
20	47,48	43,87	39,87	35,73	31,26	28,19	25,73	23,63	21,18
21	66,03	62,96	58,27	54,92	46,04	42,51	39,26	33,63	31,78
22	86,45	80,97	79,41	70,84	63,51	57,66	49,8	47,63	42,18
23	108,4	102,5	99,31	91,21	80,61	73,75	62,17	58,34	55,20
24	124,8	122,0	118,6	109,6	100,1	87,83	78,67	71,85	66,44

Table A7. Abortion rate and birth rate (/1000) among teenagers 15-19. Sweden 1985-96.
(Age refers to age at the event. Denominator is the mean population for age group and year.) (Figure A4).

Abortion: The National board of Health and Welfare, data file.
Births: Official Statistics of Sweden. Population Changes 1980. Part 1. Statistics Sweden. Official Statistics of Sweden. Population Changes 1985. Part 1. Statistics Sweden. Official Statistics of Sweden. Population Changes 1990. Part 1. Statistics Sweden
Official Statistics of Sweden. Population Statistics 1995. Part 4. Statistics Sweden.

Abortion rate

	15	16	17	18	19
1985	6,5	12,8	17,4	24,1	25,8
1986	7,2	14,4	19,8	24,2	29,2
1987	8,4	15,4	21,2	28,1	32,2
1988	9,8	18,8	25,0	30,3	34,4
1989	9,9	19,3	25,9	30,6	34,3
1990	10,0	18,3	25,2	30,8	34,4
1991	8,9	17,5	21,4	28,7	33,2
1992	8,3	14,8	20,8	24,5	29,0
1993	6,9	13,7	18,8	24,0	26,4
1994	7,1	13,1	17,8	21,7	26,4
1995	7,2	13,3	16,3	20,2	25,2
1996	7,6	14,5	18,8	21,2	24,0

Birth rate

	15	16	17	18	19
1985	0,43	2,02	6,34	14,49	29,63
1986	0,59	2,06	6,24	15,68	30,47
1987	0,43	2,34	6,01	15,28	30,45
1988	0,68	2,48	6,94	15,20	32,73
1989	0,67	2,95	7,70	16,79	34,90
1990	0,83	2,96	8,50	19,04	37,74
1991	0,81	2,70	7,81	18,25	34,41
1992	0,54	3,04	7,87	14,59	31,31
1993	0,58	2,27	6,61	15,44	27,97
1994	0,45	2,18	5,76	12,75	25,56
1995	0,66	2,10	5,81	11,53	22,67
1996	0,55	2,12	5,31	10,06	20,80

Table A8. Foreign-born persons or aliens by country of birth or citizenship in Sweden 1995.

	Citizenship	**Women 18-19 y**	**Women 20-24 y**	**Women 25-29 y**	**Women 30-34 y**
Foreign	Sweden	4737	12773	14759	18294
Foreign	Foreign	4499	16815	25913	28175
Sweden	Foreign	2035	4237	3169	1710
Finland	Sweden	147	786	2614	5207
Finland	Finland	301	1459	2875	3873
Sweden	Finland	483	960	544	239
Greece	Sweden	17	45	227	419
Greece	Greece	22	76	151	216
Sweden	Greece	51	102	60	5
Turkey	Sweden	169	772	883	956
Turkey	Turkey	239	1033	1005	1126
Sweden	Turkey	179	135	22	4
Poland	Sweden	242	583	578	747
Poland	Poland	213	722	1180	1213
Sweden	Poland	8	10	3	2
USA	Sweden	36	106	156	140
USA	USA	41	234	541	602
Sweden	USA	30	55	78	29
Chile	Sweden	433	866	557	587
Chile	Chile	182	525	634	923
Sweden	Chile	1	1	1	0

Table A9. Percentage distribution according to the age when respondents first had intercourse by respondent's age at the survey and gender

Females

Percent who first had intercourse at age:	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
<13	1.6	0.7	0.0	0.6	0.8	0.8	1.4
13	4.9	2.6	4.6	9.3	2.4	3.8	0.7
14	8.2	8.6	11.1	11.8	7.9	10.7	5.8
15	21.3	18.5	21.6	19.9	29.9	21.4	12.9
16	13.1	18.5	20.9	14.9	24.4	15.3	17.3
17	19.7	14.6	9.8	11.2	9.4	18.3	16.5
18	8.2	10.6	10.5	7.5	8.7	13.7	21.6
19	3.3	9.3	6.5	8.1	3.9	2.3	7.9
20		2.6	4.6	4.3	0.0	3.8	7.2
21 or older		2.7	7.9	9.3	7.9	7.0	5.7
Never had intercourse	19.7	8.6	2.0	1.2	1.6	1.5	0.7
Age not reported	0.0	2.6	0.7	1.9	3.1	1.6	2.2
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)							
Number-unweighted (N)	61	151	153	161	127	131	139

Males

Percent who first had intercourse at age:	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
<13	0.0	0.0	2.4	1.8	0.0	3.5	3.5
13	4.2	2.8	4.1	2.5	0.0	4.9	2.2
14	8.3	9.5	11.2	8.6	14.4	10.5	7.2
15	16.7	15.1	16.0	15.4	19.0	17.5	20.9
16	15.3	17.3	14.8	13.0	15.7	14.7	12.9
17	12.5	17.9	10.1	13.6	9.2	11.2	9.4
18	12.5	12.8	14.2	11.1	14.4	9.8	20.1
19	2.8	5.0	6.5	5.6	5.2	8.4	4.3
20		10.1	3.6	6.2	8.5	8.4	2.2
21 or older		2.8	14.8	14.8	9.3	7.7	10.6
Never had intercourse	25.0	6.7	5.3	4.9	2.4	2.8	3.6
Age not reported	2.8	0.6	1.2	2.5	2.0	0.7	2.9
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)							
Number-unweighted (N)	72	179	169	162	153	143	139

Source(s): Sex in Sweden (see reference #27 in text)
Year of survey: 1996

Table A10. Percentage distribution according to the age when respondents had their first birth by respondent's age at the survey

Females

Percent whose first birth was at age:	Age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
<15	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15	0.0	0.0	0.0	0.0	0.0	0.0	0.0
16	0.0	0.0	0.0	0.6	0.8	2.3	2.9
17	0.0	2.0	0.7	0.0	2.4	4.6	2.2
18	1.6	0.7	2.0	2.5	0.0	1.5	5.8
19	0.0	1.3	1.3	2.5	4.7	5.3	3.6
20		3.3	3.3	3.1	3.1	10.7	5.8
21 or older		7.9	44.3	68.9	71.6	70.6	65.4
Never had a birth	96.7	78.1	45.1	21.1	15.7	5.3	13.7
Age not reported	1.6	6.6	3.3	1.2	1.6	0.8	0.7
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)							
Number-unweighted (N)	61	151	153	161	127	131	139

Source(s): Sex in Sweden (see reference #27 in text)
Year of survey: 1996

Table A11. Percentage distribution according to the number of sexual partners in the past year by respondent's age at the survey and gender

Females

Number of sexual partners in past year	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	15.5	5.8	1.3	0.0	0.0	0.0	0.0
No partners past year	0.0	4.3	4.0	5.8	7.4	6.3	10.5
1 partner	48.3	65.5	76.8	83.3	84.4	84.3	87.2
2 partners	13.8	11.5	9.3	7.7	4.9	7.9	2.3
3 or more partners	22.4	12.9	18.6	3.2	3.3	1.6	0.0
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)							
Number-unweighted (N)	58	139	151	156	122	127	133

Males

Number of sexual partners in past year	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	19.7	6.7	3.8	2.7	0.7	0.0	0.8
No partners past year	3.0	6.1	3.8	4.0	7.4	9.1	6.3
1 partner	53.0	49.7	65.6	72.0	79.2	77.3	82.7
2 partners	10.6	16.8	13.1	9.3	7.4	9.1	3.1
3 or more partners	13.6	20.7	13.8	12.0	5.4	4.5	7.1
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)							
Number-unweighted (N)	66	179	160	150	149	132	127

Source(s): Sex in Sweden (see reference #27 in text)
Year of survey: 1996

Table A12. Percentage distribution according to the frequency of intercourse in the past month by respondent's age at the survey and gender

Females

Frequency of intercourse in past month	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	14.8	7.3	1.3	0.6	0.0	0.8	0.0
0 times in past month	26.2	17.9	13.1	16.1	18.1	14.5	19.4
<1/week	9.8	12.6	16.3	22.4	21.3	25.2	28.1
1 time/week	4.9	6.0	9.8	13.0	12.6	19.8	7.2
2-4 times/week	36.1	46.4	54.9	41.6	43.3	36.6	39.6
5+ times/week	3.3	3.3	0.7	1.9	0.0	1.5	0.0
Not reported	4.9	6.6	3.9	4.3	4.7	1.5	5.8
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)							
Number-unweighted (N)	61	151	153	161	127	131	139

Males

Frequency of intercourse in past month	Respondent's age at survey						
	18-19	20-24	25-29	30-34	35-39	40-44	45-49
Never had sex	23.6	5.0	4.1	3.1	1.3		1.4
0 times in past month	19.4	26.3	16.0	18.5	11.8	9.8	11.5
<1/week	13.9	15.6	24.3	21.6	26.8	25.2	20.9
1 time/week	4.2	3.4	6.5	6.2	7.2	11.2	12.9
2-4 times/week	20.6	43.0	41.4	43.2	47.1	47.6	45.3
5+ times/week	4.2	4.5	3.6	1.2	1.3		0.7
Not reported	4.2	2.2	4.1	6.2	4.6	6.3	7.2
Total Percent	100%	100%	100%	100%	100%	100%	100%
Number-weighted (N)							
Number-unweighted (N)	72	176	169	162	153	143	139

Source(s): Sex in Sweden (see reference #27 in text)
Year of survey: 1996

Table A13. Percentage distribution according to the contraceptive method used at last sex by age of respondent at the survey and gender

Females	**Respondent's age at survey**					
Percent using each method at last intercourse *	18-19	20-24	25-29	30-34	35-39	40-44
Sterilization	0.0	0.0	0.0	3.1	4.7	13.7
Oral contraceptives	37.7	45.0	28.8	18.6	11.0	9.2
IUD	1.6	2.6	11.8	17.4	26.0	22.1
Condoms	18.2	13.2	15.7	14.9	15.7	11.5
Diaphragm/Cap/f.condom	1.6	0.7	0.7	0.0	0.0	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.7	0.0	0.8	0.0
Withdrawal	11.5	6.0	8.5	6.8	5.5	5.8
Rhythm (periodic abstinence)	0.0	2.0	3.3	1.9	3.1	2.3
Method not reported	0.0	6.7	4.6	9.9	9.5	8.4
No method used	9.2	7.3	8.5	14.9	15.7	18.3
Not at risk for unintended preg.**	1.6	7.9	15.7	11.2	7.1	8.4
Never had intercourse	19.7	8.6	2.0	1.2	0.8	0.8
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N)						
Number-unweighted (N)	61	151	153	161	127	131
Percent using both condoms and selected medical method***						

Males	**Respondent's age at survey**					
Percent using each method at last intercourse *	18-19	20-24	25-29	30-34	35-39	40-44
Sterilization	0.0	0.6	0.0	0.0	2.6	6.3
Oral contraceptives	31.9	52.5	28.4	20.4	13.7	11.9
IUD	0.0	3.4	9.5	10.5	22.9	14.0
Condoms	23.6	14.0	15.4	12.3	13.7	11.9
Diaphragm/Cap/f.condom	0.0	0.0	0.6	0.6	1.3	0.0
Foam/jelly/cream/suppository	0.0	0.0	0.6	0.6	0.0	0.0
Withdrawal	5.6	6.1	11.2	7.4	11.1	4.2
Rhythm (periodic abstinence)	0.0	1.1	1.2	1.9	0.7	3.5
Method not reported	8.3	7.3	10.1	9.9	9.2	11.9
No method used	5.6	6.7	12.4	25.3	19.0	30.1
Not at risk for unintended preg.**	0.0	1.7	5.3	6.8	3.3	3.5
Never had intercourse	25.0	6.7	5.3	4.3	2.6	2.8
Total Percent	100%	100%	100%	100%	100%	100%
Number-weighted (N)						
Number-unweighted (N)	72	179	169	162	153	143
Percent using both condoms and selected medical methods***						

* If multiple methods are reported, classify according to the most effective method used. Totals should add to 100%.
** Not at risk because currently pregnant, postpartum, seeking pregnancy, infecund or sterile.
*** Selected medical methods include sterilization, oral contraceptives, IUD, Norplant and Depo Provera.

Source(s): Sex in Sweden (see reference #27 in text)
Year of survey: 1996

Table A14. Percentage distribution according to socio-economic measures by age and gender

Age and gender	Cohabitation status*				Total Percent	Number (n)
	Living alone	Currently married/ Cohabitating	Living with parents	Other forms		
Youth aged 18-19	13.8	9.8	72.9	4.5	100%	133
males	12.5	8.3	77.8	1.4	100%	72
females	13.1	11.5	67.2	8.2	100%	61
Youth aged 20-24	32.7	35.8	25.5	6.0	100%	330
males	36.3	26.8	33.8	3.9	100%	179
females	28.5	46.4	16.6	8.5	100%	151

Age	Education				Total Percent	Number (n)
	9 year public school	Upper secondary practical line	Upper secondary theoretical line	University		
Youth aged 18-19	43.6	18.8	35.3	2.3	100%	133
Youth aged 20-24	7.4	33.9	43.9	14.8	100%	330

Age	Region/province of the country*			Total Percent	Number (n)
	City	Town	Rural area		
Youth aged 18-19	27.1	40.6	32.3	100%	133
Youth aged 20-24	28.8	43.9	27.3	100%	330

Age	Race/ethnicity - groups as applicable for country*				Total Percent	Number (n)
	Swedish	Other Nordic	Other European	Other		
Youth aged 18-19	95.5	0.8	1.5	2.3	100%	133
Youth aged 20-24	94.5	1.2	2.4	1.8	100%	330

Age	Immigrant status*		Total Percent	Number (n)
	Native born	Foreign born		
Youth aged 18-19	97.0	3.1	100%	133
Youth aged 20-24	95.5	4.5	100%	330

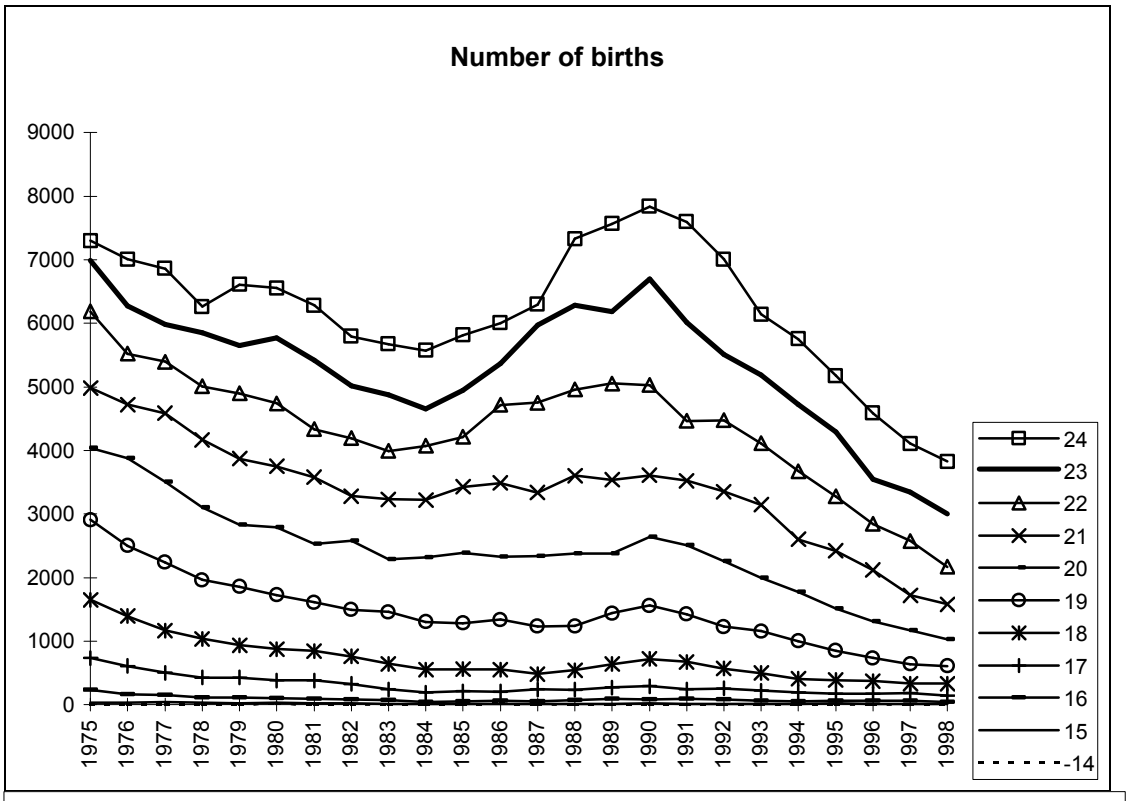
Age and gender	School status*			Total Percent	Number (n)
	In School Only	Employed only	Neither		
Youth aged 18-19	69.9	14.3	15.8	100%	133
males	61.1	18.1	20.8	100%	72
females	80.3	9.8	9.8	100%	61
Youth aged 20-24	35.5	46.4	18.1	100%	330
males	31.8	51.4	16.8	100%	179
females	39.7	40.4	19.8	100%	151

*Please provide category labels and definitions for each variable that is available and used

Source(s): Sex in Sweden (see reference #27 in text)

Year of survey/censu 1996

Figure A1 and A2. Number of births and abortions. Sweden 1975-1998. Women up to 14 years and 15-24 years. (For births, age refers to the age at the end of the year and not at the event. For abortions, age refers to the age at the event.)



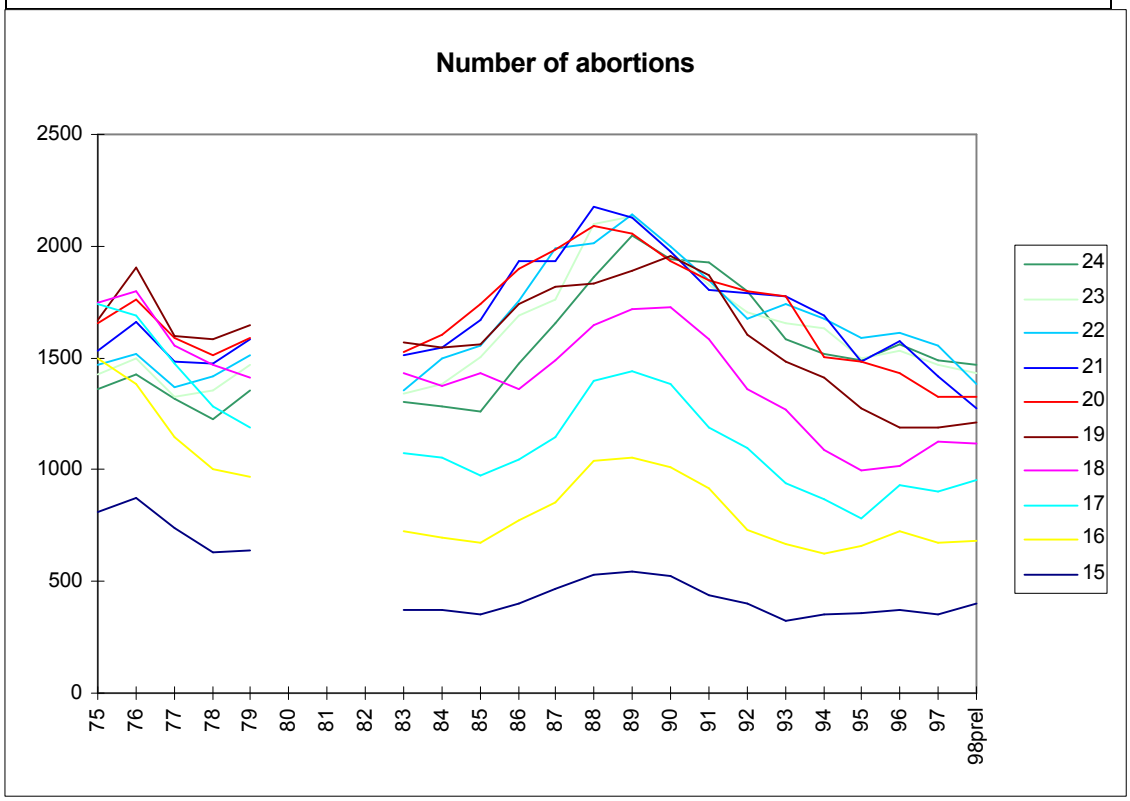
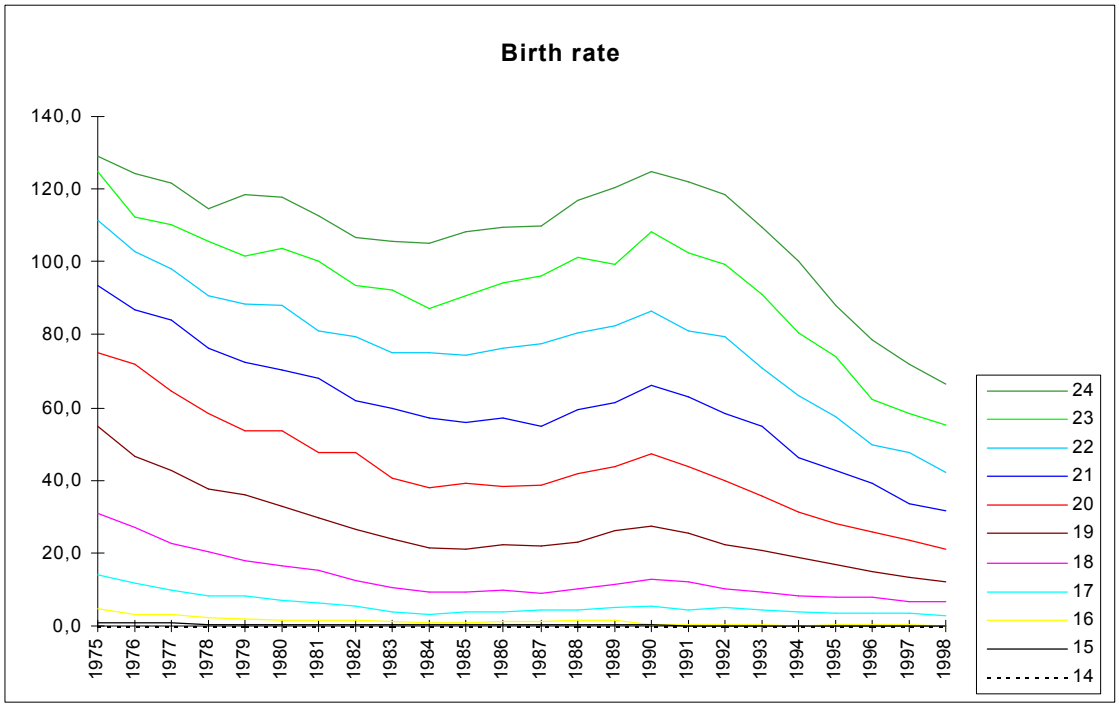
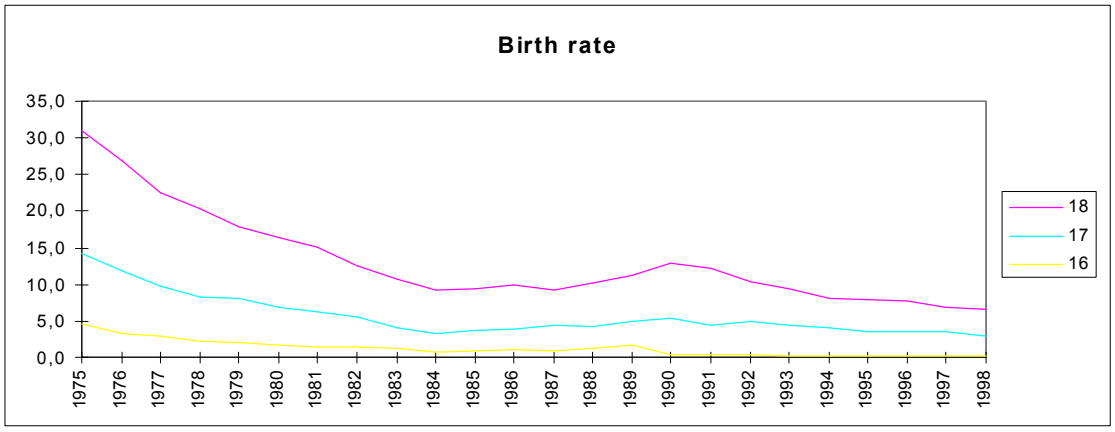


Figure A3. Live births /1000 women. Sweden 1975-1998. (Age refers to the age at the end of the year (not at the event) for both numerator and denominator.)

Birth/1000





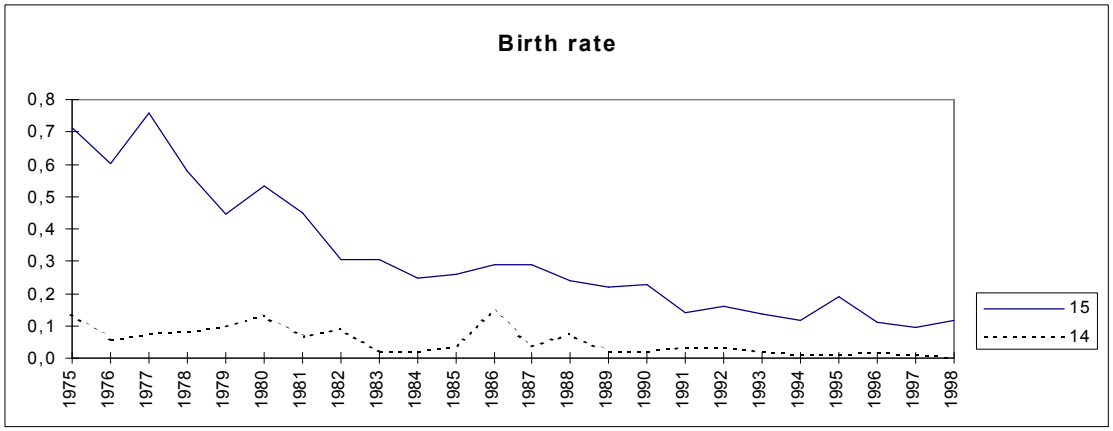


Fig A4. Abortion rate and birth rate (/1000) among teenagers 15-19. Sweden 1985-96. Age refers to age at the event. Denominator is the mean population for age group and year.

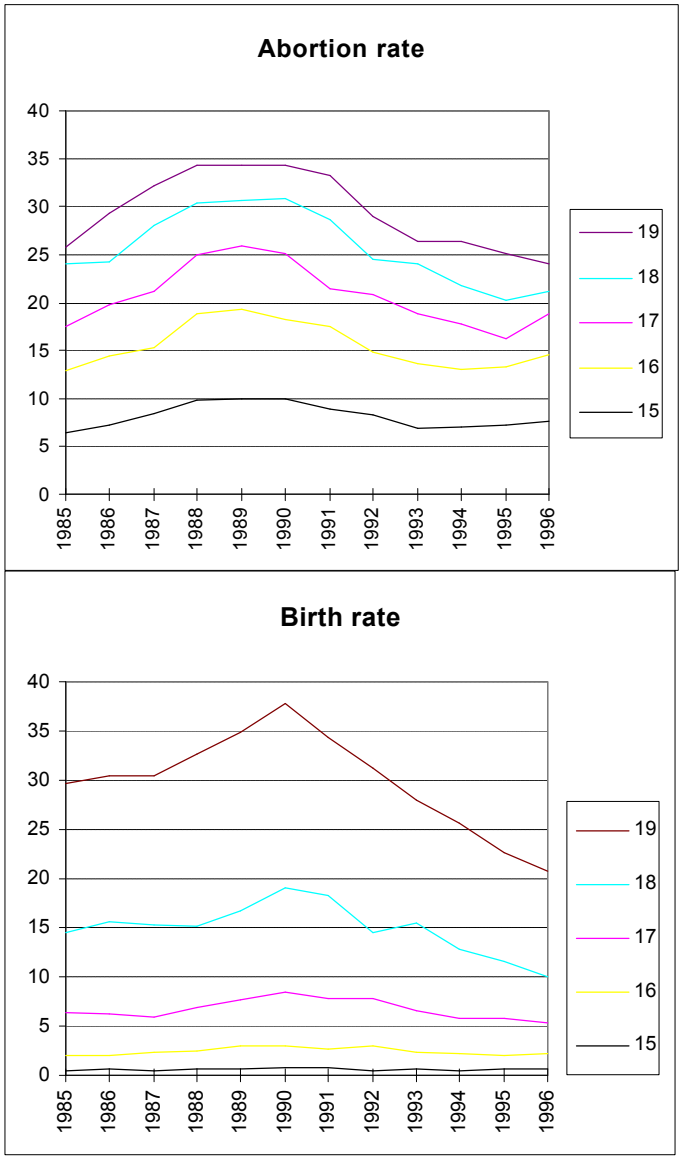
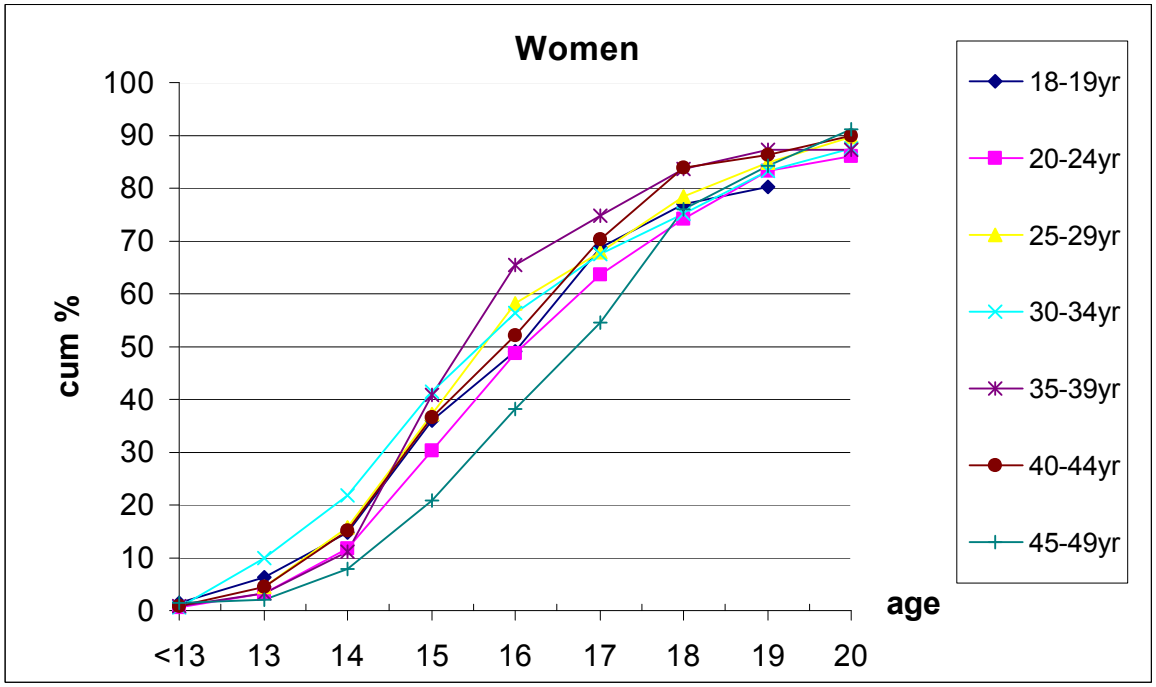
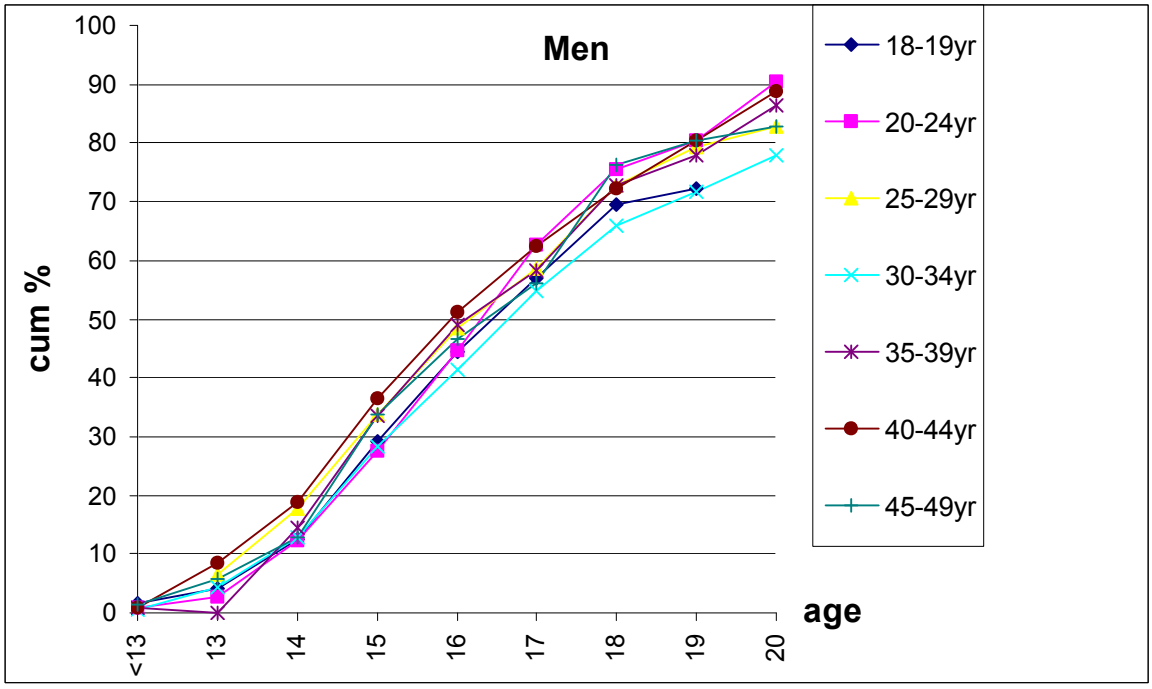


Figure A 5. Cumulative percentage distribution according to the age when the respondents first had intercourse by respondents age. Sweden 1996.





Appendix B

Country Visits

People and institutions visited by the Swedish and AGI-teams in August, 1999:

Fittjaskolan, Norsborg:
Anita Jacobsson, teacher, responsible for the program on sexuality and interpersonal relationship

FSUM, Swedish Society for Youth Centres: Martha Hansson, Chair

LAFA, Stockholm County Council AIDS Prevention Unit:
Anna-Karin Asp, Barbro Gustafsson, Gisela Helmius, Gunilla Neves-Ekman, Hans Olsson

National Institute of Public Health, Stockholm:
Mia Faber, Editor of the Magazine Glöd,

RFSU, Swedish Association for Sexuality Education, Stockholm:
Marianne Göthberg, Stefan Laack, Viveca Urwitz

Tensta Youth Clinic, Spånga
Pia Höjeberg, Nurse midwife, Head of Clinic, Martha Gialamas, Annika Nilsson