

EWHNET
European Women's Health Network



Women`s Health Network:

**State of Affairs, Concepts, Approaches, Organizations
in the Women`s Health Movement**

**Country Report
Finland**

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1. Introduction

Women's health care has developed in an evolutionary manner in Finland. "Gender neutral", "gender avoidance", "gender-blind", "gender bias", "gender-specific", "gender difference" and "gender-sensitive" are terms to be clarified as they either appear or otherwise have meaning in this context. Gender is understood as consisting of a combination of physical (genetic codes), emotional (identity issues), social (male/female), and intellectual (mental) components.

"Gender neutrality" refers to no mention of gender in writing, and this is prevailing in Finnish research, writing, and practices all the way through the health care development and administration. One potential significant contributor is the Finnish language itself as there is only one pronoun for the third person (hän=he/she) with no gender indicated.

"Gender avoidance" refers to a situation in which discussion about potential gender issues is dodged altogether. In such a significant issue as expressions of opinion, it does not seem important enough to record gender differences in literature review (Sihvo and Uusitalo 1993). A couple of sentences of explanation are found on the pages in the present guidelines of health care development: "Practices aimed at individual population groups are avoided. Universal health policy seems to have narrowed differences in health" (Terveysthuollon kehittäminen 1998;1:15). - A very real situation emerged during this writing. The existence of the network section almost folded because those contacted for information avoided the issue. One contacted person joked that women can participate in their network. Many others referred the author to each other.

"Gender-blind" refers to a situation whereby a person fails to see the existence of gender as important. This is different from deliberately wanting to reject potential contrast, dissimilarity, discrepancy, or disagreement, or to purposefully wanting to injure or abuse someone because of gender. Much of the lack of medical findings may be because methods have failed to be generated in order to test the validity of the premise about true women's interests. Some of the avoidance issues may be due to being gender-blind.

"Gender bias" refers to a failure to obtain appropriate data for a given gender and evidence from one gender is applied to another. More importantly, the common practice is that when gender is not indicated, the male gender is assumed. This is particularly common in medical research where findings of research performed on men may be generalized to women. Health issues of men have been considered of more importance in the past. The 1987 inventory of National Institutes of Health (United States) expenditures revealed that 13.5% of the budget had been devoted to issues pertaining to women, and diseases and conditions unique to women or more prevalent and serious among women, or diseases which involve different risk factors and for which interventions are different have been discussed in more detail only recently (Kirschstein 1991). Traditionally, there has been been a shortage of evidence on e.g. heart disease and women. It is now known that women have this disease later than men have.

"Gender-specific" means that knowledge is applied along gender lines: knowledge obtained about women is applied in cases of women's issues. Selected issues, such as work related evidence, are illustrating that there are true differences between the two genders. As women live longer, it is e.g. learned as to what is important in the female picture of heart disease, illustrating "gender differences".

"Gender-sensitive" means that information is recognized as pertaining to a given gender in a positive way and considered important. Research groups to be mentioned in the network section belong to this category.

Well-organized feminist health movement does not exist in Finland (Ilka Kangas 1999, personal communication with permission). In 1982, Riska recorded that it will be unfortunate unless a women's health movement to critically observe health care development issues will emerge. In her opinion, many issues should be further studied from this perspective. Women's studies have begun to emerge as a separate scientific approach to reckon, and projects in health care are beginning to report findings using this line of questioning (see e.g. Ruusuvoori, 1992, 1994).

Riska (1998) compared and contrasted American and Nordic women's health movements during the 1970s and 1980s, time when this author resided in the US and lived through many of those women's health care experiences Riska reviewed regarding Health Maintenance Organizations (HMOs), health care development, books of the feminist collectives in academia, work with the women's health centers, knowledge and practice by health professionals. Riska felt that some of the named concerns have been integrated in the Nordic welfare states. In her words, "the argument is that health services for women have been organized and integrated into health care provided by the public sector, and therefore, there are no reasons for feminist actions in this arena" (Riska 1998, p. 2).

Her analysis conveys research contributions and women's health curricula at medical schools. An element or two appear missing from her analysis during the previous decades: educational contributions by health educators and psychologists on comprehensive women's health and sexuality issues. The practical experiences of these two separate official occupations did not get reported in literature as greatly as the research and writings by feminists and traditional medical personnel did.

This report on women's health in Finland will be delimited to:

- health care with an emphasis on maternal health care,
- occupational health-related issues,
- women's reproductive and maternal health care,
- health education, and
- the health of the aging population. The writing period was limited to 30 days which put a restriction on the potential searches and readings possible for this work, particularly so in terms of general health background. A number of individuals assisted in locating resources (see list at the end).

1.1 Population background

Finland (1996) has a population of 5 125 000 (2 628 000 female) with 65.1% of the population living in urban areas. With a stable population, the natural increase is 2.3, population increase 2.8 (live births 11.8, deaths 9.6).

The mean age of women is 40.2 years, mean age at first marriage 27.9 years. In 1996, a female child at birth was expected to live 80.5 years, a 45-year old woman 36.8 years. Infant mortality which is a sensitive indicator of a nation's health is 4/1000 infants. The Nordic countries are considered to have a very low perinatal mortality rate by international standards.

Aland, an island group between Finland and Sweden, has a population (1996) of 25 000 (13 000 female). By many health indicators, such as infant mortality rate 3.7/1000 infants, life expectancy of 84.8 years at birth and of 36.8 years at 45 years of age for women, Aland would perhaps be the best place in Europe to live in. The islands have their own legislation for the health sector with the exception of administrative interventions as far as personal freedom, infectious diseases, sterilization, abortion, insemination, forensic medicine, and common rules for companies offering health care services are concerned. (Health Statistics in the Nordic Countries 1996)

1.2 History of health care

Organization of health and medical care has been the task of the State and municipalities. Areas of emphasis have varied with time, starting with infection control at the beginning of the century and continuing to build a group of hospitals and mental health centers and the tuberculosis ward network between the world wars. Maternal and child health care were structured in the 1940s, school health care with physicians was organized in the 1950s, hospitals were built again in the 1950s and 1960s, education of physicians was emphasized in the 1960s, and construction of preventive health care in the 1970s. (Health Care in Finland 1997) With the exception of the midwives within maternal health care, no great efforts were devoted to increasing women's issues among those stated above.

During the last decade, a system of health care was built containing practically all working people, including great amounts of social benefits, and seeming capable of sustaining services through the years of turmoil, downsizing, and cutbacks of the 1990s. It is typical for Finnish health care to emphasize equal access (gender equality assumed) regardless of social group, income, and place of residence (Terveydenhuollon suuntaviivat 1996). Perhaps the greatest challenge lies in the service of client needs (Terveydenhuolto 2000-luvulle 1998).

Regional differences existed with fewer physicians in the countryside and the eastern sections of the country. First reports about a lack of physicians all over the country have begun to emerge. There were 300 people/physician in 1998. In comparison, there are about 1000 people/dentist.

In 1999, there were 18 179 physicians (48% female; over 50% female in age groups 44 years of age or under), 58% of all specialize. Only 6.5% of the physicians (49% female) work solely for the private sector (Lääkärit 99). More female than male students have been accepted to medical schools in the 1990s. Unlike in other western countries, being a dentist has traditionally been a female occupation in Finland. Henrickson (1998) examined the professionalism of the medical occupation.

1.3 Structure of health care

Finland has a comprehensive municipal health care system. The 1993 legislative efforts granted autonomy to 436 (452 in 1999) municipalities. These municipalities have independent political decision making. About 188 municipalities have their own health care center, 27 of them have a separate social and health care organization; 158 (36%) have a common social and health care organization (as of October 1998). The rest of the smaller municipalities offer services as a group of municipalities.

On the other hand, 40% of the citizens live in municipalities where social and health services work within the same organizational structure (Terveydenhuollon suuntaviivat 1996). In some

communities, health care certifications are used (e.g. non-urgent visit scheduled within three days). In others, service contracts specify what is expected of health officials (e.g. promises of given quality). Vouches (e.g. patient are given tickets used to purchase services) add to a set of alternatives when one can purchase the same service from public or private sectors. The new administrative guidelines indicate that vouchers are being tested.

All national health guidelines are now in the form of strategic planning and/or recommendations rather than mandates, and obtained data can also be regionally specified. Despite the variation in population sizes, these municipalities have equally allocated responsibilities as stated by law, and alliances are formed together with other area municipalities for practical health care purposes.

Offices and departments of the health care administration can be found (www.vn.fi/stm) for social and health ministry and for related links, (www.kuntaliitto.fi) for municipalities.

Primary health care is managed through local health centers (243 in 1994; 13 without in-patient facilities; 3.7 beds/1000 inhabitants supervised by general practitioners; 23 000 beds at health centers in 1994), and these centers normally have a number of clinics in different geographic locations. Health centers are e.g. responsible for visits by medical personnel to elderly residents only; the visits are not common. Population responsibility areas or personal physicians are assigned to patients: 1/3 of the municipalities comply with the requirement at this time; personal physician can be a woman when there are women on staff; in reality, physician can be changed for a reason, although the guidelines suggest that it should be easy to change one.

The functions of the health centers include:

- to provide health counseling (e.g. public health education including family planning and contraception) and organize medical examinations;
- to arrange medical care of the citizens within the municipality (including examination by physician, treatment given and supervised by this physician in health center hospital or other medical establishment), medical rehabilitation and emergency care within the area of the local authority;
- to make arrangements for the provision of mental health services in health centers;
- to see that the local ambulance service is organized, to organize and maintain selected medical rescue services as stated by law;
- to organize dental health care with dental education and prevention, dental inspection and treatment as stated by law (the Primary Dental Care decree requires dental treatment at the health center for those born in or after 1956);
- to maintain school health care as stated by law regarding compulsory education and subsequent educational institutions;
- to arrange health care for entrepreneurs within the municipality as stated by law;
- to arrange selected screenings and other health inspections as stated by law; and
- to provide those occupational health services stipulated by law so that employers can arrange them to employees in work places and offices located within the municipality (Social and Health Care Law 1997, p. 147).

While the municipalities have the responsibility to arrange and offer health care for all citizens, they may purchase products of services together within the boundaries of the alliance or from private clinics or hospitals in the area or outside it. Three or four municipalities have thus far decided to purchase all health care services from private groups rather than to provide the services themselves.

Each municipality has to belong to one of the 21 hospital districts for specialized medical care; most districts have several hospitals within them. University hospitals are located in Helsinki, Turku, Tampere, Oulu and Kuopio. There is an effort to increase collaboration between institutional and community services and in some cases to reduce institutional care. Psychiatric services are provided by psychiatric out-patient departments of hospitals, mental health offices, and health centers. Residential services (private nursing homes and rehabilitation units) in some instances have set up programs for people with mental health problems.

The stress is on the patient, client or consumer of the services to endeavor for personal gain and the written materials let readers to believe that there are many problems tied to service while over 80% of the respondents record satisfaction with the health care services. Consumer empowerment refers to a concept whereby the consumer should be able to make decisions regarding health professionals and utilization of health care. A semantic issue is involved as words are defined by the people who use them. The present effort is what feminists attempted all along: women strived to obtain health care to their own advantage. Now this is a part of the organization of cultivated service models where the user or consumer of health care services is actively participating (Terveyden huollon kehittämissuunnitelma 1998;1) and expectations are to be taken into account.

The author has a course on Reproduction and Sexuality - a Public Health Perspective, at the University of Turku Medical School, Postgraduate School of Health Sciences since 1995. The course, which is centered around current topics, is meant as an elective for those writing their dissertations, with many students from other countries participating. As the spring 1999 course ended there was a request for feminist content from men for the fall sessions without reference as to what is meant by feminist content. As the instructor of the course, the author wondered if this request is a sign of the feminist and other about health care finally coinciding or perhaps it has become less threatening to inquire about it.

In democracy, there is a distinction between large (representation) and small (between individuals) democracy. In methods of small democracy used in daily interaction between people, four points need to be recognized:

- participating in production of knowledge, receiving information and giving
- feedback;
- consultation in two-way interaction between parties;
- making decisions, having power and resources;
- participating as an active citizen within change processes involving one's own
- personal life (Terveydenhuollon kehittämissuunnitelma 1998;1, p.18)

Patient status and rights law

Although Finland has a law on patient status and rights (see e.g. Ojanlatva et al. 1997), it is actually understood as a guideline. Right to care is defined by resources, availability of health care personnel, expectations, treatment as a person. Informed consent is essential. Patient must be informed about his/her care. It does pose a challenge in those situations where cultural issues feature in as in e.g. Romany culture (Ojanlatva et al. 1997). There are an estimated 10 000 Romanies in Finland who continue to observe their own codes of behavior. Patient's own language should be used when possible. Saame and Swedish languages are two other official languages of the country which have to be taken into account in health care and in education.

Patient advocate must be located in each health care unit, although two or more units may also share one. (Terveydenhuollon kehittämissuunnitelma 1998)

1.4 National health insurance

In a medical event requiring sickdays, every permanent resident of Finland is covered through national health insurance operated by the Social Insurance Institution (KELA). Residents pay an insurance contribution in their local taxes and employers together with and defined by the salaries they pay to employees.

Compensation for losses of earnings is paid through a daily sickness allowance when ill, pregnant, giving childbirth and caring for offspring. Medications prescribed by a physician or dentist, travel expenses to health provider, and visits to private health care provider are also covered in part when classified as indemnifiable and charged beyond personal liability.

Two thirds of the health care expenses (about 42 billion mk) were spent for health care within municipalities in 1990-91 (Terveydenhuollon suuntaviivat 1996). Municipalities receive their funding from municipal taxes and funds from the State.

Fee for payment is a method used in some areas of health care. Services at health centers were free of charge until 1993 but presently, 100 mk fee per year and/or individual 50 mk fee for service for a maximum of three times can be charged. Home visits by physician or dentist cost 50 mk for the first professional service and 30 mk for service by another practitioner. Charge set for a continuous care is determined by the family's monthly income.

In funding health care 1990-96, the proportion of public funding decreased (81-75%) and private funding increased (19-25%). Specifically, state funding decreased the most, and household portion increased the most (Terveydenhuolto 2000-luvulle 1998). In-patient care particularly in psychiatry has been cut down, while periods of care, procedures, and out-patient visits have increased in specialized hospital care. Alternative services such as services for the elderly have grown. At the same time, personnel has not shifted but being cut back within in-patient care and not being hired in new areas. There is a 9% unemployment rate in health care, mostly consisting of nurses. (Terveydenhuollon suuntaviivat 1996)

1.5 Alternative care/self-care

Finns use unofficial health care services but due to the relatively small number of studies the frequency of the use of such services has been unclear (Meriläinen 1986, p. 1). Alternative care practices appear as new practices (Vaskilampi 1992) apparently in part because traditional medicine does not promote patient communication adequately. Many of these new services are provided by groups of women.

Meriläinen (1986) discovered that more women than men used the alternative health care services indicated in her study, and there was clear regional variation in how they were used, with those living in the south using fewer alternative and ethnic treatments. Massage and naproathy were common in the west, cupping in the east, and natural healers in the north. Official and unofficial services were mixed, and it looked as if using vitamins, minerals and other food preparations was a part of health care while the rest were tied to treatment and care. The existing official services are not necessarily responsive to the needs of the population, and Meriläinen found that women were particularly critical of the official health care system. The study population seemed fairly healthy and interest in alternative care was mostly incidental. Among women, the most appropriate health behavior was noted for those in the North.

Self-care has been investigated in Finland as an option of health promotion in a couple of instances (Urponen et al. 1987, Meriläinen 1986) but the meaning of it is still unclear as the

questions in the survey by Meriläinen turned out not to measure it appropriately. Riska (1982) observed that Finnish interest in self-care is epitomized as procedures in health education and preventive medicine and individually seen as jogging, joga, vegetarian diets, use of vitamins and minerals, etc. While a reform-oriented approach was to create a helpful patient, radical feminism attempted to create self-help so that women can gain for personal reasons particularly in the gynecological areas of service when the official system was not created to do so. Riska had been hesitant about whether a feminist self-care movement would emerge, and it did not (Riska 1982).

Riska (1982) did point out that it is important to separate personally-oriented self-care from one being directed by others. Personally-oriented self-care seems to be less popular but Finns have recently expressed displeasure in the official health care services, and selected changes have resulted following research in alternative care practices. It is typical for the Finnish system to trust findings of research. The present patient rights orientation appears to satisfy personal needs and said feministic health care emphasis may continue to decrease --if it ever existed. Riska (1982) expressed concern for the passive orientation in directed self-care, and it could be expected, that with trial and error in studying what works, her suggested new groups and forms of service could eventually emerge in this country.

2. Occupational health-related issues

Finnish working age population included of 3 398 000 people (1 691 000 female) in 1997 and a total employment of 2 170 000 people (1 028 000 female). The mean age is less than 40 years old. As the work force becomes older, the aging of companies will also be seen as finding younger employees becomes increasingly more difficult. (Employment in Europe 1998)

About 64% (61% female) of the population was employed in 1997 of which about 22% in the age group 60-64 years of age. Of those being employed, 17% (19% female) are on fixed term contracts, 14% (9% female) are self-employed, and 11% (15% female) are part-timers. Unemployment rate was 13% (14% female). There are more working women in Finland than in the EU on the average. (Employment in Europe 1998)

2.1 Occupational issues

2.1.1 Educational issues

The proportion of the women among those with basic university degrees is 60%, with teaching, social and health field occupied with women. As many as 80% of the new students entering technical fields are men (Aitta 1999).

About 40% of the doctoral degrees are by women but only 18% of professors are women. Women do not advance in their careers as men do (Stenbäck 1999), and Stenbäck cited a professor who feels that equality in Finnish academia is a utopia. It has been observed that women find it difficult to locate permanent employment with career advancement opportunities in the private sector. "Glass ceiling" is a reality in Finland as well. (Kauppinen 1999)

In Finland, "equality" appears to have been delimited to one between the genders (Vahtera and Sihvo 1994). Education and degrees have not contributed to this equality in salaries and contracts (average monthly salary 19 120 mk for the male and 14 340 mk for the female employee, information from the trade union for professional workers). While 11% of men in 1997 and 1998 were in temporary contract positions, about 20% of women were in the same situation during those years. More women than men were acting as a substitute for a regular employee. More than half of the women accepted or had to take a temporary appointment as the first job while the percentage was clearly smaller than 50 for men. More than half of those surveyed (61% of men 55% of women) felt that temporary appointments were a problem. (Aitta 1999)

2.1.2 Nature of work among women

Somewhat less than 70% of the adult women participate in working life (Kauppinen and Kandolin 1998), 58% in the age group of 55-59 years of age --with the service sector providing most of the jobs for that age group. As in the EU in general, women's work in Finland differs from that of men's, and correspondingly, the working conditions are different from each other. Most women work in health and social welfare, in commercial settings and in administration and offices. (Kauppinen and Kandolin 1998)

The nature of women's work has to do with other people and relationship issues. It requires communication skills, and consequently obligations and burdens are psychologically heavy,

while men's work in industrial settings contributes to susceptibility to chemical and physical hazards and to noise (Kauppinen and Kandolin 1998). Most occupational injuries consist of hearing damage (Health Care in Finland).

Mental cruelty (harassment, belittling, intimidation, inappropriate behavior and demeanor) is experienced by women more than by men, and women seem to sense it easier (Kauppinen 1999). Working in psychological interaction with others sets a person up for potential preference, discrimination and harassment. Although a reasonably small section of employees (3% of women) experienced sexual harassment in the EU study, they did encounter stress, tension, and depression (Kauppinen and Kandolin 1998).

Talking about troublesome issues is not easy and contributes to issues not being articulated. Each culture has its own politically-correct discourse which can emerge e.g. in health care settings in significant ways when not addressed, one is not prepared for them, or the matters emerge in timely circumstances (Heino and Ojanlatva, in press). Reciprocity in communication is not a common topic of study in work settings.

Women perceive failing in inequality in the work settings more than men do with less than half of those surveyed agreeing that there is equality and a fifth having felt inequality (Kauppinen 1999). Disturbances in well-being, poor and tense atmosphere, and conflicts at work were also cited. Men generally feel more unconcerned about these issues than women do. Half of the women work in typically female occupations, and it is typical of women to be exposed to negative stress, with changing conditions, increasing competition, and short term and atypical contracts making life tough. Sexual harassment, emotional violence, intimidation and threats, even terror are cited as new forms of work problems. (Kauppinen 1999)

2.1.3 Age discrimination

Kouvonen (1999) used four different data settings and studied the prevalence and nature of age discrimination at present and previous work places and at recruitment and dismissal as well as the attitudes of employers at small and medium-sized enterprises (n=878). A total of 27 elderly job seekers were also interviewed. Age discrimination was estimated as being mistreated without cause either directly (expressed directly as due to age) or indirectly (recipient feeling that he/she is being discriminated against).

According to Working Life Barometer study (n=1178), 8% of the employees had noticed age discrimination, and 10% according to Quality of Work Life Survey (n=2979). Those under 55 years of age had rarely felt direct discrimination while 55-64 -year old employees felt that they had experienced direct discrimination. These events materialize as inadequate opportunities for career advancement and education, insufficient information, missed opportunities in reorganization, or inappropriate attitudes of co-workers. It seems disturbing that women appear never to be of correct age for a given job situation.

As many as a third of the respondents said that they poorly knew the law regarding age discrimination. "The provision on age discrimination does not meet the requirement as prevention of age discrimination in recruitment or work" the author stated (Kouvonen 1999).

2.1.4 Burnout at work

Burnout is defined as a serious syndrome which develops at work. Changes in working life, hurrying, and increase in productivity are considered important factors contributing to burnout. Three elements of burnout have been identified and studied in Finnish working life: feeling tired or exhausted, cynicism, and poor professional self-esteem. (Kalimo & Toppinen, 1997)

Feeling tired is the kind of burnout which does not disappear by daily resting. Cynicism is considered to be present when 1) delight no longer exists, 2) there is uncertainty in experiencing work, and 3) there are misgivings about the meaning of work. Lowered professional self-esteem is tied to a fear that one cannot do the job. (Kalimo & Toppinen 1997)

The study by Kalimo & Toppinen (1997) addressed four questions in their own study. Which are the fields where burnout is prevailing? How serious is it? Has it increased? How to prevent it?

The study contained 3300 subjects (53.3% women, 2300 working women). There was burnout in 55% of the cases (exhaustion 61%, cynicism 50%, poor professional self-esteem 32%). Both long and short work experience were tied to burnout. Poor professional self-esteem was the worst among part-time workers. Great prevalence existed in medium-sized work places; poor professional self-esteem alone varied according to size of work place. Burnout varied according to profession and kind of work place, and 61% of the participants felt need for education. (Kalimo & Toppinen 1997)

The authors suggested that the experience of stress has increased, and that women have generally reported more burnout than men. Burnout is rather stable and found to exist after a year of identification, and will result in depression if not treated. Burnout is an issue for those who work with personal relationship issues and when goals cannot be obtained or are limited in being obtained. (Kalimo & Toppinen 1997)

There are individual ways to handle burnout. Their effectiveness can be noted when the following are present: regulation of the working situation, assessment of one's personal working attitudes, and relief of personal ill-feeling (Leiter 1991 in Kalimo & Toppinen 1997).

2.1.5 Health effects

Negative stress in the form of strain is a part of the livelihoods of women. All this poses a challenge on life expectancy and mortality as early as by midlife.

It seems that life and life style issues (tobacco smoking, alcohol use, long working days, rapid work) are harder today than 50 years ago, and indicate that today's women are no healthier than women then. The issues are propagated by the fact that there are family responsibilities involved and gender roles have changed in the public life but very little in the private sphere. (Kauppinen 1999)

A survey from the Population Institute of Finland was mailed to 2000 men and women of 30-45 years of age (67% response rate). Family is valued the most. In principle, Finns divide the tasks at home but in reality women attended to home and kitchen, men to building and repairing of that home. Child care and economy caught the attention of both genders. Men are more satisfied with the division of the tasks than women are. Procreation and an active sex life were more important to men than women. (Pirttijoki 1998)

Finland is a part of the European Heart Network (EHN) linking 26 national heart foundations. Cardiovascular disease (CVD) is presently studied there from the lower social class perspective, since the customary risk factors (smoking, diet, physical activity) appear to explain less than half of the difference in the CVD rates between higher and lower social classes. Occupational factors together with e.g. social support is considered to play a major role. (European Heart Network 1998)

A nine-fold difference between high and low risk occupations among men and a five-fold difference among women are noted and considered too large a difference to be explained by conventional risk factors. Two stress models are looked at:

- in the job strain model, people in jobs with high demands and little control over decisions are in a high job strain situation and at a higher risk of CVD, and low social support at work increases the risk further.
- in the psychosocial model, people work hard (high effort) but receive little reward (money, esteem, status control) and experience an imbalance which puts them at increased risk of CVD, and when additionally having a high 'need for control' to be at particularly high risk. (European Heart Network 1998)

It has been estimated that 22% of the risk in women could be prevented by eliminating all occupational risk factors from the work environment. Job strain accounts for 14% in women and shift work 7% in both sexes. With sedentary work in the calculation raises the proportion of CVD cases caused by work to around 50%. (European Heart Network 1998)

In particular, the "concept of status control may be of central importance for understanding the stressors of the modern and future labor market where change and need for flexibility are the main characteristics." (European Heart Network 1998 p. 16)

New findings suggest that poorly organized work contributes to disease. There is e.g. a significant association between downsizing and medically certified sickness (Vahtera et al. 1997). Psychosocial factors at and outside work, including low job control, low social support, negative life events and personality trait sense of coherence have predicted future absence due to sickness among women (Kivimäki et al. 1997). In addition, personality appears to play a role in response to stressful change within working life. There is e.g. heightened vulnerability to ill health through hostility after organizational downsizing among women (Kivimäki et al. 1998)."

Women are particularly vulnerable to worklife changes because of their double role. Women's work is fast-paced, socially demanding, and few women have a chance to advance in their careers. (Kauppinen and Kandolin 1998)

Finland endured a period of serious recession during the 1990's. However, the health status and its social patterning has been reported as stable during the recession with no significant differences between the female employed and unemployed persons in limiting long-standing illness or self-assessed health (Lahelma et al 1997). Martelin (1994) remarked that occupational life shapes a personal life style and influences purchases of healthy products in the form of food, medical services, etc. contributing to choices and selections. The effects of direct influences pertaining to economic factors remain unexplained.

2.2 Occupational health organizations

The following organizations play a role in the occupational health picture of this nation.

2.2.1 Ministry of Labor

Two divisions exist:

1. Occupational Safety and Health Division (safety, inspections and supervision, cooperation, international relations, occupational health care and institutions, organizations in safety) in Tampere, and
2. Working Environment Division (employment relations, working time, systems in participation in working life, legislation, bankruptcies and pay security) in Helsinki.

2.2.2 Finnish Institute of Occupational Health

As a specialist organization with six regional institutes and a staff of 500, this Institute conducts appropriate research and helps solve problems associated with work places.

Research (39% of time, 180 on-going projects), advisory services (42% of time), training (150 courses annually), and dissemination of information (periodicals, newsletters, online information and library services through the Information Service Center) are the core activities.

2.2.3 Center for Occupational Safety

The Center serves the labor market as a training, information and service agency. The general goal is to increase well-being and success in working life.

2.2.4 The Finnish Work Environment Fund

The organization funds research and development projects in occupational health and safety and finances the activities of the Center for Occupational Safety.

2.3 Occupational health services

Occupational health services cover 100% of the large and medium-sized companies and about 50% of the small companies and self-employed persons (Rantanen 1998).

The contents of the occupational health service act essentially display preventive risk-directed orientation with gender-neutral emphasis, follow up health of susceptible individuals, promote work, working abilities and health education, and aim at equality. Historically, e.g. women's shiftwork had been regulated before guidelines were set for everyone. (Rantanen 1998)

In 1990, active and multidisciplinary orientation with Maintenance of Work Ability (MWA) is recognized in occupational work. Through an amendment, the MWA was integrated into the Act of Occupational Health Services in 1991. An emphasis on the development of healthy and innovative working organizations is also recognized. (Rantanen 1998)

2.4 Occupational health law

The occupational health law states that employers are responsible for arranging health care for employees and municipality is responsible for those who are entrepreneurs or otherwise working alone as stated by law:

- through visits and other methods when necessary, to assess dangers and complications to employees resulting from work and circumstances when planning or beginning/implementing work;
- adequate information given to employees about dangers at work and necessary
- supervision to avoid dangers;
- when information not available, assessment of personal health hazards which may be caused due to work when work being initiated;
- arrangement of a physical examination and repeated examinations when needed as there is suspicion about health hazards, as well as repeated physical examinations at stipulated time intervals during the employment period at work which is particularly hazardous or when a labor official so indicates (two separate points);
- follow-up of a person whose working ability is affected by injury, disability, or ailment by taking the person's abilities into account, instructions for care and rehabilitation, and personal participation in maintenance of the working abilities as stated by law;
- participation in the arrangements of first aid (Sosiaali- ja terveydenhuollon lainsäädäntö 1997, pp. 153-154)

3. Women's reproductive and maternal health care

Research on women's health issues particularly by women is briefly recited on selected issues, including issues of maternal care.

3.1 Maternal health care

Good maternal and child care practices are contributing to low infant mortality rates in Finland. Health of a woman is followed up throughout pregnancy and follow-up visits after it with the newborn at the Maternity Health Care Clinics, and the new baby is similarly an object of physical, mental, and social observations by nurse and physician at the Well-Baby Clinics several times during the first year and at six or twelve-month intervals thereafter. Vaccinations are also provided and over 90% of the parents agree to have their children vaccinated (Health Care in Finland 1997).

Maternal health care was organized in 1944 and the law stipulated that one midwife should be available for an area of 5000 inhabitants and one for each 5000 inhabitants in a city (e.g. Turku has 16 visitation sites). The existence of midwives is a strong one and cited in feminist literature, with education of midwives since the 17th century.

A pregnant woman living in Finland has the right to maternity and parental allowances when pregnancy has lasted at least 154 days and the potential mother has made the first visit to a maternal health care or personal physician before the end of the fourth month of pregnancy. The family allowance may be obtained as a package or as money (760 mk in 1999) and is per child so that having twins will bring two allowances, etc. Application for this allowance is to be made two months prior to the estimated birth.

The maternity/parental leave is 263 days long, Sundays not included in the counting (105 for mother alone as maternity leave allowance, 158 for mother or father as parent, parent leave allowance). The maternity leave allowance is based on the existing or previous salary as is later parental allowance. Maternity allowance needs to be applied for two months prior to child birth.

Father is allowed paternity leave 12 days off paid immediately after the birth of the baby and 6 additional days off sometime during the mother's maternity or parental leave. A father may also use the 158 days of parental leave instead of the mother using it. The allowance is determined in both cases by the existing or previous salary. If mother and/or father is not employed, the amount of the allowance is 60 mk/day. Following the birth of the child, a child living in Finland will be paid child allowance which is 535 mk/month for the first child and increases stepwise for the other children. While the allowances paid to parents are taxable income, child allowance is tax-free and cannot be used to deduct payments. The parents need to have lived in Finland for 180 days prior to child birth in order to claim the needed allowances, and the father must be living with the mother in order to claim the paternity allowance. There are no days of living restrictions for the child.

About 99% of the mothers attend the maternal health care, and there is a recommendation for 13-16 maternity health care visits with an uncomplicated first pregnancy and 9-12 visits in subsequent pregnancies, including two post-partum visits (Screening and collaboration in maternity care 1996). The City of Turku which is different in maternal health care from the rest of the country in that gynecologists are a part of it had about 17 visits per pregnancy in the 1980's (Rautava 1985). While about 4 physician visits take place in normal circumstances

elsewhere in the country and the rest are with public health nurses, women in Turku are referred to hospital physicians in problem issues only (Hanna-Leena Rouna, Helena Äyräs 1999, personal communication). Medical tests are mapped out for each week of pregnancy and visits with the physicians are reported to the woman's own maternity health care center.

Reproductive health of working women (and men) has been legislated in Finland specifying a potential public allowance for a pregnant woman since 1991. General risk reduction was specified in the occupational regulations above. An employer must reduce a given risk or attempt to find a less hazardous assignment for a pregnant woman, and when that is not possible, this woman has the right to a paid leave without reduction in the regular maternity leave. Fewer than expected women take advantage of the provision. (Taskinen et al. 1995)

Pregnancy is a normal function but it can involve illnesses and diseases. The primary aim of maternal health care is to help increase mother's knowledge of child bearing and to assist in making appropriate choices for health behaviors (Rautava et al. 1994). A recent doctoral dissertation revealed that advice giving for mothers in maternity and child care is related to family policy measures, social class and gender systems, historical and cultural tradition, customs and ways of thinking in a given society (Kuronen 1999). Rautava (1989) evaluated the effectiveness of health education efforts within the maternity health care system in the 1980s.

Sihvo and Koponen (1998) investigated how well the offerings of the health care services corresponded with the reproductive health care needs of the clients. A questionnaire was mailed to 3000 women (74% response rate) and 400 men (53% response rate). Almost all women had visited a physician because of contraception at least once. The services were considered satisfactory, and no major shortcomings were found. The counseling at the maternal health care centers was requested to be changed and brought up-to-date. More information was desired on fertility.

Parenthood is considered among one of the greatest challenges in adult life, and education should be offered so that one gains the most of it, referring to issues stated in the law of patient status and rights: integrating personal culture and language for all, minority groups included.

Salo (1994) suggested that effectiveness of maternal and child care has possibly been considered due to adequate supervision in a given time period and due to successes of the authorities in selling the services. Expressed in another way, Finns have nicely adapted to the contemporary circumstances and used the services for their benefit. Health education in this context is accepted well. (Ojanlatva 1999)

3.2 Childbirth

The average length of stay at a Finnish hospital during pregnancy and childbirth are 3.9 days (Health Statistics in Nordic Countries 1996).

In Turku in 1996, most births (62%) were to women 25-35 years of age. Practically all of these mothers (97.3%) were Finnish citizens, 64.2% were married, 23.6% reported living in a marriage-like relationship without being married. Over 60% had none or one previous child. During the pregnancy, 77% of the women had reported having visited maternal health care 9-19 times, and 95% had had a routine check-up at the hospital out-patient clinic. (Syntymärekisterin palautetilasto 1996)

Based on ten interviews of women having their first babies prior to childbirth and after it, Ruusuvoori (1994, 1992) suggested that while the normal course of childbirth is established using medical terminology and technology, aspects of counter-discourse are being integrated in this practice. The women negotiated the process by conforming to the standard practice of a hospital patient but acting out their own feelings during the process of giving birth. Safety of the process seemed to be valued as the most important factor. Nine in ten women wanted to have the process take place at hospital; in fact, almost 100% of the births do take place at hospital.

Fear of childbirth can be serious and have long-standing impact (Saresma and Ruotsalainen 1998). Ruotsalainen and Saresma (1999) are presently studying the many kinds of reasons contributing to fears of childbirth and educating the nursing profession as they go along. Another set of papers pertaining to the topic is also in process from a pediatrician perspective (Rautava 1999, personal communication with permission). There is need for a positive experience for all involved.

3.3 Prenatal screening

Two recent studies have disclosed as to how women feel about prenatal screening.

Santalahti (1998) described prenatal screening as a health service activity. In 1993, questionnaires had been mailed to all public hospitals with obstetrics and gynecology departments (response rate 100%) and to a random sample of public municipalities (response rate 99%). Samples of women visiting maternity centers with serum screening were included in two towns (response rates 88% and 85%) and one town with ultrasound.

Almost all women had sketchy details of the available tests in Santalahti's (1998) study. Participation did not appear to be based on active decision-making. A woman was more unlikely to participate in serum screening or to have an intention to terminate pregnancy in case of a potential fetal disorder when she knew a person with congenital disability than those who did not know one. Women receiving positive test results were found to be anxious about it.

Hietala (1998) discovered that Finns, and relatives of aspartylglucosaminuria (AGU) patients in particular, generally hold positive attitudes towards genetic testing.

3.4 Contraception

The thought that Finland should increase its population (Salmi 1995) is challenged by those who contribute to it, namely women. Education is considered one of the most effective birth control devices, and it is truly working well in Finland.

Prevalence of contraceptive use among fertile Finnish women is high; it has been suggested that more than two-thirds of those 22 to 46 years of age use a condom or another method.

The intrauterine device (IUD) was studied using a stratified random sample of 18-44 -year old women in the province around the capital of Finland in 1987-88. There was a high prevalence 77% for the use of this contraceptive. In all, 71% of those responding to the survey considered it a good method of birth control. (Makkonen 1994)

Oral contraceptives are well received in Finland with sales of 192/1000 for women 15-44 years of age in 1996, sales of IUD 67/1000 women in comparison (Health statistics in the Nordic Countries 1996).

In a study of Finnish health care services with more than 5000 inhabitants (N=185) and a random sample of women 18-44 years of age (N=2189), most women preferred a combined service of family planning and maternity health care clinics or separate clinics rather than integrating reproductive and other primary health care services (Koponen et al. 1998).

Permission for abortion is given by physician based on social/medical criteria. Number of induced abortions in 1996 was 10 437. There were 14 408 (12 600 female) sterilizations in 1996. In 1996, the following surgical procedures were performed per 100 000 Finnish women:

Hysterectomy	9 728
Mastectomy	1 992
partial excision of mammary gland	1 942
Cesarean section	9 166

(Health Statistics in the Nordic Countries 1996)

3.5 Hysterectomy

Luoto (1995) suggested that although hysterectomy has been extensively studied in other countries, epidemiology of it has largely been unknown in Finland. She used three different sources of information for her investigation: 1) representative survey about menopause and health, 2) Finnish hospital discharge register 1971-89, and 3) Mini-Finland Health Survey 1980 in 218 women had gone through hysterectomy, all confirmed with hospital records. In 163 hysterectomies, one or both ovaries were preserved, in 55 cases both ovaries were removed. She reported no statistically increased coronary heart risk and heart failure among those whose ovaries had been preserved.

3.6 Ovarian cancer

There is no cheap, easy and quick way to detect ovarian cancer, the fourth common malignancy among Finnish women in 1995 (Engblom 1999). It is the leading gynecological cause of death among women. About 600 new cases are found annually, and often too late as ovarian cancer does not have clear symptoms in early stages. Auranen (1996) studied familial occurrence of ovarian cancer and discovered that siblings have a 3.7 times higher risk.

Vuento (1996) discovered that in ovarian cancer, a useful diagnostic tool is ultrasound. The contraceptive pill has been found to provide a protective effect, and 4-5 -year long period of using the pill is adequate for a protective effect.

About 75% of the ovarian cancers are advanced. The 5-year survival rate of an advanced cancer is 42%. In addition to surgery, concomitant use of cisplatin and docetaxel was studied and found beneficial (Engblom 1999).

3.7 Sexually transmitted diseases

Of the more than 20 sexually transmitted diseases, HIV/AIDS, Chlamydia, Gonorrhoea, Human Papilloma Virus, Syphilis continue to cause problems in Finland. Reportable diseases include (with rates) e.g.

Chlamydia	16/10 000 (1993)
Gonorrhoea	1/10 000 (500 total) (1993)
Syphilis	0.1/10 000 (63 total) (1993)
HIV	0.1/10 000 (70 total in 1994)

3.7.1 Maternal HIV Screening

Following an "unlinked-anonymous" testing period for maternal HIV screening carried out from samples meant for other purposes and conducted at the National Center for Public Health in 1993-97, a decision was made by the Ministry of Social Affairs and Health to test all prospective mothers on voluntary basis beginning 1998. No additional blood sample is taken during visit for this test in case a permission is given to test for hepatitis B. For statistical comparison purposes, 80 new positive cases emerged in Finland in 1998, 32 (40%) of those were women. More women of 25-35 of age than any other group catch the HIV infection in Finland right now.

Mothers have agreed to be available for testing. In 1998, 59638 samples were drawn and only 417 (0.7%) refused the testing. The test was repeated from the existing blood sample for 22 mothers. A new sample is drawn when a repeated test is also positive or unclear. Nine (9) new samples were drawn in 1998, and five (5) were positive; one of those was a new positive: the person did not suspect it. Eleven (11) mothers had syphilis, 83 tested positive for hepatitis B.

Following birth of one child, several HIV positive mothers have elected to have another or more since none of the babies born to these women have become HIV positive themselves (Korte 1999, personal communication).

The general HIV policy is to aim at

- 1) the lowest potential amount of new cases,
- 2) the best possible treatment and care of those infected with the virus, and
- 3) treatment with respect of those infected and sick with the virus.

Information and health education are considered the corner stones of the prevention of the HIV/AIDS epidemic. The general aim is that people know about the transmission of the infection, are able to protect themselves, and can find treatment and care. HIV health education is directed at the maternal and well-baby clinics, family and adolescent clinics, school and university health care, and the general health care field. Special groups needing health care through assessed needs are those using drugs and alcohol, prostitutes and their clients, prisoners, those traveling elsewhere, those moving to Finland, those working elsewhere, and men who have sex with men.

Health care professionals are considered the primary group in the prevention of HIV/AIDS, and sexual issues including sexually transmitted infections should be discussed with clients in patient education. (HIV tietopaketti 1997 and Varti 1999 used for this section)

3.8 Human Papillomavirus (HPV)

In the early 1980s, evidence was increasing on a viral or bacterial infection possibly being responsible for cervical cancer. It seemed that sexual behavior was a key issue in what was happening, that a woman's anatomy and physiology played a part in it, and that Pap smears were important in the diagnosis of the condition (Ojanlatva 1990). It took until the 1990s before substantial new information had been collected.

Human Papilloma Virus (HPV) infection can be found in the genital area but it can also be transmitted from mother to child and be located in the oral area (Atula 1998) or in direct or indirect contact with the skin (Lu 1997). While around 1988, there were about 50 types, more than 100 types have now been recorded. There is clear geographical distribution of the HPV types by country (Ji 1991).

The most distinct risk factor in Kataja's study (1992) of a screened group of women aged 20-65 was the number of sexual partners during the past two years. Preliminary findings of studies with male partners by Kellokoski (1992) suggested that transmission in oral sex from genital area to oral cavity was unlikely.

Human Papilloma Viruses do not grow in culture but need to be retrieved from the natural lesions and may illustrate new evidence in the future (Auvinen 1992). Still during the early 1990s, there was no clear ob/gyn practice at hospitals in Finland (Paavonen et al. 1992). Since Ji's study (1991) also suggested that traditional methods of clinical practice are of little value in diagnosing subclinical and of no value of diagnosing latent cases, there is a concern as to how the advanced cases can be found in reasonable amounts to save lives.

4. Health education

The Center for Health Promotion coordinates the health education and promotion activities in this country. Health organizations form the membership under this umbrella.

Similarly to all other work in health care, health education has generally been made gender-neutral with the exception of the work in maternal health care despite the fact that clearly most health education staff and personnel consist of women. At the same time, no female health educator is working in leadership capacity at the national level, and interestingly enough, no Finnish health education specialists were invited to function as evaluators of two recent open positions for professorships. And only men were qualified for the positions.

4.1 Health policies

Finland is following the World Health Organization (WHO) strategies and reporting the findings back to the WHO. Equality in general, health promotion using large sociopolitical activities, and collaboration between various clusters of activities are being emphasized in writing. It is considered important that large groups of people participate. (Health Care in Finland 1997)

With a great population movement to large centers impacts individuals and families: loneliness, couple relationship problems, difficulties between parents and children, sexual dysfunctions, psychosomatic symptoms and suicides. Recognition of mental health problems and promotion of mental health are considered some of the most difficult tasks right now. (Health Care in Finland 1997)

Promotion of health habits, reduction and removal of health hazards due to environmental factors, and development of the health care system have been defined as corner stones of the health strategy. Health education addresses personal health habits of these three. (Health Care in Finland 1997)

Improvement of nutrition (attention to refined foods, saturated fats, sugar in energy, salt), promotion on non-smoking behavior (through legislative steps in the work place), and reduction of alcohol related hazards (due to liberalization of liquor sales in stores) are important. Primary health education is also concentrating in human relationships and mental health. School health education's main job is to educate people about their health. Hospital health education efforts address the above stated issues in clinical setting, with nutritionists doing an outstanding job in the nutrition and food habits domain in this respect. According to a hospital health educator, sexuality issues are valid patient education concerns today.

4.2 Forms of health education

4.2.1 School health education

School health education as an academic field of study and research is found at the Department of Health Sciences of the University of Jyväskylä. Until 1993, school health education had been mandated. When the municipality law was established, school districts were also given the permission to design their own health education policies, practices, and procedures.

According to Juho Korhonen (1999, personal communication), teaching materials and lectures at the school level are gender-neutral with the exception of those pertaining to maternity and

smoking as educational issues. This policy is repeated in the education of health education professionals with the exception of two textbooks which provide gender sensitive content for exams: Tobacco and women's health (Vierola 1996), and Sexuality (Hovatta, Ojanlatva, Pelkonen and Salmimies, 1995).

4.2.2 Physical activity/health psychology

The Urho Kaleva Kekkonen Institute in Tampere is concentrating on research on physical activity and also participates in the teaching and research of health education at the various academic levels. The health education research being conducted there is oriented towards physical activity and health psychology.

Health counseling and tasks associated with somatic diseases were considered important functions of the public health law, and e.g. 20% of women are considered to need psychological counseling. A group of 250 health care center psychologists serve the primary health care network (Psykologipalvelut 1993).

4.2.3 Clinical health education

Several medical schools have integrated health promotion/education teaching, research, and service activities at their Departments of Public Health and General Practice, mainly in terms of patient health education activities. Patient education efforts have existed for two reasons: legislative efforts and public health efforts due to problems.

One present orientation of health education research is social support. As an example, the findings of a study by Nygren (1997) suggested that clients will be ready to change health behaviors with individually tailored social support. In other words, when people have personally planned programs, they make needed changes in health behaviors.

In patient education like in every field, professionals need to be prepared for work. Patient education is seen in medical education through health education activities (Ojanlatva 1994). The study assessed the teaching of health topics and particularly of health education at the University of Turku Medical School. The results illustrated that health education is covered, yet in varying degrees. In 1995, the required health promotion/ education course for medical students was changed into educational experience using problem-based education principles.

Three laws (public health law, occupational health law, patient status and rights law) guide health education activities in health care with patient status and rights law specifically directing to patient education practices in that when a suggested treatment is not acceptable to the patient, another one must be found together in communication with the physician.

4.2.4 The health care laws are skeleton laws

They define limits of functions with basic tasks but practical actions are directed by professional skills, ethical practices, professional norms, and habits of the land, in that order (Amberla 1994, personal communication in educational session). A law applying to health care practitioners (1994) suggests that health promotion together with treatment and disease prevention constitute the health care in Finland.

Two kinds of health education efforts organized at the national level by policy have traditionally existed in Finland: primary and secondary health education in maternal health

care (by nurses and physicians) mentioned above and during dental appointments (by dentists and dental hygienists).

Maternal health care was explained earlier. Emphasis on oral health education issues varies by the person providing it and to some extent by municipality due to administrative structure (Pentti Alanen 1999, personal communication). In these two situations, most of those offering health education services are women and they have been able to and allowed to use their personalities as a tool for work.

Dental health has conventionally been a significant health issue in Finland, although dentists and dental hygienists have not necessarily been included in all strategic health planning in the past, despite the fact that oral health is significant in everyone's health status. About 10% of the total health budget involves oral health care.

Dentists have a reputation as patient health educators at the office, in using interventions for the patients' benefit and in educating themselves through continuing education efforts.

Substantial new caries information is now gathered through a maternal health education project (e.g. Mattila et al., in press) with the two areas potentially combined and new approaches are suggested for health care.

Nutrition education. Registered dieticians are doing a good job in nutrition education with personal interaction as the most important tool. The purpose is to see that people increase their chances for health promoting behaviors or manage their lives. The renewed dietary recommendations suggest no alcohol during pregnancy and no lactation immediately after having had alcohol (Hasunen 1998) but other references to gender do generally not exist.

Health education is acknowledged as an important tool for the betterment of health. The 1993 legal developments did disservice to this area of health care within municipalities, however, with new accent on health promotion and attempt to oversee people's lives. Many health promotion practices are aimed at policies, environments, and practical circumstances. When properly implemented, health education contributes to empowerment in an ethical manner and should be recognized as such. The health education components (assessment, planning, implementation, evaluation) need to be systematically appraised in various settings in order to acquire the needed knowledge in order to advance the discipline.

5. Health of elderly finnish women

5.1 Demographic data

Instead of using the term "retirement age", years of age or age groups will be used in the text as the Finnish retirement age is different from that of the other countries. Many Finnish people retire early (normally 58 years of age or later and part-time retirement is now possible at the age of 56 or 55). Reports appear to suggest a movement to increase the age at retirement.

The purpose of the national aging program 1998-2002 is to provide support to those who are 45 years of age or older, both unemployed or working. Three main areas of responsibility exist at the national level: new means to assess working conditions and working abilities (Ministry of Health), comprehensive development of alternatives for work (Ministry of Labor), and development of adult learning (Ministry of Education). The program appears gender-neutral.

The (1999) proportion of Finnish people 65 years of age or older is almost 17% (Luoto et al. 1999)

5.2 Marital status, family and children

Of the Finnish women 65 year of age or older, a half are widows, one third married, 11% never married, and 2% divorced while most of their male counterparts are married (Kivelä 1996). Roughly 80% of the Finnish elderly women have been married only once, the mean number of marriages being 1.1 (Kivelä and Ijäs 1996).

Couple relationships lasting less than a life time commitment have become common, and "individuality" has gained prominence with women included among these individuals. Yet, despite this emphasis on individuality, "family" has changed little. While families disintegrate when problems occur, others become stronger in similar circumstances. In this study, the concept of family has been a subject of more scrutiny (e.g. considering ideology vs. service to individuals), and five organizational levels of family were recognized as background: households, living arrangements, kin relationships, generations, and love/sexual/gender/power relations. (Forsberg 1994)

In addition to women who never married, another 10% of the married women have no surviving children in the study of Finnish women over 65 years of age or older. Almost 20% of the rest of them cannot expect to be supported by their surviving children in any way. As many as 6% of the women (but only 1% of men) have no immediate family to speak of (spouse, children, grandchildren, siblings, parents). (Kivelä 1996)

5.3 Social contacts

With the exception of sports activities, women are more active and participate in social activities more than men of the same age do. Women are visited more than they visit others themselves, and women visit others more than men do (Kivelä 1996). More than half of the women were satisfied with the contacts they had but one third would like more frequent visits. Grand-children visited less than one's own children did, and contacts with siblings were as frequent as visits with grand-children. Paavilainen (in Hyvärinen 1999) suggested that when neutral people are needed in the lives of grand-children in emotionally charged situations, grand-parents should be considered as a possibility. These may involve a fight with an important other, sorrow as a result of death, etc.

In a study of 500 (380 women) people interviewed, 60% had children who visited them at least once a week (10% daily, 24% two to three times and 27% once a week), and 75% were contacted by phone (Karjalainen and Kivelä 1996). (Cellular) phone is the most common instrument for making contact in this country. The women also read papers and magazines, listen to radio and watch TV, and had handicrafts or gardening as hobbies (Kivelä 1996). Social life of elderly women seemed rather stable regardless of circumstances. The social contacts with children did not change for 69% of the women after they had to move to a sheltered housing unit (Karjalainen and Kivelä 1996).

5.4 Living conditions

One's living arrangements and conditions could be expected to be important indicators when health is considered. Anson (1988) studied living arrangements and women's health and discovered that when health profiles were taken into account, health varied according to living arrangements (women living with parents, women living in children's/relatives' household, women living with husbands, women living alone, and women heads of household, from the best to the worst). Social support tends to increase health and nurturant obligations to constrict it, the author felt. No such study exists regarding Finnish women but the findings may suggest need for social support on one hand and discussion about "nurturant obligations" in the case of older women on the other.

More than one third of the women over 65 years of age or older are living at home alone, slightly less than a half live at home with their husbands, and one tenth in institutionalized care (Kivelä 1996) but nurturant obligations probably vary in the first two instances. The Finnish social and health policy supports the idea of living at home as long as it is feasible, and independent living principles for disabled old persons were already stated in policy in 1898 (Karjalainen and Kivelä 1996). Group living and individual living in flats exists as does sheltered housing with personnel and shared facilities. Only about 2% (15 000 units) exist for the people 65 years of age or older. The idea is that someone else will take care of the nurturant obligations mentioned previously. It is common that when there is a daughter in the family and the spouse has died that the daughter will care for the parent in his/her eighties. At that time, the daughter is often retired herself (Eloniemi-Sulkava 1999, personal communication with permission).

Services for the elderly have been constructed for five kinds of needs: meals, hygiene practices, household cleaning and help, miscellaneous transactions, and an emergency alarm system. In a third of the provisions, 24-hour service is available. (Karjalainen and Kivelä 1996)

5.5 Health issues, sexuality and marital satisfaction

In a Turku study from 1991-92, completed among those 1055 (678 women) born in 1920, 73% (87% of women) felt that they were healthy. For 70% (69% women) health had stayed about the same, and 77% expected it to remain so in the following year (Lehtonen and Tilvis 1994).

Aro et al. (1992) studied experienced health using five categories, and 19% of the older citizens (64 years or older) reported their health to be bad or very bad. Women reported slightly better experienced health.

In the national 1986 and 1994 surveys, average or poor experienced health becomes more common by age until 55 years of age and then levels off. The higher the education, the fewer the amount of those who perceived their health average at the most. The older citizens

generally seemed to feel that health had either remain the same or improved (Huuhka et al. 1996). This may be in part due to what has been said that young people tend to assess their health based on symptoms, older people by their own functional abilities.

Most of the women 65 years of age and older are able to move around and function independently each day. This research also indicated that 90% were able to function by themselves, 80% to be independent but there is also greater variation in becoming worse among women than men as people age (Lehtonen and Tilvis 1994). In another study, walking was more difficult to women than men. Light housework and cooking were accomplished well among women since they have learned to do so during earlier years (Kivelä 1996).

The Turku old age study by Lehtonen and Tilvis (1994) suggested that 73% of the respondents assessed their own health to be good. The question was asked using a continuum (good-bad) but there was no indication as to how the categorization was made. They also estimated that health status among the elderly was equal to that of their peers.

5.5.1 Physical health behaviors

Health care, health promotion/ education, and occupational health are understandably of concern for those who are elderly. Among others, staff at the Alzheimer's Association of Finland is asking for collaboration between clinicians and others on health promotion issues (Kettunen 1999, personal communication). Health and health behaviors are difficult to study, and the findings sometimes conflict with each other.

Data have been collected on health behaviors of the elderly by the National Institute for Public Health but analyzed only for the first national survey of 1985. Response rate was 75% (N=1331; 679 women). Cigarette smoking and alcohol use seemed more appropriate among women than among men, as did nutritional habits, but women exercised less. Smoking among women 65 years of age or older is rare. In this study, smoking was not well defined in order to speculate the use further. There were differences between age groups in alcohol and full milk consumption (Piha et al. 1987). The meaning of sound and proper health habits have not been established for the elderly as yet, or it may be unclear (Piha et al. 1987) but health education could be considered beneficial.

A sample of 457 individuals in another study in the eastern part of the country was surveyed and called to a physical examination in 1982, and 80% (N=366, 182 women) participated. Fair or good self-perceived health was associated with non-smoking behaviors while no other health behaviors were featured. Smoking was tied to alcohol use and frequent consumption of sweets with heavy drinking. While some "unhealthy" behaviors were stated as being associated with each other, behaving "negatively" in one way was not indicative of another undesirable behavior (Kivelä and Nissinen 1986).

In a second study with the same sample from the eastern part of Finland, health knowledge level was beneficially associated with subjective health status and functional capacity. Low knowledge about health was associated with poor self-perceived health among women, lowered functional capacity, abstinence of alcohol, high fat consumption, and low coffee consumption. (Nissinen and Kivelä 1986)

5.5.2 Positive emotional health

Positive emotional health begins with an optimistic image about oneself. Concept of self may be one of the most important to consider for positive emotional health. Good self-esteem is exhibited when positive characteristics prevail with a realistic touch. Perspectives of self include real self, ideal self, and normative self. Each of the three consists of four parts: performance self-concept, social self-concept, emotional self-concept, and physical self-concept, and an assessment in each is needed when a reliable appraisal is desired. (Aho 1995)

Laine (1998) discovered that Finnish students displayed emotional loneliness of the three alternatives (global, emotional, social) without an apparent explanation to it. "We have company for social interaction but not true friends", she suggested (Laine 1999, personal communication with permission). To break out of a shell will require a set of positive things at the same time when to have positive things to happen will suppose activity. A kind person in-between might help things along.

In the Turku study of old age, 95% of women felt that they were satisfied with life, 83% felt that they were needed, 50% made plans for future, and 96% had zest for life (Lehtonen and Tilvis 1994).

5.5.3 Oral health

A study by Leimola-Virtanen (1998) indicated that the oral structures are estrogen dependent despite the fact that the molecular mechanisms and pathophysiology largely remain unexplained. Hormone Replacement Therapy (HRT) benefits most of the women with oral dryness and mucosal discomfort.

In the Mini-Finland study 1977-80, use of toothbrush was common (96% of women), frequency of brushing at least once a day (93% of those women with dentition, 99% of those women without dentition). Daily brushing of teeth among the oldest (55-64 years of age) women was 89%. The higher the educational level, the more of them belonged to the group brushing twice a day. Women comply with the requirements more easily than men. (Vehkalahti et al. 1991)

Women also use the dentistry services more than men do, but the oldest group contains fewer women than men (13% of women using services over 65 years of age). This is due to the fact that there are now more older women without dentition as women have cared for their overall appearance. Men have kept their aching teeth and have to use more services during older years. (Vehkalahti et al. 1991)

A person without a dentition (edentulism) is a phenomenon involving women and greater in Finland than in the other Scandinavian countries but gender specific research indicates that differences are now disappearing (Suominen-Taipale et al. in press).

Kuttila (1998) studied temporomandibular (TMD) problems in the Finnish population. Although past research evidence implied an even distribution between the genders, recent evidence is suggesting that there are more joint and musculoskeletal problems in women than among men. Kuttila also reported that TMD problems have been found to correlated with poor general health. - There was no significant difference in frequency of visits to dentists between the genders. Those with the lowest education visit dentists least often.

5.5.4 Sexual behavior

Old age and female gender are traditionally associated with a low frequency of sexual intercourse (Kivelä 1996) but it must be remembered that a sexual intercourse is only one form of sexual interaction, and the presence of a male partner is necessary in it. In those instances when a sexual partner was present, the reasons for a lack of intercourse included poor health and partner's impotence (Kivelä 1996). When only a third of the women are married and have a potentially constant partner, it is expected that sexual needs in other cases may need to be satisfied in other ways than through sexual intercourse. There are also women who are willing to share a partner as they wish no longer to be married themselves. Understandably, a number of women also prefer the company of women for sexual purposes.

A more important indicator than sexual intercourse may be the lack of desire reported by three of four women over 60 years of age or older. Kivelä (1996) reported that the older the woman was the less desire she felt. Estrogen replacement therapy can help those women to whom it is an acceptable method. Finnish women appear to use hormone therapy less than five years (Topo 1997). The issue is still controversial as most physicians appear to consider this therapy self-evident and many women not necessarily so (Alanen 1999, personal communication). A grass roots group of women has been meeting for years to discuss this issue (see Hot Flashes in the network section).

There is a physiological issue in maturity as it may take a longer time of caress for an older woman to reach orgasm, the orgasm may be shorter in duration and intensity, and the ability to achieve multiple orgasms may be reduced with age (Kivelä 1988). An issue worth mentioning is that with time, the sameness of caresses may lead to boredom and thus reduce sexual activity between partners. Hardly any researcher recognizes the fact that it may not feel worthwhile to attempt sexual satisfaction in relationships which are doomed to failure. The chances granted men to marry a younger partner are also not easily available to women, and even masturbation may be more difficult to allow for an older woman than for the male counterpart.

5.5.5 Marital satisfaction

Marital satisfaction of older couples in the form of happiness and relationship issues has not been discussed in detail in many studies (Kivelä and Ijäs 1996). For some women, family life has a lot to be desired.

In a study including 498 married men and women, 73% of the women defined their marriages as happy as in most marital relationships; 11% of the women felt that their marriages were happier while 16% were less happy (unhappier) than most marital relationships. There was a statistically significant difference between the genders ($p=0.0001$). (Kivelä and Ijäs 1996)

Marital adjustment scores were poorer for women than for men. Agreement was illustrated in being able to manage affairs with children, in-laws or grand-children, the time spent together, and in taking care of household tasks while disagreement was described in demonstrations of affection, correct and proper behaviors, religious matters and philosophy of life. Selected items revealed feelings about the marriage with high scores for women in discussing divorce, leaving house after fight, and confiding in spouse with low scores in considering issues between spouses going well and getting on each other's nerves. Being able to discuss issues calmly went well but stimulating discussions were lacking. (Kivelä and Ijäs 1996)

Marital adjustment was not related to age, education, previous occupation, current work, current smoking, alcohol consumption, frequency of exercise, social participation of hobbies. Those with experienced good health perceived marital adjustment positively. A substantial correlation was obtained symptoms and adjustment scores, functional capacities, and depression was found to be of significance in terms of adjustment. Feelings of loneliness were related to poor adjustment scores as were low satisfaction with life scores. (Kivelä and Ijäs 1996)

The authors suggested two possible reasons for the differences in scores between the genders in this study. First, women may accept different things for and within their marriages than men do as men are expected to use power within the relationship and control communication. The women's expectations may not be met and fulfilled. Silence does not signify satisfaction. Second, family has functioned as an avenue of self-esteem since these women have not worked outside the home as the women do today. Women may have expectations of being respected by their spouses and fall short of their goal. Third, women demonstrate their feelings more readily and might expect their spouses to do the same while men are not socialized into doing that. The study illustrated that there are differences between the genders, not what they are, however. (Kivelä and Ijäs 1996)

5.6 Medical conditions

Incidence and prevalence of diseases increase with age. Heart diseases and cancers must be mentioned. Musculoskeletal diseases and a use of pain-killers for them, psychiatric conditions, mainly in the form of depression, recurrent falls or injuries (Kivelä 1996), blood pressure, and diabetes (Kekki and Laamanen 1992) add to distress, and as one ages, there is a greater chance for dementia (Lehtonen and Tilvis 1994).

Obesity has been observed to increase with age during the last working age years and early retirement and to level off thereafter. Being slightly overweight is good for an aging female body but obesity can contribute to diseases.

Due to the fact that only a small portion of women in this age group smoked earlier, there is a reasonably low prevalence of chronic respiratory diseases among older women (Kivelä 1996), adding a positive point to this time when everything else seems to be negative in health terms. Older women in the Helsinki area smoke more than the women in the rest of the country and thus have more respiratory conditions and diseases later on (Luoto et al. 1999).

It is more common for women than men to have symptoms in general but some diseases never surface physically. Autopsies have e.g. revealed that hidden coronary artery disease is present in most elderly individuals, and the prevalence of heart disease rises with increasing age in women (Elveback and Lie 1984 in Ahto et al. 1998).

5.6.1 Heart disease

The prevalence of coronary heart disease is as high as 42% among Finnish women aged 64 or older (Ahto et al. 1998). Her study suggested that higher prevalence of coronary heart disease (CHD) was associated with increasing age and a lower educational level. Half of the deaths among the population aged 64 years or over in Finland are caused by cardiovascular diseases and every third death is caused by ischemic heart disease, mainly acute myocardial infarction (MI) (Causes of death 1992).

Epidemiologic evidence is suggesting that cardiovascular diseases will be the main group of diseases since already now, women 75 years of age and older form the largest group of

hospitalized patients (Romo 1999, personal communication). In 1994, women over 75 years of age used 26% of the coronary disease treatment periods and 33% of all days used for care in coronary disease (Miettinen 1999).

Lehtonen and Tilvis (1994) compared 65-year old women from Vantaa, 70-year old women from Turku, and 75-year old women from Helsinki and also observed an increase in heart attacks.

5.6.2 Depression

Depression prevalence was 17.9% for women 65 years of age or older (Pulska and Kivelä 1996), with the highest prevalence of 26.7% for divorced women and the lowest (9.9%) among unmarried women. Being unmarried seemed to provide protection against depression. (In comparison, the highest percentage was for divorced men, the lowest for married men.) Depression among women was associated with detached relationships, few hobbies, and infrequent social interaction. There was evidence of a lack of confidential relationships (Pulska and Kivelä 1996).

5.6.3 Dementia

In 1997, an estimated 100 000 people suffered from dementia (expenses 10 billion Marks) in this country and the numbers are expected to increase to 130 000 in 2010 (and to 12 billion Marks). The disease increases 1.5% in those 60-65 -years of age, and 20% in those after 80. The main challenge has to do with an early diagnosis: if the onset of disease could be delayed by five years, the problem would be halved (Erkinjuntti 1998). The goals to save expenses include better life quality and a longer period of living at home. There is a need for a paradigm shift from dementia to problems in memory and from social problems to cognitive limitations (Erkinjuntti 1998). Lapses in memory (dementia) increase with age. In the Turku old age study by Lehtonen and Tilvis (1994), 1055 people born in 1920 estimated that memory had become clearly worse in 12% (10% of women) and slightly worse 61% (62% of women).

The goals of care in lapses of memory (dementia) include: secure meaningful and humane life, allowance for the experience of good feeling, satisfaction, and feeling of security.

Areas of care include: secure environment, basic functions (nutrition, voiding), cleaning and personal care, moving around, attractions, sleeping, sexuality.

5.7 Violence and injuries

Violence is a part of everyday life today. Newspaper reports are beginning to reveal a new trend: instead of older single sons causing violence to elderly parents, a new disturbing trend is appearing with young children in their twenties threatening, injuring and even killing their parents (Ojansivu 1999). A newspaper title points to a large part of the youth being willing to kill in order to protect personal belongings (Salminen 1999) when in fact there is a gender bias involved: the statistics indicate that the youth means young men who are like American young men in this regard, not women who shun this behavior.

Two women/100 000 women die as a result of violence in Finland each year, and an estimated 6000-10 000 rapes occur annually (Naisiin kohdistuva väkivalta 1991). Some women are exposed to abuse by their husbands, children or relatives. Roughly 7% of emotionally able (not emotionally troubled) women reported to have been an object of such abuse, mostly by their

husbands and most commonly subjected to physical abuse but also by economic exploitation and neglect of care (Kivelä 1996).

Women 65 years of age and older appear to be victims of violence by men, the least (3.1% or less) of all age groups but unnecessary nevertheless (Heiskanen and Piispa 1998).

Finland passed a law of rape in marriage and it became effective in June of 1994. This author has heard personal comments of its necessity from older women when it was passed but there may not be adequate data to date to observe this necessity as yet.

One in six Finns 15-74 years of age (633 000) had suffered injury as a result of an accident or violence in 1997. Most of the injuries appear to include pulled muscles, bruises, fractured and broken bones in that order. For home accidents and accidents during leisure time, the high risk group is women 65 years or older. (Heiskanen and Aromaa 1998) External causes of injuries are due to the same as for anyone involved in an injury: inappropriate living and working conditions, lighting, height of working level, etc.). Internal causes include various illnesses and diseases and those can be remedied by taking appropriate precautions.

Injuries and falls at home may also reveal that there is osteoporosis involved. An estimated 100 000 people in Finland suffer from osteoporosis. The increase of the Parathyroid hormone (PTH) in the bloodstream is thought to be a contributor to osteoporosis as one ages. When a woman is having appropriate D-vitamin intake (1100 mg/day), the levels of PTH remain stable (Kärkkäinen et al. 1998).

Käkönen (1999) developed new specific immunoassays to measure circulating osteocalcin forms in serum and plasma samples. The measurement of the ratio of two osteocalcin forms (gamma-carboxylated to total osteocalcin) has been demonstrated to predict the occurrence of bone fractures among the elderly. The method is perhaps too expensive for general screening but it is considered to effectively screen those in need.

5.8 Medications

Physicians tend to prescribe medications for women more easily than for men, and e.g. blood pressure medications are more common among elderly women (Kivelä 1996). Slight variation in medicine use may also be seen regionally (preventive aspirin, sleeping medication in Turku where a third of the study group used medications) (Lehtonen and Tilvis 1994).

5.9 Mortality

The gender difference in Finnish mortality was 2.8-fold for 1969-71 and has remained virtually unchanged (Koskenvuo et al. 1986; Martelin 1994). Cause-specific rates for the same years revealed that no clear-cut highest and lowest social class patterns existed for women the same way as for men and variation decreased with age (Koskenvuo et al. 1979).

5.9.1 Use of social and health care services

In 1992, a third of the social expenditures and 12% of the cross national product were tied to elderly people (Vaarama 1995). Looking at the 1988 services, not enough out-patient services were available while there was an overabundance of in-patient services. Out-patient services were to be diversified, planning of care for elderly and functional collaboration increased in social and health care, motivation of personnel increased, appreciation of work boosted,

resources of education expanded, administration and leadership developed, administrative and attitudinal barriers removed, knowledge levels of ombudsmen raised (Vaarama 1995).

Kekki and Laamanen (1992) investigated use of health care services and noticed that as visits to physicians increased in frequency, the numbers of clinical investigations increased for those patients 65 years of age or older. The age of the physician was associated with the frequency of visits in that the older the physician, the more clinical investigations. There were 2.5 times (34%) more clinical treatment visits among the older citizens than among those less than 65 years of age. Health care physician was able to care for 79% of the patients on out-patient basis. Most non-urgent referrals contained surgery, internal medicine and ophthalmology. (Kekki and Laamanen 1992)

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8. PART II

8.1 Networks

An announcement was placed in several e-mail networks to obtain information about networks pertaining to women and health. Information was forwarded to the author on several www-home pages and on three women's networks, and four research projects investigating women and health.

8.2 WWW-home pages

www.ktho.pspt.fi/imetys.htm (national breastfeeding homepage)

www.lists.oulu.fi/imetystukilista (discussion network for support of breastfeeding)

www.lists.oulu.fi/lapsiperhelista (discussion network for support of families)

www.vaestoliitto.fi (Finnish Federation of Population, English version at the beginning)

www.utu.fi/research/crede (home page for Center for Reproductive and Developmental Medicine; please see sexology program information under research projects/Ansa Ojanlatva)

One of the first women's grass roots networks has been Kuumat Aallot (Hot Flashes) pertaining to hormone replacement therapy. The coordinator is Kaarina Alanen (kaarina.alanet@yle.fi), tel. +358-9-1480 5265
www pages are under construction.

Name of organization:

Aktiivinen Synnytys ry
(Active Childbirth)

Address:

contact one of the area coordinators or see the www-home page
(www.dlc.fi/-sakuru/aktiivinsynnytys.htm)

Goal:

to allow women, children and families to create new culture for childbirth since 1986 when women were concerned about care during pregnancy and birthing practices to become to technically oriented and routine; to encourage women to take responsibility about themselves and to engage in birthing practices which satisfy personal wants about pregnancy and birthing, since a pregnant woman knows herself and her state the best.

Individuality and autonomy must be respected at maternity health care centers and birthing hospitals. Birthing place must be possible to be selected. Instruction for childbirth ought to be superior and comprehensive. Family must be allowed to be together 24 hours a day. Family must be able to stay together after childbirth. Women must have continuity in care.

Contact person:

Patricia Siljama (+358-9-791 575) in English

Name of organization:

Suomen Punainen Risti
Finnish Red Cross

Address:

Keskustoimisto
Tehtaankatu 1 a
00140 Helsinki
phone: +358-9-12931
www.redcross.fi

Contact Person:

Henna Korte (henna.korte@redcross.fi)

Network:

SPR HIV-Positive Women's Group

Purpose:

to support those women with new infections (goals not stated as yet); established in 1999.

Contact person:

Eija Ikonen (eija.ikonen@redcross.fi)
phone. +358-9-612 3224

Network:

Positiivi-yhdistys ry

Goal:

to promote status and well-being of HIV positive women, to strengthen contacts with international organizations, and to arrange regular meetings.

Contact person:

(no individual designated)

Address:

Eteläinen Rautatienkatu
00100 Helsinki/Finland
phone. +358-9-685 1845
e-mail:(posy@dlc.fi)

Name of Organization:
Unioni (est. 1892)

Address:
Bulevardi 11 A 1
00121 Helsinki/Finland
phone: +358-9-643 158

Program:
Tukinainen
(Crisis Center in Cases of Rape)

Address:
PL 243
00121 Helsinki/Finland
phone: +358-586 0360
fax: +358-685-1979

Contact Person:
Kristiina Valkama (kristiina.valkama@tukinainen.kolumbus.fi), Director
direct phone: +358-9-5860 3666 or +358-50-3637 872
(no cost to caller)
National telephone line 0800 97899
National attorney 0800-97895

Goal:
To provide support and guidance to women who have been raped or sexually assaulted and to those important in the lives of these women. The main purpose is to make violence directed at women visible. The program (est. 1993) offers educational and consultation interventions to parties involved in helping women, to collaborate with police, social, health, and legal officials, and to influence public opinion and legislation as well as practices of justice and bureaucracy.
All professionals are women who have education and experience called for in this work.

Staff:

- Riitta Raijas (riitta.raijas@tukinainen.kolumbus.fi)
- Crisis worker
- Meri-Heidi Stenberg
- Attorney
- Maija Saarinen (maija.saarinen@tukinainen.kolumbus.fi)
- Secretary

Support Programs:

- Crisis groups
- Group of important others
- Groups to get on with life
- Support person functions
- Open evenings
- Crisis meetings with a therapist

Name of organization:

**Health Services Research Unit
National Research and Development Center for Welfare and Health
(STAKES)**

Address:

STAKES
Terveysthuollon yksikkö
PL 220
00531 Helsinki
phone. +358-9-39671
fax: +358-9-3967 2485
(www.stakes.fi/thty/)

Contact person:

Elina Hemminki, Research Professor

Research group:

Assessment of Health Services for Healthy People

Goal:

aims to assess health services pertaining to normal life processes, health promotion, primary and secondary prevention of diseases, and self-care so as to be critical, socially conscious, gender sensitive, and outcome oriented. Evaluation of health technology is given special consideration. Unintended consequences of technology and interfaces with professional and non-professional responsibilities are highlighted.

Staff:

- Elina Hemminki, MD, Docent (elina.hemminki@stakes.fi)
- Mika Gissler, PhD (mgi@who.dk)
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- Eeva Ollila, MD (ollilae@who.ch)
- Päivi Santalahti, MD, PhD (paisan@utu.fi)
- Sinikka Sihvo, BSc, MPH (sinikka.sihvo@stakes.fi)
- Saila Sormunen, MA (saila.sormunen@stakes.fi)
- Hanna Toiviainen, MA (hanna.toiviainen@stakes.fi)
- Kirsi Viisainen, MD, MA (kirsi.viisainen@stakes.fi)

Name of organization:

**Section of Psychosocial Research
Finnish Institute of Occupational Health**

Address:

Finnish Institute of Occupational Health, FIOH
Laajaniityntie 1
FIN-01620 Vantaa/Finland
phone: +358 9 47471
fax: +358 9 890 713

Contact person:

Kaisa Kauppinen, Chief (kaisa.kauppinen@occuphealth.fi)

Description of organization:

to carry out research and offer scientifically grounded methods, consultation services and training on selected occupational health issues.

Research Group:

Gender Equality, Work Organization and Well-being

Goal:

The overall goal is to ensure gender equality, productivity and job satisfaction and to prevent marginalization at work. More specifically, the program promotes four specific issues. First, it conducts research, develops evaluation criteria on gender equality, and promotes equality plans in work organizations. Second, it encourages innovative work time arrangements to solve the problems of combining work and family life as well as promotes social auditing at work places. Third, it conducts intervention research on re-employment and career transitions among the unemployed and other groups which are at risk for marginalization. And fourth, it carries research on the emerging cultural diversity at work and conducts research on aging and attitudes towards retirement and work.

Staff:

- Kaisa Kauppinen (kaisa.kauppinen@occuphealth.fi)
- Irja Kandolin (irja.kandolin@occuphealth.fi)
- Leena-Maija Ojala (+358-9-454 4550)
Pro Competence, Inc.

Research Group:

**Women's health and well-being
during social transition in Estonia**

Address:

Finnish Institute of Occupational Health, FIOH
Laajaniityntie 1
FIN-01620 Vantaa/Finland
phone: +358 9 47471
fax: +358 9 890 713

Goal:

to examine changes in women's status at work and family caused by societal reformation as well as these changes are reflected in women's health and well-being. Data have been collected in 1993, 1995, and 1998 using a survey and a qualitative interview process and are based on a representative sample of the Estonian population of working age. The data will allow for a follow-up investigation of the change process as it relates to women's health. Comparisons will be completed between Finland and Estonia in women's health and well-being.

Staff:

- Kaisa Kauppinen (kaisa.kauppinen@occuphealth.fi)
- Irja Kandolin (irja.kandolin@occuphealth.fi)
- Elina Haavio-Mannila (haavioma@valt.helsinki.fi)

Members of Research Group at the:

- Pedagogical University of Tallinn
- Institute of International and Social Studies
- Anu Narusk (narusk@iiss.ee)
- Leeni Hansson (hansson@iiss.ee)

Sample publications:

Narusk, A, Kauppinen, K., Kandolin, I., Haavio-Mannila, E. & Kelam, A.: Women and Transition: The case of Estonia. *The Finnish Review of East European Studies*. 3-4 issue, iii volume, 1996.

Kandolin, I.: Gender, worklife and family responsibilities in Finland and Estonia effects on economic and mental well-being. Finnish Institute of Occupational Health, *People and Work research reports* 15, 1997.

Name of Organization:

**Department of Public Health
University of Turku**

Address:

Lemminkäisenkatu 1
FIN-20520 Turku/Finland
phone: +358-2-333 8472
fax: +358-2-333 8439
(www.utu.fi/med/kansanterv/)

Research Group:

The Finnish Family Competence Study
([http:// www.utu.fi/med/kansanterv/ffc.html](http://www.utu.fi/med/kansanterv/ffc.html))

Goal:

to examine factors which lead to coping vs. social isolation among children and youth, and to develop methods of operations aimed at pregnant women and their partners, children, and families with children in preventive care.

Contact person:

Päivi Rautava, Professor
(<http://www.utu.fi/~rautava/>)

Staff:

- Matti Sillanpää, MD, PhD (matti.sillanpaa@utu.fi)
- Päivi Rautava, MD, PhD (paivi.rautava@utu.fi)
- Liisa Hyssälä, DDS, PhD (liisa.hyssala@eduskunta.fi)
- Päivi Paunio, DDS, PhD
- Minna Aromaa, MD, PhD (minna.aromaa@utu.fi)
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- Heikki Uljas, MD (heikki.uljas@tk.laitila.fi)
- Katri Louhi, MD (katlou@utu.fi)
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- Hannele Kallio, MD
- Leena Pihlakoski, MD (leena.pihlakoski@tyks.fi)

Name of Organization:
Åbo Akademy University

Address:
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Gezeliusgatan 2 A
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Contact Person:
Elianne Riska (elianne.riska@abo.fi)
Professor of Academy of Finland

Research Group:
Images of Women's Health:
Social Construction of Gendered Health
(1997-2002)

The gendered body
Elina Oinas, PL (elina.oinas@abo.fi)
Jan Wickman, PM (jan.wickman@abo.fi)
Jeff Hearn, PhD (jeff.hearn@abo.fi)

Images of women's health
Ulrica Lövdahl, PL (ulrica.lovdahl@saunalahti.fi)
Jutta Ahlbeck-Rehn, PM (jutta.ahlbeck-rehn@abo.fi)
Elizabeth Ettorre, PhD
Vanessa May, PL

Research on the status of the medical profession and various health professions in the Nordic countries.

- Cecilia Benoit, PhD
- Sirpa Wrede, PM (sirpa.wrede@abo.fi)
- Ann Yrjälä, PM
- Judith Lorber, PhD

Selected publications:

Riska E. Unemployed doctors: A challenge to the medical profession? *Journal of the Royal Society of Medicine* 1996; 89: 383-384.

Oinas E. Medicalization by whom? Accounts of menstruation conveyed by young women and medical experts in medical advisory columns. *Sociology of Health and Illness* 1998; 20: 52-70.

Oinas E. The sexy woman and the smart girl-embodied gender identity and middle-class adolescence. *NORA (Nordic Journal of Women's Studies)* 1998; 6(2): 78-88.

Lövdahl U, Riska Å, Riska E. Gender display in Scandinavian and American advertising for antidepressants. *Scandinavian Journal of Public Health* (in print) 1999.

Riska E, Ettore E. Mental distress: Gender aspects of symptoms and coping. *Acta Oncologica* (in print), 1999.

Hearn J. Theorizing men and men's theorizing: men's discursive practices in theorizing men. *Theory and society* 1998; 27:781-816.