Attitudes of Icelandic Young People Toward Sexual and Reproductive Health Services

By Sóley S. Bender

Context: *Iceland has higher levels of fertility among both adult women and adolescents than many other western European countries. There is a need to make sexual and reproductive health services more accessible to teenagers in Iceland.*

Methods: *A descriptive, cross-sectional national postal survey was conducted in 1996 to explore the attitudes of 2,500 young people aged 17–20 toward sexual and reproductive health services in Iceland and to determine which factors might be of importance for the development of such services.*

Results: *Icelandic adolescents want specialized sexual and reproductive health services offered within a broad-based service setting. Half of them would prefer to have these services located in a sexual and reproductive health clinic, and about one-third want such services to be located in community health centers. Having services that are free, that are anonymous and that do not require an appointment are important to teenagers who live in Reykjavík, but proximity and equal access to services are more highly valued by adolescents who live outside Reykjavík. Characteristics that young women, in particular, value include close proximity to services, access to a comfortable environment, a friendly staff, absolute confidentiality, and the ability to come with a friend and to have enough time for discussion. Adolescents who have already used contraceptive services mentioned that they need enough time for discussion and that they value high-quality client-provider interaction.*

Conclusions: *The attitudes of adolescents should be considered when specialized sexual and reproductive health services are developed for young people in Iceland. Specialized services that respond to the unique concerns of adolescents may increase their utilization of contraceptive methods and other reproductive health services.*

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Iceland has higher levels of fertility than many other western European countries. The mean number of children born to Icelandic families is almost three, and more than 90% of the population approve of childbearing outside marriage.[1] High fertility rates among young people are not surprising in this context.

Young people in Iceland have higher birthrates than adolescents in many neighboring countries. In 1995, the number of live births per 1,000 females was 23.4 among 15–19-year-olds in Iceland, while it was 8.3 per 1,000 in Denmark, 8.6 per 1,000 in Sweden and 4.2 per 1,000 in Holland.[2] The birthrate among young Icelandic people dropped from 83.0 per 1,000 in 1956–1960 to 22.1 per 1,000 in 1996, but the abortion rate increased from 9.4 per 1,000 in 1976–1980 to 15.9 per 1,000 in 1994. Currently, the abortion rate in Iceland for young women aged 15–19 is similar to rates in other Nordic countries. In 1994, the abortion rate for those aged 15–19 was 17.9 per 1,000 in Sweden, 17.7 per 1,000 in Norway, 15.1 per 1,000 in Denmark and 9.0 per 1,000 in Finland.[3]

Sex education is supposed to be taught in the Icelandic schools, but whether and how this is done varies according to school and the motivation of individual teachers. The combination of sex education and the provision of contraceptive services to young people has been shown to promote the use of contraceptive methods.[4] Some school- and community-based programs that have incorporated contraceptive services have also seen a decrease in pregnancy rates.[5] It is thus important to develop specialized sexual and reproductive health services for adolescents in Iceland.* A necessary prerequisite for the development of effective services is knowledge about the attitudes that young people hold regarding such services.

Health Services in Iceland

The provision of sexual and reproductive health services for people in Iceland differs according to region. In the Reykjavík metropolitan area, services are widely available and provided by family practitioners and gynecologists. Nurses employed in the junior and senior high schools can give information and counseling about contraceptive methods, but are not allowed to prescribe oral contraceptives. Very few nurses are employed in the senior high schools. Family practitioners prescribe contraceptives within community health centers and in private practice; gynecologists primarily offer such services in private practice.

In rural areas, on the other hand, service choice is limited, since it is usually only possible to go to family practitioners, who mainly practice in community health centers. By law, sexual and reproductive health services are supposed to be available from a variety of providers in community health centers and hospitals, in connection with services like antenatal care and family counseling.[6] However, such services in Iceland have mainly been provided by medical doctors.[7]

Iceland has a system of national health insurance that makes health care services available to clients either free of charge or at low cost. Clients who seek services in outpatient clinics, community health centers and specialists' private clinics need to pay for part of their services, with a higher fee paid for a visit to a specialist than for a visit to a family practitioner in a community health center. The cost of the visit to a family practitioner is, on average, one-third that of a visit to a gynecologist.

The only family planning clinic in the Reykjavík area that primarily served young people was closed in 1994, although it continues to provide a one-hour weekly telephone service. The clinic, which had been located within the main community health center in Reykjavík,

*Due to recent developments in terminology following the 1994 International Conference on Population and Development in Cairo and the 1995 United Nations Fourth World Conference on Women in Beijing, this article uses the term sexual and reproductive health services to refer to comprehensive sexual and contraceptive services, rather than using the terms family planning clinic, family planning services or contraceptive services.

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was closed by the health authorities, who announced that there was a need to reevaluate community health services. These authorities have not subsequently made a specialized reproductive health service for young people a priority, despite the demonstrated benefits of such a service.[8]

To respond to the lack of specialized services for teenagers, in 1995 the Icelandic Association for Sexual and Reproductive Health opened a sexual and reproductive health reception and telephone service for young people aged 16–25 in the center of Reykjavík. This service is located in an information and cultural center for young people named "The Other House."

It has been understood for more than 20 years that optimal contraceptive services are oriented to the special needs of the particular populations that they are designed to serve. If the differences between groups are not considered by program planners, some individuals are likely to be failed by the services, which can contribute to contraceptive discontinuation.[9] Attending to the psychosocial needs of young people at sexual and reproductive health services, in particular, may increase their contraceptive use and improve their ability to handle use-related problems.[10]

Few studies have explored the attitudes and preferences of young people toward sexual and reproductive health services. Focus-group interviews of 253 Scottish youth aged 11–20 revealed that they wanted a place where they could go to for a variety of reasons, not just sexual health services.[11] Further, there was no time and location suitable for everyone: Most adolescents said that the ideal hours for a service to be available were between 4:00 PM and 10:00 PM on weekdays and on Sunday afternoons. Condoms and contraceptives were regarded as the most important services that a health care center could offer to young people, followed by information and advice on HIV and AIDS, emergency contraception and pregnancy tests. Young people in this study also emphasized that the service should be welcoming and the staff should be friendly.[12]

Methods

The purpose of this article is to document the attitudes of young Icelandic people toward sexual and reproductive health services and to understand the factors that Icelandic adolescents think would be important in the future arrangement of sexual and reproductive health services. There were four areas of inquiry:

- What factors affect the appeal of a particular sexual and reproductive health service organization? Does it depend on the age, sex or residence of the population it is trying to serve and on its days and hours of operation and staff?
- Is there a difference between adolescents who live in the Reykjavík metropolitan area and those who live outside Reykjavík regarding their attitudes toward access to, or their quality of care in, sexual and reproductive health services?
- Is there a difference according to gender regarding the attitudes young people have about the availability and quality of care in sexual and reproductive health services?
- Do young people who have never used contraceptive services before have different needs compared with those who have used such services? Do these differences affect their attitudes toward the availability and quality of care in sexual and reproductive health services?

Sample

The population of Iceland in December 1995 was 267,806 people, and the number of residents aged 17–20 was 16,658. In 1996, a stratified random sample of 2,500 individuals aged 17–20, representing 15% of this age-group, was selected from the Icelandic Census.[13] This age-group was selected for the survey because they were considered more likely than younger teenagers to have had some sexual experience, to have contacted sexual and reproductive health services and to have used contraceptive methods.

Because sexual and reproductive health services are disproportionately used by young women as opposed to young men,[14] the sample was stratified by sex—80% female and 20% male. Although young men do attend sexual and reproductive health services less often than young women do, their attitudes toward services were considered important due to the current emphasis on the mutual responsibility of the sexes toward sexuality.

The questionnaire developed for this study was based on Pender's theory of health promotion.[15] Content validity was established by three people aged 19–20 and three specialists in the field who evaluated the questionnaire. Two Icelandic linguists also evaluated the questionnaire. It was then tested (with a ratio of 20% young men and 80% young women) on a group of 60 students aged 17–20 in a Reykjavík-area college. Permission for the survey was obtained from the Icelandic Data Protection Commission.

Availability of services was classified by geographic, economic and administrative availability.[16] Measures of accessibility, which include the psychological hindrances that can stop people from using services, were also explored in the survey.[17] To classify accessibility, the questionnaire relied on Bruce's theoretical framework about quality of care pertaining to psychosocial hindrances.[18] Geographic availability referred to the location of the service, economic availability was the cost of the service or supplies, and administrative availability meant the rules and regulations that could affect use of the service, such as hours of operation, staff, time for discussion or waiting time for an appointment.

Most of the availability items and all of the client-provider items were measured on a five-point Likert scale, from very important (coded as five), important (four), neutral (three), not very important (two) to not at all important (one). Cronbach´s alpha was .72 for the nine quality-of-care items and was .77 for the 23 availability items.

As an incentive to complete the questionnaire, respondents could choose to have a special pamphlet about emergency contraception or a package of 10 condoms sent to their home. Two attempts were made to contact nonrespondents. There were 1,703 valid responses from the 2,500 surveys, yielding a crude response rate of 68%.[19] Sixty-six individuals were unable to participate due to being abroad, having moved, or being sick or disabled, and four questionnaires were returned but not coded, yielding an adjusted response rate of 70%.

The data are analyzed using descriptive methods and by testing hypotheses developed from the initial questions. The hypotheses generated from the first question were tested by chi-square tests, and the other hypotheses were tested by t-tests.

Results

Characteristics of Respondents

The mean age of respondents was 18.4 years, and the mean age for nonrespondents was 18.3. The majority (59%) lived in the Reykjavik metropolitan area (Table 1, page 296)—similar to the registered residency in the general population, which is 56% for this age-group.[20] About two-fifths of respondents lived outside Reykjavík, nearly identical to the proportion of registered residents nationwide (44%). The majority of nonrespondents (54%) lived outside Reykjavik, while 46% lived in the capital and surrounding areas (not shown). Nonrespondents were also different regarding rates of foreign citizenship, as more of them (63%) were foreign citizens than were those who did respond (37%).

Eighty-four percent of respondents

Table 1. Percentage distribution of Icelandic youth aged 17–20, by their preferred location for sexual and reproductive health services, according to their personal characteristics and their preferences as to the arrangement of services

Characteristics	N	Total	Clinics (N=746)	Community health centers (N=486)	Other locations (N=283)	Total (N=1,515)	χ^2	p
All	**na**	**na**	**49.2**	**32.1**	**18.7**	**100.0**	**na**	**na**
CHARACTERISTICS								
Age								
17	330	19.5	54.5	28.1	17.4	100.0	na	na
18	553	32.7	46.0	32.7	21.4	100.0	na	na
19	523	30.9	51.6	31.5	16.8	100.0	na	na
20	286	16.9	45.7	35.6	18.6	100.0	na	na
Total	1,695	100.0	na	na	na	na	9.45	.150
Gender								
Females	1,423	83.9	46.5	34.0	19.5	100.0	na	na
Males	273	16.1	49.8	31.7	18.5	100.0	na	na
Total	1,696	100.0	na	na	na	na	0.93	.628
Residence								
Reykjavík area	995	58.9	53.7	31.0	15.3	100.0	na	na
Outside Reykjavík	695	41.1	42.9	33.9	23.2	100.0	na	na
Total	1,690	100.0	na	na	na	na	21.85	.000***
PREFERENCES								
Opening days								
7 days/week	1,026	60.6	52.0	30.2	17.7	100.0	na	na
1–5 days/week	579	34.2	45.7	34.4	19.9	100.0	na	na
Do not know	88	5.2	na	na	na	na	na	na
Total	1,693	100.0	na	na	na	na	5.22	.073
Opening hours								
9 AM–4 PM	745	45.5	47.0	36.4	16.5	100.0	na	na
After 2 PM and evening	763	48.0	51.9	28.7	19.5	100.0	na	na
Not specified	105	6.5	na	na	na	na	na	na
Total	1,613	100.0	na	na	na	na	9.45	.009**
Staff								
Physicians	1,208	70.9	49.1	34.1	16.8	100.0	11.44	.003**
Social workers	1,088	63.9	52.2	30.5	17.0	100.0	12.18	.002**
Nurses	1,037	60.9	48.9	34.2	16.9	100.0	7.35	.025*
Psychologists	835	49.0	53.6	30.2	16.1	100.0	11.88	.003**
Young people	582	34.2	54.6	25.2	20.1	100.0	16.43	.000***

*p<.05. **p<.01. ***p<.001. *Note:* Clinics are sexual and reproductive health clinics; other locations are information and cultural centers, hospitals, schools, pharmacies and other facilities.

were female (Table 1). Young women had a higher response rate (71%) than young men (54%). Most respondents (78%) lived with their parents, but 10% were cohabiting with an intimate partner (not shown). Forty-four percent of respondents were in a steady relationship, and 7% either had a child or were expecting one. A total of 83% of respondents were sexually active. The mean age at first sexual intercourse was 15.4 years for both genders. About two-thirds (67%) of respondents had used contraceptive services at least once, and 60% reported having used contraceptives during their first sexual intercourse.

Sexual and Reproductive Health Services

Participants were asked about currently available sexual and reproductive health services. A small proportion (3%) said services were good, 25% said they were "in order" (not "good" but better than "not good enough"), 43% said they were not good enough, 28% did not know and 1% gave no response. A large majority of those who said that the services presently available to young people in Iceland were not good enough had used such services once or more often (72%). Suggested improvements to the present services included forming discussion groups on particular sexual matters (83%) and altering the operating hours within community health centers (64%).

Availability of Services

Young people in Iceland would prefer sexual and reproductive health services to be offered as part of a broader service for young people where most of their concerns could be dealt with, not just regarding health and sexuality, but also regarding financial matters, hobbies and legal matters. Most respondents (92%) wanted to be able to attend sexual and reproductive health services that were specialized for young people. The type of services given highest priority were discussions about sexually transmitted diseases (STDs) (88–92%), information about contraceptive methods (86%) and STD testing (85%). Only 51% of respondents expressed interest in the availability of emergency contraception, but 64% did not know what emergency contraception was. Just 16% of respondents reported wanting more contraceptive options.

Half of all participants said that the ideal location for sexual and reproductive health services would be a separate clinic (not within a hospital or community health center), while approximately one-third of the participants thought that such services should be located within community health centers (Table 1). Other potential locations for sexual and reproductive health services most often mentioned as being ideal were within information and cultural centers (10%), hospitals (5%) and schools (2%).

Preferences for the location of sexual and reproductive health services varied according to the respondents' residence and to clinic operating hours and staffing. The majority of adolescents in Reykjavík preferred that clinics be separate, a significantly higher proportion than with other young people. Likewise, preference for a separate facility was higher among those wanting such a clinic to be open seven days a week, especially in the afternoons, staffed with young people, psychologists and social workers. Adolescents who thought that sexual and reproductive health services should be located in community health centers were more likely to favor standard hours of operation (9 AM–4 PM) and believed that experts, such as nurses, physicians and social workers, should be staffing these centers.

Other issues related to geographic preferences, as well as economic and administrative availability, are presented in Table 2. About 80% of all respondents said that it would be very important or important that sexual and reproductive health services be close to their home. Only 41% said that it was similarly important that such services be discretely located. Almost 70% of respondents said the price of contraceptive methods should be lower and that contraception should be more widely available (not shown). About 60% of respondents considered it very important or important to be able to receive sexual and reproductive health services at no cost (Table 2). Only 45% of respondents wanted to get condoms free of charge (not shown).

Almost all respondents reported wanting enough time for discussion with their health care providers (97%), convenient opening hours (92%) and a "comfortable" environment (88%). Features that were

Table 2. Percentage of Icelandic youth aged 17–20 who identified selected measures of availability and quality of care as very important or important, and mean values (and standard deviations) of importance score, by measure, all according to area of residence

Measure	% important or very important				Importance score				t-test	p
	N	Total	In Reykjavík	Outside Reykjavík	In Reykjavík		Outside Reykjavík			
					N	Mean	N	Mean		
AVAILABILITY										
Geographic availability										
Service close to home	1,698	81.3	77.1	87.6	992	4.0(0.93)	693	4.3(0.87)	–6.78	.000***
Service discrete	1,697	40.5	41.4	39.0	990	3.3(1.06)	694	3.3(1.10)	0.12	.902
Economic availability										
Free service	1,690	63.1	69.0	55.2	989	3.9(0.99)	688	3.6(1.05)	5.48	.000***
Administrative availability: service arrangement										
Enough time for discussion	1,699	96.7	96.0	98.0	992	4.5(0.59)	694	4.6(0.53)	–1.57	.115
Comfortable environment	1,694	88.1	87.6	89.0	987	4.3(0.79)	694	4.3(0.77)	–1.04	.297
Pelvic examination not at first visit	1,449	47.4	47.6	47.4	842	3.5(1.09)	597	3.5(1.04)	–0.25	.803
Administrative availability: equal access										
Service for people in and not in a sexual relationship	1,698	87.6	85.7	90.2	991	4.4(0.85)	694	4.5(0.75)	–2.45	.014*
Service for both genders	1,692	73.0	69.7	78.0	987	4.1(0.98)	692	4.3(0.94)	–3.54	.000***
Service for heterosexuals and homosexuals	1,690	69.1	67.2	71.9	987	4.0(1.02)	690	4.2(1.00)	–2.53	.011*
Administrative availability: easy access										
Convenient opening hours	1,693	91.6	92.3	90.7	992	4.3(0.67)	688	4.3(0.70)	1.75	.080
Short waiting time for appointment	1,692	72.8	73.4	71.9	986	3.9(0.88)	693	3.9(0.92)	1.04	.298
Can attend with someone else	1,694	71.3	70.9	72.1	988	3.9(0.98)	694	3.9(0.86)	–1.48	.138
Walk-in service	1,695	56.8	60.4	51.6	988	3.7(0.96)	694	3.5(0.96)	3.49	.000***
Administrative availability: anonymity										
Unlikely to meet parents there	1,675	48.6	51.3	44.6	976	3.6(1.13)	686	3.4(1.18)	3.31	.001***
Not have to tell telephone number	1,690	46.7	49.6	42.5	988	3.6(1.10)	689	3.4(1.13)	2.86	.004**
Not have to tell name	1,693	42.8	45.4	39.1	990	3.5(1.10)	690	3.3(1.13)	3.27	.001***
Administrative availability: gender preferences										
Examiner is female	1,583	43.1	43.6	42.9	933	3.5(1.08)	639	3.5(1.06)	–0.44	.658
Examiner is male	1,279	8.2	8.9	7.0	773	2.8(0.91)	494	2.8(0.80)	0.26	.792
Counselor is female	1,672	31.0	31.3	30.7	977	3.3(1.06)	683	3.3(1.00)	–0.01	.985
Counselor is male	1,489	6.9	6.6	7.4	866	2.7(0.85)	612	2.8(0.76)	–1.60	.109
Administrative availability: educational material										
Videos suitable for young people	1,681	54.3	52.1	57.8	981	3.5(1.00)	687	3.6(0.97)	–1.51	.131
Posters suitable for young people	1,680	44.1	42.4	46.9	984	3.2(1.08)	684	3.4(1.04)	–2.13	.033*
QUALITY OF CARE										
Client-provider interaction										
Counselor listens actively	1,693	99.5	99.5	99.6	987	4.8(0.40)	693	4.9(0.35)	–2.27	.023*
Staff has friendly attitude	1,687	99.3	99.0	99.7	985	4.9(0.36)	689	4.9(0.33)	–0.70	.478
Staff has respect for young people	1,690	98.9	98.9	98.8	987	4.8(0.42)	690	4.8(0.42)	0.13	.893
Client feels good during visit	1,693	98.9	99.0	98.8	990	4.8(0.42)	690	4.8(0.42)	–0.63	.526
Counselor shows understanding	1,695	98.9	98.4	99.6	988	4.7(0.48)	694	4.8(0.38)	–3.16	.002**
Client can ask any question about sexuality	1,701	97.0	96.8	97.7	993	4.7(0.50)	695	4.8(0.48)	–0.96	.335
Client can make decisions about contraceptive methods	1,695	89.0	89.0	89.1	990	4.4(0.70)	692	4.4(0.71)	–1.25	.209
Client can discuss matters privately with the counselor	1,698	98.3	98.1	98.6	992	4.7(0.48)	693	4.7(0.49)	0.73	.463
Service protects absolute confidentiality	1,690	88.0	86.4	90.2	990	4.4(0.93)	687	4.6(0.80)	–3.38	.001***

*p<.05 **p<.01 ***p<.001. *Note:* Importance score assigns a value of 5 to the response "very important," 4 to the response "important," 3 to the response "neutral," 2 to the response "not very important" and 1 to the response "not at all important."

considered important by fewer respondents included not having to risk meeting one's parents at the service site (49%), not being required to have a pelvic examination at the first visit (47%), having youth-appropriate educational material on display (44–54%) and having anonymity in the service environment (43–47%).

Quality of Care

The nine quality-of-care items tested were all evaluated highly (88–100%) by the study participants (Table 2). The desire for counselors to listen actively to patients was virtually universal, as was the desire to have staff that demonstrated a friendly attitude, communicated a sense of respect for young people, made patients feel good during the visit and demonstrated understanding.

Participants were asked to prioritize the three most important items that might characterize ideal availability and quality of care (not shown). The highest priority was given to absolute confidentiality for patients, followed by the friendly attitude of a staff and an understanding attitude of the counselor.

Residential Differences

A comparison of the mean importance scores reveals that adolescents who live outside Reykjavík had a stronger wish than those in Reykjavík to have sexual and reproductive health services located near where they live, to have equal access to services (regardless of gender, sexual orientation or sexual activity), to have suitable posters, to have a counselor who lis-

Table 3. Percentage of Icelandic youth aged 17–20 who identified selected measures of availability and quality of care as very important or important, and mean value (and standard deviation) of importance score, by measure, all according to gender

Measure	% important or very important				Importance score				t-test	P
	N	Total	Female	Male	Female		Male			
					N	Mean	N	Mean		
AVAILABILITY										
Geographic availability										
Service close to home	1,698	81.3	82.8	74.3	1,419	4.2(0.90)	272	3.9(0.95)	–4.04	.000***
Service discrete	1,697	40.5	40.1	43.0	1,418	3.3(1.08)	272	3.3(1.07)	0.29	.765
Economic availability										
Free service	1,690	63.1	63.1	63.4	1,413	3.8(1.02)	270	3.8(1.09)	0.10	.919
Administrative availability: service arrangement										
Enough time for discussion	1,699	96.7	97.4	93.4	1,419	4.6(0.55)	273	4.3(0.62)	–6.59	.000***
Comfortable environment	1,694	88.1	89.5	80.6	1,414	4.3(0.76)	273	4.1(0.85)	–4.98	.000***
Administrative availability: equal access										
Service for people in and not in a sexual relationship	1,698	87.6	88.2	84.5	1,420	4.5(0.80)	271	4.3(0.85)	–3.63	.000***
Service for both genders	1,692	73.0	72.2	78.5	1,415	4.2(0.98)	270	4.2(0.88)	–1.14	.254
Service for heterosexuals & homosexuals	1,690	69.1	72.2	53.1	1,412	4.2(0.96)	271	3.6(1.16)	–7.02	.000***
Administrative availability: easy access										
Convenient opening hours	1,693	91.6	92.6	86.7	1,414	4.3(0.68)	272	4.2(0.70)	–3.27	.001***
Short waiting time for appointment	1,692	72.8	73.1	72.1	1,413	3.9(0.90)	272	3.9(0.85)	–0.28	.777
Can attend with someone else	1,694	71.3	73.5	60.0	1,417	3.9(0.87)	270	3.6(0.88)	–4.95	.000***
Walk-in service	1,695	56.8	55.4	64.6	1,417	3.6(0.97)	271	3.7(0.93)	2.36	.020*
Administrative availability: anonymity										
Unlikely to meet parents there	1,675	48.6	48.2	50.6	1,399	3.5(1.15)	269	3.5(1.17)	0.94	.345
Not have to tell telephone number	1,690	46.7	45.6	52.0	1,410	3.5(1.13)	273	3.6(1.03)	2.32	.020*
Not have to tell name	1,693	42.8	41.7	48.9	1,414	3.4(1.13)	272	3.6(1.03)	2.49	.013*
Administrative availability: gender preferences										
Examiner is female	1,583	43.1	47.3	13.8	1,381	3.6(1.07)	196	3.0(0.93)	–8.20	.000***
Examiner is male	1,279	8.2	5.1	22.1	1,048	2.7(0.83)	226	3.1(0.96)	7.49	.000***
Counselor is female	1,672	31.0	34.6	12.6	1,404	3.4(1.06)	261	2.9(0.86)	–7.23	.000***
Counselor is a male	1,489	6.9	5.7	12.6	1,220	2.7(0.80)	262	2.9(0.84)	3.78	.000***
Administrative availability: educational material										
Videos suitable for young people	1,681	54.3	55.1	51.3	1,403	3.5(0.98)	271	3.4(1.03)	–1.49	.136
Posters suitable for young people	1,680	44.1	45.5	37.8	1,403	3.3(1.06)	270	3.2(1.08)	–1.93	.053
QUALITY OF CARE										
Client-provider interaction										
Counselor listens actively	1,693	99.5	99.7	98.2	1,413	4.9(0.34)	273	4.7(0.53)	–6.00	.000***
Staff has friendly attitude	1,687	99.3	91.1	73.2	1,408	4.9(0.30)	272	4.7(0.50)	–6.29	.000***
Staff has respect for young people	1,690	98.9	99.0	98.1	1,411	4.8(0.40)	272	4.7(0.51)	–3.93	.000***
Client feels good during the visit	1,693	98.9	99.4	96.6	1,415	4.8(0.38)	271	4.6(0.55)	–7.26	.000***
Counselor shows understanding	1,695	98.9	99.0	98.5	1,415	4.8(0.41)	273	4.6(0.54)	–4.75	.000***
Client can ask any question about sexuality	1,701	97.0	97.5	94.5	1,421	4.8(0.47)	273	4.6(0.62)	–3.94	.000***
Client can make decisions about contraceptive methods	1,695	89.0	90.1	82.6	1,417	4.4(0.69)	271	4.2(0.76)	–4.15	.000***
Client can discuss matters privately with the counselor	1,698	98.3	98.9	95.2	1,420	4.8(0.45)	271	4.5(0.61)	–5.39	.000***
Service protects absolute confidentiality	1,690	88.0	89.6	78.9	1,413	4.5(0.83)	270	4.2(1.08)	–5.18	.000***

*p<.05. **p<.01. ***p<.001.

tens actively and shows understanding, and to have services provided with absolute confidentiality (Table 2).

In contrast, it was significantly more important for those living in Reykjavík that sexual and reproductive health services be free of charge than for those living outside Reykjavík. Adolescents who lived in Reykjavík were also more likely than other adolescents to report preferring a walk-in service and wanting guaranteed anonymity, including arrangements to ensure they would not meet their parents at the service site and would not have to provide their name or telephone number (Table 2).

Gender Differences

Young women were more likely than young men to report wanting services close to where they live, enough time for discussion with their health care provider, a comfortable environment, convenient hours of operation and the ability to attend the services with someone else (Table 3). Female respondents were also more likely than males to want their examiner and counselor to be female and to say that equal access to services is important. All of the quality-of-care items were significantly more important for young women than for young men, particularly the significance of friendly attitude and to be sure of absolute confidentiality.

Young men found it significantly more important than young women to have access to a walk-in service and were more likely to report wanting to be able to preserve their anonymity by not providing identifying information. Young men were more likely than young women to report a preference for a male examiner and counselor. There were no significant differences between young men and young women on the importance of a discrete location, the cost of the service or the possibility that a client could meet his or her parents at the service site.

Table 4. Percentage of Icelandic youth aged 17–20 who identified selected measures of availability and quality of care as very important or important, and mean value (and standard deviation) of importance score, by measure, all according to contraceptive service utilization

Measure	% important or very important				Importance score				t-test	P
	N	Total	Never used	Used	Never used		Used			
					N	Mean	N	Mean		
AVAILABILITY										
Geographic availability										
Service close to home	1,698	81.3	80.3	82.9	455	4.0(0.92)	908	4.2(0.90)	–2.20	.027*
Service discrete	1,697	40.5	43.7	37.2	456	3.3(1.06)	907	3.2(1.08)	1.63	.103
Economic availability										
Free service	1,690	63.1	64.1	63.1	452	3.8(1.00)	904	3.8(1.03)	0.00	1.000
Administrative availability: service arrangement										
Enough time for discussion	1,699	96.7	95.6	97.5	456	4.4(0.59)	908	4.6(0.55)	–4.24	.000***
Comfortable environment	1,694	88.1	85.9	90.0	454	4.2(0.80)	905	4.3(0.77)	–2.51	.012*
Pelvic examination not at first visit	1,449	47.4	48.6	43.7	288	3.6(0.99)	878	3.4(1.12)	2.89	.004**
Administrative availability: equal access										
Service for people in and not in a sexual relationship	1,698	87.6	88.1	87.3	455	4.4(0.81)	908	4.5(0.82)	–0.93	.351
Service for both sexes	1,692	73.0	73.7	73.4	453	4.2(0.96)	905	4.2(0.97)	–0.14	.887
Service for heterosexuals and homosexuals	1,690	69.1	67.8	71.7	453	4.0(1.09)	902	4.2(0.97)	–2.34	.019*
Administrative availability: easy access										
Convenient opening hours	1,693	91.6	90.7	93.2	453	4.3(0.68)	904	4.4(0.67)	–1.66	.097
Short waiting time for appointment	1,692	72.8	71.9	74.4	452	3.9(0.87)	907	3.9(0.90)	–0.19	.844
Can attend with someone else	1,694	71.3	71.2	72.8	452	3.9(0.86)	907	3.9(0.88)	–0.50	.612
Walk-in service	1,695	56.8	63.4	54.3	454	3.7(0.91)	909	3.6(0.99)	2.96	.003**
Administrative availability: anonymity										
Unlikely to meet parents there	1,675	48.6	51.7	43.4	453	3.5(1.10)	894	3.4(1.19)	2.75	.006**
Not have to tell telephone number	1,690	46.7	50.2	41.4	456	3.6(1.06)	900	3.4(1.15)	3.17	.002***
Not have to tell name	1,693	42.8	46.9	37.9	454	3.5(1.06)	904	3.3(1.15)	3.51	.000***
Administrative availability: gender preferences										
Examiner is female	1,583	43.1	40.4	40.6	403	3.5(1.05)	869	3.5(1.09)	0.24	.806
Examiner is male	1,279	8.2	11.5	6.2	349	2.9(0.90)	706	2.7(0.84)	2.28	.023*
Counselor is female	1,672	31.0	26.2	29.9	450	3.2(1.04)	893	3.3(1.04)	–1.34	.179
Counselor is male	1,489	6.9	7.0	5.9	415	2.8(0.82)	799	2.7(0.80)	0.43	.663
Administrative availability: educational material										
Videos suitable for young people	1,681	54.3	55.2	56.5	451	3.5(0.98)	899	3.6(0.99)	–1.17	.241
Posters suitable for young people	1,680	44.1	43.3	46.4	453	3.2(1.07)	898	3.3(1.06)	–1.32	.186
QUALITY OF CARE										
Client-provider interaction										
Counselor listens actively	1,693	99.5	99.3	99.8	455	4.8(0.43)	906	4.9(0.35)	–3.83	.000***
Staff has friendly attitude	1,687	99.3	81.9	91.6	453	4.8(0.44)	901	4.9(0.29)	–4.83	.000***
Staff has respect for young people	1,690	98.9	98.5	99.2	452	4.7(0.46)	904	4.8(0.39)	–3.05	.002**
Client feels good during the visit	1,693	98.9	98.0	99.3	453	4.7(0.49)	907	4.8(0.38)	–4.09	.000***
Counselor shows understanding	1,695	98.9	98.9	99.3	456	4.7(0.48)	905	4.8(0.40)	–3.62	.000***
Client can ask any question about sexuality	1,701	97.0	95.0	98.6	455	4.7(0.58)	910	4.8(0.42)	–4.08	.000***
Client can make decisions about contraceptive methods	1,695	89.0	86.1	91.9	453	4.3(0.74)	909	4.4(0.67)	–3.97	.000***
Client can discuss matters privately with the counselor	1,698	98.3	98.6	97.5	453	4.7(0.55)	909	4.8(0.45)	–3.01	.003**
Service protects absolute confidentiality	1,690	88.0	85.7	88.0	454	4.4(0.95)	904	4.5(0.89)	–1.23	.218

*p<.05. **p<.01. ***p<.001.

Service Utilization

Sixty-seven percent of the respondents had used contraceptive services; of those, 25% had used the services only once. The differences between adolescents who have never used contraceptive services compared with those who have are presented in Table 4, according to respondents' attitudes regarding measures of availability and the quality of care of the sexual and reproductive health services.

Adolescents who had never used the services considered it significantly more important not to be required to have a pelvic examination at the first visit, to be able to have walk-in service, to be anonymous and to have a male examiner than did adolescents who have already used such services. In contrast, those who have used available services at least once placed more importance on geographically proximal services, on having enough time for discussion, on a comfortable environment and on equal access to services than did adolescents who have never used such services. Adolescents who had already visited a sexual and reproductive health service also considered every item that measured quality of care (except the absolute confidentiality measure) to be significantly more important than those who had never attended such services (Table 4).

Discussion

This cross-sectional survey, which is based on a nationally representative sample, provides information about factors that young people in Iceland find important in the arrangement of sexual and reproductive health services. The results confirm those of previous research demonstrating that young people desire broadly based services,

including sexual and reproductive health services.[21] The majority of adolescents want sexual and reproductive services in special clinics, but one-third prefer to receive such services within community health centers. It is possible that larger numbers of adolescents would identify community health centers as a potential service site for sexual and reproductive health services if community health centers currently offered some special service for them.

The significant findings presented in Tables 2–4 are of limited importance due to the small differences between the means, a result of a large sample size.[22] Thus, the items were reexamined to determine which ones had a difference of greater than 10%; those are considered to be of special importance.

Young people outside of Reykjavík usually have only one service choice regarding contraceptive methods, and they reported finding it more important to have services close to where they live than did adolescents who live in Reykjavík. The importance of service proximity to these adolescents may be surprising to those who are knowledgeable about Iceland, since most places in the country have fairly accessible community health centers; thus, services are actually probably not far away from these young people. This may suggest that young people with limited service options find current services inaccessible, even though these physically exist. Some young people out in the country may also travel great distances to obtain contraceptive services. The use of community health centers by young people outside Reykjavík needs further study.

It was surprising that only 2% of respondents named their school as a possible service site for sexual and reproductive health services. Again, as very few of the schools for this age-group presently employ school nurses or other health care professionals, the lack of a model for this source of care may explain students' dismissive attitude toward this possibility.

Adolescents who live in Reykjavík find it more important to receive services free of charge than do young people living outside Reykjavík. Adolescents living outside Reykjavík tend to work for wages earlier and attend school for a shorter time than young people living in the capital area. Thus, current costs of services may be more of a barrier to students in the Reykjavík area.

It has been documented that young men use sexual and reproductive health services less than do young women.[23] This study affirms that finding, as young women were more likely than young men to complete the questionnaire. The finding that young women consider it more important than young men that the service environment is comfortable, that the staff have friendly attitudes and that confidentiality is ensured probably reflects that gender difference in service utilization.

It was notable that young women stressed the importance of being able to attend sexual and reproductive services with someone else, which may indicate that they find it more comforting or supportive to have someone with whom they can continue discussions after a visit. Most of the young women who come for counseling about emergency contraception in "The Other House" are accompanied by a female friend.

Iceland must find ways to reduce high fertility rates among its young people and, to that end, both sex education and sexual and reproductive health services for adolescents need to be strengthened.[24] This study provides some guidance regarding factors that might increase adolescent utilization of sexual and reproductive health services, both in special youth clinics and within the community health centers.

Young people need to have multiple service options. Adolescents who will not or cannot attend community health centers for these services need alternatives. However, community health centers might also be able to increase utilization by reevaluating their existing services. Community health centers might benefit from considering the type of services they offer, their economic and administrative accessibility, and the quality of care they provide, according to the measures explored here. Special hours of operation for young people should be considered in community health centers as well. Similarly, the most populated areas of Iceland might benefit from the establishment of separate youth clinics for both genders, which would make it possible to respond to the special needs of young men and their gender preferences for a counselor and an examiner.

If sexual and reproductive health services and contraceptive methods are to be made more available to young people, it would seem that the costs of the services, as well as the price of contraceptive methods, need to be reduced. Young people might benefit from easier access to emergency contraception, perhaps via school health nurses. To ensure maximum utilization, young people need to be involved both in the planning and implementation stages as services are reevaluated and developed, no matter where they will be located.[25]

These results also demonstrate the almost universal importance that adolescents place on quality of care. Counselors in such environments need to actively listen to their clients. If service providers do not exhibit understanding attitudes and guarantee confidential services, they may not attract the maximum possible numbers of new clients, and they also risk losing those adolescents who have the courage to seek such services.[26]

Young people are at a vulnerable stage of their life. They have been going through great physical changes that will render them physically able to have children at a time when they usually are neither emotionally, socially nor cognitively ready for childbearing. Their emotional and cognitive abilities are developing and they are gradually gaining more independence from their parents. During this sensitive period, they make many decisions that can affect the rest of their lives. Professionals need to recognize that when a young person attends sexual and reproductive health services, it is a sign of responsible behavior that should be rewarded by sensitive counseling.

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