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CONTINUUM *Complete*

International

ENCYCLOPEDIA OF SEXUALITY

Updated, with More Countries

continuum
NEW YORK • LONDON

2004

The Continuum International Publishing Group Inc
15 East 26 Street, New York, NY 10010

The Continuum International Publishing Group Ltd
The Tower Building, 11 York Road, London SE1 7NX

Typography, Graphic Design, and Computer Graphics by
Ray Noonan, ParaGraphic Artists, NYC http://www.paragraphics.com/

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

The Continuum complete international encyclopedia of sexuality / edited by Robert T. Francoeur ; Raymond J. Noonan ; associate editors, Martha Cornog . . . [et al.].
p. cm.
A completely updated one-volume edition of the 4-volume International encyclopedia of sexuality (published 1997-2001), covering more than 60 countries and places, 15 not previously included.
Includes bibliographical references.
ISBN 0-8264-1488-5 (hardcover : alk. paper)
1. Sex—Encyclopedias. 2. Sex customs—Encyclopedias. I. Title: Complete international encyclopedia of sexuality. II. Francoeur, Robert T. III. Noonan, Raymond J. IV. Cornog, Martha. V. International encyclopedia of sexuality.
HQ21.I68 2003
306.7′03—dc21 2003006391

Contents

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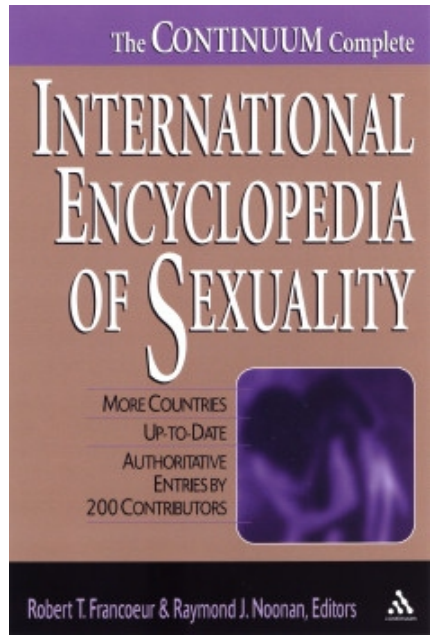

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Updates by the Editors

Contents

Demographics and a Brief Historical Perspective

SÓLEY S. BENDER

A. Demographics

Iceland is an island nation located just south of the Arctic Circle in the North Atlantic Ocean. Geographically isolated until 870 when the first settlers arrived, Iceland's nearest neighbors are Greenland about 190 miles (305 km) to the northwest, Norway about 620 miles (1,000 km) to the east, and the United Kingdom 500 miles (800 km) to the south. Iceland's total land area is just under 40,000 square miles (103,000 km^2), with a coastline of 3,100 miles (4,990 km), making it slightly smaller than the state of Kentucky. About 65% of the country is mountainous, with glacial rivers coursing through sandy deserts and lava fields. About 11% of Iceland is covered with glaciers (Hagstofa Íslands 1998).

There are innumerable hot springs both in the lowlands and in the mountains. Natural hot water is used to heat houses. There are many geysers in Iceland, the most famous being the Great Geyser in Haukadalur, which gives its name to geysers all over the world. The Gulf Stream makes Iceland's climate much warmer than the name suggests. Icelanders import grain and vegetables, but are self-sufficient in meat and dairy products.

In July 2002, Iceland had an estimated population of 279,384. (All data are from *The World Factbook 2002* (CIA 2002) unless otherwise stated.)

Age Distribution and Sex Ratios: *0-14 years*: 23% with 1.07 male(s) per female (sex ratio); *15-64 years*: 65.1% with 1.02 male(s) per female; *65 years and over*: 11.9% with 0.81 male(s) per female; *Total population sex ratio*: 1 male(s) to 1 female

(CIA 2002)

Life Expectancy at Birth: *Total Population*: 79.52 years; *male*: 77.31 years; *female*: 81.92 years

Urban/Rural Distribution: 92% to 8%. In 1999, 61.5% of Icelanders lived in the Reykjavík metropolitan area.

Ethnic Distribution: a homogeneous mixture of descendants of Norwegian (Norse) and Celtic settlers who arrived over 1,300 years ago

Religious Distribution: Evangelical Lutherans: > 90%; other Protestant and Roman Catholic: 3%; no affiliation: 1%

Birth Rate: 14.37 births per 1,000 population

Death Rate: 6.93 per 1,000 population

Infant Mortality Rate: 3.53 deaths per 1,000 live births

Net Migration Rate: –2.27 migrant(s) per 1,000 population

Total Fertility Rate: 1.99 children born per woman; in 1997, Icelandic women had a TFR of 1.8 children. The mean age of having the first child in 1998 was 25.1 years and the mean age of women in general to have a child was 28.8 (Hagstofa Íslands 1999b).

Population Growth Rate: 0.52%

HIV/AIDS (1999 est.): *Adult prevalence*: 0.14%; *Persons living with HIV/AIDS*: 200; *Deaths*: < 100. (For additional details from www.UNAIDS.org, see end of Section 10B.)

Literacy Rate (*defined as those age 15 and over who can read and write*): 99.9% (1997 estimate); schooling is compulsory from age 6 to 16. The language is Icelandic, which is actually similar to the language spoken by the Vikings who settled in Iceland in the early days. Most education is free. The number of women graduating from universities is rising, with 59% of the 1995-1996 graduates being women and 41% male, compared with a 93:7 ratio in the early 1950s (Hagstofa Íslands 1997).

Per Capita Gross Domestic Product (*purchasing power parity*): $24,800 (2000 est.); *Inflation*: 3.5%; *Unemployment*: 1% (April 2001 est.). Iceland's unemployment rate in 1998 was 2.7%, 3.3% for females and 2.3% for males (Hagstofa Íslands 1999b). The majority of Icelandic women, 83%, participate in the labor force, which is higher than in the other Nordic countries (Nordic Council of Ministers, 1999). *Living below the poverty line*: NA

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B. A Brief Historical Perspective

The first settlers of the volcanic island of Iceland were Vikings who arrived from Norway in 874 C.E. accompanied by a number of Scots and Irish. The Icelandic people are therefore mainly Scandinavian, genetically very homogeneous because of their longstanding geographic isolation. In 930, the Vikings established their legislative assembly, the Althing at Thingvellir, the world's oldest parliament. Christianity arrived in Iceland around the year 1000. In the year 1262, Iceland came under Norwegian rule. In 1380, it came under the rule of Denmark when the Danes gained control of all of Scandinavia. In 1918, Iceland became an independent sovereign state in union with Denmark through a common king. In 1944, with the Nazis occupying Denmark, Iceland deposed its king and declared itself a republic. The republic developed a Scandinavian-style welfare state, with comprehensive social benefits, that have produced one of the healthiest and best-educated populations (Olafsson 1989, 1990, 1999). Since 1944, Iceland has been an independent republic with the president chosen by a general election every four years.

1. Basic Sexological Premises

SIGRÚN JÚLIÍUSDÓTTIR

The character of gender roles, the sociolegal status of males and females, and general concepts of sexuality in Iceland are dealt with here as the product of the interaction between macroconditions and cultural values on the macro level, and lifestyle and adjustment on the meso or family level within Icelandic culture. These three basic sexological premises are discussed on the basis of statistics and research, as well as on clinical experience.

A. Character of Gender Roles

The rather young and small Icelandic society is known for its ancient literature, the *Sagas*, from which some basic cultural values derive. From the 1,000-year-old Saga period, we have colorful and influential descriptions of powerful gender characteristics of men and women and their equally esteemed gender roles as Vikings and Valkyries.

The written sagas and their narratives reflect cultural-ethical values and social norms, which have been transmitted through the generations in written texts, oral history, and developing myths. They have brought with them strong ideas, or even ideals, for modern men and women, for good and for bad. Also, some of the old values linked to survival and social adjustment in a tough natural environment under poor socioeconomic conditions in earlier times are still today reflected in men's and women's tough attitudes to work, love, and children (Juliusdottir & Asmundsson 1987). Accordingly, the modern woman sees herself as strong and independent, but simultaneously, she still assumes almost single-handedly the responsibility for the internal life of the family, reproduction, emotional care, and survival. Modern young men still see themselves as socially and economically responsible for the family's external, reproductive, and economic survival.

A family study on coping strategies in Icelandic families with children includes an analysis of the interaction of old cultural values and modern lifestyle. The results show how the ties to earlier times shape a set of gender-based complementarity of responsibilities enchaining both sexes to old hidden loyalties, which often seem to be a stumbling stone to individual freedom and career goals (Juliusdottir 1993).

Strivings for equality in Iceland started more than a century ago with women's movements and activity in different social organizations. Several factors, such as different formal human rights early in the 20th century, have contributed to the development of a myth about the strong Icelandic woman. Icelandic women gained eligibility and the right to vote in 1915, and the first woman was elected to the Parliament in 1922 (Erlendsdottir 1993; Kristmundsdottir 1997). Other historical events are often referred to as verifying instances of gender equality and the somewhat special position of Icelandic women. These are the strong Redstocking Movement (for sexual equality) around 1970, the celebrated "Day of Women's Strengths and Solidarity" (*Kvennafrídagur*) on October 24, 1975, the Women's Slate Movement and the subsequent Women's Party from 1982 onwards, and the election of Vigdis Finnbogadottir in 1980 as the first woman president of a nation in the world. Also cited are the establishment of the Society for Sheltering Battered Women in 1979, followed by the first study of violence against women (Olafsdottir et al. 1982; Juliusdottir 1982), and the Women's Counselling Service in 1984. All these are evidence of the progress modern Icelandic women have made in their endeavors for solidarity with victims of violence and injustice.

Being strong, however, is not the same as being free and independent, a distinction that may apply to both men and women. In spite of the positive image of the strong Icelandic women, statistics give another picture. Figures on the low wages and occupational status of Icelandic women, and their poor participation and lack of recognition in the public sphere, in politics and the economy, show the opposite, i.e., a much lower status of women than men (Hagstofa Íslands 1999b, 67, 184).

The increasing pressures of globalization have reduced the historic isolating effects of Iceland's geographical distance from other countries. Modern electronic and computer/Internet media rapidly import new scientific knowledge and convey the latest ideas from abroad about gender equality and behavior patterns. Ideas about the personal freedom to choose and plan one's educational path, occupational career, children, and family obligations thus often collide with the persistent old values related to the virtue of personal sacrifice, hard work, and social adjustment in Iceland.

The labor force is in short supply and both professionals and qualified and unqualified workers are badly needed. Thus, the relatively few inhabitants are not only expected to contribute with long working hours, but also are simultaneously expected to find for themselves effective solutions for family matters, such as childcare and care for the elderly. A strong informal family network often comes into play when public services and support are lacking for dual-career couples. Another example of how social concerns are dealt with in the private sphere is the expectation that married couples will successfully negotiate their own marital/familial roles and responsibilities (Rafnsdottir 1994; Olafsson 1990).

There is strong social pressure to reach the goal of a first-class housing standard, high educational level, and modern material consumption pattern for all Icelanders. Simultaneously, the old values of still having many children, taking care of one's own parents, and other "old fashioned" family obligations often put young parents in a situation of heavy conflicts in their daily lives.

B. Sociolegal Status of Males and Females

The small, traditionally rural Icelandic society changed rapidly after World War II. The process of urbanization with a civil environment and modern lifestyle did not appear until the 1950s. Iceland is supposed to share the welfare-state ideology of the Nordic countries. The implementation of constitutional and juridical issues is, however, somewhat different (Olafsson 1999, 1989). Iceland's healthcare expenditure is in

line with the other Nordic countries and even higher in some cases. In Iceland, consumers of health services, however, pay a larger part of the medical costs themselves. The high-quality health-service results include the lowest infant mortality rate and the highest life expectancy in the Nordic countries (NOMESCO 1998, 67-69, 161, 164).

On the other hand, the government's economic contribution to social and family matters is much lower than it is for the health services. Thus, daycare centers and services for the elderly are insufficient to meet the needs of the people (NOSOSCO 1996). The difference is striking, when long working hours, the number of children, and the considerable number of three-generation households are taken into account. In spite of the high divorce rate, approximately 40% of the weddings, the strong and still increasing familialism with its emphasis on building families early and having many children, makes the percentage of intact families (married or cohabiting with their own children) up to 50% plus. At the same time, the number of single-parent households is 8.5% and 7.3% for stepfamilies (Hagstofa Íslands 1999b, 33, 60, 65; Juliusdottir et al. 1995, 40-41).

Statistics show that, on average, men between the ages of 25 and 54 have a workweek of 54-plus hours and women 45 hours (Hagstofa Íslands 1999b, 88). Ninety-six percent of the men and 85% of the women between ages 25 and 54 are actively employed (Hagstofa Íslands 1999b, 79). The choice of fields in this labor market is highly segregated by gender. The proportion of women is highest in public services, healthcare, and education, whereas that of men is highest in administration, special techniques, fishing, and agriculture (Hagstofa Íslands 1999b, 86). The wages of women are only 52% of those of the men, and that has not changed in recent years (*Heilsufar Kvenna* 2000).

Icelandic women have reached a high level of education. Among the 20-year-olds, 42.3% of the women and 28.5% of the men pass the matriculation examination. Also, proportionally more women than men are admitted to universities, and they graduate more frequently than men, both with undergraduate and graduate-level degrees (Hagstofa Íslands 1999b, 269). Women do not seem, however, to realize their potential in a vocational career to the same extent Icelandic men do, as already pointed out above.

After World War II, the work of Icelandic women outside the home increased and their educational level improved considerably. There has, however, been a significant difference between single and married women. The latter continued to give birth to many children and take care of their parents, although the daycare system and services for the elderly did not expand in proportion to the demand. As elsewhere, the social care services have developed as a gender issue, both regarding the employed and the families as consumers (Rauhala et al. 1997).

During the last decade, several improvements of crucial importance for equality have been legislated. One sign of progress for equality of the sexes was new legislation on parental leave of nine months at childbirth, which is to be implemented in steps in the next few years. It allows three months leave for the mother, three months for the father, and three months to be divided as the parents choose.

In 1992, Iceland was late in introducing legislation on joint custody for children of divorced parents. A new study on the experience of this alternative shows that parents who choose joint custody adjust in several ways better and more equally to their new life circumstances. Both parents and children report better health on average, and the frequency of depression and social isolation is less than among parents with divided custody. They use alcohol less often and the contact with families of origin is more frequent, especially for the fathers. The parental responsibilities also came out more equal for both sexes than when custody was divided (Juliusdottir & Sigurdardottir 2000).

A recently established public Family Council, followed by the Year of the Family in 1994, has played a role in preparing an integrated and comprehensive family policy, recommending political initiatives, and facilitating actions in family matters, such as family planning and family life education. The Family Council is also supposed to serve as a consulting organ for the government.

The rapid socioeconomic evolution has caused a cultural lag, where families and couples are struggling with adapting to the new society's demand for consumption and self-realization, but at the same time taking on family obligations in the spirit of the still-alive old values and images.

Sometimes the loyalty to old values is beneficial and sometimes it restricts the changing character of Icelandic gender roles. The influences of the macro- and mesofactors mentioned above often appear strikingly in parental roles and in couples' intimate relationships affecting their emotional and sexual lives. A comparison between two Icelandic and Swedish counseling services shows that the reasons for seeking professional help are different. The Swedish clinical population in marital and family therapy seems more prone to seek help to improve couples' emotional relationships and communication when dealing with personal and interactional conflicts. This may, unlike the case in Iceland, have to do with the fact that Swedish parents are not so busy struggling with practical (e.g., financial, housing, working, and daycare) problems of daily life as Icelandic parents are. Such practical needs and the problems related to them are not so prominent in Sweden. They are, to a greater extent, taken care of through effective family policy with sufficient official family support (Juliusdottir 1993).

In modern European societies, where the public is generally well educated and conscious about qualities of life, there is also increasing emphasis on harmonious proportioning of work, private life, leisure, sex, and pleasure. In Iceland, some similar changes in cognitive attitudes are appearing. In a comparative European study, 66% of Icelanders agreed with the statement, "The government must offer extensive social services, even if it requires higher expenditures and increased taxes." This percentage of agreement was similar to that in other European countries. On the other hand, 79% in the Icelandic sample were strongly against the statement, "Social service is too expensive and must be cut down" (Olafsson 1999; Olafsson et al. 1998).

C. General Concepts of Sexuality and Love

Icelandic constructs of sexuality related to family building, health, work, values, and moral attitudes provide a third domain of basic sexological premises.

The Icelandic population, in general, holds rather permissive attitudes regarding sexual relations and other related social-moral issues. Although the age of majority for males and females is 18 years, young people start working already at an earlier age and consequently identify with adult behavior in many regards. Icelandic adolescents, boys earlier than girls, start petting early in comparison to other countries, often before age 16, and have their first sexual intercourse, on average, at age 15 (Jonsdottir & Haraldsdottir 1998). Approximately 55% of 14-year-olds, girls more often than boys, have started smoking. A somewhat higher proportion at this age has started drinking. There is no difference between the sexes until the age of 17, when the proportion is significantly higher for the girls (Adalbjarnardottir et al. 1997). Another Icelandic study confirms these results, but also shows that young Icelandic adolescents in general use alcohol and drugs

to a somewhat lesser extent than those in the other European countries (Thorlindsson et al. 1998).

Young people, on average, leave home at the age of 20-plus and start cohabitation or marriage, on average, about the age of 21. It is most common to start "going steady" at about the age of 18 and to have experienced two longer relationships before cohabitation. At least 40% start cohabiting in the housing of their parents or parents-in-law (Juliusdottir et al. 1995, 52).

The generally liberal attitudes of Icelanders are reflected in the Icelandic part of an international opinion study of a nationwide representative sample (Jonsson & Olafsson 1991). In some moral attitudes and values concerning sexuality and family life, Icelanders do not differ from the average on most items. Approximately 24% agree on a requirement of "totally free and unregulated sexual behavior," whereas the other Nordic countries are harder on that issue. Icelanders differ from other Scandinavians, on average, in holding more-positive attitudes towards divorce, abortion, and homosexuality. On the other hand, Icelanders are, on average, more negative than other Scandinavians when it comes to marital infidelity.

In the 1991 family study just cited, approximately 80% of responding husbands and wives said that it never occurred in their relationship. The respondents, however, reported that they would discuss it rather than see it as a reason for divorce. Asked about their attitudes to their own sexual life, they commonly reported that they have intercourse six to ten times per month (45% of the men; 49% of the women). They emphasized caring more than intercourse (45% men; 70% women), and preferred showing physical closeness and warmth (30% men; 21% women) (Juliusdottir 1993, 186, 190).

In an international study of 60 countries (Gallup 1999) with a representative sample of Icelanders, the respondents evaluated similar factors as the other Nordic countries as most important in life, specifically, good health and happy family life. A recent nationwide Icelandic opinion study on moral values and virtues showed similar results (Proppé 2000). What Icelanders saw as more important to care about and to pursue were family and friendship (50%) rather than education and vocational career (11%). This was especially true among younger people.

2. Religious, Ethnic, and Gender Factors Affecting Sexuality

SÓLEY S. BENDER

A/B. Source and Character of Religious and Ethnic Values

In Iceland, about 89% of the population are registered members of the state Lutheran Church, 3.6% belong to the Lutheran free churches, 3.3% belong to other religious organizations, and of those, there are 1.4% Catholic (Hagstofa Íslands 1999b). There is not a strong religious influence on sexual life. According to the Lutheran religion, people should only have sex within marriage. In the earlier days, marriage was arranged between two clans. Both the bride and the bridegroom had to have enough money to be able to get married (Gudmundsson 1990).

In Thorvardarson's 1978 study, students in the age group 16 to 18 were asked about the importance of teaching about Christian values, especially regarding sexuality and marriage. Only 10% considered it very important to teach religious values in sex education. This issue had the lowest value when compared to other topics in sex education, such as sexually transmitted diseases (97%), contraceptive methods (92%), where to get information (86%), and sexual problems (61%).

Nowadays, marriage is not a prerequisite for living a sexual life. Cohabitation is common and some people never get married, although they may have several children. Icelanders widely accept single persons having a sexual life.

3. Knowledge and Education about Sexuality

SÓLEY S. BENDER

A. Government Policies and Programs

In the 1950s, sex education in Iceland's schools was limited. For the most part, it consisted of two pages in the human health book. In many schools, the teachers skipped these two pages. In 1948, *Sexuality* by Fritz Kahn, M.D., was published in Iceland. It was a popular possession of many families at that time. Through the years, several books about sexuality have been translated into Icelandic. Some of these books have been used in teaching sex education. In 1976, *The Man, Birth, Childhood and Adolescence* was written by Icelanders to be used for sex education (Eiriksdottir et al. 1976). It has since been widely used for 5th and 6th graders (10- and 11-year-olds). *Human Reproduction*, published in 1983 (Kjartansson & Brynjolfsson), was another Icelandic addition to textbooks for sex education in the schools. It has been widely used in the schools for 13- to 16-year-old students.

The 1985 diagnosis of the first person in Iceland with AIDS raised the importance of preventive work in the schools. This meant increased emphasis on sexually transmitted diseases and the importance of condom use. Because of AIDS, new Icelandic educational material about sexually transmitted diseases was published in 1988 by the Ministries of Education and Health for use by teachers and others in sex education. In 1989, the Ministry of Education issued a curriculum plan for grades 1 through 9. In this plan, sex education was emphasized as a part of many subjects in the schools, like Christianity, sociology, and biology. Teachers in the schools and health professionals from the local community health center were encouraged to work together on sex education. In the fall of 1999, a new curriculum plan was released by the Ministry of Education for grades 1 through 10 and beyond. Presently, teachers in every school make their own teaching plan, and the number of hours devoted to sex education can vary considerably. Sex education is, therefore, in the hands of individual teachers and schools. Some schools have very good sex education, whereas others are very limited.

A standard curriculum for sex education was lacking for many years. It was not until 1991 that a holistic curriculum for sex education for the 8th through the 10th grades was introduced in the schools. This program, *Human Sexuality, Values and Choices*, was an American sex education curriculum from Minnesota. It was translated, adapted to Icelandic culture, and pilot-tested in seven schools in 1990 (Axelsdottir et al. 1990). The pilot test was based on an experimental design. It showed that there was a significant increase in knowledge among those in the experimental group compared to those in the control group, but it showed very limited changes of attitudes. This sex education curriculum is based on 15 lessons, with lessons about the biological facts of human sexuality, but also about feelings and intrapersonal relations. It does stress identity, feelings, how to make decisions, and knowing what to do when it comes to making decisions about sexuality. It has a comprehensive handbook for teachers, with objectives and the contents of the lessons, as well as projects for the students. It also has a video of 120 minutes that has short episodes of certain sex education sessions meant to facilitate group discussion. There is an additional handbook for parents.

The teachers are supposed to have three meetings with the parents about the curriculum. Many projects are intended to be completed by the students in cooperation with their parents or other adults. This program is now in use in many schools and it has made a considerable difference for sex education. A 1993 study showed that this curriculum was used by 63.6% of the 60 schools participating in that study (grades 8 through 10) (Palsdottir & Hardardottir 1993).

No comprehensive curriculum has been developed for students younger than 13 years old or for those older than 16 years old. There is no sex education in the junior colleges except when students arrange it themselves. Representatives from the Icelandic Association for Sexual and Reproductive Health have been asked to go to several schools to give sex education. Also lacking are regular training courses about sex education for teachers and school health nurses. The last time such a training course was offered was in 1992.

A regulation about health promotion in schools from 1958 is probably one of the oldest legal documents that deal with sex education. In addition, sex education is based on 1975 laws about information and counseling regarding sexuality and responsible parenthood, abortion, and sterilization, 1976 laws about gender equality, and 1978 laws about sexually transmitted diseases. A 1975 law stated: "Educational authorities should in cooperation with the chief school health physician give information about sexuality and moral issues regarding sexuality in the compulsory school system. Additionally information should be given in other educational programs."

In Thorvardarson's 1978 study, 6.4% of boys and 13.7% of girls in the 6th grade said that they received good enough sex education. In the 8th grade, the percentages were 2.9% for boys and 3.7% for girls. In the same study, 79% of the 6th graders and 96% of the 8th graders wanted the school to provide sex education. A nationwide study of sex education, based on a sample of 60 teachers in 60 schools, showed that the mean hours of sex education for the 9th grade was 19.7 hours, and for the 10th grade, it was 15.6 hours (Palsdottir & Hardardottir 1993). In this same study, participants were asked how they taught each issue. More teachers reported that they taught the contraceptive methods (condom, pill, diaphragm, IUD, etc.) well, than reported that they taught the STDs (gonorrhea, chlamydia, herpes, etc.) well (91% to 84% for contraception versus 62% to 81% for STDs). Eighty-eight percent thought they taught about puberty and human reproduction very well, and 81.8% felt they did well teaching respect for the decisions of others (Palsdottir & Hardardottir 1993).

Although the 1993 study showed that there were several issues considered by the teachers to be taught well, the survey results can give us only limited information about the actual sexual education on these topics. The study had a response rate of 60%, and it is a question whether the 40% who did not answer did not respond because they were not motivated to teach the subject or because of some other reasons. These study results do not agree with the results of three interviews with student focus groups, who frequently stated that they got very limited sex education in grades 8 through 10 (Johannsdottir 2000).

What needs to be done in the future is to have sex education as a compulsory subject in the school system, to have training courses on a regular basis, and to develop a curriculum for junior college (age groups 16 to 20).

B. Informal Sources of Sexual Knowledge

People have had access to sexual information from books, magazines, films, and the media. There has been a considerable increase in the publication of educational material about sexual and reproductive health from the Director of Public Health, from the Icelandic Association for Sexual and Reproductive Health, and from the Icelandic Incest Center (Stigamot). In 1990, Ottar Gudmundsson wrote *Íslenska Kynlífsbókin* (*The Icelandic Sexuality Book*), the first comprehensive Icelandic book about sexuality. Before that time, the books that were available were translated from other languages and cultures. Over the last few years, especially after AIDS got into the picture, sexuality has been discussed more openly on television and on the radio.

4. Autoerotic Behaviors and Patterns

SÓLEY S. BENDER

There are many negative terms in the Icelandic language for masturbation, starting with *self-pollution* (*sjálfsflekkun*). In *Sexuality* by Fritz Kahn, which was translated and published in Iceland in 1948, masturbation was explained in a detailed manner for both genders. It was stressed that masturbation was not bad for the health and that this behavior was not related to diseases. Kahn mentioned that Simon André Tissot, who published a treatise on the vice of "onanism" in 1760, had a considerable negative influence on attitudes toward masturbation. Tissot described the terrible effects of masturbation, ranging from nervousness to insanity.

There is no Icelandic study that provides any information about masturbation. Today, it is stressed that masturbation is a good way to get to know oneself. It is considered important to know one's own body sensations before sharing it with someone else.

5. Interpersonal Heterosexual Behaviors

SÓLEY S. BENDER

A. Children

No Icelandic studies have been done about the sexual explorations of young children.

B. Adolescents

A 1977 study by Sigurgestsson showed that among 14-year-olds, 23.2% of the boys and 21.2% of the girls said they had had sexual intercourse. This was considerably higher than in countries like Denmark, and the difference between genders was less in Iceland compared to other countries like Norway. A 1990 study showed results similar to those reported by Sigurgestsson: 25.6% of 14-year-old boys and 22.5% of the girls said they had had sexual intercourse (Axelsdottir et al. 1990).

A study by Jonsdottir (1994) showed that the mean age at first sexual intercourse was higher among the older age group than the younger, suggesting that the age of first sexual intercourse has been going down. For 50- to 60-year-olds, the mean age at first sexual intercourse was 17.6 for males and 18.6 for females. For 16- to 19-year-olds, the mean age at first sexual intercourse was 15.1 for males and 15.4 for females. Among the 50- to 60-year-olds, 4.1% had never had sexual intercourse, 48.7% were 16 or younger when they had their first sexual intercourse, and 47.2% were 17 or older. Among the 16- to 19-year-olds, 25% had never had sexual intercourse, 64.3% were 16 or younger when they had their first sexual intercourse, and 10.7% were 17 or older. This is a considerable difference for the age group 50 to 60, where 3.3% had never had sexual intercourse, 32.9% had sexual intercourse at age 16 or younger, and 65.8% were 17 or older.

A 1996 study showed that the mean age of sexual conduct was 15.4 years for both genders. The main author of this chapter conducted this national study based on a random sample of 1,703 people in the age group 17 to 20 years

old (Bender 1999a). Table 1 shows the age distribution for first sexual intercourse.

C. Adults

Marital Data

Between 1961 and 1965, the rate of marriage per 1,000 population was 7.9; in 1995, this was 4.6 (Hagstofa Íslands 1997). In 1998, 34.5% were married or cohabiting, 56% were not married, and 9.3% had been previously married and divorced (Hagstofa Íslands 1999b). The divorce rate has been increasing, doubling from 0.9 in 1961 to 1.8 in 1995 (Hagstofa Íslands 1997). The mean age of people who get married has also been going up. In 1961 to 1965, the mean age was 24.4 for brides and 27.4 for bridegrooms. Thirty years later, it was 29.9 for brides and 32.4 for bridegrooms. The attitudes of people to having a child out of wedlock are quite relaxed. A Gallup study (1997) showed that 95% did not think this was wrong.

Heterosexual Behaviors

A study conducted in 1992 by Jonsdottir and Haraldsdottir (1998) about sexual behavior and knowledge of AIDS showed that the average number of sexual partners is nine over the life span. Men have more sexual partners than women (12 versus 6). There is an identical ratio of men compared to women who have had anal sex (16.2% and 16.3%). The majority of men, 62.7% of those between ages 16 and 60, had experience with cunnilingus.

Those who have had two or more sexually transmitted diseases have had much higher numbers of sexual partners (26.4%) than those who were infected by one STD (11.9%) or none (6.2%). Casual sex is most frequent among those who are 16 to 25 years old.

This same study asked if participants had or knew about someone close to them who had had an affair while married or cohabiting. The results showed that 71.8% answered yes to this question (Jonsdottir & Haraldsdottir 1998). This may not be very reliable or accurate information, but it is the only available information about extramarital affairs.

6. Homoerotic, Homosexual, and Bisexual Behaviors

THORVALDUR KRISTINSSON

As of late 2000, no study provided reliable information about the frequency of homosexuality in Iceland. A study conducted in 1992 came closest to this by asking the participants about the sex of their partners. This national study of sexual behavior and knowledge about HIV had a sample of 971 people 16 to 60 years old. The response rate was 65%, with 53% of the respondents being women and 47% men. The percentage of people who reported having had sex with a person of the same sex ranged from zero to 1.8% for different age groups, with an overall average of 0.7%. In the age group 16 to 19, 1.8% reported a same-sex partner. Among 30- to 34-year-old respondents, only 0.6% reported a same-sex partner. Of those who had had homosexual experience, 0.3% were married, 2.2% single, and 5.6% divorced (Jonsdottir 1994; Jonsdottir & Haraldsdottir 1998).

Table 1

Age at First Sexual Intercourse

Age	Percent	Cumulative Percent
12 or younger	1.2	1.2
13	6.4	7.6
14	17.9	25.5
15	27.2	52.7
16	24.8	77.5
17	15.5	93.0
18	5.7	98.7
19	1.2	99.9
20	0.1	100

(*Source*: Bender 1999b)

Until the 1970s, lesbians and gay men were practically invisible in Icelandic society, which surrounded them with contempt and a massive silence. Their reaction was either to hide their sexual orientation completely, finding an occasional escape from the oppression while touring abroad, or to move to the metropolitan cities of continental Europe and North America. Many of those people never returned, being later referred to as sexual political refugees. The silence was first broken in 1975 when the first gay Icelandic man, influenced by the international liberation movement, revealed his sexual identity publicly in the media. Three years later, Samtokin 78, the organization of lesbians and gay men in Iceland, was founded by some 20 people. After 20 years, it has become the most powerful force in the gay liberation movement of Iceland with a little less than 400 members. Typical of the prejudice and hostility that met this small group on its way to visibility in its early years, was the case of a discotheque in Reykjavik, which in 1983 advertised in newspapers: "Everyone is welcome—except gays and lesbians." Another example from the same year took place in the Nursing School of Iceland, which forbade its students from meeting with the educational group of Samtokin 78, a meeting which the students themselves had organized after a gay student found himself forced to leave the school because of group harassment and hazing.

Nevertheless, the few who had the courage to speak up for homosexuals saw remarkable progress in the 1980s. They rejected, for instance, the commonly used derogatory Icelandic terms, such as *kynvilla* (sexual aberration) for homosexuality, a term analogous to the older word *truvilla* (religious aberration) for heresy. For a decade, they fought with the Icelandic State Radio against being labeled in such a derogatory manner, and suggested their own popular words, *lesbia* and *hommi* for themselves, and *samkynhneig*, a compound of same-sex and orientation, for homosexuality. Finally, they won.

Since then, gay activism in Iceland has been characterized by educational and legislative work with positive results. Several other gay associations have recently appeared, including an association of gay, lesbian, and bisexual students at the University of Iceland, and an association of gay junior college students (Stonewall), both founded in 1999. In 1983, a new political party, the Socialdemocratic Alliance, was the first one to place gay human rights on its agenda, and two years later, a recommendation was presented in the Parliament by four political parties demanding action to abolish discrimination against lesbians and gay men. It never passed, and it was not until 1992 that a similar recommendation passed Parliament, after the original recommendation had been reworked by five political parties. As a result of the research work ordered by this recommendation, a law on registered partnerships for same-sex couples passed the Parliament in 1996, although it denied same-sex couples any right to adopt children or to seek insemination in an official clinic. With this law, Iceland became the first country in the world to legalize common custody of children brought into a same-sex partnership from previous marriages. At the same time, the Protestant Lutheran state church did not approve of a formal church wedding, causing friction and open fights with the church authorities, which are still unresolved. In the year

2000, the Parliament passed a new law on registered partnerships giving same-sex couples the right to adopt stepchildren who are brought into the partnership. An antidiscrimination law passed the Parliament in 1996. It is worth noting that the parliamentary opposition in the debate preceding these legislative improvements was minimal, compared to the parliamentary opposition in other Nordic countries. To find an example of organized opposition, one has to go to the very small Christian fundamentalist congregations functioning outside the state church of Iceland.

Opinion polls nowadays show a surprising change of values in the society, and they express, in fact, more respect and tolerance towards gay men and lesbians than in other Western societies. When asked by an international opinion survey in 1990 about to what extent certain acts were justifiable on a one-to-ten scale, Icelanders expressed more tolerance than people in other nations regarding homosexuality, showing an average of 5.5. Other nations placed around 4.7 on the average, with the United States at a low 3.0. An international opinion survey of the same kind from 1984 gave the Icelanders an average rate of 3.3. This positive change is generally confirmed by what lesbians and gay men experience in their everyday life (Olafsson 1991). In a surprisingly short period of time, Icelandic society has left its homophobic attitude of the past and opened up for new visions and ideas.

7. Gender Diversity and Transgender Issues

SÓLEY S. BENDER

There is no study that provides information about Icelandic persons with gender conflicts or confusion. Given the clinical experience and incidence figures for gender-conflicted persons in nearby culturally similar countries, it seems reasonable to assume that a few hundred or more of the 280,000 modern Icelanders experience various forms of transsexualism, transvestism, hermaphroditism, pseudohermaphroditism, and intersexualism. Given the presence of support groups for gender-conflicted persons on the Internet and World Wide Web, one can reasonably assume that some gender-conflicted Icelanders may find local counselors and psychologists sensitive to their needs and explore possible medical help on the island and abroad.

8. Significant Unconventional Sexual Behaviors

SÓLEY S. BENDER and GUDRÚN JÓNSDÓTTIR

A. Coercive Sex

Sexual Harassment

No prevalence studies have been done regarding the frequency of sexual harassment, but the Icelandic Office for Gender Equality has made some small surveys in a limited number of workplaces. They show that between 12% and 16% of the female workers have been subjected to sexual harassment in their workplace. In the last few years, employees have been better informed than before about their rights if they are victims of sexual harassment. However, many myths still exist regarding this issue.

Sexual Abuse and Incest

No prevalence studies have been conducted regarding sexual abuse and incest in Iceland. Even so, it was clear to a group of women who had been working as volunteers in different services for women that incest and sexual abuse of women and children is not unknown in Iceland. In 1986, these women formed a group whose purpose was to develop services for survivors of sexual violence. The group was named the Working Group Against Incest. In 1987, when an office was opened half a day, the demand for the service increased steadily. The Stigamot (The Icelandic Incest Center), which opened in 1990, is the product of this movement. Stigamot is an information and counseling center for women and children who have experienced sexual violation. In its first decade, Stigamot helped a total of 2,811 persons, with 213 new individuals seeking help in 1999. The two main reasons women and children have come to Stigamot are incest (about 60%) and rape (about 30%). Those who use the service are mainly 19 to 49 years old (80.2%); the majority have limited education (Jonsdottir & Sigurdardottir 2000).

The Government Agency for Child Protection does coordinate and strengthen child protection in Iceland. In 1997, this agency recommended to the Minister of Social Affairs that a special Children's House (Center for Child Sexual Abuse) should be developed to coordinate the work of child protection authorities, social service, police, the state prosecution, doctors, and others when investigating sexual abuse, to improve the quality of the service for children, and to protect the child from having to go through many traumatic forensic interviews and possibly relive the difficult experience. In November 1998, this Children's House started as a two-year experimental project. In 1998, there were 21 children referred to this center and in 1999, there were 119. In 1999, laws were passed about new procedures for court cases, which gives the responsibility of the forensic interview to the judge (Gudbrandsson 1999). The experience has been that not more than 10% of cases go to court. The center also offers treatment services. On average, each child has about 14 interviews during the treatment process. This center serves the whole country. In late 2000, the future of the center was uncertain.

The criminal law about incest (1940) states that a parent who has sexual intercourse, vaginally or by other means with his child, shall get up to six to ten years in prison. Conviction for other types of sexual harassment by a parent towards a child can bring a prison sentence of up to two years and four years if the child is younger than 16 years old. Whoever has sex with a child younger than 14 years old can get imprisonment up to 12 years. Other types of sexual harassment and assault can lead to imprisonment up to four years.

In 1998, 58 legal charges of sexual abuse were brought in all of Iceland (Ministry of Law and Justice, personal communication, 4 July, 2000). Since 1981, the number of prison sentences stemming from sexual crimes has been rising. Between 1981 and 1985, there were 11 prison sentences and in 1998, there were 28. The mean number between 1985 and 1998 was 19.1 annually (Hagstofa Íslands 1999b).

Rape

In 1984, a group of women formed a group of counselors for survivors of rape. In the City Hospital in Reykjavik, a rape trauma center was established in 1993. As of mid-2000, 640 individuals had been attended to by the service. Seven were mentally retarded. In 1999, 103 individuals, 97 women and 6 men, used the service (Arsskyrsla Sjukrahuss Reykjavikur 2000). The majority of clients are females, but annually three to four men seek help. The clients range in age from 12 to 78 years, with 65% to 70% 25 years old or younger. The service is free of charge (Jonsdottir 2000). Rape is punishable under a 1940 law with imprisonment of between one and 16 years.

B. Prostitution

Prostitution has probably been organized in Reykjavik, but valid information is hard to obtain. In recent years, several nightclubs offering nude dancing have opened both in Reykjavik and other cities. The women there have mostly

come from abroad, particularly from Eastern European countries, to work as "dancers." This is probably hidden prostitution.

Sexual telephone service has become more and more obvious and is advertised in one of the main newspapers. This service was temporarily advertised with porno pictures. This was recently changed and now there is only text in the advertisements. These advertisements for sexual telephone services are also probably hidden prostitution services.

The 1992 study of sexual behavior and knowledge of AIDS showed that there were 71 individuals who had had sexual experience with a prostitute. Most of them were men and two were women. The majority were in the age group 25 to 39. The greater majority, 91%, had this sexual experience abroad (Jonsdottir & Haraldsdottir 1998). A person convicted of making a living by being a prostitute can get a prison sentence of two years. A person who gains a living from organizing the prostitution of others can get four years imprisonment. A person who encourages someone who is younger than 18 years old to work as a prostitute can get up to a four-year sentence in prison.

D. Pornography and Erotica

Pornography and opposition to it have existed in Iceland for centuries (Gudmundsson 1990). In the 20th century, there has been some control over pornography in books and movies. Today, there seems to be very limited control. Books, magazines, movies, and videos showing pornography are easily available.

According to the 1940 criminal law, it is illegal to make, import, sell, and/or distribute pornographic material. It is also criminal to give pornographic material to a person younger than 18 years old. It is also not allowed to store pornographic material of children. These offenses can lead to a fine and/or up to six months in prison.

9. Contraception, Abortion, and Population Planning

SÓLEY S. BENDER

A. Contraception

Contraception is available through Iceland's community health centers, gynecologists, and some hospitals. Around 1994, the only specialized family planning clinic, which served mostly young people, closed. In 1995, the Icelandic Association for Sexual and Reproductive Health started an information and counseling service for young people on sexuality, STDs, and contraceptives. As with the early clinic, mostly young women have used this service.

Few studies have been conducted about the use of contraceptives of women in their reproductive years. In the 1977 Sigurgestsson study, young people 14 years old gave information about their use of contraceptive methods at their first sexual intercourse. Overall, 40.6% of the respondents, 43.7% of the boys and 36.7% of the girls, said they had used contraception for their first full sexual intercourse. A 1990 study showed that the most frequent reasons for not using contraception were: not having thought about it, 61.7%; not daring to go to the community health center, 61.1%; being too shy to discuss this with their partner, 51%; and believing coitus interruptus was sufficient contraceptive protection, 49.2% (Axelsdottir et al. 1990). A 1996 study of 1,703 individuals ages 17 to 20 showed that 59% used contraception at first coitus. The methods most used were the contraceptive pill, 7.6%; condom, 61.7%; diaphragm, 0.58%; and other, 1.0%. After first coitus, the pill, the condom, and coitus interruptus were in that order the most frequently used methods (Bender 1999). There are no national studies of contraceptive use among the over-20 population.

Some data from the Cancer Society have been analyzed. This data shows that the most frequently used contraceptive method for younger women is the contraceptive pill and for older women the intrauterine device. In the 20-to-44 age group, 35% of contracepting Icelanders used the IUD and 18% the contraceptive pill (Geirsson & Gudmundsson 1988, 1987). In 1997, sterilization was used as a permanent method by 640 (83%) of contracepting women and by 130 (17%) of contracepting men. In 1983, this gender ratio was 95% for contracepting women and 5% for men.

A 1988 survey exploring information and counseling about sexual and reproductive health in Icelandic community health centers showed that the more-common subjects for counseling and information were: contraceptive methods, 84.4%; menopause, 72.8%; STDs, 72%; pregnancy tests, 67.1%; and premenstrual syndrome (PMS), 65%. Less frequently provided information dealt with: abortion, 23.4%; sexual problems, 29.8%; and sexual health, 30.2%. Most of these services were provided by family practitioners (Bender 1990).

The present legislation about contraception, abortion, and sterilization took effect in 1975. This 25-year-old law suggests that people should get subsidized contraceptive methods, but this has not been acted on.

B. Teenage (Unmarried) Pregnancies

The incidence of teenage pregnancies is considerably higher in Iceland than it is in other Nordic countries. Table 2 compares the rate of teenage pregnancies in these countries. Table 3 compares the birthrates. Although the birthrate among young women in Iceland has been dropping significantly, from 73.7 per 1,000 in 1970 to 24.9 in 1998, it is still much higher than in the other Nordic countries.

The percentage of live births by mothers under age 20 as a percentage of all live births in Iceland declined from 15.3% in 1977 to 6.3% in 1998 (Hagstofa Íslands 1999b). Table 4 shows comparable Scandinavian percentages for 1998.

A recent study showed that the birthrate among young women in Iceland is considerably less in the capital area compared to other places in Iceland, but the abortion rate is

Table 2

The Rate of Teenage Pregnancies per 1,000 Pregnancies in 1997

Country	Rate per 1,000
Iceland	46.2 (1997)
Norway	31.7 (1997)
Sweden	25 (1997)
Finland	19.2 (1997)
Denmark	23.5 (1996)

(*Source*: NOMESCO 1999)

Table 3

The Birthrate among Young Women per 1,000 Pregnancies in 1998

Country	Rate per 1,000
Iceland	24.9 (1998)
Norway	12.7 (1997)
Finland	9.0 (1998)
Denmark	8.4 (1998)
Sweden	7.2 (1998)

(*Source*: NOMESCO 1999)

also higher (Adalsteinsdottir 2000). At the same time, as the birthrate among teenagers (15 to 19 years old) there has been declining, the abortion rate has been rising (5.8 per 1,000 in 1976 and 21.7 in 1997). Now, close to 50% of pregnancies end in abortion and 50% in childbirth. A descriptive study of the health of teenage mothers (15 to 19 years old) during pregnancy and the health of their newborns, compared to older mothers (25 to 29 years old) and their newborns, based on a sample of 50 mothers in each group and 50 newborns of both groups, showed that the mean numbers of prenatal visits were identical in both groups. Teenage mothers attended 11.0 times and the older mothers 12.0 times. The younger mothers did not start to attend the prenatal visits later than the older mothers did. Health problems, such as pre-eclampsia and anemia, were more common in the older age group. There were fewer medical and surgical interventions during the delivery for the younger mothers. The percentage of low birthweight was identical for both groups (6% in each). The younger mothers, on the other hand, smoked more than the older mothers (25.5% versus 18%) and had higher frequency of delivering before the 37th week of gestation (6.3% versus 2.1%). The easy access to and no cost of prenatal service seem to contribute to fewer health risks among young mothers (Lorensdottir et al. 1994).

Young people do encounter some hindrances in obtaining contraceptive methods based on their insecurity, shyness, and the cost of the product. They also consider the health service at the community health centers to be too expensive and difficult to obtain, in contrast with the no-cost and easy availability of prenatal care (Johannsdottir et al. 2000). Young Icelanders want sexual and reproductive health services that are organized according to their needs. They have special needs regarding open hours and are sensitive to the environment and the interactions with the healthcare providers (Bender 1999a). This was further verified in a recent focus group study. This focus group study was based on three interviews of young people 16 to 19 years old, and showed that their special needs were better service hours in the afternoons or evenings, healthcare providers who show respect to young people, and a friendly staff attitude and friendly environment. They want to have music channels on the television in the waiting room, but not educational movies about STDs (Johannsdottir et al. 2000).

Most young mothers are probably single. Often they get good support from their families. A study based on two focus group interviews with young mothers showed that it was their mother who mostly helped them. They sensed the great responsibility of being a mother. Their inexperience, however, was demonstrated in being intolerant to breastfeeding and not knowing what to do when caring for the child. In spite of that, they felt good about being alone with the child, but often sensed insecurity when they were with others. Oftentimes, they felt that adults were interfering with their childrearing practices. They sensed that they had little time for themselves, had less freedom, and often felt isolated from their friends. All of the participants had some future vision. Most of them wanted to go to school or to finish the school they were attending (Sveinsdottir & Gudmundsdottir 2000). These results show the need of young mothers for support and guidance about childrearing practices.

Based on the high teenage pregnancy rate, more preventive efforts need to be made. Sexuality education needs to be improved, and specialized sexual and reproductive health services for young people need to be developed.

C. Abortion

The present law legalizing abortion took effect in 1975. Anyone can apply for an abortion for medical or social reasons or following a rape. Abortions can only be done within a hospital setting. According to the legislation, permission is required for the intervention to be performed. The application form needs to be signed either by a social worker and medical doctor or two medical doctors depending on the reason. Women who apply for an abortion report low use of contraceptives. In 1977 to 1980, about 30% of women seeking an abortion had used some type of contraception at the time of conception; in 1981 to 1984, contraceptive use rose to 37% (Oskarsson & Geirsson 1987). Because of the rising number of abortions, a contraceptive counseling service has been developed within the National Hospital for women before and after an abortion.

Abortion is free of charge, but there is small outpatient fee for the laboratory tests and physical examination before the operation. The majority of abortions are done for social reasons. The rate of abortions for all age groups has been rising over the last 24 years and is now identical to those in other Nordic countries; but their abortion rates have has been going down over the years (Bender 2000). Between 1976 and 1980, 472 abortions were preformed; in 1998, the number was 901. Table 5 shows the abortion rate by age group in 1998. Between 1976 and 1980, the abortion rate for the age group 15 to 19 was 9.4 per 1,000. In 1996, the abortion rate among 15- to 19-year-old Icelandic women was the highest among the Nordic countries.

There has been a group opposed to abortion in Iceland, but it has never been very active.

D. Population Programs

Iceland is a pronatalistic country, as demonstrated by the positive attitude to having many children. In 1997, a Gallup study showed that about 70% of Icelanders wanted to have three or more children. Eighty-five percent of those surveyed considered it necessary to have a child to feel fulfilled. This pronatalism is also evident in the fact that there are no government-run teenage clinics. Teenage pregnancy is high and seems to be generally accepted. There is a trend of population movement from the rural to the urban areas.

Table 4

Live Births by Mothers Under Age 20 per 1,000 Live Births in 1998

Country	Rate per 1,000
Iceland	6.3
Norway	2.7
Finland	2.6
Denmark	1.7
Sweden	1.3

(*Source*: Haagensen 1999)

Table 5

Abortions in Iceland in 1998

Age Group	Abortions per 1,000 women
15 to 19 years	24.1
20 to 24	23.2
25 to 29	16.2
30 to 34	11.0
35 to 39	9.1
40 to 44	3.8
45 and older	0.2

In some rural areas, there are recent efforts to increase the local population by using some financial incentives for young people to have children.

The discussion about the need for better contraceptive counseling services for people at reproductive age is new. The Icelandic Family Planning Association (The Icelandic Association for Sexual and Reproductive Health, or IcASRH) was established in 1992. This Association has been giving information to professionals and the public about these issues. One of these issues has been about emergency contraception. IcASRH published a special pamphlet about emergency contraception in 1996 and this has been widely distributed. The 1996 study about the attitude of young people to sexual and reproductive health services showed that only 35% of the 17- to 20-year-old participants knew what emergency contraception was.

In 1991, an infertility program was established at the National Hospital in Reykjavik. Before that time, people had to go abroad to have infertility treatment. The success rate of the Icelandic in-vitro fertilization (IVF) program has been high.

10. Sexually Transmitted Diseases and HIV/AIDS

SÓLEY S. BENDER

A. Sexually Transmitted Diseases

Incidence and Trends

Iceland's national registration of sexually transmitted diseases does not provide accurate information about the prevalence of those diseases. The most accurate information about the rate of STDs is based on data from the Department of Infectious Diseases at the National Hospital in Reykjavik. Based on their information, there were 9,415 chlamydia cases between 1981 and 1990, about 941 annually. The number of positive tests for chlamydia has been dropping from 26% in 1981 to 11% in 1990 (Steingrimsson et al. 1991). From 1991 to 1997, the incidence of positive tests was 11 to 13%.

Chlamydia trachomatis has been the most frequent sexually transmitted disease in Iceland for several years. The number of gonorrhea cases has been dropping over the years, but herpes and condyloma have increased. The 1992 sexual behavior study showed that there were 9.3% who had gotten *Pediculus pubis* (pubic lice), 8.4% chlamydia, 8.0% scabies, 5.6% condyloma, 4.5% gonorrhea, and 2.5% herpes (Jonsdottir 1994). In the same study, 20% of the participants said they had had one STD, while 6.8% reported two or more infections, with men having a higher frequency at 9.3% compared with 4.7% for women (see Table 6).

Treatment and Prevention Efforts

There is one STD clinic in Reykjavik offering diagnosis and treatment. People can also visit their family practitioner at community health centers all over Iceland. The diagnosis and treatment is free for the client.

Table 6

Percentage Infected with STD

	All (n = 966)	Men (n = 450)	Women (n = 516)
Never infected	73.1%	70.2%	75.6%
Once infected	20.1	20.4	19.8
Infected by two or more STDs	6.8	9.3	4.7

(*Source*: Jonsdottir & Haraldsdottir 1998)

There are many aspects that need to be considered regarding prevention and risk-reduction efforts regarding STDs in Iceland. The 1992 study showed that about 8% of those surveyed had had casual sex once or more often in the last three months before the study was conducted. Casual sex was most frequent in the age group 16 to 24. About 10% of those who had casual sex were always or most often under the influence of alcohol or drugs during sexual intercourse (Jonsdottir & Haraldsdotttir 1998).

In the same study, 9% of men 16 to 24 said it was difficult to talk to their partner about the use of condoms; 5% of the women in the same age group shared this difficulty. Fifty-two percent of the men and 44% of women felt that the condom spoiled sexual pleasure. In the 16-to-19 age group, 23.1% of participants who had had casual sex in the last 12 months before the study never used a condom during that time. The average non-use of condoms for all other age groups was 14.9% (Jonsdottir & Haraldsdottir 1998).

STD preventive efforts in Iceland have been focused on the importance of increasing knowledge about STDs and influencing attitudes. There are several hindrances that make this preventive work not as effective as it could be. In Icelandic society, as in many other countries, there are not many healthy role models for young people regarding the use of condoms. Most movies show sexual intercourse without anyone mentioning the need for protection against STDs or pregnancy.

B. HIV/AIDS

Incidence and Trends

As of January 2000, Iceland had 140 individuals diagnosed with HIV. The annual number of individuals diagnosed with HIV has ranged from zero to a high of 16. Most of those who became infected were homosexuals, but the number of infected heterosexuals is growing. Men have a higher frequency of HIV infection than women, as shown in Table 7. As of the end of 1999, a total of 50 cases of AIDS had been diagnosed and reported to the authorities; 33 Icelanders have died of AIDS.

Treatment, Prevention Programs, and Government Policies

In 1988, a national AIDS committee was formed by the Ministry of Health. The role of this committee included creation of guidelines regarding prevention of HIV. This committee decided to conduct a study about the sexual behavior of Icelanders and their knowledge about HIV/AIDS (Jonsdottir 1994; Jonsdottir & Haraldsdottir 1998). This study showed that Icelanders were interested in three ways to promote safer sex behaviors in order to reduce the risk of HIV infection: increasing the use of condoms, having fewer

Table 7

Incidence of HIV from 1985 to 1996 per 100,000 Population

	Total	Women	Men
1985	7.5	1.7	13.2
1990	2.0	—	3.9
1991	3.9	1.6	6.2
1992	4.2	0.8	7.6
1993	1.1	0.8	1.5
1994	3.0	1.5	4.5
1995	1.9	1.5	2.2
1996	1.9	1.5	2.2

(*Source*: Hagstofa Íslands 1997)

casual sexual partners, and being more careful with the use of alcohol and drugs.

[*Update 2002*: UNAIDS Epidemiological Assessment: The HIV epidemic remains at a low level in Iceland. By mid 2001, a cumulative total of 148 cases of HIV infection had been reported. Testing is mandatory in blood donations; the first HIV-positive case was detected in 1995. Among 400 persons attending the HIV-testing site in the capital city between 1987 and 1992, 2 (0.5%) were detected positive. Diagnosed HIV cases are reported at the national level.

[The estimated number of adults and children living with HIV/AIDS on January 1, 2002, were:

Adults ages 15-49:	220	(rate: 0.2%)
Women ages 15-49:	< 100	
Children ages 0-15:	< 100	

[An estimated less than 100 adults and children died of AIDS during 2001.

[No estimate is available for the number of Icelandic children who had lost one or both parents to AIDS and were under age 15 at the end of 2001. (*End of update by the Editors*)]

11. Sexual Dysfunctions, Counseling, and Therapies

SÓLEY S. BENDER

A. Sexual Dysfunctions and Availability of Therapy

Since only very limited studies about sexual dysfunctions have been done in Iceland, very little is known on a national level about the prevalence of these problems. Sexual dysfunctions have been reported postpartum in relation to postpartum depression. Sexual dysfunctions are mostly presented in connection with other problems that people have when they visit their family practitioner. It therefore depends on the sensitivity of the attending physician to discover the oftentimes hidden problem. In general, people seem inhibited about discussing sexuality in general and sexual problems in particular. This reluctance often seems to apply to medical practitioners as well. The 1992 study about sexual behavior showed that 28.2% of the respondents had had some discussion with a family practitioner or a nurse at the community health center, and 16.8% had discussed sexuality with a healthcare professional in a hospital (Jonsdottir 1994). From the healthcare providers' perspective, 29.8% said they often and rather often provide information and counseling in the community health centers about sexual problems (Bender 1990). Psychiatrists, psychologists, social workers, urologists, and gynecologists are the practitioners most likely to be consulted or involved in diagnosing sexual problems. Some people turn to the IcASRH for advice about their sexual problems.

There is no one certified as a sexual therapist by the Ministry of Health or a professional association in Iceland, and no sexual treatment center run by the government of Iceland. In 1975, a treatment center was launched and functioned for about ten years. Information and counseling services about sexuality and its relation to diseases are lacking within the hospital setting. There is no therapist practicing in Iceland who has a master's or doctoral degree in sexology.

12. Sex Research and Advanced Professional Education

SÓLEY S. BENDER

A. Graduate Programs and Sexological Research

No undergraduate or graduate sexology programs are offered at the University of Iceland or in other universities in the country.

Very few Icelandic studies have been done about human sexuality. Before the 1975 abortion law took effect, there had been considerable discussion about the issue, and members of Parliament were stressing the need for preventive work. Following this, Sigurgestsson completed a psychology dissertation in 1977 based on a sample of 1,420 young people and conducted among all 14-year-old students in the Reykjavik area. The response rate was 92%. This study was the first of its kind to explore sexuality among this age group. The focus of this study was on puberty, sexual activity, and sex education. A year later, in 1978, Thorvardarson conducted a study of sex education as part of a Bachelor in Education program. This study was based on a sample of young people in the 6th grade ($n = 460$), 8th grade ($n = 480$), and among 16- to 18-year-olds ($n = 345$).

Following the first cases of HIV/AIDS, the first national study about sexual behavior and knowledge of HIV/AIDS was sponsored in 1992 by the Directorate of Public Health (Jonsdottir 1994; Jonsdottir & Haraldsdottir 1998). The purpose of this study was to get information for the direction of preventive strategies regarding HIV and AIDS. This study was a cross-sectional postal survey based on a national sample of 971 individuals in the age group 16 to 59. As noted in Section 6, Homoerotic, Homosexual, and Bisexual Behaviors, the response rate was 65%; 47% of those responding were males and 53% females.

Another national cross-sectional study was done in 1996 based on a stratified random sample of 2,500 young people 17 to 20 years old, 20% being teenage boys and 80% being teenage girls. The crude response rate was 68%. This study explored the attitudes of young people to sexual and reproductive health services, sexuality and the use of contraceptives, and the use of contraceptive services (Bender 1999).

B. Sexological Organization and Publications

The Icelandic Sexology Association was established in 1985 and was active for the first ten years. Its goal was to promote sexology and the cooperation of people working as teachers, therapists, and researchers in the field of sexology. It was a member of the Nordic Association for Clinical Sexology (*Nordisk Forening for Klinisk Sexologi*, NACS).

The Icelandic Family Planning Association (The Icelandic Association for Sexual and Reproductive Health, IcASRH) was established in 1992. The Association has been focusing on teenage sexuality and the special needs of young people. It has published several pamphlets, postcards, and a semiannual newsletter. It is a member of International Planned Parenthood Federation (IPPF) and belongs to the European Network of IPPF. The address of the Association is: P.O. Box 7226, 127 Reykjavik, Iceland; email: fkb@mmedia.is; www.mmedia.is/fkb.

Stigamot (The Icelandic Incest Center), discussed in Section 8A under Sexual Abuse and Incest, has a website at www.stigamot.is.

There is no Icelandic sexological journal or periodical published exclusively about sexology. There have been some articles published in the Icelandic medical and nursing journals about sexuality. The Icelandic Sexology Association published a few issues of a newsletter, and the Icelandic Association for Sexual and Reproductive Health currently publishes a newsletter two times a year.

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