The Question of Abortion in Serbia

La question de l’avortement en Serbie

Mirjana Rasevic
The reproduction of the population has never been animal, it has always been social, enriched with human values and aims. On each level of the human development and in every type of the human community, the man had to face the problems of survival and to find ways to solve them. This means that the reproduction of the population has always been followed by the birth control. Although, the birth control is historical category, what is present basic characteristic of population fertility in developed countries is intensive birth control. Therefore, birth control is the most important direct factor of low fertility.

All known birth control methods, including induced abortion, are being practiced in Serbia nowadays, both mechanical and chemical, effective and less effective, and classical and modern. However, the results of various surveys show the diffusion of conservative birth control in which the use of coitus interruptus dominates and the consequential resort of induced abortion in cases of pregnancy which is unwanted or cannot be accepted. Traditional means and methods are incorporated in the system of values to a great extent, present a natural part of sexual relations, and represent a rational selection. Thus, induced abortion has for a long time been a predominant method of birth control in Serbia.

Towards better understanding the abortion question in Serbia we will discuss several components. First of all, trends and characteristics of induced abortion including complications attributed to this method will be identification based on health and vital statistic data together with estimation. In addition, legal aspect of birth control as an important element of a complex determinist base of abortion problem will be analyzed. The answer of crucial question why women do not rely on modern contraceptive methods and means will be also open through research finding synthesis.
Reliable data on abortion numbers are not available for longer time period. Nevertheless, it may be said that between the two world wars, the number of abortions in the then Kingdom of Yugoslavia was a big one. At the 17th Congress of Yugoslav Physicians (Belgrade, 1935), the Head Health Care Council estimated the total number of abortions (legal and illegal) at about 300,000 a year [Novak, 1964]. Although there are no estimates of the number of abortions performed before the Second World War in Serbia, it can be assumed that abortion was practiced on a large scale.

As for the years after the Second World War, there are records of the abortions performed in medical institutions in 1948, 1949, 1950, 1951 and 1952. The abortions carried out in the mentioned years totaled 10,399, 11,787, 12,080, 13,442 and 14,151 respectively [Lunacek, 1953], which is indicative of a growing number of abortions carried out in medical institutions. However, illegal abortions prevailed at that time. The latter is indicated by the number of incomplete abortions (provoked but not completed, by women themselves, non professionals and even professionals) which because of hemorrhage, pain and symptoms of inflammation, had to be completed in medical institutions. Their number was growing, exceeding considerably the share of spontaneous abortions in registered pregnancies, which is accepted in literature.

The data on the number of abortions performed in 1960 (81,516), 1961 (95,196) and 1967 (167,209) are incomplete, but even so, they are indicative of a large number of abortions performed in medical institutions. That is the result of the expansion of the network of medical institutions qualified for abortions and the gradual liberalization of the right to perform abortions. This was corroborated by a survey conducted by the Federal Public Health Bureau in 1964, the results of which showed that more than 95 percent of the total number of legal abortions were performed on social grounds, and only 5 percent on medical and legal and ethic ones [Mojic, 1967].

The data on abortions are deemed complete as from 1969 to 1989, although an insignificant number of abortions were still carried out outside medical institutions. From that year, the number of abortions kept growing continuously until 1985 (Figure 1), from

Figure 1. Number of abortions in Serbia, 1969-1989

Source: Official health and vital statistics data.
162,643 in 1969 to 214,806 in 1985, meaning that it went up by a third (index 132). The number of abortions grew at a considerably faster pace until 1980. In 1986, 1987 and 1988, the absolute number of abortions was decreasing slowly, so that in 1989, with the level of 193,755, it was the same as that in the preceding year.

Until 1985 or 1986, the absolute growth of the number of abortions was paralleled also by a relative growth of abortions in relation to the number of live births and number of women of childbearing age. The number of abortions to 100 live births was 107.0, 138.0 and 133.7 in 1969, 1986 and 1989 respectively. Every 14th, 11th and 12th woman of childbearing age had an abortion in 1969, 1985 and 1989 respectively.

Suspicion to complete registration of induced abortions in Serbia appeared at 1990. This was based on quite different trends of induced abortions, slow decrease in Central Serbia and high increase (24.8%) in Vojvodina, both with same reproductive model. In next years, however the number of abortions registered in Serbia was underestimated. It was 154,449 in 1991, 135,907 in 1992, 113,720 in 1993, 94,382 in 1994, 92,785 in 1995, 80,003 in 1996, 60,723 in 1997 and 55,360, last available data, in 1998. Radical change, is not realistic having in mind the long lasting of this phenomena and new circumstances caused by dissolution of the former Yugoslavia as a civil war, economic sanctions, large number of refugees, almost total lack of availability of contraceptives, and the high prices of the few supplies that exist in the 1990s, and, today the process of overall transition which brings feelings of insecurity, high prices of contraceptives and more and more new illegal private units. Having in mind all these reasons, it is reasonable to suppose that the trend up to 1989 of a slow decrease in the rate of induced abortion would be more probably opposite.

The number of abortions kept growing in all major regions of Serbia (Table 1), though not uniformly, since this number grew at a much faster pace in underdeveloped than in developed regions. Thus, the number of abortions grew the fastest in Kosovo and Metohia (index 217) (167) and the slowest in Central Serbia (112) and particularly Vojvodina (97). Such an incidence of abortions was largely brought about by different rates at which the birth control was being spread, resulting from fertility trends in the regions in the 1969-1989 period. In the same period, fertility declined more quickly in the less developed than in other regions, in which it was low already.

In relative terms, the incidence of abortions differs also by regions. In terms of the number of abortions to 100 live births in 1989, the incidence of abortions was the highest in Central Serbia (198.1) and Vojvodina (158.9). The difference between developed and less developed regions is evident. The markedly low abortion rate in Kosovo and

<table>
<thead>
<tr>
<th>Region</th>
<th>1969</th>
<th>1989</th>
<th>per 100 live births</th>
<th>per 1000 women 15-49</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Serbia</td>
<td>119,879</td>
<td>133,848</td>
<td>151.8</td>
<td>82.1</td>
</tr>
<tr>
<td>Kosovo and Metohia</td>
<td>5,086</td>
<td>11,015</td>
<td>10.5</td>
<td>19.5</td>
</tr>
<tr>
<td>Vojvodina</td>
<td>37,678</td>
<td>36,612</td>
<td>142.3</td>
<td>70.8</td>
</tr>
</tbody>
</table>

Metohia (20.5) can be explained in the first place by the moderately high fertility in this province. Similar relationships had existed also in 1969, but the abortion rates were lower in each of the regions. The rates in Central Serbia and Vojvodina were almost the same in 1969, while 20 years later, this rate was markedly higher in Central Serbia. Similar are also the regional variations in the number of abortions to 1000 women aged 15-49 years.

Moreover, importance is attached also to qualitative properties of abortions (Table 2). First of all, the data on abortions according to type point at the preponderance of legal induced abortions (about 95 percent). There are hardly any illegal abortions, meaning that one of the major risks to the life and health of women has been reduced. This can be concluded indirectly on the basis of a decreased incidence of illegal induced abortions resulting in some complications, which is why they were registered. The share of such abortions in the total number has been insignificant (0.1 percent) in many years. Another important precondition for the reduction of death rate and incidence of the complications associated with abortion has also been achieved. An overwhelming majority of women in Serbia (98.3 percent) had their abortion in the first 10 weeks of pregnancy, while more than 99 percent of abortions were performed in the first trimester of pregnancy in 1989. Such a state of affairs is a positive one and to a certain extent, it lessens the whole problem of abortion. The structure of abortions by gestation stage in the regions shows no substantial variations. These two positive characteristics of abortion are owed in the first place to the legislation and, probably, also to the women being informed, as well as to a good network of medical institutions and a simplified procedure to be followed in order to have an abortion.

The mentioned properties of abortions helped to reduce the incidence of lethal outcome of abortions. Namely, the number of women who died from such causes decreased from 49 in 1969 to 2 in 1989, meaning that the death rate in this 20 year period decreased from 29.3 down to 1.0. Despite the reduction of the death rate from such causes by almost 20 times, compared to the industrialized countries, the risk of death from abortion is still considerably higher in Serbia.

The age structure of the women who have had an abortion in 1989 shows that about 90 percent of them were between 20 and 39 years old. Such a structure is determined in the first place by the model of fecundity, sexual activity, level of reproductive norms and fertility control mode. Mention worthy is also the relatively low incidence of abortions among the adolescents, whose share varies from 2.1 percent in Kosovo and Metohia to 4.2 percent in Vojvodina.

Married women account for a very high share in the total number of women who have had an abortion in Serbia (92.1 percent). Variations by regions are not marked. The high share of married women who have had an induced abortion is yet another proof of a widely spread practice of abortion as a birth control method.

The structure of women who have had an abortion according to the number of their living children shows indirectly, among other things, the effect of the number of children in the family on the decision to have an abortion. In 1989, at the time of abortion, 75.8 percent of women in Serbia had one or two living children. Also in low birth rate regions of Serbia, most women who have had an abortion in that year had one or two living children (Central Serbia 79.5 and Vojvodina 76.3 percent). On the other side, at Kosovo and Metohia, where the birth rate is moderately high, most women who had an abortion already had four or more living children (32.9).

The data relating to repeated abortions show that about 80 percent of the women who decided to have an abortion in a year have already had a history of abortions. In other words, more than 150,000 abortions performed each year are repeated ones (in 1989, for example, 155,730 abortions were second or subsequent ones). Along with the large number of abortions, this too is a markedly adverse aspect of birth control. It shows that women are opting for and relying on abortion or that they are using less effective contraceptives or using the appropriate ones carelessly. Needless to say, abortions have a detrimental effect on the health of women and outcome of their future preg-
nancies, especially if they are repeated. Mention worthy is also the fact that every fourth woman subjected to abortion in 1989 had already had four or more abortions in the past. This shows that a relatively large number of women accept abortion as a normal birth control method, not as one to be resorted to in special cases only. Such a composition was contributed to mostly by Central Serbia and Vojvodina, which accounted for the largest number of induced abortions. One of the reasons for such a high share of the women who have had four or more abortions is the absence of sterilization, which is still in the budding stage in Serbia.

Table 2. Characteristics of abortions in Serbia, 1989

<table>
<thead>
<tr>
<th></th>
<th>Serbia</th>
<th>Central Serbia</th>
<th>Kosovo and Metohia</th>
<th>Vojvodina</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of legal abortions</td>
<td>96.5</td>
<td>96.8</td>
<td>96.1</td>
<td>95.2</td>
</tr>
<tr>
<td>% of abortions within 10 weeks of pregnancy</td>
<td>98.3</td>
<td>98.6</td>
<td>95.2</td>
<td>98.2</td>
</tr>
<tr>
<td>% of women of 20-39</td>
<td>90.0</td>
<td>93.0</td>
<td>87.6</td>
<td>88.5</td>
</tr>
<tr>
<td>% of married women</td>
<td>92.1</td>
<td>93.1</td>
<td>91.0</td>
<td>88.4</td>
</tr>
<tr>
<td>% of women with one or two living children</td>
<td>75.8</td>
<td>79.5</td>
<td>25.3</td>
<td>76.3</td>
</tr>
<tr>
<td>% of women with 4 and more abortion in reproductive history</td>
<td>22.4</td>
<td>24.2</td>
<td>6.8</td>
<td>19.9</td>
</tr>
</tbody>
</table>

Source: The same as for Table 1.

LEGAL ASPECT

The liberalization of abortion before modern contraceptives were developed and made available, is a common and important factor to the large number of abortions in Central and East European countries, including Serbia. Namely, in Yugoslavia socio-medical indications were accepted as grounds for abortion from 1952. In 1969 the law was further liberalized. Abortion was permitted at a woman’s request up to the tenth week of pregnancy and, beyond ten weeks, with the approval of a medical commission. These laws covered the whole of the former federation of Yugoslavia, and still apply in Serbia with one addition. From 1995 abortion is available on request of women aged not 18 or more but 16 or more years.

DETERMINISTIC BASIS

The incidence of induced abortions in Serbia is still high, despite the fact that scientists have developed new methods and means of birth control which are much more acceptable, medically and socially. This fact points at certain contradictions and poses a number of questions, among which the most important one is why are
women not relying on modern scientific knowledge in the selection of birth control methods and means? Several abortion related surveys were conducted over the last few decades in Central Serbia and Vojvodina the regions in which induced abortion has become an epidemiological problem. They were focused in the first place on the scale of abortions and their characteristics, followed by the legal aspects of abortions and related policies in the sphere of family planning. The causes were investigated only partly, leaving the explanations generalized and limited to educational, psychological, social and other characteristics of the women resorting to abortion as a birth control method. Hence there is absence of specific answers to many important questions in this field. The question why do so many women in Serbia still opt for induced abortion as a preferred method of birth control is of particular relevance in Belgrade, which is located in one of the more developed regions of the country, with a high level of education and a well developed network of family planning centers. In 1989 almost a quarter of all abortions in Serbia, over 45,000 abortions, were carried out in Belgrade. In research\(^1\) - it done in 1990 and includes four hundred Belgrade’s population of women who decided to terminate their pregnancies - confirmed was the accepted hypothesis that the extension of induced abortion developed from the discordance between comprehension of the need of birth control and the way it should be accomplished [Rasevic, 1993]. This discordance is caused by a complex array of factors, including insufficient and inaccurate knowledge of contraception and abortion, a belief that modern contraceptive methods are harmful to health, and a number of psychological barriers, including those arising from relationships with partners. Additionally, there are few organized efforts to promote sex education and information on contraception, as well as limitations in the family planning programme, which contribute to this discordance. The women’s knowledge of reproductive physiology and of the short and long term risks and benefits of contraception and abortion was very restricted. Not only did they know very little about reproductive physiology and their own bodies, phenomena which are part of their daily lives, they had also developed their own interpretations and understandings of these phenomena. While the things they said were often far from accurate, the women, nevertheless strongly believed in them. This was similarly true of their knowledge and understanding of contraceptives and abortion. Only one in ten of the women were able to identify the fertile days of a menstrual cycle. Some of them, who may once have been taught this information but had not understood or retained it accurately, thought that the most fertile days were the lest fertile and vice versa. Others, who may have had negative experiences with coitus interruptus, believed that the chances of conception were equal for all the days of the menstrual cycle. One in five of the women did not connect abortion with its potential complications, although having had abortions, they may have experienced these. Level of education made little difference to level of knowledge, including among those women whose education should have included such knowledge. Both those women with higher education and others knew very little about abortion. Traditional beliefs and attitudes were still strong. Namely, 78.3 per cent of the women believed that breastfeeding prevented conception and 29.8 per cent thought that coitus interruptus was a safe and effective method of birth control. It is important to stress the definiteness of such beliefs. Only five out of 400 women said that they did not know whether coitus interruptus was safe and effective. What was striking was the uniformity of the woman’s beliefs and misconceptions.

\(^1\) The research was based on face to face interviews. The interviews were done on the day of fixing in advance the date of abortion. It was estimated that the sample satisfied the demands of representative quality. The size of the sample (1.04% of Belgrade’s population of women who legally terminated pregnancies in 1989.) and the results on basic demographic structures gained by means of the sample and of the current statistics of abortions proves that especially.
They not only thought in the same ways, they often even answered questions in the same words. It seems that every negative experience with contraceptive methods, whether their own or someone else’s, had been generalized, shared and integrated into a wider social cognition. In the absence of information, many of the women also seem to have made up their own theories. For example, when asked how different contraceptives worked, some of their answers were:

- «The Pill accelerates menstruation so that there is no pregnancy.» (High school chemistry teacher, age 41, sixth abortion)
- «The Pill keeps the tubes closed during the 21 days when it is being taken. After that, the tubes open and there is bleeding.» (Worker, age 23, second abortion)
- «The IUD cleans the uterus and scrapes off pregnancy.» (Leather factory worker, age 29, forth abortion)
- «The IUD forms a tumor inside the uterus and then there is no pregnancy.» (Textile worker, age 36, fourth abortion)

Although it might be supposed that lack of information, or misinformation, could easily be remedied with better dissemination, the situation is actually more complex. Many of the women seemed to resist the idea of having to take on any information they did not already have about modern methods. One third of 400 women said they did not want to learn anything more about modern contraception. In many cases, there was a mistrust of modern methods of contraception and the lack of understanding that the prevention of unwanted pregnancy contribute to better health. Instead, many of the women viewed modern contraceptive methods as harmful to health and as a cause of disease. For example, when describing the way the Pill works in a woman’s body, a large number of the women used words such as kills, destroys, disturbs, ruins, deadens. These convey a perception of the Pill as essentially destructive.

There seemed to be many psychological barriers to using modern methods, so that although both abortion and modern methods were equally accessible, contraception was often not the women’s first choice. They considered abortion to be an equally valid choice and in fact, one which was less burdensome psychologically. In an exercise aimed at evaluating the relative psychological costs of contraception and abortion, the women were presented with the five negative costs of birth control (an unpleasant experience, negative effect on health, source of conflict with partner, complicated to use, moral burden) and asked to score modern contraceptives and abortion on a three point scale: more (2), a little (1), or none (0).

Contraceptives were ranked by the women as having higher costs than abortion overall. Negative health consequences ranked topmost among these, followed by uncomplicated and unpleasant to use, and a source of conflict with their partners. The obligation of having to use the methods regularly and consistently was felt to an unnatural and irritating imposition on their lives. The major psychological cost associated by the women with abortion, on their hand, was that it was an unpleasant experience. The moral burden of abortion was ranked second, followed by the negative health impact. Abortion as a source of conflict with partners was considered least important for this group of women. The ranking procedure revealed that the women thought abortion was less harmful to health than contraception and was less complicated to use, despite the unpleasantness of the experience.

The women’s lack of acceptance of modern methods of contraception was reflected in their patterns and duration of contraceptive use and their reasons for discontinuation. Current use of a modern method was very low among group of women. The Pill was least used (0.8 per cent), followed by IUD (2.4 per cent). Four per cent were using condoms and spermicidal methods. The great majority were not using a modern method when they became pregnant.

Further, less than a third of the women had ever used any of these methods in the past. Spermicides had been used by 31.3 per cent, condoms by 34.5 per cent, the Pill by 29.0 per cent, and IUD by 14.3 per cent. Most of the women who had used one of these methods in the past had discontinued it, with the highest discontinuation rates associated with the Pill and IUD.
The majority of the reasons they gave for not using the contraceptives were psychological and subjective. For example:

- «I took the Pill only for seven days. The whole time I vomited and was dizzy. I needed a doctor’s help.» (Lawyer, age 31, fifth abortion)
- «With the IUD, I had bad headaches.» (Housewife, age 32, second abortion)
- «Using condoms is like making love with a gynecologist.» (Bank clerk, age 37, third abortion)
- «Having sex with spermicides is like having sex in mud.» (Post office clerk, age 22, fourth abortion)

Psychological side effects were given as the reason for discontinuing of the Pill by 55.7 per cent of former users, while 42.3 per cent of former IUD users cited excessive bleeding. Just over half the spermicide users (51.9 per cent) reported that these were irritating and unpleasant for them, and 44.2 per cent of former condom users were against condoms due to negative experiences attributed to gender differences in their relationships.

In relation of the Pill and IUD, discontinuation was also strongly influenced by fear of negative health consequences, irrespective of whether any problems had actually been experienced. One in three of the women cited fear as their main reason for their discontinuation of the Pill, most often fear of cancer and overall negative effects for health. In addition to real or perceived adverse health effects, other stated reasons for non-use or discontinuation of modern methods included issues related to sexual identity, sexual potential and desires, sexual demands of partners, and undefined feelings related to women’s reproduction. Some women gave up contraception in order to avoid sexual conflict with partners. Overall, there was resistance to the use of contraceptives, whether they were more or less effective, mechanical or chemical.

The only method of birth control that many of the women accepted without resistance was coitus interruptus. This was the method of birth control used by 72.0 per cent of the women when they first began sexual activity and was also the method that 69.4 per cent of them had used the longest. Indeed, 50.4 per cent of the women were using coitus interruptus at the time they became pregnant.

This traditional method was very much incorporated in their system of values, considered a natural part of sexual intercourse, and therefore seen to be a rational choice.

Figure 2. Women’s partners’ attitudes on contraception
The women felt that the psychological cost of coitus interruptus was law because there were no adverse health effects and contact with a physician was not required. What they perceived to be a fundamental conflict between sexuality and technology was, for them, avoided with this method. What is more, choice of coitus interruptus did not cause conflicts with their partners and made them take active responsibility for prevention if pregnancy.

Two months after the abortion that brought them into this study, 52.6 per cent of the women were still using coitus interruptus, while the rest of the women had changed methods. The majority had adopted a modern method - 12.6 per cent had begun to use the Pill and 18.9 per cent the IUD.

The women were asked about their partners’ attitudes. Their replies indicate that resistance to modern methods of contraception is not confined to women in our country. Twenty-nine per cent of partners believed that only women ought to use contraceptive methods. This turned out to be a relatively supportive attitude, since most were said to resist the women’s adoption of contraception either actively or passively. Nineteen per cent of partners were said to be definitely against contraceptive use, the great majority because they believed it to be harmful to health, while 25.7 per cent were said to be indifferent about contraception and 6.2 per cent did not talk about it with the woman at all. Nine per cent of the partners accepted only coitus interruptus as a method, two per cent accepted only condoms, and nine per cent were willing to use any method (Figure 2).

Thus, a considerable number of unwanted pregnancies have occurred in sexual relationships where mail partners have left the decision about and practice of birth control up to the woman or, in one way or another, have discouraged the woman from using a method that might have prevented the pregnancy.

Sex education for this group of women was neither a part of growing up nor a component of a school curriculum. Parents (7.5 per cent) and schools (8.8 per cent) were the least likely sources of information on sexual relations, abortion and contraception cited by the women of this group. Newspaper articles on topics related to sexual life and contraception were cited as sources by 36.5 per cent of the women and discussion with friends (33.2 per cent) was the other main source of information mentioned.

The liberalization of the abortion law occurred at a time when birth rates were declining and there was only a modern presence of modern contraceptive methods. Moreover, the change in the law was not followed by an effective or extensive family planning programme. The introduction of the Pill, IUD and sterilization has proved difficult in a situation in which women have had access to and relied upon abortion for a long time. The lack of organized and systematic social and partner support for contraceptive use supports a continuing tendency to postpone decisions about birth control until the fact of pregnancy makes the decision unavoidable.

To make matters worse, the family planning programme does not enjoy women’s confidence. Nearly half of the women (45.0 per cent) reported a negative experience with a gynecologist in the contraceptive guidance centers. It was clear that they had not been given the professional help and support they needed and felt they had been left very much to their own devices. They insisted on the need for open and human discussion of contraception in relation to their individual problems, fears, attitudes and values. And they suggested how service providers could overcome these problems, intuitively putting forward solutions that family planning programmes in other countries have adopted. In addition, 31.2 per cent of the women underlined poor organization of the service in the contraceptive guidance centers, such as long waiting times and being forced to stand for long periods, as the reason why they disliked attending them. Eighteen per cent of them would have preferred to see a woman gynecologist, yet this choice was not offered. Only 5.5 per cent of the women felt that their problems in deciding to use and obtaining modern contraceptive methods lay with them rather than with the contraceptive guidance centers (Figure 3).
The analysis of complications of induced abortion in Serbia relies on partial investigations by a number of gynecologists and several studies treating this problem in a more complex manner. Unfortunately, no representative study on this issue was ever made nor the post abortion complications make up a part of the national program on health statistics.

The biggest study, a study made by the Gynecology Obstetrics Clinic from Belgrade on 2,359 women in Serbia, shows that early complications of induced abortion occur in 21.3% cases and display large variations. Every tenth abortion in Vojvodina, every fifth in Belgrade, i.e. almost every third in Central Serbia (excluding Belgrade) implies complications [Malacic, 1983]. The incidence of early complications can be assessed as high. Such frequency of complications following induced abortion is characteristic for the less developed countries. It is, however, difficult to compare our data with those of the industrialized world because of the differences in the manner of data compilation and definition of individual complications. The percentage of complications is certainly inflated by the fact that every complication which is subjectively felt by a woman and not objectively checked is also included.

In addition to the causes verified in the research, there are some questions which are still open. Firstly, in addition to insufficient knowledge of both women and men which are the sources or an irrational behavior in the control their own reproduction? The second question refers to the nature of the relation of the mentioned causes and abortions in Serbia. To which extent do they effect individually and to which extent jointly and how big is the intensity of such a relation? Next, to what extent an abortion is consequence of a mistake of a woman, her partner, medical institution and a physician? The question of the men’s attitude towards contraception is of such a nature that it could be posed to the man himself, not only as a question posed to an individual which is obligated to explain his own attitude towards the use of contraception, but as a question to one of the partners, whose attitude cannot be completely independent from the other partner’s behavior.

**COMPLICATIONS AND SEQUELAE**

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But, results of a series of investigations confirmed that severe early complications of abortion are rare, though the risk of their occurrence is higher relative to the industrialized ones. Thus, for example, perforation of the uterus occurs in 665 abortions (Bocev), 705 (Drazulović), 1,200 (Burdjelas) or in 2,331 abortions (Kupresanin). According to Grubisic who studied complications of abortion for a number of years, about 1.1% of the residua postabortum were registered every year [Antonovski, 1982].

Most of the early complications of induced abortion are nowadays curable by appropriate treatment and do not leave lasting effects. They, however, are often the source of post abortion complications which may become chronic, i.e. become permanent. This is particularly important for women without children who have decided to terminate their first pregnancy and for those who do not have a desired number of children when taking the decision to undergo abortion.

Results of the above study prepared by the Gynecology Obstetrics Clinic in Belgrade point to the effects of induced abortion on female sterility. By testing 21 socio-economic, demographic and medical variables, the authors have shown that the induced abortion and the number of such interventions carry a statistically significant weight factors (0.459 and 0.440) which classify them as significant determinants of infertility [Malacic, 1983].

Particularly significant in this respect is sterility of nulligravida as a consequence of induced abortion. Mojsilovic and Stefanovic have determined that 14.4% of such women develop secondary sterility though the intervention was made under optimal medical conditions. They note that other authors have determined an even higher percentage, for example, Mladenovic and Zivanović speak of 22% [Antonovski, 1982]. Although these results seem to be on a high side, they certainly draw attention to this problem.

Further significant complications of induced abortion are: insufficiency of the internal isthmus of the uterus and lacerations of the cervix of the uterus which cause miscarriage and premature delivery. The multi-variant discriminatory analysis contained in the above study of the Gynecology Obstetrics Clinic has shown that of the total of 21 socio-economic, demographic and medical indicators analyzed, the major discriminating factors for women who have had a miscarriage are: induced abortion (factor weight 0.486) and the number of induced abortions (0.443). The same kind of analysis was conducted to link abortion and premature delivery. It is found out that the induced abortion represents the sixth important factor inducing premature delivery (factor weight 0.145) [Malacic, 1983].

An analysis has also been conducted to investigate psychological consequences of induced abortion. Some authors argue that an adverse reaction to undesired pregnancy is much more serious than an adverse reaction to abortion, and point out the practical value of abortion as a way out of a stressful situation. Thus, Nila Kapor-Stanulovic (1985) divides the procedure of induced abortion into three parts: prior to intervention, intervention and the post-intervention period. This division has enabled a detailed analysis of the reaction to abortion. It is found out that the worst period for majority of women (60%) is the period prior to intervention which is characterized by the state of nervousness, anxiety, revolt, loss of concentration and conflicts with one’s partner. It is also found out that these different psychological expressions, which come as a result of the reaction to undesired pregnancy, the pregnancy which can not be accepted, is often replaced by a feeling of relief after the intervention. It must, however, be emphasized that these results were obtained in an environment in which abortion has for long been the dominant method of fertility control. Others, however, including psychiatrists, argue that every abortion is a stressful experience and a risk to mental health. Simic (1964) has, for example, determined that one year after their first abortion, 40% of women display neurotic reactions in the form of a constantly bad temper, loss of self-confidence, lack of spontaneity in affective reactions, problems with sleeping, feeling of tiredness, loss of ability to work. Besides, investigations made in the Institute for Health Protection of Mother and Child of Serbia has shown that abortion represented a serious emotional stress for about 11% of adolescents and was a direct cause for
depression [Milojevic and associates, 1972]. Results of the survey questionnaire on the causes for a large number of abortions in Belgrade have confirmed that abortion is a difficult experience for many women (Figure 4). About 45% of women show unexplained emotional reactions towards abortion even two months after the intervention. The psychological trauma varies in degree. In retrospect, abortion is felt as a difficult experience but without cognitive signs (14.0%), painful experience which often comes to mind (14.6%) or, an experience which is so disturbing that one prefers not to think of it (15.9%). Induced abortion causes unresolved psychological reactions twice as often in case of women for whom the preceding abortion was the first such experience. To them the abortion is more often both a painful and disturbing experience they would rather not think of. It is, however, important to underline that more than one third of the women interviewed who have had two or more induced abortions in their reproductive history, have some kind of psychological reaction to their latest termination of pregnancy [Rasevic, 1993].

The reasons for the high incidence of mortality and complications of induced abortion are considered to be the huge number of these procedures conducted in abortion services per day, inadequate pre-operative measures, as well as the predominant use of conventional abortion techniques. The abortion services, spread throughout the country, are burdened with ten to thirty abortions every day. Such a situation increases chances for immediate, delayed and long-term complications of induced abortions. There are no national protocols for the treatment of these complications which would be in accordance with current methodological guidelines relevant to this domain. Women resorting abortion are not treated for gonorrheal and chlamydial cervicitis, trichomoniais or other sexually transmitted infections before abortion. Therefore, the pelvic inflammatory disease is one of the main reasons why women have gynecological examination for (24.1–27.2%) in dispensers for women within primary health care [Rasevic, 1993]. The huge number of women with infertility due to tubal occlusion has been observed in Serbia, also. The induced abortion is in some urban and most rural parts of Serbia performed by dilatation and curettage, using ovum forceps for removing the contents of the uterus. This abortion technique results in greater blood loss and the increased risk of damage to the cervix, compared with suction curettage. Only in
large cities of Serbia it is possible to obtain induced abortion by the vacuum aspiration method, but only with cannulas of bigger sizes, from 8 mm or more in diameter. The menstrual regulation method and the use of mifepristone (RU 486) for the termination of pregnancy have not been available in our country, still.

CONCLUSION

Although there is no recent data and representative research findings related to the deterministic base and complication associated with induced abortion, it is clear that the abortion question in Serbia is complex, serious and asks for solution. It supposes the promotion of knowledge, the network of family planning services, the access to all kinds of modern contraceptive methods, widening the categories of health care workers who are involved in offering a contraceptive advice, increasing public information and advertising of contraceptives, stressing out the importance of post abortion counseling, involvement of males in taking over responsibility for birth control, enabling young people to make right, responsible and healthy choices regarding sexual life. Also, very important is to establish a legal basis for voluntary sterilization, as accessibility to this birth control method clearly correlates with the reduction of repeat abortions.

Results are not likely to be achieved quickly. Duration of prevalence of induced abortions indicates that underlying causes of frequency are numerous and stable over time. Considering this, and the slowness of any spontaneous change, it may be expected that the problem of abortions will be present in the years to come. However, duration of abortion prevalence will depend, to a large extent, on the ability and willingness of the State to cope with this issue.

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