

Induced abortions in Bulgaria

Trends during the period 1986–1996

VIOLETA V. STOYANOVA, JAN H. RICHARDUS *

Background: Bulgaria is in a state of socioeconomic transition. Along with the political, economic and social system, the current changes affect the health care sector. The present article focuses on the issue of induced abortions. Bulgaria has one of the highest abortion rates in Europe, and this poses an important public health concern. **Methods:** Data were collected from the Bulgarian Ministry of Health, the Bulgarian National Statistical Institute, articles and the reports of WHO, UNDP, UNICEF, and AIHA. The data was analysed by stratifying abortion rates according to age, marital status, parity, socio-economic status, level of education, and ethnicity. In addition, possible contributing factors were reviewed. The main factors included were demographic characteristics of the country; legislation related to induced abortions; financing of the health care system; organization of family planning services; and data on contraceptive prevalence and practices. **Results:** Abortion rates show a general trend of shift towards younger age groups, as well as to single nullipara women. Definite associations with ethnicity, level of education and socio-economic status could not be established, mainly because sufficient data was not available. The observed cases of multiple abortions indicate the inadequacy of the post-abortion counselling. The new financing system is expected to make the family planning services more effective. Finally, recent data still show a relatively low rate of modern contraception prevalence. **Conclusions:** The objective of this review is to contribute to a better understanding of the problem of high rates of induced abortions in Bulgaria. Detailed analysis of associations between different factors related to the problem would be important for developing adequate strategies for intervention, i.e. reduction of the number of induced abortions. This would undoubtedly be of social, financial and public health benefit for Bulgaria.

Keywords: maternal and child health, induced abortion rate, family planning

The economic dislocation associated with the transition to a free market system has had serious consequences in all spheres of life in Bulgaria, similarly to all former communist states of Central and Eastern Europe (CEE). One of the sectors which has suffered mostly during this period is the health care sector. Bulgaria has traditionally maintained a highly centralized health care system and current changes focus mainly on the process of decentralization of the health care financing system and shifting resources from hospitals to primary and out patient care units. Maternal and child health is an important issue for public health policy makers. However, in such a period, when the setting of priorities is made under conditions of scarcity of resources, some services, such as family planning, are not given sufficient attention. Therefore, Bulgaria has maintained high rates of induced abortion and is cited as being in third place among European countries following Romania and the former USSR.¹ The present article aims at presenting data on and analysis of the

problem of the high rate of abortions by exploring all possible contributing factors and the causal relationships between them. Building a complete and clear picture of the present situation could be the basis for future research and proposals for strategies for intervention.

THE IMPORTANCE OF THE PUBLIC HEALTH PROBLEM

Reliance on abortion, which is related to the relatively limited family planning alternatives and also to the culture from past decades, is one of the reasons why Bulgaria has high abortion rates.² The current legislation allows abortions on request, so most terminations of pregnancies are performed by medical professionals in health care facilities, but complications related to the procedure do exist.³ The frequency of such complications may be low if compared to that in developing countries, but among countries in Europe, Bulgaria is third (after Romania and USSR) for mortality related to induced abortions.⁴ The high rate of abortions leads to an increase in several categories of morbidity and mortality (both adult and infant) figures.³ Apart from the medical consequences, abortions also have moral and psychosocial effects, as well as a financial impact on the individual, the health care system and society.³ All these consequences could be avoided if induced abortions are reduced as much as possible. Prevention of unwanted pregnancies and reduc-

* V.V. Stoyanova¹, J.H. Richardus²

¹ Laboratory of Molecular Pathology, University Hospital of Obstetrics and Gynecology, Medical University, Sofia, Bulgaria

² Department of Public Health, Faculty of Medicine, Erasmus University Rotterdam, The Netherlands

Correspondence: Violeta Stoyanova, MD, PhD, MPH, 23 Patriarch Evtimii Blvd, 1142 Sofia, Bulgaria, tel. +359 2 98115886

tion of induced abortion rates has been given much attention and the problem is considered a priority on the WHO agenda.⁵ From the public health point of view, a preventive strategy should always be preferred instead of a curative where possible and, therefore – high abortion rates are considered an important public health problem.

SOURCES OF DATA

The data presented in this article were collected at the Bulgarian Ministry of Health and are available at the Bulgarian National Statistical Institute.⁶ Other sources of data were articles and reports of the WHO, UNDP, UNICEF, and AIHA.

ANALYSIS OF FACTORS ASSOCIATED WITH THE PROBLEM

Trends in child birth in Bulgaria

Trends in childbirth have contributed to the general demographic tendency observed during the past decades in Bulgaria. The phenomena of demographic and epidemiological transitions has followed an accelerated pattern in Bulgaria. One element of the epidemiological transition was the decline in fertility and the reduction in the number of children per couple. The birth rate has been declining and was recently estimated as 10.3 per 1,000 population per year (data for 1990–1995), while the crude death rate for the same period was 12.7 per 1,000 population per year.⁷ The present population of the country is 8.363 million (data for 1996) with a negative population growth of approximately –0.5%.⁷ Bulgaria, along with Hungary, has maintained the lowest fertility rates in CEE countries. Currently, the total fertility rate is 1.5 (average number of children per woman during her fertile period of life).⁷ The pro-natalistic policy of the Bulgarian Government, which was introduced in the late 1960s, resulted in a slight increase in the total fertility rate through the 1970s, but since the 1980s it has showed a rapid decline.

Legislation related to abortions

Legislation related to induced abortion has a direct impact on the reproductive health of a population. From 1956 to 1968 first trimester abortion was provided on request. In 1968 the Bulgarian Government introduced pro-natalistic policies, including restrictions for abortions in childless women. These restrictions were further tightened in 1973. After 1974 the legislation permitted abortion for social and sociomedical indications. Every woman requesting abortion presented her case to a commission. After examination of her medical status (age of gestation of present pregnancy, and medical record), social status (marital status, and number of children) and economic status (income for the previous year, housing, etc.) the commission decided whether or not there were solid grounds for permitting an abortion. This system created several bureaucratic, organizational and social problems, both for the providers and the patients. Yet, induced abortions were frequent and remained one of the primary means of family planning. There was also a cer-

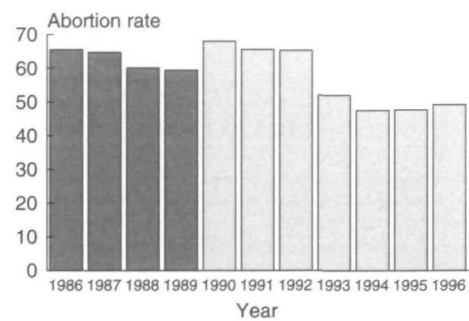


Figure 1 Legal abortion rates (number of abortions per 1,000 women aged 15–44 years) in Bulgaria, 1986–1996
Source: Bulgarian Ministry of Health⁶

tain proportion of illegal abortions, which were requested by women who were not eligible for a legal abortion according to the legislation at the time. Such abortions were usually performed by a doctor or a midwife in a home environment and, therefore, under suboptimal hygienic conditions. Even more threatening were the cases in which people without medical background were applying certain 'traditional' methods of abortions. Since February 1990 the legislation in Bulgaria has allowed first trimester abortions on request. However, because of the inadequate quality and availability of family planning services and sex education, the need for abortion remains high.^{8,9}

Epidemiological data

The most important factor influencing the high rate of abortions is the high rate of unwanted pregnancies. The reliability of direct measurement of unwanted pregnancies is possibly suspect, because of the nature of the issue. However, the abortion rate can be used reliably as an indirect indicator. In addition, research on this topic in Bulgaria was not available.

Abortion rates and ratios

The abortion rates (number of abortions per 1,000 women of age 15–44 years per year) for Bulgaria for the period 1986–1996 are presented in figure 1, in which two periods in the recent history of Bulgaria (1986–1989 and 1990–1996) are presented.⁶ In the period 1986–1989 a slight trend of a decrease in abortion rates is observed. This mainly reflects the increasing interest in modern contraception among the population, the accessibility to more information and increase of condom use because of anti-AIDS campaigns. After the change in legislation in 1990, the abortion rates for that year increased. The difference between the rates in 1989 and 1990 mainly reflects the proportion of abortions which would have been performed illegally under the previous legislation. Over the next two years the abortion rates reached levels similar to those in 1986 and 1987. Afterwards there was a significant drop from 1992 to 1993 and from 1993 to 1996 there appeared to be little change. The decline in 1993 is

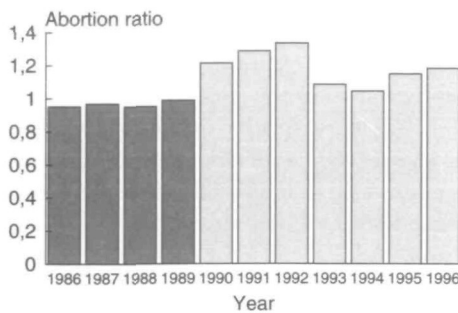


Figure 2 Legal abortion ratios (number of abortions per 1,000 live births) in Bulgaria, 1986–1996

Source: Bulgarian Ministry of Health⁶

partially due to improvements in family planning services. When analysing these data, however, some other factors should also be taken into account. One factor is the deterioration in the health care sector in these years, which also applies to the system of registration. Another important factor is the wave of emigration from the country. In the period 1989–1992 alone, approximately 5.6% of the population emigrated and the majority of them were between 20 and 35 years old.¹⁰ This emigration may have led to biased estimates of abortion rates, because the latter are calculated on the basis of mid-year estimates and/or projections of the female population for every year. Due to the high rate of emigration (mostly of young people) it may well have been the case that some of the women who were still on the population register had in fact left the country. In practical terms this would be reflected in the calculations since they are based on the number of registered abortions per year (realistic number in the numerator) and the number of female population of childbearing age (overestimated number in the denominator). As a result lower abortion rates would be obtained.

Figures for the abortion ratios (number of abortions per 1,000 live births) might be a better indicator in such cases of substantial emigration (figure 2). Abortion ratios in Bulgaria increased from 1990 to 1992, then in 1993 there was a substantial decline and, later, they increased again (1995, and 1996). However, this indicator is above 1 for the whole period of 1990–1996, which means that, in Bulgaria, more pregnancies are terminated than completed.

Age

In countries where contraception has been widely available for many years (e.g. The Netherlands) over 50% of all abortions are in women under 25 years of age. In contrast, the current data for Bulgaria indicate that the peak age of women requesting abortion is around 30 years.^{4,11} This finding is consistent with the general tendency observed in CEE countries, where unmarried young

women who become pregnant often marry and continue the pregnancy, while for married women abortion is a frequent method for spacing or limiting the number of children.

Age-specific abortion rates (figure 3) were calculated from data obtained from the Bulgarian Ministry of Health.⁶ The highest abortion rates are in the age groups 20–24 years and 25–29 years. Until 1993 the abortion rates in all age groups had declined, but since 1994 they have remained unchanged.

Marital status and parity

In most Western European countries abortion rates are higher among women without a stable partner than among married/cohabiting women. As parity and marital/cohabiting status are closely related, it is also true that the higher abortion rates are among nullipara. The trend in Bulgaria is contrary to that in Western European countries, where less than 20% of women having abortions are single and childless.^{6,12} Data for 1990 show that more than 50% of those requesting abortion were women with two children, but, in the following years, the proportion of women with one child requesting abortion increased. This could be explained by the fact that a growing number of Bulgarian couples are limiting their number of children to one.

Socioeconomic status

Research in the USA shows a negative correlation between abortion rates and socioeconomic status.¹³ However, the influence of socioeconomic status on abortion rates has rarely been studied in Bulgaria.

Ethnicity

The Bulgarian population consists of 85% Bulgarians, 10% Turkish, 4% Gypsies and 1% other. These ethnic groups differ in culture, religion, and level of education. Therefore it is logical also to expect differences in reproduction choices and behaviour. The Turkish (Islamic) population is expected to have a lower abortion rate because of religious considerations. The same trend is presumed for the Gypsy minority, but here cultural factors would mainly play a role.³

Level of education

Since 1949 primary and secondary education have been compulsory in Bulgaria, and therefore, school enrolment is almost 99%.¹⁴ There is practically no illiteracy. However, several studies in other countries have shown a clear correlation between level of education and, related to that, health literacy and contraceptive practices/abortion rates.¹⁵ A study of 792 pregnant teenagers indicated that requests for abortions are higher among girls with higher level of education.¹⁶ A more complete study of this aspect of the problem would be desirable.

Multiple abortions

Ivanov et al.⁴ discussed their observation of the high rate of multiple abortions among Bulgarian women. Unfortu-

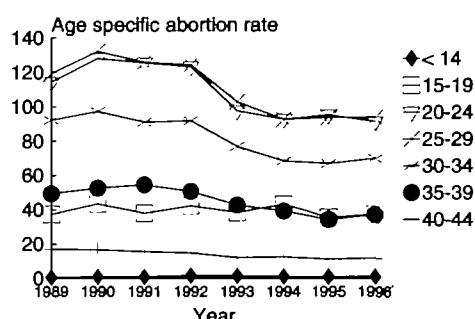


Figure 3 Age-specific abortion rates (number of abortions per 1,000 women in this age group) in Bulgaria, 1989–1996
Source: Bulgarian Ministry of Health⁶

nately, neither solid statistical data on the issue were presented, nor were the causes explored in detail. It is not clear whether cases of multiple abortions are due to inadequate post-abortion counselling, ineffective contraceptive practices or their failure or to a combination of these factors.

Adolescents

Adolescents are a group which require special attention because they are the future potential of the population and future mothers. Abortion rates among girls aged 15–19 years have tended to remain high (figure 3). A recent study among pregnant adolescent girls showed that only 12.9% used a contraceptive method and, obviously, in an unsuccessful manner.¹⁶ However, no data for contraceptive use among the total population of adolescents were found. According to a study from 1995 among teenagers aged 13–19 years, approximately 94% had a positive attitude towards and a high interest in modern contraception.¹⁷

Family planning services

Family planning services were formally available during the years of the communist regime. However, because of the pro-natalistic policy of the government, few contraceptive devices were available on the market and promoted to the population.

Traditionally, the health care system in Bulgaria has been centralized, highly specialized and heavily staffed. It was organized into district, provincial, regional and national levels. Bulgarians in general have good access to health care but there is a big overlap in the provision of services. Primary health care was provided to the general population by local and district clinics (which serve approximately 1,500–2,500 people), often staffed by a doctor or a 'feldsher' (medical assistant) and a nurse. More specialized out patient care was provided by doctors and nurses at polyclinics and, further, in general, paediatric and obstetric and gynaecology hospitals. Special units on family planning were maintained in the structure of every obstetrics and gynaecology hospital. Counselling was also

given by the obstetricians at the polyclinics and by the doctors or 'feldshers' at the district and local clinics. The family planning services structure has not changed in recent years. The difference is the growing interest in contraceptives among the population and their wide availability. Related to this, besides medical professionals, there are also several informal sources of information on contraception, such as mass media, friends, programmes on sex education at schools, etc.

Financing

Currently, family planning services (laboratory testing, medical examinations and counselling) are included in the basic benefit package. However, the patient has to pay out of their own pocket for contraceptive devices and also for an induced abortion on request. As part of the current reforms, a new system of referral was introduced in January 1998. It aims at strengthening the role of the primary care providers as gatekeepers. In practical terms this means that a patient is referred to a higher level of health service only if the diagnosis or treatment cannot be provided at the primary care level. If the patient insists on receiving more specialized care (i.e. to be examined and treated by a higher level of specialist) they have to pay for examination, testing and treatment.

Contraceptive prevalence

In the past, most unmarried couples relied on traditional methods of contraception, such as withdrawal and timing. For married couples with children, intrauterine devices (IUDs) were the only available contraception recommended by medical professionals. Oral contraceptives were not prescribed frequently and had a bad reputation for being related to many risks and side-effects. Condoms were rarely used as a method of contraception because of their poor quality and irregular supply. Other means of contraception were known to medical professionals, but not promoted to patients as they were not available on the market.

Although the spectrum of contraceptive devices now available on the market is more diverse, their usage is relatively low. The most recent data found a contraceptive prevalence rate of 22% for the Bulgarian population (modern contraception) in 1992.¹⁸ However, this indicator does not give information on the true picture in Bulgaria, because it is defined as the percentage of married women aged 15–49 years currently using some form of modern contraception. Hence, non-married couples were not included in the study.

The tradition of mainly using IUDs continues and is maintained by the providers. The method is only recommended for women who have delivered a child, and is a provider-dependant contraception. Oral contraceptives, particularly third generation contraceptive pills, are particularly recommended and used by teenagers and young women.¹⁹ Within its anti-AIDS campaign, the Bulgarian Ministry of Health has promoted the use of condoms and also provided their supply on the market, so their use is increasing. Data on application of other methods (female

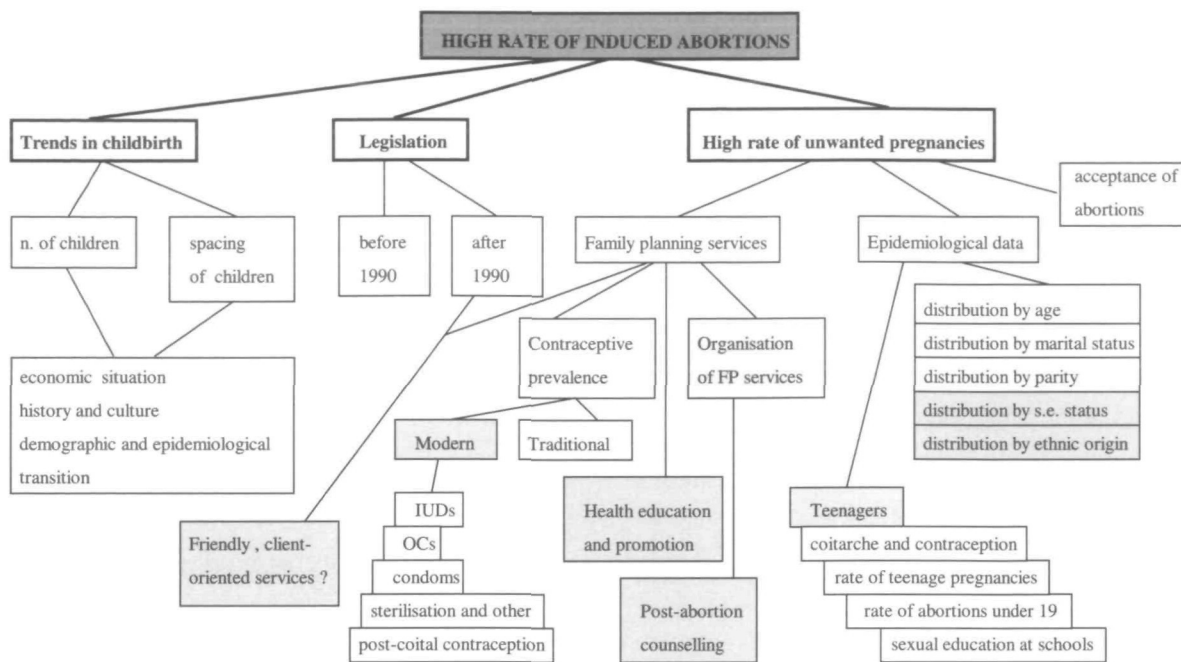


Figure 4 Different factors and aspects associated with the problem of high rates of induced abortions in Bulgaria

diaphragm, injectable or implantable hormonal devices, and sterilization) were not available.

Sex education in schools

Programmes on sex education are included in the agenda of Bulgarian schools. Information on methods of contraception is also included, but more emphasis is placed on the 'harmful' effects of early sexual activity and methods of protection from sexually transmitted diseases. Data on the quality of this education and the coverage would be necessary for an evaluation of its role in the family planning service scheme.

CONCLUSIONS

The rate of induced abortions in Bulgaria is higher than in most other European countries.¹⁰ The research presented in this paper aimed at discovering the weak points in the system. Some of the underlying causes were presented, but, due to incompleteness of data, other components of the problem remain unexplored. The relationships between different aspects are presented in figure 4. Those parts of the system where, according to the present analysis, more attention and/or changes would be advisable are highlighted.

Analysis of stratified abortion rates according to factors such as age, marital status and parity showed that there is a general trend shifting towards single nullipara women in the age groups 20–24 and 25–29 years.⁴

The association between socioeconomic status, ethnicity or level of education and contraception, respectively abortion practices, have not been explored for the Bul-

garian population. Data collection and analysis of these associations would be important in identifying high-risk subgroups in the population and designing adequate strategies with tailor-made interventions for each group.

The new financing system of the health services should reflect on the delivery of family planning services. In practice, a larger proportion of the population should have to refer to primary care providers and consider them as a source of information on contraception. However, the services could be brought closer to clients, if both consumers and providers become used to discussing family planning issues between them. A key to achieving higher contraceptive prevalence would be training of GPs in all methods, their delivery and providing objective counselling.

In reference to the observed cases of multiple abortions among Bulgarian women, the issue of adequate counselling about contraceptive practices, which should be an integral part of the services for termination of pregnancies, arises again.

The growing interest among adolescents in modern contraception is encouraging. Further research on issues such as the mean age of first sexual intercourse, the interval between coitarche and contraception (period of unprotected sexual activity), and the coverage of programmes for sex education, will be essential. Prevention of unwanted pregnancies among teenagers gains much advantage for the public health of the population in the future. Most data strongly suggest that the trends in childbirth in Bulgarian society have not so far been met by adequate contraceptive practices. Termination of pregnancy is

primarily used as a method of family planning and spacing of children. This is in contradiction to main public health principles, according to which induced abortion should by no means be promoted as a method of family planning, but rather applied as a last alternative where contraception has failed and for strict medical reasons.²⁰

There is a growing interest in contraceptive methods in Bulgarian society. The activities of the Bulgarian Family Planning Association and the project 'Family planning' of the Ministry of Health aim at improvement in the family planning services.¹⁹ The present review points out some of the factors to be explored further and taken into consideration when designing future intervention strategies for reducing the number of induced abortions. Family planning services should be made more available and accessible to the general population. Creating a friendly, comprehensive and client-oriented approach (non-judgement attitudes, confidential counselling, and adequate information presentation) would definitely obtain better results. Both formal and informal sources of information should be considered. Reducing the number of unwanted pregnancies by improvement in contraception practices would undoubtedly be of social, financial and public health benefit for Bulgaria.

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