



THIRTY YEARS OF FAMILY PLANNING IMPLEMENTATION IN SLOVENIA

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Family planning programmes were introduced in Slovenia 35 years ago. Births were planned more successfully than pregnancies. The prevailing family planning method in the first stage was abortion, later on contraceptive use. Despite a consistent improvement in family planning and a decreased number of abortions, the maternal mortality rate among Slovenian women is still by three to five times higher than elsewhere in the developed world. Maternal mortality among adolescents is by three times higher than among older women, and their infants die more often than those born to older women. This makes adolescent pregnancies the most important risk factor for reproductive health.

FAMILY PLANNING AS A FUNDAMENTAL HUMAN RIGHT

Family planning is a fundamental human right. It grants each individual the right to freely choose their partner, the number of children and spacing between them, to freely choose the way to achieve a satisfying and safe sexual life, and to make all other fundamental choices in life. It also grants access to informed choice and to a sufficient number of safe and effective contraceptive methods. Experience shows that only informed individuals can and will take appropriate actions relative to their needs and the needs of their families and communities (Ministry of Work, Family and Social Welfare of the Republic of Slovenia, 1995). Informed individuals know how to protect their health, how to protect themselves against sexually transmitted diseases and thus reduce the risk of infertility, how to prevent unplanned pregnancies and how to choose the optimal time for a planned pregnancy, reducing the risks for their own health and for the health of their living and

DRUŠ. ISTRAŽ. ZAGREB
GOD. 8 (1999),
BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

future children. This right is equally important for infertile couples who want to have a child.

How important this right is for mankind may be seen from the fact that it was universally accepted and recognised at the 1994 Cairo International Conference on Population and Development, where all the member states made a commitment to work towards its maximum implementation by the end of the next decade.

The development of the modern concept of family planning has been profoundly marked by the deeply rooted disregard for women's fundamental human rights and for their health. Throughout history, societies have used their norms and values, and in recent times also the health-care systems were assigned only to protect maternal and infant health in so far as to provide for women's basic duties, i. e. childbearing and founding a family. Judging from legal regulations and practices, women's health as such has never been and is even today hardly anywhere treated as a social priority. Poor health of women in reproductive age has been blamed on fate and God's will. It has been socially acceptable that maternal mortality and morbidity were not regulated by legal, educational and health-care measures. It has been much more important to protect moral values related to sexual life and family. In a widely held view, these values were threatened if women found sex gratifying, using contraception to prevent unplanned pregnancy and sexually transmitted diseases.

Many women around the world still die of pregnancy and illegal abortion related causes (between 20 and 50 per cent of all maternal deaths); even more get permanently handicapped. The reasons for these deaths and physical handicaps are to be found in discriminatory treatment of women in childhood and adolescence, permitted early marriage, heavier malnutrition of female populations in developing countries and inadequate and less accessible health-care in several developed countries. In many countries, health-care systems regularly violate women's dignity and autonomy, failing to respect their wishes, needs and right to informed consent; instead, decisions are taken by health-care providers and this results in an excessive number of hysterectomies, Caesarean sections, and late abortions.

The more developed a country, the more the neglecting of women's fundamental rights and their health is refined and covert. In certain developed countries, the insufficient and poor-quality reproductive health-care is reflected in excessive numbers of preventable deaths and diseases in women and infants and in excluding women from educational, economic in social opportunities (WHO, 1995).

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BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

The fundamental component of the concept of family planning is not reducing the number of births, as is often said, but rather their careful planning. The deviated perception of family planning as a measure to contain population growth has resulted from its initial application in demographic programmes in countries whose social and economic development was threatened by rapid population growth. In these circumstances a more or less aggressive promotion of contraceptive methods was hoped to help reduce the fertility rates. These programmes failed to produce expected results until they began to observe the basic elements of the concept, i. e. the principles of women's human rights and protection of their health.

Family planning is not only a civilisational achievement but also a substantial achievement in improving the health of women, men, and their children. It has come to be recognised that care for women's health must begin at a very early stage in childhood, especially protection against unplanned pregnancy. Even before pregnancy occurs, adequate counselling is needed to reduce the influence of the main risk factors for maternal and perinatal mortality, premature births and low infant birth-weight. These factors are a high number of births (more than four), pregnancies and births at a young age (under age 20), births later in life (after age 40), and short spacing between births (less than two years), and they are relevant regardless of the social and health-care level.

Compared to other developed countries, implementation of the concept of family planning in Slovenia has been relatively slow; it is only in recent years that family planning has become a pattern of behaviour and a life style for the majority of its population.

ACHIEVEMENTS AND SHORTCOMINGS OF FAMILY PLANNING IN SLOVENIA

Development of Family Planning Programmes in Slovenia

Family planning programmes began in Slovenia 35 years ago. Young and adult people were offered information and education on principles of planned parenthood, use of modern contraceptive methods to implement these principles, and ways of diagnosing and treating infertility. The activities were mostly carried out by medical professionals of outpatient departments for women who had very quickly adopted family planning principles into routine care for women's health. These services were available to all women, yet unfortunately information about their availability was not uniformly spread. They existed in all primary health centres and were increasingly staffed by adequately trained gynaecologists and registered nurses (Andolšek Jeras et al., 1991).

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GOD. 8 (1999),
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STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

The leading role in the development and promotion of these programmes was taken over by the Family Planning Institute in Ljubljana, which in the relatively short period of its independent existence (1972 – 1981) significantly contributed to the improved infant survival and child health and to a better reproductive health of women and men in Slovenia. The Institute did a significant amount of research in the field, especially on ways of improving the safety and efficacy of hormonal and intrauterine contraception, optimising the abortion procedure, and diagnosing and treating of infertility. Together with experts from other fields it fostered the adoption of a comprehensive legislation that regulated all aspects of family planning, from prevention of pregnancy by use of contraception to diagnosing and treating of infertility, as well as legal induced abortion (Andolšek Jeras, Obersnel Kveder, 1991). Other public systems (social welfare, education) and non-governmental organisations occasionally participated in these programmes or added to them some of their own.

One of the main weaknesses of these programmes was lack of co-ordination. Their realisation depended on the experience and commitment of individual health professionals. The programmes were not sufficiently adapted to people's needs, and less accessible to most men in fertile age. Secondly, there was no systematic monitoring and assessment of the programmes' efficiency and no studies on the acceptance of contraceptive methods and contraceptive behaviour. These shortcomings are reflected in reproductive health indicators, which were used to assess efficacy of family planning programmes in protecting the population's reproductive health.

Planned Child-Bearing and Reproductive Health Risk Factors in Slovenia

Even before the concept of family planning began to be introduced in Slovenia, most women probably realised that a large family size and having children after the age of 40 were a threat to their health and that of their children. Less was known about the risk of early childbearing and short spacing between births. Unfortunately, fertility regulation methods in those days were very ineffective (periodic abstinence, withdrawal, postcoital douching) and highly dependent on the cooperativeness of male partners. In consequence, women had recourse to the only remaining and sufficiently effective method through which they could exercise their own choice – illegal abortion, although it was a risk to their health and life.

When awareness of the family planning principles had spread first among health professionals and then also among the population, in particular among women, there was a shift

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GOD. 8 (1999),
BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

in planning child births, which has progressively continued till the present day. In the 1970s, 75 per cent of children were born to women aged between 20 and 35; by 1996 the percentage increased to 90. The number of women giving birth after 35 has been relatively low over the last 25 years (around 9 per cent) and has not been following the recent trend of growth characteristic of the rest of Europe. What is important is a noticeable decline in the proportion of adolescents among women giving birth: from 14 per cent in the 1970s to only 3 per cent in 1996 (Obersnel Kveder, Truden Dobrin, Rudolf, 1997). This is a significant achievement, as pregnancy and delivery are a much higher health risk for adolescent women and their children than for older women.

Less successful have the Slovenian couples been in planning pregnancies. At the beginning, there were many unplanned pregnancies, because contraceptive methods were used inappropriately and irregularly, also because the mechanism of action of available contraceptive methods was not widely understood. Besides, the range of effective contraceptive methods was limited. In addition, there was a strong opposition to family planning in some circles and a considerable scepticism about the safety and efficacy of modern contraceptive methods among some health professionals. All this was reflected in a high abortion rate and high mortality related to illegal abortion. Between 1970 and 1979, there were 11 abortion-related deaths (Simoneti Kranjc, 1976), and the last such case was recorded in 1983. In the early 1980s, there were 40 abortions per 1,000 women aged 15-49, and, on the average, each woman had more than one legal abortion during her entire fertility age (the total fertility rate). Despite such a high number of induced abortions there was no single case recorded of an abortion-related death or sequels that would threaten women's reproductive capacity. The main reason was that a large majority (90 per cent) of women seeking abortion could make their decision early on in pregnancy, that abortions were performed by skilled doctors in hospitals and that medical institutions performing abortions were numerous and easily accessible. After the abortion, women were given quality information and counselling on sexual and contraceptive behaviour that reduced the risk of pelvic inflammatory disease and of repeated unwanted pregnancies (Figure 1).

From the early 1980s on, the number of unplanned pregnancies and abortions has been consistently decreasing. In 1996, the abortion rate dropped below 20 per 1,000 women of fertile age for the first time, approaching the average abortion rate in Europe (15/1,000). The abortion rate has been declining in all age groups. Besides adolescents, the age group most at

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BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

risk is women over 35. These are the target groups that should receive a particularly careful counselling in choosing the most adequate contraception. Special attention should be paid also to populations of reproductive age in the regions with the highest abortion rates. In 1982, the highest regional abortion rate was 53 per 1,000 women aged 15-49. By 1996, the same region recorded a decline by over a half (21/1,000). The lowest regional abortion rate in Slovenia in 1996 was 9/1,000 (Obersnel Kveder, Kirar Fazarinc, Dirjec, 1997).

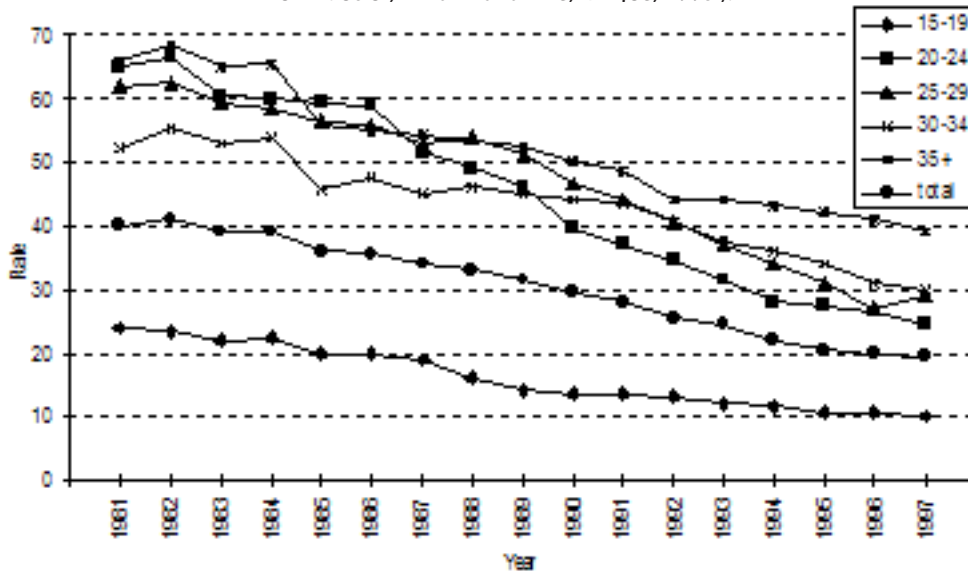


FIGURE 1
Age specific induced
abortion rate per 1000
women in fertile age,
Slovenia 1987-1997

The main factor behind the improved abortion rate is undoubtedly the increasingly responsible contraceptive behaviour of the population. However, the shift from traditional ways of preventing unplanned pregnancies to modern contraceptive methods has been very slow and it is only in recent years that Slovenia may be said to be catching up with developed European countries. In 1995, effective contraceptive methods were used by two thirds of the sexually active population. Only 15 – 20 per cent of women had been using hormonal contraception for over 20 years, while the percentage of current users was higher, viz. 35 per cent. The number of IUD users grew at a faster rate, reaching 25 per cent in the late 1980s (Andolšek et al., 1993). In recent years, the number of IUD users has been declining (16 per cent), but there has been an increase in the number of condom users (15 per cent). The greatest difference between Slovenia and some European countries is in the use of sterilisation (3 per cent), regarded as the most effective contraceptive devices for the population over 35, which has already completed its family size (Obersnel Kveder et al., 1995). The number of female sterilisations has been slowly growing, while male sterilisation remains very modest.

DRUŠ. ISTRAŽ. ZAGREB
GOD. 8 (1999),
BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

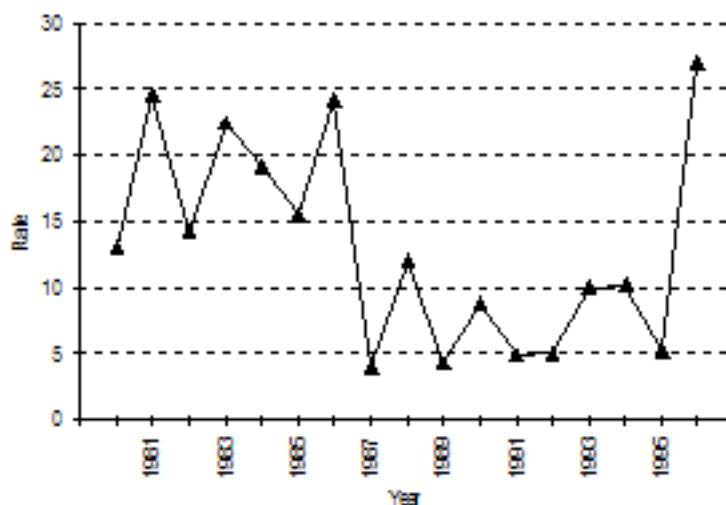
One of the important risk factors for maternal and infant health in Slovenia has been the short spacing between births. A new pregnancy that follows too soon after a childbirth is not only a risk for the survival of the future baby, but also a threat to the growth and development of the previous child, who may be deprived because of a possible interruption of breast-feeding or because of a possible deterioration of the family's socio-economic and other conditions. In Slovenia, data on child spacing began to be recorded only in the 1990s, so nothing much can be said about the trends in this factor over a longer period of time. Annually, some 15 per cent of deliveries occur with a spacing of less than two years. 36 per cent of these women are under 25, compared to only 14 per cent of the same age group among those with larger spacing between childbirths. The main reasons for such a short spacing may be sought in women's unawareness of the risk related to it and their lack of interest for efficient counselling regarding the most appropriate contraceptive method during breast-feeding and in the postpartum period, when women's first concern is care of the infant. Some gynaecologists tend to avoid this time-consuming counselling altogether, or deal with it only superficially. Some women will probably deliberately choose a short spacing between two births simply not to lose the social advantages pertaining to maternal leave and employment post as during maternal leave women cannot lose the employment post, renting contract and student's status.

Despite the encouraging results – improving child birth planning and the declining number of abortions, which today have almost no sequels, Slovenia still has a higher maternal mortality than other developed countries. In the 1970s and 1980s, it gradually decreased (an average of 15 deaths per 10,000 live births), to reach the lowest level between 1987 and 1992 (4-5 deaths per 100,000) (Obersnel Kveder, 1994). In recent years, however, the trend has turned upwards again and in 1996 maternal mortality was 26 per 100,000 live births (5 women) (Obersnel Kveder, 1996). Prevailing causes of maternal deaths are similar as in other European countries: bleeding during pregnancy and after delivery, cardiovascular disease and sepses. These all belong to the category of less preventable deaths, but results from other countries, where maternal mortality is several times lower than in Slovenia, show that they can be prevented more effectively than is currently the case in Slovenia. Occasionally, maternal deaths are due to more preventable causes, like ectopic pregnancies, which can be diagnosed at an early stage and successfully treated. The reason for the failure to prevent these deaths may be sought in insufficient access to health services for some women. Mostly, these are less educated and health-aware and come from less developed or economically deprived environments (Figure 2).

DRUŠ. ISTRAŽ. ZAGREB
GOD. 8 (1999),
BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

➔ FIGURE 2
Maternal mortality
per 100 000 livebirths,
Slovenia 1980-1996



It is estimated that the most important risk factor for reproductive health in Slovenia is early childbirth. Unplanned adolescent childbirths have health consequences for adolescents as potential parents, their infants and for the reproductive health of the whole population.

Reproductive and Contraceptive Behaviour of Adolescents

At the outset, Slovenian adolescents had considerable problems in family planning, but to a lesser extent than elsewhere in Europe. In the 1970s, Europe was witnessing an epidemic of adolescent pregnancies. In Slovenia, this phenomenon occurred with some delay. At the time, the birth rate among women under 20 was about 15 per cent. Approximately 65 adolescents per 1,000 got pregnant annually (4,500 adolescents). Almost two thirds of them gave birth, the rest underwent abortion. Since the early 1980s, adolescent pregnancy has been on the decrease. The number of adolescent pregnancies in 1996 was by three times lower than 25 years earlier, only 20 per 1,000 adolescent girls (5, 7). Their decision regarding the outcome of pregnancies has also changed. Nowadays, fewer – only 43 per cent – choose to have the child, while the majority chooses an abortion. This decision may appear less desirable, but in fact childbirth is a more serious risk for adolescents than an abortion. Between 1988 and 1994 maternal deaths among adolescents were by three times more frequent than among other women, and also their new-borns died more frequently than those of older women. The average maternal mortality rate among adolescents was 30 per 100,000 live births, compared to only 10 per 100,000 live births in the total population. The average perinatal mortality rate in infants born to adolescents was also by 40 per cent (13,6/ 1000)

DRUŠ. ISTRAŽ. ZAGREB
GOD. 8 (1999),
BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

higher than in infants born to older women (9,7/ 1000) (Obersnel Kveder, 1997). Reasons for this are undoubtedly complex and require a detailed analysis of health problems experienced by the young. Although this may not be the most important among the reasons, it is obvious that current health services are not very well adapted to the needs of adolescents. Out-patient departments for women are not readily accessible to adolescents, and even if they are, young persons see them as a real or apparent obstacle to the fulfilment of their sexual and reproductive needs. One indicator of this attitude is the very low number of adolescents who attended parental schools in 1996. Only one third of adolescent mothers-to-be attended these courses, compared to 48 per cent of those aged between 20 and 30. The percentage of adolescents attending these courses exceeded that of older mothers only in two Slovenian regions, while in three regions it did not even attain 20 per cent (Obersnel Kveder, Truden Dobrin, Rudolf, 1997). On the other hand, adolescents express quite a strong wish to receive this kind of counselling, but they expect it from the school doctor.

Among the young, family planning is becoming a way of life. This is a result of the many years of health education for good interpersonal relations and responsible sexual and contraceptive behaviour. In the Slovenian Family and Fertility Survey, carried out in 1995 on a representative sample of 4559 women and men, three quarters of adolescents said they had used contraception at their first sexual intercourse. Girls did this in a slightly higher percentage of cases (75,3 per cent) than boys (64,7 per cent). It was interesting to compare these results with answers of their parents' generation: the latter had used contraception at first intercourse in only 12 per cent of the cases. The contraception used at first intercourse by two thirds of the young (65 per cent) was the condom. One fourth (24 per cent) still opted for a less effective contraception (withdrawal and periodic abstinence). Among young women this choice was twice as frequent as among young men (30 vs. 13 per cent). The survey also showed that the most common contraceptive method among the young was the condom (46 per cent), followed by hormonal contraception (31 per cent) and withdrawal (17 per cent) (Obersnel Kveder et al., 1995)(Figure 3 and 4).

Despite these achievements, it has to be pointed out that adolescent pregnancy remains an important risk factor for reproductive and infant health also in Slovenia. Efforts have to continue to further reduce the number of unplanned pregnancies among the young and to promote their responsible contraceptive behaviour. Conditions have to be created in which their educational, health and other needs will be fulfilled.

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GOD. 8 (1999),
BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

FIGURE 3
Contraceptive use
at first intercourse
among male
respondents,
Slovenian FFS 1995

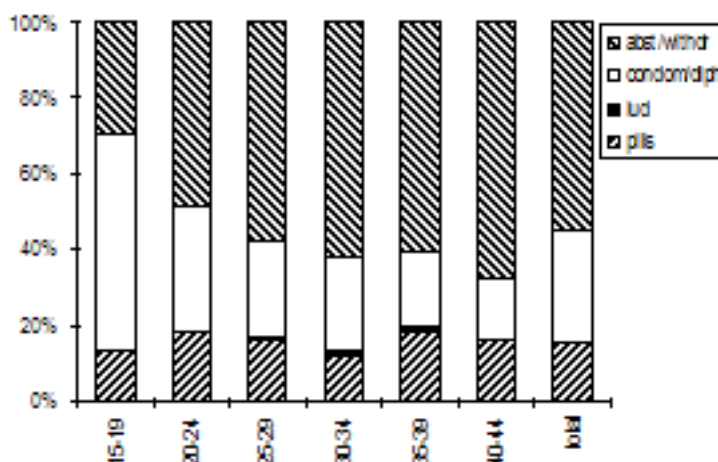
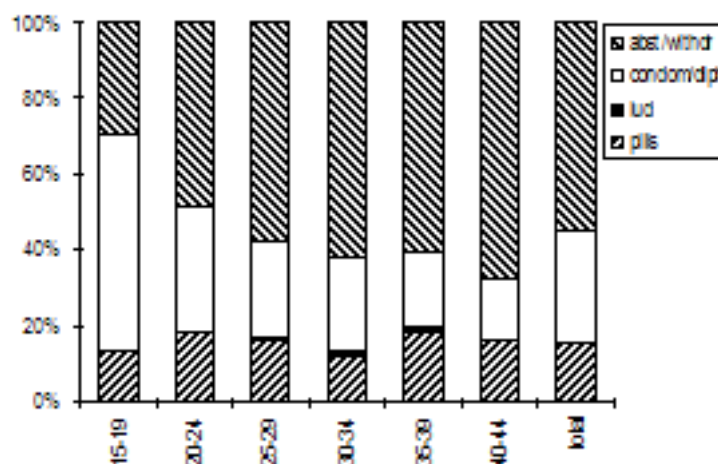


FIGURE 4
Contraceptive use
at first intercourse
among female
respondents,
Slovenian FFS 1995



GUIDELINES FOR IMPROVEMENT OF REPRODUCTIVE HEALTH IN THE FUTURE

1. Slovenian experts recognise that the introduction of the family planning concept was a significant investment in safe motherhood, and that it needs further elaboration and development. It has to become a concern of the entire society, which has to accept that investment in health is investment in its social and economic development.

2. To achieve reproductive goals, basic conditions for improving women's health have to be met, viz. strict protection of women's human rights according to the Universal Declaration of Human Rights. These rights are as follows:

- the right to life, liberty and security, under which the state is obliged to provide access to adequate health-care during pregnancy and childbirth (the right to life) and to free choice of the number of children and spacing between them (the right to liberty and security);

DRUŠ. ISTRAŽ. ZAGREB
GOD. 8 (1999),
BR. 2-3 (40-41),
STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

– the right to found a family, under which the state is obliged to provide access to health-care and other services helping the woman to found a family and have a gratifying family life;

– the right to health-care and to benefit from scientific development, including health information and education, under which the state is obliged to provide reproductive health-care and pertaining information;

– right to equal treatment and protection against discrimination on the grounds of sex, marital status, age, cultural and socio-economic status, under which the state is obliged to provide access to services like education and health-care to women, who are different in terms of their age, marital or socio-economic status (WHO, 1998).

3. The results achieved so far oblige the professionals to continue the work undertaken and to develop new, innovative and quality programmes for responsible partnership education, for reproductive health promotion and improvement of the preventive reproductive health-care. In view of this, the following activities have to be carried on:

– to promote responsible and healthy reproductive behaviour of adolescents steps have to be taken to provide quality information, counselling and health-care for adolescents that will be generally accessible and age-specific. These programmes have to foster a more active participation of parents, school counsellors and teachers, so that they will be able to guide adolescents in their sexual and reproductive needs. Services have to be set up that will ensure protection of adolescents' rights to privacy, confidence, dignity and free informed consent. To improve their reproductive health, research into specific health problems from an adolescent perspective has to be intensified. Concerted efforts of all social sectors are needed to cover also other vital needs of young people, especially working and living conditions indispensable for a healthy and creative life;

– to promote sharing responsibility for family planning between woman and man, more attention has to go to men's specific needs. Men have to be encouraged to take a more active part. Accordingly, changes have to be made in current services, which are basically adapted to health-care for women;

– to improve the quality and accessibility of reproductive health-care, permanent monitoring is needed of the implementation of preventive programmes in primary reproductive health-care and accessibility of primary health-care services for women. Outpatient departments for women, in cooperation with the home nursing service, should cover the entire population;

4. Reducing maternal mortality is the first priority in reproductive health-care. It is necessary to analyse each case of maternal death, to formulate and update professional reproduc-

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STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

tive health guidelines and measures to monitor their consistent implementation. Legal provisions are needed for adequate medical records and health statistics and activities of the appointed commissions and boards which monitor and assess maternal and infant deaths and reproductive health of the population.

5. It is necessary to further develop the field of public health, so that it will be capable to monitor the efficacy of preventive programmes, accessibility of health-care and promotion of reproductive health. Special efforts are necessary to intensify monitoring of reproductive health in view of the expectations that health consequences of the changes in the social and health-care systems introduced eight years ago, which we are beginning to notice at present, will only deteriorate in the future. In this, particular attention should be focussed on the growing differences among various groups of population and among various geographical areas.

6. It is necessary to foster development of non-governmental organisations that will advocate protection of reproductive rights and bring pressure to improve availability and accessibility of reproductive health-care services, including family planning.

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Trideset godina provođenja obiteljskog planiranja u Sloveniji

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Programi obiteljskog planiranja uvedeni su u Sloveniju prije 35 godina. Rođenja su se uspješnije planirala od trudnoća. Prevladavajuća metoda planiranja obitelji u prvom je razdoblju bila prekid trudnoće, a kasnije upotreba sredstava za sprječavanje začeća. Usprkos dosljednom poboljšanju planiranja obitelji i smanjenju broja abortusa, smrtnost majki među slovenskim ženama još je uvijek tri do pet puta veća nego drugdje u razvijenom svijetu. Smrtnost adolescentnih majki je tri puta veća nego među starijim ženama, a njihova djeca umiru češće od djece koju rađaju starije žene. Stoga su trudnoće adolescentnih majki najznačajniji čimbenik rizika za reproduktivno zdravlje.

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STR. 253-266

OBERSNEL KVEDER, D.
ET AL.:
THIRTY YEARS OF FAMILY...

Dreißig Jahre Familienplanung in Slowenien

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Vor 35 Jahren wurden in Slowenien erstmals Programme zur Familienplanung eingeführt. Dabei erwies sich die Geburtenplanung erfolgreicher als die Planung der Zahl der Schwangerschaften. Die vorherrschende Methode der Familienplanung bestand zunächst im Schwangerschaftsabbruch, später in der Einnahme von Empfängnisverhütungsmitteln. Trotz der konsequenten Verbesserung der Familienplanung und der verringerten Zahl von Abtreibungen liegt die Sterblichkeitsrate unter slowenischen Frauen noch immer drei- bis fünfmal über den Durchschnittswerten in anderen Industriestaaten. Die Sterblichkeit von adoleszenten Gebärenden ist dreimal größer als die unter älteren Frauen, auch sterben Säuglinge gebärender Jugendlicher häufiger als die Säuglinge älterer Frauen. Es erweist sich also, daß Schwangerschaften in der Adoleszenz den größten Risikofaktor darstellen, der die Gesunderhaltung der Reproduktionsfähigkeit bei Frauen gefährdet.