An Evaluation of ACCESS-FP's Work in Albania: Postpartum and Postabortion Family Planning

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ACCESS-FP, a five-year, USAID-sponsored global program, is an associate award under the ACCESS Program. ACCESS-FP focuses on meeting the family planning and reproductive health needs of women in the postpartum period. Interventions are designed to complement those of the ACCESS Program in the promotion and scale-up of postpartum family planning through community and clinical interventions. ACCESS-FP will reposition family planning through integration with maternal, newborn and child health programs, including the prevention of mother-to-child transmission of HIV.

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More importantly, we would like to thank the respondents who took the time to be interviewed for this evaluation. Without them, this report would not have been possible.

I. BACKGROUND

A. Family Planning in Albania

Desire of Family Planning

Albania has experienced dramatic changes in family size over the past 30 years. In the 1970s, the total fertility rate (TFR) was 4.7. Since the legalization of contraception and abortion in 1991, the TFR has fallen dramatically and is currently 1.6.[1] The Albanian Council of Ministers declared in 1992 that family planning (FP) should be seen as a basic human right. The overall goals of the reproductive health care system are to offer good quality and improve access to reproductive health care services. By encouraging couples to plan the number and spacing of pregnancies, the health status of women, newborns, infants, children and adolescents will improve.

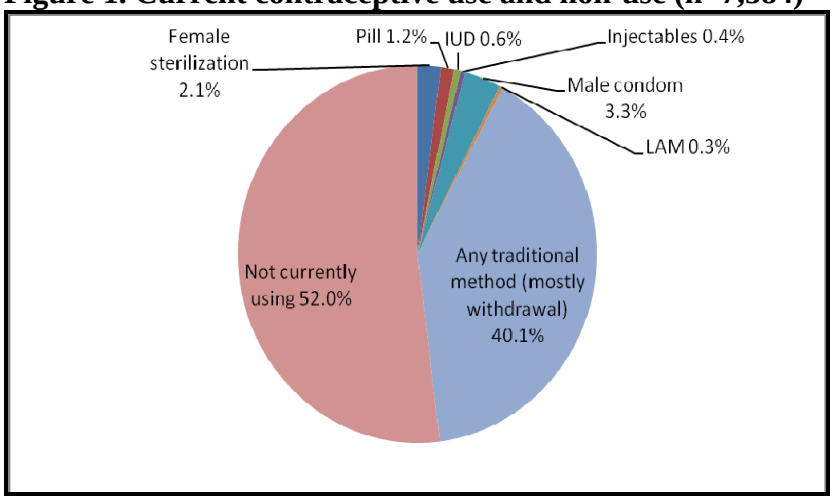
The 2008-09 Albanian Demographic and Health Survey (ADHS) indicated that (n=7,584 women):

- 70% of married women want no more children; and 9% want to wait two years or more before the next birth.
- 22% of women with one child want no more children; 79% of women with two children want no more children; and 90% of women with four or more children want no more children.
- The desire to delay the next birth for two years or long is highest (36%) among women with one child.

Currently, the rate of modern contraception is 8%; while notably withdrawal is very popular (40%), especially among married women (58%). The distribution of modern contraception use, traditional methods and non-use is illustrated in **Figure 1**.[2] Elective abortion is commonly used as a backup measure.

[1] Institute of Statistics, Institute of Public Health [Albania] and ICF Macro. 2010. *Albania Demographic and Health*
Survey 2008-09. Tirana, Albania: Institute of Statistics, Institute of Public Health and ICF Macro (2008-09 ADHS).
[2] 2008-09 ADHS

Figure 1. Current contraceptive use and non-use (n=7,584)



B. ACCESS-FP in Albania

FP Counseling during Antenatal and Postpartum Periods

In Albania, public antenatal care, FP and pediatric services are offered at primary health care centers. Per the 2008-09 ADHS, approximately 97% of births occurred in health institutions, and three percent of deliveries took place at home in rural settings when the facility could not be reached.

Although the vast majority (97%) of Albanian women receive antenatal care, only 40% reported receiving any counseling on postpartum contraception.[3] Fewer than 20% of women reported receiving postpartum FP. In contrast, more than 85% of women reported that their babies had been seen by a health professional after delivery, and the majority received services during the first two weeks postpartum.[4]

Abortion Services and FP Counseling

Abortion is legal in Albania and provided in public sector maternity hospitals and maternity houses. Abortion is provided in maternity hospitals (secondary level facilities) at the public sector and private clinics. The procedure is conducted by an obstetrician/gynecologist who is assisted by a nurse or midwife. According to the official national statistics, the abortion rate has fallen in recent years. INSTAT 2005 statistics show one abortion for every three or four deliveries[5], but it is likely that many abortions go unreported, especially those conducted in private clinics, which would result in a lower ratio. Monthly data from the project facilities (public maternity hospitals) for two years of project implementation (2008-2009) shows one abortion for every five deliveries (1:4.95).[6]

[3] 2008-09 ADHS
[4] Ibid
[5] INSTAT
[6] Service statistics obtained from ACCESS-FP project sites.

At the service delivery level, routine counseling that is provided to abortion clients is procedural with the focus on pain management and complications. No FP information is given to the client before or after the procedure.

Currently, ACCESS-FP is working in Tirana, Korca and Shkoder cities, with a programmatic focus on implementing immediate postpartum and postabortion FP services at the district maternity hospitals. In addition, the project is implementing an innovative approach designed to reach women during the extended postpartum period (12 months) through pediatric services at selected polyclinics in the project areas. **Figure 2** shows the programmatic framework developed for ACCESS-FP/Albania.

Figure 2. ACCESS-FP/Albania Programmatic Framework

C. Evaluation Purpose and Objectives

Between March 2008 and October 2009, ACCESS-FP conducted an evaluation to determine the effectiveness of program activities. In particular, the level and quality of FP counseling provided to postpartum and postabortion clients were assessed. In addition, clients' attitudes toward FP and knowledge about contraception for postabortion women, and contraceptive use after six months delivery or abortion were examined.

II. METHODOLOGY

A. Design

The evaluation employed a pre/post intervention approach and was conducted among postpartum and postabortion women just after or during discharge from the Obstetric-Gynecologist University Hospital "Queen Geraldine Hospital" (Tirana Maternity Hospital #1). Data collection methods included client exit interviews at postpartum and postabortion wards, and six-month follow-up interviews via phone for those who agreed to be contacted after being discharged from the facility.

B. Site Selection

Queen Geraldine Hospital was selected because it had the highest number of births and abortions among all project sites (5,800 births and 2,287 abortions in 2007[7]). It was also one of the project sites for the American International Health Alliance (AIHA) FP project from 1999 through 2004 and had established a "woman's wellness center" through this partnership. In addition, this hospital had benefited from Family Planning Service Expansion and Technical Support Project (SEATS), a USAID-funded project led by Johns Snow, Inc., which provided FP materials and equipment through the Albanian FP Project (AFPP) and ended in 2007. During ACCESS-FP's initial assessment visit in November 2007, staff demonstrated a positive attitude toward FP services and potential collaboration in this area. Because of the positive attitude toward FP and previous staff training, ACCESS-FP expected that the provision of postpartum and postabortion FP services at Queen Geraldine Hospital would be a benchmark for other services, as well as an example of improvement which may be achieved by other ACCESS-FP project sites.[8]

C. Sample

The plan for evaluation included interviewing 100 women discharged from postpartum services and 100 women discharged from postabortion services to satisfy the minimum of estimated sample size (n=91) at both pre-intervention and post-intervention. This sample size was based on estimating differences in FP use between pre- and post-intervention with 80% power, 95% confidence level, 5% detectable differences, an outcome variable of 10-25% (1:1 to 20% difference in FP use). Due to the exploratory nature of this evaluation, convenience sampling was used. Women selected for interviews represented 100% of postpartum and postabortion clients exiting the relevant departments of Queen Geraldine Hospital during the data collection period. For the follow-up, those who agreed to be contacted six-months after client exit interviews were all included if they could be reached in three attempts.

[7] Queen Geraldine Hospital's service statistics, obtained in March 2008.

[8] At post-intervention data collection, similar data collection was also conducted at "Koco Gliozheni" Maternity in Tirana, one of ACCESS-FP's project sites. Results from Koco Gliozheni were comparable with Queen Geraldine.

D. Data Collection Tools

For data collection at pre-intervention, the data collection tools were composed of four separate questionnaires developed for each client group (postpartum and postabortion) at pre-discharge and follow-up. For data collection at post-intervention, the same tools were used with only minor modifications. These modifications included an additional question to ask about healthy spacing for postpartum clients and fertility return for postabortion clients. Another question was added to assess women's perception of the usefulness of the client materials that they received during their stay at the hospital as postpartum or postabortion clients. All questionnaires were pre-tested and adjustments were made as appropriate prior to data collection. (See appendices for the data collection tools.)

E. Procedure

Training of Data Collectors

For client exit interviews, four female reproductive health service providers[9] with data collection experience served as interviewers for client exit interviews. The same interviewers were used for both pre-intervention and post-intervention data collection. All interviewers participated in a one-day orientation workshop prior to data collection at both pre-intervention and post-intervention collection periods. During the workshop, data collectors were trained on the objectives of the evaluation, design, methodology, tools and process including ethical considerations and confidentiality.

For the follow-up interviews at six months, two data collectors at pre-intervention and three others at post-intervention were used to make the calls. Because they were familiar with the tools and data collection effort, these were the same data collectors who participated in the data collection for client exit interviews at Queen Geraldine Hospital.

Data Collection

The pre-intervention data collection took place between 23 February and 26 March 2008, and the post-intervention data collection took place between 17 March and 14 April 2009. All logistical arrangements were made by the hospital administration. Departmental staff was very supportive and did not intervene before or during the interviews. Interviewers were present at the departments between 9 am and 2 pm Monday through Friday and on Saturday (at the postpartum department only), as women were discharged only during these hours. For postpartum women, they were discharged within one to three days after delivery; for postabortion women, they were discharged on the same day.

A separate area adjacent to the discharge nurse station was provided in both the postpartum and postabortion wards. Although there was no private room dedicated to the data collection, this setting was acceptable to women and their confidentially was not jeopardized. Each interview took 15 to 25 minutes, depending on the respondent's desire

[9] The four reproductive health care providers were: a medical doctor who previously worked at the Institute of Public Health (currently retired); a community mental health nurse-midwife; a sociologist working as a high school teacher; and a social worker from Tirana Municipality).

to elaborate on her answers. All interviews were conducted after obtaining verbal consent from the respondents.

Data Management and Analysis

Data collection forms were stored in a secured location at the ACCESS-FP project office in Tirana. Access to data was limited to those who were part of the evaluation and no individual identification was recorded on the form. Data management and analysis was done in SPSS® version 15.0 for Windows® software.

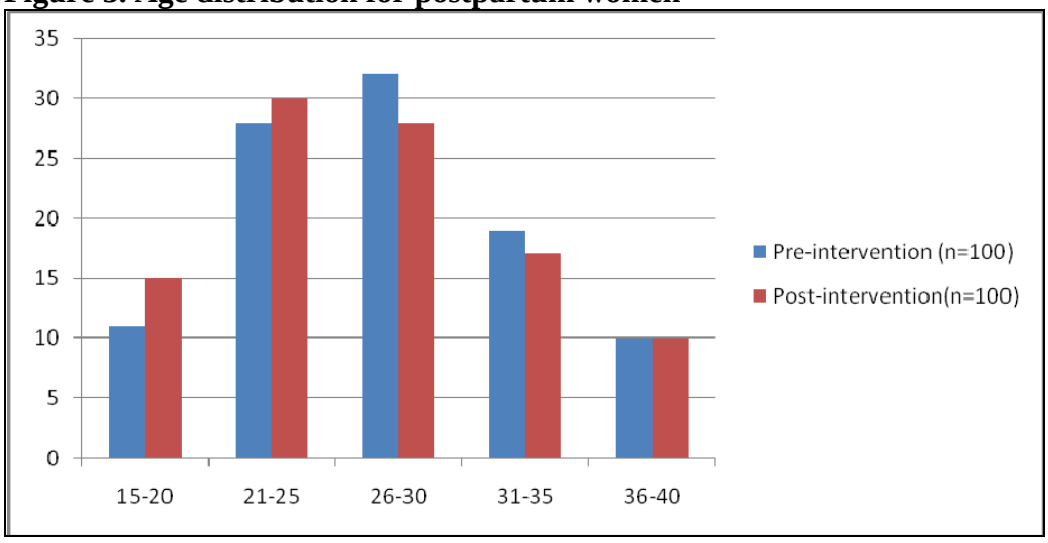
III. RESULTS

A. Postpartum Women

Respondent Profile

A total of 200 postpartum women (100 for pre-intervention group and 100 for post-intervention group) participated in the evaluation. The average age was 27.5 years old at pre-intervention (range=16-40, SD=5.7), and 27.0 years old at post-intervention (range 15-39, SD= 5.6). Most of these women were within three days postpartum (80%, 80/100 at pre-intervention and 70%, 70/100 at post-intervention). There was no significant difference in age distribution and number of days postpartum between the two groups. See **Figure 3** for the breakdown of age distribution for both pre-intervention and post-intervention groups.

Figure 3. Age distribution for postpartum women



The evaluation did not collect information on women's education, home location and household income, as the respondents may have become inhibited when responding to questions. It was assumed that those women's social and economic characteristics were similar.

During the six-month follow-up data collection effort, 53 women from the pre-intervention group and 58 women from the post-intervention group were reached. After comparing age and parity, there was no significance difference between those who were reached verses those who were not reached.

Discuss FP with Providers

In the pre-intervention group, most women (94%, 94/100) reported that they wanted to discuss FP options with their providers. The remaining 6% (6/100) said they did not want

to discuss FP because they had enough related information already. Despite the demand for FP information, only four women reported receiving it and none received a FP method. One was asked to come back at a later date. None of the women reported receiving any written FP materials during postpartum care services at the facility.

In the post-intervention group, the desire to discuss FP options with providers remained high (95%, 95/100), but there was a significant increase (p-value less than 0.05) in the proportion of women who reported discussing FP with providers, who reported receiving FP information, and who reported receiving a method (all were Lactational Amenorrhea Method [LAM]). **Table 1** presents data on the above variables for both pre-intervention and post-intervention groups.

Table 1. Percentage of women who discussed FP options with their providers and/or reported receiving FP information and/or a method for pre- and post- intervention groups

Variable	% at pre-intervention (n=100)	% at post-intervention (n=100)
Discussed FP with providers	4	92
Reported receiving FP information	0	94
Reported receiving a FP method	0	70

Breastfeeding and Use of LAM at Pre-discharge

In the pre-intervention group, the vast majority of women (96%) said they were breastfeeding or intended to breastfeed at pre-discharge, but none of the women reported discussing LAM with the providers. LAM is a modern, temporary contraceptive method based on natural infertility resulting from certain patterns of breastfeeding, and is over 98% effective when women meet the following three criteria: (1) Menstrual periods have not resumed; AND (2) The infant is full or nearly fully breastfed frequently both day and night; AND (3) The infant is under six months of age[10]. While the majority (85%) of respondents claimed they were using LAM, only six out of 85 women were able to correctly name the three criteria for LAM without probing. However, the translation of "LAM" into Albanian was difficult, and interviewers reported that women did not understand the correct term. It was interpreted as "breastfeeding that provides protection from pregnancy," which could have been misunderstood by women as the traditional belief is that any breastfeeding does have a contraceptive effect.

In the post-intervention group, 95% of women said they were breastfeeding or intended to breastfeed at pre-discharge. Among these, the majority (87%, 83/95) of postpartum women reported their intent to use breastfeeding for the first six months as a FP method (referring to LAM) after probing, and more than two-thirds (71%, 59/ 83) were able to correctly name the three LAM criteria without probing. LAM was described as a

[10] World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project. *Family Planning: A Global Handbook for Provider*s.(2008 update). Baltimore and Geneva: CCP and WHO, 2008.

contraceptive method based on breastfeeding with the three criteria, which eliminated any confusion.

Breastfeeding and Use of LAM at Six Months Postpartum

In the pre-intervention group, 79% (42/53) of women continued breastfeeding at six-months postpartum, but it was unclear if other food was introduced. Four women said they used LAM (all were able to name the three criteria) but had stopped by the time of interview. The length of LAM use varied among these women: two used for four months; one used for five months; and one used for six months. Notably, three out of the four women were using condoms after they stopped using LAM.

In the post-intervention group, similarly, 78% (45/58) of the women were still breastfeeding, including two women who introduced other food to the children, 19% (11/58) had stopped breastfeeding, and 3% (2/58) said they did not breastfeed at all. The majority (93%, 54/58) of women recalled being counseled on LAM. Of these, 24% (13/54) of them reported using it at any time after delivery (ranging from three to six months). Among those 13 women, two were using a modern FP method (one injectables and one condoms), while nine were using the withdrawal method at the time of the follow-up interview.

Anecdotally, postpartum women who did not breastfeed were more likely to have their menses returned by six-months postpartum, which was consistent for both the pre-intervention and post-intervention groups. **Table 2** illustrates the breastfeeding status and return of menses.

Table 2. Percentage of women who ever breastfed, by return of menses for pre-intervention and post-intervention groups

Pre-intervention	**Menses returned since the birth of last baby**		
	Yes	**No**	**No. of women**
Have you ever breastfed your baby			
Yes, still breastfeeding	69%	31%	42
Yes, but stopped as of now	100%	-	6
No	100%	-	5
Post-intervention	**Menses returned since the birth of last baby**		
	Yes	**No**	**No. of women**
Have you ever breastfed your baby			
Yes, still breastfeeding	60%	40%	45
Yes, but stopped as of now	91%	9%	11
No	100%	-	2

Use of FP and Method Mix at Six Months Postpartum

In the pre-intervention group, 34% (18/53) of women thought they were at risk of getting pregnant but only 15% (8/53) of them were using a modern FP method (all condoms – one obtained from a FP clinic and seven obtained from pharmacies outside the facility). In addition, 77% (41/53) were using the withdrawal method, and the remaining 8% (4 /53) were not using any method.

In the post-intervention group, nearly half (47%, 27/58) of the women knew that they were at risk of getting pregnant at six-months postpartum. However, only 12% (7/58) of them were using a modern FP method: condoms (five); female sterilization (one); and injectables (one). In addition, 80% (46/58) were using the withdrawal method, and the remaining 9% (5/58) were not using any method.

Fertility Preferences at Six Months Postpartum

In the pre-intervention group, 36% (19/53) of women said that they would like to have more children in the future, while 34% (18/53) did not want any more children, and 30% (16/53) were undecided. For those who would like to have more children, the majority (95%, 18/19) wanted to wait at least two years after the birth of their last child.

In the post-intervention group, 45% (26/58) of women said that they would like to have more children in the future, while 36% (21/58) did not want any more children, and 19% (11/58) were undecided. Similarly, the majority (88%, 23/26) of those who wanted more children said they wanted to wait at least two years after the birth of their last child.

Overall, the desire for having more children decreased as parity increased. This trend was observed at both the pre-intervention and post-intervention, and is consistent with the results of the 2008-09 ADHS.

Feedback on Client Materials

In the pre-intervention group, none of the women reported receiving any materials related to FP prior to discharge.

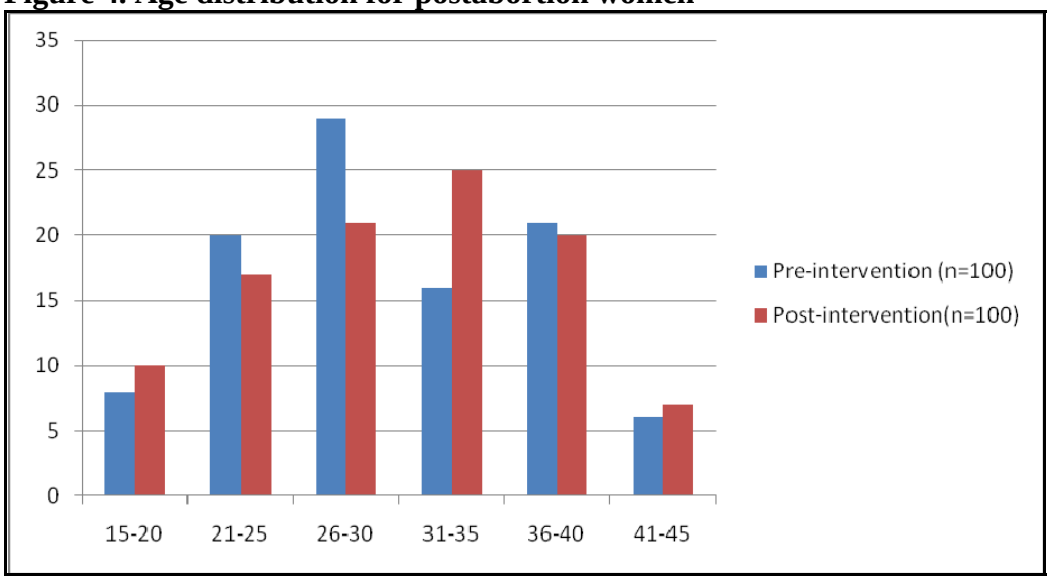
In the post-intervention group, the vast majority (94%, 94/100) of women said that they received FP materials during their client exit interview. At the six-month follow-up, 71% (41/58) of women remembered receiving FP materials at the maternity hospital, mostly (78%, 32/41) from staff at the maternity ward. Of these, over half (59%, 24/41) said the materials were helpful, 29% (12/41) said they were not helpful, and 12% (5/41) said they never read the materials.

B. Postabortion Women

Respondent Profile

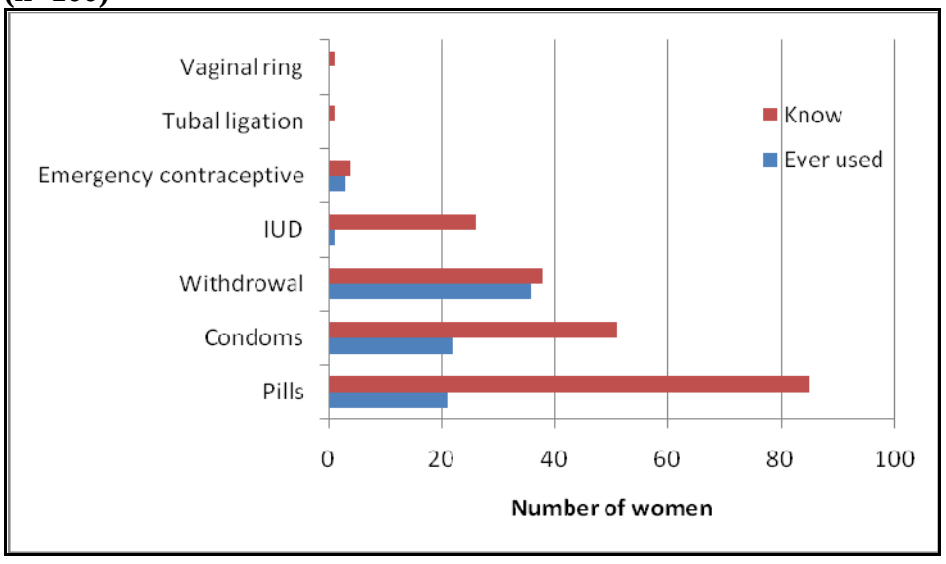
A total of 200 postabortion women (100 from the pre-intervention group and 100 from the post-intervention group) participated in this evaluation. The average age was 30.1 years old at the pre-intervention (range=18-44, SD=6.8) and 30.7 years old at the post-intervention (18-43, SD=6.8). There was no significant difference in age distribution between the pre-intervention and post-intervention groups. **Figure 4** illustrates the age distribution from both groups.

Figure 4. Age distribution for postabortion women



Knowledge of FP was also similar between the pre-intervention and post-intervention groups. **In the pre-intervention group,** almost all women (99%) said that they knew about some contraceptive options prior to the visit. **Figure 5** provides information on respondents' unprompted knowledge of FP methods. The methods most commonly known include oral contraceptives (pills), condoms, withdrawal and IUD. The methods most used by women were withdrawal, followed by condoms and oral contraceptives. **In the post-intervention group,** 93% of women said that they knew about some contraceptive options prior to the visit. The methods most commonly known and used were similar in the pre-intervention group.

Figure 5. FP methods mentioned and used prior to abortions at pre-intervention (n=100)



During the six-month follow-up, no women from the pre-intervention group[11] and 31 women (out of the 55 who agreed to be followed up at the client exit interview) from the post-intervention group were reached. Due to the small numbers, it is difficult to draw conclusions of any differences between those who were reached verses those who were not reached.

FP Information and Services Received at the Facility

In the pre-intervention group, about four-fifths of women (80%, 80/100) said that they wanted to discuss FP options with the providers, but only one-fifth (20%, 16/80) did so. Of those who discussed FP, 13 women received another appointment, two were referred to another facility, and one said that she did receive a method but it was not her method of choice[12]. The remaining 64 women received neither FP counseling nor referral.

The 20 women who reported that they did not want to discuss FP options gave the following reasons: have enough knowledge about FP (8); discussed FP before abortion or at polyclinic already (4); do not want to or do not need (3); stated it is her responsibility (1); she can plan for herself (1); did not like it (1); said she is too old (1); and no response (1).

In the post-intervention group, 86% (86/100) of the women wanted to discuss FP methods with providers. In addition to the 86 women, another eight women also discussed FP methods with their providers. In total, 94 women (94%, 94/100) reported discussing FP information prior to discharge from postabortion care. For those 14% (14/100) who didn't want to discuss FP, the reasons were as follows: said she was informed (10); said leaflets were enough (2); don't like someone to talk to her about such issues (1); didn't need such info (1). While women appeared to have some knowledge about FP, almost three-fourths (74%, 74/100) of them did not know that fertility returns as early as 11 days after an abortion.

Of those women who discussed FP with a provider, over one-third (41%, 38/94) received a FP method immediately after abortion at the facility. Of those, 19 women (50%, 19/38) received pills, 11 women (29%, 11/38)) received condoms, and 9 women (24%, 9/38) received an initial injection of Depo Provera. Almost two-thirds (66%, 25/38) reported that the method given was the method of their choice. Among these who did not receive a method (n=62), 16% (10/62) expressed interest in the IUD, including seven with future appointment dates for insertion.

Use of FP and Method Mix at Six Months Postabortion

In the post-intervention group, no one (0 out of 31) was pregnant at the time of follow-up, although two women reported having had repeat abortions during the last six months. Both of these women were using the withdrawal method, which failed. After the second abortion, one woman started an injectable (Depo Provera for three months at the time of follow-up) and the other one was still using the withdrawal method.

[11] During pre-intervention data collection, only 27% (27/100) postabortion women agreed to be called for follow up and none of them was reached at six-month follow-up.

[12] This client requested oral contraceptives, but received counseling about the Standard Day Method instead

One woman who responded to a follow-up call reported that she wanted to get pregnant and thus was not using a contraceptive method. She said: *"I want to get pregnant. I did the abortion six months ago, and the doctor told me to wait six months before starting the other pregnancy. During these six months, I was once afraid of getting pregnant and I used emergency contraception"* Excluding this women wishing to get pregnant, all (100%, 30/30) women used a FP method at the time of the call. However, less than half (45%, 14/30) were using a modern method while the remaining (55%, 16/30) were using the withdrawal method. **Table 3** illustrates the method mix and length of use among postabortion women at six-month follow-up. As there was no comparison from the pre-intervention group, any improvement would not to be able to be captured.

Table 3. Main method and length of use among postabortion women at six-month follow-up (n=30)

Main method used	Using the main method without stopping				
	1 Month	3 Months	4 Months	6 Months	Total
Pill	0	2	1	2	5
IUD	1	0	1	0	2
Injectables	0	1	0	0	1
Condom	0	0	1	5	6
Withdrawal	0	0	1	15	16
Total	1	3	4	22	30

A few women were using a second FP method to prevent pregnancy. One woman used a condom as a second method in addition to withdrawal; four used withdrawal in addition to condoms; and three women use EC in addition to withdrawal. They reported using the second method when they didn't use or didn't have the first one, or were afraid of getting pregnant.

Client Materials

In the pre-intervention group, no one received any client materials on postabortion FP prior to discharge.

In the post-intervention group, more than three quarters (77%, 77/100) of postabortion women reported receiving materials on postabortion FP prior to discharge for them to take home. At the six-month follow-up, the majority (81%, 25/31) reported remembering the FP materials they had taken home after the abortion. Women who remembered the FP materials were also more likely to be using a modern method at six-month follow-up (p-value less than 0.05). See **Table 4** for percentage distribution.

Table 4. Percentage of women who remembered the FP materials, by use of modern method at six-month postabortion (n=30)

	Remembered FP materials taken home after abortion		
	Yes	**No**	**No. of women**
Use of modern FP method			
Yes	100%	-	14
No	63%	37%	16

IV. DISCUSSION

Characteristics of Postpartum and Postabortion Women

The age distribution for postpartum and postabortion women demonstrated a pattern consistent with typical childbearing patterns in Albania for both the pre-intervention and post-intervention groups. The majority of the postabortion women were between 26-40 years of age, implying that these women might be married or possibility having children already. Our findings are also consistent with other evaluations conducted among women of reproductive age in Albania, which found a lack of knowledge about modern contraceptive methods with the exception of condoms and oral contraceptives.[13]

In terms of actual FP practices, withdrawal, condoms and oral contraceptives were the most commonly used methods by postabortion women. A research study using a qualitative interview schedule[14] found that this may be due to the fact that Albanian married women thought that the withdrawal method and condoms are "more intimate" contraceptive methods. Consistent with findings elsewhere, postpartum and postabortion women in Albania expressed an interest in FP information and services. This indicates a potential for FP services to be effective, and shows that the integration of FP services will most likely have a positive effect, not only by informing women but also by encouraging them to access FP services, which will ultimately meet their FP needs.

Effect on Pre-discharge Counseling and Materials

A recent study in Pakistan demonstrated the potential to increase modern contraceptive use with pre-discharge counseling and postpartum information sharing15. Results of this evaluation support the programmatic assumption that demand for services increases with the level of information. It is important, though, for a woman to be able to internalize information received. Of special interest is the fact that all FP counseling and discussions with women at the facility were initiated by the service providers; simply putting out client brochures was not effective, as women did not take them. On the other hand, supplementing face-to-face counseling sessions with printed materials that support the messages was appreciated by women as the materials helped them remember the information and discuss it with their husbands and friends.

In Albania, ACCESS-FP focuses on the provision of FP services to postpartum and postabortion women during their stay at the facility, including ensuring the availability of printed information materials for women to take home at discharge, and contraceptive commodities for those women who wish to start a method while at the facility. It was demonstrated that the integration of FP with postpartum and postabortion services helps women to meet their FP needs at the time of pre-discharge with a significant increase of

[13] PRO Shëndetit: Two pager – Knowledge and use of modern methods of contraception: 2002 and 2005.
[14] Albania Family Planning Project. Results of interviews on family planning for development of Albanian family planning project behavior change strategy. July 2005.
[15] Saeed, G. et al. 2008. Change in trend of contraceptive uptake-effect of educational leaflets and counseling. Contraception. January 2008.

contraceptive use (76% postpartum women and 38% postabortion women). However, continuation of method use at six-month follow-up is low and the withdrawal method remains popular among postpartum and postabortion women.

Postpartum-specific Interventions

To incorporate FP services into postpartum care, ACCESS-FP conducted a series of workshops for providers, mostly nurses and midwives. During these three-day workshops, providers received a contraceptive technical update focused on the postpartum and postabortion periods, training in counseling skills, and embraced the concept of postpartum FP counseling. Through regular supervision visits, the program staff worked to encourage trained providers to use every opportunity to talk to women about LAM and other postpartum contraception methods while they are staying at the facility. The project developed several job aids for providers to facilitate the counseling process, as well as a selection of client materials that were used by providers to initiate discussions and then by clients to review again at home. Support from the hospital administration and the immediate supervisors were the most important factors in the providers' compliance with the new service.

In the postpartum setting, counseling of women was focused on: fertility return; encouragement to exclusively breastfeed; explanation of LAM and its three criteria; and appropriate contraceptive options for breastfeeding and non-breastfeeding women.

Postabortion-specific Interventions

With a goal to integrate FP with postabortion services, ACCESS-FP helped the maternal hospital to install a cabinet that stored FP methods inside the abortion department. Having these methods on hand helped providers (ob/gyns and midwives) bring the services closer to clients. Now, a woman can receive a FP method immediately after the procedure, which is very different from the practice that previously existed. Before, a woman was sent to the outpatient clinic for a FP method, or most often received the suggestion to do so after her menses returned. The staff of the abortion department appreciated having FP methods available right where they are needed.

Through ACCESS-FP's program implementation, over one-third of women receiving postabortion care accepted a modern FP method at the time of discharge, and six-months after, use of modern contraception was much higher than the national average per ADHS. In addition, results from the post-intervention group also demonstrated a need to provide IUDs in the abortion department as most of the referrals were for IUD insertions. In June 2008, ACCESS-FP introduced immediate postabortion IUD insertion but there were no insertions during the time of post-intervention data collection, as this service was not immediately embraced by providers or clients. In addition, at the time of the survey, contraceptive counseling was conducted after an abortion as part of postabortion care, and women were very hesitant to have another invasive procedure after they had already left the abortion room. This demonstrates that, in order to be effective, counseling on postabortion FP methods—the IUD in particular—should happen before the procedure rather than after. Women who were interested in IUDs but wanted to either talk to their husbands or come back later were given referrals.

V. Recommendations

Standardization and Institutionalization of Routine FP Integration

While contraceptive counseling and provision of methods have been successfully integrated in postabortion and postpartum care at the project sites, the quality of counseling services still remains limited in other facilities where ACCESS-FP is not present. Quality training, provision of job aids, and countless supportive supervision visits to the facilities by the project staff helped providers at the project sites embrace the new task, although not initially. Full support of the hospital directors and department heads was vital to achieving results. Nevertheless, lack of standards for service provision, performance standards, and, importantly, job descriptions for the providers presented a problem when introducing the new task in the every day work of the department. As a result, this may potentially hamper the future of the intervention. Success of the intervention (and ensuring that it becomes a norm) should not depend on the dedication of an individual person, but rather on standardization/institutionalization of the new services and providers' buy-in.

Addressing Unmet Need for FP

The results of the evaluation conducted by ACCESS-FP during 2008-2009 at one of the leading reproductive health facilities in the country—Queen Geraldine Hospital—demonstrated that the overwhelming majority of both postpartum and postabortion clients are interested in FP information. Therefore, there is a great deal of opportunity for improvement and, as the results of the evaluation showed, the maternity service is an excellent place to provide essential FP information and services.

Assuring Continuation of FP Use

Incorporation of provider-initiated FP counseling and services, complemented by various and appropriate client materials, in immediate postabortion and postpartum care in Albania proved to be successful, significantly increasing the level of modern contraceptive use at the time of discharge. Nevertheless, the challenge of method continuation several months after discharge has yet to be overcome.

Integration of FP services with maternal and child health services is a very promising approach, helping to meet FP needs of women in a very vulnerable period of their lives, thus improving their quality of life through the prevention of unintended pregnancies. To ensure that postpartum women who come to their primary health care (PHC) facilities for further care receive high-quality FP services, it is necessary to ensure that the PHC staff is able to provide information on the benefits of breastfeeding and healthy pregnancy spacing, and to counsel on the correct use of LAM and other appropriate FP methods. A new mother visits a pediatrician for well-baby visits approximately 15 times during the first year postpartum, and therefore pediatricians and pediatric nurses are in the best position to offer information about fertility return and appropriate methods of contraception for both breastfeeding and non-breastfeeding mothers. Also, family physicians are usually the first point of contact for women with service provision, and

they should be able to initiate a discussion on woman's fertility plans and contraceptive options.

Sustainability

It is worthwhile to mention that, at the time of finalization of this report, the Ministry of Health (MOH) of Albania approved the first National FP Clinical Protocols as a national standard for provision of FP services on all levels of care. The development of these protocols was supported by ACCESS-FP in collaboration with the MOH and local reproductive health experts during 2008-2009. While it is encouraging, there is still a need for performance standards to ensure the quality of services and sustainability. Furthermore, a successful program approach should ensure that high-quality training for providers is complemented by an enabling environment that includes supportive supervision, availability (and knowledge) of job descriptions that include specific FP responsibilities, and performance standards for the relevant services. More effort must be put forward in order to address these areas.