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FAMILY PLANNING SITUATION ANALYSIS 2007



The Europe and Eurasia Regional Family Planning Activity

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John Snow, Inc. implements the Europe and Eurasia Regional Family Planning Activity.

The views expressed in this document do not necessarily reflect those of USAID.

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ACRONYMS

ACSP	Albanian Child Survival Project
AFPP	Albania Family Planning Project
BCC	Behavior change communication
CDC	Centers for Disease Control and Prevention
CME	Continuing medical education
COC	Combined oral contraceptive
COPE	Client-oriented and provider-efficient methodology
CPR	Contraceptive prevalence rate
DHS	Demographic and Health Survey
EU	European Union
FP	Family planning
GDP	Gross domestic product
GP	General practitioners
GOA	Government of Albania
HII	Health Insurance Institute
HIMS	Health information management system
IEC	Information, education, and communication
IPH	Institute for Public Health
IUD	Intrauterine device
JSI	John Snow, Inc.
KfW	Kreditanstalt für Wiederaufbau
LAM	Lactational amenorrhea method
LMIS	Logistics management information system
MMR	Maternal mortality ratio
MWRA	Married women of reproductive age
MOH	Ministry of Health
Ob/gyn	Obstetrician/gynecologist
ONC	Outreach negotiation counseling
PHC	Primary health care
PHR*plus*	Partners for Health Reform*plus*
POP	Progestin-only pill
RHS	Reproductive Health Survey
RHU	Reproductive Health Unit
SDP	Service delivery point
SEATS	Family Planning Service Expansion and Technical Support
STI	Sexually transmitted infection
TASC	Maternal and Child Health Technical Assistance and Support Contract
TFR	Total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

SUMMARY

In the early 1990s, Albania emerged from nearly 50 years of communist repression and severe isolation. The transition from a centralized economy in a rigid communist state to a free market economy in a democratic republic has been neither smooth nor easy. Successive governments have struggled to deal with high unemployment, widespread corruption, a dilapidated physical infrastructure, powerful organized crime networks, and continual political infighting. Over the past decade and a half, Albania has undergone major political, economic, and social changes that have affected almost all aspects of Albanian life, including health outcomes and health care service delivery. These transition years have also resulted in marked lifestyle changes and have exposed the population to new health risks.

Albania is one of the poorest countries in Europe and is the Eastern European country with the highest level of poverty, ranking 73rd among the 177 countries on the United Nations Development Programme (UNDP) 2006 Human Development Index. Any analysis of Albania's health status is made difficult by data limitations. The available data are scarce and often of questionable reliability. While all data sources show an improvement in key health outcome indicators over the past decade, different data sources paint different pictures as to how well Albania is faring compared to other countries in the region. By most accounts, Albania compares relatively favorably to other lower middle-income countries outside the Europe and Central Asia region, but not to other lower middle-income countries in the South East European region.

Albania's total fertility rate (TFR) is estimated to be between 1.8 and 2.03, generally achieved by using withdrawal and the occasional condom, backed up by legal voluntary abortion. Modern family planning method knowledge and use are extremely low, but there is evidence that this is rapidly changing. Family planning (FP) services and free commodities are now available down to the commune level through a network of 429 Ministry of Health (MOH) maternities, women's consultation rooms, and health centers. Method choice and availability are still a challenge. While condoms, pills, and injectables are widely available, intrauterine device (IUD) access and availability are limited, as is the availability of emergency contraception. Permanent methods are effectively not available.

TEN BEST FAMILY PLANNING PRACTICES IN THE EE/EA REGION

To better understand the situation in Albania, the Activity reviewed progress against ten regional best family planning policy and program practices. This list is based on the 2005 Senlet and Kantner report, "An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region," a recent literature review on global best family planning practices and programs, and field interviews in selected countries participating in USAID's Europe and Eurasia Regional Family Planning Activity program. These best practices include:

1. **Liberalized provision of FP services.** National health regulations require that family planning counseling and services are readily available through a range of health professionals, including not only obstetricians and gynecologists, but also family doctors, general practitioners, pediatricians and nurse/midwives.

2. **Family planning counseling, services, and contraceptives are part of the Basic Health Benefit Package**. At the primary health care level contraceptives are provided to all women, regardless of ability-to-pay. The country's Essential Drug List includes a mix of different types of contraceptives.

3. **Up-to-date and evidence-based policies, regulations, standards, guidelines and supportive supervision systems are in place to ensure the quality of family planning services at all levels of health care:**

    a) **Service providers –** A **c**ompetency-based national qualification system is in place that allows health professionals to provide quality family planning counseling and services;
    b) **Up-to-date national regulations set minimum standards** for health facilities, equipment, commodities and infection prevention;
    c) **National guidelines and protocols for family planning counseling and service delivery** are evidence-based, widely available and updated regularly;
    d) **Effective quality assurance and supportive supervision systems** are in place to ensure the quality of family planning services and strengthen provider performance and support, especially at the primary health care level;
    e) **National health protocols** require that postpartum and postabortion women are offered family planning counseling, methods and services**;**
    f) **Breastfeeding and the lactational amenorrhea method (LAM)** are promoted as family planning methods.

4. **A broad range of family planning methods are available, accessible, affordable, and acceptable** in both rural and urban areas.

5. **Special programs are in place that are designed to meet the needs of vulnerable target groups**, such as adolescents, internally displaced persons (IDPs), new urban migrants, prostitutes, and the very poor.

6. **Family Planning is part of pre- and in-service training programs for health care providers.** This includes the pre-service training programs in medical universities and technical schools for nurses, as well as in-service training for continuing medical education for doctors and in-service training for re-licensing health professionals, including midwives and nurses.

7. **Contraceptive security is ensured through adequate planning within the government,** guided by a well-functioning Logistics Management Information System (LMIS) that enables targeting of subsidized contraceptives and efficient supply chain management of all contraceptive commodities throughout the country.

8. **Adoption of a "culture" that promotes family planning counseling,** where providers and clients engage in frank and regular conversation about sensitive reproductive health issues and family planning and appropriate services are offered.

9. **Family planning is actively promoted through social marketing and behavior change/social mobilization efforts**, including wide distribution of quality informational materials for clients and "job aids" for providers.

10. **A well-functioning national health management information system** collects, analyses and uses FP data to monitor progress and evaluate and improve program effectiveness.

Albania has made substantial progress in strengthening family planning programs in several key areas. At the same time, there is room for further improvement. The following table describes Albania's progress against the ten family planning best practices described above.

Summary Table of the Albania Situation Analysis

Best Practices	Existing Situation	Needs Improvement
#1: Liberalized provision of FP services	• FP services widely available at the primary health care level and maternity hospitals • Both doctors and midwives at the community level counsel and supply hormonal contraceptives and condoms	• Only ob/gyns are allowed to provide IUDs • Other health practitioners (e.g., pediatricians) do not provide FP counseling and services
#2: Family planning counseling, services and contraceptives are part of the Basic Health Benefit Package	• Contraceptives in the public sector are free	• FP is not well defined in Basic Health Benefit Package • Contraceptives not included in the essential drug list
#3: Up-to-date and evidence-based policies, regulations, standards, guidelines and supportive supervision system are in place to ensure quality of FP services at all levels of health care	• Supportive supervision and quality assurance systems are in place in pilot districts	• Supportive supervision and quality assurance systems are not institutionalized nationwide • Updated evidence-based national FP guidelines are not available • Lack of postpartum and postabortion guidelines and services • LAM is not promoted as a FP method
#4: A broad range of FP methods are available, accessible, affordable, and acceptable in both rural and urban areas	• A wide variety of contraceptives are available through the commercial sector • Free contraceptives are available through public health care facilities	• Lack of access to IUD services • Lack of access to voluntary sterilization
#5: Special programs designed to meet the needs of vulnerable target groups are in place	• Some UNFPA-funded youth programs exist	• Services for vulnerable groups are limited
#6: FP is part of pre-and	• USAID funded projects	• Lack of basic contraceptive

in-service training program for health care providers	provide FP training for heath care professionals	technology pre-service training for doctors and nurses • Training of ob/gyns for IUD is not competency-based • Continuous Medical Education System is not in place
#7: Contraceptive security is ensured through adequate planning within the government	• LMIS being used nationally • Ministry of Health has assumed central warehousing and distribution • Ministry of Health plans to assume full cost of commodities by 2010 • Subsidized contraceptives are available from social marketing program • Donated and government procured contraceptives are free in public sector	• Lack of forecasting and trends analyses • Lack of a market segmentation strategy
#8: Adoption of a "culture" that promotes family planning counseling	• Strong providers' in-service counseling training at primary health care and community level	• Limited counseling in maternity hospitals and Women's Consultation Centers
#9: FP is actively promoted through social marketing and behavior change/social mobilization efforts	• Active social marketing program • BCC through mass media and print materials • Community mobilization using household visit strategy	• Need to strengthen and synchronize social mobilization efforts
#10: A well functioning National Health Management Information System is in place	• National HMIS developed and used	• HMIS and LMIS are not synchronized

I. PURPOSE AND METHODOLOGY

PURPOSE

This review of the family planning situation in Albania was conducted as part of the USAID-funded Europe and Eurasia Regional Family Planning Activity. The Activity is a regional effort with an overall goal to leverage best practices in family planning in order to accelerate family planning program implementation across the region and ultimately, to increase modern contraceptive use and decrease abortion rates.

This desk review is designed to:

- Assess factors that affect family planning service delivery in Albania;
- Identify and document supportive policies and best practices in family planning program implementation; and
- Propose recommendations for scaling up best family planning practices and new interventions to improve program effectiveness and increase utilization of contraception.

This Albania review is one in a series of situation analyses of the family planning environment in selected countries in the region, chosen for their interest in participating in this regional program. This document first describes the background of the country, with a special focus on the health care system and the status of reproductive health. Then, each of ten best practices is reviewed within the country context and recommendations are made for focusing further interventions and resources.

METHODOLOGY

In order to systematically assess the family planning situation in each of the priority countries, the Europe and Eurasia Regional Family Planning Activity team began by reviewing Senlet and Kantner (2005), "An Assessment of USAID Reproductive Health and Family Planning Activities in the Eastern European and Eurasian Region."

The team identified a list of ten family planning policy and program best practices based on the Senlet and Kantner assessment report, a literature review on global best family planning practices and programs, and field interviews in the region. The team conducted a review of available documents and an internet search to obtain additional information on country background, policies, and programs in family planning. These ten best practices are briefly described in Annex III.

John Snow, Inc. has worked on various family planning activities in Albania since the mid-1990s. This country summary is based on in-depth knowledge of the programming context that comes from this long-term field experience. The review's intention is to serve as a basis for discussion of country and regional priorities for family planning program improvement, based on the best available information. It is not intended as a comprehensive analysis of the country situation, but rather as a brief "snapshot" of this particular point of program development to guide future programming.

II. BACKGROUND

COUNTRY CONTEXT

In the early 1990s, Albania emerged from nearly 50 years of communist repression and severe isolation. The transition from a centralized economy in a rigid communist state to a free market economy in a democratic republic has been neither smooth nor easy. Successive governments have struggled to deal with high unemployment, widespread corruption, a dilapidated physical infrastructure, powerful organized crime networks, and continual political infighting. Over the

past decade and a half, Albania has undergone major political, economic, and social changes that have affected almost all aspects of Albanian life, including health outcomes and health care services. These transition years have also resulted in marked lifestyle changes and have exposed the population to new health risks.

Any analysis of Albania's demographic and health status is made difficult by data limitations. Data are scarce and often of questionable reliability. Data utilized in this document include official data from the MOH, the Albanian Institute of Statistics, and the Institute for Public Health (IPH) as well as data from international databases such as the World Health Organization (WHO), etc. The results of household surveys often provide a very different picture from that of the official data but, in some cases, are of questionable reliability despite the robustness of the methodology used. For example, the 2002 Albania Reproductive Health Survey (RHS) reported a number for induced abortions that was 64 percent *lower* than the official data, leading to the conclusion that the underreporting of abortions likely made the survey results unreliable.

As of July 2007, Albania's population was estimated at 3.2 to 3.6 million with a population growth rate of 0.5 to 0.8 percent. With over 50 percent of its population under the age of 24, Albania has the largest proportion of young people in Europe. Ethnically, Albania's population is estimated to be 95 percent Albanian, three percent Greek, and two percent other (Vlach, Roma, Serb, Macedonian, Bulgarian). Estimating religious affiliation is even more difficult. In 1967, all mosques and churches were closed and religious observances prohibited; only in November 1990 did Albania again allow private religious practice. A common estimate is 70 percent Muslim, 20 percent Albanian Orthodox, and 10 percent Roman Catholic. Albanians are generally considered to have near universal literacy, although many believe literacy levels have decreased since the early 1990s. In 2006, Albania's official per capita Gross Domestic Product (GDP) was US$5,700. However, Albania has a large informal economy that may be as large as 50 percent of official GDP.

In recent times, Albania's demographic profile has been characterized by three main phenomena: large internal and external migratory waves, improving mortality rates, and declining fertility rates. Massive migration occurred from the poorest rural areas to more developed urban centers, especially Tirana, the capital, and Durres, the largest port city.

Albania's TFR has decreased markedly over the past five decades, from about 6 in the 1950s to 3 in 1990 and 2.1 in 2001, which suggests the current TFR is at or slightly below replacement level. Other sources point to a somewhat higher fertility rate. The 2002 RHS estimated the TFR at 2.6 percent, which is only slightly higher than the 2.4 percent rate estimated by WHO and the 2.3 percent rate estimated by the United Nations Population Fund (UNFPA). Although all data sources point to an encouraging improvement in infant mortality over the past decades, Albania's infant mortality rates continue to compare unfavorably with those of other countries in the region. Likewise, although progress has been made, maternal mortality ratios (MMR) in Albania still appear relatively high in comparison with other Balkan countries.

Albania's epidemiological profile is changing. The relative burden of infectious diseases is decreasing while noncommunicable diseases, mainly cardiovascular diseases and cancer, have become the leading cause of death among adults. Infectious diseases are still a leading cause of infant and child deaths, but they are no longer a major cause of mortality among adults.

Sexually transmitted infections (STIs) are underreported, and no clear picture can be drawn from available figures. At present, no credible surveillance system for STIs is in place. Although Albania's HIV/AIDS prevalence is reportedly still low, Albania exhibits multiple risk factors that could lead to a rapid increase in prevalence, including high population mobility, human trafficking and drug abuse.

HEALTH CARE SYSTEM

Prior to the early 1990s, Albania's health care system was highly centralized, with the MOH regulating and delivering all health services in the country. Despite having a nationwide basic primary health care (PHC) network oriented towards the health of mothers and children, Albania's pre-transition health care system was led by secondary care (and largely remains so today). The construction of new facilities was favored over the maintenance and operation of existing infrastructure, which has led to considerable deterioration in facilities and equipment. Inadequate recurrent expenditures, obsolete drug therapies, and outdated medical skills have resulted in low quality of care and inefficient use of resources.

In terms of its administration, Albania was historically divided into 36 districts. These 36 districts have now been grouped into 12 regions or prefectures (*qarqe*, singular *qark*), with each prefecture consisting of two to four districts.

The MOH is still the main funder and provider of health care in Albania and private providers are very limited in number and scope. The MOH centrally operates through regional and district public health directorates. The MOH provides care through an extensive network of hospitals, maternities, polyclinics, women's consultation rooms, health centers, and health posts (*ambulanca*). Specialized services such as obstetrics/gynecology and pediatrics are integrated within the PHC system. Primary care teams led by general practitioners are supposed to act as gatekeepers for secondary care. However, bypassing is frequent due to the perceived low quality of services at the primary health care level.

The Institute for Public Health (IPH), attached to the MOH, is responsible for health protection (e.g., prevention and control of infectious diseases, national vaccination programs, and environmental health). IPH also works through the public health directorates. Other Ministries (Defense, Education, and Justice) also provide health care services, but their capacities are limited.

Over the past several years, health reforms have led to some reduction in the overextended provider network capacity and the decentralization of primary care management to district public health directorates. The pharmaceutical sector and most dental care were privatized, and a Health Insurance Institute (HII) was established to begin addressing health financing. Financing responsibilities have changed repeatedly over the past several years, with local governments at times expected to cover operating costs for primary care. As a result of dispersed funding sources, the lines of accountability are unclear, particularly at the primary care level.

The Government of Albania's (GOA) 2004 Long Term Strategy for the Development of the Albanian Health System spells out significant changes in the way it will organize and finance the health sector, including:

- Reorienting the role of the MOH away from service delivery towards policymaking and sectoral stewardship and strengthening its regulatory and oversight capacity;
- Increasing reliance on the HII as the key financier for health care services, with the HII contracting directly with providers for service delivery;
- Decentralizing service delivery by transforming hospital care providers into autonomous public entities under the governance of hospital boards. Primary care providers will eventually operate as independent providers or groups of independent providers; and
- Establishing regional health authorities that will have a planning function and responsibility for managing national public health programs.

The World Bank is Albania's primary donor in the health sector. In early 2006, the World Bank approved a US$15.4 million credit for Albania to help finance a Health System Modernization Project to improve both physical and financial access to health services with an emphasis on the poor and those in rural and remote areas. The Project is co-financed by the Government of Japan (US$1.6 million) and the Government of Albania (US$2.1 million).

REPRODUCTIVE HEALTH

Under the previous regime, Albania's government had strongly pronatalist policies aimed at substantially increasing the country's population. Consequently, family planning was illegal and services unavailable. Nevertheless, Albania's TFR shrank, highlighting the clear desire of Albanian couples to control their fertility through traditional methods like withdrawal and periodic abstinence or through abortion. Although illegal, unsafe, clandestine abortion was widely available. Consequently, while the TFR decreased, the MMR increased. By 1990, Albania's MMR was 60 deaths per 100,000 live births.

Following the collapse of communism, family planning and abortion were both legalized. Abortion was first legally practiced at maternity hospitals in 1991, after which the MMR dropped by half to about 30 deaths per 100,000 live births. Today, the TFR is estimated to be between 1.8 and 2.01 and the MMR 16.[1]

Albania continues to have high rates of legal voluntary abortion, although exact figures are elusive. Many abortions are now performed in the nascent private sector and go unreported. As noted, the 2002 RHS reported a number for induced abortions that was 64 percent *lower* than the official data. The main demographic and reproductive health indicators are summarized in Annex II.

In 2004, the data from the 2002 RHS were first reported. The Albania 2002 RHS showed very low levels of modern method use, very high levels of traditional method use, and exceptionally low levels of contraceptive knowledge. The reported knowledge levels for modern contraceptives were also surprisingly low for a population that is highly literate. Men were significantly less informed about modern contraceptive methods than women. Although knowledge and use of the lactational amenorrhea method (LAM) were not covered in the survey, the duration of exclusive breastfeeding reported was only 2.8 months.

[1] WHO Health for All Database. http://www.euro.who.int/hfadb, accessed July 2007.

Most likely because of the high use of withdrawal, the 2002 Albania RHS defined unmet need as the proportion of *all women* who are fecund, currently sexually active, currently exposed to risk of pregnancy, not wanting to become pregnant, and not using *modern contraception*. This differs from the conventional definition that considers only *women in union* not using *any method* of contraception. The unmet need for limiting was more than twice the unmet need for spacing.

III. TEN BEST PRACTICES IN FAMILY PLANNING: ALBANIA

BEST PRACTICE #1 – LIBERALIZED PROVISION OF FAMILY PLANNING SERVICES

JSI/SEATS II/Albania defined quality family planning service delivery based on three criteria: the presence of trained health providers, the availability of multiple modern methods of contraception, and the availability of IEC materials for clients. Counseling and re-supply of methods could be provided by a wide range of practitioners (specialists, general practitioners, nurses and midwives); by tradition, only ob/gyns insert IUDs.

The three sequential USAID-funded projects that had family planning as a main or key component then introduced facility-based family planning services in close to 100% of the MOH maternities, women's consultation rooms, and health centers down to the commune level throughout Albania's 36 districts by focusing on these three criteria. Training involved MOH doctors, nurses, and midwives. At Albania Family Planning Project's (AFPP) conclusion in July 2007, 429 MOH service delivery points (SDPs) reported the availability of family planning services.



JSI/SEATS II/Albania and JSI/TASC I/Albania also trained community midwives at the health post (*ambulanca)* level. In the first two projects, these midwives provided counseling and then referred clients to the nearest SDP for services; during the implementation of USAID funded AFPP, community-based midwives increasingly supplied injectables, pills, and condoms to their clients and referred for other services, thus increasing access.

In 1996, after field-testing with service providers and clients, the initial JSI/SEATS II/Albania project introduced a family planning logo to serve as the national symbol for the availability of quality reproductive health services. Mass media campaigns promoted the logo; 2007 endline survey showed that more than three quarters of married women of reproductive age (MWRA) could connect the logo with family planning both when shown on a clinic wall, as well as when they were asked out of context.

The contraceptive method mix in Albania is skewed toward re-supply methods (pills, condoms, injectables). The vast majority of the SDPs offering services reported that they provide

injectables, low-dose combined oral contraceptives (COCs), progestin-only pills (POPs), and condoms. Permanent and long-term methods (IUDs, female tubal ligation, and male vasectomy) have not been actively promoted and are not yet readily available, or available at all. Only a small number of SDPs (typically maternities, polyclinics and WCRs) offer IUD services since traditionally they are inserted only by ob/gyns. At present, the MOH does not stock or distribute emergency contraception. Health facility-dependent methods should increasingly be the MOH's "niche," with the private sector providing more and more of the re-supply methods—pills and condoms.

POTENTIAL FOCUS AREAS

- To expand access to IUDs, explore the feasibility of **training other practitioners, especially nurse midwives and family doctors, to provide IUD services.**

BEST PRACTICE #2 – FAMILY PLANNING COUNSELING, SERVICES AND CONTRACEPTIVES ARE PART OF THE BASIC HEALTH BENEFIT PACKAGE

Health care reform in Albania is still very much a work in progress. At present, because contraceptives are free, the financial barriers to accessing services are not overwhelming. However, should the MOH decide to impose criteria for receiving free commodities or should a "basic health benefit package" be defined that excludes family planning services, this situation would change drastically.

In 1992, Albania's Council of Ministers legalized family planning, allowed general practitioners to prescribe contraceptives, and introduced sex education into the educational system. In 1996, the MOH, by ministerial decree, ordered that MOH facilities distribute contraceptives free of charge. A reproductive health law, approved by the parliament in 2002, incorporated a reproductive rights-based approach. The GOA supports the Programme of Action of the International Conference on Population and Development, and considers reproductive health and reproductive rights as part of its development agenda, in line with regional development strategies and the Millennium Development Goals.

Historically, international donors have provided all contraceptives for the public and social marketing sectors—UNFPA and at one point USAID for the public sector and Kreditanstalt für Wiederaufbau (KfW) and at one point USAID for the social marketing sector. It should be noted that UNFPA has been the only source for POPs in Albania, and KfW the only source for emergency contraception (brand name Postinor).

In 2003, the GOA agreed to increasingly assume the cost of procuring public-sector contraceptives in a step-by-step fashion (while the UNFPA share correspondingly decreased) and, in 2005, the MOH began contributing to its own contraceptive costs.

In theory, health insurance is now mandatory in Albania, but less than half the population is actually covered. As might be expected in a country with a large informal labor market, coverage is significantly higher among the urban population and upper income groups. Active contributors account for less than one third of the active labor force, suggesting large contribution evasion. The introduction of user fees for outpatient care for those not covered by health insurance or for

those who circumvent primary care has not been applied evenly. This situation has tended to create uncertainty among providers and clients, leaving ample room for abuse. While informal payments are relatively modest for outpatient care, they are widespread and substantial for inpatient care.

POTENTIAL FOCUS AREAS

- To ensure that financial issues do not become a barrier to accessing quality family planning counseling, services, and commodities, **monitor Albania's evolving health financing situation to ensure that FP counseling and services are included** in any "basic health benefit package", that contraceptives are included on the essential drug list, and that the MOH continues to allocate funds for contraceptive procurement.

BEST PRACTICE #3 – UP-TO-DATE AND EVIDENCE-BASED POLICIES, REGULATIONS, STANDARDS, GUIDELINES AND SUPPORTIVE SUPERVISION SYSTEMS ARE IN PLACE TO ENSURE QUALITY FAMILY PLANNING SERVICES AT ALL LEVELS OF HEALTH CARE

Service providers

Counseling and re-supply methods can be provided by a wide range of practitioners. However, only ob/gyns currently insert IUDs.

Guidelines and protocols for FP service provision

At present, Albania does not have agreed upon guidelines or protocols for reproductive health or FP service provision.

In early 2007, with UNFPA support, the MOH agreed to reconstitute a previously existing National Reproductive Health Commission. The Commission was formed with four main technical subcommittees:

- Reproductive Health Policy, Strategy, and Legislation
- Norms and Standards for Reproductive Health Services
- Reproductive Health Situation Analysis and Indicators
- Social Aspects and Media in Support of Reproductive Health

The Commission did meet and the subcommittees also have met several times, but reportedly are still struggling with exactly how they should function.

Quality assurance and supportive supervision systems

Although not primarily a family planning project, the USAID-funded PRO Shendetit project has a strong quality improvement component and has introduced the client-oriented, provider-efficient (COPE) instrument originally developed by EngenderHealth as its quality improvement tool. COPE has been approved by the MOH for nationwide use. A Quality Center has also been established within the MOH.

JSI/TASC I/Albania and JSI/TASC II/AFPP both included an integrated field monitoring and evaluation system as part of their training component to assess the quality of the training sessions

and the ultimate integration of new knowledge and skills at the health facility level. The system consists of a series of monitoring checklists and forms that provide a guide for evaluation, promote a supportive approach to supervision, and elicit direct feedback from clients. In most visits, the District Inspectors for Mothers and Children participated in all follow-up activities, thus increasing their capacity to monitor FP activities, provide support to providers, be more aware of the challenges faced by providers and facilities providing family planning services, and help resolve problems (e.g., stockouts).

Postpartum and postabortion FP counseling and service provision

At present, Albania does not have an agreed upon standardized approach to providing postpartum/postabortion counseling and services. In the 2002 RHS, 62 percent of postabortion women reported receiving no contraceptive counseling and 84 percent reported receiving no contraceptive prescription or method.

Breastfeeding and LAM

At present, Albania does not have agreed upon guidelines or protocols for LAM beyond the content of the USAID-supported national FP curriculum. The UNICEF-supported Albanian Group for the Protection and Promotion of Breastfeeding provides limited training for health personnel, advocates for breastfeeding, and monitors implementation of the law on the marketing of breastmilk substitutes.

POTENTIAL FOCUS AREAS

- Incorporate a **supportive supervision** component in all FP training.
- To expand access, help the MOH develop upgraded/expanded standardized **postpartum/postabortion counseling and services** with a strong link to PHC services.
- To expand access, help the MOH strengthen its antenatal and postpartum counseling to emphasize the health benefits of breastfeeding for the infant and the contraceptive benefits for the mother (**LAM**).

BEST PRACTICE #4 – A BROAD RANGE OF FAMILY PLANNING METHODS ARE AVAILABLE, ACCESSIBLE, AFFORDABLE, AND ACCEPTABLE IN BOTH RURAL AND URBAN AREAS

The three sequential USAID-funded projects with family planning as a main or key component have made the re-supply methods (condoms, pills, injectables) increasingly available and accessible throughout Albania. Unnecessary screening and diagnostic procedures do not appear to be a problem. Low-dose COCs, injectables, condoms, and emergency contraception are available through pharmacies.

In September 2006, JSI/TASC II/Albania conducted a market segmentation analysis in Albania using a total market approach. A total market approach looks at the characteristics of existing and likely future markets to define the comparative advantages of commercial, social marketing, and public-sector actors in terms of ability and efficiency in delivering a range of products and services to different market segments, including the poorest. Using a total market approach strategy often leads to improved coordination and collaboration among sectors so that more total clients are reached and government subsidies go to those who most need them. The gradual

shifting of consumers with sufficient purchasing power out of the public sector and into the commercial sectors allows the private commercial sector to thrive alongside the subsidized sectors.

Although Albania has no formal market segmentation strategy for contraceptives, data collected in 2005 showed that de facto market segmentation was occurring. For example, NESMARK supplied 93 percent of the condoms distributed in the country, while the public sector provided the majority of IUDs (98%) and injectables (80%). The commercial sector was supplying an estimated 28 percent of oral pills in spite of having to compete with the 'free' and subsidized contraceptives being provided by the public sector and NESMARK. The commercial pills and NESMARK pills are low-dose COCs; only the MOH offers POPs.

Although the MOH is effectively the only current provider of IUD services, these services are in fact difficult to access. Only ob/gyns are allowed to insert IUDs, and these specialists are concentrated at the district level. Permanent methods are effectively not available at all. Emergency contraception is only available via NESMARK. The rate of exclusive breastfeeding is low, and LAM is not promoted for postpartum women.

POTENTIAL FOCUS AREAS

- To expand method choice, assess the availability and accessibility of **long-term and permanent methods** within the MOH system.
- To expand method choice and access, help the MOH develop a **long-term and permanent methods clinical training program** that focuses especially on IUD services using the "no-touch" insertion technique.
- To expand method choice and access, work with the MOH to add **emergency contraception** to their list of available contraceptive commodities.
- To support appropriate market segmentation and contraceptive security, collaborate as closely as possible with the **social marketing and commercial for-profit sectors**.

BEST PRACTICE #5 – SPECIAL PROGRAMS IN PLACE DESIGNED TO MEET THE NEEDS OF VULNERABLE TARGET GROUPS

To date, very little attention has been given to designing special programs to meet the needs of vulnerable target groups. UNFPA has supported limited efforts targeting adolescents (see Annex I) but there are no widely available youth-friendly services specifically organized and targeted to meet the needs of young people. Although sex education is permitted in the schools, the approach and content are reportedly not standardized.

Given the sizeable demographic shifts within Albania since the early 1990s, some NGOs have offered limited programs to reach new urban migrants but much more could be done. Albania's most marginalized citizens—the very poor, the Roma, and trafficked women—could benefit from outreach efforts specifically designed for them.

POTENTIAL FOCUS AREAS

- Conduct an **assessment to better understand the needs of Albania's various vulnerable groups** and determine the feasibility of developing outreach programs specifically tailored to their needs.

BEST PRACTICE #6 – FAMILY PLANNING IS PART OF PRE- AND IN-SERVICE TRAINING FOR HEATH CARE PROVIDERS

Currently, all medical, dental, and pharmacist training takes place at the University of Tirana in the capital. Nursing and midwifery training occurs in Elbasan, Gjirokaster, Korce, Shkoder, and Vlore, as well as Tirana. While the responsibility for licensing, employing, and planning for the health care workforce lies with the MOH, the responsibility for health professional education lies with the Ministry of Education.

Newly graduated physicians, nurse/midwives, and pharmacists are not usually familiar with the contraceptive technology and counseling concepts included in the national family planning curriculum developed by the USAID-funded programs and last updated in 2005 because family planning receives scant attention at the pre-service level. Likewise, it could be expected that ob/gyns would have additional exposure to contraceptive technology and counseling skills during their residency program, but again, in practice, this reportedly has not always been the case. Ob/gyn residents do learn to insert IUDs, but there is no standardized hands-on clinical skills training program.

To date, the three USAID-funded family planning programs have been the almost exclusive providers of in-service FP training. PRO Shendetit has been working with the MOH on a training program to improve the skills of general practitioners (GPs). The Faculty of Medicine has a team currently training trainers from among the most promising physicians in each prefecture. The prefecture teams will then train all GPs in the prefecture in 30 modules. The American Academy of Family Physicians is providing part of the training of the prefecture teams. Completion of this program moves GPs part way through a program that will certify them as family physicians.

There is a provider licensing system, but as yet no functioning system for periodic renewal (re-licensing) conditional upon completion of continuing education requirements. The MOH does have plans to create a Center for Continuing Medical Education.

POTENTIAL FOCUS AREAS

- **Collaborate with the various health professional training institutions to incorporate the national family planning curriculum into their existing curricula**, including the provision of training of trainers for faculty members using MOH trainers.
- **Collaborate with the ob/gyn residency program to strengthen its FP component**, especially with regard to postpartum/postabortion counseling and services and hands-on clinical skills with regard to IUD services (using the no-touch technique).

BEST PRACTICE #7 – CONTRACEPTIVE SECURITY IS ENSURED THROUGH ADEQUATE PLANNING WITHIN THE GOVERNMENT

Contraceptives are available from three sources in Albania: at no cost from the government (although "informal" payments and "gifts" to providers are common); at subsidized prices from social marketing programs; and at market prices from the commercial for-profit sector (primarily Schering).

With the collaboration of the JSI/Family Planning Logistics Management (now DELIVER) project, JSI/SEATS/Albania worked with the MOH and UNFPA to design, field-test and install an LMIS beginning in 1996. The system collects service statistics—first visits, re-visits, counseling visits, total visits, and couple-years of protection generated—as well as contraceptive logistics data.

The program trained relevant service providers and public health officials at the service sites, at district-level Directorates of Public Health and at the central MOH. It also provided continuous support and supervision as the LMIS was installed in each new district. As a rule, as service providers were trained in FP in new districts, the health centers were stocked with relevant IEC materials and staff trained in the use of the LMIS.

In mid-2002, the LMIS was introduced as a national system. The creation of a truly national LMIS enabled the MOH, for the first time, to estimate total national contraceptive requirements. The LMIS was computerized centrally during JSI/TASC I/Albania and installed in the MOH's Reproductive Health Unit (RHU). In mid-2005, after discussions within the MOH and with AFPP, the Vice-Minister of Health decided to shift LMIS operations from the MOH's RHU to the IPH's Health and Reproductive Health Indicator Department where there would be more technical and administrative support for the LMIS. This shift required increased training and technical assistance to IPH, but, in the long term, it has the potential to fully institutionalize the LMIS within the government system. In mid-2006, IPH also assumed responsibility for the central-level warehousing and distribution of contraceptives, a function UNFPA had performed previously. The process of converting the district-level LMIS to an electronic system is underway. UNFPA provided 36 computers, one for each district.

In 2003, a National Contraceptive Security Strategy was developed and signed by the Minister. A key component of the strategy is the commitment of the GOA to increasingly assume the cost of procuring public-sector contraceptives in a step-by-step fashion (while the UNFPA share correspondingly decreases). Under this agreement, by 2010, Albania will be completely self-reliant and independent of outside donor support for contraceptives.

POTENTIAL FOCUS AREAS

- To support contraceptive security, collaborate with IPH, the MOH, and UNFPA to **further institutionalize the LMIS and develop Albania's capacity to forecast its needs and make procurements** in a timely fashion.

BEST PRACTICE #8 – ADOPTION OF A "CULTURE" THAT PROMOTES FAMILY PLANNING COUNSELING

The development of family planning counseling skills has received considerable attention at the in-service level. The initial USAID-funded FP project—JSI/SEATS II/Albania—developed a three- to four-day contraceptive technology update/interpersonal communication and counseling curriculum for doctors, nurses, midwives, and pharmacists that covered contraceptive methods, client counseling and STI prevention. The training strongly emphasized a client-centered approach to service provision and the development of appropriate counseling and communication skills. Laminated cue cards were developed for the providers to use to support and improve their counseling skills and strengthen the content of the information they provided to clients. The cards covered ten methods: condoms, spermicides, low-dose COCs, POPs, LAM, injectables, IUDs, male (vasectomy) and female (tubal ligation) voluntary surgical contraception, and emergency contraception.

The JSI/TASC I/Albania project revised and updated the curriculum to give even more focus to counseling. Attempting to train the newly privatized pharmacists by engaging them in formal training had turned out to be exceedingly difficult during the previous project; therefore, a more informal system of on-site visits and orientation to the use of the counseling cue cards and client brochures was adopted. Given that two social marketing projects that targeted pharmacists were by then operational in Albania, this approach seemed to function reasonably well, if not optimally. In early 2005, JSI/TASC II/AFPP again reviewed and updated the FP curriculum to more clearly emphasize needed counseling skills and also updated the supporting cue cards. This revised curriculum was then officially approved by the MOH.

In mid-2006, based on formative research results as well as the needs suggested by the 2002 RHS, AFPP introduced an innovative approach to community outreach and mobilization called Outreach Negotiation Counseling (ONC) and piloted it in two districts. The intent of ONC was to increase women's access to information about the benefits of FP and the modern methods available to help women/couples achieve their reproductive health goals. This pilot effort utilized community midwives to communicate directly with married women and couples regarding FP, usually in their home. The ONC pilot results were extremely promising. To achieve this, AFPP developed an ONC curriculum and supporting cue cards and trained a small group of trainers. The MOH and IPH both showed considerable interest in this innovative approach to community outreach and counseling.

POTENTIAL FOCUS AREAS

- In all programmatic efforts, continue to stress the **need for an evidence-based, client-centered approach** that supports the concepts of voluntarism and choice.

BEST PRACTICE #9 – FAMILY PLANNING IS ACTIVELY PROMOTED THROUGH SOCIAL MARKETING AND BEHAVIOR CHANGE/SOCIAL MOBILIZATION EFFORTS

Currently, the KfW-funded NESMARK project is the only social marketing program operational in Albania; NESMARK's share of the market is considerable.

Table 1: Contraceptive Market Share as Percent of the Total Market, 2005

Sector	Pills	Injectables	IUDs	Condoms
Public Sector (MOH)	29%	80%	98%	7%
Social Marketing (NESMARK)	43%	20%	0	93%
Private Commercial Sector	28%	0	2%	0
	100%	100%	100%	100%

Source: Contraceptive Security Report March 2006

NESMARK on occasion has had disagreements with the MOH over pricing and has withdrawn its products from the market. This action results in considerable disruption of contraceptive supply, especially with regard to pill demand at MOH facilities and with regard to emergency contraception. NESMARK is currently Albania's only provider of emergency contraception.

NESMARK has always done BCC via print and mass media. In recent years, NESMARK was pressured by its funder to become more self-sustaining. Consequently, NESMARK saw its pill brands as being somewhat in competition with MOH pill brands and its media efforts pushed NESMARK brands rather than improved method knowledge or modern contraceptive use. With KfW support, NESMARK has recently re-oriented itself and has returned to a more generic promotion of modern FP method use.

All three USAID-funded family planning projects have had a robust BCC/social mobilization component involving logo promotion, method-specific print materials, mass media (both radio and television), bus-side ads, and community events. The AFPP ONC pilot was an innovative approach to community mobilization that appeared well received. PRO Shendetit uses a somewhat different, but complementary, approach to community mobilization, and family planning is a key topic. The USAID-funded ACSP also has community mobilization as a key strategy and family planning as a key topic within that strategy.

POTENTIAL FOCUS AREAS

- Closely **co-ordinate any further BCC/social mobilization efforts** with NESMARK, PRO Shendetit, and ACSP.
- Encourage the MOH, IPH, and ACSP to **expand use of ONC**.

BEST PRACTICE #10 – A WELL FUNCTIONING NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM COLLECTS, ANALYZES AND USES FAMILY PLANNING DATA

More than five years have passed since the 2002 RHS was conducted. Reportedly, major donors, including USAID/Albania, are negotiating with the GOA and each other to plan and fund a Demographic and Health Survey (DHS). A DHS would be extremely informative and useful for Albania.

In addition to the functioning LMIS now institutionalized at the IPH, USAID's PRO Shendetit has invested considerable resources in designing a Health Information Management System (HIMS) to be implemented nationwide. At various points, merging or synchronizing the LMIS

with the HIMS has been discussed, but this has yet to happen. Some logistics data is time-sensitive, so it may never make sense to completely merge LMIS and HIMS, but they should be seen as vital parts of an overall MOH health information system.

POTENTIAL FOCUS AREAS

- Support efforts to **merge or synchronize the LMIS and HIMS** to the extent that is feasible and useful to the GOA.

ANNEX I

FAMILY PLANNING PROGRAMS FUNDED BY USAID AND OTHER DONORS

USAID

THE IMPROVING PRIMARY HEALTH CARE IN ALBANIA PROJECT *(PRO SHENDETIT)* (2003–2008)

Implemented by University Research Co., LLC, PRO Shendetit is a five-year program that works with the MOH and the HII and has the following objectives and approach:

- **Improved Health Systems to Support PHC**: working with partners to improve healthcare financing and reform and to strengthen the health information system.
- **Improved Quality of Services in the Delivery of PHC**: providers' skills further developed, with a client focus, and standards established for licensing, certification, and accreditation systems.
- **Increased Utilization of PHC Services**: public awareness raised and communities engaged in accessing and utilizing services.

Although FP is not a main component of PRO Shendetit, many of PRO Shendetit's activities enhance and support FP. PRO Shendetit has strong quality improvement and health promotion components.

PRO Shendetit's approach to quality improvement has four main subcomponents: 1) the introduction of COPE at the PHC facility level; 2) a training program for doctors, nurses, and midwives; 3) a supportive system of facilitative supervision and coaching to support improvement in performance; and 4) a certification system for physicians and an accreditation system for health centers.

The FP training in PRO Shendetit's target districts and in the target districts of its predecessor, PHR*plus*, was initially provided over the years by the USAID-funded, JSI-implemented projects but has increasingly been incorporated into PRO Shendetit's training component. PRO Shendetit's health promotion component includes FP as a key health promotion topic; PRO Shendetit produced an all-methods brochure that was distributed by all the USAID-funded projects and used throughout the MOH system.

THE ALBANIAN CHILD SURVIVAL PROJECT (ACSP) (2003–2008)

Implemented by the International Services Division of the American Red Cross, ACSP operates in the three districts (Bulqize, Diber, Mat) that comprise Diber Prefecture. To improve the health status of women of childbearing age and children 0-59 months, ACSP focuses on three objectives and their associated key technical interventions:

- **Nutrition:** To reduce morbidity and mortality-associated malnutrition through breastfeeding promotion, nutrition education, and increased iodized salt consumption.
- **Management of the Sick Child:** To reduce diarrhea and acute respiratory infection-associated morbidity and mortality through preventive measures (hygiene), prompt and

appropriate home-based case management, and recognition of danger signs with appropriate utilization of formal health services.

- **Family planning /Reproductive Health:** To improve reproductive health through appropriate micronutrient supplementation during pregnancy; increased early initiation of prenatal care; and increased awareness, knowledge and utilization of modern FP methods by couples.

Three cross-cutting implementation strategies are applied to all technical interventions: 1) capacity building to improve access, availability, and quality of services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored BCC to improve key household behaviors and care-seeking practices.

ASCP used the national FP training curriculum and the relevant MOH trainers to train additional health care professionals in their target districts and then adapted the curriculum to train a broad spectrum of volunteer health educators. In collaboration with ASCP, AFFP selected Diber District to be one of two districts for outreach negotiation counseling pilot.

UNFPA

UNFPA has worked with the GOA since 1983. UNFPA support initially focused on introducing FP and safe motherhood within the PHC context. UNFPA worked with the MOH to establish 12 FP centers. In 1996, UNFPA established an office in Tirana and appointed a representative. The first country program (1997–2000) focused on building institutional capacity in the MOH and also included outreach activities for youth as well as STI and HIV/AIDS prevention. A bridging project initiated in 2002 provided modern contraceptives and helped develop the LMIS. It also promoted the social marketing of condoms to prevent STIs and HIV/AIDS among young people. UNFPA provided support to the first knowledge, attitudes, practices, and beliefs survey and the 2002 RHS. To increase access to services, UNFPA supported several centers run by nongovernmental organizations, including a women's clinic in Vlore and a young people's centre in Shkoder.

The current five-year (2006–2010) US $4 million project has a population and development component and a reproductive health component. In support of the reproductive health component, UNFPA will assist the GOA to implement the MOH's health promotion strategy and the action plan of the youth strategy approved by the Ministry of Culture, Youth, and Sports. UNFPA will assist the MOH in re-establishing the multidisciplinary national reproductive health committee, which will elaborate a health strategy linked to the health law. UNFPA will also support the national program to prevent STIs and HIV/AIDS in accordance with the approved HIV/AIDS strategy.

Support will be given to (a) training in reproductive health for service providers, based on the revised curricula for reproductive health, maternal care, and counseling, and focusing on quality of care; (b) support to the MOH to manage and sustain the vital health statistics system; (c) support for the national contraceptive LMIS to ensure reproductive health commodity security; (d) support to the GOA in providing contraceptive commodities; (e) the development of improved reproductive health services, information, and counseling, including HIV/AIDS; (f) the development and pilot testing of a regulatory framework for reproductive health, including protocols on the diagnosis, treatment, and reporting of STIs at the district level and at the MOH; and (g) the regulation and accreditation of service providers.

ANNEX II

DEMOGRAPHIC AND REPRODUCTIVE HEALTH INDICATORS: ALBANIA*

Indicator	Parameter
Total population (July 2007 estimate, CIA World Factbook)	3.6 million
Population growth rate (July 2007 estimate, CIA World Factbook)	0.53%
Number of women of reproductive age, 15–44 years (2005 estimate, WHO)	860,000
Total fertility rate per woman of reproductive age, 15–44 years (2007 estimate, CIA World Factbook)	2.01
Knowledge of at least one modern contraceptive method, all women of reproductive age, 15–44 years	90.0%
Contraceptive prevalence rate, all methods, married women of reproductive age, 15–44 years	75.1%
Traditional methods, all	67.1 %
- Withdrawal	67.1 %
- Periodic abstinence (rhythm)	0.0 %
Modern methods, all	8.0 %
- Female sterilization (tubal ligation)	4.0 %
- IUD	0.5 %
- Injectable	0.4 %
- Condom	2.1 %
- Pill	1.0 %
Contraceptive prevalence rate, all methods, all women of reproductive aged 15–44 years	50.5 %
Traditional methods, all	44.8 %
- Withdrawal	44.8 %
- Periodic abstinence (rhythm)	0.0 %
Modern methods, all	5.6 %
- Female sterilization (tubal ligation)	2.7 %
- IUD	0.3 %
- Injectable	0.3 %
- Condom	1.6 %
- Pill	0.7 %
Most important reasons for not using modern methods among women aged 15–44 currently using traditional methods	
- Partner preference	86.8 %
- Lack of knowledge	75.9 %
- Fear of or experience with side effects	72.5 %
- Cost	68.5 %
- Difficult to get	64.2 %
- Doctor recommendations	60.6 %
- Religion	56.7 %
Unmet need for modern contraception, married women of reproductive age, 15–44	68 %
Number of abortions per 1,000 live births (2004, WHO)	244.5
Postabortion women who report receiving no pre- or postabortion FP counseling	62 %

Indicator	Parameter
Postabortion women who report receiving no pre- or postabortion contraceptive method or prescription	84 %
Average duration of exclusive breastfeeding in months	2.3
Maternal mortality per 100,000 live births (WHO, 2005)	20.0
Maternal morbidity ratio attributable to abortion (MOH)	3.0 %
HIV prevalence (UNAIDS)	> 0.2 %
Number of verified HIV cases (UNAIDS)	>> 1,000

*Unless indicated, data is from the 2002 Albania RHS

ANNEX III

LIST OF DOCUMENTS CONSULTED

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