The pilot program also seems to have influenced a change in the method mix. In the six months preceding the intervention, the method that abortion clients were most likely to accept was the condom (44%), followed by no method (35%), the IUD (20%) and tubal ligation (1%, Table 2). In the six months following initiation of the intervention, the proportion of abortion clients choosing the IUD increased more than twofold, to 49%, and the percentage deciding on a tubal ligation rose dramatically, to 15%. Given that the majority of Turkish couples want no more children, a postintervention method mix weighted toward highly effective methods is more in line with actual fertility preferences than the preintervention mix.

Table 2. Percentage distribution of postabortion clients at the ZTB Women’s Health Education and Research Hospital, by method adopted following abortion, according to timing of the procedure relative to the intervention

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
<td>44</td>
<td>25</td>
</tr>
<tr>
<td>IUD</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pill</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: Contraceptive implants and injectables were not introduced into the program until after 1991. The dates do not necessarily correspond to the six months immediately preceding or following initiation of the intervention, but instead were selected because

The strategy to replicate the ZTB experience involved expanding the availability of postabortion family planning services to 10 more large public hospitals throughout Turkey from 1992 to 1998. These hospitals received varying levels and types of technical assistance based on their individual needs and interest. Some initiatives were as simple as conducting a contraceptive technology update for staff, while other sites required more extensive training, renovation and assistance in arranging for additional contraceptive supplies to expand the method mix.

For example, in Konak Maternity Hospital in Izmir, the primary program activity was training providers to expand the method mix they offered. One provider was trained in no-scalpel vasectomy technique and another in the insertion of contraceptive implants; this professional training helped make the Konak clinic one of the leading family planning facilities in Turkey. As a result of this particular hospital’s efforts to recruit vasectomy clients from among the husbands of abortion clients, it won a unique reputation for offering “postabortion vasectomy.”

The intervention carried out in the Maternity Hospital (Ettlik) of the Turkish Social Insurance Organization in Ankara provides a different example, as it was conducted more formally and required the assistance of an international consultant to facilitate postabortion family planning counseling and services. The intervention later involved renovations, including the purchase of equipment for an operating theater for tubal ligations. Finally, to improve method choice, several providers were trained in no-scalpel vasectomy technique and in the provision of injectable contraceptives.

One of the later interventions, conducted in Eskeisehir Maternity Hospital in 1997, was more comprehensive. It began with on-site training in both postabortion and postpartum family planning that lasted five days; staff were trained in communication skills, family planning counseling, infection prevention and contraceptive technology.

The interventions at the original ZTB pilot site and at the 10 expansion sites served as prototypes in the curriculum drafted by Turkey’s General Directorate of Maternal-Child Health and Family Planning (the “Postabortion Family Planning Curriculum”). This curriculum includes modules from several others developed by EngenderHealth (i.e., “Family Planning Counseling: A Curriculum Prototype,” and “COPE—Client-Oriented Provider-Efficient Services”), as well as modules that were written in-country. The counseling piece of the curriculum adapts the GATHER* approach to postabortion family planning. The curriculum was field-tested in Eskeisehir and was later used in the expansion of the intervention into Istanbul.

Unfortunately, standard data were not routinely collected when these postabortion services were being established in the expansion sites. Thus, service statistics to adequately track the progress of the postabortion program from 1991 through 1998 are incomplete. To assess program progress, we sent a questionnaire to the 10 expansion sites in 1999, requesting data from the previous year. We then compared these data with other data collected in 1994 as part of a situation analysis of Turkey’s reproductive health care services, that situation analysis had included all but two (the Adana clinic and the Zubeyde Hanim Maternity Hospital) of the original 10 postabortion program expansion sites.

The results were encouraging: By 1999, six of the nine expansion sites for which 1998–1999 data were available—a 10th site (Zubeyde Hanim Maternity Hospital) had dropped out of the initiative by then—had reached postabortion family planning acceptance rates of more than 90% (Table 3). The three hospitals that had achieved more modest acceptance rates nevertheless represent noteworthy increases from their 1994 levels. Of the six high-performing sites in 1999, two had had relatively high acceptance rates in 1994, which reflect interventions begun prior to that year.

Lessons Learned
The importance of commitment from the hospital leadership emerged as the key lesson learned from the expansion phase of the intervention. Some of the participating public-sector hospitals—and the original ZTB pilot program hospital—achieved high contraceptive acceptance rates because hospital directors were committed to providing postabortion family planning services. In sites where leadership and support did not exist, however, progress was either slow or nonexistent.

Perhaps this initiative’s most striking aspect is its ongoing self-sustainability. Ex-

Table 3. Percentage of abortion clients leaving a public hospital with a family planning method, by hospital and year of intervention, according to year of data collection

<table>
<thead>
<tr>
<th>Hospital and year</th>
<th>1994*</th>
<th>1998–1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zeynep Kamil Maternity Hospital, 1991</td>
<td>50</td>
<td>93†</td>
</tr>
<tr>
<td>SSK Bakirkoy Maternity Hospital, 1993</td>
<td>0</td>
<td>100†</td>
</tr>
<tr>
<td>SSK Goztepe Hospital, 1993</td>
<td>73</td>
<td>100†</td>
</tr>
<tr>
<td>Konak Maternity Hospital, 1993</td>
<td>62</td>
<td>98‡</td>
</tr>
<tr>
<td>SSK Ankara Maternity Hospital (Ettlik), 1993</td>
<td>31</td>
<td>46‡</td>
</tr>
<tr>
<td>SSK Ege Maternity Hospital, 1994</td>
<td>81</td>
<td>98‡</td>
</tr>
<tr>
<td>Samsun Maternity Hospital, 1994</td>
<td>0</td>
<td>32‡</td>
</tr>
<tr>
<td>Adana MCH/F, 1995</td>
<td>0</td>
<td>93‡</td>
</tr>
<tr>
<td>Zubeyde Hanim Maternity Hospital, 1996</td>
<td>u</td>
<td>u</td>
</tr>
<tr>
<td>Eskeisehir Maternity Hospital, 1997</td>
<td>40</td>
<td>60‡</td>
</tr>
</tbody>
</table>

*From situation analysis data. †From 1998 Istanbul Family Planning Quality Survey (see reference 27). ‡From mail survey. Notes: u=unavailable, because the 1994 situation analysis did not include the Adana MCH/F or the Zubeyde Hanim Maternity Hospital. Also, because Zubeyde Hanim dropped out of the intervention, 1998–1999 data are unavailable.

*The six counseling elements or steps that are described by the acronym GATHER are G—greet, A—ask, T—tell, H—help, E—explain and R—return.