



**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. 12

**Factors Influencing Women's Reproductive
Health Choices in Tirana, Albania**

**Arian Boci, Independent Consultant
Margaret Eichleay, FHI 360
Hannah Searing, EngenderHealth**

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This report was edited by Michael Klitsch and formatted by Elkin Konuk.

Acronyms and Abbreviations

DHS	Demographic and Health Survey
FP	family planning
GDP	gross domestic product
GNI	gross national income
ISOP	Institute for Public Opinion Studies
IUD	intrauterine device
MOH	Ministry of Health
ob-gyn	obstetrician-gynecologist
USAID	U.S. Agency for International Development

Executive Summary

As in many countries in Eastern Europe and Eurasia, Albania has a high abortion rate and very low use of modern family planning (FP) methods. Previous research has demonstrated that Albanian women fear side effects and have misconceptions about the negative health effects of modern contraceptive methods. Some providers even share these concerns. Although FP programs have attempted to address these behavioral reasons for low contraceptive use, anecdotal reports suggest that the payments clients make for health care might also impact the provision of modern FP services and their uptake. This study explored the reasons behind the low level of modern contraceptive use among abortion clients in Tirana, Albania, and the role that financial factors might play in it.

In May and June 2012, data were collected from 112 abortion clients and 65 obstetrician-gynecologists (ob-gyns) at facilities that offer abortion services in Tirana, the capital city of Albania. Data were collected at both public- and private-sector facilities.

This study found no evidence that providers actively discourage FP or that clients perceive cost to be a major barrier to contraceptive use; however, we found that providers recommend a greater number of tests prior to the initiation of oral contraceptives and more follow-up visits for pill and intrauterine device (IUD) users than the World Health Organization (WHO) recommends. Given the fee-for-service structure of informal payments in the public sector and all private-sector payments, these extra test and visits could carry additional costs. They could also increase the perception that modern contraceptives are dangerous for a woman's health.

In addition to this potential financial disincentive, this study found many other partial explanations for low contraceptive use in Tirana. Although the physicians in this study were experienced and had been recently trained in both abortion and FP counseling, many lacked knowledge regarding the effectiveness of modern methods. In addition, few providers had practical training in IUD insertion, which could make them less confident in their ability to correctly place the device. Nearly one-quarter of abortion clients said they would use an IUD in the future, but not one had an IUD inserted immediately postabortion; it is possible that lack of competency-based training contributes to low IUD use in this population.

Another contributing factor is the extremely low frequency of contraceptive counseling for abortion clients. Fewer than half of women said their provider mentioned any method of FP, and less than 10% received counseling on more than two FP methods. The lack of comprehensive FP counseling for these clients is a missed opportunity. Providers say that they do not counsel because their clients do not want contraception and have health concerns about it. Indeed, women exhibited fears of modern contraception and had fairly low levels of knowledge about contraceptive effectiveness, choices, and sources. For those reasons, providers should make an increased effort to provide correct information.

Nearly all abortion clients had discussed FP with their partners, but while the women preferred more modern methods (the condom being their first choice), their partners often preferred

withdrawal. It is important for couples be well-educated on the options so they can effectively resolve these differences.

The decision to use FP methods is a complex one, likely to be governed by many factors, and not solely financial ones. Based on findings from this study and the context of Albanian culture, the following actions are recommended:

1. Strengthen preservice and in-service FP training curricula to be competency based (including both theoretical and practical components) and include patient-centered counseling
2. Create tailored innovative educational and long-term behavioral change communication programs that cover all FP methods, as well as general reproductive and sexual health issues
 - a. Tailor these messages to address misconceptions and fears of modern methods, specifically providing accurate information about the risks and the likelihood of side effects
 - b. Promote male involvement in FP education and postabortion follow-up care, to foster responsible sexual and decision-making behaviors
 - c. Allocate long-term funding to these efforts, to enable time for behavior change to occur
3. Reorganize reproductive health care and referral services so that FP counseling and service delivery are very easily accessible to abortion clients, particularly in large public-sector facilities
4. Strengthen national reproductive health protocols and monitor adherence transparently to encourage accountability
 - a. Implement performance reviews, or a similar competitive system, to give providers an incentive to adhere to protocols and promote best practices
 - b. Harmonize national abortion and FP guidelines with international ones (WHO) for the number of tests required to initiate, and follow-up visits needed to safely use, modern FP methods.

In addition to programmatic efforts, research that provides reliable and scientific data is another component that can help improve acceptance of modern contraception and reduce reliance on abortion in Albania. The following research studies are recommended:

1. A qualitative analysis of the proximate and systemic factors influencing men's contraceptive choices
2. An evaluation of reproductive health curricula in public-sector schools, as well as knowledge about and attitudes toward modern FP use among students and teachers
3. An evaluation of the reasons behind ultrasound use prior to contraceptive initiation, for abortion clients, and for other women's health services.
4. Implementation research to assess the most effective models of FP service provision, particularly in the private sector and once the Albanian government restricts eligibility to free contraceptives (Part of this work should include an assessment of method availability and changes in use following policy changes.)

Background

General

In many parts of Eastern Europe and Eurasia, modern contraceptive use is quite low, and induced abortion is a common means of managing family size (Serbanescu et al., 2005; CDC & ORC Macro, 2003; Westoff, 2005). With withdrawal the most widely reported method of contraception in the region (INSTAT et al., 2010; Sedgh et al., 2007a), unplanned pregnancies are frequent, and the average woman has had multiple abortions, more than in most other parts of the world (Sedgh et al., 2007a; Sedgh et al., 2007b).

This regional reproductive health profile has been explained by a variety of factors. The most salient thread joining this region together is the shared socialist political history. Socialist policies—pronatalism, restricted access to contraceptive methods, relatively easier access to abortion services, and centrally organized health care systems—all contributed to a reliance on traditional family planning (FP) methods, and on abortion when those methods failed (CDC & ORC Macro, 2003; David, 1992; Kovács, 1999). Other factors include a lack of knowledge about modern methods and biases against hormonal methods (Serbanescu et al., 2005; CDC & ORC Macro, 2003).

Informal payments for health care are another common characteristic in the region (IMB International, 2000; Shishkin et al., 2003; Lewis, 2000; Vian & Burak, 2006; Balabanova et al., 2004; Gaal et al., 2006). Informal payments are payments made “in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services the patients are entitled to” (Gaal et al., 2006). In public-sector systems, where services are part of complimentary care, the presence of these payments can add a level of financial incentives where none previously existed. Payments, if made per procedure or per visit, may offer an incentive for the provision of more expensive services and excessive numbers of tests, as well as the requirement of extra visits (Kovács, 1999; Rich, Lake, & Valenzano, 2012).

To better understand the reasons behind low levels of modern contraceptive use in this region and the role that financial factors may play in it, the Europe and Eurasia Bureau of the U.S. Agency for International Development (USAID) asked the RESPOND Project¹ to conduct several studies: a background paper on informal payments for reproductive health in the region (Patel & Janowitz, 2010) and two country-specific studies in Azerbaijan and Albania. This report is specific to the study in Albania.

¹ The RESPOND Project is a five-year USAID Leader with Associates Cooperative Agreement awarded in October 2008, the purpose of which is to address the need for FP through expanding contraceptive choices and program services. Its overall objective is to increase the use of high-quality reproductive health and FP services. The role of research in RESPOND is to add global knowledge to the field, with a focus on informing policy development and programming and demonstrating the effectiveness of selected models and approaches in field programs. RESPOND is led by EngenderHealth, in partnership with five organizations, including FHI 360, which provided support for this research.

Albania Context

Albania is home to 3.2 million people; 53% are of reproductive age (15–49 years), and 25% of the total population lives in the capital city of Tirana (INSTAT et al., 2010). The national total fertility rate is low, at 1.6 lifetime births per woman (INSTAT et al., 2010), and literacy is quite high (98.7%) (CIA, 2011). The country spends 6% of its gross domestic product on health, which represents about US \$265 per capita; about half of these expenditures are private out-of-pocket costs (WHO, 2010a; MOH, 2010). These private costs include health insurance payments, formal out-of-pocket expenditures, and informal payments.

Health Care System

Albania has a mix of public- and private-sector health care service provision. Access to public-sector services is universal and is based on a primary health care model, with referral to specialist services. However, anecdotal reports suggest that this referral system is often bypassed due to the perception that it is inefficient. In 1995, a social health insurance system was implemented to cover primary health care, hospital care, and some medication fees. Without insurance, these services are still available in public-sector facilities for a small fee. The private sector operates on a fee-for-service basis and does not yet accept the social health insurance.

Physicians who work in the public sector may also work in the private sector. For this reason, private facilities are often open only in the afternoons and evenings, when public-sector facilities have closed. While services are expected to be less costly in the public sector, clients may prefer to receive services at private-sector facilities, because services can be obtained more quickly and anonymously; this may be especially true of services that clients want to receive discreetly, such as abortion.

The private health care sector is relatively young in Albania and operates primarily in the capital city. The government has guidelines for approving private-sector facilities; however, in large city centers, many function without the appropriate licensure.

Albania's reproductive health profile

As in many countries in Eastern Europe and Eurasia, Albania has very low use of modern FP methods. The majority (58%) of married women in Albania use withdrawal to prevent pregnancy (INSTAT et al., 2010). Of the mere 11% who use a modern method, 4% use condoms, 3% are sterilized, and only 2% use oral contraceptives; the use of other methods is minimal (INSTAT et al., 2010). Fewer than 3% of women have tried emergency contraceptive pills (ECPs) (INSTAT et al., 2010). The low use of hormonal methods may be explained by Albanian women's fear of side effects (Stolarsky & DeCamp, 2010). Misconceptions that hormones cause cancer or infertility are common among clients (Gryboski et al., 2009) and are reinforced by some providers (Stolarsky & DeCamp, 2010).

Given the country's very low fertility rate and very low use of modern FP methods, it is unsurprising that Albania has a relatively high abortion ratio. In 2008–2009, Albania had 270 abortions for every 1,000 live births (Merdani et al., 2013), a level higher than estimates for Western Europe as a whole (230 per 1,000) (Segdh et al., 2012). Although 2011 data show a reduction in Albania's ratio—to 242 abortions per 1,000 live births (Merdani et al., 2013)—this reduction coincides with the increase in private-sector clinics in large cities, like Tirana. Anecdotal evidence suggests that the official figures for Albania in recent years are

underestimates because they do not take into consideration abortions occurring illegally in unregistered private-sector clinics. To address underreporting and illegal abortion, the Ministry of Health (MOH) recently revised the law on voluntary termination. As of January 2013, private-sector health care clinics no longer had permission to perform abortions; only public- and private-sector hospitals would be allowed to do so (Shekulli News Agency, 2013).

Historical context and organization of reproductive health services

Albania's unique history has contributed to its reproductive health profile. In the mid-to-late 20th century, when modern contraceptive methods were developed and popularized in other countries, Albania was a Popular Socialist Republic. Under the socialist system, the Albanian government had a pronatalist policy that banned abortion. Modern FP methods were virtually unknown and, although some were available, access was strictly controlled. Discussions about sexuality, safer sex, and modern contraception were taboo; abortion was a crime and was socially stigmatized. However, abortion was performed illegally, outside of the health care system, primarily by midwives (Gjonça et al., 2009).

The Albanian Parliament legalized abortion in 1995 under the law on Interruption of Pregnancy (People's Assembly of the Republic of Albania, 1995). According to this legislation, abortion can be performed only by trained obstetrician-gynecologists [ob-gyns]). At the client's request and in a licensed facility, it is permissible up to the 12th week of pregnancy. In cases where pregnancy threatens the life or health of the woman, or there is a psychosocial concern, such as rape, abortions can be performed until the 22nd week of pregnancy, upon review by three specialists (a physician, a social worker, and a lawyer). Although misoprostol (a drug with many uses, one of which is to induce abortion) is not legally registered by the National Drug Control Center of Albania, anecdotal reports suggest that it is available in some pharmacies and private ob-gyn clinics. By protocol, all abortion clients are to be educated on the health risks of the procedure, available alternatives, and FP options (Boci et al., 2011).

Modern FP methods were openly introduced in Albania in 1992. Since then, modern contraceptives have been provided free of charge in public-sector health care and FP centers. In recent years, contraceptives have become available at a subsidized rate under a social marketing brand and in the private sector (MOH, 2003). Financing for contraceptives has changed substantially in the past few years. Prior to 2010, the United Nations Population Fund (UNFPA) funded contraceptive methods in Albania, but in the new decade, the MOH assumed full financial responsibility (USAID, 2010; Tien & Rao, 2008). Under the Contraceptive Security Strategy, the MOH will provide modern FP methods free of charge to anybody in need in the public sector only until the end of 2013 (MOH, 2011). From 2014 to 2016, modern methods will be available for free only for the most vulnerable groups of population. (At the time this report was written, however, these most vulnerable groups had not yet been defined.)

The methods intended to be available at all public-sector facilities are: oral contraceptives, condoms, and the Copper-T intrauterine device (IUD). Clients can find these methods, as well as more diverse brands of oral contraceptives, the Mirena® IUD, and emergency contraception, in private pharmacies. Although oral contraceptives officially require a prescription, they can be easily obtained without prescription at local pharmacies (Riley & Maddock, 2009). At large public-sector hospitals, contraceptive methods are often available in FP rooms, located in the maternity wards. Abortion wards are separate from maternity wards

and may be far enough away that an abortion client would need to go outside to reach the FP room.

Prior efforts to improve FP in Albania

Despite many efforts of the Albanian government and international donors, interventions to improve attitudes toward and use of contraception in Albania have not yet demonstrated the desired long-term effect. C-Change and ACCESS-FP, two USAID-funded programs that focused on FP behavior change, both ended in 2011. Their activities included: providing competency-based education and training and supportive supervision of practitioners (ob-gyns), conducting mass media campaigns for demand generation, promoting peer education projects, and developing and distributing national FP protocols. Though these activities addressed a broad spectrum of clients, evaluations that were conducted on limited, purposive sample populations after a very short time period of implementation showed minimal impact (People's Assembly of the Republic of Albania, 1995; Boci et al., 2011; Zazo et al., 2011).

The only program aimed specifically at postabortion clients was conducted by ACCESS-FP. It evaluated uptake of modern contraception among postabortion clients whose providers had been trained in FP provision and IUD insertion. Between baseline and postintervention follow-up, the percentage of postabortion women leaving the facility with a contraceptive method increased from 1% to 38%. However, of the women who accepted a modern method at their postabortion visit (the pill, injectables, and condoms), fewer than half had continued using it six months later; the majority had reverted to using withdrawal (Stolarsky & DeCamp, 2010). The return to withdrawal is perhaps not surprising, given Albanian women's extreme reluctance to use medication, particularly hormones (Stolarsky & DeCamp, 2010).

Since 2011, when C-Change and ACCESS-FP ended, no other FP programs have been implemented in Albania.

Paying for Abortion and FP

Paying for health care in Albania can involve formal fees, informal payments, or both.

Formal payments

For elective abortion services, both public- and private-sector facilities have an official fee. In the public sector, the formal charge of 6,000 Lekë (US \$57²) covers the cost of performance of the abortion, a blood test, a urine test, an ultrasound, and anesthesia (local or general). The private sector uses a fee-for-service system in which each procedure, or package of services, has a set price. Prices in the private sector vary from one facility to the next, but fee schedules are posted.

Women receiving a medically indicated abortion (e.g., woman's health at risk, fetal anomaly) do not pay a formal fee at public-sector facilities, but would still pay at private-sector facilities.

Informal payments

Informal payments are very common at public-sector health care facilities (UNODC, 2011). They are cash payments typically given by the client (or a family member of the client) directly to the physician in excess of the amount to which he or she is entitled (INSTAT et al., 2010;

² 105.6 ALL: US \$1. Conversion rate on November 28, 2011, at www.xe.com.

UNODC, 2011). In addition to the attending physician, the client and/or her family might also give informal payments to nurses, lab technicians, guards, or other staff members encountered during their visit (UNODC, 2011).

Clients make informal payments in the public sector because they feel that “good health is worth any price,” it is traditional to express gratitude, and they fear they will not get quality care without paying (Vian & Burak, 2006; UNODC, 2011). Although such payments are an unpleasant part of visiting the doctor and many clients recognize them as wrong, they are considered necessary (Vian & Burak, 2006).

From the health care provider’s perspective, informal payments can be a way to supplement low salaries. At 39,500 Lekë (US \$423³) per month, wages for health care workers in the public sector were 3% lower than the average monthly wage in 2009 (INSTAT, 2010), although 30% higher than the monthly gross national income of 30,365 (US \$329) (World Bank Group, 2012).

For abortion services, informal payments could be made in addition to the formal fee or in substitution for the official price. In the latter scenario, a client may pay less than the formal fee, but the entire payment is received by the physician, thereby benefiting both parties.

Goals and Objectives

This project’s goal was to better understand the reasons behind low modern contraception use among abortion clients⁴ in Tirana and the role financial factors play in it. Specific study objectives are listed below. Each pertains to both the public and private sectors:

- a. To understand clients’ knowledge of, attitudes toward, and use of FP and abortion
- b. To understand providers’ knowledge of and attitudes toward FP and abortion
- c. To learn how frequently providers counsel abortion clients on FP
- d. To measure what clients pay (formally and informally) for FP and abortion services in the public and private sectors

³ 93.2 ALL: US \$1. Conversion rate on June 1, 2009, at www.xe.com.

⁴ USAID is prohibited by law from paying for the performance of abortion as a method of FP or motivating or coercing any person to practice abortion. Since the enactment of legislation in 1973, recipients of U.S. FP assistance have been legally prohibited from supporting abortion as a method of FP using U.S. funds. USAID places high priority on preventing abortions through the use of FP, saving the lives of women who suffer complications arising from unsafe abortion, and linking those women to voluntary FP and other reproductive health services that will help prevent subsequent abortions. USAID assistance in the Europe and Eurasia Region is to expand access to and use of modern FP methods and thereby decrease reliance on abortion. Findings from this study will provide further information on how to increase modern contraceptive use for women in countries where abortion is legal, thereby decreasing reliance on repeat abortion.

Study Design

This was a descriptive study that used structured interviews to obtain data from both abortion clients and abortion providers in Tirana. The Institute for Public Opinion Studies (ISOP), a research group within the University of Tirana, collected data for 20 days in May and June 2012. The study protocol was approved by the Protection of Human Subjects Committee at FHI 360 and by the Albanian National Committee on Ethics.

Recruitment for this study was organized through health care facilities. At the time of this study, Tirana had a total of 15 facilities registered for abortion: four Maternity Hospitals and 11 private clinics.⁵ This study aimed to interview providers from all 15 facilities and a convenience sample of clients from four facilities.

Providers

The provider population of interest was ob-gyns providing abortion services in public-sector and registered private-sector facilities in Tirana. To be eligible for this study, the provider had to be an ob-gyn and provide abortion services. Lists of all ob-gyns working at all public-sector and registered private-sector facilities in Tirana were provided by the MOH and double-checked with administrators at each facility. Every provider on the list was contacted and invited to take part in the study. To compensate for the time taken away from work, providers who participated in the interview were compensated 1,000 Lekë (US \$10).

Of the 67 providers on the list, two did not wish to be interviewed (3%). The final sample size was 65 ob-gyns: 55 in the public sector and 10 in the private sector.

Clients

The client population of interest was women who received abortion services in Tirana. To be eligible for this study, clients had to be at least 18 years old, had to have visited an ob-gyn on the day of the interview for an abortion, and must not have received general anesthesia.⁶ Data collectors recruited every eligible client at selected facilities on every day during the data collection period; this recruitment strategy was designed to capture a roughly proportional sample of women from all facilities, while ensuring the largest possible sample size over the study period. Women were recruited and asked their consent in the waiting room, prior to seeing the doctor. Upon discharge, those who had given consent were once again asked for their informed consent before being interviewed. Clients were compensated with the cost of a taxi fare within the city limits of Tirana: 800 Lekë (US \$8).

⁵ Although anecdotal reports suggest there are about 50 nonregistered private ob-gyn facilities in the city, we did not sample them due to the difficulty of requesting participation and budget constraints.

⁶ Clients who received intravenous sedation with Diprivan, Diazepam, or a similar short-acting drug were eligible. Those who received general anesthesia were not eligible.

A total of 132 women were recruited for the study; 20 did not wish to participate (a 15% refusal rate). The final sample size was 112 abortion clients: Eighty-seven were interviewed at public-sector facilities and 25 at private-sector facilities.

Analysis and Definition of Variables

All analyses for this study are descriptive. Frequencies are presented by health sector, and differences between sectors were tested using the chi-square statistic. T-tests were used to compare means across categories. For payment data, the median, rather than the mean, is presented, to avoid the influence of outliers, thereby better representing the typical payment amount. Data were double-entered into SPSS, converted using DBMS copy version 8, and analyzed in SAS version 9.3.

Payments

Payments for abortion are reported as the total amount that abortion clients paid on the day of the abortion for the procedure, associated tests, medicine, registration, and staff. Any payment for supplies that women brought with them to the facility was subtracted from the total, to ensure that we measured only payments made on the day of the abortion. For clients who were unwilling or unable to tell us the amount they paid at the time of service, we separately reported the total amount they expected to pay prior to coming to the facility.

Payments are also reported for individual laboratory tests. Clients may have received and paid for some laboratory tests prior to the day of the abortion; therefore, the payments reported specifically for tests may be larger than what the same client reported for payment on the day of the abortion procedure.

Any public-sector client who said they paid a staff member a financial incentive was considered to have made an informal payment. This payment could have been made to a physician, anesthetist, nurse, laboratory technician, registration clerk, or any other facility staff member.

All financial data are in Albanian Lekë. The conversion rate to U.S. dollars is for the midpoint of the data collection period: June 1, 2012 (112.08 Lekë=US \$1) (www.xe.com).

Income Level

Income categories were based on expert opinion, placing the monthly per capita gross national income (GNI) in the middle-income category and making the categories of similar ranges to the sister study conducted in Azerbaijan. In 2009, the monthly GNI per capita in Albania was 30,635 Lekë (US \$329).

Ranking Exercise

To understand relative opinions about contraceptive methods and abortion, clients and providers were asked to put a series of cards in order of various themes. There was a card for abortion and one for each the following contraceptive methods: IUD, oral contraceptives, condoms, ECPs, and withdrawal. The FP method cards displayed a word and an image. Respondents were then asked to put these cards in order, according to themes such as safety, effectiveness, ease of use, and preference.

As a separate exercise, providers were asked to rank barriers to contraceptive counseling. The barriers listed on the cards were: knowledge, supply, client demand, profitability, time constraints, and health concerns. Respondents were allowed to remove a card from the exercise if they were unfamiliar with it. Any card that was ranked by fewer than 75% of respondents was not used in analyses. Analyses of the ranked cards are restricted to respondents who used the same cards in the exercise.

Knowledge questions

For questions related to knowledge, we report the proportion of respondents who gave the correct response. Those who responded with “don’t know” were coded as incorrect. For the question asking clients and providers to rank various contraceptive methods in order of effectiveness, the correct order, from most to least effective was: IUD, the pill, condoms, withdrawal (Hatcher et al., 2011).

Side effect misconceptions/overstatements

Previous studies have shown that women and providers in Albania consider side effects (or health concerns) to be a major barrier to modern contraceptive use (INSTAT, IPH, & ORC Macro, 2010). Although modern methods have common side effects, many of Albanians’ side effect concerns are overstated or incorrect (Serbanescu et al., 2005). For this study, the following side effects were considered overstated concerns or misconceptions. We did not differentiate between hormonal and nonhormonal IUDs.

Method	Side effect misconceptions/overstatements
Combined oral contraceptives	Breast disease, cancer, health problems, heart damage, kidney damage, lung damage
IUD	Cancer, infection, spontaneous expulsion

Results

An abortion client's decision to use FP may be influenced by several factors. The results of this study are organized into five sections relating to individual characteristics, health care system factors, knowledge, and behaviors that may play a role in contraceptive choices. Section 1 presents study participant characteristics. In the second section, we examine clients' FP experience and intentions. The remaining sections address potential reasons for the low contraceptive use: health care system factors (Section 3), knowledge (Section 4), and attitudes (Section 5).

1. Respondent Characteristics

1.1. Providers

A total of 65 ob-gyns providing abortions participated in this study; 85% of those interviewed were in the public sector. As 71% of providers see clients in multiple facilities, it is possible that several providers work in both the public and the private sectors. For that reason, provider characteristics are not stratified by sector in Table 1.

The providers interviewed in this study were highly experienced, with an average of 17 years working as an ob-gyn (Table 1, page 12). Roughly 40% of interviewed providers were female (Table 1). Forty percent had been trained in FP within the past year (Table 1). Training in FP universally covered IUD counseling, but only 58% of providers had a practical component to this training during which they actually inserted an IUD (Table 1). Oral contraceptives and ECPs were covered in the trainings attended by most of these providers; injectables, condoms, and female sterilization were also commonly covered (Table 1).

Seventy percent of ob-gyns had been trained on abortion service provision in the last five years (Table 1). The majority of abortion providers (83%) had been trained to perform abortions using drugs (i.e., mifepristone and misoprostol) as well as mechanical methods (manual vacuum aspiration, electric vacuum aspiration, and dilation and curettage) (data not shown).

Ob-gyns at the sampled facilities saw more women for abortion services than for FP consultations. Physicians in the public sector reported that 281 clients came for FP services in one month, compared with 402 abortion clients (Table 2). In the private sector, 62 clients sought FP services, compared with 84 abortion treated in the last month. In both the public and private sectors, the majority of FP clients were given oral contraceptives (Table 2, page 12). The Copper T IUD was inserted more frequently than the Mirena[®] IUD, which is less widely available (only in the private sector).

Table 1. Provider demographics and training

Characteristic	Ob-gyns mean or % (n=65)
% female	38
Mean age in years	44
Mean no. of years working as ob-gyn	17
Last FP training (%)	
Within past year	40
1–5 years ago	46
>5 years ago	6
Don't remember	8
Methods trained to discuss (%)	
IUD	100
Pill	98
ECPs	83
Injectables	77
Condoms	72
Female sterilization	72
Rhythm/calendar	57
Withdrawal	52
Male sterilization	52
% who inserted an IUD during training	58
Last abortion training (%)	
Within past year	41
1–5 years ago	30
>5 years ago	19
Don't remember	11

Table 2. Number of clients seeking abortion and FP services over one month, as reported by providers, by sector

Service	Total no. of clients in 1 month	
	Public	Private
Abortion	402	84
FP consultation*	281	62
Prescribed pill	326	49
Gave pill	225	44
Inserted Copper T IUD	75	16
Inserted Mirena® IUD	27 [†]	1

Note: All 55 public-sector and 10 private-sector providers were asked how many FP clients they had seen in the past three months; from those data, we divided by three to get the number seen in one month.

* These are client-initiated consultations; the woman came to the doctor seeking FP services.

† Although these providers were interviewed in the public sector, where the Mirena® IUD is not available, many of these providers also work in private practice.

1.2. Clients

As Table 3 shows, women seeking abortion services at public-sector facilities were demographically quite similar to those at private-sector facilities. In both groups, the clients were, on average, 31 years old, had about 1.6 children, and had already had 1.7 abortions. Most abortion clients were married (80%). Clients in the public and private sectors had fairly similar income distributions. Although the private sector captured a larger proportion of middle-income clients than did the public sector, the latter had slightly higher proportions in both the lower and higher income categories (Table 3). Annual income did not appear to be a strong determinant in selecting the type of facility.

There were some differences between public- and private-sector clients. Compared with private-sector clients, public-sector clients interviewed for this study had higher educational status and were more likely to live in Tirana (Table 3). A greater proportion of private-sector clients had health insurance than those at public-sector facilities (Table 3).

Client parity varied with prior abortion status. One-third (31%) of women who were experiencing their first abortion had no children (Table 4, page 14). In comparison, only 9% of women who had received a prior abortion were childless. Over 70% of women with a prior abortion had two or more children (Table 4).

Table 3. Selected client demographics, by sector

Characteristic	Mean or %	
	Public (n=87)	Private (n=25)
Mean age in years	31	31
Mean no. of children	1.6	1.8
% with at least one child	78	76
Mean no. of abortions (including today)	1.7	1.8
% who had an abortion before today	37	56
% who ever used a contraceptive method*	68	46
% who ever used a modern contraceptive method*	54	44
% married/living together	79	80
Education (%)		
Secondary or less	23	32
Secondary specialized	40	48
Higher education	37	20
Annual income (new Lekë)		
Low (0–20,000)	22	16
Middle (20,001–45,000)	46	56
High (>45,001)	31	24
Don't know/no response	1	4
% insured	45	76
% living in Tirana	81	60

* Nine women refused to answer the question about past use of contraception; sample sizes were 79 in the public sector and 24 in the private sector.

Table 4. Percentage distribution of abortion clients, by number of children, according to prior abortion status

Number of children	% of clients with no prior abortion (n=65)	% of clients with 1 or more prior abortions (n=46)
0	31	9
1	20	19
2	26	48
≥3	23	24

2. Use of FP

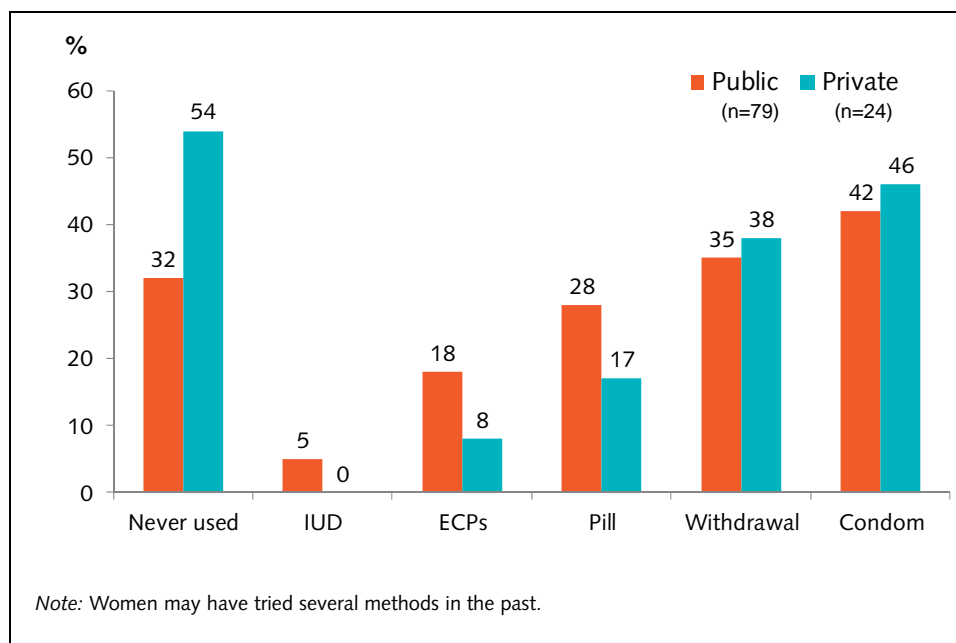
This section describes the contraceptive methods clients have tried in the past and those they intend to use in the future.

2.1. Past Use of FP

Abortion clients in the public sector were more likely to have used FP methods in the past than were those in the private sector. This was true for all methods, as well as for modern methods. Whereas 54% of public-sector clients had tried a modern method in the past, only 44% of private-sector clients had (Table 3).

Figure 1 shows the proportion of women who had ever used each method, by sector. Condoms and withdrawal were the most commonly reported methods, with more than 40% of women in both groups having tried condoms. Between 20% and 30% of clients in both sectors had tried oral contraceptives, but long-acting contraceptive methods such as the IUD and injectables (not shown in figure) had been used only by a small proportion of abortion clients at public-sector clinics (6%) and by none of those interviewed at private-sector clinics.

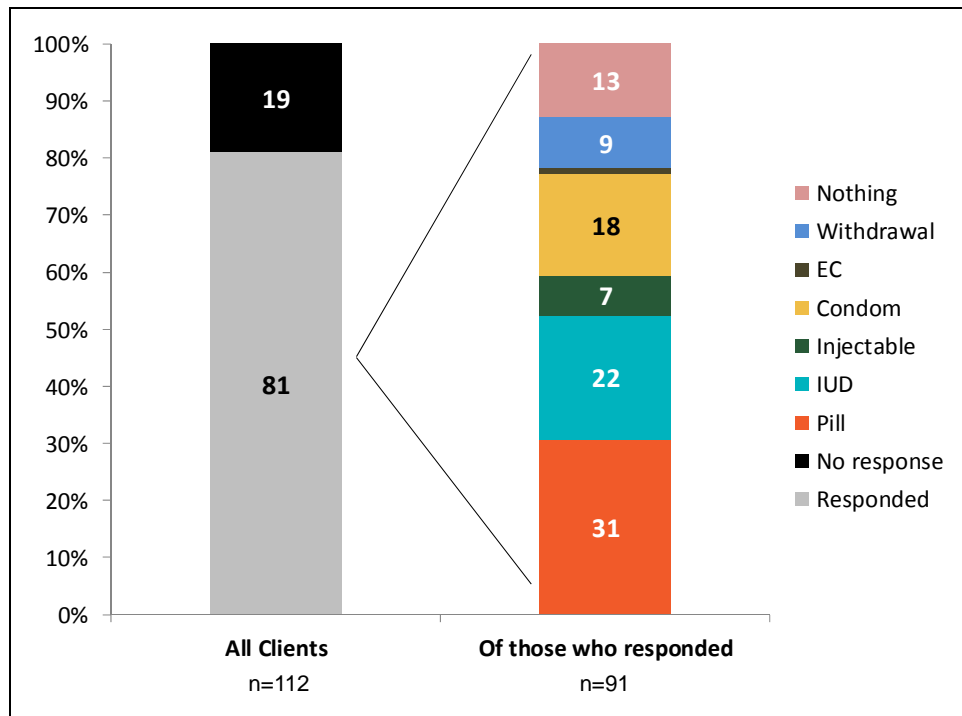
Figure 1. Percentage of abortion clients who have ever used contraception, by method, according to sector



2.2. Intention to Use FP

When asked what they intend to do to avoid pregnancy in the future, 19% of the women did not respond (Figure 2). Of those who responded, the majority said they would use a modern FP method. The most popular modern method was the pill (31%), followed by the IUD (22%), condoms (18%), and injectables (7%). It is notable that although the vast majority of women had never tried the IUD (Figure 1), many intended to use it in the future (Figure 2).

Figure 2. Percentage distribution of abortion clients, by intention to use contraceptive methods in the future

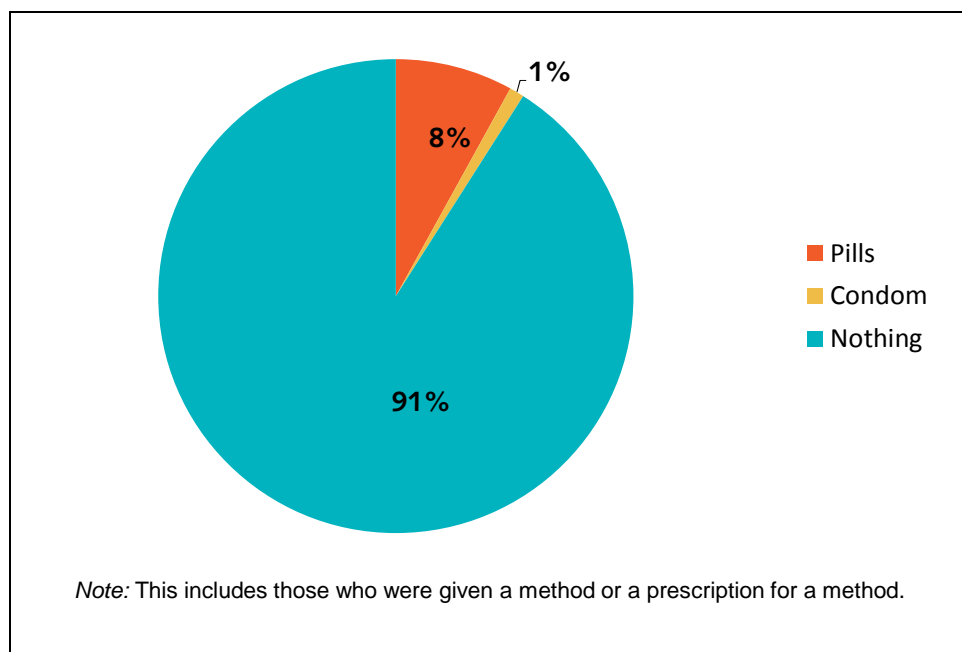


2.3. Receipt of an FP Method

The WHO strongly recommends offering a contraceptive method to abortion clients before they leave the health care facility (WHO, 2012). Although a large proportion of clients in this study intended to use a modern contraceptive method, very few left the facility with one. Fewer than 10% of abortion clients went home with an FP method or a prescription for a method on the day of the abortion (Figure 3, page 16). Only four women at public-sector facilities took a method home (all the pill), as did six women at private facilities (the pill and condoms) (data not shown). No women had a postabortion IUD insertion, even though 22% intend to use this method in the future.

Many women may need more time to decide about modern contraceptive method use than is available in one client-provider encounter. Women first need to be adequately informed and given time to consider their options. Therefore, we next consider contraceptive counseling practices.

Figure 3. Percentage distribution of abortion clients, by whether they received an FP method or a prescription for a method at the abortion visit (n=112)



2.4. Contraceptive Counseling

Comprehensive counseling is crucial for women to make an informed choice about modern FP method use. This study found that fewer than half of clients reported that their provider mentioned FP during their abortion visit or at a visit in preparation for the abortion (46% in the public sector and 44% in the private sector) (Table 5, page 17). In the public sector, the IUD and the pill were the most frequently discussed methods (38% and 35%, respectively), followed by condoms (14%). A much smaller proportion of women in the private sector talked to their providers about these methods, particularly the IUD (12%).

The counseling that did occur with these abortion clients was not comprehensive. Figure 4 (page 18) shows that only 11% of clients in the public sector and 4% in the private sector talked about three or more methods with their doctors.

The relationship between counseling and the intention to use modern contraception is unclear, due to the large amount of missing data for the intention to use question. Among those who responded, it appears that women who were counseled were more likely to intend to use a method than those who were not counseled. Eighty-six percent of women who were counseled (n=43) said they intended to use a modern method, compared with 71% of those who were not counseled (n=48); although this result has borderline statistical significance ($p=0.08$), the large number of missing values raises questions about the association.

Table 5. Percentage of clients reporting FP methods that providers mentioned, and percentage of providers reporting FP methods that they typically mention to clients, by sector

	Clients' report		Providers' report*	
	Public % (n=85)	Private % (n=25)	Public % (n=55)	Private % (n=10)
Any method	46	44	100	100
IUD	38	12	98	100
Pill	35	28	95	80
Condoms	14	20	73	50
ECPs	5	8	11	10
Injectables	5	0	38	20
Female sterilization	0	0	31	30
Male sterilization	0	0	25	20

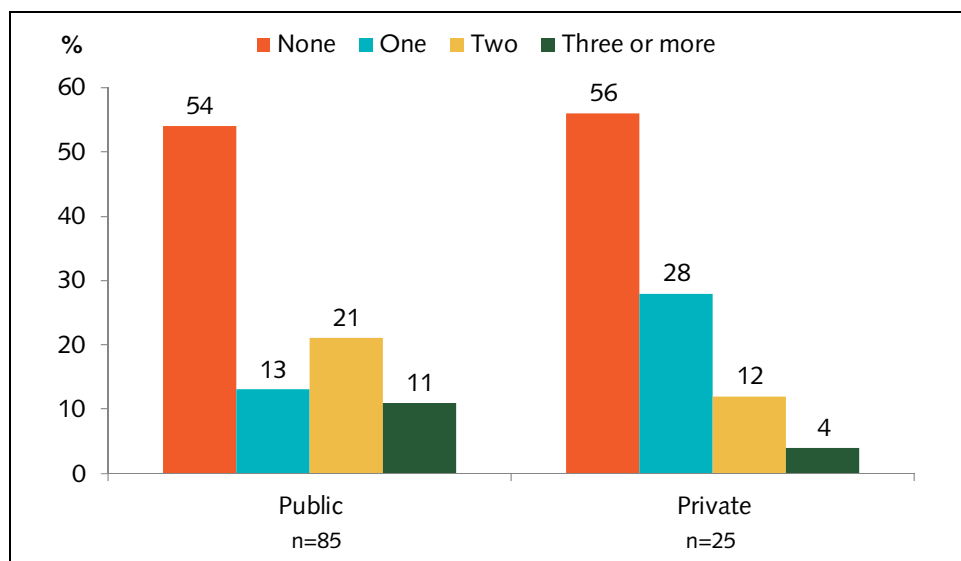
* Clients were asked specifically what methods their provider mentioned during their abortion visit, or on a visit in preparation for the abortion. Providers were asked what methods they typically discuss with abortion clients.

In Albania, anecdotal evidence suggests that it is common for family members to be present in the room during health procedures, and their presence may inhibit discussions between client and health care provider about sensitive topics. However, the presence of family members in the room during the discussion of FP did not appear to explain the low levels of counseling in this sample, since fewer than 3% of clients reported having relatives in the room. All women reported the presence of nurses, and about half reported that other doctors were in the room during their visit (data not shown).

Despite the low levels of counseling for abortion clients, nearly all women reported that their providers encouraged them to use the contraceptive methods they discussed (data not shown). The only method that any woman said her provider discouraged was ECPs, and only one woman mentioned this.

As frequently observed in FP research, client-reported and provider-reported counseling practices differ. When asked what methods they discuss with clients, the overwhelming majority of ob-gyns (80–100%) reported that they counsel abortion clients on the IUD and the pill (Table 5). One-third of ob-gyns said they typically counsel abortion clients on sterilization as well, but none of the interviewed clients said their providers had mentioned this procedure (Table 5). Possible explanations are that the providers are not making themselves clear during counseling sessions, that they overestimate how frequently they counsel their clients on all available options, or that clients cannot remember what was said.

Figure 4. Percentage distribution of abortion clients, by number of FP methods discussed with provider, according to sector



The low level of counseling is not due to a lack of counseling tools. Ninety-five percent of providers reported having tools for FP counseling and were able to show them to interviewers upon request (data not shown).

Providers were asked to look at the terms on six cards and rank them by how much of a barrier they would present to contraceptive counseling. The terms on the cards ranged from systemic barriers like supply of contraception, time constraints, and profitability to such nonsystemic barriers as client demand, knowledge, and concerns about medical consequences. Providers ranked health care system factors as the smallest barriers to contraceptive counseling (Table 6). The two barriers perceived to be the biggest problems were client demand and health concerns. If lack of client demand gets in the way of contraceptive counseling, it creates a vicious cycle by which little progress can be made. Clients may be voicing a lack of interest in FP before the provider has a chance to bring the subject up, or providers might not bring up the topic due to a perception that clients do not want to discuss it. In either case, it is in the client's best interest for the provider to attempt to discuss it and ensure that she is at least making her decision based on accurate information.

Table 6. Percentage of provider perceiving that a particular topic is one of the two greatest barriers to contraceptive counseling

Barrier	% (n=56)
Health concerns	79
Client demand	73
Knowledge	30
Supply/availability	0
Doctor time constraints	16
Profitability	0

Among those who ranked at least four barriers.

No providers listed profitability as one of the top two barriers. In fact, nearly all providers ranked it last, regardless of whether they worked in the public or the private sector (data not shown).

3. Health Care System Influences

Besides counseling practices, several health care system factors might influence a woman's decision to use FP. Systemic factors include the health infrastructure (e.g., where services can be obtained), payments for health care, the organization of services (e.g., who can offer services and the amount of time it takes to do so), and supply availability. However, this study focused on the first two of these factors.

3.1. Location and Source of Information about FP

Knowing where to find FP information and methods is crucial to uptake. Clients interviewed in this study knew where they would go to find condoms or oral contraceptives, but fewer knew where to get the IUD and ECPs (Table 7). Those who did know where to go generally reported that health care facilities are the place to go for the IUD and that pharmacies are for all other methods (condoms, pill, ECPs).

Table 7. Percentage distribution of clients, by where they would go to get a particular FP method, according to method (n=112)

Location	% of clients			
	IUD	Pill	Condom	ECPs
Health care facility	57	16	1	4
Pharmacy	4	77	95	73
Don't know	39	7	4	23

Clients mentioned various sources for FP information; the most common were doctors or nurses, followed by partners, friends, and family (Table 8). Women going to public-sector clinics were more likely to report getting advice from their partners than were women at private-sector clinics (31% vs. 16%), while family and friends played a larger role for women at private-sector facilities (Table 8). The Internet and other media were the least frequently mentioned source of receiving information for both groups.

Table 8. Percentage of clients reporting sources of FP information, by sector

Source of information	% of clients at public facilities (n=87)	% of clients at private facilities (n=25)
Doctors/nurses	49	44
Pharmacist	14	8
Partner	31	16
Family	24	44
Friends	20	36
Internet/media	14	8
Nobody	10	8

3.2. Payment for Services

We asked clients how much they paid for abortion services, to understand the frequency of payment, the magnitude of payment, and how payments might impact service provision.

Frequency of payment

The majority of women in both sectors paid for abortion-related services. In the private sector, as expected, all women paid (Table 9). In the public sector, where voluntary abortion carries a formal fee, 74% of women paid and 13% of women did not (Table 9). Most of the women who did not pay in the public sector had insurance (nine of 11 women).

Table 9. Percentage distribution of abortion clients, by whether they paid for various services, according to sector

	% who paid	% who did not pay	% who did not respond
Public sector (n=87)			
Total visit on day of abortion	74	13	14
Labs*	79	20	1
Supplies	58	41	1
Staff			
Doctor	4	64	32
Anesthetist	14	56	30
Nurse	1	67	32
Lab technician	24	46	30
Registration clerk	6	66	29
Other	32	39	29
Private sector (n=25)			
Total visit on day of abortion	100	0	0
Labs	84	16	0
Supplies	12	88	0
Staff			
Doctor	0	100	0
Anesthetist	52	48	0
Nurse	0	100	0
Lab technician	80	20	0
Registration clerk	0	100	0
Other	96	4	0

* Lab tests may have been paid for on a visit prior to the abortion, whereas the total payment question referred only to the day of the abortion; this explains the higher percentage paid for labs than for the total visit in the public sector.

Not all women with insurance received services for free. In the public sector, 72% of women with insurance paid during their visit. However, the proportion who paid was smaller for those with insurance (72%) than for those without it (95%). Interestingly, one-third of insured women (33%) sought services in the private sector, where they must pay full price. When

women seeking services at private facilities were asked why they chose that facility, the overwhelming response was for quality (of the facility or physician) (80%), suggesting that women are willing to pay for quality.

Magnitude and formality of payment

The median payment made for the abortion-day visit by private-sector clients was 8,000 Lekë (US \$71), compared with 6,000 Lekë (US \$54) in the public sector (Table 10). This includes everything that the women paid at the facility on the day of the visit (for tests, procedures, medication, and gratuities). The official fee for abortion services in the public sector is 6,000 Lekë, demonstrating that most public-sector clients paid the official amount.

Having paid the official amount does not necessarily mean these women paid formally. It is possible that women paid 6,000 Lekë for services but that the money was not paid to the facility. Of the 64 public-sector clients who responded to our question about a staff gratuity, 44 of them (69%) said they paid a gratuity, thereby signifying an informal payment.⁷

In addition to looking at the total payment, we asked specifically about payments for tests and procedures. The median amount paid for tests and procedures was slightly higher in the private sector than in the public sector (1,500 Lekë compared with 1,000 Lekë; US \$14.20 vs. US \$9.46) (Table 10). This result should be interpreted with caution because of the very small number of private-sector clients reporting the amount they paid for tests and procedures.

Table 10. Median payments made for total abortion visit and for tests/labs among women who paid something and reported paying, by sector, according to currency

	Public			Private		
	n	Median	Range	n	Median	Range
Albanian Lekë						
Total paid on day of abortion	64	6,000	1,000–17,000	25	8,000	2,000–17,000
Tests/labs*	41	1,000	1,000–10,000	5	1,500	200–1,500
US \$						
Total paid on day of abortion	64	57	9–161	25	76	19–161
Tests/labs*	41	9	9–95	5	14	2–14

105.6 Lekë=US \$1.

* Tests/lab services may have been paid during a visit on a day prior to the interview. Total payments were reported only for the day of the abortion service. For that reason, payment for tests may not be included in the reported total amount paid.

The 12 public-sector clients who did not say how much they actually paid for services were asked what they had expected to pay before coming for services. The median expected payment for these 12 clients was 5,000 Lekë, which is on par with what other clients told us.

⁷ Twenty-three women did not respond to the question about a staff gratuity. Collecting data about informal payments in health care is difficult for many reasons. First, neither clients nor providers are supposed to offer or accept them. Secondly, clients are not able to clearly identify what is a formal or an informal payment. Thirdly, payments are made in a “confidential manner,” often by a third party, so the respondent frequently does not know exactly how much was given. For those reasons, this estimate should be interpreted cautiously.

Their expectations ranged from 2,000 to 10,000 Lekë. Many of these clients said they did not know the exact amount to be paid because their partner or family member was making the payment.

Two-thirds of clients in both the public and the private sectors thought the amount they paid was reasonable (data not shown).

How payments might impact service provision or contraceptive use

The mean payment for abortion-related services did not differ by whether a woman was counseled on modern contraceptive methods ($p=0.27$), suggesting that payments do not drive a provider’s decision to discuss FP. Unfortunately, too many women were missing data to investigate the relationships between: the size of payment and intention to use modern contraception; whether a woman made an informal payment and counseling; and whether a woman made an informal payment and intention to use a modern method.

3.3. Preservice Tests and Procedures

Abortion

Included in the official fee for a public-sector abortion are an ultrasound, blood test, urinalysis, and anesthesia. Results showed that nearly all providers typically recommended an ultrasound, and more than 70% recommended the blood and urine tests (Table 11). Considering that the other tests are part of the official abortion fee in the public sector, it is surprising that providers did not say they recommended them all of the time. One-third of providers typically also recommended a pregnancy test.

Clients interviewed for this study reported receiving these tests/procedures in similarly high proportions (Table 12, page 23).

Although an ultrasound is included in the official public-sector fee, we wanted to know how much one would cost independently. The median payment for an ultrasound was 1,000 Lekë (US \$9) among the 41 public-sector clients who paid and responded to the question on level of payment (data not shown).

Table 11. Percentage of physicians who recommended various tests and procedures prior to an abortion, by sector

Test/procedure	% of ob-gyns at public facilities (n=55)	% of ob-gyns at private facilities (n=10)
Ultrasound	98	90
Urinalysis	73	80
Hemoglobin/blood test	73	70
Pregnancy test	35	30
Other*	20	30

*Other: tests for sexually transmitted infections, Pap smear

Table 12. Percentage of abortion clients who received various tests and procedures, by sector

Test/procedure	% of abortion clients at public facilities (n=87)	% of abortion clients at private facilities (n=25)
Ultrasound	100	100
Urinalysis	95	64
Hemoglobin/blood test	98	48
STI test	48	0

FP

In fee-for-service systems, the more tests and procedures that are ordered, the more income is generated for the health care provider or facility. A well-documented problem with this system is that physicians have an incentive to order unnecessary procedures or tests for their clients (Rich et al., 2012). In terms of modern contraception, the recommendation of unnecessary tests not only can impose financial barriers, but can also increase a woman's perception that modern methods are unsafe. For this study, we asked physicians what tests and procedures they generally recommended for clients who wish to use an IUD or the pill. To get providers to think about healthy patients with no complications, we asked for their typical practice.

More than 70% of providers said that they recommend an ultrasound prior to starting a woman on either type of IUD, and 60% of providers routinely recommended a pregnancy test (Table 13). Over a third of physicians habitually recommend both a pregnancy test and an ultrasound and this practice is common to both the public and the private sectors (Table 13). The WHO Medical Eligibility criteria note that it is important to rule out pregnancy prior to inserting an IUD (WHO, 2010b) but do not clarify the method that should be used to rule it out. Given the much higher cost of an ultrasound, it could be argued that other methods would be less expensive to the health care system or to the individual.

Table 13. Percentage of ob-gyns* who typically recommend a test/procedure prior to starting a client on modern contraception, by type of method and sector

Test/procedure	Copper T IUD		Pill	
	Public (n=49)	Private (n=10)	Public (n=55)	Private (n=10)
Ultrasound	71	70	73	70
Pregnancy test	59	60	58	60
Pap smear	59	20	20	10
STI tests	39	50	9	10
Other [†]	27	20	15	20
Both ultrasound and pregnancy test	35	30	38	40

* Among those who have inserted an IUD or prescribed the pill in the last three months.

† Uterine exam, glycemic index, hemoglobin, mammogram, hormone panel, breast exam.

For potential oral contraceptive users, about 70% of the interviewed physicians recommended an ultrasound, and 60% recommended a pregnancy test; this result was similar in both the public and private sectors (Table 13). According to the WHO, an ultrasound is not indicated

for pill users, nor is it essential to rule out pregnancy prior to starting the pill, as long as the provider is reasonably certain a client is not pregnant (WHO, 2012). For those reasons, the high proportion of providers recommending these tests for pill users is surprising and represents not only a financial cost, but also a time investment for the client.

3.4. Follow-Up Visits

Returning to the health care facility for a follow-up visit is important for some procedures that have a risk of complications. The WHO offers recommendations for the number of follow-up visits necessary for best practice. These internationally accepted guidelines are for the typical client, rather than for anyone with special medical needs. In this study, we asked providers how many follow-up visits they recommended routinely for abortion and FP clients and compared the results with the WHO guidelines.

For typical abortion cases, providers reported an average of 1.6–2.0 follow-up visits, with the first visit after 2.7 weeks (Table 14). Prior to 2012, the WHO recommended one follow-up visit for abortions after the procedure (WHO, 2003); however, this guideline has recently been revised to no longer recommend a routine follow-up visit (WHO, 2012). The reasons providers gave to most clients about the need for a follow-up abortion visit included the following: to check for complications; to check on general health; and to ensure that the abortion was complete. Only one client reported that the provider told her to return for an IUD insertion (Table 15, page 25).

For the use of modern contraception, the interviewed ob-gyns in both sectors recommended more visits than the WHO guidelines (Table 14). The average response for the number of visits following IUD insertion was 2.5 in the public sector and 2.3 in the private sector, compared to the 1 suggested by WHO (WHO, 2004). In the first year of pill initiation, the doctors said they typically recommend 2.3 or 2.4 visits, whereas the WHO suggests one visit within six weeks of starting the pill and then one annual visit every year thereafter (WHO, 2004).

Table 14. Number of recommended number of follow-up visits for abortion, IUD, and oral contraceptive clients*

Type of client	No. of recommended follow-up visits		
	Ob-gyns		WHO
	Public (n=55)	Private (n=10)	
Abortion	2.0	1.6	0–1
IUD [†]	2.5	2.3	1
Oral contraceptives [†]	2.3	2.4	1–2

* Ob-gyn data represent the mean number of recommended visits reported by the respondents;

WHO data represent the number of recommended visits by international standards.

† In the first year of use

Table 15. Percentage of abortion clients reporting various reasons their providers gave for the first postabortion follow-up visit

Reason	% of clients (n=90)
Check for complications	51
Check on general health	39
Ensure complete abortion	26
Insert IUD	1

4. Knowledge

Although health care system factors likely contribute to low modern contraceptive use, knowledge is another important component.

4.1. Clients' Knowledge of Fertility

The use of traditional methods of contraception and withdrawal is most effective when women avoid intercourse on the most fertile days of their menstrual cycles. Although withdrawal is the most commonly used method of contraception among women in this study, fewer than one-quarter of respondents (24%) knew that they are most likely to get pregnant halfway between their two periods (Table 16). Knowledge of postabortion return to fertility was fair, at 63%; this indicates that more than one-third of women who had just had an abortion (37%) did not know how quickly they could become pregnant again (Table 16). Knowledge about return to fertility after stopping contraception was also low for oral contraceptives (42%) and especially for the IUD (16%) (Table 16).

Table 16. Percentage of clients with correct knowledge of fertility-related items

Knowledge item	% of clients (n=112)
Most fertile halfway between menses	24
Fertility returns within 1 month:	
Postabortion	63
After stopping oral contraceptives	42
After IUD removal	16

4.2. Clients' Knowledge of FP

Clients' knowledge of FP methods varied by health care sector. Women in the public sector were more familiar with modern contraceptive methods, such as the IUD, the pill, and injectables, than were those in the private sector (Table 17, page 26). Withdrawal was mentioned much more frequently by private-sector clients than by public-sector clients (76% vs. 40%).

Given that only 46% of women could name the IUD without prompting, it is not surprising that only 36% of women knew that the IUD is effective for at least five years (not shown).

Table 17. Percentage of clients who had heard of specific FP methods, by sector

Method	% of clients at public facilities (n=87)	% of clients at private facilities (n=25)
Pill	94	48
Condom	78	72
IUD	55	16
Withdrawal	40	76
Injectables	33	0
ECPs	35	20
Other	15	24

Women were asked to rate five FP methods in order of their effectiveness (IUD, the pill, condoms, ECPs, and withdrawal). Because so few women were familiar with the IUD and ECPs, we used the ranking for just the remaining three methods. In order of most-effective to least-effective, those methods were: the pill, condoms, and withdrawal. Among those who were familiar with these three methods, 61% public-sector clients responded with the correct order (n=54), as opposed to only 29% of clients in the private sector (n=14) (data not shown). Despite the low proportion of women who could rank the methods correctly, 74% did rank withdrawal as the least effective method (data not shown).

4.3. Providers' Knowledge of FP

Clients' poor knowledge about the relative effectiveness of FP methods may stem from their health care providers' similar perceptions. Out of the same three methods that clients ranked for effectiveness (oral contraceptives, condoms, and withdrawal), only 72% of providers placed them in the correct order (data not shown). Because providers were familiar with the IUD, they also ranked it. Fifty-two percent put all four methods in the correct order, with the IUD as the most effective, followed by the pill, condoms, and withdrawal (Table 18). Only 50 of the 65 providers participated in the ranking exercise; 15 chose not to respond to the question on effectiveness.

Three quarters of providers (74%) knew that the IUD can be inserted immediately postabortion and that the IUD is a suitable method for postabortion clients (data not shown).

Table 18. Percentage of providers* reporting correct or incorrect knowledge of the effectiveness of four common FP methods

Knowledge item	% of ob-gyns (n=50)
Correctly ordered methods by effectiveness [†]	52
<i>Incorrectly ranked:</i>	
Pill more effective than IUD	30
Condoms more effective than IUD	24

* Among those who ranked the four most common methods.

† Correct order from most to least effective is: IUD, pill, condoms, withdrawal.

5. Attitudes about FP Methods

A woman's decision to use an FP method is not solely based on system-level factors, knowledge, and counseling practices. Factors such as clients' attitudes, preferences, and priorities are an integral part of the decision-making process and can impact behavior. This section explores feelings about various methods, as well as abortion, among providers and clients.

5.1. Rationale for Choosing a Particular Method

The majority of women who said they would use an IUD in the future said it was because this method held the least amount of worry (60%) (Table 19). One-third of those choosing the IUD said it was because it had few side effects or because the doctor recommended it. Women who chose the pill had an array of reasons; the most popular were having personal control over it (36%) and its causing the least amount of worry (25%) (Table 19). Of the 16 who chose condoms, 63% did so because it has the fewest side effects (Table 19). Six of the eight women selecting withdrawal said it is because they trust their partner (data not shown).

Table 19. Percentage of clients giving various reasons for choosing a particular FP method, by method

Reason	% of clients		
	IUD (n=20)	Pill (n=28)	Condom (n=16)
Least expensive	5	7	25
Least amount of worry	60	25	38
Fewest side effects	30	18	63
Doctor's advice	30	14	6
Safe for health/effective	25	14	19
Personal experience	0	14	0
Personal control	10	36	0
Partner preference	20	14	0

Of the 12 women saying that they would not do anything to prevent pregnancy in the future, five (42%) reported it was because they feared side effects, and three (25%) said that their partners disliked contraception (data not shown).

In fact, side effects were a common concern about oral contraceptives for abortion clients. Thirty-two percent voiced concerns about using the pill, and the overwhelming majority of concerns were about side effects (Table 20, page 28). Whereas the majority of concerns were about legitimate side effects like weight gain and headaches, 13% of all women were concerned about unlikely side effects, such as cancer and liver disease. Very few women voiced concerns about using an IUD (12%), and even fewer could verbalize the concerns that they had (Table 20); however given that nearly three-quarters of clients were unfamiliar with the IUD, it is possible that other concerns were not captured in this study. Besides side effects, the IUD was perceived by one-third of women (33%) as a method only for women who do not want any more children (data not shown).

Providers who voiced concerns about oral contraceptives all mentioned actual side effects and some also mentioned difficulties with patient adherence to the pill regimen (data not shown).

Table 20. Percentage distribution of clients, by concerns about using FP methods, according to method

	% of clients (n=112)
Oral contraceptives	
Concerned	32
Actual side effects	21
Overstated side effects*	13
Not concerned	28
Unfamiliar with method	38
No response	3
IUD	
Concerned	12
Actual side effects	<1
Overstated side effects [†]	3
Not concerned	15
Unfamiliar with method	72
No response	1

* For the pill, overstated/misconceptions about side effects include: cancer, kidney disease, heart disease, any medicine causes damage.

† For IUD, overstated/misconceptions about side effects include: cancer, infection, and spontaneous expulsion.

In terms of safety, respondents ranked the pill and the IUD as less safe than withdrawal or condoms. Half of providers (48%) and clients (55%) ranked withdrawal safer than oral contraceptives (data not shown). One-third of providers (35%) ranked withdrawal safer than the IUD. Both groups of respondents placed the condom as one of the safest methods (data not shown).

5.2. Partner Attitudes and Communication

Without the support of a partner, certain contraceptive methods could be hard to use. We asked clients if they had talked to their partners about FP and how their partner's preferences aligned with their own. Almost all of the interviewed abortion clients had talked to their partners about the abortion (97%), and 75% had talked to their partners about FP methods.

Sixty-five women ranked the pill, condoms, withdrawal, and abortion by their own preference, their partner's preference, and their family's and friends' preferences. Clients preferred modern contraceptive methods, and condoms were the most popular first choice, with 40% of the top rankings (Table 21, page 29). Only 6% of women said they preferred abortion over the contraception. Most women reported that abortion was their least preferred way to determine their family size, because abortions hurt, damage your uterus and future fertility, and are expensive (data not shown).

These preferences differ from what the women perceived to be their partners' preference. Women perceived that their partners preferred withdrawal rather than other modern methods. The clients' perception of their family's and friends' preferences mirrored those of their partners.

Table 21. Percentage distribution of clients,* by their own preferences and their perceptions of their partners' and family's/friends' preferences for contraceptive methods and abortion

Liked most	% of clients reporting		
	Client's preference	Partner's preference	Family's/friends' preference
Condoms	40	12	22
Pill	28	29	22
Withdrawal	26	46	38
Abortion	6	12	18

* Among 65 clients who ranked all four methods.

5.3. Why Modern FP Methods Are Unpopular in Albania

Clients and providers were asked why more women in Albania do not use modern FP methods. The overwhelming majority of respondents responded that a lack of contraceptive knowledge and a fear of the impact modern methods have on a woman's health keep modern method use low (see Table 22). Some providers attributed the low modern method use to a mentality or culture of aversion to modern methods. Cost was mentioned by fewer than 10% of abortion clients and 11% of providers, suggesting that financial barriers play a much smaller role in the low use of contraception than cultural ones.

Table 22. Percentage of clients and providers reporting reasons why modern FP is unpopular in Albania

	% of clients (n=112)	% of providers (n=65)
Lack of knowledge	50	77
Fear health effects of modern methods	45	40
Partner	13	2
Cost	6	11
Mentality/culture	4	23
Other	1	4

Discussion

This study explored potential barriers, knowledge, attitudes and practices about modern contraception among abortion clients in Tirana.

Payments

The goal of this study was to explore the possibility that payments for health care affect FP use in Tirana, Albania. We did not find evidence that providers actively discourage FP or that clients perceive cost to be a major barrier to contraceptive use. Payments seem to be more related to insurance status and service location rather than to counseling practice. However, we observed an inflated number of tests and visits recommended for FP users, which could present barriers to modern contraceptive use.

Most clients in the public sector paid the official amount for abortion services, but two-thirds paid a staff member directly, suggesting that some or all of their payment was informal. Regardless of the legality of the payment made in the public sector, private-sector clients paid slightly higher fees.

This study provides evidence of a potential financial barrier to contraceptive use. Ob-gyns reported recommending more tests and follow-up visits for women initiating the IUD and the pill than are suggested by the WHO. Given the fee-for-service structure of informal payments in the public sector and all private-sector payments, these extra test and visits could carry additional costs. They could also increase the perception that modern contraceptives are dangerous for a woman's health.

While the motivations for ordering extra tests and visits are unclear, possible explanations include: outdated training information; a genuine concern about the health impact of these methods; a desire to maximize financial gain; or a combination of all three options. Although financial incentives for adding extra tests or visits are facilitated by an informal payment system, they are also present in the private, fee-for-service system in Albania and other countries, like the United States. They are also present in many sectors of society, not just reproductive health care. The evidence that insurance status impacts payments for services suggests that financial reform efforts are working but still need to be encouraged. However, changes to the payment system alone will not improve FP use in Albania; this study highlighted several other areas that need to be improved simultaneously to realize real and permanent change.

Nonfinancial Factors

The providers in this study were experienced and had recently been trained in both abortion and FP counseling. Yet there is room for improvement. Despite the recent FP trainings, a great proportion of providers lacked knowledge regarding the effectiveness of modern methods. In addition, few providers had practical training in IUD insertion, which could make them less confident in their ability to correctly place the device. Nearly one-quarter of abortion

clients said they would use an IUD in the future, but not one had an IUD inserted immediately postabortion; it is possible that lack of competency-based training is contributing to low IUD use in this population.

Another contributing factor is the extremely low frequency of contraceptive counseling for abortion clients; fewer than half of the women said that a provider mentioned any FP method. Despite health care providers' recommendation for postabortion follow-up visits, results suggest that providers consider these visits as a means of check-up rather than a counseling session. Providers say that they do not counsel about FP because their clients do not want it and have health concerns, but that is exactly why providers should make an increased effort to provide correct information. FP decision making is a process that can take time and continues throughout the reproductive life cycle; therefore, the lack of comprehensive FP counseling for clients, particularly repeat abortion clients, is a missed opportunity to encourage informed decision making.

Many studies have shown that health concerns play a major role in Albania's low level of FP use, and this study confirms them. Addressing these fears is going to take time and strong, multigenerational efforts. Women and men need accurate information about basic reproductive health/fertility and the safety and effectiveness of modern FP methods. Broadly speaking, although abortion clients are well-educated in general, they are poorly educated in regard to FP and modern contraception.

FP use is not exclusively a female responsibility but one of the couple; therefore, the role of the male partner and his involvement in this process is paramount. Nearly all abortion clients had discussed FP with their partners, but while the women preferred more modern methods (condoms being their first choice), their partners often preferred withdrawal. It is important for couples be well-educated on the options so they can effectively resolve these differences.

Access to and referral for FP also should be strengthened. Abortion clients lacked information about where to obtain IUDs. In addition, despite oral contraceptives' supposedly being available for free at public-sector facilities, most clients said they would go to a pharmacy to purchase them. This could be due to the relative convenience of pharmacy visits, a real or perceived lack of supplies at facilities, or poor awareness that the pill can be obtained at health care facilities for free. Given the changes to FP method provision expected under the Contraceptive Security Strategy, it could be beneficial that women use pharmacies for pill provision; however, the lack of knowledge of where to get an IUD demonstrates a need for more effective referral practices within health care facilities and stronger educational efforts outside of health clinics.

This study explored barriers to contraceptive acceptance among abortion clients in Tirana. Abortion clients are quite literate and aware of different available modern contraception methods, but they are poorly educated about the benefits and effectiveness of modern contraceptive methods and the sources where these methods can be found. Male partners are part of the decision-making process of abortion, but they rely mostly on withdrawal as an FP method, which increases the likelihood of unintended pregnancy and abortion. On the other hand, health care providers contribute to factors that deter the use of modern contraceptives. Some lack up-to-date information about the effectiveness of these methods, lack appropriate counseling skills, and require unnecessary tests and visits (compared with the WHO

guidelines), which can increase the cost of modern methods. In summary, the decision to use FP methods is a complex one, likely to be governed by many factors, not solely financial ones.

This study showed that facility type (public-sector vs. private-sector) and insurance status are important factors for determining the amount paid for abortion-related services. Women's choices to use FP appeared to be more related to concerns about the safety of contraception than to any financial factors. The potentially excessive use of follow-up visits and unnecessary tests may increase women's fears about contraception and may require a little extra financial investment, but it seems that most women never get to the point of even discussing this level of FP detail with their providers. To improve FP use in Tirana, particularly among abortion clients, basic information must be provided and behavior change must be promoted. Given that women with insurance, who are eligible for treatment at discounted rates in the public sector, still go for services in the private sector suggests that some women are willing to pay for premium care and quality. If the physicians that women know and trust encourage FP use with each client and publicly, women may begin to associate modern methods with high-quality care. Behavioral change will take time to show results.

Limitations

Prior to offering recommendations, a few study limitations must be discussed.

The recruitment rate was close to 85% for clients and 97% for providers. However, some questions had quite a few missing responses, particularly those relating to payment, intention to use, and ranking exercises. These high rates of missing impact our ability to come to conclusions representative of our sample. Two reasons for these low rates were the sensitive nature of payment questions and the low levels of knowledge regarding some methods of contraception. We used the data we had to the best of our ability, but payment data, intention to use, and the ranking exercises must be interpreted with caution, as we do not know in which direction the respondents who refused to answer would take the results.

The sampling strategy for this study has implications for generalizability. By sampling only registered private facilities, we miss an unknown, and potentially large, proportion of abortion clients who seek abortion services at clinics operating outside of government jurisdiction. Our results cannot be generalized to these women, and if certain population groups (e.g., the Roma or the poor) attend these facilities more than official ones, these populations were missed. In addition, policy changes concerning the registration of private abortion clinics made after this study was concluded mean that some private facilities involved in this study may no longer be in operation. The impact of this change on the generalizability of results is not addressed in this report.

As in most studies about sensitive issues, social desirability bias likely played a role in this study. The fact that providers reported typically counseling all abortion clients on FP, but that half of clients were not counseled, exemplifies this bias. In cases like these, we did our best to minimize the bias by asking the population with the least interest (e.g., clients, in terms of counseling).

Conclusions and Recommendations

Albania continues to have one of the lowest rates of modern FP use in Europe. Additionally, negative perceptions about method effectiveness and safety are common. Reliance on abortion remains high and underreported. Anecdotal data show that unsupervised and self-administered medical abortion rates are growing rapidly. On the other hand, FP interventions are no longer attracting donor agencies, and the Albanian government does not plan to subsidize modern contraceptives for the general population. Expressly because of low contraceptive use, its persistence over the last decade, negative attitudes toward contraception, and the lack of subsidies, it is possible that the abortion rate will grow without dedicated efforts for FP programs.

To address FP clients' needs and improve services in Albania, programmatic efforts should be focused on switching the approach from abortion toward strategic prevention interventions. The time has come to develop new policies and programs to break the “abortion culture,” alleviate misconceptions about modern contraception, and quickly move to a preventive FP approach—a “modern contraception culture.” This can be done through combined and integrated socioeconomic and long-term behavioral health interventions.

In Albania, managing the number of children a couple wants is a complex issue that is influenced by many factors, and there is no single approach to address it. Nevertheless, based on our findings and the context of Albanian culture, this study concludes with the following programmatic recommendations:

1. Strengthen pre-service and in-service FP training curricula to be competency-based (including both theoretical and practical components) and include patient-centered counseling.
2. Create tailored, innovative education and long-term behavioral change programs that cover all FP methods, as well as general reproductive and sexual health issues.
 - a. Tailor messages to address misconceptions about and fears of modern FP methods, specifically by providing accurate information about the risks and likelihood of side effects.
 - b. Promote male involvement in FP education and postabortion follow-up care, to foster responsible sexual and decision-making behaviors.
 - c. Allocate long-term funding to these efforts, to enable time for behavior change to occur.
3. Reorganize reproductive health care and referral services so that FP counseling and service delivery is very easily accessible to abortion clients, particularly at large public-sector facilities.
4. Strengthen national reproductive health protocols and monitor adherence transparently to encourage accountability.
 - a. Implement performance reviews, or a similar competitive system, to incentivize providers to adhere to protocols and promote best practices.
 - b. Harmonize national abortion and FP guidelines with international guidance (WHO) for the number of tests required when initiating, and the number of follow-up visits needed to safely use, modern FP methods.

In addition to programmatic efforts, research that provides reliable and scientific data is another component that can help improve acceptance of modern contraception and reduce reliance on abortion in Albania. The following research studies are recommended:

1. A qualitative analysis of the proximate and systemic factors influencing men's contraceptive choices
2. An evaluation of reproductive health curriculum in public schools, as well as knowledge of and attitudes about modern FP use among students and teachers
3. An evaluation of the reasons behind ultrasound use prior to contraceptive initiation, for abortion clients, and other women's health services.
4. Implementation research to assess the most effective models of FP service provision, particularly in the private sector, and once the Albanian government restricts eligibility to free contraceptives (Part of this work should include an assessment of method availability and changes in use following policy changes.)

References

- Balabanova, D., McKee, M., Pomerleau, J., Rose, R., and Haerpfer, C. 2004. Health service utilization in the former Soviet Union: Evidence from eight countries. *Health Services Research* 39(6 Pt 2):1927–1950.
- Boci, A., Volle, J., and de Negri, B. 2011. C-Change MNCH Intervention: Baseline and follow-up surveys with clinic attendees. Washington DC: C-Change.
- Centers for Disease Control and Prevention (CDC) and ORC Macro. 2003. *Reproductive, maternal and child health in Eastern Europe and Eurasia: A comparative report*. Atlanta, GA, and Calverton, MD.
- CIA. 2011. *CIA world factbook: Albania*. Accessed September 20, 2011, at <https://www.cia.gov/library/publications/the-world-factbook/geos/al.html>.
- David, H. P. 1992. Abortion in Europe, 1920-91: a public health perspective. *Studies in Family Planning* 23(1):1–22.
- Gaal, P., Belli, P. C., McKee, M., and Szocska, M. 2006. Informal payments for health care: Definitions, distinctions, and dilemmas. *Journal of Health Politics, Policy and Law* 31(2):251–293.
- Gjonça, A., Aassve, A., and Mencarini, L. 2009. The highest fertility in Europe—for how long? Determinants of fertility change in Albania. *Demográfia* 52(5):76–96 [English edition].
- Gryboski, K., Hoxha, E.G., Volle, J., and deNegri, B. 2009. *Women's perspectives on contraception: A qualitative study among university students in Tirana, Albania. Report of findings*. Washington, DC: Academy for Educational Development (AED)/C-Change.
- IMB International. 2000. *Public information advocacy: Albania: the Albanian public's perceptions of the health care system*. Brussels, Ministry of Health and World Bank.
- Institute of Statistics (INSTAT), Institute of Public Health [Albania] (IPH), and ICF Macro. 2010. *Albania Demographic and Health Survey 2008–09*. Tirana, Albania.
- INSTAT. 2010. *Albania in Figures, 2010*. Tirana, Albania.
- Kovács, L. 1999. From abortion to contraception in Europe. *European Journal of Contraception and Reproductive Health Care* 4(4):229–236.
- Lewis, M. 2000. *Who is paying for health care in Eastern Europe and Central Asia?* Washington, DC: World Bank.

Merdani A, Çanaku D., Kakarriqi E. *Abortion indicators in Albania for the period 2009 - 2011*. Albanian Medical Journal: International Public Health Conference Supplement. Tirana 6-7 May 2013. Accessed July 22, 2013 at [http://www.ishp.gov.al/multimedia/revista_mjekesore/Suplementi_Konferenca_Ok%20\(4\).pdf](http://www.ishp.gov.al/multimedia/revista_mjekesore/Suplementi_Konferenca_Ok%20(4).pdf)

Ministry of Health (MOH). 2003. *National contraceptive security strategy*. Tirana, Albania.

MOH. 2010. Development and institutionalization of National Health Accounts (NHA), Albania. Health System Modernization Project. Project No. 4154. Tirana, July 27, 2010.

MOH. 2011. *National contraceptive security strategy 2012–2016*. Tirana, Albania.

Patel, L., and Janowitz, B. 2010. *Informal payments and reproductive health in Eastern Europe and the Caucasus. Report to USAID. The RESPOND Project Study Series: Contributions to Global Knowledge—Report No. 1*. New York: EngenderHealth/The RESPOND Project. (www.respond-project.org/pages/files/6_pubs/research-reports/Study1-EEC-Background-Paper-March2011-FINAL.pdf)

People's Assembly of the Republic of Albania. 1995. Law No. 8045 of 7 December 1995: On the Interruption of Pregnancy. Fletorja Zyrtare No. 26. pp. 1144–1148.

Rich, E .C., Lake, T., and Valenzano, C. S. 2012. *Paying wisely: Reforming incentives to promote evidence-based decisions at the point of care*. White Paper. Center on Health Care Effectiveness, Mathematica Policy Research. Accessed February 7, 2013, at: www.mathematica-mpr.com/publications/PDFs/health/chce_poc_wp.pdf.

Riley, P., and Maddock, K. 2009. *Albania laws and regulations affecting commercial supply of modern contraceptives: Analysis and recommendations*. Bethesda, MD: Private Sector Partnerships (PSP)-One Project/Abt Associates, Inc.

Sedgh, G., Henshaw, S., Singh, S., Ahman, E., and Shah, I. 2007a. Induced abortion: estimated rates and trends worldwide. *Lancet* 370(9595):1338–1345.

Sedgh, G., Henshaw, S. K., Singh, S., and Bankole, A. 2007b. Legal abortion worldwide: Incidence and recent trends. *International Family Planning Perspectives* 33(3):106–116.

Sedgh, G., Singh, S., Shah, I., Ahman, E., Henshaw, S. K., and Bankole A. 2012. *Abortion ratios worldwide in 2008*. Author's version of the original Lancet research article, "Induced abortion: Incidence and trends worldwide from 1995 to 2008" *Lancet* 379(9816):625–632. Accessed on Jan. 31, 2013, at www.guttmacher.org/pubs/journals/Sedgh-Lancet-2012-01.pdf.

Serbanescu, F., Goldberg, H., and Morris, L. 2005. Reproductive health in the transition countries of Europe. In *The New Demographic Regime: Population Challenges and Policy Responses*. ed. by M. Macura, A. L. MacDonald, and W. Haug. New York and Geneva: United Nations, pp. 177–198.

Shekulli News Agency. 2013. Abortinuk do kryhetmënëklinika, pornëspital. Published January 10, 2013, at: <http://shekulli.com.al/web/p.php?id=13246&kat=109>.

- Shishkin, S., Bogatova, T., Potapchik, Y., Chernets, V., Chirikova, A., and Shilova, L. 2003. *Informal out-of-pocket payments for health care in Russia*. Moscow: Moscow Public Science Foundation and Independent Institute for Social Policy.
- Stolarsky, G., and DeCamp, K. 2010. *Expanding method choice and increasing quality of family planning services in Albania: Program Report*. Washington DC: ACCESS-FP.
- Tien, M., and Rao, R. 2008. *Albania: Sustainable financing for contraceptives 2009–2013: Analysis, findings, and implementation plan*. The Europe and Eurasia Regional Family Planning Activity. Tirana and Washington, DC: John Snow Inc., for the U.S. Agency for International Development (USAID).
- United Nations Office on Drugs and Crime (UNODC). 2011. *Corruption in the western Balkans: Bribery as experienced by the population*. Vienna..
- USAID|DELIVER PROJECT, Task Order 4. 2012. *Measuring Contraceptive Security Indicators in 2011*. Arlington, Va.: USAID|DELIVER PROJECT, Task Order 4.
- Vian, T., and Burak, L. J. 2006. Beliefs about informal payments in Albania. *Health Policy and Planning* 21(5):392–401.
- World Bank Group. 2012. GNI per capita, Atlas method (current US\$). World development indicators. Accessed October 3, 2012, at <http://data.worldbank.org/indicator/NY.GNP.PCAP.CD>.
- World Health Organization (WHO). 2003. *Safe abortion: Technical and policy guidance for health systems*. Geneva.
- WHO. 2004. *Selected practice recommendations for contraceptive use—2nd edition*. Geneva.
- WHO. 2010a. Global health expenditure database: Table of key indicators and sources by country. Accessed Sept. 20, 2011, at <http://apps.who.int/nha/database>.
- WHO. 2010b. *Medical eligibility criteria for contraceptive use—4th edition: A WHO family planning cornerstone*. Geneva.
- WHO. 2012. *Safe abortion: Technical and policy guidance for health systems—2nd edition*. Geneva.
- Zazo, A., Dragoti, E., Karaj, T., and Volle, J. 2011. *Albania family planning: Improving access to and use of modern contraceptive methods among young men and women*. Washington, DC: C-Change.