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Evaluating Antepartum Perspectives on Postpartum Family Planning Related to the Jhpiego ACCESS-FP Program in Albania

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Evaluating Antepartum Perspectives on Postpartum Family Planning Related to the Jhpiego ACCESS-FP Program in Albania

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An abstract of
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Abstract

Evaluating Antepartum Perspectives on Postpartum Family Planning Related to the Jhpiego ACCESS-FP Program in Albania

By Anne C Blauvelt

Background: Albania, a small Mediterranean nation, has undergone significant demographic change. Since 1955, Albanian TFR fell from 6.8 to 1.6. This occurred without use of modern methods of family planning (couples instead relying on withdrawal and abortion) and contributed to high rates of unwanted pregnancies. Recently, Jhpiego introduced nationwide provider training, with focused attention on postpartum and postabortion counseling in four cities. Providers in these cities received more detailed training on postpartum family planning, including IUD insertion instruction. **Objectives:** This study evaluates how antenatal counseling for postpartum family planning may increase uptake by looking at past use, current knowledge, and anticipated postpartum use of different methods. I hypothesized: Women whose Antenatal Care providers have received specialized family planning counseling training have heard of and plan to use more methods of postpartum family planning than women whose ANC providers did not receive this training. **Methods:** 242 women were surveyed from antenatal care clinics at maternity hospitals and polyclinics. Multivariate logistic models, controlling for age, education, rural/urban status and parity, were used to determine relationships between survey city and knowledge about, past use of, and anticipated use or family planning methods. **Results:** Evidence shows women in Tirana reported a higher rate of postpartum family planning counseling during ANC visits, 39.4%, than those in Durres, 18.5% (OR = 2.736; p = 0.0058). Additionally, 65.7% of women in Tirana planned to use a modern method of family planning postpartum, compared to only 38.2% of women in Durres (OR = 2.252; p = 0.0080). Furthermore, the methods specifically promoted by Jhpiego showed greater gains from ever use to anticipated use in Tirana than in Durres. **Discussion:** Although other factors could contribute to a higher anticipated rate of postpartum family planning use in Tirana over Durres, these results may be partly attributed to training providers for antenatal counseling for postpartum family planning, as supported by Jhpiego's work in Albania.

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CHAPTER 1. INTRODUCTION

Isolated from the world for nearly five decades, Albania remains a mystery to most of the world. While isolated – economically, diplomatically and socially - Albania experienced several major cultural changes, including: a decreased importance of religion and traditional honor codes, an increase in female employment, and widespread financial strife. Upon re-opening its borders in the late 1980s, these changes became apparent to the outside world, and several demographic shifts were noted, particularly the drop in total fertility rate from around 6 in the 1945 to 3 in 1990.

Following international research demonstrating the low knowledge and use rates for contraception and the high frequency of abortion, both the national government and international aid organizations moved to increase modern method use in the country. This research evaluates a program promoting both modern and traditional methods: ACCESS-FP, led by Jhpiego. Jhpiego worked with several partners to help the Ministry of Health develop a set of National Family Planning Protocols, train providers in these protocols, and improve providers' ability to counsel patients in family planning methods. Jhpiego chose to focus its component of the ACCESS-FP work specifically on postpartum and postabortion women. This included additional targeted training of providers at four maternity hospitals in three cities on family planning service provision for postpartum and postabortion women. An evaluation of postpartum and postabortion women's understanding of family planning before and after intervention has already been conducted. Therefore, this new research complements previous program evaluation by exploring anticipated use of family planning by antepartum, currently pregnant, women.

Specifically, this study evaluated Jhpiego programming by determining if women's knowledge about, comfort with, and anticipated use of postpartum family planning methods were higher in areas with more comprehensive and specialized Jhpiego provider training.

Jhpiego hoped to gain a better understanding of the success of this additional programming, and hypothesized that: *Women whose Antenatal Care providers have received specialized family planning counseling training have heard of and plan to use more methods of postpartum family planning than women whose ANC providers did not receive this training.* To test this hypothesis, data were collected from two cities, one where practitioners received expanded Jhpiego training, and the other where practitioners received standard MOH training.

Specifically, this study evaluates the postpartum counseling-uptake relationship, which improved uptake in other settings [1-3], by looking at past use, current knowledge, and anticipated postpartum use of different methods. Specifically, this study asked women to identify methods they had heard of, methods they had used in the past, methods they had discussed with their antenatal care providers, and methods they planned to use in the future. Using the data collected from these responses, my research compliments earlier studies by Jhpiego, looking at differences between women attending clinics in one of Jhpiego's target cities and women in a city that did not receive specialized postpartum family planning training.

CHAPTER 2. LITERATURE REVIEW

HISTORICAL AND CULTURAL CONTEXTS

Historical Setting

Albanians pride themselves in their strength and determination as a people. Descendents of Illyrian tribes, Albanians did not realize sovereignty until the early 1900s. Even then, their independence was fleeting. Once given the ability to self govern, Albania turned inward, not emerging until the early 1990s. Although crucial in shaping what it means to be an Albanian today, this history also isolated Albania from the development experienced by the rest of Europe.

Geographically, Albania is a small country. At roughly 28,748 square miles, it is roughly the size of the U.S. state of Maryland [5, pg. 13]. However, this modern state is often considered a smaller version of an Illyrian state, founded by the Albanoi tribe, that settled in the area as early as 1000 B.C. [6, pg. 6]. Although the Illyrians experienced a period of relative peace, Roman invasion between 229-168 B.C. began a 1600 year period during which the region was invaded by no less than 10 different ethnic/national groups, only to end with 500 years of occupation

Figure 1. Courtesy of CIA Factbook, source 4

by the Ottoman Empire [5, pg. 5-7]. It was not until 1912, two millennia after the Romans invaded Illyrian lands, that Albania was recognized as an independent nation-state, only to fall under Italian, and then German, occupation until 1944 [5, pg. 7]. While Albanians then gained independence, they turned inward, entering a state of isolation.

Enver Hoxha promoted Albanian isolationism, rising to power and taking control of the national government in 1944. Originally incorporated into the Soviet bloc, Albania's communist ideology favored the Chinese during the Sino-Soviet split in 1961. However, even this relationship, at the time Albania's only official diplomatic relationship, would only last until 1968. Around this time, the Albanian Government wrote and implemented a new Constitution, sealing Albania's fate for the next 25 years by forbidding "the undertaking of loans, credits or joint ventures with any capitalist, imperialist or revisionist government or institution" [5, pg. 40]. Originally intended to mandate Albanian "self-reliance," this move made it virtually impossible for foreign development, businesses, or academic institutions to assist in Albania's growth.

In addition to restricting contracts with foreign governments, Hoxha's system of self-reliance limited media, making it illegal to listen to or view foreign entertainment within Albania's borders [5, pg. 66]. Closing Albania's borders also ensured that no new modern methods of family planning could enter the country [7].[1] Isolation affected daily Albanian life and contributed to major changes in the concept of religion, demographic structure, and role of women in the nation. Each of these changes added to a collective effect that reduced fertility in Albania, and created modern Albania.

[1] ?

Religious and Cultural Context of Albanian Family Planning

Because Albanian family planning and population data is unreliable before 1990 [8, pg. 309], neighboring countries serve as reference on family planning in the region. However, Albania is a more religiously diverse nation than many of its neighbors; it is home to Muslim, Greek Orthodox and Catholic populations.

Despite relative heterogeneity in religious groups, the importance that religion plays in defining Albanian self remains unclear. Muslim and Catholic groups transferred religious control of Albania over the centuries, and religion was legally "abolished" in 1967 during the communist regime [5, pg. 44]. Following this proclamation, religious leaders were prosecuted and religious institutions were closed across regions and religions. However, as Albanian historian Derek Hall accounts, "[a]t the individual level, religious faith could not be so easily eradicated: 'crypto-atheism', whereby Albanians outwardly went along with the regime, but secretly continued their religion at home, appears to have been widespread. . . " [5, pg. 45]. Today, as Albanians re-emerge from communist power, religion has begun to re-emerge as well, taking on new power and responsibility. Although it may not be a major factor in decision making yet, its future influence is likely to expand.

Further discussion of the major religious groups, as well as the Kanune e Leke, a set of social laws which dictated Northern Highland life for centuries, will show how religion plays into traditional and modern Albanian life. Additionally, each religion will be looked at to determine how it views marriage, intercourse, family planning and women's reproductive health, in order to understand the socio-religious context in which Jhpiego found Albanian family planning.

Islam

Islam is the primary religion in Albania, accounting for roughly 70% of the population [9, pg. 118]. About 15% of the population consists of the little known Bektashi Muslims, a sub-sect similar to the dervishes of Turkey. The remaining Muslim population in Albania, 55% of the total population, is Sunni, with little to no Shiite representation [9, pg. 118]. Because of the prominence of Islam in Albania, understanding traditional views of family planning must also include a discussion of family planning in Islam.

Scholars assert that Islam provides many opportunities for family planning. In general, sexual intercourse is reserved for marriage, but is not solely for the purpose of procreation [10, pg. 132]. A report by the Population Reference Bureau on family planning in Islam cited several verses of the Koran - Al-Bagara (Sura 2:185); Al-Hajj (Sura 22:78); and, Al-Nisa (Sura 4:28) – which suggest that Allah does not intend any undue strain resulting from ill-timed births [11, pg. 3]. Both articles assert that the explanation of family planning as birth spacing instead of limiting family size would be more acceptable to Muslim couples [10-11].

Although this analysis of Islam in Albania is important to our understanding of family planning in the nation, we must also acknowledge the diminished hold of the Islamic Community nationwide. Nathalie Clayer explains that although the Community received financial assistance from many other Islamic nations following the legalization of religion after the Hoxha era, a major uptake in orthodoxy had not occurred. She states that with this history "significant numbers [of former Muslims] are either atheist or, while retaining their faith, do not attend places of worship" [9, pg. 123]. However, Clayer also

indicates that the presence of all religious groups is growing, indicating the potential for future involvement as the nation continues to emerge from isolation.

Greek Orthodox

Greek Orthodoxy accounts for 20% of the population in Albania [9, pg. 118]. The Greek Orthodox Church does not regulate sexual activity as closely as some factions of Christianity. Unlike Catholicism, conception does not need to be the intended outcome of sexual intercourse within Orthodox couples. However, intercourse is limited to marriage [10, pg. 130]. While more liberal than some similar religions, the Orthodox Church discourages the use of long-term methods, like IUDs [10, pg. 131]. This discouragement results from a belief that these methods affect the egg after it has already been fertilized [10, .pg. 131]. However, as Hatcher, et al. explains, most modern IUDs prevent fertilization rather than implantation [12, pg. 120]. Within the Albanian context, Greek Orthodox couples should be receptive to family planning discussion and suggestions. However, the fertilization prevention mechanisms of IUDs must be emphasized to couples considering longer acting methods.

Kanuni e Leke Dukagjinet

While religious beliefs about family planning are important to consider, traditional common laws dictated Northern Albanian life for centuries. This set of laws was most notably codified in the 15th Century Canon of Leke (Kanuni e Leke Dukagjinet) [5, pg. 26]. An examination of Books 2 and 3 of the Kanun,[2] focusing on the family and

[2] Only Books 2 and 3 were examined for this analysis. In all, there are 12 Books: The Church; The Family; Marriage; House, Livestock and Property; Work; Transfer of Property; The Spoken Word; Honor; Damages; The Law Regarding Crimes; Judicial Law; and, Exemptions and Exceptions. In literature, Books 2 and 3 were most commonly cited when discussing women's status in the nation, and were thus the only ones included.

marriage respectively, have no direct reference to fertility regulation. However, offspring are acknowledged as one of the main reasons for marriage. According to the Kanun, marriage means "to form a household, adding another family to the household, for the purpose of adding to the work force and increasing the number of children" (Kanun, 3.XI § 28). This indicates that many children may be wanted in order to support the household.

The only other direct reference to sexuality in the Kanun's Second and Third Books references the wife's responsibilities to her husband. According to the Kanun, some of wives' duties include: preserving the honor of her husband (13, 3.XIII § 33 a); submitting to her husband's dominance (13, 3.XIII § 33 c); and, fulfilling her conjugal duties (13, 3.XIII § 33 d). Collectively, it appears that procreation is an important part of traditional Northern Albanian society. However, these practices were outlawed during Communist rule and their hold on Albanian society has been substantially decreased.

Religion and Culture in Contemporary Albania

The roles of traditional common laws and religion in Albanian society remain unclear, but their influence seems to be growing as religious groups begin to struggle for power in the country. Clayer states that this competition "revolves around issues of 'tradition versus modernity,' the integration of Albania into Europe and more generally the country's position between East and West, ties with Albanians in neighboring countries, and the preservation of national identity" [9, pg. 133]. It therefore stands that while the Albanian population as a whole may not see religion as a major factor in their lives, it still holds considerable power at the national and international policy level.

POPULATION AND HEALTH IN ALBANIA

The Albanian Fertility Decline

As was previously noted, major fertility changes occurred during Albania's period of isolation. These changes are explained well by Jane Falkingham and Arjan Gjonca, who compared data from the 1950, 1955, 1960, 1969, 1970, 1989 Censuses and the Albanian Statistical Yearbook from 1991.

Falkingham and Gjonca demonstrate how fertility changed between 1945 and 1990. In 1945, an Albanian woman could expect to have around 6 children. By 1990, that expectation had fallen to around 3 [8, pg. 314]. According to the 2008-2009 DHS, that number is now below replacement, at 1.6 [14, pg. 53]. Between 1945 and 1990, the greatest changes were seen in fertility after age 45. By 1990, fertility for women in this age group was only 4% of its 1945 level [8, pg. 310]. Age at first birth also rose, suggesting a "compression" of the reproductive years of Albanian women [8, pg. 313-314]. The authors attribute this change to many of the policies implemented by the Communist regime, as well as the gradual improvement of women's status in the nation.

Policies Influencing Fertility

Politics have played a huge part in fertility in Albania for decades. Albania's Communist constitution states that "'The State give special protection to the interests of mother and child.'" The government aimed to achieve this goal through: increased access to pre-school care; free place in state funded kindergarten; and, decreased cost of children's clothes [8, pg. 314]. Furthermore, women were rewarded for multiple births. For example, women were designated "Heroic Mothers" on the first birthday of their eighth surviving child. Women with between four and seven children were given third, second

and first class awards of "Mother's Glory" [8, pg. 315]. The government implemented these policies and awards at the same time that women were nudged into the workforce, creating a double standard of productive worker and fertile child bearer.

Many authors accept that these policies affected Albanian fertility, but do not fully evaluate why. For example, three different articles cite the statistic that 50-55% of all maternal deaths were a result of an unsafe abortion [15-17]. However, Senturia states that "the pro-natalist philosophy of the communist government may have been so widely accepted because it played into an already pervasive positive attitude towards childbearing" [18, pg. 1105]. In earlier sections, the importance of childbearing among religious and cultural groups in Albania was discussed and, according to Senturia, these sociocultural groups and ideals still affect Albanian reproductive and sexual health today.

After the Communist government fell, many changes were made to laws dictating the use of family planning methods. In 1990, abortion was made legally permissible for more reasons, and by 1991, it was essentially available on request. This shift in policy led to a noticeable decrease in maternal mortality, as well as an increase in reported abortions, at nearly 2 abortions for every 5 births by 1991 [16, pg. 25].

Social Factors Influencing Fertility

Several authors attribute Albanian social changes to the policies mentioned above, arguing that they created an environment that both promoted women's health and economic success, while enforcing traditional societal pressures. Despite this conflict, data shows that many social indicators changed dramatically during the Hoxha regime.

These changes are demonstrated in changing habitation and mortality patterns. For example, Falkingham and Gjonca found that 4/5ths of the population lived in rural

areas in 1945. Only 1/5th of the population was literate and 95% of women were illiterate. In addition to the differential literacy rates between men and women, the genders differed on major mortality indicators. In 1950, female life expectancy at birth was 51.3, while men were expected to live until 51.9. Similarly, infant mortality among females was higher, 144, than in males, 142 [8, pg. 316]. In most post-demographic transition nations, women will naturally live longer and are less likely to die during infancy. Of these results, Falkingham and Gjonca state that "in short, there are few, if any, documented cases of female status being lower than that seen in traditional Albania" [8, pg. 316].

Today, social and health conditions have improved for both men and women. The 2009 DHS found that life expectancy was 79 years for females and 72 years for men [14, 217]. Mortality inequalities also changed for infants. Infant mortality for females fell from 144 in 1950 to 15 in 2009. Furthermore, infant mortality for males in now higher than for females, at 22 deaths per 1,000 live births [14, pg. 118]. As these changes evidence, women's health in particular has drastically improved over the past 60 years.

The rapid, and seemingly unaided by contraception, decline in fertility in Albania is a popular discussion point among researchers. Dumani posits that this decline can be attributed to "the interacting effects of the growth of female participation in the paid labour force, the increased level of education of the population, the increased availability of clandestine abortion, and rising costs of childbearing" [19, pg. 17]. This fits with the previous discussion about women's changing status within Albania society.

Family Planning in Albania

To understand why Jhpiego implemented family planning counseling in Albania, we must first explore trends in family planning use and examine how couples access

methods. Overall use remains low, as will be demonstrated. Sehatchi cites three primary reasons for low use: (1) Persistent effect of previous prohibition of contraceptives, leading to limited knowledge among Albanian men and women; (2) Lack of family planning training within the medical profession, meaning health professionals are unable to discuss or recommend family planning to patients; (3) Scarcity of contraceptives due to limited import and export infrastructure [16, pg. 25].

Abortion

Before import channels reopened in the early 1990s, Albanian women had to rely on abortion for family planning. Although illegal during the Communist period, the practice remained widespread and significantly contributed to the nation's maternal mortality rate. Dumani explores abortion trends in the ten years before its legalization in 1990. By 1990, Dumani shows, provoked (those initiated at home by the woman herself) abortions comprised 45% of all abortions in Albania. He also shows an overall increase in abortions per live births from 22.5 per 100 in 1980 to 31.8 by 1990 [19, pg. 18]. In 1987, before the legalization of abortion and the opening of the national economy, the Tirana Maternity Hospital (Maternity Hospital 1/Queen Geraldine) conducted a study into reasons for abortion. Among respondents, likely those experiencing complications as very few would have been allowed a legal abortion at that time, 50% cited economic reasons, 20% said they had too many children already, 12% each complained of housing problems or too frequent pregnancies, and 6% explained that they sought an abortion because they were unmarried [19, pg. 18].

Comparatively, abortions were more common in cities than in towns. This may be an issue of access to the medical assistance following complications with provoked

abortion. However, the difference is startling: 90 abortions per 100 births in Tirana compared to fewer than 35 in all but three other cities [19, pg. 18].

Knowledge and Use Trends

Since the early 1990s, women and couples have had access methods other than abortion for family planning. However, knowledge and use of family planning, especially modern methods, remains low in Albania. Citing an unnamed 1992 survey, Dumani states that among humanities and social sciences students at the University of Tirana, generally among the most educated individuals in the nation, 51% stated that they had limited or no knowledge of even one method of family planning. The same study found that women were much more likely than men (59% compared to 22%) to cite no or limited knowledge of any method [19, pg. 18].

Recently, the 2008-2009 DHS captured population level data on family planning in Albania. The DHS found that 98.6% of women, aged 15-49, and 99.8% of men in Albania had heard of at least one method of family planning [14, pg. 64]. On average, women had heard of more methods, 5.2, than men, 4.2 [14, 0g. 64]. The DHS also determined that modern methods were more widely known than traditional methods. Male condoms were the most commonly recognized (88.3% for women; 95.7% men) method among both men and women. The second most commonly heard of method was withdrawal, 83.5% of women and 91.4% of men [14, pg. 64]. Married men and women who did not have any education or were in the lowest economic quintile were less likely to have heard of modern methods, but at least 99.5% of all currently married respondents had heard of at least one method [14, pg. 65].

Overall, 66.0% of women had ever used a method of family planning. This proportion increased dramatically when looking solely at married women, of whom 90.9% had used at least one method [14, pg. 67]. Among married women, the most commonly used method by far was withdrawal, 88.5% [14, pg. 67]. The most women using a modern method used the male condom, 15.5% [14, pg. 67]. Married men also seemed to rely on withdrawal: 94.6% had used withdrawal and 41.8% used male condoms [14, pg. 68]. Currently, only 48.0% of all women reported using any method and only 7.9% were using a modern method [14, pg. 69]. Compared to other similar countries, Albanians use fewer modern methods. For example, 14% of women in Azerbaijan, 19% in Serbia, and 17% in Montenegro currently use modern methods [14, pg. 70-71]. These results indicate a high reliance on withdrawal and other traditional methods, despite high self-proclaimed knowledge of various modern methods.

Legal History

Some hesitation to modern methods use may relate to past legal uncertainties. Family planning services were legalized in 1992, allowing providers to prescribe contraceptives and sex education [7, pg. 10]. Additionally, the Ministry of Health (MOH) mandated that all MOH facilities distribute family planning methods free of charge beginning in 1996 [7, pg. 10]. In 2002, the Albanian legislature passed the Law on Reproductive Health, which "establishes that all individuals and couples have the right to benefit from the use of secure, affordable, and acceptable methods of family planning (FP), according to their choice" [20, 17]. In 2003, the country developed a National Contraceptive Security Strategy, defining Contraceptive Security as "a guaranteed long-term supply of quality contraceptives for every Albanian who wants them" [20, 17]. Despite emphasizing access

to family planning, new legislation mandating insurance coverage, which also introduces user fees, jeopardizes the accessibility of contraceptive methods [7, pg. 10].

Sources of Contraceptives

There are currently three sources for family planning in Albania: the government; social marketing programs; and the commercial for-profit sector. Currently, NESMARK, the only social marketing organization in Albania, acts as the primary distributor of contraceptives [20, pg. 22]. In fact, NESMARK provided 93% of condoms, 43% of pills, 20% of injectables and 100% of emergency contraceptives in 2005 [7, pg. 17].

Many of the contraceptives available in Albania are donated by various international organizations. As of 2007, the UNFPA was the only source for Progestin-only pills, while Kreditanstalt fur Wiederaufbau (KfW), a German development bank, provided sole access to emergency contraceptives [7, pg. 10]. However, the MOH has recently taken steps to assume contraceptive costs. In 2009, the MOH 80% of contraceptive procurement with plans to cover 100% of costs by 2010 [14, pg. 63]. If successful, Albania will be self-sufficient in contraceptive procurement.

Pricing

Two aspects of contraceptive pricing must be considered. First, the primary social health insurance company, the Health Insurance Institute, which covers 45% of the population, covers all provider visits, including educational sessions about family planning. However, a report by the Commission for the Elimination of Discrimination Against Women (CEDAW) reported that although these services were free, “not many women take advantage of them since they are not sure that their confidentiality will be kept by health personnel” [21, pg. 46].

Next, we must examine the actual contraceptive market. While provider visits are covered by HII, contraceptive methods themselves are not [20, pg. 33]. This contradicts the original 1996 legislation mandating free contraceptives at all MOH facilities, and demonstrates changes that have occurred as a result of shifting market mechanism and attempts to privatize the health market. Furthermore, Albania does not produce any methods of family planning, and must instead rely on imports [20, pg. 29]. During import, many contraceptive methods, especially medical devices such as IUDs and Condoms, are subject to import tariffs, VAT [20, pg. 34]. These taxes, up to 20% of the total price, are transferred directly to the purchaser.

Based on increasing market prices for contraceptive methods, a USAID report on contraceptive security in Albania found that prices for several types of methods, predominately hormonal contraceptives, are prohibitive for many Albanians [20, pg. 31]. Thus, while the government has maintained a supply of contraceptive methods, proper outlets for obtaining these methods do not exist.

Medical Family Planning Training

Support for Postpartum Family Planning Counseling

In 1994, Bruyniks compared family planning in various Eastern European states. During his investigation, Bruyniks asserts that "there is an inverse relationship between the use of effective contraception . . . and use of abortion; the higher effective contraceptive use, the lower the abortion rate" [15, pg. 206]. This is important because of the high rates of Abortion in Albania, and the historic impact of abortion on maternal mortality in the nation. To combat high abortion rates, Bruyniks suggests increased provider training and knowledge. He states that "whatever type of doctor (or health worker) is involved, this

provider must be trained in both counselling [sic] and the provision of contraceptive technology" [15, pg. 212]. He explains that all health professionals, including doctors as well as nurses, must receive this training and be prepared to provide counseling and technologies to clients [15, pg. 214].

Bruynik's recommendations drew from several studies into provider knowledge in Russia and the Czech Republic. In Russia, Bruyniks and his colleagues found specifically that 75% of gynecologists looked to medical journals and books, not formal coursework, for their primary source of contraceptive information [22, pg. 99]. This may have contributed to incomplete provider knowledge and poor counseling techniques. For example, 13.4% of providers believed the contraceptive pill was never safe, 6.1% did not have an answer when asked how the pill functioned, and only 37.1% had a complete understanding [22, pg. 100]. This study demonstrates how provider knowledge may impact women's and couples use of modern family planning methods.

In addition to research on provider knowledge, several studies have examined the impact of quality family planning counseling on postpartum method uptake. For example, a randomized study in Pakistan found that 56.9% of women who received family planning counseling before hospital discharge following birth had started using contraceptives at an eight week postpartum follow-up visit. This compared to 6.3% of women who did not receive family planning counseling [1, pg. 379]. A similar randomized study in Nepal found that the odds of a woman who received counseling before discharge using postpartum contraceptive at 6 months postpartum were 1.62 times ($p = 0.03$) greater than women who had not had counseling [2, pg. 809].

The studies in Pakistan and Nepal looked at counseling that took place after delivery, a different time period than was studied in this report. Support for antepartum family planning counseling appears less concrete, and must also be explored. A study in Turkey found that women who received personalized one-on-one training did not have significantly higher postpartum family planning use rates than a control group that received family planning information in pamphlet form. A study looking at postpartum contraceptive use in Edinburgh, Cape Town and Shanghai found similar results, with the exception of sterilization in Edinburgh [23]. However, the study in Turkey did not have a representative sample, consisting of only 147 subjects, and trends suggest that a larger sample size may have produced different results. For example, 86.0% of women in the intervention group had used postpartum contraception at follow-up, compared to 76.3% in the control group [24, pg. 1246]. This leaves one study to dispute improved postpartum uptake from antenatal family planning counseling.

Despite some dispute from these two studies, other research shows that family planning counseling during prenatal care visits improves postpartum family planning uptake. One study following 423 pregnant women in Nigeria found that contraceptive counseling during the course of pregnancy and delivery significantly increased the intention to use postpartum contraception ($p = 0.01$) [25, pg. 989]. Additionally, research in Mexico, following the integration of national protocols for family planning similar to those in Albania, found a connection between prenatal family planning counseling and postpartum uptake. The study found that prenatal counseling was tied specifically to higher rates of postpartum condom, IUD, and sterilization use [3, pg. 10]. These methods

were generally preferred nationwide, and this evidence suggested strong and significant impacts of the national protocols.

Provider Knowledge

The ability of counseling programs, like those above, to improve postpartum method uptake relies on the strength of the providers involved. However, providers themselves are not always well informed, as was the case in Albania before Jhpiego training. One study in particular noted limited knowledge among medical students in Tirana. As recently as 1994, Dr. Vjollca Tare, part of the medical staff at Queen Geraldine Maternity Hospital, stated in an interview that discussion of sex was so taboo that it was forbidden even within a medical context, including for medical education and when investigating legitimate medical concerns [17, pg. 4].

In 1997, another nongovernmental organization (NGO), John Snow Incorporated (JSI), identified insufficient provider knowledge as a serious barrier to family planning uptake by John Snow Incorporated (JSI) in 1997. During focus group sessions, Albanian women described a lack of knowledge about family planning for themselves and their providers. One woman explained that providers at her local clinic had refused to discuss family planning with her [26, pg. 13]. Additionally, adolescents seeking family planning services identified many problems, particularly with the Maternity Hospital in Tirana (presumably the older of the two, Queen Geraldine) [26, pg. 15]. This report specifically stated in their recommendations section that “Service providers need up-to-date information on contraception and on the reproductive rights of all clients” [26, pg. 18].

Previous Efforts to Improve Provider Training

John Snow Incorporated's [26] evaluation demonstrated the lack of patient and provider knowledge about family planning methods. These results come from 1997; six years after two projects were approved to target family planning in Albania. One project focused on health education, while the other, under support from UNFPA, targeted family planning. Both projects started in mid-1992 [19, pg. 19]. The primary component of the family planning project was the training of medical staff, with the goal of training 240 gynecologists and 400 nurse midwives [19, pg. 19], but a set of national protocols for training had not yet been established.

To support family planning in the country, the Family Planning Association of Albania was also established. The Association has five main objectives:

> "the promotion of information, education, and communication concerning family planning; the coordination of family planning activities; the provision of technical support and training in family planning for health professionals; the promotion of research into the science and management of family planning services; and, the establishment of a model family planning clinic at the Maternity Hospital in Tirana." [17, pg. 5]

This training initiative also mandates that all medical students spend part of their internship working in the family planning clinic. Unfortunately, the results of these initiatives remained unseen by JSI years later. Senturia explains further that "Although the reduction in fertility . . . appears promising for family planning advocates, according to other data from [her study], the UNFPA and IPPF have had very little effect" [18, pg. 1105]. These actions are among several implemented by Jhpiego and will be discussed in more detail in the next section.

JHPIEGO AND ACCESS-FP ALBANIA

Jhpiego was founded in 1973 as an affiliate institution with Johns Hopkins University. The organization originally acted as a global source of maternal and child health experts, but has since expanded to include a staff knowledgeable in many health topics, including HIV, malaria and cervical cancer. Today, Jhpiego's vision is to empower "front-line health workers by designing and implementing effective, low cost, hands-on solutions that strengthen the delivery of health care services, following the household-to-hospital continuum of care" [27]. Over the past 35 years, Jhpiego has worked in over 140 countries, including Albania.

Identifying a Problem

With funding from USAID, Jhpiego conducted a baseline assessment of postpartum family planning attitudes and services in 2008. Conducted in polyclinics and maternity hospitals in Tirana, Shkoder and Berat, results represent the Central, Northern and Southern regions of Albania [28, pg. 2]. During this assessment, Jhpiego and ACCESS-FP discovered several things. First, 80% of women reported receiving antenatal care, but only 40% reported getting any family planning counseling during these sessions [28, pg. 9]. They also determined that current breastfeeding practices would be conducive to promoting the Lactation Amenorrhea Method (LAM) of family planning, as women breastfed, on average, for 14 months, with 2.8 months of exclusive breastfeeding [28, pg. 9]. Finally, Jhpiego and the ACCESS-FP team determined that health care providers, obstetricians/gynecologists and nurse-midwives alike, were not well versed in family planning methods, and often made recommendations based on social issues rather than other scientific evidence [28, pg. 10]. For these reasons, Jhpiego and ACCESS-FP planned to tailor intervention to medical providers.

The baseline assessment included several recommendations regarding postpartum family planning:

1. To create clinical protocols for postpartum family planning;
2. To train maternity and polyclinic personnel in updated modern family planning method counseling and techniques;
3. To establish systematic postpartum follow up visits;
4. To integrate family planning discussion into newborn and pediatric visits; and,
5. To continue partnerships with other NGOs to ensure contraceptive security, encourage family planning counseling and contribute to teaching/learning modules. [28, pg. 15-16]

Jhpiego Programming

Recognizing the gap in Albanian women's access to family planning, Jhpiego began working on programming following their initial evaluation in 2008. The USAID ACCESS-FP program funded Jhpiego's Albania staff and partnered with the Academy for Educational Development (AED) and American College of Nurse-Midwives (ACNM) to provide information and training to Ministry of Health (MOH) staff. The project, which ended in November of 2010, had two main objectives:

1. "strengthen FP in the postpartum and postabortion periods, reinvigorate the provision of IUD services, and increase demand for modern contraceptives; and
2. improve overall quality of FP services through development and dissemination of current, evidence-based National FP Protocols and introduction of performance standards." [29]

To adequately address these objectives, Jhpiego worked with the Ministry of Health to develop the Protokolli Kombetar i Planifikimit Familjar (Protocol to Combat Family Planning), a set of national standards for family planning counseling and care in Albania. Jhpiego worked to ensure that these protocols were understood and integrated in

services by conducting a series of three-day workshops with providers, nurses, and nurse-midwives. The project also included the development of job aids and patient leaflets, and provided regular supervisory visits by project staff [29, pg. 19].

Additionally, Jhpiego identified four hospitals in three cities – Tirana, Korce, and Shkoder – to target with expanded family planning training. This training focused on the postpartum and postabortion periods, and included more complete training in the Lactation Amenorrhea Method (LAM) and Postpartum Intra-Uterine Device (PP-IUD) counseling and insertion. Because Jhpiego programming targeted increased use of LAM and PP-IUDs, this study highlights differences in acceptability of these two methods.

Previous Program Results

In addition to the interviews with antenatal women described in this report, Jhpiego conducted interviews with 100 postpartum and 100 postabortion women at Queen Geraldine Maternity Hospital in Tirana. Two sets of women were interviewed, one before and one after intervention. The team collected data through interviews before hospital discharge and phone interviews with consenting women six months later [30, pg. 8]. Interviews focused on access to family planning counseling and methods during hospitalization resulting from childbirth or abortion.

Jhpiego found that around 95% of women wanted to discuss family planning with their providers, a dramatic difference was seen after programming was implemented, with 4% in the pre-intervention group and 92% in the post-intervention group [30, pg. 12]. Similarly, none of the pre-intervention women properly identified all three criteria for LAM, compared to 71% post-intervention [30, pg. 12]. Furthermore, 70% of post-intervention women, compared to 0% pre-intervention, reported receipt of family

planning methods before leaving the hospital [30, pg. 12]. These results support Jhpiego's work to increase family planning uptake during the immediate postpartum or post-abortion state. However, they do not completely depict the impact of the organization's family planning efforts in Albania.

To provide a more comprehensive understanding of the overall differences observed after intervention, Jhpiego commissioned this survey of antenatal women. In this survey, women were asked about their understanding, past use, and anticipated postpartum use of family planning methods. Antenatal women were also questioned about ANC family planning counseling and what methods were discussed during this counseling. This study establishes a basis for further exploration of the role of family planning counseling in postpartum method uptake in Albania.

CHAPTER 3. PROJECT CONTENT

STUDY METHODS

Study Design and Setting

Jhpiego's programming focused on increasing postpartum family planning counseling by training providers to introduce contraceptive options during antenatal care visits. This study aimed to determine whether Jhpiego's programs of training medical professional in family planning contribute to women's knowledge about, comfort with, and anticipated use of postpartum family planning methods. For the purposes of this study, family planning methods were divided into two categories: modern methods and traditional methods. Often, modern methods are classified based on DHS standards and include: female sterilization, male sterilization, pill, IUD, injectables, implants, male and female condoms, Lactation Amenorrhea Method (LAM), Emergency Contraception. Traditional

methods include: Rhythm, withdrawal, and other folkloric methods [14]. However, this study classified LAM as a traditional method as it modifies breastfeeding practices rather than utilizing additional devices. This study used data collected from two cities, one where practitioners received expanded Jhpiego training, and the other where practitioners received standard training.

In this study, Tirana, the capital, represented a high-program influence area. In Tirana, Obstetricians/Gynecologists (OB/GYNs) from both maternity hospitals participated in the expanded postpartum family planning training, including postpartum counseling and postpartum IUD insertion. Several nurses from the best maternity hospitals and polyclinics in Tirana were also trainers for Jhpiego. Finally, Jhpiego donated a family planning room to Maternity Hospital 2 in Tirana. Situated in the delivery wing of the hospital, this room provided a space for women to learn about various family planning methods and receive counseling in their use from midwives.'

The comparison population consisted of women selected from the maternity hospital's antenatal clinic in Durres, another major city 24 miles away. Nurses and doctors in Durres received only the standard minimum training in postpartum family planning counseling offered by Jhpiego. However, fewer providers in Durres received even this standard training than in Tirana. For example, there were about 8-9 trainings conducted in Durres of between 250-280 doctors and nurses. Comparatively, 480-500 providers were trained in 12-13 session in Tirana.[3] However, we cannot compare the percentage of providers trained in each city because no record of the total number of providers in each city could be found.

[3] Personal communication, Altina Peshkatari

Ethics

Before implementation of this survey, the study design and plan, including the survey itself, was read by the Internal Review Board at Emory University, which declared it not research. In country, program staff received permission for sampling in the hospital from both the ministry of health and hospital officials prior to survey initiation.

Subject Identification

The Albanian MOH reports that 93% of births occur in health institutions [28, pg. 9]. Women who choose to give birth in an institutional setting have the option of a public maternity hospital or a private clinic. Maternity hospitals provide several specific services, including: labor and delivery suites, emergency obstetrics services, and antenatal care (ANC) clinics. ANC clinics in both Tirana and Durres were on the ground floors, easily accessible to all women and separated from other services, which were usually on higher levels or in other buildings. [4] Polyclinics differed from maternity hospitals because they were not full-service hospitals. Additionally, polyclinics may include pediatric and male care facilities in the same building. Like maternity hospitals, polyclinics separated different services by floor and corridor.[5] These ANC clinics, as well as the women's clinics at the public Polyclinics in Tirana, were the focus of this survey.

Women in Tirana were sampled from the two public maternity hospitals in Tirana and eight of the city's polyclinics. Women in the control group were sampled from the Durres Maternity Hospital in Durres, the only facility organizationally similar to those in Tirana. The study's sample includes all consenting pregnant women who attended the clinics between May 31-June 8 in Tirana, and June 9-14 in Durres. Upon entering the

[4] Personal observation and correspondence, Galina Stolarsky and Altina Peshkatari
[5] Personal observation during site visits and survey management.

clinic, women were approached by one of two interviewers and asked for verbal consent to participate in the survey. Once consent was obtained, women were moved to a private space, if available, and asked a series of questions on basic demographics, family planning knowledge and knowledge sources, past and anticipated use of family planning, and comfort with family planning knowledge sharing (See Appendix A for the survey tool). Each interview took approximately 15 minutes. We estimated a non-response rate of roughly 30%,[6] resulting in a sample of 242 women – 140 in Tirana and 102 in Durres. Because this study is based on a convenience sample, its results are not applicable to Tirana, Durres, or Albania as a whole. However, samples in both cities are similar in size to previous studies on postpartum family planning [see 1- 3] and results provide a basis for review of survey sites.

Data Management

The author of this report initially entered data from surveys conducted in both Tirana and Durres into a Microsoft Excel spreadsheet for data management. She later imported data from the Excel sheet into SAS 9.0 for data analysis. Finally, the author cleaned and coded data with the assistance of interviewers for clarification.

Model Selection

Model design is based on previous research, which uses multivariate linear and logistic regression for measuring family planning program impact. For the purposes of this study, four control variables were included in the multivariate model: the woman's completed education level, urban/rural habitation, age, and parity.

[6] Discussion with interviewers, Brunilda Dervishaj and Griselda Dedja

This study evaluated postpartum family planning by looking primarily at: predicted future use of any method, predicted future use of Post-Partum IUDs, and predicted future use of LAM. Antenatal care counseling will also be examined using this model. The main variable of interest in this model is city (coded as either Tirana or Durres), which corresponds to the presence of extra postpartum family planning counseling provider training. This variable is the most important variable in measuring program success and acts as the primary independent variable.

The multivariate model includes several control variables, which were not included in Jhpiego's own self-evaluation drafted in early 2010. The National Center for Population Research (NCPR) suggests the inclusion of both education and urban/rural habitation in fertility analysis. The NCPR contends that the effect of education on fertility is constant and that "educational differences tend to persist when other controls, such as income and residence, are introduced suggesting that education is independently related to fertility [31, pg. 78]." This independence warrants our inclusion of education (see Appendix B for coding), particularly in the absence of income or employment status.

The NCPR additionally describe reasons for including a variable to adjust for rural/urban distinction. They state that differences may exist between groups because "rural populations tended to maintain the traditional structure of the family, with emphasis on the extended family, the division of labour [sic] between husband and wife, and the utility of children as contributors to the family-based economic enterprise" [31, pg. 75]. The NCPR additionally calls for the consideration of occupation, income, religion, and ethnic/national identity. While in some settings these characteristics may be important to control for, research into Albanian demography has not traditionally

included these characteristics. Therefore, this study only includes rural/urban variation as a control, capturing information on village, town and city dwelling and considering both villages and towns to be rural.

Two additional variables were included in the multivariate model to control for differences in populations: age and parity.[7] These variables were included after review of Arjan Gjonca, Arnstein Aassve, and Letizia Mencarini works, which provide a comprehensive evaluation of fertility changes in Albania during the 20th century. In Gjonca et al.'s most recent article, published in July 2008, four variables are considered when modeling fertility changes in the nation: age cohorts, education, rural/urban residence, and geographic region (Coastal, Central, Mountain, and Tirana) [32, pg. 272-275]. We already determined to include education and rural/urban variables, but Gjonca et al's work led to our inclusion of age as and independent variable in this model. While, as later discussion will show, the age groups in Tirana and Durres do not vary significantly, age affects many aspects of fertility, particularly lifetime exposure to risk of pregnancy and knowledge of family planning methods. Similarly, parity affects women's family planning decision making. For example, one study in Turkey, which shares history with Albania, found that older women were more likely to know about and use more methods of postpartum family planning [24].

The multivariate model includes each of these, building off of bivariate analysis that uses the equation: $Y_i = \beta_0 + \beta_1$ (CITY). Bivariate analysis gives us a clear picture of which relationships may be important, and how survey location may influence our outcome variable. However, we must adjust this relationship to incorporate control

[7] In this model, age is a continuous variable coded 0-100. Parity was originally captured through an open-ended question allowed individual respondants to report their total number of previous births. However, in this model, parity is coded 0 = "no previous births" and 1 = "previously gave birth."

variables in order to understand what real relationships exist. Based on the inclusion of all independent variables, the final multivariate model for this analysis is:

$$Y_i = \beta_0 + \beta_1 (\text{CITY}) + \beta_2 (\text{SOCIAL \& DEMOGRAPHIC CONTROLS}) + \text{Error}$$

For this model, education, city, parity, and urban are categorical variables, while age is continuous. This model was used for all analysis in this study, where Y is equal to the outcome of interest (See Appendix B for complete list of outcome variables). While many additional variables, like economic or employment status, could be considered in determining program success, this model acts as a starting point for program analysis.

RESULTS

Demographic characteristics

Women were surveyed from 11 different clinics. Roughly 1/3rd of all women were surveyed at clinics in the Tirana maternity hospitals, just under 1/4th at Tirana Polyclinics, and about 47% from the Durres maternity hospital. Characteristics of the surveyed women varied across clinic type (see Appendix C), as described below.

More than half of all women, 54%, were between 25-34 years old, and the average age was 26. Women surveyed from maternity hospitals were younger, around 27 years, than those sampled from polyclinics, roughly 28 years. About 60% of all women had completed at least secondary education, and only 30% had less than primary. Women sampled from polyclinics were generally better educated, 81.1% reported completing secondary school compared to 61.7% and 44.6% at Tirana Durres maternities.

Almost half of all women surveyed, 48.5%, reported that this pregnancy would result in their first birth. Few women stated having more than 1 child, 22.5%, none more

than 3. Parity appeared consistent across clinics, but more women (27.8%) in Durres had at least 2 children (16.8% and 19.6% at Tirana sites). In this sample, 62% of women said they were from cities, and few, 7.9%, were from towns. Differences were apparent in the rural/urban distribution across clinics. For example, 48.0% of respondents from the Durres Maternity Hospital were from a city, compared to 87.9% at the Tirana Polyclinics. Very few women, 8.0% overall, reported coming from a town.

Further results have been adjusted for the differences noted above. Table 1, below, shows how the two cities demographics differ.

Table 1. Demographic Differences Between Respondents, Tirana and Durres, Albania

Binary Variable	N	Percent Tirana	Percent Durres	Chi-Sq	p-value
Completed Secondary or Higher	241	69.29%	44.55%	14.8264	<0.001
Gave Birth Before	242	47.14%	58.82%	3.2259	0.0725
Lives in A City	240	72.86%	48.00%	15.3783	<0.001
Contraceptive Failure This Pregnancy	241	25.18%	8.82%	10.5459	0.0012
Continuous Variables	**N**	**Mean Tirana**	**Mean Durres**	**T-Statistic**	**p-value**
Age	242	27.41	27.00	0.59	0.5575
Age at First Child Birth (including this pregnancy)	242	24.08	22.68	2.68	0.0078
Number of Children (not including this pregnancy)	241	0.70	0.91	-1.80	0.0725
Desired Number of Children	197[1]	2.61	2.79	2.40	0.0172

[1] Included: "don't know"; "no preference"; and, "up to god." These were coded as missing.

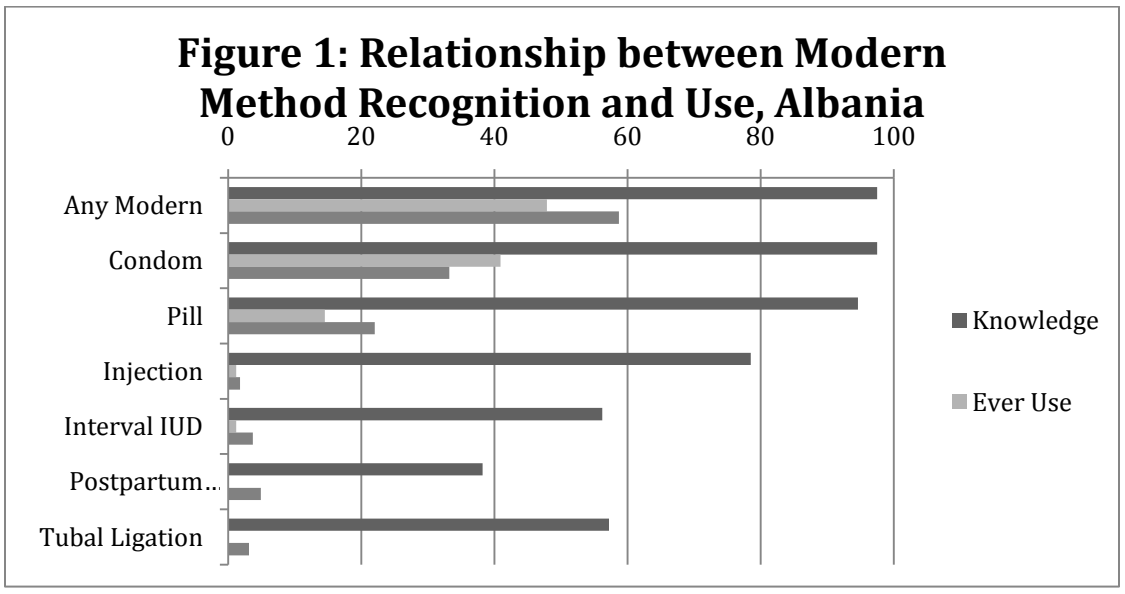
While differences were apparent between maternity hospitals and polyclinics, all clinics in Tirana were combined for the following analysis. This was done so that researchers could provide as accurate a demonstration of difference available. Including all clinic types, some control variables significantly differ between the two cities (Table 1). For example, about 73% of women interviewed in Tirana reported living in a city (as opposed to village or town), compared to only 48% of women in Durres ($p < 0.001$). A

similar relationship exists for education, with 69% of women in Tirana reportedly completing secondary or higher, as opposed to 45% in Durres ($p < 0.001$). A significant relationship between city and age at first birth, 24 in Tirana and 23 in Durres ($p = 0.0078$) also exists. However, it should also be noted that age and parity, both control variables in this study's analysis, did not yield significantly different results between the two cities.

Family Planning

Considering knowledge of various methods, 97.5% of women stated that they had heard of at least one modern method of family planning, but only 47.9% of women had ever used one, with expected use only slightly higher, 58.7% overall. This relationship is most striking in Durres, where 97.1% of women have heard of modern methods, but only 37.3% have ever used one, and 44.3% plan on using one postpartum.

Data also demonstrates that women knowledge of more methods related to higher rates of past and planned use. The only exception to this relationship was tubal ligation, an expected result as all women were currently pregnant. Figure 1, below, graphically shows patterns related to recognition and method use, based on this study's results.



Traditional Methods

Withdrawal was the most commonly heard of traditional method, 99.6%; the most commonly used, 92.2%; and, the most expected to be used, 73.5%. The next most common was LAM, followed finally by periodic abstinence. No women who reported a family planning failure resulting in *this* pregnancy reported LAM as the cause for failure (see Appendix D). Aside from LAM, more women attributed family planning failure to traditional methods, 15.4% of women overall, than modern methods, 2.9%. Overall, 81.8% of all failure was attributed to withdrawal (Appendix D).

Table 2a. Use of Traditional Methods, Tirana and Durres, Albania (N=241)

	Withdrawal	LAM (has other child)	LAM (no other child)	Periodic Abstinence
Knowledge	99.6%	74.6%	59.5%	59.9%
Ever Use	92.2%	23.8%	1.7%	21.9%
Future Use	73.5%	28.3%	26.5%	7.6%

Modern Methods

Most women, 97.5%, had heard of condoms, but only 40.9% had ever used a condom, and even fewer, 33.2% planned to use them postpartum. The second most common method was the pill (Table 2b). Unfortunately, the data collection tool for this survey did not distinguish between a daily oral contraceptive pill and emergency contraceptive pills, making the pill data unreliable. After pills, injections were the most common method. While many people recognized this method, 78.5%, few had ever used, or planned to use, injections for family planning.

Table 2b. Use of Modern Methods, Tirana and Durres, Albania

	Condom	Pill	Injection	Interval IUD	Postpartum IUD	Tubal Ligation
Knowledge	97.5%	94.6%	78.5%	56.2%	38.4%	57.2%
Ever Use	40.9%	14.5%	1.2%	3.7%	0.0%	0.0%
Future Use	33.2%	22.0%	1.8%	1.2%	4.9%	3.1%

Long term methods followed a slightly different pattern of use than those of temporary or occasional use methods. Tubal ligation was the most commonly recognized method, but none of the three long-term methods had high past use rates. The most women planned to use PP-IUD, 4.9%. While this is greater than either other method, these methods do not appear to be preferable.

Program Results:

Of particular interest to Jhpiego, were any differences seen related to Lactation Amenorrhea (LAM) or Post-Partum Inter Uterine Devices (PP-IUD). Basic statistics on the use of these methods were already introduced, and program analysis will concentrate on differences, on the bivariate and multivariate levels, between Tirana and Durres.

City and General Family Planning Use

As Table 3, below, shows, no apparent association existed between survey city and the number of family planning methods used. Women in Tirana had used, on average, 0.2 more methods than women in Durres. When this relationship was tested in the multivariate model, the difference attributable to city decreased further to 0.07 methods ($p = 0.5351$). Education was the only variable found to significantly influence the number of methods used, accounting for a difference of 0.36 method ($p < 0.001$) (Appendix E).

Table 3: Linear Relationships Between City and Family Planning Program Measures[8]

	Bivariate Model			Multivariate Model		
Outcome Variable	N	Parameter Estimate	P-Value	N	Parameter Estimate	P-Value
Number of Methods Known	242	0.86807	0.0021	239	0.21629	0.3446
Number of Methods Used	242	0.17101	0.1964	239	-0.07412	0.5351
Number of Methods Discussed at ANC	242	0.20448	0.2472	239	0.09674	0.5938

This model also tested knowledge of methods. The bivariate model showed that women in Tirana used significantly more (about 0.86, nearly one more method; $p = 0.0021$) methods of family planning than in Durres. However, significance disappeared with the addition of control variables ($p = 0.3446$). Specifically, three other variables related to knowledge: education (0.62 method; $p < 0.001$); age (0.13 method; $p < 0.001$); and, urban/rural (0.48 method; $p < 0.001$) (Appendix E).

One final continuous variable was investigated on the multivariate level: the number of methods discussed with an Antenatal Care (ANC) provider. No significant difference between the number of methods discussed existed on either the bivariate or multivariate levels. In the simple model, city accounted for a difference of 0.2 methods, which was reduced to 0.1 when controls were introduced. In the full model (see Appendix E), only education (0.18 method; $p = 0.0402$) and parity (0.34 method; $p = 0.0085$) were found significantly related to discussion of methods with ANC providers.

City and IUD Use

[8] Multivariate linear regression model includes: age, education, urban/rural and parity. See Methods section for complete explanation of model.

Slightly more than half of the women in Tirana had heard of Interval and Postpartum IUDs, 60.7% and 50.0%, respectively (Table 5a). While half the women in Tirana had heard of PP-IUD, less than a quarter of the women in Durres recognized the method. Additionally, more women in Tirana, 16.7%, had discussed PP-IUDs with an ANC provider than women in Durres, 7.8%. This relationship continued for future use, with 7.4% of women from Tirana and 1.4% from Durres planning to use PP-IUDs.

Table 4a. Patterns in IUD Use, Tirana and Durres, Albania

Interval IUD	Tirana n (%)		Durres n (%)		Total N (%)	
Knowledge	85	60.7%	51	50.0%	136	56.2%
Ever Use	3	2.1%	0	0.0%	3	1.2%
Discussed at ANC	13	9.3%	10	9.8%	23	9.5%
Planned Use	2	2.3%	6	4.4%	8	3.6%
Interval IUD	Tirana n (%)		Durres n (%)		Total N (%)	
Knowledge	70	50.0%	23	22.6%	93	38.4%
Ever Use	0	0.0%	0	0.0%	0	0.0%
Discussed at ANC	15	10.7%	8	7.8%	23	9.5%
Planned Use	10	7.4%	1	1.4%	11	4.9%

Because so few women had ever used either an interval IUD or a PP-IUD, 1.2% and 0.0% overall, we could not measure an accurate difference between the two cities. However, several important relationships were identified using both models.

Table 4b. Odds of IUD Knowledge and Use in Tirana, Compared to Durres, Albania

	Bivariate			Multivariate		
Outcome Variable	N	Odds Ratio	P-Value	N	Odds Ratio	P-Value
Heard of PP-IUD	242	3.435	<.0001	239	2.623	0.0025
Expected to Use PP-IUD*	223	6.959	0.0667	219	4.180	0.2058

*The expected use model additionally controls for knowledge of the method.

For example, we found a significant relationship between city and knowledge of PP-IUD. In the bivariate model, women in Tirana were found to be more than 3.4 times ($p < 0.001$) more likely to have heard of the PP-IUD. This relationship remains significant in

the multivariate model, which shows that the odds that a woman in Tirana has heard of a PP-IUD is roughly 2.6 times greater (p = 0.0025) than in Durres (Table 4b). In the multivariate model, only education has a significant impact (OR = 1.6; p <0.001).

Past use cannot be statistically tested because of a small sample size, but associations between city and future use are measurable. In the bivariate model, the odds of planned use of PP-IUD are roughly 7.0 time greater in Tirana than in Durres (p = 0.0667). In the multivariate model, the odds change to 4.3 times greater for Tirana (p = 0.2058). While this relationship, and those of the control variables (Appendix E), appears insignificant at 0.05, it suggests a trend.

City and LAM Use

Overall recognition of the Lactation Amenorrhea Method (LAM) was higher in Tirana, 70.7%, compared to Durres, 62.8%. However, past use was higher in Durres, Knowledge sources was similar in both places; 10.7% overall heard of LAM from ANC providers. Like past use, fewer women in Tirana planned to use LAM in the future, despite slightly higher recognition and ANC discussion rates (Table 5a).

Table 5a. Patterns in LAM Use, Tirana and Durres, Albania

Previously Gave Birth	Tirana n (%)		Durres n (%)		Total N (%)	
Knowledge	49	74.2%	45	75.0%	94	74.6%
Ever Use	9	13.6%	21	35.0%	30	23.8%
Discussed at ANC	11	16.7%	7	11.7%	18	14.3%
Planned Use	16	24.6%	18	32.7%	34	28.3%
First Child	Tirana n (%)		Durres n (%)		Total N (%)	
Knowledge	50	67.6%	19	45.2%	69	59.5%
Ever Use	0	0.0%	2	4.8%	2	1.7%
Discussed at ANC	5	6.8%	3	7.1%	8	6.9%
Planned Use	17	24.3%	10	31.3%	27	73.5%

These relationships were explored further using the bivariate and multivariate models explained earlier. Although more women had heard of LAM in Tirana, this relationship was not significant at either the bivariate or multivariate level (multivariate p = 0.1915). However, the odds of a woman in Durres ever using LAM were 86% greater than in Tirana (p < 0.001). This relationship appeared strengthened by the addition of significant and important controls: education (p = 0.0166); urban/rural (p = 0.0570); and, age (p = 0.0716). Parity did not seem to affect LAM use. Additionally, women in Durres were significantly more likely to plan to use LAM after this pregnancy (p = 0.0175).

Table 5b: Logistic Odds of IUD Knowledge and Use in Tirana, Compared to Durres, Albania

	Bivariate Model			Multivariate Model		
Outcome Variable	N	Odds Ratio	P-Value	N	Odds Ratio	P-Value
Heard of LAM	242	1.434	0.1925	239	1.025	0.1915
Used LAM	242	0.236	0.0006	239	0.146	0.0001
Expected to Use LAM*	222	0.682	0.2084	219	0.423	0.0175

*Expected use model additionally controls for knowledge of method.

City and ANC Based Family Planning Discussion

Overall, the odds that a women in Tirana discussed any method of family planning with their ANC provider were 2.7 times (p = 0.0058) greater than women in Durres. This relationship was associated with parity (OR = 1.6; p – 0.0480), and possibly urban/rural (OR = 1.5; p = 0.0859). Despite greater odds of discussing methods with ANC providers in Tirana, associations between ANC discussion of LAM and PP-IUDs and city were not significant. For example, women in Tirana were not significantly more likely to have heard of the PP-IUD from their ANC provider (multivariate p = 0.8220), or more specifically, a doctor (multivariate p = 0.9264). There was also no significant relationship between city and discussion of LAM with an ANC provider (p = 0.8314).

Table 6: Logistic Odds of Discussing Family Planning with Antenatal Care Providers in Tirana, Compared to Durres, Albania

	Bivariate Model			Multivariate Model		
Outcome Variable	N	Odds Ratio	P-Value	N	Odds Ratio	P-Value
Discussed Methods at ANC	208	2.857	0.0019	205	2.736	0.0058
Discussed LAM at ANC	242	1.187	0.6872	239	1.106	0.8314
Discussed PP-IUD at ANC	242	1.410	0.4538	238	0.893	0.8220
Heard About PP-IUD from Doctor*	83	1.029	0.9560	83	0.952	0.9264
Knows Someone with IUD	242	1.963	0.0144	239	1.162	0.6450
Friend was Satisfied with IUD**	93	3.727	0.0050	92	3.452	0.0158
Experience of Friend Influenced Feelings about IUD**	92	0.963	0.9395	91	0.953	0.9338

*Includes only women who had heard of IUD
**Includes only women who knew someone with an IUD

Some significance was found in social experiences with IUDs in the two cities. For example, the bivariate model showed that women in Tirana had greater odds of knowing someone with an IUD ($p = 0.0144$), but this relationship was no longer significant ($p = 0.6450$) once adjustments, specifically education (OR = 2.6; $p < 0.001$), were made. Women in Tirana showed greater satisfaction with IUDs, having odds of their friend liking their IUD of 3.5 times those in Durres (multivariate $p = 0.0158$). However, this did not appear to be associated with a women's decision about IUD use, as no difference between the odds of a woman being affected by a friend's experience existed in Tirana and Durres (multivariate $p = 0.9338$).

Perceptions of Methods

After the first week of data collection, we added one open-ended question to the survey, asking why women chose did not use certain methods of family planning. Responses were open ended and coded by theme are presented in Table 7, below.

Table 7. Reported Reasons for Not Using Methods Among Antenatal Women in Tirana and Durres, Albania (N=141[ł])

Reason	Tirana (%)	Durres (%)	Combined (%)
Other Methods are Dangerous*	50.0	30.7	36.2
This Method is Easy	5.0	9.9	8.5
This Method is Comfortable	5.0	10.9	9.2
This Method is Natural	20.0	6.9	10.6
Husband Prefers this Method	10.0	10.9	10.6
I Prefer this Method	10.0	20.8	17.7
I Have Heard Bad Things About Other Methods	7.5	0.0	2.3
Other Methods Have Negative Side Effects*	20.0	5.0	9.2
I Wanted to Get Pregnant	2.5	9.9	7.8
I Have Not Heard of Any Other Methods	2.5	4.0	3.6

łThis question was added after the first week of data collection, resulting in 101 missing
* Indicates significance at $p<0.05$ controlling for age, education, urban/rural, and parity

The most common reason for using a method was perceived danger of other methods, 36.2% overall. The second most common reason was a general preference for past methods, 17.7%. The least common answers were negative outside knowledge of the method, 2.3%, or no knowledge of other methods, 3.6%.

CHAPTER 4. DISCUSSION

This study aimed to help Jhpiego understand if any measurable differences in expectations about postpartum family planning could be found between Durres, acting as a control city, and Tirana, where provider training included additional sessions on postpartum methods and counseling. Specifically, we hoped to identify differences in recognition of, comfort with and potential use of two family planning methods emphasized during Jhpiego programming: LAM and PP-IUD. Based on the results of this study, differences do exist between women in the two cities, supporting Jhpiego's efforts in improving postpartum family planning uptake in Tirana.

In particular, this study found better recognition of PP-IUDs in women from Tirana than from Durres. In fact, women in Tirana were 2.6 times more likely to have heard of the PP-IUD than women in Durres. Not surprisingly, given the more traditional nature of the method, high proportions of women in both cities had heard of LAM, 62.8% in Durres and 70.7% in Tirana. Further supporting a higher level of knowledge in Tirana, 2.5% of women in Tirana, compared to 4.0% in Durres, cited no knowledge of other methods as the reason for using their last method.

In addition to more women having heard of PP-IUD in Tirana, women in Tirana who knew someone who had used any IUD were 3.4 times more likely to report that that woman had a positive experience with an IUD. However, when asked why they had used their last method, women in Tirana cited negative side-effects of other methods. For example, 70% of women in Tirana said something related to the dangers or negative side-effects of other methods. In contrast, only 35.7% of women in Durres cited these reasons.

Further analysis suggests that knowledge and perceptions about methods are associated with use in both cities. As Figure 1 earlier demonstrated, women who had

heard of more methods had used more methods in the past, and planned to use more methods in the future. For example, the three modern methods most commonly heard of – condom, pill, and injection – were also the three that were most often used. Most women also planned to use condoms and pills in the future. However, widespread knowledge of injectable methods did not translate to anticipated future use, possibly tying back to uncertainties and fear of side-effects.

These findings agree with those from previous studies, which have tied improved knowledge to increased uptake of postpartum family planning [1-3, 24]. Those studies generally included a follow-up component to measure uptake after intervention. Unfortunately, this study does not include follow-up data. We hope, however, that the strength and consistency of past studies, and our results that indicate greater desire for postpartum family planning among the target population, that uptake in Tirana will improve with rates similar to those of other studies.

The strength of this programming comes from the proven power of family planning counseling, which provides recipients with a more detailed and cohesive understanding of methods than information women and couples receive from media and social outlets. Saeed states that ". . . advertisements may act as a good mode of spreading information, but they are not a good method of counseling people because people are unable to discuss their concerns. For actual informed decision making, medical personnel who can address individual concerns are necessary" [1, pg. 380]. As several studies have found, providers themselves lacked knowledge and understanding of many of the modern method of family planning before Jhpiego intervention [16, 21], making this population especially suited for improved training and counseling.

The emphasis on negative side-effects of other methods suggests that some women may misunderstand the various methods discussed. Other data showed that almost 5% of women in Durres who had not given birth claimed to have used LAM as a method of family planning in the past. Because LAM can only be used postpartum, this suggests that while many women said they had heard of methods, an in-depth assessment of their knowledge may have shown otherwise. Saeed found that counseling in Pakistan was important because it gave patients a chance to ask questions and learn about side-effects, so that they were prepared to handle them when they appeared. Therefore, family planning counseling not only led to higher rates of postpartum family planning uptake, it led to lower rates of discontinuation at 6 month follow-up [1, pg. 391]. This demonstrates how the benefits of counseling extend beyond simply increasing the number of women using methods. Additionally, counseling can also improve couples' and women's understanding of potential side effects and complications.

Family planning counseling may also prove useful in Albania's familiar structure, given the power of husbands and mothers-in-law in women's decision-making. In the JSI evaluation from 1997, many women stated that while they did not think their husbands would oppose contraceptive use, it should be a joint decision and many men were not well informed [26, pg. 15]. Although women thought their husbands would be accepting, they thought their mothers in law would disapprove. One subject stated "'My mother-in-law wants her son to have more children, because she had 8 herself'" [26, pg. 15]. Partner and mother-in-law involvement was observed during implementation of this survey as well. Many interviews were conducted with one or both of these parties present, emphasizing the importance of these individuals' opinions. Family planning counseling

provides a way for couples to learn about methods together, so that both parties have the same information and a decision can be made jointly. However, these programs need to address the involvement of mothers-in-law in family planning counseling.

Given the appropriateness of family planning counseling in Albanian society, this strategy for improving postpartum uptake is likely to have an impact. However, one final measure of appropriateness must be looked at: need. As we have shown, there are low rates of modern method use in Albania. This fact is often used by family planning organizations around the world to advocate for improved family planning services. However, Albania does not exhibit many of the other characteristics often correlated with low modern method use, particularly high total fertility. In fact, the Albanian fertility level is below replacement, even lower than in many "developed" nations. Between 1960 and 1990, fertility dropped from 6.9 to 3.0 without access to any modern methods [8, pg. 312 [8, pg. 312; 18, pg. 1105]. Since modern methods became available in the early 1990s, total fertility has dropped again to 1.6 [14, pg. 53]. This second major drop occurred despite an increase in modern method use to only 10.6% of married women in 2009 [14, pg. 69]. If couples are controlling and reducing fertility on their own, we must question the need for supporting modern methods of family planning in Albania.

Some of the explanation for this need is based on the high rates of abortion in the country. Several authors have cited the great impact of abortion on maternal mortality in Albania, at one point accounting for 50% of all maternal deaths [15-16]. Today, at least 18.7% of all pregnancies result in abortion and the live birth to abortion ratio remains at 4.3:1 [33]. However, even this relationship seems to be falling, as more than 30% of all pregnancies were aborted in 1993, according to INSTAT and the Ministry of Health [33].

Furthermore, the legalization of abortion in 1991 [34, pg. 167] allowed safe abortion services to be provided in clinical settings, rather than attempted at home or without the assistance of a skilled professional. One study found that between 1988 and 1992, maternal deaths due to abortion at the University Hospital of Obstetrics and Gynecology fell from 42.8% to 20.0% of all maternal deaths [34, pg. 167]. This again, occurred without a marked increase in use of modern methods.

Evidence for promoting modern methods of family planning for the reduction in abortion seeking behavior in Albania is weak. However, there is another reason to promote family planning counseling and postpartum family planning: the empowerment of women. As earlier discussion of religion and the traditional common law in Albania suggested, women traditionally occupy positions of low status [8, 13, 18]. The CEDAW Report on Albania further states that girls are taught "to be submissive, and to obey their husbands and in-laws" [21, pg. 11]. Family planning counseling provides a forum for open discussion of family planning between couples, allowing women to actively participate in their reproductive health and giving them the opportunity to choose a female controlled method if couples desire.

While the results evaluated in this report provide support for Jhpiego's programming in Albania, this study had several weaknesses. For example, in all sites, issues of privacy were found. Albanian public clinics do not have a system for scheduling appointments and all services are provided on a first-come, first-served basis. Because of this system, we found that many women were uncomfortable getting out of line to take the survey. In fact, we estimated non-response, almost entirely attributed to this issue, to be about 30%. Of those women who consented to taking the survey, many opted to do so

in line, with family members, strangers, and medical personnel present. We also experienced interference from hospital staff, primarily in Durres, where housekeeping staff attempted to help in the recruiting process despite instructions to the opposite. Despite these limitations, outside influence affected all clinics equally and comparisons between the two cities remain sound.

Collectively, this data suggests that Jhpiego's programming may improve women's knowledge and acceptance of methods, contributing to a more comprehensive knowledge of methods in the country. Therefore, continuing the programming would likely lead to increased modern method use during the postpartum period in Albania. However, steps must be taken to ensure that women's and couples privacy is maintained, and program designers must understand that their work may not have a significant influence on the already low fertility rate in Albania. With these caveats in mind, family planning counseling should be promoted throughout the country through improved provider training, similar to that initiated by Jhpiego.

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APPENDICES

Appendix A

PERCEPTIONS OF POSTPARTUM CONTRACEPTIVES IN ALBANIA:
NEAR-TERM QUESTIONNAIRE

SPONSORING ORGANIZATION: Jhpiego
SURVEY DATES: May 31-July 2, 2010
SURVEY LOCATIONS: Tirana, Shkodër, Korcë

RESPONDENT INFORMATION

Health Center Name
_____

City
_____

Respondent Identification Number ☐ ☐ ☐

**Family/Friend present?* ☐

INTERVIEWER INFORMATION

Date
_____

Language of interview (English/Albanian)
_____

Interviewer name

_____

INTRODUCTION

Good morning/afternoon, my name is _____ (please state name of interviewer). I am working with a program of the Ministry of Health and am conducting interviews with pregnant women who use this clinic. We want to learn about women's experiences with this clinic from the time they become pregnant until after they give birth in order to improve services during this time. We will be asking you questions about yourself, your experiences with family planning methods, and your health care. If you are willing to answer our questions, we will now proceed with the interview.

To Interviewer: Once you have read this paragraph to participant and received their verbal consent, check the boxes below.

Subject and interviewer discussed informed consent ☐

Subject gave verbal consent to be involved in the study ☐

**If both boxes have been checked, proceed with the interview.* ☐ :

**Please record the time that the interview started*

OVER

QUESTIONNAIRE

****Read:*** *First, I will ask you some questions about yourself and your family.*

Number	Question	Answer Codes	Skip
1	How old were you at your last birthday?	Age In complete Years ☐☐	
2	What was the last level you completed in school? ****To interviewer****: Read answers to respondent*	Never attended school . . . . . 1 Some primary . . . . . .2 Completed primary . . . . . 3 Some secondary . . . . . .4 Completed secondary . . . . . 5 Tertiary or higher 6	
3	Please describe the town where you live. Is it a: ***To Interviewer****: Read answers to respondent*	Village . . . . . 1 Town . . . . . . 2 City . . . . . 3 Other . . . . . .88 Don't Know 99	

4	Have you ever given birth? ****To interviewer:*** *Exclude miscarriages and abortions. Code these as "No."*	Yes. . . . . 1 No 2	➔ If no, go to 7
5	How old were you when you first gave birth?	Age in complete years ☐☐	
6	How many living children do you currently have?	Total ☐☐	
*****Read:*** *Now, I will ask you some questions about different family planning methods and your experiences with these methods.*			
7	How many total children do you want to have? ****To Interviewer:*** *Include "not sure" with "don't know."*	None . . . . . 0 1 . . . . . .1 2 . . . . . .2 3 . . . . . .3 4 . . . . . .4 5 . . . . . .5 More than 5 . . . . . 6 No preference . . . . . 7 Up to God . . . . . . 8 Don't know 99	
8	When you became pregnant this time, did you want to become pregnant earlier, then, later or not at all?	Sooner . . . . . .1 Then . . . . . 2 Later . . . . . 3 Not at all . . . . . .4 Didn't answer . . . . . .98 Don't know 99	
9	How soon after this pregnancy would you prefer to get pregnant again? ****To Interviewer:*** *If woman indicated that she wanted 1 child total in question 6, you can code this question as 6.*	As soon as possible . . . . . 1 Less than 1 year . . . . . .2 1-2 years . . . . . .3 2-3 years. . . . . 4 More than 3 years . . . . . 5 Do not want more children . . .6 Up to God . . . . . .7 Don't know 99	
10	Have you ever heard of any of the following methods of family planning?	a. Withdrawal . . . . 1. Yes 2. No b. Periodic Abstinence . . . . . 1. Yes 2. No c. LAM/Exclusive	

	***To interviewer:** read each method and code each response appropriately.*	Breastfeeding . . .1. Yes 2. No d. Interval IUD . . . . 1. Yes 2. No e. Postpartum IUD . . . . 1. Yes 2. No f. Injection . . . . . 1. Yes 2. No g. Condom . . . . . 1. Yes 2. No h. Pill . . . . . .1. Yes 2. No i. Female Sterilization . . . . . .1. Yes 2. No j. Other . . . . . .1. Yes 2. No	
11	Of those listed in the previous question, which methods of family planning have you used?	None . . . . . 0 Withdrawal . . . . . .1 Periodic Abstinence . . . . . 2 LAM/Exclusive Breastfeeding .3 Interval IUD . . . . . 4 Postpartum IUD . . . . . 5 Injection . . . . . 6 Condom . . . . . 7 Pill . . . . . 8 Sterilization . . . . . .9 Other 88	
12	Why did you choose to use that/those method(s) of family planning and not any of the others you heard of?		
13	Were you using a method of family planning when you became pregnant this time? **To Interviewer:** *If woman answered "None" in question 10, code this question as "No" and skip to 14.*	Yes. . . . . 1 No 2	➔ If no, go to 15
14	Which method were you using?	Withdrawal . . . . . .1 Periodic Abstinence . . . . . 2 LAM/Exclusive Breastfeeding .3 Interval IUD . . . . . 4 Postpartum IUD . . . . . 5 Injection . . . . . 6 Condom . . . . . 7 Pill . . . . . 8 Sterilization . . . . . .9 Other 88	
15	For what reason did you stop using the last method of family planning?	Became pregnant . . . . . .1 Wanted to get pregnant . . . . . 2 Side-effects . . . . . .3 Did not have access	

		to more . . . . . .4 Partner did not approve . . . . . .5 Other 88	
16	If you have used contraceptives, where do you usually get family planning from? ***To Interviewer:** Ask this question if woman answered a modern method to question 10.*	Does not use contraceptives . .0 Maternal Hospital . . . . . 1 Polyclinic . . . . . .2 Pharmacy . . . . . 3 Social Marketing Agency . . . . .4 School . . . . . 5 Other . . . . . .88 Don't know 99	
17	Can you tell me what influences your decision about using family planning?	Nothing . . . . . .0 Family . . . . . 1 Doctors/Nurses . . . . . 2 Friends . . . . . 3 Media . . . . . 4 Other . . . . . .88 Don't know 99	
**Read:* *Now, I'm going to ask you some questions about your experiences with this clinic during your pregnancy.*			
18	Is this your first visit to this clinic for antenatal care?	Yes. . . . . 1 No 2	➔ If no, go to 21
19	Have you discussed postpartum family planning with your antenatal care provider?	Yes. . . . . 1 No 2	➔ If no, go to 21
20	What methods of postpartum family planning did you discuss?	None . . . . . 0 Withdrawal . . . . . .1 Periodic Abstinence . . . . . 2 LAM/Exclusive Breastfeeding .3 Interval IUD . . . . . 4 Postpartum IUD . . . . . .5 Injection . . . . . 6 Condom . . . . . 7 Pill . . . . . 8 Sterilization . . . . . .9 Other 88	
21	Do you know that you can have an IUD inserted directly after childbirth?	Yes. . . . . 1 No 2	➔ If no, go to 23
22	If yes, who told you?	Doctor . . . . . .1 Family Member . . . . . 2 Friend . . . . . 3 Pamphlet/Handout 4	

		Other . . . . . .88 Don't know 99	
23	Do you plan to start using a method of contraceptive after having this baby?	Yes. . . . . 1 No . . . . . 2 Don't know 99	➔ If no, go to 25
24	If so, what method do you plan to use after giving birth? *__To interviewer:__ *If respondent answered "No" to above question, code answer as 0 (None) for this question.*	Withdrawal . . . . . .1 Periodic Abstinence . . . . . 2 LAM/Exclusive Breastfeeding .3 Interval IUD . . . . . 4 Postpartum IUD . . . . . 5 Injection . . . . . 6 Condom . . . . . 7 Pill . . . . . 8 Sterilization . . . . . .9 Other 88	
25	Who would you feel comfortable discussing family planning with? *__To interviewer:__ *ask a-h individually. If respondent answers no to a-h, code i as 1. No.*	a. Doctor . . . . . 1. Yes 2. No b. Nurse . . . . . .1. Yes 2. No c. Partner . . . . . 1. Yes 2. No d. Mother . . . . . .1. Yes 2. No e. Sister . . . . . .1. Yes 2. No f. Other family member . . . . . 1. Yes 2. No g. Friend . . . . . .1. Yes 2. No h. Other. . . . . .1. Yes 2. No i. Religious Leader. 1. Yes 2. No i. None . . . . . 1. Yes 2. No	
26	Would you be comfortable **initiating** discussion about family planning with your primary antenatal care provider? *__To Interviewer:__ *Make sure to emphasize comfort asking questions to doctors rather than answering questions doctors may ask.*	Yes. . . . . 1 No 2	
27	How do you think family planning services can be improved in this clinic?		
*__Read:__ *Finally, I have a few questions specifically about Inter-Uterine Devices, IUDs, that I would*			

like to ask.			
28	Do you know any woman who has had an IUD?	Yes. . . . . 1 No 2	➔ If no, go to 27
29	To your knowledge, is she satisfied with her IUD?	Yes. . . . . 1 No 2	
30	Has her experience influenced your opinion about IUDs?	Yes. . . . . 1 No 2	
31	Is there anything else you would like to add about your experience with postpartum contraceptives or your expectations for postpartum care?		
**Please record the time the interview ended*		:	

Appendix B. List of Variables

Variable Name	Type	Coding
City	Binary/Categorical	0 = Durres; 1 = Tirana
Education	Categorical	0 = None; 1 = Some Primary; 2 = Primary; 3 = Some Secondary; 4 = Secondary; 5 = Tertiary +
Age	Continuous	Open-Ended 1-99
Parity	Continuous	Open-Ended 1-99
Town	Categorical	1 = village; 2 = town; 3 = city
Methods Used	Binary	0 = No; 1 = Yes
Methods Known	Continuous	Array variable 1-10
Discussed FP with ANC	Binary	0 = No; 1 = Yes
Heard of PP-IUD	Binary	0 = No; 1 = Yes
Planned Use of PP-IUD	Binary	0 = No; 1 = Yes
Know Someone with IUD	Binary	0 = No; 1 = Yes
Friend Satisfied with IUD	Binary	0 = No; 1 = Yes
Ever Used LAM	Binary	0 = No; 1 = Yes
ANC Discussed Any Method	Binary	0 = No; 1 = Yes

Appendix C. Demographic Characteristics by Clinic Type, Tirana and Durres, Albania

	Polyclinics (Tirana) (N=58)	Maternity Hospitals (Tirana) (N=81)	Maternity Hospitals (Durres) (N=102)	All (N=240)
AGE GROUPS (N=241)				
15-19	2 (3.5)	7 (8.6)	6 (5.9)	15 (6.2)
20-24	11 (19.0)	25 (30.9)	33 (32.4)	69 (28.6)
25-29	24 (41.4)	23 (28.4)	28 (27.5)	75 (31.1)
30-34	16 (27.)	14 (17.3)	26 (25.5)	56 (23.2)
35-39	5 (8.6)	11 (13.6)	8 (7.8)	24 (10.0)
40-44	0 (0.0)	1 (1.2)	1 (1.0)	2 (0.8)
Mean Age	27.7	27.1	27.0	27.2
EDUCATION (N=240)				
None	0 (0.0)	1 (1.2)	0 (0.0)	1 (0.4)
Some Primary	1 (1.7)	3 (3.7)	2 (2.0)	6 (2.5)
All Primary	10 (17.2)	22 (27.2)	48 (47.5)	80 (33.3)
Some Secondary	0 (0.0)	5 (6.2)	6 (5.9)	11 (4.6)
All Secondary	22 (38.0)	27 (33.3)	34 (33.7)	83 (34.6)
Tertiary	25 (43.1)	23 (28.4)	11 (10.9)	59 (24.6)
URBAN/RURAL (N=239)				
City	51 (87.9)	51 (63.0)	48 (48.0)	150 (62.8)
Town	1 (1.7)	5 (6.2)	13 (13.0)	19 (8.0)
Village	6 (10.3)	25 (30.9)	39 (39.0)	70 (29.3)
PARITY (N=240)				
0	33 (56.9)	42 (51.9)	42 (41.6)	117 (48.8)
1	15 (25.9)	23 (28.4)	31 (30.7)	69 (28.8)
2	9 (15.2)	12 (14.8)	23 (22.8)	44 (18.3)
3	1 (1.7)	4 (4.9)	5 (5.0)	10 (4.2)

Appendix D. Frequencies of Family Planning Use, Albania 2010 (bold is significant at p = 0.05)

	Modern (%)							**Traditional (%)**			
Knowledge											
	Any	Condom	Pill	**Injection**	IUD	**PP-IUD**	Tubal Ligation	Any	Withdrawal	LAM	Periodic Abstinence
Durres	*97.1*	*97.1*	*92.2*	***69.6***	*50.0*	***22.6***	*56.9*	*99.0*	*99.0*	*62.8*	*58.8*
Tirana	*97.9*	*97.9*	*96.4*	***85.0***	*60.7*	***50.0***	*57.1*	*100.0*	*100.0*	*70.7*	*70.7*
Total	*97.5*	*97.5*	*94.6*	***78.5***	*56.2*	***38.4***	*57.2*	*99.6*	*99.6*	*67.4*	*59.9*
Ever Use											
	Any	Condom	**Pill**	Injection	IUD	PP-IUD	Tubal Ligation	**Any**	**Withdrawal**	**LAM**	Periodic Abstinence
Durres	***37.3***	*36.3*	***4.9***	*0.0*	*0.0*	*0.0*	*0.0*	***88.2***	***88.2***	***22.6***	*24.5*
Tirana	***55.7***	*44.3*	***21.4***	*2.1*	*2.1*	*0.0*	*0.0*	***96.4***	***95.0***	***6.4***	*20.0*
Total	***47.9***	*40.9*	***14.5***	*1.2*	*1.2*	*0.0*	*0.0*	***93.0***	***92.2***	***13.2***	*21.9*
Future Use											
	Any	Condom	**Pill**	Injection	IUD	**PP-IUD**	Tubal Ligation	Any	**Withdrawal**	LAM	Periodic Abstinence
Durres	*44.3*	*30.0*	***12.5***	*0.0*	*2.3*	***1.1***	*4.6*	*88.5*	***84.1***	*32.2*	*9.1*
Tirana	*68.2*	*35.6*	***28.2***	*3.0*	*4.4*	***7.4***	*2.2*	*71.1*	***66.7***	*24.4*	*6.7*
Total	*58.7*	*33.2*	***22.0***	*1.8*	*3.7*	***4.9***	*3.1*	*77.9*	***73.5***	*27.5*	*7.6*
Failure (Using when became pregnant this time)											
	Any	Condom	Pill	Injection	IUD	PP-IUD	Tubal Ligation	**Any**	**Withdrawal**	LAM	Periodic Abstinence
Durres	*1.0*	*1.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	***7.8***	***7.8***	*0.0*	*0.0*
Tirana	*4.3*	*2.2*	*2.2*	*0.0*	*0.0*	*0.0*	*0.0*	***20.9***	***20.1***	*0.0*	*0.7*
Total	*2.9*	*1.7*	*1.2*	*0.0*	*0.0*	*0.0*	*0.0*	***15.4***	***14.9***	*0.0*	*0.4*
Methods Discussed during ANC Appointment											
	Any	Condom	Pill	Injection	IUD	PP-IUD	Tubal Ligation	Any	Withdrawal	LAM	Periodic Abstinence
Durres	*13.7*	*5.9*	*11.8*	*3.0*	*9.8*	*7.8*	*1.0*	*10.8*	*2.0*	*9.8*	*0.0*
Tirana	*30.0*	*4.3*	*17.1*	*8.6*	*9.3*	*10.7*	*0.7*	*15.7*	*7.1*	*11.3*	*2.1*
Total	*23.1*	*5.0*	*14.9*	*6.2*	*9.5*	*9.5*	*0.8*	*13.6*	*5.0*	*10.7*	*1.2*

Appendix E. Parameter Estimates for Multivariate Models

Continuous Variables				
Outcome Variable	Independent Variable	Parameter Estimate	Standard Error	P-Value
Methods Used	Education	0.36	0.06	<.0001
	Age	0.03	0.01	0.0500
	Parity	0.08	0.08	0.3545
	Urban/Rural	0.04	0.08	0.6070
Methods Known	Education	0.62	0.11	<.0001
	Age	0.13	0.03	<.0001
	Parity	-0.10	0.16	0.5499
	Urban/Rural	0.48	0.15	0.0012
Discussed with ANC	Education	0.19	0.09	0.0402
	Age	-0.03	0.02	0.1391
	Parity	0.34	0.13	0.0085
	Urban/Rural	0.19	0.12	0.1076
Binary Outcomes				
Outcome Variable	Independent Variable	Odds Ratio	Standard Error	P-Value
Heard of PP-IUD	Education	1.64	0.16	0.0017
	Age	0.10	0.04	0.7661
	Parity	1.25	0.22	0.3137
	Urban/Rural	1.33	0.21	0.1785
Planned Use of PP-IUD	Education	1.31	0.41	0.4464
	Age	1.05	0.08	0.7500
	Parity	1.45	0.46	0.2398
	Urban/Rural	0.83	0.54	0.7415
	Knew Method	<0.001	145.8	0.9308
Know Someone with IUD	Education	2.56	0.19	<.0001
	Age	1.05	0.04	0.2496
	Parity	0.88	0.22	0.5681
	Urban/Rural	0.85	0.23	0.4540
Friend Satisfied with IUD	Education	1.57	0.32	0.1557
	Age	0.97	0.07	0.6658
	Parity	1.19	0.35	0.6291
	Urban/Rural	0.63	0.39	0.2250
Ever Used LAM	Education	1.45	0.16	0.0166
	Age	1.07	0.04	0.0716
	Parity	1.22	0.23	0.3884
	Urban/Rural	1.45	0.20	0.0570
Discussed Any Method at ANC	Education	1.31	0.18	0.1362
	Age	0.94	0.04	0.1266
	Parity	1.63	0.25	0.0480
	Urban/Rural	1.53	0.25	0.0859