Emergency contraception in Albania: A multi-methods study of awareness, attitudes and practices

By Florida Doci
University of Ottawa

Presented to the Interdisciplinary School of Health Sciences
In Partial Fulfillment of the Requirements for the Degree
Master of Science in Interdisciplinary Health Sciences
University of Ottawa
July 2017

ABSTRACT

Modern methods of contraception are freely available in Albania, yet contraceptive prevalence among Albanians is relatively low (11%). Abortion on the other hand has long been the mainstay of family planning in the country. Emergency contraception is not very popular in Albania either, even though two different levonorgestrel-only EC pills (NorLevo® and Postinor®) are widely available in Albanian pharmacies. This study aimed to investigate potential factors that influence women's choices of contraception. In 2016, we conducted a multi-method qualitative study with women and service providers in Albania. Women were invited to report their knowledge of, attitudes toward, and practices surrounding contraception in an online survey. Also, we conducted in-depth semi-structured interviews with key informants to better understand the current reproductive health landscape in the country. Additionally, we conducted structured interviews with pharmacists in Tirana to assess their training and practices with regard to different available contraceptive methods. Misinformation, lack of awareness, fear of judgement and embarrassment, and lack of infrastructure are the strongest influencers of women's choice of contraception in Albania. Training of health service providers, as well as development of materials for distribution are warranted to improve knowledge and uptake of contraception among women.

RÉSUMÉ

Les méthodes de contraception modernes sont disponibles gratuitement en Albanie. Par contre, les taux d'utilisation de contraception chez les Albanais sont relativement faible (11%). D'un autre côté, l'avortement est souvent utilisé comme méthode primaire de planification familiale dans le pays. De plus, la contraception d'urgence n'est pas très populaire en Albanie, même si deux différentes options de contraception d'urgence (NorLevo® et Postinor®) sont largement disponibles dans les pharmacies. Cette étude visait à étudier les facteurs qui influencent les choix de contraception chez les femmes albanaises. En 2016, nous avons mené une étude qualitative multi-méthodes avec des femmes et des fournisseurs de services de santé en Albanie. Les femmes ont été invitées à partager leurs connaissances, leurs attitudes et leurs pratiques de contraception sous forme d'un sondage en ligne. De même, nous avons mené des entrevues approfondies semi-structurées avec des fournisseurs de services pour mieux comprendre le contexte de santé reproductive dans le pays. De plus, nous avons effectué des entrevues structurées avec des pharmaciens à Tirana pour évaluer leur formation au sujet des différentes méthodes de contraception ainsi que leurs disponibilités. La désinformation, le manque de sensibilisation, le stigma et la peur du jugement, et le manque d'infrastructures semblent être les influences les plus fortes par rapport au choix de contraception chez les femmes en Albanienne. La formation des fournisseurs de services de santé, ainsi que le développement de matériaux à distribuer semblent nécessaire pour améliorer l'adoption de contraception et le niveau de connaissance des femmes entourant les méthodes de contraception.

ACKNOWLEDGMENTS

I will be forever thankful to *Angel*, who gave me the opportunity to embark on what has become the most wonderful and rewarding experience of my life. Thank you for your unwavering support, invaluable mentorship, and continuous inspiration you provide me with.

I would like to also thank the members of my thesis advisory committee, *Dr. Raywat Deonandan* and *Dr. Karen Philips*, for their feedback and contributions to this project.

Thank you to *Kathryn, Abdi and Elyse* for their patience, understanding and kind never-ending encouragement; and to my classmates from whom I continue to learn and get inspired every day.

I will always be grateful for the wonderful research assistants that worked with me throughout this project, and provided continuous support in Albania, including *Jonida Thaci*, and *Andi Rabiaj*. I am also very thankful to *Dr. Dorina Tocaj* of UNFPA and *Holta Koci* of ACA, who were focal points in Albania, and provided logistical support throughout this research project.

This study was supported by a grant provided by the *European Society of Contraception and Reproductive Health*, and I am very grateful for their generous contribution which allowed me to travel to Albania and dedicate time to data collection. I would also like to acknowledge the *United Nations Population Fund* in Albania, whose support in the field made this project a success. I am also thankful to the *University of Ottawa* and the *Society of Family Planning*, whose financial support made it possible for me to travel and present my findings at different conferences in North America.

Lastly, I would like to dedicate this accomplishment to my amazing family, and Lukas, who have supported me continuously and have made countless sacrifices so I could thrive; and to the greatest friends one could wish for: I.M, I.R, and L.L who have always been there to cheer me up in difficult times, and cheer me on in happy moments.

TABLE OF CONTENTS

List of acronyms and abbreviations

EC	Emergency contraception
ECPs	Emergency contraceptive pills
FGDs	Focus group discussions
FP	Family planning
HSP	Health service provider
IDIs	In-depth interviews
IUD	Intrauterine device
LNG	Levonorgestrel
NGO	Non-governmental organization
OCP	Oral contraceptive pills
PI	Principal investigator
REB	Research Ethics Board
STI	Sexually transmitted infection
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UPA	Ulipristal acetate
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Overview of Albania

Albania is a relatively small country, geographically located in the Balkan peninsula in southeast Europe. Numbers on the population of the country are conflicting, however the most recent estimate from the World Bank indicates that approximately 2.9 million people lived in Albania in 2014 (World Bank, 2015). Albania is an important geopolitical actor in the Balkan region. The country played a crucial role during the 1998 Kosovo war and refugee crisis, and has since been a strong advocate and lobbyist for the recognition of Kosovo as an independent country. Due to lucrative natural resources such as uranium, gold, silver, copper, and water supplies, economic interest in the region is high. Hence, the region is very often in the centre of geopolitical power plays between the US, Western Europe, and Russia (Kovacevic, 2009). In addition, Albania is key to the security and stability of the Balkan region, due to the fact that over 2.2 million Albanians live outside of the official borders of the country. In light of the war in Kosovo, and continuous uprisings in Macedonia, there is a persistent fear that the Albanian minorities in the countries neighboring Albania will attempt to push for a "Greater Albania" (Judah, 2001).

Since 1990, Albania has struggled to transition from a communist dictatorship characterized by an underdeveloped centralized forced-labour economy, into a free and open market democracy. Pre-existing political conditions, the degree of its previous totalitarianism, and the country's late start at democratization have put Albania at a disadvantage. Following the fall of the communist regime, state legitimacy and efficiency continued to weaken due to the lack of adequate institutions and political leadership. The newfound democracy was perceived as unrestrained freedom, hence people had no regards for the common good, private property rights,

or fairness (Nence, 2013). In addition, Albanians had no faith in the rule of law and thus relied more on personal connections than the system. Corruption, organized crime, and judicial bribery filled quickly the vacuum created by the fall of the totalitarian regime (Stern et al., 2012). To this day, the functioning of democratic institutions is characterized as inefficient, the rule of law is obstructed by political interference, and the state is considered vulnerable to the interests of the private sector (Bertelsmann Stiftung, 2014). Corruption continues to be a significant problem in Albania, especially in the public sector (Jenkins, 2014). According to the Global Corruption Barometer conducted by Transparency International in 2013, 66% of Albanians believed that corruption has increased over the years (Transparency International, 2013). More than half of the people surveyed for this report believed that the government is controlled by entities acting in their own best interest, and that measures taken by the government are ineffective in fighting corruption. The same report, indicated that judiciary, and medical and health services are among the most corrupt institutions in the country (Transparency International, 2013).

The Albanian health system is characterized by extremely low per capita public expenditure (US$116), and scarce public resources (WHO, 2013). The quality of care is of great concern. Wages in the health sector are the lowest in the region, and there is an evident lack of infrastructure. Consequently, Albanians face numerous challenges accessing health care services. Health care services are often costly, and informal payments are a common practice among Albanians, who believe that bribery will get them better services or safer treatment (Vian et al., 2006).

In the face of high levels of political corruption, nepotism, flawed administrative and regulatory systems, and an overall volatile environment, doing business in Albania is a risky prospect (OECD, 2010). As a result, Albania has trouble attracting foreign investment, placing

the country economically behind most of the other countries in the region. The International Monetary Fund lists Albania among thirteen emerging and developing countries in Europe, with an estimated GDP per capita of US$3945 (IMF, 2015; The World Bank, 2017). Only 53.7% of the population participates in the labour force, and unemployment is estimated at 17.5% (INSTAT, 2015). In the face of all the challenges and international influences, Albania has turned into a stabilocracy (a geographic entity described as stable in the international community, but chaotic on the inside) (Primatarova et al., 2012). Even though Albania submitted its application for EU membership in 2009 and signed the visa liberalization agreement with the European Union in 2010, progress, development, and growth have been slow in almost all sectors.

Women's role in the Albanian society

Traditionally, Albania is a male-dominated society, which is also reflected in the labour force: 48.7% of women in Albania do not participate in the workforce compared to only 27.8% of men (INSTAT, 2015). Women are more likely to engage in informal employment and take on vulnerable jobs (Elezi, 2014), which are characterized by lack of representation, difficult working conditions, and inadequate earnings (ILO, 2010). In Albania, the gross average monthly wage per employee is 45,539 Albanian Lek (equivalent of US$370). However, according to the country's statistics women are badly remunerated and are more likely to participate in unpaid work, despite their high level of education (Isis-WICCE, 2002). Historically, women's roles were constrained within the household, and were dictated by the men of the family. Honour and morality have always been the foundation of patriarchal family values and social order in Albania (Ademi et al., 2013). However, the honour of the entire family rests on women, and has

fueled feminization of familial shame (Nixon 2009). In that sense, Albanian culture is hostile to women perceived as immoral, and collective shame is used to police women's actions and female sexuality (Nixon 2009). Ancient customary laws such as the "Kanun" also gave men the right to publicly humiliate, and verbally or physically abuse, women in their family, if they defied the rules and roles of their households (Vokshi et al., 2013).

After the second World War, the communist regime recognized women "as a great force of the revolution", and created provisions to defend women's legal and social rights, and encourage women's involvement in the economy (Alb. Const. art. 41, 1976). However, the reality was considerably more complex, and political agendas and aggressive pronatalist policies of totalitarian rule infringed on women's sexual and reproductive health rights. Historians have argued that empowerment and emancipation of women during the communist regime was a myth; rather women's empowerment served as a strategy for the communist leader to expand and maintain power over the society (Ikonomi & Woodcock 2010). During communism, women remained vulnerable to sexual violence and abuse that was de facto sanctioned by the system. The political, economic, and social turbulence in post-communist Albania also affected the role of women in the society. Issues such as human trafficking, prostitution, and domestic violence are still very much prevalent in the country (DOS, 2015; UNDP, 2013; Haarr, 2013).

The reproductive health landscape in Albania

In the 1950s, the total fertility rate (TFR) in Albania was estimated as more than six children per woman, the highest in Europe (Falkingham et al., 2001). Over the next 40 years, Albania's TFR witnessed steady decline. However, traditional patriarchal family values combined with a pronatalist environment and the virtual absence of contraceptive methods

reinforced high fertility. Induced abortion was illegal in Albania until 1991, and performing an abortion was a punishable offence of up to 5 years in prison (Kodi Penal [Penal Code] 1952). Yet, banning of abortions during the communist regime did not stop abortion practices. Anecdotal evidence suggests that abortion still occurred and was never taboo among Albanian women. Abortion was routinely used as a method of family planning in a time when contraceptives were prohibited and the procedure was routinely performed clandestinely.

Consistent with practices in other settings where abortion is legally restricted, during this period women would often self-induce abortions using sharp objects, belly-flopping onto hard surfaces, consuming poisonous herbs, or resorting to any lethal chemical available on hand. Unqualified nurses also performed abortions in their spare time, using unsafe techniques and unsanitary tools. As a consequence, abortion carried a high risk of life threatening complications. According to medical staff, sepsis and hemorrhage due to unsafe abortion was the biggest contributor to maternal mortality during the communist era (Sahatci 1993, Morris et al. 2005). Although there is very little published literature on unsafe abortion during this period, case reports were documented in several media reports, news articles, books, novels, and even movies recounting life at the time (Culi 1989; Vdekja e Kalit 1991; Woodcock 2015).

At the end of the communist era Albania's TFR remained the highest in the region (UN, 2015). In 2015, Albania's TFR was 1.78 children per woman, only slightly above the European average of 1.6 (UN, 2015). While fertility rates have been on the decline, the reported prevalence of contraceptive use is unreliable and the rate of abortion is relatively high. In 2013, the Albanian Institute of Statistics reported 180 abortions per 1,000 births, which is six times higher than the reported WHO figures on abortion in the European Union (30 abortions per 1000 births) (INSTAT, 2015; WHO, 2015).

Abortion was decriminalized in 1991 and fully legalized in 1995. Since then, women have been able to terminate a pregnancy up to 12 weeks' gestation without restriction as to reason. Termination of a pregnancy for social or medical reasons can be performed up to 22 weeks' gestation contingent on the approval of an expert panel (Law Nr.8045). Pre-abortion counseling is mandatory and doctors performing the procedure are required to counsel the patient on her rights, options, side effects of the procedure, and the sources of support that the woman can reach out to should she chose to terminate her pregnancy (Law Nr.8045). According to the same law, women are required to take seven days to consider their options before formally requesting to proceed with the termination, and parental consent is required when the patient is under the age of 16 and unmarried. After the liberalization of the abortion law in 1995, abortion procedures could be performed by any trained obstetrician-gynecologist in any licensed public or private clinic or hospital. However, in an attempt to reduce non-specified risks, prevent selective abortions, and increase access to safe procedures, the Albanian government passed new provisions in 2013 that prohibited private clinics from offering services such as termination of pregnancies (Panorama, 2013). Currently, abortions can only be performed in hospitals although several media investigations and reports have revealed that private clinics continue to perform the procedure illegally (Gazeta Shqip, 2015; Ora News, 2016). Post-abortion counselling is also required by law. Nevertheless, studies suggest that this service is virtually inexistent; a study conducted in 2013 with 112 abortion clients reported an extremely low frequency of post-abortion contraceptive counselling (Boci et al., 2013). Although the authors of the study consider this a missed opportunity, the doctors interviewed during this project tell a different story; Ob/Gyns claimed that clients are not interested in contraceptive counselling because they have concerns about the health side effects of contraceptives (Boci et al., 2013).

The Reproductive Health Survey conducted in 2002 revealed that only 8% of women in Albania used modern contraceptive methods (Morris et al., 2005). Similarly, in 2009 the Albanian Demographic and Health Survey showed that less than 8% of women between the ages of 15-49 used modern methods of contraception. While government reports indicate that women are aware of modern contraceptive methods (INSTAT et al., 2010), other research studies have suggested that lack of knowledge and misconceptions are very common among both women and men. Findings from a study conducted in 2009 that explored the views and perceptions of 80 university students on contraception revealed that there is an unmet need for accurate information on contraceptives (Gryboski, 2009). In addition, there is evidence suggesting that significant misinformation and misconceptions exist among providers as well. Key findings from another project conducted in 2010 showed that Albania lacks evidence-based guidelines and protocols on reproductive health care services, hence providers rely on outdated information, anecdotal evidence, or personal beliefs when providing advice on contraceptive methods (Stolarsky et al., 2010).

Discussing sexuality, contraception, and abortion in public is taboo in Albania. Most young women reported getting information on contraceptives from friends, the internet, or TV ads (Gryboski, 2009), hence it is not surprising that participants are misinformed about modern contraceptive methods. A project funded by United States Agency for International Development (USAID) in 2011 showed that attitudes and behaviours of young women and men toward contraceptives improved after the delivery of communication interventions (Zazo et al., 2011). This indicates that educational programs have the potential to improve women's knowledge on contraception, and are key to improving access to modern methods.

The lack of awareness among the population and health service providers (HSPs) is even larger when it comes to emergency contraception (EC). Emergency contraceptives are medications or devices that are used after intercourse to reduce the risk of pregnancy (Glasier, 1997; Trussell, 2012). The Yuzpe method is the earliest method of EC, and it uses combined oral contraceptive pills in large doses to prevent pregnancies. This form of EC was used for nearly twenty years before dedicated emergency contraceptive pills (ECPs) became available in the late 1990s. Regimens of combined estrogen and progestin were initially the most dominant form of ECPs until research showed that progestin-only regimens were more effective and caused fewer side effects (Duffy et al., 2011). Currently, there are two types of dedicated ECPs: progestin pills and antiprogestin pills. Levonorgestrel (LNG) is the most popular progestin ECP; it is administered as a 1.5 mg single-dose regimen within 120 hours of unprotected intercourse, and can prevent pregnancy mainly by delaying or preventing ovulation (Trussell, 2012). Antiprogestin pills could be partial progesterone receptor agonists, selective progesterone receptor modulator (SPRM), or progesterone receptor antagonists that act by delaying ovulation or changing the endometrial morphology (Spitz et al.,1996). Mifepristone, which is largely known as the golden standard of medication abortion, is a partial progesterone receptor agonist drug that in low doses can serve as a highly effective EC (Trussell, 2012). More recently, researchers have developed a novel dedicated form of antiprogestin ECP known as ulipristal acetate (UPA). This second-generation SPRM antiprogestin is highly effective at inhibiting ovulation up to 120 hours after intercourse, even when the efficacy of LNG is lower, and shows only mild short-lasting side effects (Jadav et al., 2012). In addition to medication, post-coital insertion of the copper-T IUD is nearly 100% effective at preventing pregnancies (Trussell, 2012).

Emergency contraceptives are excellent preventative measures following unprotected sex, contraceptive failure, or coerced intercourse (WHO, 2012), as they provide women with a last chance to prevent unwanted pregnancies (Trussell et al., 2014). In the context of Albania, EC could play a significant role in addressing women's need for an effective and discreet method of contraception. Currently, women rely on participation of men to prevent unwanted pregnancies, and withdrawal is the most common method of contraception (INSTAT et al., 2010). Some women report that they would prefer to use modern contraceptive methods, nonetheless most let their partners have the final say on the decision (Boci et al., 2013). Intimate partner violence is also highly prevalent in Albania, and nearly one third of women have reported experiencing one episode of violence in the form of physical, emotional, or sexual abuse (Burazeri et al., 2006). Thus, emergency contraception could be a safe and convenient contraceptive method among Albanian women.

However, EC is not very popular in Albania. Although two different levonorgestrel-only EC pills (NorLevo® and Postinor®) are widely available in Albanian pharmacies, only 2.4% of women of reproductive age in Albania reported ever using EC (ICEC, 2015). According to the International Consortium on Emergency Contraception (ICEC), whose mission is to "expand access to and ensure safe and locally appropriate use of emergency contraception worldwide," less than one third of Albanian women are knowledgeable and informed about EC (ICEC, 2015). Literature on EC in Albania is practically nonexistent, thus information about attitudes and practices is limited.

Research rationale and objectives

Research on emergency contraception in Albania is overdue, even more so as the country aspires to join the European Union family. The Albanian Ministry of Health recognizes that there is still a gap in reproductive health services and information in Albania, despite the efforts by both the government and international partners to address these issues. I hope that my work will fill a gap in the literature and inform future decision and policy making in the country.

My study had three primary research questions:

1) What are the dynamics shaping EC service delivery and accessibility in Albania?
2) What are the barriers to accessing EC?
3) What efforts could be undertaken to improve access to and use of EC in Albania?

More specifically this study aimed to:

1. Explore factors that influence women's reproductive health choices in Albania.
2. Assess the levels of awareness and perceived need for emergency contraception among women, health care professionals, service providers and other stakeholders.
3. Identify barriers to accessing emergency contraception among women in Albania.
4. Determine future steps that can contribute to improve EC accessibility.

Thesis structure

This thesis follows the guidelines and format of a thesis-by-articles, and it includes six chapters. Chapter One: *Introduction* provides some background on Albania's historical, political, and socioeconomic landscape. Additionally, this chapter describes the evolution of reproductive health trends in the country and the current challenges with regard to women's sexual and

reproductive health. Finally, this chapter contains the rationale and objectives of the study we conducted in Albania in the summer of 2016.

Chapter Two: *Methods* describes the methodological approach adopted for this research project. This chapter provides general details on data collection tools, recruitment strategies, and analytic approaches for each of the components of this multi-modal qualitative study.

The next three chapters present the research articles. Chapter Three: *"Emergency contraception in Albania: A multi-methods qualitative study of awareness, knowledge, attitudes, and practices"* presents an article prepared specifically for this thesis and formatted according to the requirements and guidelines of *The European Journal of Contraception & Reproductive Health Care*. This article is a summary of the entire research project, with a particular focus on the rationale and methodology of this study. Chapter Four: "*The ultimate gatekeepers: Exploring pharmacists' contraceptive service delivery practices in Albania*" presents an article formatted according to the requirements and guidelines of *Contraception*. This article explores pharmacists' knowledge, attitudes and practices towards modern methods of contraception in Albania and offers recommendations for improving provision and access to contraception in the private sector. Chapter Five: "*The talk of Shame: The history of abortion in communist and post-communist Albania*" was prepared specifically for this thesis, and formatted as per requirements of *"Abortion, politics, and the pill that promised to change everything: The global journey of mifepristone"* edited by Angel M. Foster and L.L. Wynn. This chapter documents the history of abortion in communist and post-communist Albania, and focuses on availability and accessibility issues as they pertain to the golden standard of medication abortion.

Chapter Six: The last chapter of this thesis consists of a discussion of the different chapters. I begin by briefly synthesizing the findings from each article, and discussing the

findings from all components of this study. Additionally, in this chapter I discuss the significance and implications of my findings, followed by conclusions and future directions. In this section, I also reflect on my own positionality as a researcher and the potential limitations of this study.

CHAPTER 2: METHODS

As part of this multi-methods research project, I collected data in the field (Albania) between June 2016 and September 2016 with follow-up research in December 2016-January 2017. This project comprises four components (Figure 1): a community based survey, focus group discussions with women of reproductive age, interviews with pharmacists, and semi-structured key informant interviews.

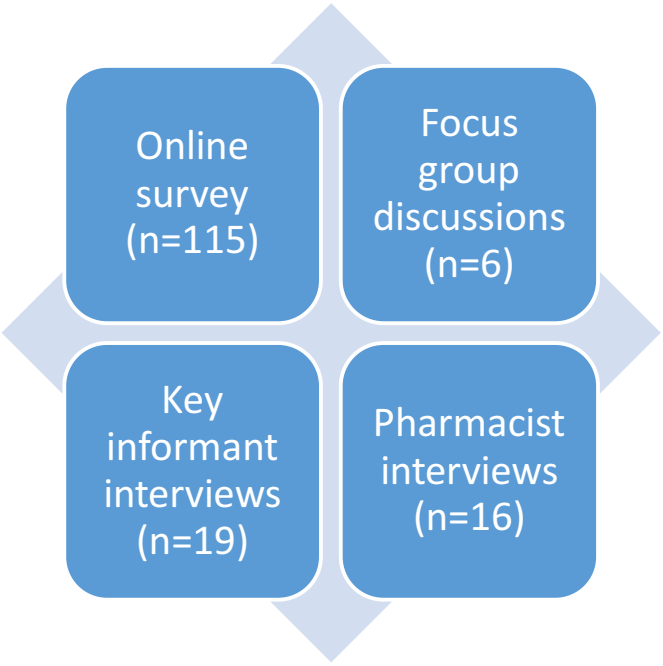

Figure 1. Components of the multi-methods research project

Community based online survey

We used FluidSurveys to design a survey that would assess women's knowledge, attitudes, and practices related to contraception, with an emphasis on emergency contraception. The survey began with a series of demographic questions about the woman's background, education, employment, living arrangements, and beliefs. Next we asked questions pertaining to

her reproductive health, including her history, sources of information, the services she accesses and factors that influences her choices. We also asked women about their knowledge, familiarity, and use of different modern methods of contraception, including EC. Finally, we asked participants whether they would be interested in participating in a follow-up focus group discussion. We also asked all participants to participate in a draw for one of three CA$50 cash prizes awarded as a token of appreciation for participating in the study.

I originally designed the survey in English with input from my supervisor, Dr. Angel M. Foster. We later translated the instrument into Albanian with the input of a research assistant in Albania. I revised the Albanian survey following translation to ensure reconciliation between both versions, and later shared it with Dr. Dorina Tocaj of United Nations Population Fund (UNFPA), local partner in Albania, for further feedback and quality checks.

We used a multi-modal recruitment strategy that included social media, emails/listservs, and flyer-and ad-based efforts to recruit participants across the country from both urban and rural areas. Our local partner in Albania (UNFPA) also distributed the link of the survey in all their social platforms, as well as through their emails/listservs to several partner organizations in the country. The survey remained opened from June 16th until October 3rd of 2016, although active recruitment ended on September 20, 2016. I used open enrollment such that all people who completed the survey while the survey remained opened were included in the analysis. Through such recruitment strategies, we collected 115 eligible responses from women between the ages of 17 and 50 years old, from different cities, education levels, and socioeconomic backgrounds. Upon completion of data collection, we analyzed all responses using descriptive statistics tools available on FluidSurvey. We analyzed additional comments separately using inductive techniques.

Focus group discussions

We conducted focus group discussions (FGDs) with women of reproductive age to assess and explore women's beliefs and attitudes towards contraception and EC in-depth. We conducted six focus group discussions with 3-11 participants each. In order to address power dynamics and judgment and to create a degree of homogeneity, we segregated FGDs based on the marital status of the participants (married vs. unmarried). For this component of the study, I worked closely with Albanian Community Assist and Y-Peer Network, two organizations that helped with recruitment, logistics and facilitation of the FGDs in Tirana, Vlora, Korca and Shkodra. These four major cities in Albania are fairly representative of the main cultural entities in the country: the vibrant metropolis, the south, the east, and the north (see the map of administrative divisions of Albania in Appendix A). To recruit participants, I created flyers and information sheets with details of the study and the two organizations and other local partners distributed them to (potentially) interested women. Research assistants from these organizations conducted recruitment and intake of the participants for this component and also assisted with note taking during the FGDs.

In each city, I facilitated FGDs in neutral spaces (provided by a local partner), where women could feel safe and comfortable to discuss said topics. At the beginning of each discussion I consented all of the participants and ensured that they met eligibility requirements. Discussions began once each participant had consented to participating in the study and to being recorded. Through these discussions I explored women's levels of awareness, the perceived need for EC, and the perceived barriers related to accessing EC. I used a semi-structured guide to lead the discussions, which started with introductions, followed by a discussion of the sexual and reproductive health services available and women's experiences with accessing these services.

Next, I invited women to discuss the modern methods of contraception they were familiar with, factors influencing their contraceptive decision-making, and their knowledge and perceptions of EC. Finally, I asked women to reflect on the current state of sexual and reproductive health services in the country and provide their thoughts and suggestions on how these services could be improved. Similar to the survey and other tools of this study, I originally created the FGD guide in English with the help of my supervisor and later translated it into Albanian with the assistance of a research assistant.

The FGDs lasted between 40 and 60 minutes; I provided snacks and drinks at each focus group discussion and gave each participant CAD10 as a token of appreciation for participating in the study. Lastly, I distributed a short demographic questionnaire to each participant. I transcribed all audio-recordings and later translated them into English. I memoed after each FGD to both reflect on the overall experience and begin the analytic process.

Structured in-depth interviews with pharmacists

All drugs in Albania, including progestin-only emergency contraception, are carried and sold behind-the-counter. Consequently, pharmacists play a key role in EC accessibility. Depending on their knowledge, training and personal beliefs, pharmacists can either be a resource or a barrier to women who need to access EC. From May 2016 until December 2016, I visited 19 sites in Tirana county and conducted 16 in-person interviews with pharmacists. I purposively recruited pharmacists from different neighbourhoods and districts of Tirana county to capture a range of perspectives (see the map of pharmacies visited in Appendix B). When determining which sites to visit, I took two factors into consideration. First, I wanted to cover as much ground within the county as possible, hence I travelled to other cities and/or remote villages as well. Second, I wanted to properly represent the areas with the highest population

density, thus most of the pharmacy visits were within Tirana city itself, which has a population density of 500-700 inhabitants/km2.

I followed a structured interview guide that began with a series of demographic questions about the pharmacist's background, education, professional experience, and training on reproductive health. I then asked pharmacists questions related to the services offered at the pharmacy including the availability of different contraceptive methods, the characteristics of clientele, their personal knowledge and beliefs of different contraceptive methods, and the overall accessibility of these services. Finally, I asked pharmacists about their awareness and perceptions of emergency contraception, followed by their thoughts on how to improve access to EC in Albania.

Interviews lasted on average 15 minutes and I field coded the responses. Following each interview, I wrote a short memo documenting the interactions with each pharmacist. The analytic process for this component was iterative in that I was reviewing the data as I was collecting it. This process allowed me to identify common themes and determine when we had reached thematic saturation. Upon completion of data collection, I inputted all responses into FluidSurveys and conducted descriptive statistical analyses of the collected responses. I analyzed the interviews qualitatively using inductive techniques.

Semi-structured in depth interviews with key informants

Interviews with key informants provided more insight into women's reproductive health policies in the country and the decision-making processes involved in the development of such policies. These interviews allowed me to understand better the landscape of reproductive health services available in Albania, determine the levels of awareness and opinions of emergency

contraception among such stakeholders, and identify potential barriers and facilitators that can improve access to EC in Albania.

Between June 2016 and December 2016 I interviewed nineteen key informants including clinicians, reproductive HSPs, policymakers, local experts and scholars on reproductive health. I recruited participants through purposive and snowball sampling, both through local partners and collaborators, as well as other professional networks in Albania. The interviews lasted on average 40 minutes and were semi-structured to allow for flexibility, while capturing a range of perspectives on key questions. I adopted a guide that began with a series of questions about the background of the participant, including education, qualifications, professional experiences and engagement in the field of reproductive health in Albania. Next, I asked participants questions about the sexual and reproductive health services available in Albania, their knowledge of emergency contraception, provision of EC in the country, and potential obstacles women might face accessing these services. Finally, I asked key informants about potential ways the availability, accessibility, and quality of sexual and reproductive health services could be improved.

I recorded Interviews with the participant's consent and I used memos to capture important facts, themes, and reflections from each interview. I transcribed the interviews in their entirety and translated the content into English, with the help of a volunteer research assistant.

Data analysis

I conducted qualitative analysis of the data collected from this study using inductive and deductive techniques. I developed a preliminary codebook of pre-determined codes and themes based on the research questions and the guides for the IDIs and FGDs. I started the analysis by reading and familiarizing myself with the transcripts and the memos. This helped me identify

additional emerging codes and themes that I added to my initial codebook. I used both these pre-determined and inductive codes and themes to perform content and thematic analysis of the data from the transcripts and memos. Additionally, I adopted a constant comparative approach to analyzing the data collected from the FGDs. In this case, I reviewed each transcript in relation to each other, and looked for both similarities and differences among the groups.

While we initially analyzed each component of the project separately, we integrated all components in a second phase, during which I was able to explain the meaning and significance of the findings (Figure 2), and provide a comprehensive view of the reproductive health landscape in Albania. During this phase, feedback from early presentations of preliminary findings, as well as continuous discussions with peers and collaborators within our research team informed the interpretation of the findings.

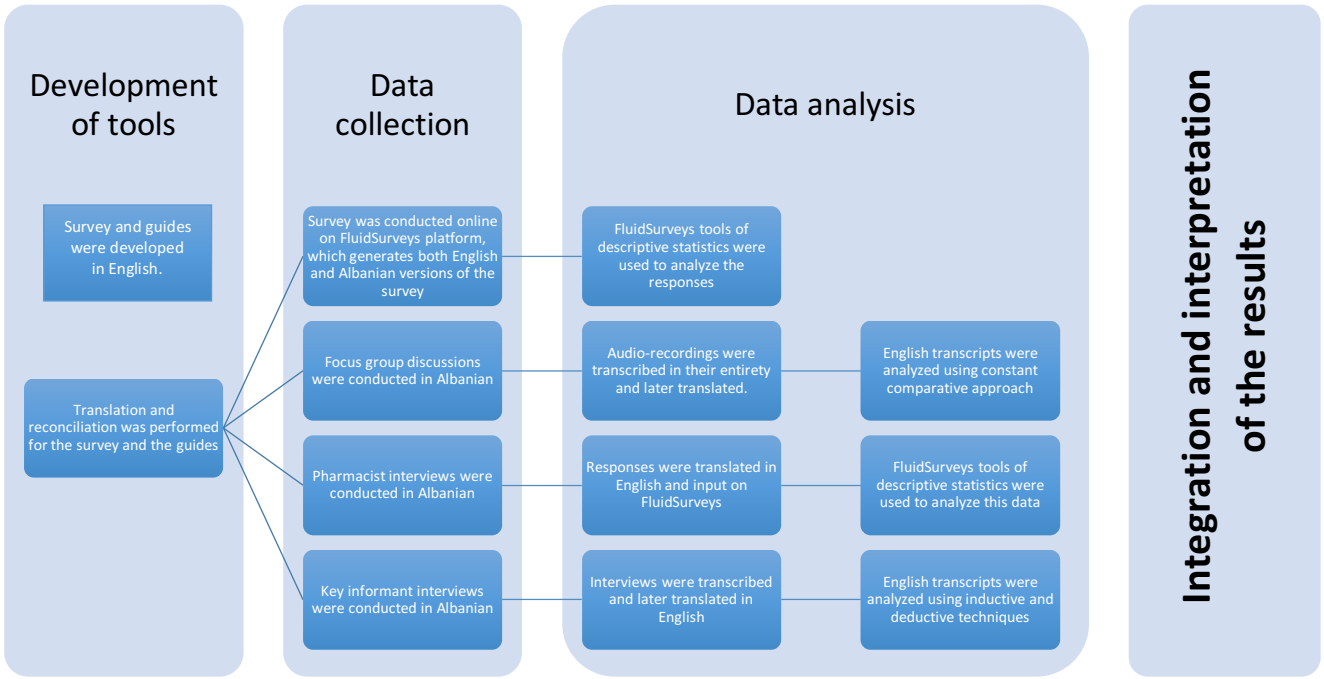

Figure 2. Key steps in the methodological approach

Ethical considerations

As per institutional requirements, I acquired research ethics approval prior to travelling to Albania for data collection. I completed and submitted an application for review to the Social Sciences Research Ethics Board early in February 2016. As part of this application, I submitted detailed information about my recruitment strategies, data collection methods, including copies of survey, interview and focus group discussion scripts, consent forms and guidelines, etc. I received ethics Approval for this project (File #03-16-19) in April 2016 (See Appendix C)

CHAPTER 3 : Emergency contraception in Albania : A multi-methods qualitative study of awareness, knowledge, attitudes, and practices

Emergency contraception in Albania:
A multi-methods qualitative study of awareness, knowledge, attitudes, and practices

Florida Doci, MSc(c)[1]
Jonida Thaci[2]
Angel M. Foster, DPhil, MD, AM[1,3*]

1. Faculty of Heath Sciences, University of Ottawa, ON, Canada
2. Independent consultant, Tirana, Albania
3. Institute of Population Health, University of Ottawa, ON Canada

* Corresponding author
1 Stewart Street, 312-B
Ottawa, ON K1N 6N5 Canada
+1-613-562-5800 ext. 2316
angel.foster@uottawa.ca

Word counts
Abstract: 227
Manuscript: 3464

Formatted for: *The European Journal of Contraception & Reproductive Health Care*

Emergency contraception in Albania:

A multi-methods qualitative study of awareness, knowledge, attitudes, and practices

Abstract

Purpose: Contraceptive prevalence is relatively low in Albania and abortion is the mainstay of family planning. Although two different levonorgestrel-only emergency contraceptive pills are available, uptake of this method is minimal. Emergency contraception (EC) could play a significant role in addressing women's need for an effective and discreet method of pregnancy prevention. However, information about the dynamics surrounding EC is limited.

Materials and methods: In 2016, we conducted a multi-methods qualitative study that aimed to explore awareness, knowledge, attitudes, and practices towards EC in Albania. This project comprised four components: a community-based survey with 115 responses, six focus group discussions with women of reproductive age, 19 in-depth semi-structured key informant interviews, and 16 structured interviews with retail pharmacists. We analysed our data using descriptive statistics and for content and themes.

Results: Our findings suggest that EC is widely available in pharmacies in Albania. However, women face numerous barriers to accessing this form of contraception. Misconceptions about hormonal contraceptives, misinformation about the side effects and risks of EC, and lack of training among providers, as well as stigma and fear of judgment, were common obstacles identified by participants.

Conclusion: Misinformation about EC among women and providers in Albania appears common. Training health service providers, raising awareness among women, and developing Albanian-language and culturally resonant materials for distribution could be key in improving access to and use of EC.

Key words: Albania, reproductive health, emergency contraception, provider training, qualitative research

Introduction

Until 1990, the communist regime in Albania pursued aggressive pronatalist policies to reinforce population growth. Contraceptives were banned and induced abortion was illegal; performing an abortion was punishable by up to 5 years in prison [1]. However, the reproductive health landscape in Albania changed drastically over the last three decades. Contraceptives were legalized in Albania in 1992 and abortion was decriminalized in 1991 and legalized without restriction as to reason in the first trimester in 1995. Several methods of contraception are available free-of-charge in over 420 public sector health centres across the country. However, despite ongoing programs and efforts to improve the uptake of modern contraceptive methods, the contraceptive prevalence rate remains low. Indeed, in 2009 less than 11% of married women aged 15-49 used modern contraceptive methods [2]. Albanian women rely heavily on men's participation to prevent unwanted pregnancies; withdrawal is the most commonly used method [2]. Some women report that they would prefer to use contraceptive methods with greater efficacy but most let their partners have the final say in the decision [3].

In the Albanian context, emergency contraception (EC) could play a significant role in addressing women's need for an effective and discreet method of pregnancy prevention. Emergency contraceptives, medications or devices used after sex to reduce the risk of pregnancy are excellent preventative measures following unprotected sex, contraceptive failure, or coerced intercourse [4-7]. However, EC is not very popular in Albania. Although two different levonorgestrel-only emergency contraceptive pills (NorLevo® and Postinor®) are available, only 2.4% of women of reproductive age reported ever using EC [7]. According to the International Consortium on Emergency Contraception (ICEC), less than one third of Albanian

women are knowledgeable about EC [7]. Literature on EC in Albania is sparse and thus information the dynamics surrounding EC is extremely limited.

In 2016, we conducted a multi-methods qualitative study in Albania to explore the EC awareness, knowledge, attitudes, and practices of women, pharmacists, and other health care professionals and decision-makers. Through this study we also aimed to identify facilitators and barriers to EC availability, accessibility, and acceptability and explore strategies for improving utilization.

Methods

We collected data in Albania during June-September 2016 and December 2016-January 2017. This project comprised four components: a community-based online survey, focus group discussions with women of reproductive age, semi-structured, in-depth interviews with key informants, and structured interviews with retail pharmacists. FD, a master's student in Interdisciplinary Health Sciences at the University of Ottawa who grew up in Albania, led all data collection. She received training from her supervisor AMF, a medical anthropologist and medical doctor with extensive experience conducting research on emergency contraception. JT served as a local research assistant and worked on the translation of the research instruments, transcription of interviews, and other components of data collection and analysis.

Data collection: Community-based online survey

We used FluidSurveys to design a survey assessing women's knowledge, attitudes, and practices related to sexual and reproductive health, in general, and EC, in particular. Any self-identified woman age 18 or older living in Albania and sufficiently fluent in English or Albanian

to complete the survey was eligible to participate. The survey began with a series of demographic questions about the woman's background, education, employment, and beliefs. Next, we asked questions pertaining to her sexual and reproductive health, including her reproductive health history, her sources of information, the services she accesses, and the factors that influence her reproductive health decisions and choices. We also asked about her knowledge, familiarity, and use of different contraceptive methods, including EC. We used a multi-modal recruitment strategy that included social media posts, email/listserv announcements, and flyering. We collected data over a four-month period in the summer and fall of 2016 and offered a 5000ALL (40 Euro) cash prize through a draw (one prize per 50 respondents).

Data collection: Focus group discussions

We conducted focus group discussions (FGDs) with women of reproductive age to explore their beliefs and attitudes towards contraception, with a specific emphasis on EC. Over the summer of 2016, we conducted six focus group discussions with 3-11 participants each, in Tirana, Vlora, Korca, and Shkodra (see Fig. 1). We purposively chose these areas as they reflect country's major administrative and cultural divisions, including the vibrant metropolis and capital city and cities in the south, east, and north. In order to create a degree of homogeneity and mitigate power imbalances, we segregated FGD participants based on geography and marital status. Research assistants from local organizations conducted recruitment and intake and also assisted with note-taking during the FGDs.

Discussions began once each woman had consented to participating and being audio-recorded. FD facilitated the FGDs using a semi-structured guide developed specifically for this study. We began with a round of introductions, followed by a discussion of available sexual and

reproductive health services and women's experiences accessing these services. Next, we invited women to discuss the contraceptive methods they were familiar with, factors influencing their contraceptive decision-making, and their knowledge, perceptions, and use of EC. Finally, we asked women to reflect on the current state of sexual and reproductive health services in Albania and provide their thoughts and suggestions on how services could be improved. The FGDs lasted between 40 and 60 minutes; we provided snacks and drinks at each FGD and gave each participant 1000ALL (approximately 9 Euro) as a token of our appreciation. At the end of each discussion, we distributed a short demographic questionnaire.

Data collection: Key informant interviews

Between June 2016 and December 2016 FD interviewed 19 key informants. We purposively recruited participants through local partners and collaborators and other professional networks in Albania, as well as through early participant referral. The semi-structured interviews lasted an average of 40 minutes. We developed a guide specifically for this project and adapted it to each individual interviewee. However, each interview began with a series of questions about the background of the participant, including education, qualifications, professional experiences, and engagement in the field of sexual and reproductive health in Albania. Next, we asked participants about available sexual and reproductive health services, their knowledge of EC and its provision, and potential obstacles women might face accessing services. Finally, we asked key informants about potential ways the availability, accessibility, and quality of sexual and reproductive health services could be improved. FD audio-recorded the interviews with the participant's consent and used memos to capture important themes as well as reflect on the interview-interviewee interactions.

Data collection: Structured interviews with pharmacists

FD conducted 16 in-person interviews with pharmacists in Tirana county in the summer of 2016. We followed a structured interview guide that began with a series of demographic questions about the pharmacist's background, education, professional experience, and reproductive health training. We then asked pharmacists questions related to the services offered at the pharmacy, including the availability of different contraceptive methods, the characteristics of clientele, their knowledge of and beliefs about different contraceptive methods, and the overall accessibility of services. Finally, we asked pharmacists about their awareness and perceptions of emergency contraception, followed by their thoughts on how to improve access to EC in Albania. Interviews lasted an average of 15 minutes and FD field coded the results and later entered this information into a FluidSurveys database.

Data analysis

We initially analysed each component of the study separately. For the surveys, we analysed responses using descriptive statistics. For the FGDs and key informant interviews, FD and JT transcribed the recordings and translated the content into English. We then analysed the data for content and themes using both predetermined and emergent codes and categories [8]. For the FGDs, we also employed a modified constant comparative approach [9] in which we conducted pair-wise comparisons to look for similarities and differences between the groups. For the structured interviews with pharmacists, we reviewed data as they were collected, a process that allowed us to identify common themes and determine when we had reached thematic saturation. We analysed these responses with descriptive statistics and for content and themes. In

the final phase of the analytic plan we integrated the results to explore concordant and discordant findings and develop a global interpretation.

Ethical considerations

This study received research ethics approval by the Social Sciences and Humanities Research Ethics Board at the University of Ottawa. To protect participant confidentiality, we have redacted or masked all identifiable information. We organize our results around domains of inquiry.

Results

Participant characteristics

We collected 115 responses through the online survey and present basic participant demographic information in Table 1. More than half of the survey participants were college-aged women. Most surveyed women (n=58, 56.9%) reported that they rarely or never visit a doctor, clinic, or other health facility to obtain counselling, care, or services related to sexual and reproductive health. An overwhelming majority of them (n=69, 80.2%) reported obtaining their preferred method of contraception directly from pharmacies, and lack of side effects was the most important criterion (n=72, 81.8%) for choosing a method of contraception. We conducted six FGDs in four different cities in Albania, with 37 women between 17 and 56 years of age. We present basic participant demographic information on Table 2. Of all participants, 19 identified as heterosexual, whereas the remaining preferred not to answer.

Of our 19 key informants, 11 worked in the public sector and 8 participants were affiliated with private institutions or non-governmental organizations (NGOs). We interviewed

seven clinicians and service providers, four coordinators from the Institute of Public Health, five representatives from national NGOs that deliver reproductive health programs, two youth program coordinators, and one representative from a regional institute of health. We also interviewed 16 pharmacists in Tirana county;13 identified as women and 3 as men. Six pharmacies were located in urban areas, five in suburban areas, and five in rural areas within the county.

Awareness and knowledge of EC

The results of the survey and the FGDs indicate that knowledge and awareness of EC among women is limited. While the majority of women (n=64, 64.6%) described their knowledge of contraception as excellent or good, most were not familiar with the full range of contraceptive methods; only a quarter of women (n=25, 26%) were very familiar with the oral contraceptive pill and far less (n=19, 19.8%) were familiar with progestin-only emergency contraceptive pills (ECPs). One third of women (n=30, 33.3%) did not know whether EC was available in Albania and nearly half of respondents (n=43, 47.8%) did not think EC was safe to use. Furthermore, more than half of the respondents did not know that the side effects of using EC are transient.

Our FGDs revealed similar findings. For example, many women believed that levonorgestrel-only EC can be used only a certain number of times in a lifetime and side effects can be dangerous and even permanent. As exemplified by a married woman in Korca, 'I have read that it is dangerous if you use it time after time…this is the information I have, that it is dangerous if you use it often.' However, once we provided participants with basic information about EC, women in the FGDs were overwhelmingly positive and expressed the belief that

emergency contraceptive pills (ECPs) would be an excellent method to prevent unwanted pregnancy.

Our key informants were generally aware of ECPs and accurately reported on availability. However, many key informants were unfamiliar with the mechanism of action or the side effects and some expressed unfounded concerns about frequent use of ECPs. Similarly, pharmacists in Tirana were both uninformed and misinformed regarding EC. None of the pharmacists could identify EC modalities other than dedicated levonorgestrel-only ECPs, and almost none could describe the mechanism of action by which EC prevents pregnancy. Moreover, the majority of pharmacists could not explain the side effects of the medication (n=10, 63%) or the efficacy and safety of ECPs (n=9, 56%).

Availability and accessibility of EC

Dedicated emergency contraceptive pills are not provided through the public health sector in Albania. However, the two registered brands are widely available in pharmacies at 500ALL to 750ALL (4-6 Euro). Although the majority of key informants had positive attitudes toward EC, many believed that women were misusing ECPs by accessing the medication too frequently and substituting EC for other methods. As reported by a reproductive health program coordinator, 'What we see among younger generations is that they do not consider [an ongoing] contraceptive method [but] my main concern relates to the disuse of condoms…Because among youth we see that they have short-term relationships…and under such circumstances, the main method for this generation, from my point of view, should be the condom.'

Although demand for EC varied by location, pharmacists reported that ECPs are very popular among women. Indeed, more than one third of pharmacists (n=6, 38%) expressed

concern about women using EC too frequently and relying on ECPs as a 'regular' form of contraception. As explained by a 34-year-old female pharmacist, 'I think they're a good thing, but women should use [EC] more cautiously…Use of ECPs has spread like a fever, and it baffles me how brave some women are that use them like candies.'

Barriers to EC access

Although key informants and pharmacists raised concerns about ECPs being 'too accessible,' women reported facing a number of barriers to access. Some women, particularly younger women, reported being hesitant to discuss their EC needs with service providers and feared being judged. As a young unmarried woman from Tirana reported on her experience seeking EC '[T]o be honest, I had to walk past two or three pharmacies, I would walk past the window and glance at the seller, I mean the pharmacist…for instance in the first pharmacy there was a middle-aged male [pharmacist] and I thought that it's unseemly going in. I went in [a pharmacy] where there was a young [female] pharmacist instead.' Additionally, women in FGDs felt that they did not receive accurate information or appropriate counselling from providers. As another young woman from Tirana expressed '[Y]ou go to a pharmacy and the [pharmacist] gives you EC without telling you what effects [it] might have on you…the counselling is null.'

Key informants expressed similar concerns about the health service providers' knowledge and awareness of EC and acknowledged they are often insufficiently trained to provide sexual and reproductive health services. Pharmacists in our study lacked dedicated EC materials for clients and most rely on the patient information leaflet or their personal beliefs to counsel patients about the usage, dosage, efficacy, and safety of the medication.

Half of pharmacists in our study identified the lack of awareness on the part of the client as the biggest obstacles to accessing EC. As a 48-year-old female pharmacist in a suburban area explained 'Many might not even know that this method is available…and sometimes they hear all sorts of things or read all sorts of things, and they are afraid of using them because of the side effects.' Some pharmacists (n=6, 38%) also reported that women are often embarrassed to discuss their need for EC, hence they are hesitant to seek the medication in pharmacies.

Avenues for improving EC service delivery

Many key informants suggested that training health service providers and pharmacists would serve as a first step towards raising awareness and improving accessibility of EC. As explained by a reproductive health program analyst, 'If you [train] health service providers, it is easier to see results in the community, because health service providers play a key role in changing the mentality within a community.' Additionally, some key informants expressed concerns about the lack of accurate data regarding the uptake of EC, and emphasized the need for rigorous research to explore the factors that affect women's contraceptive choices and identify accessibility barriers. As one epidemiologist in Tirana explained, 'A misinformed woman does not use [EC], whereas a misinformed provider does not promote it. So it is necessary to conduct qualitative research to understand or identify the barriers due to [each actor's] perceptions.'

Many key informants are supportive of ECPs being offered through the public sector, and suggested that EC become a priority in the government's contraceptive procurement strategy. As a youth program coordinator in Tirana expressed, 'EC should have a more important place in the new strategy. EC has been in the shadow. Many other methods are actively promoted. But now

there should be a concrete plan how to promote [EC], and involve the government, activists, social marketing sector, media etc. [EC] should have its own specific place, and it should be promoted and offered for free.'

The majority of pharmacists (n=12, 75%) believed that written materials and resources targeting women would make it easier for them to provide EC information to clients. Several pharmacists explicitly identified the translation of the patient information leaflet as a priority. As one pharmacist explained, 'Women are embarrassed to ask questions or discuss their need for EC with the pharmacists, so having a flyer with information that women can take home and read on their own would be useful and helpful.'

Discussion

Sexual and reproductive health in Albania has come a long way since the change of regimes. All stakeholders agreed that sexual and reproductive health services have improved tremendously over the past two decades, both in quantity and quality. Currently, services are provided in numerous public and private health facilities across the country, contraception is available free-of-charge in the public sector and widely accessible in the private sector, and both the government and non-governmental partners have engaged in numerous campaigns and initiatives to improve availability and accessibility of these services. However, consistent with research in other countries and contexts [7,11-13], our study indicates that the absence of public sector provision, the lack of information and persistent misinformation about ECPs among women and providers, and women's fear of being judged for seeking post-coital contraception pose obstacles to timely access to EC, even though the medication is widely available in pharmacies.

Key informants in our study were unanimous in their support for making dedicated ECPs available through the public sector. The lack of inclusion of ECPs in government services affects service delivery, cost, and the overall legitimacy of the medication. Although some women may prefer to obtain ECPs through community pharmacies, our findings suggest that women experience several barriers in the process. Provision of ECPs through public health centres would afford women another option with respect to service delivery, could eliminate a number of these obstacles, and might encourage women to seek more services at the health centres.

Given the overarching dynamics in Albania, it is unsurprising that both providers and women are uninformed and misinformed about ECPs. Emergency contraception has not been prioritized in national strategies dedicated to contraception and has not been the focus of major health promotion campaigns and health service provider training efforts. Consequently, women are obtaining ECPs directly from pharmacists who often lack appropriate training or skills to provide quality counselling for this medication. Pharmacists in our study were seemingly unware that they were perpetuating misinformation about ECPs. Indeed, our results suggest that pharmacists rely heavily on the patient information leaflet in packets of levonorgestrel-only EC but these inserts have not been translated into Albanian. Translation of the packet insert could improve the knowledge of both pharmacists and women, improve the quality of counselling that women receive, and address some common misconceptions about ECPs. Developing flyers, pamphlets, and targeted promotional campaigns to increase knowledge and awareness could also help change attitudes and increase uptake.

As expressed by participants in both the survey and the FGDs, women are often embarrassed to discuss their reproductive health and contraceptive needs with service providers. That both key informants and pharmacists reported that women may be ‘overusing’ or ‘abusing’

EC, even though overall knowledge is minimal and use appears to be low, may reflect biases and stigma related to EC and the women who use the medication. Supporting values clarification and transformation efforts, among both existing health service providers and those in training, appears warranted.

Limitations

Like any qualitative study, the findings of our research are not intended to be generalizable. Rather our findings capture the perspectives of different stakeholders in Albania regarding a specific phenomenon. The survey sample is also in no way representative. However, the data provide a snapshot of common contraceptive attitudes and practices. Additionally, with the exception of the FGDs, our data largely come from Tirana county, the largest county both by area and population. As such, we expect that the availability and accessibility of services, including EC, in Tirana will be greater than other counties in Albania.

Conclusion

Our findings suggest that EC is widely available through Albanian pharmacies. However, women continue to face numerous challenges accessing this form of contraception and misinformation is is common. Conducting more research on EC in Albania, training health service providers, and developing linguistically appropriate and culturally resonant educational materials could play a key role in raising awareness and improving uptake of EC among women.

Acknowledgments

We would like to thank all the local research assistants who provided continuous support in Albania, including Andi Rabiaj, Iv Reci, and Ilda Mullaymeri. We are also grateful to Dorina Tocaj and Holta Koci, who were focal points in Albania and provided logistical support throughout the process.

Funding details

We received a generous grant from the European Society for Contraception and Reproductive Health in support of this project. Dr. Foster's 2011-2016 Endowed Chair in Women's Health Research was funded by the Ministry of Health and Long-Term Care in Ontario and we appreciate the general support for her time that made this project possible. We are also grateful to the Society of Family Planning for a mentorship grant that supported this work. The conclusions and opinions expressed in this article are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

Declaration of interest statement

We have no conflicts of interest, financial or otherwise, to disclose.

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Table 1: Demographic characteristics of survey participants (N=115)

Characteristics	n	%
Age (years)		
18 – 24	64	55.7%
25 – 29	17	14.8%
30 – 35	10	8.7%
36 - 40	12	10.4%
40 - 44	5	4.3%
45 – 49	7	6.1%
Level of Education		
High school maturity diploma	15	13.3%
Some university level courses	17	15.0%
Higher education degree (Bachelor's)	30	26.5%
Some graduate school courses	9	8.0%
Graduate degree (Master's, PhD)	42	37.2%
Employment		
Self-employed	3	2.6%
Management occupations	3	2.6%
Business, finance and administration occupations	17	14.8%
Natural and applied sciences and related occupations	5	4.3%
Health occupations	15	13.0%
Occupations in education, law and social, community and government services	18	15.7%
Sales and service occupations	11	9.6%
Other	10	8.7%
Unemployed	6	5.2%
Full-time student (as the only occupation)	27	23.5%
Belief system		
Atheism	4	3.5%
Catholicism	12	10.4%
Islam	35	30.4%
Russian Orthodox Church	19	16.5%
Other [Bektashi; Agnostic; Budhist]	11	9.6%
None	8	7.0%
Prefer not to answer	17	14.8%
Identifies with more than one belief system	9	7.8%
Relationship status		
Single, not dating, not in a relationship	63	57.8%
In a committed monogamous relationship	11	10.1%
Engaged	6	5.5%

Married	25	22.9%
Separated/divorced	3	2.8%
Prefer not to answer	1	0.9%
Place of residence		
County of Diber	2	1.9%
County of Durres	10	9.4%
County of Elbasan	7	6.6%
County of Fier	2	1.9%
County of Korce	2	1.9%
County of Lezhe	2	1.9%
County of Tirana	80	75.5%
County of Shkoder	1	0.9%

Table 2: Composition of six focus group discussions

FGD	Location	Number of participants	Description
1	Tirana	6	Single women from Tirana, age 19-23
2	Vlora	10	Married women from Vlora, age 32-56
3	Vlora	3	Single women from Vlora, age 18-21
4	Korca	7	Married women from Korca, age 18-48
5	Korca	7	Single women from Korca, age 17-24
6	Shkodra	4	Married women from Roma community in Shkoder, age 19-39

CHAPTER 4 : The ultimate gatekeepers : Exploring pharmacists' contraceptive service delivery practices in Albania

The ultimate gatekeepers:
Exploring pharmacists' contraceptive service delivery practices in Albania

Florida Doci, MSc(c)[1]
Angel M. Foster, DPhil, MD, AM[1,2]*

1. Faculty of Health Sciences, University of Ottawa, Ottawa, ON, Canada
2. Institute of Population Health, University of Ottawa, Ottawa, ON, Canada

*Corresponding author
1 Stewart Street, 312-B
Ottawa, ON K1N 6N5 Canada
+1-613-562-5800 ext. 2316
angel.foster@uottawa.ca

Conflicts of interest: The authors declare that they have no conflicts of interest, financial or otherwise.

Word counts: Abstract: 249
Manuscript (excluding title page, abstract, figures, references): 2946
Introduction (500), methods (444), results (1283), discussion/conclusions (711)

Running title: Pharmacists' role in contraceptive service delivery in Albania

Formatted for: *Contraception* journal

The ultimate gatekeepers:

Exploring pharmacists' contraceptive service delivery practices in Albania

Abstract

Objectives: Modern methods of contraception have been freely available through the public sector in Albania for more than two decades. Yet, the contraceptive prevalence rate remains low. Recent research suggests that women prefer to obtain services through the private sector pharmacies. Consequently, pharmacists play a key role in contraceptive service delivery in Albania. This paper explores the availability and accessibility of different contraceptive methods in Tirana county, as well as the knowledge, opinions, and provision practices of retail pharmacists.

Methods: In 2016, we conducted 16 in-person interviews with retail pharmacists in Tirana county, Albania. We also observed practices and dynamics in the pharmacies. After field coding responses, we analyzed our data using descriptive statistics and for content and themes using inductive and deductive techniques.

Results: Our findings suggest that although a number of contraceptive methods are available in pharmacies, there are numerous barriers to access. Pharmacists were both uninformed and misinformed about reproductive health technologies, in general, and hormonal contraceptives, in particular. Pharmacists reported that the lack of awareness, fear of judgment, and embarrassment among women are among the biggest obstacles for women seeking contraceptives from pharmacies. Yet few pharmacists reflected on their own lack of knowledge and the role that health service provider misinformation and judgment plays in contraceptive service delivery.

Conclusion: Pharmacists play a key role in contraceptive service delivery in Albania. Supporting continuing education efforts appears warranted. Improving pharmacists' knowledge of reproductive health technologies and fostering values clarification and transformation could address current barriers to access.

Implications: Our findings shed light on the barriers to contraceptive access in Albanian. Developing strategies to raise awareness about contraception, training pharmacists to provide medically accurate counselling, improving knowledge within the community, and designing culturally resonant campaigns to change societal attitudes toward contraception appear warranted.

1. Introduction

Geographically located in the Balkan Peninsula in southeastern Europe, Albania is a relatively small country with a population of approximately 2.9 million [1]. Albania's total fertility rate of 1.8 children per woman is only slightly above the European average of 1.6 [2]. Although fertility rates have been on the decline, the reported contraceptive prevalence remains low; in 2009, less than 8% of women of reproductive age used modern methods of contraception [3]. The majority of women who use any method rely on traditional practices, such as withdrawal, to prevent unwanted pregnancies [3]. Abortion has long been the mainstay of family planning in Albania; since 1995, women have been able to terminate a pregnancy through 12 weeks' gestation without restriction as to reason. In 2013, Albania's abortion rate, at 180 abortions per 1,000 births, was six times higher than the European Union average [4-5].

For over 45 years, the single-party communist regime in Albania pursued aggressive pronatalist policies to reinforce a high fertility rate and population growth. Hence, the government banned contraceptives and prohibited abortion. Following the legalization of contraceptives in 1992, a number of methods of contraception including male condoms, oral contraceptive pills (OCPs), Depo-Provera, and the intrauterine device (IUD) became available. Postinor-2®, the two-pill brand of levonorgestrel-only emergency contraception, was introduced in Albania in the late 1990s. In order to improve knowledge and uptake of modern methods of contraception, government, foreign partners, and non-governmental agencies designed and led numerous educational, promotional, and training campaigns. Additionally, a newly created social marketing agency procured, distributed, and promoted methods of contraception at affordable prices and raised awareness among health service providers and other target groups [6].

Since 1993, public sector facilities have provided a full range of contraceptives free-of-charge. Yet, recent research suggests that women prefer to obtain services through the private sector and through pharmacies, in particular [7-8]. Officially, hormonal methods of contraception are prescription-restricted. However, this requirement is not enforced and Albanian women can easily obtain contraceptives directly from pharmacists [9]. Because most drugs are effectively sold behind-the-counter, irrespective of the actual regulatory status, pharmacists play a key role in contraceptive service delivery. Research from a multitude of countries has shown that pharmacists can serve as either facilitators or barriers to women seeking reproductive health technologies [10-14]. However, little published research exists on reproductive health, in general, or contraception, in particular, in Albania.

Studies in this area are overdue, even more so now that Albania is a candidate state for accession to the European Union. The Albanian Ministry of Health has recognized that there is still a gap in reproductive health information and services in the country. In 2016, we conducted a multi-methods qualitative study to explore the awareness, knowledge, attitudes, and practices related to emergency contraception [8]. In one component of the study, we explored the availability and accessibility of different contraceptive methods in pharmacies in Tirana county, as well as the knowledge, opinions, and provision practices of retail pharmacists. In this paper, we report on these contraception-related findings.

2. Methods

From May to December 2016, we visited 19 sites in Tirana county and conducted 16 in-person interviews with retail pharmacists. Informed by previous studies with pharmacists [11-12], we purposively recruited pharmacists from different neighborhoods and districts within the county so as to capture a wide range of perspectives (Fig. 1). When determining which sites to

visit, we took two factors into consideration. First, we wanted to cover as much ground within the county as possible and thus we visited cities as well as villages and rural areas. Second, we wanted to ensure inclusion of the areas with the highest population density. Consequently, most of the pharmacy visits were within Albania's capital, Tirana.

[Fig. 1 about here]

2.1 Data collection

FD, a master's student in the Interdisciplinary Health Sciences program at the University of Ottawa who was raised in Albania, conducted all interviews in Albanian. She received qualitative methods training from her supervisor, AMF, who has considerable experience conducting global research on sexual and reproductive health. FD followed a structured interview guide developed specifically for this study. Interviews began with a series of questions about the pharmacist's background, education, professional experiences, and training in sexual and reproductive health. She then asked pharmacists questions related to the services offered at the pharmacy including the availability of different contraceptive methods, the characteristics of clientele, the pharmacist's personal knowledge of and attitudes toward different contraceptive methods, and the overall accessibility of contraceptive technologies. Finally, she asked pharmacists about their awareness and perceptions of emergency contraception (EC), followed by their thoughts on how to improve reproductive health services in Albania. FD also observed the physical structure of the facility, placement of contraceptive products, and practices and dynamics in the pharmacies.

2.2 Data analysis

These targeted Interviews lasted 15 minutes on average; FD field coded responses. Immediately following each interview, FD wrote extensive notes about the visit as well as a short memo documenting the interactions with each pharmacist. This memoing process [15] represented the first phase in the analytic plan, allowing us to identify common themes and determine when we reached thematic saturation. Upon completion of data collection, we inputted responses into a FluidSurveys database. We analyzed the data using descriptive statistics and for content and themes using inductive and deductive techniques. Team meetings informed our interpretation of the results and we resolved disagreements through discussion.

2.3 Ethical considerations

We obtained ethical approval for this study from the Social Sciences and Humanities Research Ethics Board at the University of Ottawa. We have organized our results around major themes and included illustrative quotes. We have redacted or masked all personally identifying information about pharmacists and the specific location of pharmacies.

3. Results

3.1 Participant characteristics

Of our 16 participants, 13 identified as women, 3 as men. Participants ranged in age from 26 to 64 years old; the majority (n=11, 69%) were in their late 20s or early 30s at the time of the interview. All participants had completed their education and pharmacist training in Albania in a variety of public and private institutions within and outside of the capital. The majority of our participants (n=12, 75%) had 3-6 years of experience as pharmacists; most (n=11, 69%) had received no training on providing sexual and reproductive health services. We present these data

in Table 1. Our pharmacists hailed from different areas of the country; nearly half (n=7, 44%) were from Tirana county, a quarter (n=4, 25%), were from Dibra county, and the remainer came from one of the four other counties in central and southern Albania (data not shown).

3.2 A limited range of contraceptive methods are available in pharmacies

Although a full complement of contraceptive methods are available in Albania, pharmacies in our study carried only a limited range of methods. All of the pharmacies carried male condoms, several brands of OCPs, and two brands (Norlevo® and Postinor®) of progestin-only emergency contraceptive pills (ECPs). As a male pharmacist working in a suburban area explained, "Demand for these methods has been growing over time, and I'd say it is relatively high…[W]e see lots of clients come in for these products." Pharmacists explained that injectable contraceptives, other hormonal methods, other barrier methods, and the IUD are only available through clinics and hospitals. Pharmacists consistently reported that male condoms were the most popular contraceptive product; on average pharmacists reported responding to 50 client requests for condoms each month and men make most requests. The price of 4 condoms varied from ALL50 to ALL200 (USD0.40-USD1.15). By way of comparison, OCPs typically cost between 500ALL and 2500ALL (USD4-USD21) for one packet and the price of ECPs ranged from ALL500 to ALL750 (USD4-USD6.5). Approximately 10-20 women seek OCPs and more seek EC from our study pharmacies each month. However, pharmacists in suburban and rural areas reported that demand was modest. As a 48-year old woman practicing in a suburban area explained, "Very few clients come in for these products [referring to contraceptive methods], and it's mainly young people."

3.3 Pharmacists are misinformed about hormonal contraceptive methods

Almost all of the pharmacists in our study saw it as their duty and responsibility to counsel patients on any medication dispensed at the pharmacy, including different methods of contraception. As expressed by a 25-year-old female pharmacist in an urban area "[Our] job is not just to sell products, but also counsel clients." However, participants were both uninformed and misinformed about reproductive health technologies, in general, and hormonal contraceptive methods, in particular. Repeatedly, we heard from pharmacists that they believed that the side effects of OCPs were long-lasting or irreversible. As a 57-year-old female pharmacist in a rural area explained, "[OCPs] cause breast swelling, bloating, weight gain, stomach problems, psychological distress…or you may have an unknown tumor and this thing will feed it without you realizing it."

Pharmacists appear to incorporate this misinformation into their counseling. As a female pharmacist in a rural area explained:

> They ask for them [OCPs] but I always recommend condoms because I know what side effects [OCPs] have. Mostly women use them following a doctor's recommendation to treat irregular cycles. But to give them out, without a prescription, knowing their side effects, I would never recommend them to prevent pregnancies. They are very harmful! I always try to talk women out of taking them regularly.

Another pharmacist in a rural area shared her misgivings about emergency contraception.

> I, myself wouldn't recommend [EC] to women. I'm afraid of these things [hormones] because I feel like they will just destroy your body. You hear all sorts of things, that they cause cancer and infertility and things like that. So I don't want to be responsible for that; I always send women to the doctor and the doctor can recommend them if they see fit."

Our interactions with pharmacists were often transformative; in responding to questions and discussing different contraceptive methods, several of our participants realized, seemingly for the first time, that their knowledge of contraceptive methods was limited.

3.4 Women are embarrassed to discuss contraception with pharmacists

Although Albanian women's knowledge and awareness of contraception has improved over the last two decades [3], most pharmacists in our study felt that women face considerable access barriers. The majority of pharmacists (n=9, 56%) identified embarrassment and fear of judgment as a significant obstacle to obtaining a full range of services. As explained by a 33-year-old male pharmacist in a rural area, "Clients feel embarrassed when they need to buy these products. Sometimes they will spend a good amount of time lurking in the pharmacy, before they muster up the courage to ask for condoms or pregnancy tests. You can tell by their faces that they are uncomfortable."

Pharmacists suggested that broader socio-cultural taboos related to contraception, especially in smaller communities, shaped women's health seeking behaviors. As noted by a 34-year-old female pharmacist in a rural area, "They are afraid of the mentality, of people seeing them buying such products, or of the pharmacist gossiping about them, especially because this is a small community so word spreads quickly." Pharmacists reported that women have great concerns about privacy and are thus hesitant to access services locally. As reported by the same 34-year-old female pharmacist

> They know that I don't live here and that I travel from Tirana, so a lot of people come in specifically about this product…They [clients] think that I don't know them, whereas the other pharmacists [in the area] live nearby and so customers are ashamed to go to those other ones.

Our visits to pharmacies also provided insight into why women might be embarrassed or concerned about judgment. Contraceptive products are often held in cabinets behind the counter, hence interactions with pharmacists are required. Often pharmacists will ask several questions before they decide which products to offer you, and sharing intimate details becomes

uncomfortable for many. Furthermore, pharmacies are often small and crowded. They lack designated counseling spaces and thus information between women and providers is shared within earshot of other clients.

3.5 Pharmacists identified a number of ways that contraceptive service delivery could be improved

Most pharmacists reported that there was a significant need to raise awareness and educate women about modern methods of contraception. In particular, participants emphasized the need to address the underlying socio-cultural issues that pose obstacles for women who seek reproductive health services. As one pharmacist explained, "Education is really important; raising awareness in the community and making women more aware and informed about it. But it's also important to address the root causes, all the underlying social issues that lead to such mentality and barriers." As explained by another participant, "I think that fear and embarrassment come from the lack of knowledge, the culture, the mentality…Educating the community, and providing more accurate information on the benefits of these things [contraception] might be useful, to help people think differently about family planning and reproductive health." Pharmacists in our study advocated for the development and distribution of medically accurate materials such as posters, brochures, and flyers. As a 36-year-old male pharmacist in a suburban area explained, "I think providing more information through leaflets or posters, with the appropriate terminology, so that women can actually understand how [contraception] works, would be useful."

Interestingly, very few pharmacists reflected on their own lack of knowledge and the role that health service provider misinformation plays in contraceptive service delivery. Indeed, only

two pharmacists identified training of providers as a way to improve the accessibility of contraception.

4. Discussion

Numerous sexual and reproductive health services are available under the umbrella of family planning services in over 420 public health centres across Albania. Contraceptives have been available free-of-charge in all these locations for more than two decades. Yet, pharmacies remain the focal point of contraceptive service delivery in Albania in part due to their ubiquity, convenience, and rapid service. However, clients' experiences accessing reproductive health services in pharmacies may differ from those involving other types of services or products. Findings from our study suggest that although a number of contraceptive methods are available in pharmacies, there are numerous barriers shaping access. In particular, pharmacists' lack knowledge about a full range of methods, most have not received training in providing sexual and reproductive health care services, and most evince considerable misinformation about hormonal contraceptive methods.

Lack of awareness on the part of providers poses a significant barrier to access. First, misinformed pharmacists perpetuate misconceptions about contraception, thus directly influencing women's attitudes toward and knowledge of specific methods. Second, pharmacists appear to be assuming the role of gatekeeper; some are preventing women from adopting methods that they believe to be harmful. Our interviews revealed that some pharmacists allow their personal beliefs to interfere with the services they provide, a dynamic which compromises the quality of care that clients receive. Although our sample was small, it appears that older and more experienced pharmacists were more likely to have received some form of training in the field of reproductive health than younger and more recently trained pharmacists. Indeed, between

1991 and 2008, a number of national training programs and promotional campaigns took place in Albania [16] and several participants referred specifically to these post-transition initiatives. Younger generations of pharmacists would not have directly benefitted from these activities and in the absence of exposure during their years at university, it is unsurprising that they lack formal training in contraceptive counselling and service delivery. Rekindling some of these previous activities could address this challenge. Incorporating sexual and reproductive health training modules in the available continuing education platforms in the country, developing values clarification and transformation workshops, and incentivizing providers' participation appear warranted. Of course, ensuring that medically accurate informational resources are also distributed to women and within communities is a priority.

Pharmacists in our study reported that clients, and women in particular, are embarrassed to seek services and fear being judged by health care providers and others in their communities. A complex web of social and cultural ideas shape Albanians' attitudes towards contraception and influence their reproductive health decisions. However, participants raised the issue of internalized and externalized stigma repeatedly; based on our observation the physical spaces themselves likely contribute to the stigma surrounding contraception. Shaming, a tool of gender policing, is rooted in the country's traditional patriarchal culture [17] and fed by misconceptions associated with contraception. Within this framework, use of contraceptives is a sign of promiscuity or immorality and women who deviate from socially accepted roles require punishment. Given this context, it is crucial to address these underlying gender inequalities by raising awareness, educating men, and empowering women. Developing gender-inclusive policies to increase women's participation and improve their role in the society can change how women are valued. Efforts to change societal attitudes toward women will eventually give

women more freedom to make autonomous choices regarding their sexual and reproductive health.

4.1 Limitations

Although we are confident of the broader significance of the identified themes, our research findings are not generalizable, as is true of any qualitative research. Due to logistical and financial constraints, we limited data collection to Tirana county. Residents of Tirana county are more educated than those living in other areas of the country and have more resources. The viewpoints and experiences of participants from this county could be significantly different from those of pharmacists in other areas. Future research would benefit from engaging with pharmacists in other regions.

4.2 Conclusion

Pharmacists play a key role in contraceptive service delivery in Albania. However, our study suggest that they are both uninformed and misinformed about modern methods of contraception. Their lack of knowledge poses a barrier to contraceptive access and shapes women's experiences seeking pharmacy-based care. Supporting continuing education efforts and developing initiatives to improve pharmacists' knowledge of reproductive health technologies appear warranted.

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Table 1. Participant characteristics (n=16)

		Age				
		25-29	30-39	40-49	50+	Total
Sex	Female	6	3	2	2	13
	Male	1	2	0	0	3
Type of institution where training was received	Public university in Albania	2	0	1	2	5
	Private university in Albania	1	4	1	0	6
	Unidentified institution in Albania	4	1	0	0	5
Training on sexual and reproductive health	Yes	1	1	1	2	5
	No	6	4	1	0	11

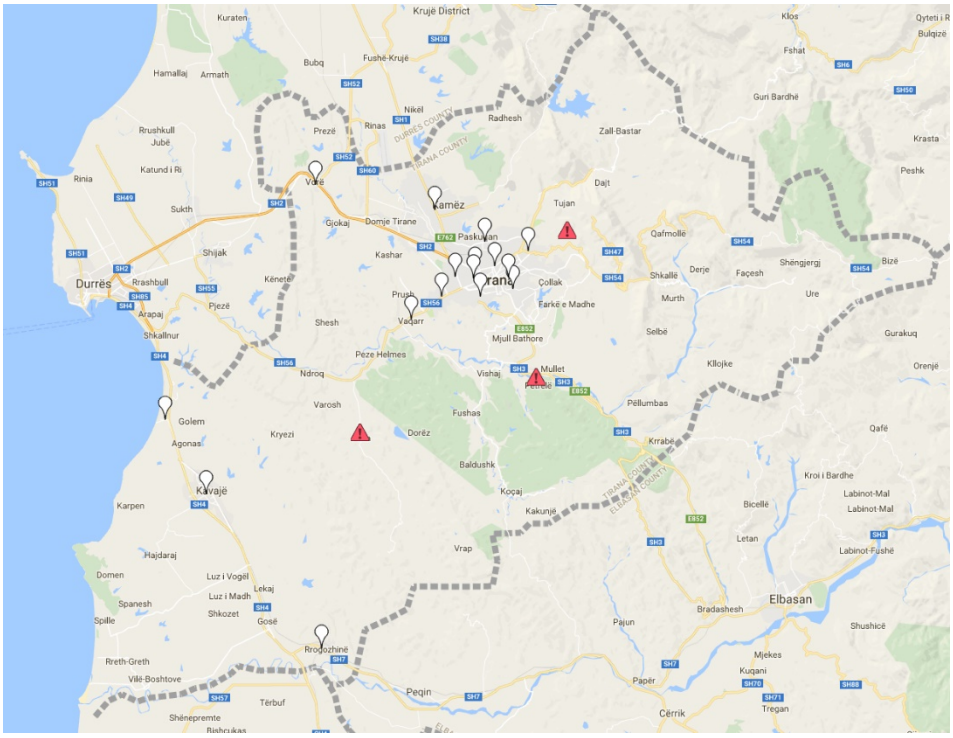

Figure 1. Location of all sites visited within Tirana County

Areas marked with triangles indicate areas that had no pharmacies in the vicinity.

CHAPTER 5: The talk of shame: The history of abortion in communist and post-communist Albania

The talk of shame: The history of abortion in communist and post-communist Albania

Author: Florida Doci, MSc[1], Jonida Thaci, BA[2]

1. Faculty of Heath Sciences, University of Ottawa, ON, Canada
2. Independent consultant, Tirana, Albania

Abstract: 259
Induced abortion was illegal in Albania until 1991, although anecdotal evidence suggests that abortions were never a taboo among Albanian women. Albanian women used abortion as a method of family planning in a time when contraceptives were prohibited, and the procedure was routinely performed clandestinely. Since the legalization of abortion in 1995, women have been able to terminate a pregnancy up to 12 weeks' gestation without restriction as to reason. Following the fall of communism and legalization of abortion, women continued to use abortion as a form of family planning mainly due to the lack of knowledge and the scarcity of modern methods of contraception. At 180 abortions per 1,000 births, Albania's abortion rate is six times higher than the average figures in the European Union; in contrast the estimated contraceptive prevalence rate is relatively low. Yet, accessing abortion care has not always been easy in Albania, a country characterized by a corrupt health system that lacks infrastructure, investments, and quality in care. Medication abortion could provide a safe, convenient and discreet method of terminating unintended pregnancies. Despite the bureaucratic evidence of its availability, there are several factors that influence accessibility of medication abortion in Albania including systems failures, widespread confusion, and misinformation. In addition to impacting the accessibility of medication abortion, these factors influence the cost and quality of abortion care and shape the experiences of women seeking an abortion. This chapter explores the history of abortion in the pre- and post-communist Albania and sheds light on current challenges that women face when seeking medication abortion care.

Word count: 3794

Acknowledgements: We would like to thank all the key informants that collaborated with us during this study, and the local research assistants who provided continuous support in Albania, including Andi Rabiaj, Iv Reci, and Ilda Mullaymeri. We are also grateful to Dorina Tocaj and Holta Koci, who were focal points in Albania, and provided logistical support throughout the process. This study was supported in part by a generous grant provided by the European Society for Contraception and Reproductive Health, and a small grant from the Society of Family Planning.

Introduction

For nearly half a century, the single-party communist system in Albania pursued aggressive pronatalist policies to reinforce a high fertility rate. The government banned contraceptives, and prohibited induced abortions. However, anecdotal evidence suggests that abortions were never a taboo among Albanian women. Albanian women used abortion as a method of family planning in a time when contraceptives were prohibited, and the procedure was routinely performed clandestinely. Since the legalization of abortion in 1995, women have been able to terminate a pregnancy up to 12 weeks' gestation without restriction as to reason. Following the fall of communism and legalization of abortion, women continued to use abortion as a form of family planning mainly due to the lack of knowledge and the scarcity of modern methods of contraception. At 180 abortions per 1,000 births, Albania's abortion rate is six times higher than the average figures in the European Union; in contrast the estimated contraceptive prevalence rate is relatively low. Yet, accessing abortion care has not always been easy in Albania, a country characterized by a corrupt health system that lacks infrastructure, investments, and quality in care. Medication abortion could provide a safe, convenient and discreet method of terminating unintended pregnancies. Despite the bureaucratic evidence of its availability, there are several factors that influence accessibility of medication abortion in Albania including systems failures, widespread confusion, and misinformation. This chapter explores the history of abortion in the pre- and post-communist Albania and sheds light on current challenges that women face when seeking medication abortion care. In addition to literature, this chapter also draws from an original multi-method qualitative research study conducted in Albania in 2016, which aimed to investigate the availability of reproductive health services in Albania, including contraceptive and abortion services, and explore factors

influencing Albanian women's reproductive health choices, with a focus on contraception and emergency contraception (Doci et al., under review). This study involved an online survey and focus group discussions with women of reproductive age, on-site visits and interviews with 16 pharmacists, and in-depth semi-structured interviews with 19 key informants. Key informants that contributed to this study came from a range of governmental and non-governmental agencies, and included clinicians, health service providers, scholars on reproductive health, policymakers, reproductive health experts, youth program coordinators etc (Doci et al., under review).

The history of abortion in communist and post-communist Albania

Following the end of World War II, former Albanian communist leader Enver Hoxha installed a single party regime in the country, devoted to the implementation of totalitarian socialist policies. For over forty-five years, Albania was a communist dictatorship characterized by an underdeveloped centralized forced-labor economy. The system perpetrated unjustified restrictions on democracy and gross violations of human rights. The Albanian government abolished private property (Alb. Const. art. 16, 1976), banned freedom of speech and association (Alb. Const. art. 55, 1976), and forbade citizens from travelling abroad. In 1976, Albania officially became an atheist country and the government outlawed religious expression (Alb. Const. art. 55, 1976; Alb. Const. art. 37, 1976). As a consequence, the dictatorship banded religious practices, persecuted religious leaders, and razed hundreds of religious institutions across the country. Resistance was met with severe retribution. The government used terror and repression to enforce its discriminatory laws and oppress opposition; detention, re-education, internal exile, long-term imprisonment, and even execution were common punishments for dissidents (Austin and Ellison 2008). These led to the eventual isolation of the country, which

continued until 1990.

Albania is a male-dominated society. Historically, women's roles were constrained within their household and dictated by the men of the family. Ancient customary laws such as the "Kanun" also gave men the right to publicly humiliate and verbally or physically abuse the women in their family if they defied the rules and roles of their households (Vokshi and Rystemaj 2013). After the Second World War, the communist regime recognized women as "as a great force of the revolution", and created provisions to defend women's legal and social rights and encourage women's involvement in the economy (Alb. Const. art. 41, 1976). However, the reality was considerably more complex and political agendas and aggressive pronatalist policies of totalitarian rule infringed on women's sexual and reproductive rights and autonomy. Historians have argued that empowerment and emancipation of women during the communist regime was a myth, a strategy for the communist leader to expand and maintain power (Ikonomi and Woodcock 2010).

During communism, women remained vulnerable to sexual violence and abuse that was de facto sanctioned by the system itself. In an article published in 2010, researchers presented archival evidence of women being sexually exploited, coerced, abused, or raped by their partners, party officials, or men who held some power over these their livelihoods and futures (Ikonomi and Woodcock 2010). In all of these documented cases, sexual crimes were handled lightly; the perpetrators were never punished and blame was often placed on the victims, who were eventually alienated from society and labeled as "immoral" (Ikonomi and Woodcock 2010; Woodcock 2015). Many women who were politically persecuted and imprisoned during communism have also recounted that sexualized torture was a common practice during interrogations, detention, and imprisonment (Woodcock 2014). However, historians argue that

sexual abuse during this time was underreported due to feelings of shame that were reinforced by the society's patriarchal family values. The only well-documented cases were those that resulted in unintended pregnancies; in these situations women had limited options and often resorted to life-threatening decisions (Ikonomi and Woodcock 2010).

Until 1991, induced abortion was illegal in Albania and performing an abortion was a punishable offence by up to 5 years in prison (Kodi Penal [Penal Code] 1952). Yet, the banning of abortion during the communist regime did not stop abortion practices. Anecdotal evidence suggests that abortion still occurred and was never a taboo among Albanian women. Women routinely used abortion as a method of family planning in a time when contraceptives were prohibited and the procedure was routinely performed clandestinely. Indeed, for over 45 years, the Albanian government prohibited the sale of contraceptives as part of a pronatalist population policy that aimed to maintain high fertility rates (Morris et al. 2005; Abortion Policies 2001). Given this context, women would often self-induce abortions using sharp objects, belly-flopping onto hard surfaces, consuming poisonous herbs, or resorting to any lethal chemical available at hand. Unqualified nurses also performed abortions in their spare time, using unsafe techniques and unsanitary tools. During this period, abortion carried a high risk of life threatening complications. According to medical staff, sepsis and hemorrhage due to unsafe abortion was the biggest contributor to maternal mortality during the communist era (Sahatci 1993; Morris et al. 2005). Although there is very little published academic research on unsafe abortion during this period, media reports, news articles, books, novels, and even movies recounting life at the time documented cases and portrayed women's experiences (Culi 1989; Vdekja e Kalit 1991; Woodcock 2015).

After a more than 40-year prohibition on the sale of contraceptives, the Albanian

government lifted the ban in 1992. This occurred in conjunction with the liberalization of the abortion law; the Albanian government decriminalized abortion in 1991 and fully legalized the procedure in 1995. Since then, women have been able to terminate a pregnancy of up to 12 weeks' gestation without restriction as to reason. Termination of a pregnancy for social or medical reasons can be performed up to 22 weeks' gestation contingent on the approval of an expert panel (Law Nr.8045). Pre-abortion counseling is mandatory and doctors performing the procedure are required to counsel the patient on her rights, options, side effects, and the sources of support that the woman can reach out to should she chose to terminate her pregnancy (Law Nr.8045). According to the same law, women are required to take seven days to consider their options before formally requesting to proceed with the abortion, parental consent is required when the patient is under the age of 16 and unmarried, and post-abortion contraceptive counseling is mandatory. Nevertheless, the application of the law varies by provider. In 2016, I conducted interviews with clinicians and health service providers in Albania, who claimed that the mandatory wait time is often waived, whereas post-abortion counseling is virtually non-existent. These interviews were part of a much larger study that was conducted in Albania in 2016, as described in the introduction of this chapter (Doci et al. under review).

After 1995, abortion procedures could be legally performed by any trained obstetrician/gynecologist (Ob/Gyn) in any licensed private clinic or hospital as well as in any public sector secondary and tertiary care facility, including regional and maternity hospitals. However, in an attempt to reduce risks, prevent sex-selective abortions, and increase access to safe procedures, the Albanian government passed provisions in 2013 that prohibited private clinics from offering services such as termination of pregnancy (Panorama 2013). However, several media investigations and reports have revealed that private clinics continue to perform

the procedure illegally (Gazeta Shqip 2015) and use native advertising[i] to attract patients (Anabel.al 2015). These new provisions had no evidential basis but imposed harsh restrictions with consequences for both the health system and patients.

Extremely low per capita public expenditure (approximately US$136 per year) and scarce public resources (WHO 2014) characterize the Albanian health system. The quality of care in the public sector is of great concern. Wages in the health sector are the lowest in the WHO southeastern region and there is an evident lack of infrastructure. Consequently, women face numerous challenges seeking an abortion in the public sector. Privacy also remains a significant concern. Honor and morality have always been the foundation of patriarchal family values and social order in Albania. However, the honor of the entire family rests on women, a longstanding dynamic that has fueled the feminization of familial shame (Nixon 2009). In that sense, the Albanian culture is hostile to women perceived as immoral and collective shame polices women's actions and female sexuality (Nixon 2009). The burden of shame is often far too heavy for women to bear. Consequently, most women seeking an abortion will choose to obtain one in a private clinic or hospital, even if it is illegal or costlier. In addition to privacy, the private sector offers better infrastructure and greater quality of care. According to public records (QSUT 2016), the cost of an abortion in the public health system, including the tests and the procedure itself, is 5000 ALL (approximately US$40). The cost of abortion relative to the annual per capita GDP in Albania, a marker of affordability, is 0.8%; based on costs reported by Jones and Kooistra (2010) obtaining the procedure in Albania is roughly as affordable as in the US. However, these costs do not take into account informal payments, which are a common practice among Albanians, many of whom believe that bribery results in better services or safer treatment (Vian and Burak 2006).

Since 2007, the Albanian Institute of Public Health has developed a structure to report on

and survey abortions across the country. In 2013, Albania reported 180 abortions per 1,000 births, an abortion rate six times higher than the reported WHO figures from the European Union (30 abortions per 1,000 births) (INSTAT 2015; WHO 2015). However, as the abortion surveillance system is flawed, the true abortion rate in Albania is likely much higher. Following the provisions passed in 2013, the surveillance system no longer monitors activities in the private sector. Consequently, many abortions performed clandestinely in private clinics go unreported. Further, induced abortions are often intentionally misreported by medical staff as spontaneous miscarriages in order to preserve the privacy of women seeking an abortion and, in the case of medication abortion, protect themselves from legal action. Despite this overall trend, key informants from the Albanian Institute of Public Health that I interviewed acknowledged an increase in the last decade in abortion rates in rural areas. Such data highlight the growing need for increased access to abortion care in rural areas, as well as the inevitable demand for a simplified, convenient, and confidential method of abortion that could address women's needs.

Social perceptions and attitudes toward contraception and abortion

Following the fall of communism and legalization of both contraception and abortion, women continued to use abortion as a primary form of family planning, largely due to the lack of knowledge and the scarcity of modern methods of contraception (Sahatci 1993). Despite several educational campaigns and numerous efforts to improve access to contraception in the country, the reported prevalence of contraceptive use among Albanians is relatively low. According to the Albanian Demographic and Health Survey, in 2009 less than 8% of sexually active women between the ages of 15-49 used modern methods of contraception (INSTAT et al. 2010). Currently, women rely on the participation of men to prevent unwanted pregnancy and withdrawal is the most common method of contraception among married women (58%

prevalence rate) (INSTAT et al. 2010). While government reports indicate that women are well aware of modern contraceptive methods (INSTAT et al. 2010), independent research suggests that lack of knowledge and misconceptions are common among both women, men and providers (Gryboski et al. 2009; Boci et al. 2013; Nielsen et al. 2012, Doci and Foster, under review). Discussing sexuality, contraception, and abortion in public also remains taboo in Albania. From a recent survey, most women reported getting information on sexual and reproductive health from the Internet, so it is not surprising that participants are misinformed about issues pertaining to reproductive health (Gryboski et al. 2009).

In addition, a complex web of cultural ideas around sexuality, contraception, and abortion shapes Albanians' attitudes toward reproductive health technologies. Albanians appear more reluctant to accept contraception than abortion as women fear that hormonal contraceptive methods lead to infertility or cause cancer (Gryboski et al. 2009). Moreover, use of modern methods of contraception is perceived as a form of promiscuity; it is assumed that women who use contraception will eventually cheat on their partners or engage in extra-relationship sexual interactions. While modern methods of contraception are available free of charge in the public sector, according to our key informants many women in Albania believe that it is more convenient, more affordable, and less shameful to terminate an unintended pregnancy, rather than prevent an unwanted one.

Finally, the change of regimes in the 1990s also affected the religious landscape of the country. New laws protecting religious expression as civil rights put an end to the criminalization of religious practices. Thus when missionary workers flocked to Albania to undertake different relief and humanitarian projects, they infused new religious ideologies into public life and social service programs, and diversified the religious composition in the country (Mustafa 2008). What

was once the first atheist country in the world soon became lauded as a worldwide example of religious tolerance and interfaith harmony (Schwartz 2012). However, the revival of religious life in Albania, combined with the post-communist retraditionalization of the society (Nixon 2009), influenced the social perceptions and acceptance of sexuality, contraception, and abortion. Although, there is a persistent disinterest in religious meddling, which has so far kept religion from interfering with politics, the socio-cultural impact has been well-documented.

The story of medication abortion

The history and context of Albania suggests that medication abortion could play a significant role in addressing women's need for an effective and discreet method of abortion. Currently, women face numerous challenges accessing aspiration and surgical procedures. While women's right to abortion is largely accepted (Albanian Ministry of Health 2009), women seeking an abortion still face externalized and internalized stigma. In particular, young unmarried women may be more reluctant to disclose unwanted pregnancies due to the pressure imposed by patriarchal societal values. Women's actions that bring shame upon the family can be met with punishment and violence (Nixon 2009; Qyno 2013, Sot News 2014; Tema 2016; Xhafka 2017). Thus although abortion is socially protective, it is often done secretly.

The first documented use of medication abortions in Albania dates back to 2003, when researchers at the Maternity Hospitals studied the accessibility and feasibility of using a reduced-dose mifepristone/misoprostol regimen for early abortion (Bracken et al. 2006). Women who participated in the study appreciated medication abortion as a simple, convenient, confidential, and quick method (Bracken et al. 2006). The study team, which consisted of several renowned Albanian Ob/Gyns, strongly supported the introduction of medication abortion and provided evidence of the efficacy and acceptability of the method among women and providers. However,

mifepristone remained officially unrecognized until at least 2009; a report Albanian Ministry of Health in that same year indicated that surgical and aspiration abortions were the only methods available in the country (Albanian Ministry of Health 2009). A 2009 report of the International Planned Parenthood Federation confirmed that mifepristone remained unregistered and thus the gold standard medication abortion method remained unavailable (International Planned Parenthood Federation 2009).

Yet, despite regulatory challenges, women have used medication abortion with mifepristone since the introduction of this technique for research purposes in 2005. Women's accounts on different social platforms affirm that the medication method has been around for years (Anabel.al 2014). Given the lack of registration, medication abortions were not officially reported for many years; however, the abortion surveillance system developed in 2007 provided some insights into the prevalence of this type of abortion in the country. Doctors performing abortions are required to report each case through a specific form that among others indicates whether the abortion was spontaneous or induced, and if the latter, whether induced surgically or with medication. Key informants at the Albanian Institute of Public Health reported that until 2012, medication abortion was more prevalent in the private sector, although this information was not publicized. Since there is a lack of reporting from this sector and no monitoring of this provision, accounts of accessibility, cost and women's experiences with medication abortion are limited and not well-documented.

In 2015, the national guidelines for safe abortion clinical practices were updated by a team of trained professionals to reflect the availability of regimens of mifepristone/misoprostol, methotrexate/misoprostol, and misoprostol-alone as possible forms of early medication abortion (Albanian Ministry of Health 2015). This document is an indication of the current status of

medication abortion and provides some insights into the regimens adopted. According to the guidelines (Albanian Ministry of Health 2015), abortion providers can choose to adopt

1) The IPPF/WHO recommended regimen that consists of 200mg of mifepristone followed by 800mcg of misoprostol up to 48 hours later
2) The US Food and Drug Administration-approved regimen in effect until 2016 of 600mg mifepristone followed by 400mcg misoprostol administered up to 48 hours later; or
3) Evidence-based protocols consisting of 200mg of mifepristone and 400mcg of misoprostol, followed by additional doses of misoprostol administered in cases of incomplete abortions.

The manual also indicates that it is safe for women to self-administer misoprostol at home, thus encouraging providers to adopt this evidence-based practice.

Despite the availability of mifepristone, there are several factors that influence accessibility of medication abortion in Albania. According to the Albanian National Registry of Drugs, Exelgyn obtained authorization to distribute Mifegyne (mifepristone) in 2013 and authorization to sell Misoone (misoprostol) in 2015 (National Agency for Drugs and Medical Devices 2016). However, from market observations at over twenty pharmacies across Tirana county in the summer of 2016 neither drug was available in pharmacies. I conducted sixteen interviews with pharmacists in Tirana county in 2016, during which a number of pharmacists claimed that these drugs were not registered with the National Agency for Drugs and Medical Devices and, as such, they were not allowed to sell them. Indeed, our fieldwork results suggest that both mifepristone and misoprostol are imported through black market channels and in the capital city of Tirana are sold under the table through retail pharmacies. Thus, the actual cost of

medication abortion in Albania is unclear. Further, the key informant interviews revealed that misinformation about medication abortion drugs is common; most stakeholders were unaware of the current market status of mifepristone and misoprostol.

Although unsafe abortions are largely a thing of the past, Albania still faces numerous challenges in terms of expanding and improving access to abortion care. For nearly a decade, medication abortion has been technically available in Albania, yet the adoption of this type of abortion care has been characterized by bureaucratic failures, confusion, and misinformation. All these factors affect accessibility, influence cost, impact quality of care, and shape the experiences of women seeking a medication abortion. In a country like Albania with a corrupt health system that lacks infrastructure, investment, and quality in care, expanding access to medication abortion is crucial. Improving the availability and accessibility of both mifepristone and misoprostol across the country is an important first step. The sale of these medications predominantly through illicit channels increases the cost of medication abortion care, prevents timely access to the procedure, and creates unnecessary barriers for both patients and providers. Developing a formal distribution system would improve the availability of mifepristone and misoprostol and would help expand access to medication abortion across the country. Furthermore, it is necessary to address the widely held misconceptions and misinformation regarding the status and availability of mifepristone and misoprostol. It is especially important for service providers to be knowledgeable, well-informed and well-trained in order to provide accurate information and quality care to women seeking an abortion.

However, the abortion provisions introduced in 2013 have created unnecessary restrictions on access and serve as a barrier to expanding access to medication abortion. The ban on private clinics from performing any form of abortion, including medication abortion, has led

to women and health care providers to engage in unauthorized and/or illegal activities. Driving practices underground complicates surveillance, training, monitoring and evaluation, and quality assessment and improvement. Indeed, there are currently no mechanisms in Albania to evaluate the practices of private clinics and ensure minimum training and safety standards. This may be placing women at risk. Consequently, it would be valuable for the Albanian government to rethink these restrictions and instead invest in systems to monitor the quality of services provided through the private sector.

Conclusion

Abortion remains the main form of birth control among women in Albania, mainly because men are reluctant to use modern methods of contraception. Evidence suggests the growing need for increased access to abortion care in rural areas, as well as the inevitable demand for a simplified, convenient, and confidential method of abortion that could address women's needs. Despite the bureaucratic evidence of its availability, there are several factors that influence accessibility of medication abortion in Albania including systems failures, widespread confusion, and misinformation. In addition to impacting the accessibility of medication abortion, these factors influence the cost and quality of abortion care and shape the experiences of women seeking an abortion. Supporting efforts to ensure that medication abortion is available through a range of service delivery points appears warranted.

[i] Native advertising is a form of paid content often published online that is customized to closely fit with or blend into the original content of the medium upon which it appears. For instance, online outlets will promote sponsored content within contextually relevant articles, commentaries or other forms of media that are part of the publisher's native experience

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CHAPTER 6: DISCUSSION

Integration of results

Albania has come a long way since the change of regimes. All stakeholders in this project agreed that sexual and reproductive health services have improved tremendously over the past two decades, both in quantity and quality. Currently, services are provided in over 422 health centres across the country, contraception is available for free in all of these facilities, evidence-based guidelines and protocols on reproductive health care services have been developed with the assistance of foreign experts, and both the government and non-governmental partners have engaged on numerous campaigns and initiatives to improve availability and accessibility of these services. However, our study indicates that the country still faces numerous challenges with regards to infrastructure, knowledge and capacity, institutional culture, and public awareness and perceptions.

Lack of infrastructure

Infrastructure remains a challenge that affects the accessibility and quality of services, but also women's attitudes and perceptions toward reproductive health services. In the past few years, the overall number of health centres, which are also responsible for providing reproductive health services, has gone down. While this may not seem problematic at first, depending on their location, closures present a challenge for women from remote areas. As I witnessed during my trip in Albania, remote areas often become isolated, lacking both health centres and pharmacies, thus creating burdens for women who need to access sexual and reproductive health services in general, and contraception and EC in particular. Additionally, the lack of privacy is a constant concern that often prevents women from accessing these services at all. The layout of the

facilities and the setup of the examination rooms is such that it exposes patients. During my visits in different health care facilities in Tirana, and other cities as well, I noticed that health care facilities often lacked designated waiting areas, or designated consultation spaces. While one waits to see a doctor, it is disconcertingly easy for private conversations to be overheard, and upsettingly facile to identify the kind of services a woman may be seeking at the facility. Also, examination rooms are sometimes shared among doctors, and several patients may be waiting to receive service in the same area. Coupled with an unfriendly and indiscreet institutional culture, infrastructure is an important factor influencing women's experiences. Women seeking sexual and reproductive health services in the public sector may feel embarrassed and uncomfortable to the point that they seek services elsewhere (in the private sector) or stop accessing these services altogether.

Knowledge and capacity

In addition to improving infrastructure, there is a dire need to improve knowledge and capacity of HSPs. As our study findings show, HSPs, whether doctors, nurses, or pharmacists, are often uninformed or misinformed about available sexual and reproductive health services, particularly contraception. Many providers, especially pharmacists, have received no training to provide sexual and reproductive health services, thus rely on their limited knowledge and personal beliefs when providing services to women. As our study has shown, their knowledge is often outdated and includes misconceptions that ultimately affect the quality of service that women receive, but more importantly shape women's attitudes towards contraception.

Woman may be initially hesitant to use contraception due to misinformation and misconceptions, however the inability of service providers to address any and all concerns

related to potential side effects may turn women firmly against modern methods of contraception. Additionally, lack of awareness and information among service providers affects their attitudes and perception of clients accessing these services. Service providers are sometimes unknowingly judgmental and biased against women seeking contraception or contraception counselling. The frequently repeated notion among key informants that "EC is good as long as women don't use it like candy" illustrates one of the common prejudices that providers hold against women who seek EC from pharmacies. Inadvertently, they are allowing their misconceptions interfere with the way they interact with clients, and the service they provide, thereby affecting negatively women's experiences and limiting accessibility. While new guidelines and protocols for contraception have been designed and published with the help of foreign experts, their availability is limited. Institutionalization of these protocols could be a step forward towards improving knowledge among providers and the quality of care they provide. Moreover, training of all health service providers appears warranted, especially pharmacists. The current national continuing education strategy lacks structure and provides little to no opportunities for training in sexual and reproductive health specifically. It is crucial to design and/or incorporate sexual and reproductive health training modules in the available platforms of continuing education in the country, and incentivize HSPs to participate in them.

Institutional culture

Education of health service providers could also help improve institutional culture toward sexual and reproductive health. Institutional culture is defined by the common values, beliefs, and symbols that are reflected in the operational practices within an organization (Barney, 1986). This often overlooked factor can shape one's professional and ethical standards, and can strongly

influence professional behaviour, motivation, productivity, satisfaction and quality of services (Kustra et al., 2014).

When asked about their experiences during their most recent visit in which they obtained sexual or reproductive health care, less than two thirds of women who completed the survey found the environment comfortable and welcoming, perceived the service as nonjudgmental, and felt comfortable enough to ask questions. Both the quality of infrastructure in this case and the quality of services provided are indicators of a culture that does not prioritize women's sexual and reproductive health care needs. These kind of attitudes and behaviours are enhanced by the lack of enforceable policies and guidelines that would create a more welcoming and friendly environment. At a higher level, the dismantling of the ministerial department of reproductive health care could be interpreted as a shift towards policies that no longer prioritize reproductive health. Moreover, the lack of oversight for these services specifically, and more importantly the lack of a focal point to lead efforts in promotion of sexual and reproductive health services, is discouraging.

As such it is important to improve institutional culture by providing more resources to HSPs that provide sexual and reproductive health services; by incentivizing them to seek additional training to improve their skills and service delivery; as well as by implementing performance indicators related to sexual and reproductive health care as part of institutional or personnel reviews. Quality and accessibility of services can be improved over time by establishing a culture that prioritizes women's sexual and reproductive health needs.

Public awareness and opinions

As highlighted in all three of our articles, knowledge and awareness, as well as mentality and public opinions are significant factors that influence women's reproductive health choices in Albania. As previously mentioned in the introduction, Albanians' conservative attitudes toward women's roles in the society are often reflected in collective efforts to police women's sexual behavior and expression. It is unsurprising that Albanian women maintain secrecy when it comes to their sexual and reproductive health, and feel uncomfortable seeking counselling, services or care related to it. The vast majority of women surveyed in our study *rarely* or *never* visit a doctor for such reasons, which indicates that institutional and social factors discourage women from accessing services that are otherwise freely available. Additionally, the fact that almost two thirds of women surveyed *always* or *sometimes* seek approval or consent from their partner or spouse before using any form of contraception, speaks to the strong influence that men have in women's choices regarding the woman's own sexual and reproductive health.

On the other hand, our research revealed that abortion remains the main form of birth control among women in Albania, mainly because men are reluctant to use modern methods of contraception. This is an expression of a patriarchal mentality which keeps women from making autonomous decisions about their own health and future. In this context, it is crucial to address the inherent gender inequalities in the society by raising awareness, educating men, and empowering women. Developing gender-inclusive policies to increase women's participation and improve their role in the society can change how women are valued. Efforts to change societal attitudes toward women will eventually give women more freedom to make autonomous choices regarding their sexual and reproductive health. Specifically, in terms of contraception it is important to educate the public about the benefits of modern methods of contraception, and

address common misconceptions that keep women from accessing these methods. Developing fliers, pamphlets, and targeted promotional campaigns to improve knowledge and awareness can change attitudes and increase uptake of contraceptives. Furthermore, it is key to promote the sexual and reproductive health services available in the country, and encourage women to access these services by guaranteeing privacy, ensuring quality, and providing a welcoming environment.

Youth

Albanian youth are more open-minded in terms of issues related to sexuality and reproductive health technologies than older populations. However, this generation is increasingly more at risk due to lack of information and resources available and changing sexual behaviours. For one thing, it is difficult for young Albanians to obtain counselling, services or care related to sexual and reproductive health in a society where discussing sexuality is still taboo. Youth lack sexual education and continue to rely on the internet or their peers to obtain information related to their sexual or reproductive health. Yet, these sources are often unreliable, and lead to perpetuation of misinformation. Further, the public health care system in Albania suffers from the lack of resources and infrastructure to provide youth-friendly services. While sexual and reproductive health are often articulated as priorities, there are no designated youth-friendly centres to provide these services. Moreover, health service providers lack appropriate training or skills to provide quality youth-friendly care. Currently, Albania's youth are caught between a society that is unwelcoming toward their open-mindedness and a system that is unresponsive toward their sexual and reproductive health care needs.

It is critical to provide the new generation with education and resources regarding these issues. Developing a sex-ed curriculum that discusses sexual and reproductive health matters at an early age will teach young people to become more responsible about their own health. Improving knowledge through such a curriculum could have a broader impact in terms of societal values, as it would empower girls and boys at an earlier age to make informed autonomous choices about their own sexual and reproductive health. On the other hand, establishing youth-friendly centres of care should become a priority. Interventions to improve accessibility to sexual and reproductive health services for young people can address major issues that the country is currently facing, including low contraceptive prevalence rate, high abortion rates, and increasing STI rates. Focusing resources on youth today could have a significant impact on the country's indicators of reproductive health in the future.

Implications and significance

This research provides for the first time a holistic view of Albania's current reproductive health landscape and identifies some key challenges that the country is facing in this area. Our findings fill a significant gap in the literature and have the potential to inform efforts by NGOs and clinicians to increase access to contraceptive services and utilization of modern methods. Improving knowledge of contraception and accessibility of EC has the potential to increase contraceptive uptake, and reduce the number of abortion procedures in the country. Thus, it is necessary to develop tailored interventions that can address the accessibility issues identified throughout this project.

Little has been published on reproductive health in much of this region and the results of our work will undoubtedly be of value to stakeholders working in both the regional and

international reproductive health fields. Indeed, we have already collaborated with the European Society for Emergency Contraception to get the product insert for both NorLevo and Postinor2 translated into Albanian. In addition to contributing to the peer-reviewed literature on reproductive health in Albania, we intend to work closely with our local partner in Tirana, to disseminate the results of our project. We will produce several materials with the key findings of this research, which can be widely distributed through different platforms among interested community members, stakeholders, and research partners. Overall, I hope that findings from this research will help educate members of the community on the issues surrounding women's reproductive health choices in Albania, and will influence future projects and policies that can improve accessibility of reproductive health services and contraception in the country.

Strengths and limitations

The main purpose of this project was to provide a comprehensive picture of reproductive health services available in Albania as well as to identify key factors that shape women's attitudes and experiences towards contraception and EC. This study captures for the first time the perspectives of several stakeholders in Albania, including women, clinicians, pharmacists, policy-makers and other key informants. Not only does our study offer a wide range of viewpoints, but it also provides insight into the challenges and issues that rise from different levels of governance and at different stages of service delivery. In that sense, our findings depict a holistic view of Albania's current reproductive health landscape, and provide a clear roadmap to the significant challenges that need to be addressed.

There were several limitations to this study. To begin with, some components of our research were geographically constrained to Tirana county. Tirana county is the largest county in

the country, both by area and population, and it is home to the vibrant capital city of Tirana. As such, we expect that the availability and accessibility of services in Tirana will be much greater than other counties in Albania. Additionally, service providers in Tirana have more access to professional development opportunities, resources, and general information. Thus, providers' level of knowledge and awareness could differ dramatically from that of their peers in more remote areas in the country. Furthermore, in terms of culture and mentality, Tirana represents a diverse community, where the majority of the population is highly educated and more progressive. Hence the viewpoints and experiences of participants from this county could be significantly different from those of people living throughout the country. Therefore, expanding the geographical reach of future research projects on this topic would potentially capture issues that may not be widespread, but nonetheless significant to accessibility of services and women's experiences.

Moreover, participation in all components of our study was age-restricted; in order to obtain Research Ethics Board approval, we only included participants aged 18 and older. Unfortunately, we were unable to capture the perspectives and experiences of younger adolescents with accessing reproductive health services in Albania. According to key informants in the country, the age of first sexual intercourse in Albania has decreased, and adolescents are currently more at-risk due to lack of sexual education, limited access to reproductive health services, and lack of youth-friendly resources to address their needs. Due to the unique characteristics of this population, we suspect that the challenges adolescents face when accessing reproductive health services are different and more complex than those of other populations. Consequently, conducting rigorous studies that explore more in-depth the reproductive health knowledge, attitudes, and practices of adolescents is warranted.

Statement of contributions

I served as Principal Investigator (PI) of this study, which I conducted in partial fulfillment of the requirements for the Master of Science degree in Interdisciplinary Health Sciences at the University of Ottawa. My role as PI involved conceptualizing this project, determining the methodological approach, designing the research instruments, collecting and analyzing data, and developing the articles included in this thesis as well as other dissemination tools resulting from this study.

Throughout this project I worked alongside Dr. Foster, my supervisor, who contributed to and reviewed all aforementioned elements of this study. Additionally, Dr. Foster worked with me to formulate the research proposal, prepare the ethics application, secure funding for this project, and develop a dissemination strategy for this study. She has also provided me with training in qualitative methods of research including data collection, transcription, data analysis, and a variety of other tools and materials that helped me successfully carry out this project.

Throughout this project, I have worked with a number of volunteer research assistants. Jonida Thaci assisted me with translation and reconciliation of the research instruments, as well as transcription and translation of a number of interviews. While based in Albania, I also received assistance from Ilda Mullaymeri and Iv Reci, who accompanied me during my interviews with pharmacists. They helped me identify the pharmacy sites to visit, facilitated the logistics of my travel, and assisted during the interviews by taking additional notes to ensure that all important information was captured. Andi Rabiaj provided assistance with securing locations for several FGDs in Albania, recruiting participants for FGDs and other components of this study, procuring assistants for the FGDs, and raising awareness about the project among different contacts and organizations in Albania. He also played a crucial role in securing a

partnership with the UNFPA Albania. Lastly, Dr. Dorina Tocaj assisted me with several components of the study. Her influential position through the UNFPA Albania played a significant role in the overall progress and success of the project. She raised awareness about the project and helped with recruitment of participants for different components of the study, but more importantly key informants.

Positionality and reflexivity

Qualitative research is a form of research that seeks to understand phenomena and answer questions from the perspective of the participants (Al-Busaidi, 2008). Interpretation is a core element of this type of research, as such positionality and reflexivity are critical. Positionality reflects how the researcher's identity and experiences influence her enquiry approach and interpretation of the data (Rose, 1997). It is important to understand one's position as a researcher relative to the research topic and the population, in order to be aware of and address subjective influences. Reflexivity is the process during which a researcher continuously reflects on the dynamics of her positionality and acknowledges how her views and experiences may affect the research process and outcomes (Dowling, 2006).

Because of my Albanian origin, I felt I was especially well-suited to undertake this research project in Albania. As mentioned earlier, reproductive health and family planning are relatively sensitive topics to discuss openly in Albania. However, my native knowledge of the language helped mitigate language barriers or misunderstandings, and my familiarity with the Albanian historical context, cultural norms, and traditions prepared me to address discomfort during my enquiry process. My background and previous experiences growing up in Albania provided me with great insight into the existing barriers surrounding reproductive health issues

in the country. I always perceived providers' interactions with women seeking reproductive health counseling, services, or care as charged with judgment, stigma and shame. As a young Albanian woman, I had frequently been on the receiving end of these dynamics and that made me more aware of the significant influence that these interactions have on women's choices and decisions with regards to reproductive health.

Conversely, I believe that my position as a Canadian (i.e., Western) researcher has influenced my interactions with the participants, and their level of engagement during the process. Due to my education from abroad, my exposure to a modern liberal society, and my role as researcher from a reputable institution, I was perceived as a knowledgeable, nonjudgmental, and influential person. Hence, participants were eager to share their perspectives with me and were very opened and honest about their experiences. My position as an outsider was likely perceived as reflecting my impartiality, thus allowing participants to engage in more candid conversations about the current issues the country is facing and solutions for addressing them.

CONCLUSIONS

Progress has been made to improve the quality and accessibility of reproductive health services, in general, and contraception, in particular, in Albania. However, despite ongoing efforts, contraceptive prevalence remains low, and abortion rates are high and underreported. Women face numerous obstacles when accessing reproductive health services in Albania. Women are reluctant to use modern methods of contraception due to widespread misinformation and misconceptions related to the side effects and safety of these medications. Health service providers on the other hand lack appropriate skills and training to provide patient-oriented care when it comes to reproductive health services. The majority of pharmacists we spoke with had

received no training in providing sexual and reproductive health services, and have significant misinformation about modern methods of contraception. Their lack of knowledge influences the quality of counseling that pharmacists provide to women, and ultimately shape women's experiences accessing and using contraception and EC.

Similarly, the Albanian culture and mentality are unreceptive toward women's sexual and reproductive health needs. Women seeking abortion services, contraceptive methods, or any other reproductive health service, fear judgment and are embarrassed to discuss their needs with providers. Often, internalized and externalized stigma represent significant obstacles to accessing these services. Shaming, as a tool of gender policing, is rooted in the country's old patriarchal culture and is fed by the perpetuated misconceptions associated with contraception, abortion, and other reproductive health technologies.

Infrastructure and institutional culture could play a significant role in addressing some accessibility issues. Increasing the number of FP facilities, incorporating EC in the national contraceptive strategy, establishing youth-friendly services and developing tailored interventions to improve the quality of service, have the potential to increase contraceptive uptake and overall reproductive health service accessibility. Additionally, the government and its partners need to work in devising gender-inclusive policies that encourage women to access contraception and other reproductive health services without fear of judgment or repercussions. Currently, contraception and abortion services, along with all other sexual and reproductive health services, are provided under the umbrella of family planning. One can assume that an institutional culture that shies away from terms such as sexual and reproductive health creates unnecessary barriers that prevent women and youth from obtaining the services and care they need. This may also

have important implications for youth, most of whom are not planning families at sexual onset, yet need to access sexual and reproductive health services.

Prioritization of sexual and reproductive health at the national level can be expressed in many forms, but in a society somewhat hostile and unjust toward women, language is key. As such, education of the population at large through promotional campaigns that improve knowledge and raise awareness have the potential to change societal culture over time.

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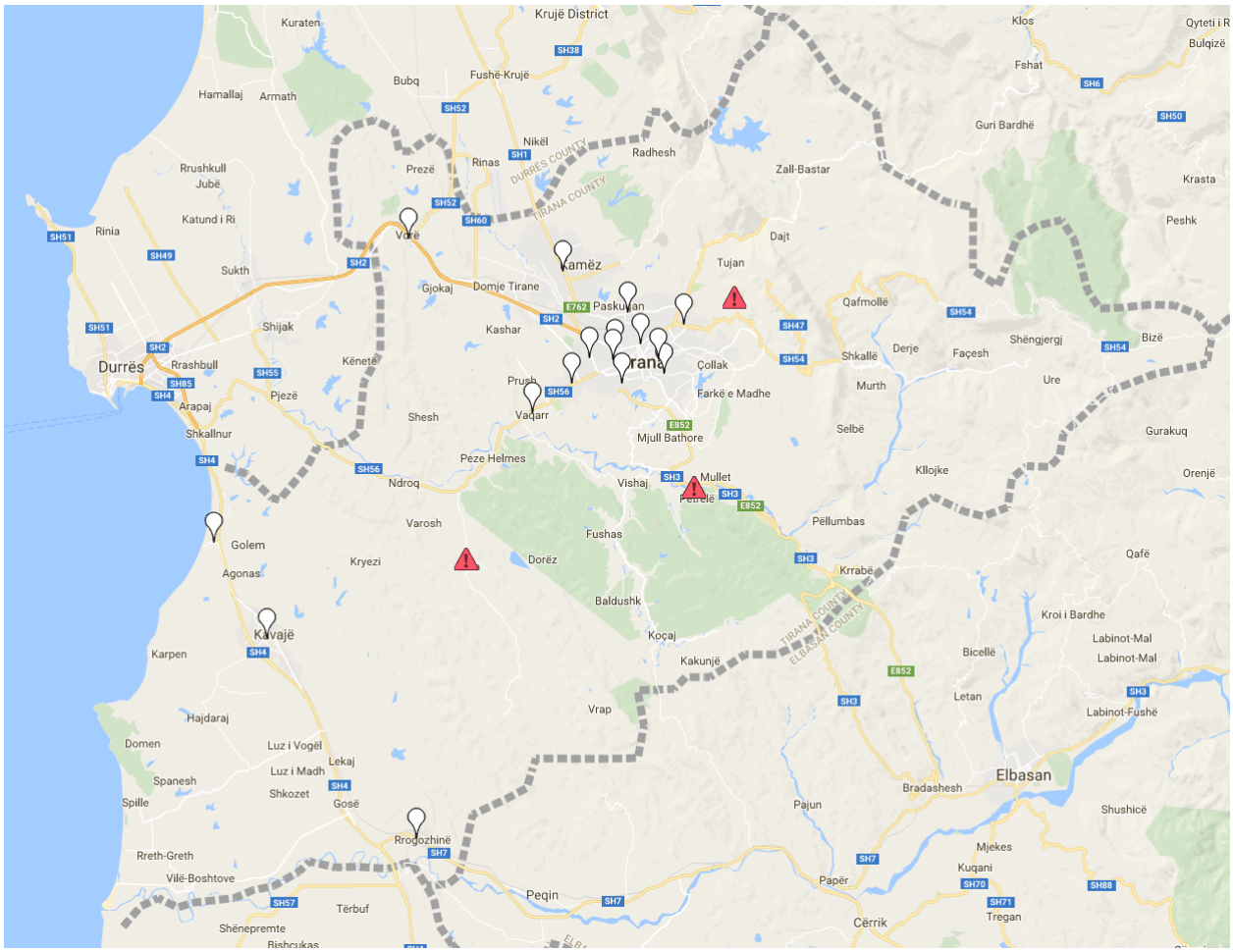
APPENDIX A: Map of administrative divisions of Albania

APPENDIX B: Geographical location of pharmacies visited in Tirana county



APPENDIX C: Letter of approval from Research Ethics Board

File Number: 03-16-19 **Date (mm/dd/yyyy):** 04/25/2016

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Angel	Foster	Health Sciences / Others	Principal Investigator
Florida	Doci	Health Sciences / Others	Student Researcher

File Number: 03-16-19

Type of Project: Master's Thesis

Title: Emergency Contraception in Albania: A multi-methods study of awareness, attitudes and practices

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
04/25/2016	04/24/2017	Approved

Special Conditions / Comments:
N/A

550, rue Cumberland, pièce 154 550 Cumberland Street, room 154
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
(613) 562-5387 • Téléc./Fax (613) 562-5338
www.recherche.uottawa.ca/deontologie/ www.research.uottawa.ca/ethics/