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ALBANIAN CENTER FOR POPULATION AND DEVELOPMENT

Quality Assessment of utilization of Family Planning Services in Albania

A qualitative study with decision-makers, service providers and family planning service users

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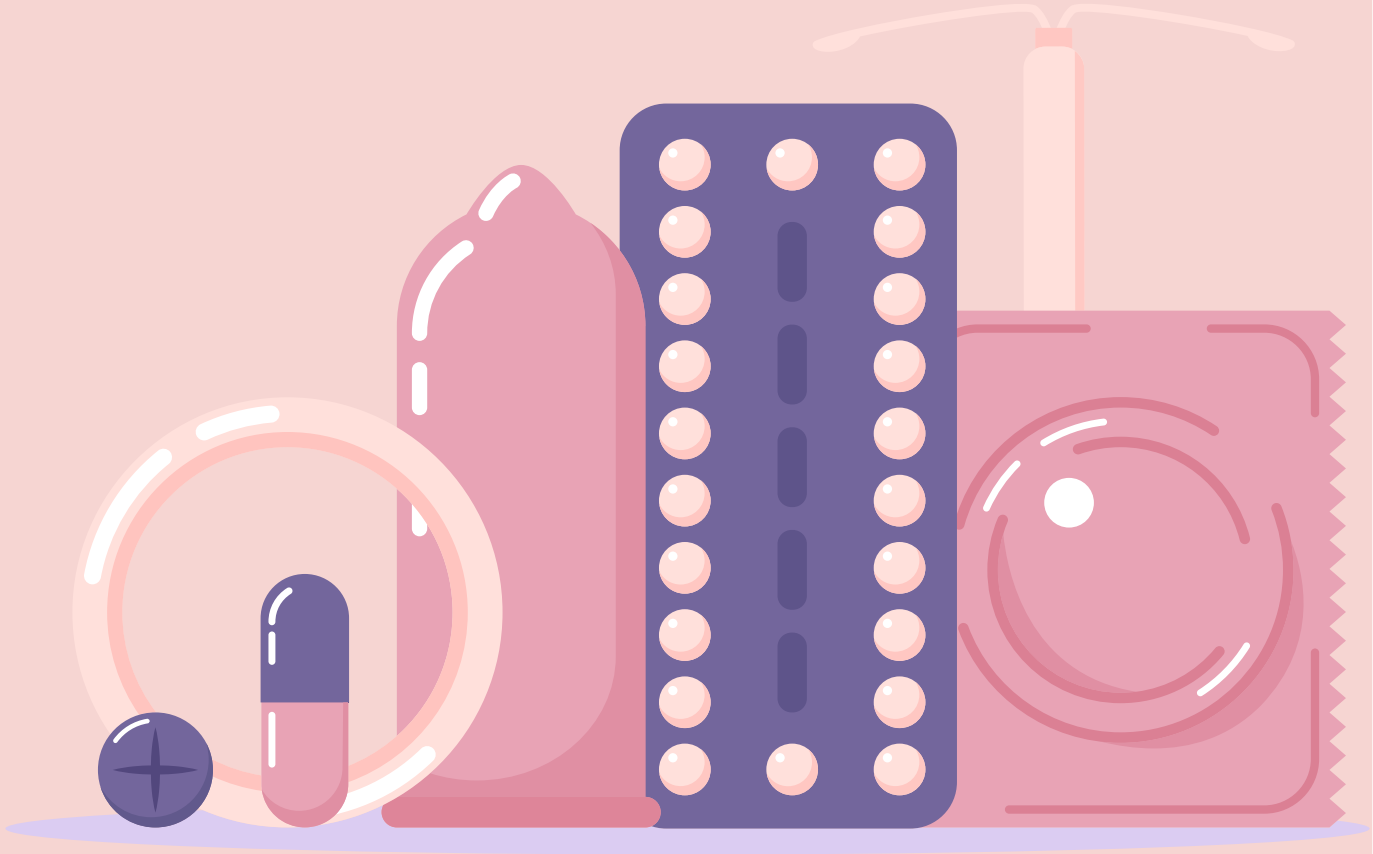

Acronyms and Abbreviations

ACA	Albania Community Assist
ACPD	Albanian Center for Population and Development
ADHS	Albanian Demographic Health Survey
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Campaigns
CBO	Community-based Organization
FGD	Focus Group Discussions
ICPD	International Conference on Population and Development
IPH	Institute of Public Health
IUD	Intrauterine Device
FP	Family Planning
KAP	Knowledge, Attitudes and Practices
MCM	Modern Contraceptive Method
MoHSP	Ministry of Health and Social Protection
NGO	Non-Governmental Organization
NESMARK	Social Marketing Agency
LMIS	Logistics Management Information System
SSI	Semi-Structured Interviews
RHA	Regional Health Authorities
RHC	Regional Health Committee
RHS	Reproductive and Sexual Health
SDM	Standard Day Method
STI	Sexually Transmitted Infections
UNFPA	United National Population Fund
USAID	United States Agency for International Development

Executive summary

In spite of significant progress in the area of family planning in the last two decades, modern contraceptive use in Albania remains low. This study intended to collect, analyze the data and on contraception related to three key components:

- Availability and quality of services and other supply related issues.
- Coordination of the health system function to enable environment for FP/SRH-seeking behaviour.
- Knowledge, Attitudes and Practices (KAP) related to modern contraceptive methods among young girls and boys and women in Albania.

Firstly, a desk review was carried out assessing the current legal framework and policies related to contraception; programmatic context in which the national FP program operates, mapping out who is involved in FP programming; organizations focused on advocacy interventions, or on service delivery and demand-creation activities

In addition, the findings presented in this study reflect opinions and comments gathered from 20 Semi-Structured Interviews (SSI) with service providers/implementers (14), key decision makers (6) and 8 FGDs with the participation of 91 participants (young people and women of reproductive age) from urban and rural health centres.

Key barriers to access FP identified include:

Analysis from this study confirms the long-standing existence of barriers that hinders the utilisation of family planning services in Albania. Use of family planning services was found to be low and several barriers that hinder that utilization were prevalent. Challenges and barriers are grouped as followings: a) organizational factors, b) societal factors –gender social and cultural; and c) promotion of family planning programs.

Organizational factors

Lack of private family planning space was the common barrier mentioned by the majority of public health provides, which in turns doesn't allow a good interaction, private and confidential counselling

between a provider and client. Fear of infection during client examination was also raised, this mainly due to lack of single-use towels, decontamination solutions and latex examination gloves.

Providers felt that their knowledge and skills regarding the new contraceptive methods, international guidelines and standards might be outdated, mostly due to lack of participation in the process of developing documents/protocols, attending trainings, workshops and national/international events. Problems with stock-out were also found as barrier, mainly due to poor coordination among IPH, Regional Health Authorities (RHA) and Health Centers themselves. Inverse ability was also mentioned as a barrier by service users who didn't have free choice to choose the preferred method, this due to shortage in the availability or reduced variety of the preferred method. Additionally, family planning services were perceived as services for pregnant women and weren't found attractive for majority of young people as well as for the bare majority of women of reproductive age.

There is in place the Albanian National Contraception Security Strategy 2017-2021, which envisages provision of contraceptives and free family planning services for every citizen who needs them, throughout the territory. i. There is a protocol on Family Planning; the process of its development has been coordinated by Albanian Center for Population and Development with the support of UNFPA in 2016. The Reproductive Health Sector in the MoH was restructured within in the new Directorate of Health Care. A full time person trained to cover contraceptive logistics and other aspects of family planning at district level would be desirable. Also, the capacity of the Institute of Public Health to coordinate the Contraception Logistics Management Information System (CLMIS) is perceived as insufficient, due to multiple tasks, staffing and financial issues. Limited funds for field trips and additional priorities lead to a low level of monitoring and supervision. In 2006 it was established by an order of the Minister of Health the Committee for Reproductive Health with the scope of work of the commission to include all issues related to the broader concept of the reproductive health, rather than just focus on contraceptive security and family planning.

Societal factors

A climate of fear still exists among contraceptive users. Fear of side effects, dangerous for fertility, severe bleeding, black spots, growing hair in the face, etc were the most common misconception

mentioned by study participants. The source of fear is rooted mostly from word of mouth and not reliable sources, such as social media and internet.

Husbands/in laws disapproval continues to be another barrier that hinder uptake of modern contraception methods. This attitude is strongly related with the socio-cultural health issues, family bond and lack of male involvement in the family planning decision making.

Social stigma and pressure were found as barrier as well. Fear of identification from family members, relatives and community members as users of family planning services or modern contraception was strongly related with promiscuity, bad behaviours or unsafe abortion.

To promote the use of modern contraceptives, a series of communication campaigns were carried out, starting in 1999. These were funded by foreign or international agencies such as USAID and UNFPA and implemented by both foreign and locally-based organizations, consultancy firms and other organizations. In addition to a media component aimed at creating awareness, these campaigns have trained health care providers, pharmacists and journalists, worked to ensure contraceptive security and implemented inter-personal communication interventions. Recently the Albanian Center for Population and Development (ACPD) and few local NGOs are the major civil society organizations providing family planning and reproductive health services and distributing contraceptives.

Promotion of family planning services

Lack of promotion materials and behaviour change interventions and mass media campaigns was widely accepted by study participants.

The Covid-19 situation has affected the quality of family planning services and has led to disruption of such services for contraceptive users. However, as we are walking in an unknown field, more time, efforts and future research needed to explore the effect of Covid-19 pandemic in the provision of family planning services.

Conclusions and recommendations

Despite good progress in developing policies favouring family planning services, yet contraceptive prevalence rate continues to be decreased in Albania. Negative perceptions and misconception about method effectiveness and safety are common and hinder the utilization of family planning services and use of modern contraceptive methods.

Albania has all ingredients to improve the utilization of family planning services and efforts should be focused on switching the approach from the climate of fear to the modern contraception culture. To ensure that, it is necessary to strengthen the accessibility and availability of services as well as to expand the range of modern contraceptive options that fits with the women and couple needs. This study concludes with the following programmatic recommendations:

- Implement interventions that focus on reducing top barriers to family planning uptake, by improving facility infrastructures and services, strengthening knowledge and skills of health providers and educating communities about benefits of family planning.
- Dedicate increased national funds and budget lines for sexual and reproductive health and provision of wide range modern contraceptive methods.
- Develop tailored, innovative education and long-term behavioural change programs that cover all FP methods, as well as general reproductive and sexual health issues.
- Design services that take into account the needs of young people. Implementation of youth-friendly services, mobile outreach and satellite programs could be implemented in areas where there is lack of family planning programs.
- Develop programs that breaks barriers that reinforce gender equity, incentivize male participation in family planning decision, reduce sexual violence and coercion, and to eliminate child marriage.
- Provide continuous training and monitoring of FP providers and develop health promotion tools (protocol and guidelines, posters, leaflets etc.) for all FP clinics.
- Revitalize the Reproductive Health Committee (RHC) and establish such structures at regional level to decentralize and boost policy-making related to family planning and Sexual and Reproductive Health.
- Pilot the Total Market Approach which will cover the existing gaps and serve as a connection bridge between public and private family planning sectors.

- Develop Telemedicine and mobile online consultations/counselling platforms to improve access to family planning services.
- Ensure sexuality education for all, including young people in and out of school, marginalized groups and others who may not ever have had access to full information about sex and reproduction.
- Call on government, donors and international agencies – to join forces and prioritize investments in family planning programs.
- Carry out intensive researches on the impact of Covid-19 pandemic in regards to utilization of family planning services and propose concrete actions/programs to ensure continuation of services.

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The study *"Quality Assessment of utilization of Family Planning Services in Albania was conducted by Albanian Center for Population and Development"* with the support of International Planned Parenthood Federation European Network.

Two experts of public health, Arian Boci and Dorina Canaku were contracted by ACPD to develop the study methodology and to lead the desk review process, to conduct the data analyses and to compile the final report. The study took place and was finalized due to involvement of high political decision-makers (central or technical directors/managers of the Ministry of Health and Social Protection and institutions responsible for family planning and reproductive health services); Managers of FP programs at both central and regional level; Healthcare providers who actually provided or directly involved in provision of family planning services (at both public and NGO sector), and Service users: women at reproductive health age and groups of men and young people.

In this case, ACPD would like to thank the experts for their precious expertise and all key stakeholders involved with the study considering all constraints imposed by the global pandemic including travel and physical meeting limitations.

The main partners included in the study included Merita Xhafaj – General Director Ministry of Health and Social Affairs, Dorina Tocaj – Program Analyst United Nations Population Fund (UNFPA/ Albania), Gentiana Qirjako – Chief of Health Promotion Department, Institute of Public Health, Miranda Hajdini – LMIS specialist, Institute of Public Health, Lidiana Lamaj – Specialist, Regional Operatory for Health care (Tirana), Alojva Xhelilaj- Gynecologist, rural healthcare center of Tirana Myzafer Islamaj – Director of Local Health Care Unit, Vlora, Ardian Paravani – Service provider, NESMARK Albania, Social Marketing Agency, Dritan Kamani –Public health expert, Holta Koci – Executive Director, Albanian Community Assist, Mirela Rista–Tirana Maternity Hospital–Center Po/ ACPD, TiranaMarjeta Boraj – Vlora Maternity Hospital - Aulona Center/ACPD, Vlora, Diana Cuberi –Vlora Maternity Hospital Aulona Center/ACPD.

The study findings identify areas of the FP programs that seemed particularly strong, with demonstrated promising practices that might be further evaluated and/or scaled up. It might be

an advocacy tool to ACPD and key stakeholders to advocate to the Ministry of Health and Social Protection for addressing barriers related to access to contraception care in Albania; it also provides evidence base for the MoHSP related to areas that need immediate intervention and reflection in the upcoming Strategy of Sexual Reproductive Health (2022-2026) and the Strategy of Contraception (2022-2026).

Background

Family planning is essential for sustainable development of a society. Therefore, family planning programs, including modern contraceptive methods, support couples and individuals in their fundamental right to decide freely and responsibly whether, when, and how many children to have. Numerous international evidences indicate that the adoption of effective family planning programs has had substantial improvements in health-related outcomes (such as reduced maternal mortality, infant mortality and child mortality), as well as improvements in education and economic development, especially for women (1-7).

Under communist regime, modern methods of family planning were illegal in Albania. A common belief was that attempts to interfere with reproduction would cause serious health problems or even permanent infertility (5-7).

Family planning services were introduced in Albania after 1990, following the fall of the communist regime and the transition to a market-oriented system. The first step in this direction for the Albanian government was to abandon its pronatalist orientation, which was strongly promoted during the socialist era. As a result, the reasons for legal abortion expanded and, by mid of 1991, abortion was legal and available on demand (6,7).

In 1992, the Albanian government began working closely with the United Nations Population Fund (UNFPA) to train physicians, midwives and nurses in family planning methods. In 1992, the government established a family planning service that provides all methods of contraception to the general population (7).

However, reproductive health services were established in Albania only after the 1994 Cairo International Conference on Population and Development (ICPD), and demographic changes, in particular with regards to migration and fertility were observed [7].

Some essential indicators about family planning in Albania (8, 9, 10) are as follows:

◊ Albania's total population: around 2.87 million (INSTAT, 2019);

◊ Women of childbearing age (15-49 years): 689,168 (INSTAT, 2019);

◊ Fertility rate: 1.54 (INSTAT, 2017); 1.8 (ADHS 2017-18);

◊ Abortion rate: 8.0 abortions per 1000 of reproductive age (15-49 years) [IPH, 2018];

◊ Abortion / birth ratio: 191.2 abortions per 1000 live births (IPH, 2018);

◊ Prevalence of contraceptive use: 4% (ADHS 2017-18);

◊ Infant mortality: 8.9 deaths per 1000 live births (INSTAT, 2018);

◊ Child mortality (0-5 years): 10.8 deaths per 1000 live births (INSTAT, 2018);

◊ Maternal mortality: 3.9 deaths per 100,000 live births (INSTAT, 2018).

The Department of Economics and Social Affairs, United Nations Population Division, reported in 2019 that the use of traditional methods was high in many Southern European countries, with 12 countries using traditional methods with prevalence over 7.2% in 2019, the highest levels being observed in Albania (24.5%), followed by North Macedonia (18.2%), Bosnia and Herzegovina (16.4%), and Serbia (15.8%). Therefore, the use of modern contraceptive methods in Albania is probably the lowest in the region (11).

According to United Nations estimates, worldwide in 2019, 48.5% of women of reproductive age (15-49 years) used one form of contraception. Any method of contraceptive use in 2019 was 58.2% in Europe and Northern America, 58% in Latin America and the Caribbean. Eastern and South-Eastern Asia had the highest use of contraception (60%), meanwhile for Central and Southern Asia it was 41.8%. Contraceptive use for Australia and New Zealand was 57.7%. While Oceania and Sub-Saharan Africa had the lowest use of any method of contraception (28% and 28.5% respectively) [11].

The United Nations estimate of contraceptive prevalence (any method) in Albania for 2019 was 28.4%, which was similar to the one reported for Oceania and Sub-Saharan Africa but below the European and Northern America average. Albania had the lowest use of any method of contraception in the Southern European region [11].

In Albania, reproductive health care and family planning services are provided at the level of primary health care as well as in maternity hospitals throughout the country. The overall goals of reproductive health care services are to provide good quality reproductive health care services to the whole population; to improve the health status of women during their reproductive age, especially during childbirth and childbearing; to improve the health status of foetuses, new-borns, infants and children up to the age of five years old; and to improve the sexual health of adolescents and adults (12, 13).

The Albanian government has foreseen a human rights approach to providing reproductive health services. Since 1992, a special Decree of the Council of Ministers provided that family planning should be regarded as a fundamental human right from which all citizens should be able to benefit at their free will. According to this Decree, the Council of Ministers approved specific family planning activities including prophylaxis, the right of couples to decide about the number of their children, birth space, infertility treatment, control and treatment of sexually transmitted infections such as HIV/AIDS and syphilis, and providing information on sexual and reproductive health issues. Moreover, gender equality and women's right to health are strongly promoted by the Albanian government as particularly important cross-border topics (12-14).

Currently, in every district of the country, there are gynaecologists and midwives who provide family planning services. In each maternity ward, the family planning center also has a specialized obstetrician-gynaecologist and a midwife. Most importantly, family planning services are integrated into the work and daily activities of all primary health care centers in the framework of the counselling centers for mothers and children in Albania (15, 16).

Since 2010, the Albanian government has fully funded contraceptive procurement for the public sector. The Ministry of Health and Social Protection finances the contraceptive procurement system, customs, transportation and storage, while family planning consultation is covered by the Compulsory Health Insurance Fund (17, 18).

In 1996, the Logistics Management Information System was established with the support of UNFPA and USAID that provided accurate and good quality data on the distribution of contraceptive products to the public system. In 2002, this system was introduced at a national level and computerized at the district level (including all 36 districts of Albania). In 2006, the Institute of Public Health was the main responsible institution for administering the Logistic Management Information System (LMIS), including the storage and distribution of modern contraceptive methods in all districts of the country. However, despite the importance of this logistic system, an accurate assessment of population trends in the prevalence levels of the use of modern contraceptive methods cannot be made (17).

According to a midterm review the strategy of contraception 2017-2021 several recent organizational changes in the MoH and districts have impacted on the coordination of the RH area. The Reproductive Health Sector in the MoH was restructured within in the new Directorate of Health Care. A full time person trained to cover contraceptive logistics and other aspects of family planning at district level would be desirable. Also, the capacity of the Institute of Public Health to coordinate the Contraception Logistics Management Information System (CLMIS) is perceived as insufficient, due to multiple tasks, staffing and financial issues. Limited funds for field trips and additional priorities lead to a low level of monitoring and supervision. In 2006 it was established by an order of the Minister of Health the Committee for Reproductive Health with the scope of work of the commission to include all issues related to the broader concept of the reproductive health, rather than just focus on contraceptive security and family planning. But the committee has not been gathered since 2012 until 2020 when the members got together to discuss on the technical group established through an order of minister to work on Revision of the Law on Reproductive Health (an initiative of ACPD).

According to the 2003 National Contraceptive Security Strategy, the Albanian government started step-by-step to cover the cost of purchasing contraceptives for public sector, while donor contributions decreased (17).

The main documents regarding sexual and reproductive health and family planning services in Albania are listed below:

- Strategic Document and Action Plan on Sexual and Reproductive Health for the period 2017-2021 (16);
- Law on “Reproductive Health”, Nr. 8876, Dated: 04-04-2002 (13);
- Law on “Termination of Pregnancy”, Nr. 8045, Dated: 07.12.1995 (14);
- National Contraceptive Security Strategy 2017-2021 (17);
- Clinical Practice Protocols on Family Planning for Health Care Providers, 2016 (18);
- Decree of the Council of Ministers, no. 201, Dated: 04.02.2015 “On the Approval of the Primary Health Care Services Package, funded by the Health Insurance Fund”. (18).

In Albania, since 1997, all family planning services provided free of charge in the public sector have been integrated into the health system at all three levels (primary, secondary and tertiary). In the public system, these services are provided in 426 family planning centers, including counselling centers for women, maternity hospitals and health centers at the communal level. In urban areas, family planning services, in addition to women’s counselling centers, are also provided in maternity hospitals, district and regional hospitals, and university hospitals (tertiary level - in Tirana only). While in rural areas, family planning services are provided in health centers and health posts (17).

With regard to contraceptive financing, most potential donors in the field of family planning have left Albania. Moreover, social marketing is facing many challenges due to financial instability and the private commercial sector is less interested in investing in family planning programs (12,17).

In these circumstances, the Ministry of Health and Social Protection, with the support of UNFPA, has begun efforts to adopt the concept of “Total Market Approach” for contraceptive security (17).

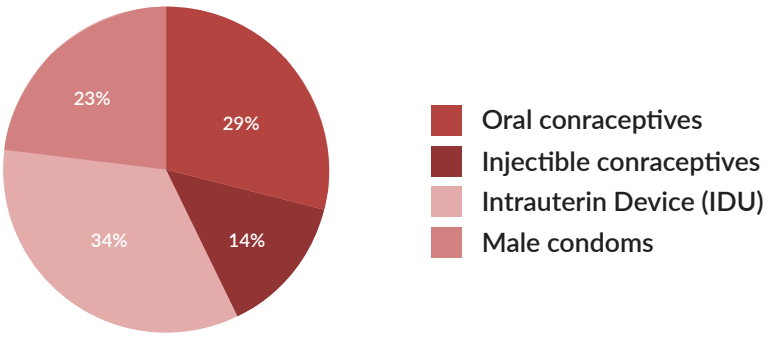
The non-profit private sector is represented by social marketing and NGOs. The only social marketing institution operating in Albania is NESMARK.

To promote the use of modern contraceptives, a series of communication campaigns were carried out, starting in 1999. These were funded by foreign or international agencies such as USAID and UNFPA

and implemented by both foreign and locally-based organizations, consultancy firms and other organizations. In addition to a media component aimed at creating awareness, these campaigns have trained health care providers, pharmacists and journalists, worked to ensure contraceptive security and implemented inter-personal communication interventions. Recently the Albanian Center for Population and Development (ACPD) and few local NGOs are the major civil society organizations providing family planning and reproductive health services and distributing contraceptives.

The main modern contraceptive methods used in the Albania include IUDs, pills, condoms and injections. According to the new National Contraceptive Security Strategy 2017-2021, the emergency contraceptive (Levonorgestrel) was introduced in 2019 in the basic family planning services package (17). The distribution of modern methods provided by the public health sector in Albania is shown in Figure 1. The intrauterine device remains the most used contraceptive method and the injectable contraceptive (Noristerat) remains the less used method.

Figure 1. Modern contraceptive use by method, public sector in Albania (IPH, 2018)

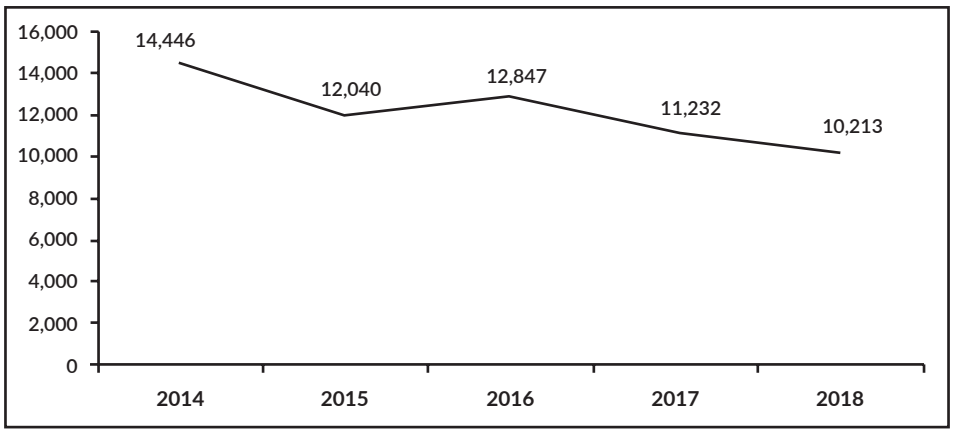


Currently, contraceptives are available in Albania from the following three sources: free (government-provided); subsidized prices (provided by social marketing programs); and at market prices (provided by the private sector) [17].

The public sector provides free contraceptives that are available at 426 public-sector family planning clinics in all districts of the country. There is a slight decrease in the number of FP clinics compared to 2011, where family planning services were provided in 431 counseling centers for women, maternities and health centers at the communal level (17).

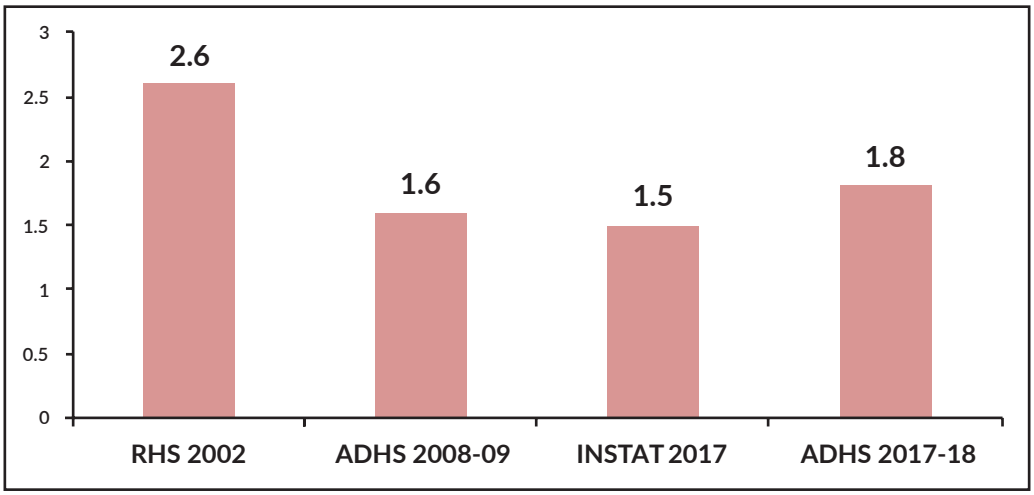
The LMIS data shows that the number of contraceptive consultations in the public sector has decreased since 2011, as well as the number of contraceptive users (10). Meanwhile the couple year protection (CYP) measured by the LMIS system showed a steady decrease, as shown in Figure 2. The CYP is a measure that estimates the protection from pregnancy provided by contraceptive methods during a one-year period. The CYP decreased by 29% from 2014 to 2018.

Figure 2. Couple year protection (CYP) in public sector of Albania, during 2014-2018, (IPH, 2018)



During the two last decades was observed a decrease in fertility rates and abortion rates, but a contradictory decreasing trend regarding the prevalence of use of modern contraception methods. The changes in fertility rate observed in Albania in the last two decades are presented below (Figure 3).

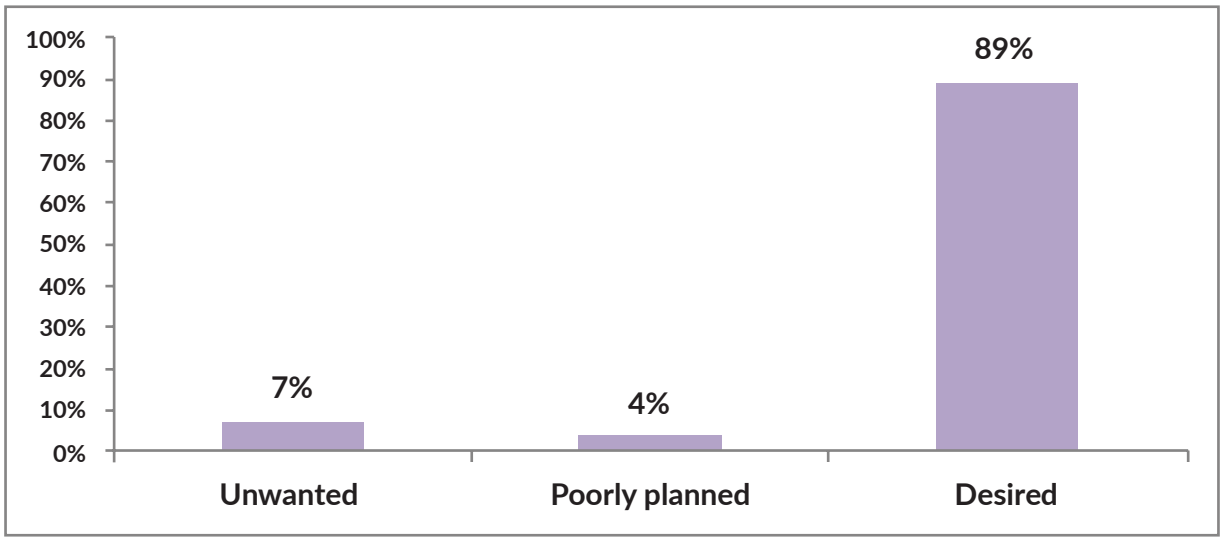
Figure 3. The fertility rate in Albania during 2002-2017



The total fertility rate is 1.8 children per woman, marking an increase from 1.6 children per woman in 2008-09 (9) but much lower compared to 2002 when it was 2.6 (9,19,20). According to the latest ADHS 2017-18, the average birth interval has increased to 50.7 months from 47.0 months in 2008-09 (9,20). The median age at first birth among women aged 25-49 in Albania is 23.8 years.

One issue of concern is the percentage of women aged 15-19 having started childbirth, which has increased to 3.5% in 2017-18 from 2.8% in 2008-09 (9,20). According to ADHS 2017-18, out of all births in the past 5 years and current pregnancies in Albania, 89% were unwanted at the time of conception, 4% were poorly planned, and 7% were unwanted (Figure 4). On average, women in Albania want almost the same number of children they currently have (ADHS 2017-18) [9].

Figure 4. The percentage of desired, poorly planned and unwanted pregnancies (ADHS 2017-18)



Still there are huge barriers that impede women, men, boys and girls to uptake family planning services. According to a study conducted in 2009 and published in 2012 the emerging barriers could be grouped into health care-related issues, socio-cultural issues and individual issues. Issues mentioned relating to health care had mainly to do with cost and availability of modern contraceptives (21). Authors stated that the attitudes of the public health care providers who offered contraceptive methods were often not supportive and sometimes avoided or refused to provide counselling and/or contraceptive methods to women (21). Also, authors stated that the main individual issues that influenced the use of modern contraceptive methods were fear of side effects, especially weight gain, infertility and cancer. Meanwhile the main socio-cultural issues that influenced the use of modern contraception were “the importance of virginity” and “being married and/or in a relationship” (21).

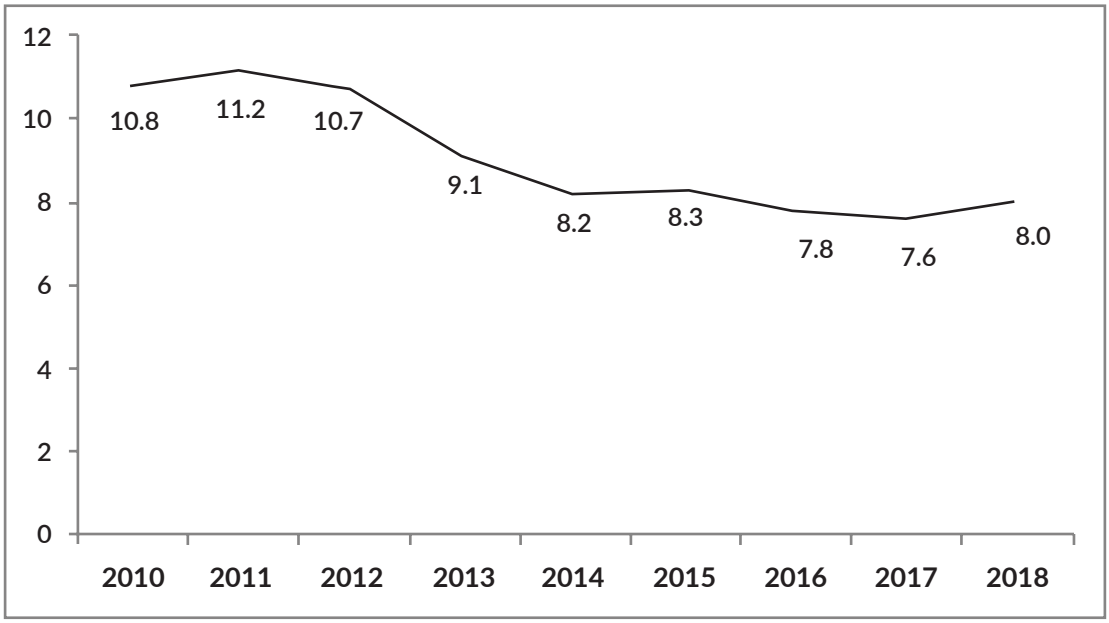
In 2013, yet another study revealed the barriers, knowledge, attitudes and practices about modern contraception among abortion clients in Tirana (22). This study didn't find evidence that health providers discourage family planning but they observed a higher number of tests and visits recommended for FP users after abortion than are suggested by WHO and a low frequency of contraceptive counselling for abortion clients, indicating outdated training information and lack of knowledge about effectiveness of modern contraceptive methods among health providers (22). According to this study, women's choices to use modern contraception were complex and more linked to concerns about the safety of contraceptives than to financial factors. Authors observed that negative perceptions about method effectiveness and safety, the extremely low frequency of contraceptive counselling for abortion clients; non supportive attitudes towards contraception among health care providers influence the low use of contraception among abortion clients in Tirana (22).

According to ADHS 2017-18, the main source of modern contraceptive methods is the private sector (56.1%) [9]. The main reason for discontinuation of all methods of contraception was the desire to become pregnant (42.3%), meanwhile the main reason for discontinuation of the pill method was the fear of side effects and health concerns (26.4%).

The total demand for family planning among currently married women decreased from 82% in 2008-09 to 61% in 2017-18 (9,20). Only 6% of demand is satisfied by modern methods. 15% of currently married women and 11% of all women have an unmet need for family planning. Unmet need for family planning slightly increased from 13% in 2008-09 to 15.1% 2017-18 (9,20).

The changes observed in the abortion rate in Albania in the past decade (since the establishment of the abortion surveillance system at the National Institute of Public Health in Tirana) are shown in Figure 5.

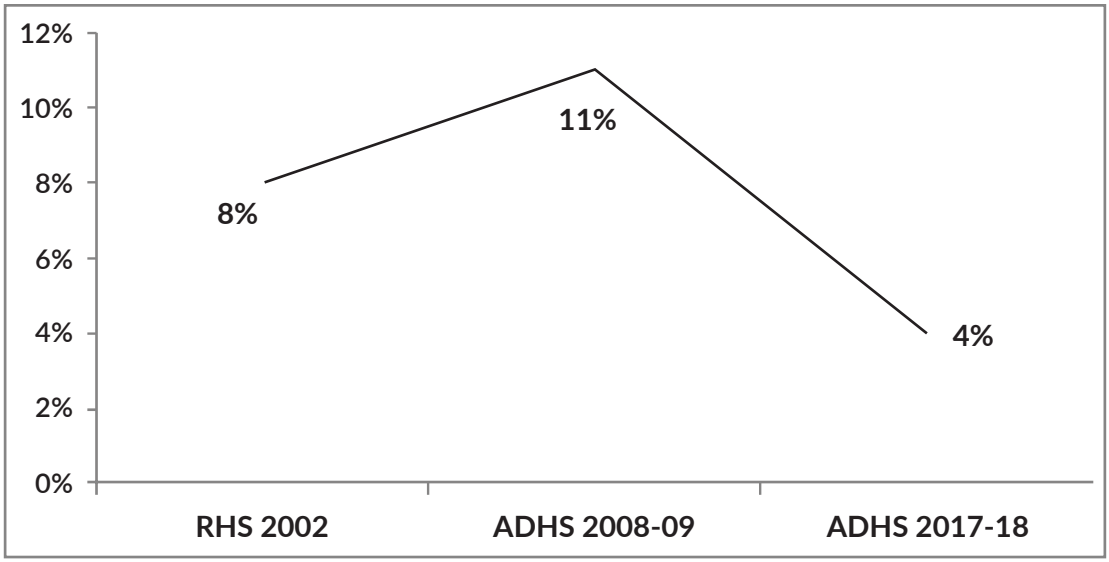
Figure 5. Abortion rate (per 1000 women 15-49) in Albania during 2010-2018 (IPH, 2018)



There is evidence of a gradual decrease in the abortion rate from 2010 to 2017, followed by a slight increase in 2018. The latest ADHS 2017-18 reported that 9.2% of all pregnancies in Albania (including women aged 15- 49 years old) resulted in abortions (9,10,23).

The changes observed in the prevalence of modern contraceptive methods in Albania in the last two decades are shown in Figure 6.

Figure 6. Prevalence of use of modern contraceptive methods in Albania during 2002-2018



As seen in the figure above, the use of modern contraception among currently married women has dropped from 11% in 2008-09 to 4% in 2017-18. But the family planning knowledge is almost universal in Albania, with 97% of all women and 96% of all men aged 15-49 years being familiar with at least one method (9).

Total family planning demand among currently married women has dropped from 82% in 2008-09 to 61% in 2017-18. Only 6% of the demand is met by modern methods (9). Regarding the unmet need for family planning, according to ADHS 2017-18, 15% of currently married women and 11% of all women have an unmet need for family planning. The unmet need for family planning increased from 2008 (20) to 2018 (9).

Recently, several meetings and trainings were held focusing on family planning services in Albania and the situation of modern contraceptive methods use and the functioning of the LMIS system. In the context of the restructuring and regionalization of the Primary Health Care Service in the country, the staff of the Institute of Public Health organized several meetings and training sessions in the main districts of the country with the main focus on introducing the new emergency contraceptive pill and addressing problems related to low use of modern contraceptives methods (10).

On the other hand, the latest study1 in Albania for the first time included a survey on the sexual violence and it found: 18.1% of women age 18-74 'ever' and 8.5% 'currently' experienced one or more of the six types of sexual harassment measured. Women who experienced sexual violence by their husbands/partners (27.1%) were nearly nine times more likely than women who did not experience sexual violence (3.1%) to report their husband/partner refused to use birth control or tried to stop them from using a method of birth control to avoid getting pregnant. The most common way that husbands/partners restricted women from using birth control was by means of psychological violence.

COVID-19 Pandemic and Family Planning

The COVID-19 pandemic is affecting the lives of people across the globe, as well as health, economic and social systems (24). This pandemic will also have a profound impact on access to family planning information and services, as well as sexual and reproductive health more broadly. Despite this

disruption, the need for family planning will not change. For women, family planning is critical, basic health care (24). As health systems shift to prevent and treat people with COVID-19, it is essential they also protect access to family planning services. The global health community now expects delays in production and shipping schedules (24).

The experience and evidence from prior outbreaks showed that this crisis could place a massive toll on women and girls. Stress, limited mobility and livelihood disruptions also increase women's and girls' vulnerability to gender-based violence and exploitation. And if health systems redirect resources away from sexual and reproductive health services, women's access to family planning, antenatal care and other critical services could suffer (25,26). Policymakers, providers and advocates must be aware of the broad links between the global outbreak response and sexual and reproductive health and rights in order to prepare to mitigate the impact (27).

A recent publication by the International Planned Parenthood Federation (IPPF) stated that the COVID-19 pandemic is having a major impact on the delivery of sexual and reproductive healthcare around the world, as many of static and mobile clinics and community-based care outlets have already closed because of the outbreak, across 64 countries (28).

Albania is also affected by COVID-19 pandemic. One of the impacts of isolation of the whole population and the change in the modality of working of primary health care centers (PHCC) is that women are not accessing the family planning services provided by PHCC (9th April until 15th May lockdown). The PHCC are offering online consultations addressing mainly the people with non-communicable diseases, the distribution of medicines for this category of people and offering online consultation and information regarding COVID-19. Up to now the provision of family planning services is interrupted. Some of the districts (local health care units) are reporting struggles to get hold of key commodities and supplies. Institute of Public Health is facing delays in moving goods within the country and therefore some of the districts are facing a shortage of contraceptives. The closure of family planning services and the lack of mobile units and community-based provision of modern contraceptive methods will likely have considerable consequences for women and girls; resulting in loss of health, autonomy and facing an even greater challenge in trying to take care of their own health and bodies (10).

Despite great contribution in providing a better picture regarding prevalence of contraceptive use and utilization of family planning services, majority of existing studies in Albania have been largely quantitative. In order to have a bigger picture, regarding opinions and needs of services users, qualitative studies are the best approaches to explore the preferences and needs of them regarding the access to services, availability of contraceptive methods and quality of care. To assess the quality of family planning services different models have developed and used by different researches based on the scope of their researchers, available tools and country context. The most common used models are the ones developed by Donebadian (29), Bruce and Jain (30-32), Creel at al. (33) and Murphy and Steel (34). Despite a few differences in their respective models, they all agree that factors that affect the quality of family planning can be categorized into three pillars: (1) availability of services, (2) structural factors and (3) process factors.

The objective of this study was to investigate the main factors contributing to low modern contraceptive use and utilization of family planning services, particularly among youth and women of reproductive age. A qualitative approach was employed regarding four quality-related elements: availability, quality of services and other supply related issues, coordination of the health system functioning to enable environment for FP/SRH/-seeking behaviour, and knowledge, attitudes and practices related modern contraceptive methods among young girls and boys and women of reproductive age.

At the time of the study, Albania is undergoing several and deep reforms in socio-health sector, in addition to problems caused by Covid-19 pandemic. Therefore, findings of this study will be good indicators that may help the government and interested parties to identify barriers more deeply, refine and implement innovative and culturally appropriate interventions to improve access to family planning and reproductive health services for all, particularly for those with unmet needs.

I. Materials and method

Study design

A cross-sectional study, combining a review of documentations and collection of qualitative data with key informants (in-depth interviews and Focus Group Discussions) was carried out in two regions where Albanian Centre for Population and Development (ACPD) works, respectively in Tirana and Vlore regions. Interviews were carried out at the public health facilities belonging to the Ministry of Health and Social Protection as well NGOs that provide family planning services. Quality of Family Planning services was analysed based on combination of models developed by Donebadian, Bruce and Jain, Creel at al. and Murphy and Steel. Despite a few differences in their respective models, they all agreed that factors that affect the quality of family planning can be categorized into three components: structure (infrastructure and equipment, management, availability of services, counselling), process (interpersonal and technical) and outcome (client satisfaction).

Sample selection

Selection of healthcare facilities: a purposive sampling approach was employed. In regions where study was carried out, two healthcare facilities per each region were selected, having an integrated balance in regards to population they serve (one urban and the other one in rural area). These included a variety of types of maternity hospitals, health centres, and health units managed by the government (public) or by nongovernmental organizations (NGOs).

Sampling of study participants were selected based on their experience with family planning services, aiming to collect information on development policies, key elements in the health-care system as well as explore key factors at the community level determining demand for Family Planning. As specified in the research proposal study participants were:

» Political decision-makers (central or technical directors/managers of the Ministry of Health and Social Protection and institutions responsible for family planning and reproductive health services);
» Managers of FP programs at both central and regional level;

» Healthcare providers who actually provided or directly involved in provision of family planning services (at both public and NGO sector), and
» Service users: women at reproductive health age and groups of men and young people.

The sample of service users (women of reproductive age) was opportunistic, meaning that clients were selected for observation as they arrived because there was no way to know how many eligible clients would attend the family planning services at the day of the survey. Whereas the sample of young people (boys/girls age 18-25 y/o) were selected among the group of peer educator/volunteers in the respective regions.

Inclusive criteria: to be a physician or a nurse who currently provides family planning services or some type of services such as: counselling, health education or consultation and provide informed consent.

Whereas for the service users the inclusive criteria included: live in the study area, be 18 -24 y.o for young boys/girls and be between 25-49 y.o for women on the day of interview, have satisfy knowledge and experience on contraception methods and FP services and consent to take part in the study.

Sample size included twenty stakeholders and ninety-one service users in order to accumulate as much evidence as possible regarding quality of services, health system environment for FP and contraception as well as perception and thought of direct beneficiaries (see Annex C: List of interviewed people).

Data collection and analyses

Data collection instruments: data collection process carried out during April – May 2020. Semi-structured interviews and FGDs guides were used to collect information based on the smixed model explained in the study design section, but was also tailored according to type of interviewers and participants, in order to collect the best information, we could.

Moreover, an evaluation of health care facilities was carried out employing an assessment grid in order to assess utilization and supply of FP services.

Data Analysis. Audio-recording of the semi-structures' interviews and FGDs were transcribed word to word/verbatim. These transcripts were used for detailed analysis. A thematic analysis approach was employed and the researchers read and reread all of the transcripts several times to be familiar with the data and to identify predetermined and emerging themes from the data.

Along with the manual analysis technique employed in the initial phase of data analysis, the codes were further refined, combined, and categorized to develop additional codes for a detailed analysis.

Ethical Considerations.

In the conformity with the ethical principles of the Helsinki Declaration for the medical research involving human subject, before the start of SII and FGDs, an oral informed consent form to all potential interviews was provided.

All of the study participants were briefed about the purpose of the study and their right to refuse to answer any question or withdraw from the semi-structured interviews (SII) or FGDs at any time. They were also informed that there is no "right" or "wrong" answer and kindly requested to express their opinions and thoughts freely. Furthermore, participants were informed that their names or any identification leading to them will be kept strictly confidential and that their names will not appear in any report or publication resulting from this study.

Audio-recordings and hard copies of the transcripts were kept under lock and key and subsequently will be destroyed in due time.

II. Results

Findings presented in this study reflect opinions and comments gathered from 20 Semi-Structured Interviews (SSI) with service providers/implements (14), key decision makers (6) and 8 FGDs with the participation of 91 participants (young people and women of reproductive age) from urban and rural health centres (Table 1).

Table 1: Type of respondents and number of SSIs and FGDs divided by location

Type of participants	SSIs (n=19)		FGDs (N= 8)		Total
	National 1	Regional	Urban	Rural	
Decision Makers	4	2			6
Service providers/Implementers	9	5			14
Young people (boys/girls age:14-24 y/o)			27	22	49
Women (age: 25-49 y/o)			22	20	42

Table 2 shows the characteristics of people interviewed. Twenty decision makers and service providers were reached from different public and non-public health agencies. A great majority of them belonged to the government agencies at national and regional level. Whereas the rest were family planning/reproductive health experts working for UN Agency (n=1), NGO sector (n=2) and social marketing (n=1).

Table 2: Decision makers and services providers divided by position and type of institution

Decision makers and service providers who were interviewed.		
Nr	**Position/Institution**	**Type**
1	General Director, Ministry of Health and Social Protection	Government
2	Chief of Health Promotion Department, Institute of Public Health	Government
3	Specialist, Health Promotion Department, Institute of Public Health	Government
4	LMIS specialist, Institute of Public Health	Government
5	Head of Sector, Regional Operatory for Health care (Tirana)	Government
6	Specialist, Regional Operatory for Health care (Vlore)	Government
7	Program analyst, UNFPA	UN Agency
8	Executive Director, Albanian Community Assist	NGO
9	Medical Coordinator, "STOP AIDS Association"	NGO
10	Service Providers at Family Planning/Reproductive Health Unit (n=6)	Government
11	Clinic Managers, Local Operatory for Health care (n=4)	Government
12	Service provider, NESMARK Albania, Social Marketing Agency.	Social Marketing

Table 3 data provides a larger picture of service users' characteristics reached during the eight focus group discussions conducted in both regions.

The average age of people who took part in the FGDs conducted with young girls/boys was 17.2 years old and for women of reproductive age was 32.5 years old. Overwhelming majority of participants in both groups were women (79.1%) and nearly one-third of them reported to be married at the day of interview. High level of education was seen among participants where 70.4% report to have attended/completed high school and 13.1% obtained a bachelor/university degree. Only 16.5% reported to have completed middle school and none of them stated to have no education at all.

Table 3: Characteristics of service users interviewed during Focus Group Discussions

Focus Group Discussions with service users (young girls/boys and women)			
Age	Average (years) for young people 14-24 y/o	17.2 y/o	
	Average (years) for Women 25-49 y/o	32.5 y/o	
Variable	Characteristics	Number (91)	%
Sex	Women	72	79.1
	Men	19	29.9
Education Level	Elementary School		
	Middle School	15	16.5
	High School	64	70.4
	University	12	13.1
	No Schooling		
Marital Status	Single	51	56
	Married	27	29.7
	Co-living	8	8.8
	Divorced	4	4.4
	Widowed	1	1.1
Main occupation	Home/Remunerated jobs	3	3.3
	Employed	19	20.8
	Unemployed	18	19.8
	Student	51	56.1
Area of residence	Urban	59	64.8
	Rural	32	35.2

Semi-structured interviews (SSIs) with decision makers and service providers

Decision makers

The SSI instrument for decision makers was composed by seven sections using the Policy Environment Score (PES) instrument1, which is meant to assess the current environment as well as year-to-year-changes in family planning and reproductive health services. This instrument has seven sections and covers items on political environment, policy formulation, organization structure, legal and regulatory framework, program resources and component, as well as Monitoring & Evaluation and research. Furthermore, they were asked to provide their perceptions regarding the access and key barriers of family planning services.

In general, all participants admitted that Albanian governments over the last two decades, has done a great progress and has instituted a series of laws and policies designed to enhance access to family planning services and commodities.

"The Ministry of Health and Social Protection (MoHSP) has intensified efforts and committed to supporting contraceptive security. We are working closely with national and international partners to ensure a lifetime supply of contraceptives for all Albanians who need them". – Decision makers, Government level.
"Nowadays there is a political willingness to support policy formulation and programs to ensure that all Albanian men and women can choose, obtain and use high-quality family planning services and contraceptives". – Decision makers, Government level.

Another decision maker at the regional level mentioned a long list of developed and updated documents and strategies in the field of family planning and reproductive health during the last decade, however concerns about their involvement and consultation in policy formulation and developing of such documents was raised. *"I receive regular update from the MoHSP about new developed/updated documents, however, we at the regional level never been invited to provide our insights during the development process. ….we are frontline workers and bring an extensive field experience, therefore our involvement needs to be considered in the future".* -Decision makers, Regional Level.

Lack of financial support of health's annual budget for the promotion of family planning was mentioned by almost all participants.

"It has been a long time since the last family planning campaign. We have capacities to develop and produce promotion materials, but have limited funds, therefore we often rely on donors' 'support".
Decision maker, Government level.

"We don't have a dedicated budget line for the promotion of family planning or modern contraceptive methods". – Decision makers, Regional level.

Organizational structure for the delivery of family planning services and reproductive health is well established. Nearly all of interviewed decision makers were aware of existing coordination mechanisms and several recent organizational changes in the MoHSP and districts, which according to them have improved the quality of healthcare services, including family planning as well. However, concerns about coordination among agencies, staff shortages/movement and limited funds particularly for Monitoring & Evaluation were mentioned by the large majority of interviewed people.

"There is a Reproductive Health Committee (RHC) composed by representatives of MoHSP institutions and other ministry of lines, as well as UN Agencies, that serves as a counselling body to the MoHSP. However, this committee doesn't meet frequently and partners from other ministry of lines do not provide their inputs regularly". – Decision maker, Government level.

The same concern regarding better coordination and partnership was also mentioned by a decision maker at regional level: *time has come for a better coordination between MoHSP and the Ministry of Education, Sport and Youth (MoESY) to find innovative ways to encourage young people to know and use more family planning services.* The same person also suggested that government should provide support for schools to hire as a consultant a family planning expert whose can organize free and open discussion with pupils and students about the benefits of using family planning services and also break the myths that exists against modern contraceptive methods.

The next group of question were related to program resources and sustainability, including specialized staff, available funds from national and international sources, as well as compliance with international standards. In general, all decision makers stated that during the last years the infrastructure and quality of healthcare services is being improved and have received continued support by the government and local health authorities. Though, they admitted the fact that despite good work and support by the government, lack of funds and programs by the international donors as well as lack of interest by the private sectors affects the quality of family planning services.

"…. it is evident that traditional potential donors in the field of family planning and reproductive and sexual health have phased out and no longer interested to invest in Albania. ..... this in turn has created a gap particularly in the field of promotion campaigns and training for healthcare providers". Decision maker, National Level

"Looks like private sector is not yet ready to invest in family planning and contraceptive methods, in addition to the financial instability of social marketing. This means that certain groups, particularly hard-to-reach population will remain outside of contraceptive coverage". Decision maker, UN Agency

Another issue that was mentioned by the large majority of participants was the need to organize frequent trainings. Even though staff shortage is no longer an issue, yet majority of staff working in the family planning services has not received adequate training on family planning and modern contraception. According to one of decision makers at regional level *"…limited access to training can prevent healthcare providers improve their skills and minimize their ability to routinely offer high-quality family planning services".*

Some of them also mentioned the idea to redesign the model of youth-friendly services and establish the concept of "satellite and/or outreach programs" in areas where healthcare or family planning centres are hard to be reached or in communities with overrepresentation of vulnerable groups. Integration of HIV/STI services into existing infrastructure were also mentioned by a few of them.
The last sets of questions were related to Monitoring and Evaluation and possible needs that may arise during Covid-19 pandemic.

The National Contraceptive Security Strategy has a full section regarding the M&E plan and all healthcare institutions providing family planning services must comply with it. In addition, the Logistic Management Information System (LMIS) is in place and managed by the IPH. Nevertheless, some problems with data collection and M&E were reported. In her testimony, one of the interviewees suggested as follow: *to my point of view, institutions that provide family planning services and contraception should have a full-time staff dedicated to family planning logistics and also trained in data collection, reporting and on the use of LMIS".* – Decision maker, National Level. Another perception mentioned by majority of interviewees was regarding the M&E technical capacities at local levels, which is perceived as insufficient and run by people with low experience in M&E. The following discourse from a decision maker at national level describes the need that Healthcare Centres at local level should have a dedicated specialist/officer trained in M&E and reporting: *"Family Planning data should be gathered periodically on performance through liaison officers at the relevant entities. Its role should be to collates, analyses, and disseminates family planning data for reporting".*

When asked about Covid-19 pandemic whether this situation may have affected the quality or utilization of family planning services, almost all of them mentioned that it is too early to give a perception regarding the impact of the epidemic, however they agreed that such services needs to be tailored to copy with problems that may arise from Covid-19 pandemic.

Service providers

Responses were collected from fourteen (14) providers: nine (9) of them were working in family planning services in urban area and the rest (5) in rural ones. Questions in this section covered issues on: structure (infrastructure and equipment, management, availability of services, counselling), process (interpersonal and technical) and outcome (client satisfaction). More information about research instruments can be found at Annex A.

The first group of questions were related to the current infrastructure and equipment of family planning services. In general, to determine the suitability or to insert a modern contraceptive method may need a patient examination, which in turn requires adequate level of infection control, physical infrastructure, medical equipment and consumables. In that regard, service providers were asked to provide their opinion about the physical infrastructure and examination room equipment at their working place.

A vast majority of them (12 out of 14) stated that physical infrastructure in their health facility is appropriate having available the basic amenities such as electricity, water and working toilet. However, nearly two-third of them mentioned lack of toilet, insufficient quantity of seats and small waiting area for clients.

“Currently, the healthcare centre where I work has been renovated and now, we have better conditions. However, there is one toilet for us [healthcare providers] and none for clients”. – Nurse, Rural Health Centre.

“The waiting area for clients is small, noisy and often overcrowded with clients from other services. …..they [clients] often argue with each other about the queue and in many cases we have to deal with that problem. This is waste of time for us [service providers]”. Doctor, Urban Health Centre.

The same satisfaction level was noted about the medical equipment and consumables, where majority of them listed the basic items (table and/or stool for ob/gyn examination, source of light, water for hand-washing, non-latex disposable gloves, clean boxes, sharp box and privacy in the exam room). These items are more present in maternity and urban family planning centres.

"This is a rural family planning healthcare centre and we provide basic examinations, however, the most needed equipment's are available". – Nurse, Rural Health Centre.

"I work in maternity, and of course we provide more specialized examinations, therefore we have better conditions [medical equipment and consumables] compared with other healthcare centers, either in urban or rural area". – Doctor, Regional Maternity.

However, nearly all of them mentioned that the most often lacking items are one-single use towels, decontamination solutions and latex examination gloves. Therefore, concerns about infection controls during pelvic examinations by not using disposable gloves were raised by service providers.

» **Management and administrative issues**

Supporting quality of family planning requires development and implementation of different management practices, such as documentations and records, staff supervision and development. Therefore, questions in this rubric aimed to explore service providers opinion regarding management and administrative practices, quality assurance and supervision.

Facility documentation and records

A system for reviewing management and administration issues was reported by all participants. The most often reported system was client register (hand written and electronic one). Variables recorded in this system include clients 'data, method use, type of visit (first and follow-up) and referrals. However, the up-to-date registers (within the past seven days) were reported by only public service providers. NGO representatives testified that they have almost similar management and administrative system to collect and report data, but not an up-to-date one. This is justified with the frequency of given services.

"The main scope of our work is not provision of family planning services or modern contraceptive methods. We provide such services in adjunct to other prevention services for People Who Inject Drugs". Doctor, NGO sectors, Urban area.

Lack of a well-developed system to collect client's opinion was mentioned by nearly two-third of interviewed people. Several participants noted that there is a ballot box that collects client's opinion and at the end of the month the supervisor is supposed to collect and address client' suggestions and

needs. Nevertheless, participants belonging to public sectors were not aware about the process of analysing and addressing clients' needs.

"As far as I know, the manager collects patients' complaints/suggestions at the end of each month, but not sure what happens aftermath". – Doctor, Urban Health Center.

"We are a small family planning unit and we know what type of concerns our clients have. Therefore, needless to have a complaint box". – Nurse, Rural Health Center.

Quality assurance and supervision

Quality Assurance (QA) is a management method that is defined as "all those planned and systematic actions needed to provide adequate confidence that a product, service or result will satisfy given requirements for quality and be fit for use".

Quality assurance seemed to be a confusion terminology for majority of services providers from the public sectors, who's in majority of cases confuse it with supervision or monitoring visits from supervisors. Therefore, in their testimonies they pretend that quality of services given by them is adequate as always, they reach yearly family planning indicators and according to them clients are satisfied.

"To my point of view, the quality of family services given at the healthcare facility where I work, is satisfied, because we reach the yearly family planning indicators and clients return every time, they need such services". – Doctor, Urban Health Center.

However, they all agreed that they lack knowledge and training skills regarding the development of quality assurance programs and respective activities. Appointing a quality assurance manager was considered as necessity.

To address the poor-quality of services, strengthening staff supervision would help them to promote adherence to standards and to identify problems that affect the quality of care. It is interesting to note that a vast majority of providers testified that supervision of family planning services is common

and participants stated that during the last 6-months they have been supervised at least once, either by their supervisor or other health authorities.

"…. of course, we undergo periodic supervision visits, starting from checking the register clients 'book, number of served clients and distributed methods". – Nurse, Rural Health Center.

However, only a minority of service providers believed that periodic supervision would help improve the quality of care provided. On the other hand, the vast majority of interviewed service providers do not feel that supervision without addressing issues found during such visits can help improve the quality of care. This finding suggests that a careful examination of the effectiveness of supervisory systems in the public and private sectors needs to be further explored and addressed.

Good-quality reproductive health care requires a continuous supply of contraceptives and other commodities. Family planning providers are the most important link in the contraceptive supply chain that moves commodities from the manufacturer to the client. Therefore, questions in this section were related to stock inventory, organized by expiry date and whether or not contraceptives are stored in a protected place from water, sun and pests.

Family planning commodity security was reportedly ensured through LMIS, data planning at national and regional level and a supply chain management. As specified by majority of participants, stock inventory is kept using recording contraceptive forms and books each time contraceptives are delivered to the facility.

"Every week we count the amount of each method on hand in the clinic and determine the quantity of contraceptives to order". – Nurse, Urban Health Center

Nevertheless, a great majority of them were not aware about storage conditions and none of them had received any training in terms of managing pharmaceutical products and stock inventory. They also stated there is another person in charge who liaison with Regional Operatory for Health and takes care of inventory and storage process.

"There is a storage room for contraceptives and a person in-charge for contraceptive logistic. We just

receive the ordered contraceptive supplies from the specialist responsible for mother and child health or other appropriate person in the supply chain, but we don't do the management of the stock of supplies". – Nurse, Regional Health Center.

However, nearly half of them stated that they don't have a full-time trained specialist to cover contraceptive logistics and other aspects of family planning.

Availability of family planning services

Availability refers to the extent to which a system provides facilities and health care services that meet the needs of people. We assessed the availability of family planning services through a review of: frequency of services, availability of providers, family planning methods offered and provision of other reproductive health services.

Family planning services are offered six days per week by all public health facilities, except NGOs that offer such services closed to 20 hours per week.

Availability of service providers was defined as the presence of at least one provider at the facility in a given month. In that regard, the following information was collected: number of health professionals engaged and trained in family planning service provision, and frequency of provider-led education sessions on family planning.

The availability of service provider was satisfied and admitted by nearly all participants (12 out of 14) who said that at least a trained health provider is always present at the family planning services. In majority of cases a doctor and a nurse/midwife were always engaged in family planning service provision, while in the rural health centers this service was mostly covered by a trained nurse/midwife and a general physician whose in the meantime is the health center manager as well.

"An ob-gyn and a nurse are available six days per week and engaged in provision of family planning services". – Doctor, Urban Health Center.

".. A trained midwife is also responsible for provision of family planning services, in addition to other duties". – Nurse, Rural Health Center.

However, they suggested that additional staff (paramedical, psychologist and other support staff) needs to be employed in order to provide a comprehensive and continuous care for family planning users.

"Family planning is a complex issue and therefore a multidisciplinary staff need to be part of this service in order to ensure a continuous and follow-up care for those who use family planning and reproductive health-care services". – Doctor, Urban Health Center.

Competence of service providers: most of them feel confident in providing family planning services (advice, counselling or referrals). However, lack of up-to-date training among service providers was prevalent and considered as barrier. In general, all participants admitted that they have been trained in family planning and reproductive/sexual health issues, but none of them reported to have been trained during the last 12-months or even more. Additionally, none of them reported to have received in-service trainings on topics related to family planning services, management of modern contraception methods, counselling and new technologies.

"I have attended a series of certified training in family planning and modern contraceptive organized by USAID funded programs. But my last family planning training dates back to 2010". – Doctor, Urban Health Center.

Even though they were aware about importance of training as a tool that improves quality of care, it was interestingly to note that majority of service providers were suspicious about future opportunities for trainings in family planning or reproductive and sexual health. Their impression was based on experience where the same person is chosen always to attend different type of trainings or providers attend trainings just to fulfil the number of required credits to renew the health professional licence.
"Trainings or workshops in family planning are rare, but when organized the health center manager delegate always the same person to attend the training. We never receive training materials or what has been discussed there". – Nurse, Urban Health Center.
"Not everyone is interested to attend trainings in family planning. Mostly attend trainings to accomplish the number of required credits to renew the professional licence rather than to expand their knowledge and skills on family planning". Doctor, Rural Health Center.

To address this problem, they suggested organization of a series of accredited trainings as part of continuing medical education.

Participants agreed that lack of participation in up-to-date trainings, workshop and conferences affect the quality of care and services given to clients, as it strongly related with lack of new knowledges, practice recommendations and application of evidence-based approaches.

"I haven't received training to insert long-term contraceptive methods [IUD] and we also do not provide here; therefore, I either refer clients to maternity [women health center] or suggest them to use another contraceptive method that I feel confident as well as is available at our facility". – Doctor, Urban Health Center.

Availability of contraceptive products in centers providing FP services is defined as the availability of contraceptives in a given month. The best method to meet the client needs is that a facility has to offer all methods of family planning. The following contraceptive methods were examined for availability: (a) male condoms, (b) oral contraceptives, (c) intra-uterine device (IUD), (d) injectables, (e) emergency contraception ("the morning after pill") and (f) implant contraceptives.

Public health facilities provide free of charge modern contraceptive methods, where the most common available ones were male condoms, oral contraceptives and injectables. Intrauterine Devices (IUD) were present only at women center at both tertiary/university and regional maternities. Female condoms and Implants were practically non-existent in all visited facilities.

The partnership between the public and community sector seem to be not formalized. The presence and level of involvement of community-based organizations (CBO) promoting family planning services is limited and mainly focused in main urban areas. Interviewed CBO representatives mentioned they provide mostly male condoms as part of HIV/STI prevention. Hence, promoting family planning services and contraceptive methods it's not their main activity but a secondary one.
"We mostly focus on promotion and distribution of male condoms, as a method that provides dual protection, either for HIV/STI and as a family planning method that prevent unwanted pregnancies". – Nurse, CBO representative.

However, it should be noted that there is an interest among CBO representatives to find ways to increase the partnership with public health sector, particularly in terms of distributing modern contraceptive methods available at public health centers to their population they serve.

"We have a cadre of trained health care workers who are every day in the field providing counselling and advice on prevention of HIV/STIs and unwanted pregnancies. If we formalize a partnership with public health centers, our team could make a great job in promoting family planning services as well as distribution of modern contraceptive methods". CBO representative, Urban area.

The representative from the social marketing agency (NESMARK) stated his agency also provides oral contraceptives at subsidized price. However, currently there are facing financial barriers which in turn affects the quality of modern contraception method's market.

Concerns about frequent delays in provision of modern contraceptive methods or stock-out contraceptive methods and supplies for certain weeks was commonly mentioned as a barrier by majority of providers. The length of stock-out varied from one month up to three months. According to them, such barriers come as a result of poor coordination between Regional Health Operatory and Institute of Public Health as well as poor planning in advance of contraceptive stock by health center managers/supervisors.

"Last year, due to some bureaucracy problems, we were out of stock for a good couple of weeks. Therefore, a lot of contraceptive users were not served and we advised them either to wait or find they preferred method at the private sector. I know my clients and I bet, that none of them has gone to find their methods in the private pharmacies". – Nurse, Rural Health Center.

Additionally, none of the visited health-care centers have established stock of modern contraceptive methods as part of emergency situations or natural disasters. Nearly half of them mentioned that lack of modern contraceptive methods is also related with loss of potentially family planning clients and also put them at higher risk for unwanted pregnancy and STIs.

Suggestion to hire a full- time trained nurse to cover contraceptive logistics and other aspects of family planning was also mentioned by service providers working in the public sector.

However, despite availability of several modern contraception methods, utilization of family planning services and particularly use of modern contraceptive methods was found to be low. Several barriers where mentioned by study participants where the most common ones were:
a) a "climate of fear" about side effects of contraceptive methods;
b) Lack of fit between available and preferred contraceptive methods (inverse availability);
c) societal factors, such reliance on withdrawal and partners refusal and e) affordability and lack of market segmentation.

"The fear of side effects was by far the most dominant attitude expressed by the women, such as sterility, health grow in the face or other health negative consequences". – Doctor, Urban Health Center.

"It looks like young people are lazier now and need either a short-term solution [emergency contraception] or to use a long-term contraceptive method, such as implants. We don't insert neither IUD or implant, only maternities do". Nurse, Urban Health Center.

"A limited range of modern contraceptive methods can be found even in the private sector. Thus, contraceptive users are left with no many options". – Doctor, Rural Health Center.

"Family planning is still a male issue. Still, it is the husband/partner who decides whether or not and dictates what contraceptive her wife/partner to use". – Nurse, Rural Health Center.
"There are two sources to obtain contraceptive methods: public and private sector. Of course, the price [contraceptive methods] is higher and not everyone can afford it. We used to have Nesmark [social marketing agency] before that provided several contraceptive methods at a reasonable price". Doctor, Urban Health Center.

Service providers highlighted that these long-standing barriers cannot be addressed without commitment and support of politicians, media and influential people.

"People change their behaviour if they are influenced by or have a positive model. It is like fashion, where people try to mimic and follow the gesture of a singer or a known public figure. The same way should be followed to encourage people to defeat the fear and use family planning services". Doctor, Urban Health Center.

Family planning clients are at risk for contracting and transmitting sexually transmitted infections, because they are sexually active. Therefore, provision of additional information, diagnose and treatment is an essential factor to increase the quality of care of family planning services. Responses gathered from study participants showed that STI and HIV/AIDS services are not integrated with the family ones and clients are referred to other specialised services within the same facility or partner institutions.

"At this facility we provide only basic lab urine and blood tests. HIV/STI testing can be conducted at Voluntary Counselling and Testing (VCT) center and we refer clients to go there. This is the Achille's heel, which means this is the point where we lost contacts and trust with our clients". – Doctor, Urban Health Center.

» **Policy, regulations and guidelines ensuring the quality of Family Planning services**

Even though in limited copies, the presence of up-to-date national policies, protocols and guidelines for family planning services and counselling were reported by all service providers. However, number of visual aids for demonstrating use of family planning methods at facility is almost lacking.

"Visual aids and other promotion materials have been provided by international programs or NGOs working in the field. We don't have internal funds to design and produce nice and colourful promotion materials and visual aids". – Doctor, Regional Maternity.

"We have a few leaflets donated by a local NGO that talks in general about benefits of utilization of family planning services". Doctor, - Urban Health Center.

Lack of interest to invest in family planning programs was noted by NGO representative who stated that no longer have dedicated funds to fully implement family planning programs.

"Family Planning is no longer a sexy topic for many donors. Family planning services we currently provide are part of the prevention and harm reduction package for vulnerable groups". – Doctor, NGO representative. Counselling on how to use the method, management of possible side effects and when a client should return for a follow-up visits must be carried out either with the new contraceptive user or a continuing one. In that regard, service providers admitted that in general family planning services are given under conditions of both visual and auditory privacy. However, overwhelming majority of them (12 out of 14) mentioned that their health-care facility doesn't have an adequate counselling room that guarantee clients' confidentiality.

"We do our best to provide a confidential counselling, but current infrastructure conditions don't allow us to give it as it should be". – Nurse, Urban Health Center.

"We are a rural health center and family planning services are provided in small room, shared with another provider. Therefore, counselling sessions are short and covering the most basic issues, such as how to use the choice method and manage possible side effects during the first days". – Nurse, Rural Health Center. Waiting time that a client had to wait before being examined by a provider was reported to be between 10-30 minutes. In majority of cases, service providers mentioned that no prior appointment is needed for a family planning client.

"We usually don't require appointment or ask too many bureaucracy papers for a family planning client. She has come to the facility and to respect the queue like other clients". – Nurse, Urban Health Center.

Individual cards or records for family planning clients are important for monitoring a client over time and for ensuring continuity of care. The presence of family planning individual client card was common and mentioned by all public service providers, who stated that client card is reviewed before or during consultations with clients. Client concerns are also recorded and entered to the patient card/medical file. NGO representatives also reported to have a client card but this is not specifically for family planning services, but includes data for other services as well.

Client assessment

A system of collecting and recording client's data (hand-writing and electronic version) is in place and service providers feel confident using it. Data about age, number of living children, last delivery date, history of complications, pregnancy status, desire for more children, desired timing of birth of next child, breastfeeding status, regularity of menstrual cycle are recorded during the first visit and updated during the continuing one.

Physical examinations and injectable procedures are being carried out following the national standards and protocols. Even though, breast examination was promoted as an early detection and prevention measure for breast cancer, just a few service providers mentioned that they taught client how to conduct breast self-examination.

Family planning services and Covid-19 pandemic

As in many countries throughout the world, the COVID-19 pandemic has caused tremendous disturbance to health systems, including disrupting access to family planning information and services, as well as sexual and reproductive health more broadly. Major attention has been to cope with the pandemic and government are prioritizing funds to prevent and treat people with Covid-19. However, despite the pandemic and lockdown the need for family planning remains the same.

Service providers were asked to provide their opinions regarding current situation and how the Covid-19 might have affected the quality of care and utilization of family planning services in their respective facilities and beyond.

Lock-down for a few months seem to have affected the utilization of family planning services as the number of users has dropped intensely. This in turn, has left out many clients without receiving their preferred family planning methods and clients may be prone of unintended pregnancies, STIs or other side effects that come from disruption of contraceptive methods.

If women, girls and marginalized communities cannot access contraceptive care in this crisis, we can expect to see a rise in unintended and forced pregnancies, an increase in sexually transmitted infections, including HIV, and, ultimately, a sharp rise in unsafe abortions.

However, they all agreed that this is a new situation and needs to be further explored.

III. Focus group discussions with young people and women of reproductive age

This section summarizes key findings from FGDs conducted with young people and women of reproductive age. The following themes and subthemes (refer to the methodology section) were identified and used for thematic analysis of data. The detailed findings are presented as follow:

Awareness of family planning services and contraceptive methods.

Questions in this rubric aimed to explore participants' knowledge and awareness towards family planning services and contraceptive methods. They were asked if they are aware of any family planning services in their area or residence or region and whether they have heard about contraception or modern contraception methods. Knowledge about contraception methods was nearly universal and an overwhelming majority of them were aware of the availability of family planning services in their area. Almost all participants had knowledge of at least one modern contraceptive method, which was condom and perceived as a dual protection method against unwanted pregnancies and sexually transmitted infections.

"Everybody knows what condom and pills [oral contraceptives] serves and where to find it. Nowadays its easier because different type of condoms can be found even in shopping centres" – Young boy, FGD with students, urban area.

Nearly 80% knew at least three modern contraceptive methods and the most common methods known were condoms, pills and emergency contraception. Their level of knowledge dropped significantly down when asked about long-term methods, such as IUD, Implants and injectables. Some of them were aware about Standard Day Method (SDM) but confused how this method works. Word of mouth and friends were the main source of information on family for the large majority of focus group participants. According to them, this source of information was the most reliable and immediate one.

"We live in a small world, so if anything knew comes around, we will share it with each other". – Young mother, FGDs with women, rural area.

The second most common sources of information about family planning and contraception was school, social media/internet and health workers. School and social media is the most common

source of information for young people. However, concerns about quality of information given at school was mentioned by nearly half of participants who stated even though school curricula include some subjects on reproductive health, yet this information is perceived as insufficient. A young girl from focus group discussions in urban area summarized her opinion as follow:

"I barely remember some information about sexual health during the school and also some free and open discussions about modern contraception with the nurse school. The rest of information, I gained either from friends or social media".

On the other hand, women of reproductive age and particularly those with pregnancy history stated that even though word of mouth and social media seems to be an immediate source of information regarding family planning and contraception methods, yet they consider receiving information by health providers as the most reliable and credible source.

"… it is true that we have too many sources where to be informed about contraceptive methods. However, when I truly decided to rely on contraceptive methods after a painful abortion, definitely I went to see the doctor". Married women, FGD with women, Urban area.

Despite the fact of having different sources of information, a large majority of participants favoured the idea that family planning and contraception should be taught in the school as part of normal education curricula.

Attitudes towards family planning and modern contraceptive methods

In order to increase contraceptive use and to address unmet needs, it is critical people's attitude towards family planning. In this regard, this study was interested on ascertaining attitudes of young people and women of reproductive age toward family planning services and use of modern contraception.

The vast majority of respondents at both groups correctly indicated advantages and benefits of family planning as means for prevention of unplanned/unintended pregnancies, child spacing, improving maternal health and STI control. Benefits of family well-being and improving social and economic factors were also cited by both groups.

However, obstacles to the use of modern contraceptive methods seemed to be dominated by fear of side effects, misconceptions and cultural influences.

Fear of side effects (health problems, bleeding, sterility, etc) from contraceptive products was prevalent, as a bare majority of them have had bad experiences. In addition, a large majority of FGD participants mentioned of hearing from others that long-term use of pills or other methods could cause cervical cancer, infertility, etc.

"I used to use pills a few years ago. I experienced bleeding, cramps and generally speaking I could say, I was totally discomfort". – Married woman, FGD with women, urban area.

Misconceptions were noted about use of other methods such as emergency contraception and injectables as methods that prevent from getting STIs. Nevertheless, an overwhelming majority of participants were interested to learn more about modern contraception.

"It would be of particular interest for youth whether a specialized health provider in family planning talks with us about sexual health and modern contraception in school. In the classroom, boys and girls study together and discussing openly such sensitive topics will help us break barriers and prejudice regarding family planning and modern [contraceptive] methods". Young girl, FGD with students, rural area.

Husband/Relatives Disapproval

The large majority of women of reproductive age indicated that despite the fact that they have positive attitudes toward family planning and do believe that use of modern contraceptive methods should be a joint responsibility, yet there are some barriers such as gender or social norms that influence contraceptive decision making. For instance, there is the male partner/husbands who mostly dictates whether to start using a contraceptive method and which one as well. *"I know a lot of friends who have had too many abortions and still don't use modern contraceptive methods, but just rely on withdrawal as their husbands don't want to use any modern method".* Married women, FGD with women. Rural area.

There is a positive fact, that a vast majority of study participants considered couple disagreement of use of family planning as a factor that may hinder uptake of modern contraceptive methods among married women.

A driver to infidelity

Another opinion mentioned in all focus groups was that use of family planning services is a trigger or jumping to prostitution and infidelity. Nearly two-third of women and young boys/girls also mentioned that it is hard to talk and discuss openly with husbands, parents or family relatives on use of modern contraception. The following testimony, too, affirms the fact that talking about family planning with family members it's not that easy.

"I believe that my parents are cool, but still I don't feel comfortable talking with my father about sexual health and family planning. Even my parents themselves don't talk about such topics in front of us [children]". Young female student, FGD with young people, Urban area.

» **Policy, regulations and guidelines ensuring the quality of Family Planning services**

Questions in this section aimed to explore service users' perception regarding modern contraception and family planning services. Queries about access, availability and barriers were explored.

Access to family planning services

Generally speaking, accessibility is related with the geographic location of patient to the location of facilities. Factors, such as physical accessibility, spatial distance, travel time, mode of transportation may inhibit the use of services, by the groups who experience difficulties in mobilizing the practical resources required to access distant services.

About two-thirds of women participants indicated that they could easily access family planning services and that services were available to most of them. Geographical accessibility was not perceived as a barrier to access family planning services. There was also a wide range of responses regarding the travel time, which varied from a few minutes to a maximum of 30 minutes. Nearly half of participants considering distance and travel time as normal. The vast majority of participants mentioned that such services could be reached by foot or by public transportations.

However, around one-third of them indicated that distance/travel time was far and considered a hindrance to the use of family planning services, particularly for women from rural area were the availability of such services is limited. The same concern was mentioned for Roma/Egyptian

community who resides in urban outskirts and have hard time to travel to the nearest facility. *"I used to use injectable contraceptive and every two months had to go to the maternity ward. I had to spend a few hours for a round trip in addition to the time I spent to see a doctor".* Married woman, FGD with women of reproductive age. Rural area.

Concerns about the operation hours and quality of services were raised by young people. The large majority of them mentioned that existing family planning services doesn't meet the needs of young people and are not designed in the way to motivate them to use such services. Nearly two-third of them regarded the hours of service operation as non-convenient. This in turn, according to them hinder utilization of family planning services and use of modern contraception methods by youngsters. *"The way family planning services operates seem to be more oriented for women who wants to get pregnant or manage birth space. I went once to a family planning service at my neighbourhood and saw only pregnant women with their mothers-in-law or husbands. Didn't feel comfortable at all and then left the facility".* Young boy, FGD with young people. Urban area.

Lack of youth-friendly services was also mentioned and their opening was considered as necessity to motivate young people to learn about sexual health and utilize family planning services.

It is worth noted to mentioned, that vast majority of FGD participants appreciated the easiness to get an appointment with a health provider, which according to them is driven factor to use family planning services. According to them, there is no need to get an appointment with a family planning provider because you can see a doctor within the same day. The large majority of them stated that in case they need to see a provider they just call him/her and set up an appointment. *"I don't need to get an appointment in advance or spent hours to see a doctor. Just walk in the health centre and wait to see the doctor. There is no long queue of people at the family planning services, hence in less than 30 minutes I am done".* Young woman, FGD with women, Urban area.

"In my area of residence, we don't have a family planning doctor, just two nurses and one midwife. I call them and ask for an appointment and that's it". Married woman, FGD with women, Rural area.

Health care facility Setup

The most important aspect of effective family planning counselling is cantering the interaction and discussions on the needs and desires of each client. Family planning counselling should be private and confidential.

Lack of sufficient space or counselling rooms for the provision of family planning services was noted as one of the barriers by majority of participants. Nearly all of them who have had experiences with the use of family planning services mentioned it is common in health facilities that the space or room for the provision of family planning is small and not offering privacy This can make it really difficult to find a place where privacy and confidentiality can be maintained.

"Even though the health centre at my neighbourhood has been recently renovated, provision of family planning services is being given again at the same small room". - Young mother, Rural area.

"There is no space for confidential counselling on the use of modern contraceptive methods. The doctor gives you some short information in front of other colleagues and clients. This is embarrassing to me". - Married woman, Rural area.

Availability of contraception and promotion of family planning services

Ensuring access to preferred contraceptive methods for women and couples and promotion of family planning is essential to securing the well-being and autonomy of women, while supporting the health and development of communities.

Even though the aim of questions in this rubric was not to assess the contraceptive prevalence among study participants, they were asked to express their opinions regarding the availability of contraceptive and family planning services.

Majority of participants from the women group revealed an interesting fact about inverse ability. More concretely, concern about shortage or reduced variety of preferred methods along with the availability of least desired methods.

"I have no choices to choose my preferred method and brand. Either I have to use what they give me [health providers] or stop using the contraceptive method". – Young woman, FGD with women, Rural area.

"Once I gave birth to the third child, I was strongly advised to undergo female sterilisation instead of injection [injectable contraceptive] or apparat [IUD]. The reason was simple: no such methods at the commune health center". – Married woman, Rural area.

The counselling provided by Family Planning providers play a key role in the FP uptake and continuation and is essential for ensuring informed and voluntary decision making. Therefore, participants were asked to share their opinions whether they have been counselled and informed by Family Planning healthcare providers regarding benefits and possible side effects of modern contraceptive methods. During FGDs with women of reproductive age, the large majority of them indicated that have been informed and counselled by healthcare providers mostly about pregnancy and breast feeding and to a lesser degree on the use of contraceptive methods.

"I have been regularly informed and counselled by the ob-gyn on the pregnancy care, but not much about the contraceptive methods. To be honest, I wasn't myself interested either". Married woman, FGD with women, urban area.

Whereas discussions with young people revealed lack of their interest to be informed and counselled about contraceptive methods. *"Why do I have to go to see a doctor to be informed about contraceptive methods. Just navigate the internet sites and within seconds you have the right information you require".* – Young boy, urban area. Another girl from the same group supported her friend by affirming the fear of being identified as user of family planning and possible prejudices by family members or community. *"If I go to the health center and require contraceptive methods, the doctor will call my mom and say that I was there and asked for contraceptives".* Young girls, rural area.

It is interesting to note, that bare majority of young people mentioned that they have been informed that doctors recommend using contraceptive methods to regulate the menstrual cycle and not as methods to regulate space births or prevent unintended pregnancies. One female participant shared her experience by indicating that she has used contraceptive methods to regulate the menstrual cycle and not counselled on the use of them as preventive methods.

"I used to go very often to consult an ob/gyn due to irregular cycle. She suggested to use pills to regulate the menstrual cycle, but was hesitant due to fear of side effects" young girl, urban area.

Promotion of family planning services

Promotion of family planning services was found low and considered as a barrier to encourage people to use modern contraceptive methods. None of respondent who have had previous experience with use of family planning services mentioned that no promotion materials have been given to them. In addition, the vast majority of them barely remembered any promotion family planning campaign or promotion messages broadcasted in mass-media (printed and electronic ones).

Affordability (cost) wasn't considered as a major barrier to reaching and using family planning services and modern contraceptive methods. All women who have had prior experiences with family planning services mentioned that the chosen contraceptive method was given free of charge and no other additional expenses were required. Affordability issues were mainly highlighted by a few women who were currently using modern contraceptive methods. This particularly in cases where there is no stock supply in the health center. According to them they are obliged either to stop taking contraceptives or buying in private market, cost of which was considered high and often not affordable.

"Last year, pills were not available for a few months at the family planning center. I went to a private pharmacy and bought pills for one month. The next month I quitted because of high price". - Married woman, FGD with women, Urban area.

» ***Societal Factors***

Lack of knowledge and fear of side effects

The majority of participants, especially women associated use of modern contraception with several side-effects, such as risk of cancer, dangerous for fertility, black spots, gain weight, etc.

"We are told that using pills for a long time increases the risk for breast cancers and sterility" – Young woman, Urban area.

"Women don't use modern methods because they cause severe bleeding and therefore there is a risk of anaemia". – Young girl, Rural area.

"I have a girl friend who works in maternity who told me that IUDs cause infection in the reproductive health organ". - Married woman, Urban area.

The same opinion regarding some side effects of modern contraceptive was among young boys and girls, who as matter of fact were confused about different type of information they have received about benefits and side-effects of contraceptive methods.
"I don't know what to believe regarding the use of modern contraceptive methods. …. Always the same contradictory information about benefits versus side effects". - Young girl, Urban area.

IV. Discussions

The results of this study highlight the persistence of problems regarding utilization of family planning (FP) services in Albania. They are consistent with findings from DHS (2008, 2018) as well as in the same line with other studies conducted in Albania and beyond (35).

The present analysis shows positive developments and achievements regarding quality of family planning services, but in the meantime found many challenges faced by service providers and users ranging from organisational to broader societal factors.

Significant progress has been made to improve the quality of care of family planning services in Albania. Currently, there is strong government support to strengthen contraceptive security, improve the infrastructure of health services and ensure dedicated resources to family planning services, backed it up with several laws, policy documents and up-to-dated strategies and action plans. The Logistic Management Information System (LMIS) is in a place covering the 36 districts within the country. Gender equity and women's right to health are strongly promoted and family planning is regarded as fundamental human right, from which all citizens should be able to benefit at their free will.

Since many years, Albania government has fully funded contraceptive procurement for the public sector. In addition to the public sector, a wide range of contraceptive methods are available from two other sources: private sector (pharmacies and non-traditional retail points) and at subsidized prices

from social marketing program (NESMARK). Education about sexual health has been introduced in school and it is already part of school curricula. According to the last two ADHS knowledge of modern contraceptives and sources where to obtain such methods is nearly universal where 97% of women and 96% of men of age 15-49 years old know at least one modern contraception method and sources where to obtain it.

However, in spite of good progress ensuring political support, improvements of infrastructure and universal knowledge about family planning services and modern contraceptive methods continues to remain low and decreases continuously (from 8% in 2008 to 4% in 2018). There is a decrease of fertility and abortion rate, but contradictory trends regarding modern contraceptive use was observed. Additionally, the total demand among currently married women decreases from 82% in 2008 to 61% in 2018. Quite interestingly, a slight increase (1.8%) of total fertility rate was marked in 2018 compared with 1.6% as reported by ADHS findings in 2008.

In the light of these data, this study tried to explore factors that hinder the utilization of family planning services by exploring perception and experience of service providers, women of reproductive age and young people.

There is a positive environment and attitude regarding family planning services. Recently, the government has developed and has updated a series of laws, policy documents and national guidelines and protocols in the field of family planning. Lately, the National Family Planning Protocol has been updated, the Reproductive Health Strategic Document and the National Contraceptive Security Strategy have been developed covering the period 2017-2021. The Reproductive Health Committee has been gathered and functional.

Furthermore, supportive attitudes were seen among decision makers and service providers regarding family planning services and also a constructive atmosphere among them to identify barriers, challenges and ways forward to increase the utilisation of family planning services and use of modern contraceptive methods.

Knowledge about contraceptive methods and sources where to obtain modern contraceptive methods was almost universal among women of reproductive age and young people. An overwhelming majority of them correctly identified at least one modern contraceptive method as well as some benefits of using such methods and family planning services in general. Nearly all of them identified condom as a dual protection method that protects from unintended pregnancies and sexually transmitted infections. However, even though this study didn't aim to assess the current prevalence of study participants, patterns of utilizations of family planning services are connected to the levels of knowledge. Utilization of family planning services was found to be low and several barriers that hinder that utilization were prevalent. Barriers are listed as: a) organizational factors, b) societal factors –gender social and cultural; and c) promotion of family planning programs.

Organizational factors

Even though the infrastructure of family planning service was considered adequate and had the most basic amenities and items to carry confidential, audio and visual examinations, yet some barriers were noted. The first one was related to small space that doesn't allow a good interaction, private and confidential counselling between a provider and client. Often this room is shared with other providers and thus information given to client about the chosen method is superficial and bordered only on the use of method and the follow-up visit. Fear of infection during client examination was also raised by majority of service providers, this mainly due to lack of single-use towels, decontamination solutions and latex examination gloves.

Another barrier perceived by both service providers and users was regarding the quality assurance and supervision, particularly in addressing the client's needs and suggestions. Even though, each health center is supposed to have a ballot box to collect clients' suggestion, only half of participants mentioned that such boxes are available. Even when available, the process of collecting, analysing, addressing client's needs and suggestions remained to be questioned as no feedback is provided by supervisors either to service providers or clients.

Some concerns were recorded in relation to the management and supervision. Majority of service providers from the public sector stated that during the last 6-months have been supervised at least once by the manager/supervisor. However, such supervision has been more focused on the

administrative issues rather than quality of care provided. No internal or external supervision or monitoring visit has been carried out to evaluate their professional performance or adherence to standards and protocols.

These results highlight opportunities to focus on these elements, in order to tailor the existing family planning service infrastructure and improve the quality of services to make it attractive and confident for clients.

Additionally, providers felt that their knowledge and skills regarding the new contraceptive methods, international guidelines and standards might be outdated, this due to lack of participation in the process of developing documents/protocols, attending trainings, workshops and national/ international events. None of them reported to have attended accredited family planning training at least during the last two years. Moreover, they felt their voices are not heard and are not involved in case when a guideline or national protocol is developed. Whereas, at the organisational level, current training opportunities are inadequate, and when they happen the selection process is opaque and the content is not necessarily relevant.

These findings suggest that lack of involvement in developing policy documents and inadequate training may hinders providers' inspiration and dedication to provide good services as well as their ability to encourage clients to use contraceptive methods and address mis-conceptions and barriers that exists against such methods. Organization of in-place trainings and development of a training schedule and respective topics could be a feasible and cost-effective approach to overcome these barriers. This in turn, needs to be negotiated with the National Center for Continuing Education (NCCE) which can require a number of certain credits acquired in family planning trainings to renew the professional licence.

It is encouraging to see that a wide range of quality modern contraceptive methods are available and provided free of charge at public facilities. However, it is disappointed to note that lack of coordination and internal mismanagement leads to problems with stock-out and disruption of services. Lack of coordination between the Regional Health Operatory, advance planning or calculating the stock before run low or out was considered as the main factors. Disruption of services put contraceptives users at higher risk for unintended pregnancies and contracting STIs, in addition to loss of clients.

These barriers could be overcome by planning in advance a stock for up to 6-months or by establishing an internal management system that periodically alerts in advance each time the stock is running low. A revision of ordering and delivery process could be revised and simplified in order to avoid bureaucracies.

This a true fact, that public health facilities in Albania provide a wide range of contraceptive methods, starting from male condoms, different oral pills, IUD and injectable. However, preferences for particular contraceptive methods varied greatly, based on different factors, such as ease of use, efficacy, side effects, cost and partner relationships, etc. Even though, not at higher percentage, the phenomenon of inverse ability was noted. Nearly two-third of service users mentioned they didn't have free choice to choose the preferred method, this due to shortage in the availability or reduced variety of the preferred method. In that regard, clients were enforced either to use the available methods suggested by service providers or discontinue use of contraceptive methods in case where they weren't able to buy in the private market. As matter of fact, affordability wasn't perceived as a barrier by majority of study participants, however particular concerns were mentioned, particularly in case of stock out. Market defragmentation regarding price and range of contraceptive methods were also mentioned by majority of service users. This is more evident, in the absence of social marketing sector which is considered as a market buffer. Findings from this section suggest that having a full range and brands of contraceptive methods from different providers, increases chances of price reduction and improve women's access and uptake of family planning services.

Lack of client's follow-up was another barrier found in this study, and this was more prevalent for clients referred to STI/HIV or more specialized services. Family planning services doesn't provide testing and therefore counselling and treatment for STI/HIV, but refer their clients either at the Voluntary Counselling and Testing center which is cantered at the Regional Health Operatory building or at Regional Hospitals. As both family planning and STI/HIV are sensitive issues lack of coordination between institutions and clients 'follow-up lead to loss of clients and disruption of services. Therefore, integration of HIV/AIDS services was considered an option. It is true that reducing structural barriers that limit a client's ability to receive multiple services at the same time it is associated with the uptake of services, however, integration of family planning with HIV/AIDS services requires more research on the effectiveness and feasibility.

Current family planning services were perceived as services for pregnant women and weren't found attractive for majority of young people as well as for the bare majority of women of reproductive age. This means, that the barrier perceived by young people was not related to poor or low quality of existing family planning services, but rather as service infrastructure that it is not tailored to their needs. Therefore, emphasis should be placed to find alternatives to adapt such services that meet the need of young people and increase the uptake of family planning services. Re-designing the concept of youth-friendly services for family planning services might be a good option, as our country has experience in implementation of such services. In addition, provision of family planning services through mobile outreach units or satellite programs could be a feasible and cost-effective option.

Societal factors

A climate of fear still exists among contraceptive users. Fear of side effects, dangerous for fertility, severe bleeding, black spots, growing hair in the face, etc were the most common misconception mentioned by study participants. The source of fear is rooted mostly from word of mouth and not reliable sources, such as social media and internet.

Husbands/in laws disapproval continues to be another barrier that hinder uptake of modern contraception methods. This attitude is strongly related with the socio-cultural health issues, family bond and lack of male involvement in the family planning decision making.

Social stigma and pressure were found as barrier as well. Fear of identification from family members, relatives and community members as users of family planning services or modern contraception was strongly related with promiscuity, bad behaviours or unsafe abortion.

The above findings show how societal factors influences quality of care and utilization of Family Planning services in many ways. Misconceptions about methods and demand for certain methods are widely influenced by what clients hear from their peers, friends or family members. Contraceptive methods are chosen based on their relationships with partners and not based on the women needs. These long-standing misconceptions require a great mobilisation starting from policy makers till to the community members. There is a need to empower young people and women to impact life

skills and enable them to develop appropriate knowledge and negotiation skills regarding sexual and reproductive health. There is a need to identify strategies that increase the support and participation of male partners.

Promotion of family planning services

Lack of promotion materials and behaviour change interventions and mass media campaigns was widely accepted by study participants. There is an urgent need to re-shape family planning programs on alleviating fears and myths about side-effects through effective counselling and providing adequate and correct information through mass media campaigns and school education.

Lastly, the pandemic situation has affected the quality of family planning services and has led to disruption of such services for contraceptive users. However, as we are walking in an unknown field, more time, efforts and future research needed to explore the effect of Covid-19 pandemic in the provision of family planning services.

Analysis from this study confirms the long-standing existence of barriers that hinders the utilisation of family planning services in Albania. However, this study has some limitation mainly arising from the study design. Therefore, such findings need to be treated cautiously to avoid overgeneralization.

V. Conclusions and recommendations

The contraceptive prevalence rate continues to be decreased in Albania, and our country still remains one of the lowest modern contraceptive use in Europe. Despite good progress in having a clear political commitment and ensuring the contraceptive security, yet negative perceptions and misconception about method effectiveness and safety are common and hinder the utilization of family planning services and use of modern contraceptive methods.

Albania has all ingredients to improve the utilization of family planning services and efforts should be focused on switching from the climate of fear to the modern contraception culture. To ensure that, it is necessary to strengthen the accessibility and availability of services as well as to expand the range of modern contraceptive options that fits with the women and couple needs.

Nevertheless, based on our findings and the context of Albanian culture, this study concludes with the following programmatic recommendations:

- Implement interventions that focus on reducing top barriers to family planning uptake, by improving facility infrastructures and services, strengthening knowledge and skills of health providers, educating communities about advantages and benefits of modern contraception and breaking down societal barriers to contraceptive use.
- Gradually improve the infrastructure of health-care services and allocated dedicated funds for family planning and sexual and reproductive health services.
- Develop tailored, innovative education and long-term behavioural change programs that cover all FP methods, as well as general reproductive and sexual health issues.
- Tailor promotion campaigns to address misconceptions about and fears of modern FP methods, specifically by providing accurate information about the risks and likelihood of side effects.
- Allocate long-term funding to these efforts, to enable time for behaviour change to occur.
- Design and adapt services that take into account the needs of young people. Implementation of youth-friendly services, mobile outreach and satellite programs could be implemented in areas where there is lack of family planning programs.
- Develop programs, reinforce institutional practices and structures that breaks barriers that reinforce gender equity, incentivize male participation in family planning decision-making, reduce sexual violence and coercion, and to eliminate child marriage.
- Strengthen the monitoring and evaluation, health information system and integrate data relatedto sexual and reproductive health issues (contraceptive use, sexually transmitted infections, abortion rates etc.).
- Improve quality of training for service providers, by organizing training accredited training in the family planning as part of continuing medical education curricula.
- Revitalize the Reproductive Health Committee and establish such structures at regional level to decentralize and boost policy-making related to family planning and Sexual and Reproductive Health.
- Forge inter-sectorial collaboration and strengthen advocacy activities in favour of family planning with public and private institutions and organizations (national and international) to increase funding and ensure long-term term support of family planning services.

- Investigate the feasibility of integration of Family Planning with other sexual and reproductive health services, such as STI/HIV services with a particular focus on young people and vulnerable communities.
- Introduce and pilot the Total Market Approach which will cover the existing gaps and serve as a connection bridge between public and private family planning sectors.
- Develop Telemedicine and mobile online consultations/counselling platforms to improve access to family planning services, as well as facing the Covid-19 pandemic situation.
- Sexuality education for all, including young people in and out of school, marginalized groups and others who may not ever have had access to full information about sex and reproduction, must be available and form a core part of governments' commitment to family planning.
- Carry out intensive research on the impact of Covid-19 pandemic in regards to utilization of family planning services and sexual health and propose concrete actions/programs to ensure continuation of services.

References

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1. United Nations Population Fund (UNFPA). Sexual & reproductive health. Available at: https://www.unfpa.org/sexual-reproductive-health. Last accessed: March 2020.

2. World Health Organization (WHO). Family planning/Contraception. Available at: https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception. Last accessed: March 2020.

3. Office of Disease Prevention and Health Promotion (ODPHP). Healthy People 2020. Family Planning. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning. Last accessed: March 2020.

4. United Nations Population Fund (UNFPA). Family planning. Available at: https://www.unfpa.org/family-planning. Last accessed: March 2020.

5. Jane Falkingham and Arjan Gjonça. Fertility Transition in Communist Albania, 1950-90. Population Studies. 2001; 55(3):309-318.

6. Geary J. Birth of a nation: family planning in Albania. ORGYN. 1994; (2):2-8.

7. Gjonca A, Aasve A, Mencarini L. The highest fertility in Europe – for how long?: determinants of fertility change in Albania. Available at: https://www.researchgate.net/publication/268435134_The_highest_fertility_in_Europe_-_for_how_long_determinants_of_fertility_change_in_Albania. Last accessed: March 2020.

8. Institute of Statistics (INSTAT). Available at: http://www.instat.gov.al/al/temat/treguesit-demografik%C3%AB-dhe-social%C3%AB/popullsia/. Last accessed: March 2020.

9. Albania Demographic and Health Survey 2017-2018. Available at: https://www.ishp.gov.al/wp-content/uploads/2015/04/ADHS-2017-18-Complete-PDF-FINAL-ilovepdf-compressed-1.pdf. Last accessed: March 2020.

10. Institute of Public Health (in Albanian). Instituti i Shendeti Publik, Sistemi i Suvejances se Abortit dhe Sistemi i Menaxhimit te Logjistikes dhe Informacionit te Kontraceptiveve (LMIS), 2020. Offline data.

11. United Nations (UN). Department of Economic and Social Affairs. Contraceptive use by method 2019. Data Booklet. Available at: https://www.un.org/en/development/desa/population/publications/pdf/family/ContraceptiveUseByMethodDataBooklet2019.pdf. Last accessed: March 2020.

12. Ministry of Health and Social Protection. Situation analysis in the reproductive health sector. (in Albanian). Available at: https://shendetesia.gov.al/wp-content/uploads/2018/08/ANALIZA_SITUATES_E_RIPUNUAR_mars_09.pdf. Last accessed: March 2020.

13. Law on Reproductive Health. (in Albanian). Available at: http://www.ishp.gov.al/wp-content/uploads/2015/ligjet/Per-shendetin-riprodhues.pdf. Last accessed: March 2020.

14. Law on Pregnancy Interruption. (in Albanian). Available at: http://www.infocip.org/al/?p=6002. Last accessed: March 2020.

15. Decision on approval of basket of health services in public primary health care funded by Compulsory Healthcare Insurance Fund. (in Albanian). Available at: https://www.fsdksh.com.al/images/stories/faqe_kryesore/sherbimet/qsh/Kontratat_QSH_2016/VKM_NR_101_DATE_04_02_2015_PAKETA_E_PARESORIT.pdf. Last accessed: March 2020.

16. Strategic Document and Action Plan for Sexual and Reproductive Health 2017-2021. (in Albanian). Available at: https://shendetesia.gov.al/wp-content/uploads/2018/08/SRH_National_Strategic_Document_2017_-_2021.pdf. Last accessed: March 2020.

17. Albanian National Contraceptive Security Strategy 2017-2021. Available at: http://www.un.org.al/sites/default/files/Contraceptive%20Security%20Strategy%202017-2021%20%281%29.pdf. Last accessed: March 2020.

18. Family Planning Clinical Practice Protocols for Health Care Providers. (in Albanian). Available at: https://www.scribd.com/document/369070328/PROTOKOLLET-E-PRAKTIKES-KLINIKE-TE-PLANIFIKIMIT-FAMILJAR-PER-OFRUESIT-E-SHERBIMIT-SHENDETESOR-pdf. Last accessed: March 2020.

19. Albanian Reproductive Health Survey 2002. Available at: https://stacks.cdc.gov/view/cdc/8243. Last accessed: March 2020.

20. Albanian Demographic Health Survey 2008-2009. Available at: https://dhsprogram.com/pubs/pdf/FR230/FR230.pdf. Last accessed: March 2020.

21. Kragelund Nielsen K, Nielsen SM, Butler R, Lazarus JV. Key barriers to the use of modern contraceptives among women in Albania: A qualitative study. Reprod Health Matters. 2012; 20(40):158-65.

22. Boci, A., Eichleay, M., and Searing, H. 2013. Factors influencing women's reproductive health choices in Tirana, Albania. The RESPOND Project Study Series: Contributions to Global Knowledge—Report No. 12. New York: EngenderHealth (The RESPOND Project). Available at: http://www.respond-project.org/pages/files/6_pubs/research-reports/Study12-Albania-Report-July2013-FINAL.pdf. Last accessed: March 2020.

23. Merdani A, Kakarriqi E, Toçi D, Dedja B, Fico A, Toçi E. Analysis of abortions for the period 2013-2017, based on data from abortion surveillance system. AMJ, 2018; 3:39-47. (in Albanian). Available at: http://www.ishp.gov.al/wp-content/uploads/2018/10/buletini-3-2018.pdf. Last accessed: March 2020.

24. Family Planning 2020. COVID-19 & family planning, Updated April 9, 2020. Available at: http://familyplanning2020.org/covid-19. Last accessed: April 2020.

25. UNFPA (United Nations Populations Fund). COVID-19 Pandemic. Available at: https://www.unfpa.org/covid19. Last accessed: April 2020.

26. UNFPA (United Nations Populations Fund). Coronavirus Disease (COVID-19) Preparedness and Response UNFPA Interim Technical Brief. Available at: https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_Preparedness_and_Response_-_UNFPA_Interim_Technical_Briefs_Contraceptices_and_Medical_Supplies_23_March.pdf. Last accessed: April 2020.

27. Ahmed Z, Sonfield A. The COVID-19 Outbreak: Potential Fallout for Sexual and Reproductive Health and Rights. Guttmacher Institute. March 11, 2020. Available at: https://www.guttmacher.org/article/2020/03/covid-19-outbreak-potential-fallout-sexual-and-reproductive-health-and-rights. Last accessed: April 2020.

28. International Planned Parenthood Federation (IPPF). COVID-19 pandemic cuts access to sexual and reproductive healthcare for women around the world. April 9, 2020. Available at: https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world Last accessed: April 2020.

29. Donabedian A. 1966. Evaluating the quality of medical care. The Milbank Quarterly 44: 166–206

30. Bruce J. 1990. Fundamental elements of the quality of care: a simple framework. Studies in Family Planning 21: 61–91.

31. Bruce J. Fundamental elements of the quality of care: A simple framework. Studies in Family Planning. 1990; 21(2):61–90. PMID: 2191476

32. Bruce J. Improving quality of care in family planning. Population Briefs. 2013; 19(1).

33. Creel LC, Sass JC. La calidad centrada en el cliente: perspectivas de los clientes y obsta´culos para recibir atencio´n. Popul concil y Popul Ref Bur. 1996; 1(2):2–8.

34. Murphy, E., and C. Steele. 2000. Client-provider interactions in family planning services: Guidance from research and program experience. MAQ Papers Vol. 1, No. 2. Washington, D.C.: U.S. Agency for International Development.

35. UNFPA and WHO 2003. Family Planning and Reproductive Health in Central and Eastern Europe and the Newly Independent States. April 25, 2020. Available at: https://www.euro.who.int/__data/assets/pdf_file/0013/120226/E71193.pdf. Last accessed: April 2020.

Annex A: Research instruments

Semi-structured Interview Questions

Samples of Questions to be used during SSIs: "Now I am going to ask you some questions about quality of FP/CM in healthcare settings." Please feel free to respond to questions that are related with your working place (health facility) or experience

Infrastructure & equipment	
Physical infrastructure	Number of amenities available at facility: electricity, water, working toilet, telephone, waiting area for clients (out of 5)
Examination room equipment	Number of following items present: table and stool for gynaecological exam, source of light, speculum, soap, single-use towel, water for hand-washing, clean gloves, decontamination solution, sharps box, privacy in exam room (out of 10)
Management	
Review of management	Whether there is a system for reviewing management/administrative issues
System to collect client opinion	Whether there is a system to obtain clients' opinions regarding services
Quality assurance program	Whether the facility has a routine program for quality monitoring
Supervision	Whether the last supervisory visit to the facility was in the last 6 months
Stock inventory, organization, and quality	Number of following items present at facility: inventory for contraceptive supplies, stock organized by expiry date, contraceptives protected from water, sun, and pests
Availability of services	
Number of days services provided	Number of days per week that FP services are provided
Availability of provider	Whether a trained provider is always available at the facility
FP methods offered	Number of methods offered: combined oral pill, progesterone only pill, IUD, 2 or 3 month injectable, 1 month injectable, Norplant, male condom, female condom, spermicide, diaphragm, emergency contraception, counselling about natural methods, tubectomy, vasectomy (out of 14)
Other reproductive health services offered	Number of RH services besides FP offered: STI services, immunization, antenatal care, postnatal care, post abortion care, and delivery (out of 6)
Counselling	
Guidelines	Number of guidelines or protocols for counselling at the facility (out of 5)
Visual aids	Number of visual aids for demonstrating use of FP methods at facility (out of 9)
Individual client card	Whether there is an individual client card/record for FP
Privacy	Whether facility has private room for FP counselling
FP experience of providers	Number of years of experience of providers in providing FP services
Providers trained in FP	Number of providers who received any in-service training in FP in last 5 years
PROCESS	
Interpersonal	
Waiting time	Number of minutes client had to wait before being examined by a provider
Privacy ensured	Whether provider ensured visual and auditory privacy during examination
Client concerns noted	Whether provider asked client about concerns with methods or with currently used method
Confidentiality assured	Whether provider assured client of confidentiality
Method use explained	Whether provider explained to the client how to use the method
Injectable prescription	Whether provider prescribed an injectable to the client

Technical	
Reproductive history	Provider asked the client about the following: age, number of living children, last delivery date, history of complications, pregnancy status, desire for more children, desired timing of birth of next child, breastfeeding status, regularity of menstrual cycle (out of 9)
Physical examination	Provider took/asked about the following during the physical exam: blood pressure, weight, asked about smoking, asked about STI symptoms, asked about chronic illness (out of 5)
Injectable procedure	Provider did the following when giving FP injection: checked client card, wash hands with soap before giving injection, use single-use towel for drying, use newly sterilized needle, stir bottle before drawing dose, clean and air-dry injection site before injection, draw back plunger before injection, allow dose to self-disperse instead of massaging, dispose of needle in puncture resistant container (out of 9)
Duration of consultation	Number of minutes provider spent on the consultation
OUTCOME	
Client satisfaction	Clients reported that they had no problem with ALL of the following: waiting time, ability to discuss concerns with provider, amount of explanation given, quality of examination and treatment provided, visual privacy during examination, auditory privacy during examination, availability of medicines at facility, hours of service provision, cleanliness of facility, staff treatment of client

Annex B: FGDs research instrument to measure users experience and client satisfaction experience with FP and Contraception Services.

Samples of Questions to be used during FGDs: "Now I am going to ask you some questions about your satisfaction you have had at FP health facilities. Please feel free to describe your opinion/experience and if so, have they affected your decision making to use contraceptive methods or any other family planning services."

• Time you waited
• Ability to discuss problems or concerns about your health with the provider
• Amount of explanation you received about any problem or method of FP
• Quality of the examination and treatment provided
• Privacy from having others see the examination
• Privacy from having others hear your consultation discussion
• Availability of contraceptive methods at this facility
• Hours of service at this facility
• Number of days services are available to you
• Cleanliness of the facility
• How the staff treated you
• Cost for services or treatment
• Barriers that affect utilization of family planning services
• Any problem you had today that I did not mention
• How would you rate quality of received services
• Would you recommend someone else to use FP services you have currently used.

Annex C: List of interviewed people

Decision makers and service providers who were interviewed.		
Nr	**Position/Institution**	**Type**
1	General Director, Ministry of Health and Social Protection	Government
2	Chief of Health Promotion Department, Institute of Public Health	Government
3	Specialist, Health Promotion Department, Institute of Public Health	Government
4	LMIS specialist, Institute of Public Health	Government
5	Head of Sector, Regional Operatory for Health care (Tirana)	Government
6	Specialist, Regional Operatory for Health care (Vlore)	Government
7	Program analyst, UNFPA	UN Agency
8	Executive Director, Albanian Community Assist	NGO
9	Medical Coordinator, “STOP AIDS Association”	NGO
10	Service Providers at Family Planning/Reproductive Health Unit (n=6)	Government
11	Clinic Managers, Local Operatory for Health care (n=4)	Government
12	Service provider, NESMARK Albania, Social Marketing Agency.	Social Marketing

http://www.un.org.al/sites/default/files/Contraceptive%20Security%20Strategy%202017-2021%20%281%29.pdf