

**Albania
Demographic
and Health
Survey
2008-09**

**Preliminary
Report**

**Institute of Statistics
Institute of Public Health
Tirana, Albania**

**MEASURE DHS
ICF Macro
Calverton, Maryland, USA**

The 2008-09 Albania Demographic and Health Survey (2008-09 ADHS) was implemented by the Institute of Statistics (INSTAT) and the Institute of Public Health (IPH) from September 2008 to April 2009. ICF Macro, an ICF International Company, provided technical assistance to the project through funding from UNICEF and the MEASURE DHS programme, a USAID-funded project providing support and technical assistance in the implementation of population and health surveys in countries worldwide. Funding for the ADHS was provided by USAID, Swiss Agency for Cooperation and Development (SCD), UNICEF, UNFPA, and World Health Organization (WHO). The opinions expressed in this report are those of the authors and do not necessarily reflect the views of USAID, SCD, UNICEF, UNFPA, and WHO.

Additional information about the 2008-09 ADHS may be obtained from either:

The National Institute of Statistics,
Lantona Sado, Coordinator ADHS
Street address: Blvd "Gergj Fishta" #3, Tirana, Albania.
Telephone: +355 (4) 2222411, Fax: +355 (4) 2228300, Email: lsado@instat.gov.al

or

The Institute of Public Health
Elizana Petrela, Coordinator ADHS,
Street address: "Aleksander Moisiu" # 80, Tirana, Albania.
Telephone: +355 (4) 2363195, Fax: +355 (4) 2370058, Email: elapetrela@ishp.gov.al

Information about the DHS programme may be obtained from the MEASURE DHS Project, ICF Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA; Telephone: 301-572-0200, Fax: 301-572-0999, E-mail: reports@macrointernational.com, Internet: <http://www.measuredhs.com>.

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PRELIMINARY REPORT

Institute of Statistics
Institute of Public Health
Tirana, Albania

MEASURE DHS
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Calverton, Maryland, U.S.A.

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Ministria e Shëndetësisë



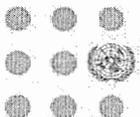
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Ms. Lantona Sado (Coordinator ADHS, INSTAT) and
Ms. Elizana Petrela (Coordinator ADHS, IPH)
Albania Demographic and Health Survey 2008-09
Government of Albania

I. INTRODUCTION

Albania's first Demographic and Health Survey (ADHS) was carried out by the Institute of Statistics (INSTAT) and the Institute of Public Health (IPH), of the Ministry of Health. ICF Macro provided technical assistance to the ADHS through funding from United Nations Children's Fund (UNICEF) and the United State Agency for International Development (USAID) funded MEASURE DHS programme. Local costs of the survey were supported by USAID, the Swiss Agency for Cooperation and Development (SCD), UNICEF, the United Nations Population Fund (UNFPA), and the World Health Organization (WHO).

Data collection was conducted from October 28, 2008 to April 26, 2009 from a nationally representative sample of almost 9,000 households. All women age 15-49 in these households and all men age 15-49 in one-half of the households were eligible to be interviewed. In addition to the data collected through interviews with these women and men, capillary blood samples were collected from all children age 6-59 months, as well as from all eligible women and men age 15-49 for anaemia testing. Additionally, all children under the age of 5 years and eligible women and men age 15-49 were weighed and measured to assess their nutritional status. Finally, blood pressure (BP) was measured for eligible women and men in the households selected for the men's interview to estimate the prevalence of hypertension among the adult population in Albania.

The 2008-09 ADHS is designed to provide data to monitor the population and health situation in Albania. Specifically, the 2008-09 ADHS collected information on fertility levels, marriage, sexual activity, fertility preferences, knowledge and use of family planning methods, breastfeeding practices, nutritional status of women and young children, childhood mortality, maternal and child health, and awareness and behaviour regarding AIDS and other sexually transmitted infections. Additional features of the 2008-09 ADHS include the collection of information on migration (out-migration, returning migrants, and internal migration), haemoglobin testing to detect the presence of anaemia, blood pressure (BP) measurements among the adult population, and questions related to accessibility and affordability of health services. The information collected in the 2008-09 ADHS provides updated estimates of an array of demographic and health indicators that will assist in the development of appropriate policies and programmes to address the most important health issues in Albania.

The purpose of this report is to highlight some of the preliminary findings from the 2008-09 ADHS. Where possible, information on trends is documented using indicators estimated from previous surveys in Albania, namely, the 2002 Reproductive Health Survey (RHS) and the 2000 and 2005 Multiple Indicator Cluster Surveys (MICS). However, the reader should bear in mind the 3 to 9-year interval between these surveys and the 2008-09 ADHS. A comprehensive analysis and presentation of detailed findings will be published early next year in the final report.

II. SURVEY IMPLEMENTATION

A. Sample Design

The 2008-09 Albania Demographic and Health Survey is based on a representative probability sample of almost 9,000 households. This sample was selected in such a manner as to allow separate urban and rural, as well as regional-level estimates for key population and health indicators, e.g., fertility, contraceptive prevalence, and infant mortality for children under five.

The 2008-09 ADHS used a two-stage sample design. The first stage involved selection of a sample of primary sampling units (PSUs) as have been used for the 2008 Living Standards Measurement Study (LSMS). In total, 450 PSUs were selected for the ADHS sample, including 245 urban PSUs and 205 rural PSUs, covering 4 geographic domains – mountains, central, coastal and urban Tirana. A listing of each of the selected PSUs was carried out in preparation for the LSMS. The ADHS survey selected 20 households from the updated household listing in each PSU, excluding those households selected for the LSMS. In two PSUs, numbers 27 (13 households) and 172 (17 households), there were less than 20 households in the re-listed PSU – all households were selected in those cases. In a further 6 PSUs there were less than 20 households after the LSMS households were excluded. In these PSUs some of the households from the LSMS sample were included to bring the number of households selected up to 20. After selection of the households, the sample selection forms were printed and the list of selected households was adapted for use in the Personal Digital Assistant (PDAs; see section B below).

All women age 15-49 in the total sample of households, and all men age 15-49 in a sub-sample of one-half of households, who were either usual residents of the households in the ADHS sample or visitors present in the household on the night before the survey were eligible to be interviewed in the survey.

B. Questionnaires

Three questionnaires were used for the 2008-09 ADHS: the Household Questionnaire, the Women's Questionnaire and the Men's Questionnaire. The contents of these questionnaires were based on model questionnaires developed by the MEASURE DHS programme.

Consultations with partners were held in Tirana to obtain input from various national and international experts on a broad array of issues. Based on these consultations, the DHS model questionnaires were modified to reflect issues relevant in Albania concerning population, women and children's health, family planning, and other health issues. After approval of the final content by the Steering and the Technical Committees, these questionnaires were translated from English into Albanian.

The Household Questionnaire was used to list all the usual members and visitors in the selected households and to identify women and men who were eligible for the individual interview. Basic information was collected on the characteristics of each person listed, including their age, sex, education, and relationship to the head of the household. In addition, a separate listing and basic information on former household members who had emigrated abroad was collected. The Household Questionnaire was also designed to collect information on characteristics of the household's dwelling unit, such as the source of water, type of toilet facilities, materials used for the floor and roof of the house, and ownership of various durable goods. A module was also included to record information about methods used in the household for disciplining children, with the information being gathered concerning one selected child in the age range 2-14 years. Finally, height and weight measurements, and the results of haemoglobin measurements for consenting women and men age 15-49 years and children age 6 to 59 months were recorded in the Household Questionnaire. The haemoglobin testing procedures are described in detail in the next section.

The Women's Questionnaire was used to collect information from all women age 15-49. These women were asked questions on the following topics:

- background characteristics (education, residential history, media exposure, etc.);
- reproductive history;
- knowledge and use of family planning methods;
- fertility preferences;
- antenatal and delivery care;
- breastfeeding and infant feeding practices;
- vaccinations and childhood illnesses;
- marriage and sexual activity;
- woman's work and husband's background characteristics;
- infant and child feeding practices;
- childhood mortality; and
- awareness and behaviour about AIDS and other sexually transmitted infections (STIs).

The Women's Questionnaire had a number of important additions compared with the DHS model questionnaire. First, the BP readings were taken for all women age 15-49 that lived in the households selected for the men's survey. Secondly, a vaccination module was added for each child under the age of 5 years to be completed at the local health clinic or centre. As indicated by the 2005 MICS survey findings and according to child health experts, immunization information in Albania is more frequently kept at the health clinics or centres than on an immunization card or child health book in the mother's possession. The purpose of this module was, therefore, to collect information on immunizations from the local health clinics or centres in addition to that collected during the woman's interview. The vaccination module provides better quality immunization indicators because information gathered during the interview is augmented with information from the local health facilities. Additionally, a series of questions were asked to assess the occurrence of chronic illnesses or disabilities and of acute illnesses or injuries among eligible women. Finally, eligible women were asked a number of questions aimed at assessing the accessibility and affordability of health services in the country.

The Men's Questionnaire was administered to all men age 15-49 living in every second household in the ADHS sample. The Men's Questionnaire collected much of the same information found in the Women's Questionnaire, but was shorter because it did not contain questions on reproductive history, maternal and child health, and nutrition.

An innovative aspect of the 2008-09 ADHS was the use of Personal Digital Assistants (PDAs) for the data collection, rather than paper questionnaires. The survey used Hewlett Packard iPAQ 212 PDAs with the Windows Mobile 6 operating system. The full Household, Women's and Men's Questionnaires were programmed in the PDAs using the software package CSPro (Census and Survey Processing). Full survey and data management, range, skip, and consistency checking were built into the data capture system. Data were backed up to a secondary storage in the PDAs as soon as the interview was completed and were copied to the supervisor's PDA at the end of each day. Data were sent back to the central office at the INSTAT electronically on a regular basis, every couple of days. Paper questionnaires were available to interviewers in case of failure of equipment.

All aspects of the ADHS data collection were pre-tested in June-July, 2008. A total of 19 trainees drawn from staff of the INSTAT and the IPH were trained for two weeks by staff from ICF Macro. The trainees were then dispatched to the field to conduct the ADHS pre-test. The pre-test provided the opportunity to review the questionnaire content and language, logistics, equipment needs, PDA software, and general protocols for the survey. In total, approximately 120 households in urban and rural areas were interviewed with 100 women's interviews and 30 men's interviews. The lessons learned from the pre-test were used to finalize the survey instruments and logistical arrangements.

C. Biomarkers

The 2008-09 ADHS included the collection of three types of biomarkers: (1) anthropometric measurements; (2) capillary blood samples for anaemia testing; and (3) blood pressure measurements. Each interviewer and team supervisor was trained to perform all three types of measurement.

Anthropometric measurements

Height and weight measurements were collected for all children listed in the household questionnaire born since January 2003 and for all women age 15-49 years. In households selected for the men's questionnaire (one-half of all households) all men age 15-49 years were also measured. Weight data were obtained using Seca 881 scales with digital screens as recommended by UNICEF and were capable of collecting mother-and-baby measurements as well as individual measurements. For measuring height (or length), two separate pieces of equipment were used. Seca 416 Infantometers were used to measure recumbent length of infants and children less than 24 months of age. For children 24 months of age or older, as well as adult women and men, Seca 214 Stadiometers were used.

Haemoglobin testing

Haemoglobin testing is the primary method of anaemia diagnosis. Reliable measures are obtained using the HemoCue system. In all households selected for the 2008-09 ADHS survey, women age 15-49 and children age 6 to 59 months were tested for anaemia; in the households selected for the men's survey (one-half of all households), men age 15-49 were also tested for anaemia. A consent statement was read to the eligible respondent or to the parent or responsible adult for children and young unmarried women and men age 15-17. This statement explained the purpose of the test, informed them that the results would be made available as soon as the test was completed, and requested permission for the test to be carried out.

Before taking any blood, the finger was wiped with an alcohol swab and allowed to air dry. Then, the palm side of the end of the third or fourth finger was punctured with a sterile, non-reusable, self-retractable lancet and a drop of blood collected on a HemoCue microcuvette, which serves as a measuring device, and placed in a HemoCue photometer which displays the result. An informative brochure was given to each household explaining what anaemia is, its symptoms, and measures to prevent anaemia. Each person whose haemoglobin level was tested was also given their results. In addition, each person whose haemoglobin level was lower than the recommended cut-off point was given a written referral recommending immediate follow up with a health professional.

Blood pressure measurements

Blood pressure was measured for all women and men interviewed in the households selected for the men's survey (one-half of all households). Interviewers were provided with the Omron HEM-711ac blood pressure monitor – fully automatic, digital oscillometric blood pressure measuring device with automatic upper-arm inflation and automatic pressure release. Three measurements of systolic and diastolic blood pressure (measured in millimetres of mercury (mmHg)) were taken during the survey interview with an interval of at least 10 minutes between measurements. At the end of the interview, respondents were provided information about their average blood pressure reading and advised to see a medical provider for further screening if that reading fell outside the normal ranges according to internationally recommended guidelines (WHO, 1999).

D. Training

Fieldwork training was conducted between October 1 and October 24, 2008 in Durres. A total of 82 trainees (47 female and 35 male trainees) took part in the main survey training. The trainees were selected from a large pool of approximately 200 potential candidates by the IPH and the INSTAT.

The trainees were recruited on the basis of their education, prior experience as interviewers or supervisors in other household surveys, interest and ability to work with PDAs, any other related experience, and their performance during the selection interview. Trainees were divided into two classrooms because of the large number of trainees, with the second group of trainees receiving the same training from the same trainer as the first group, but with a half day delay. Interviewer training was conducted mostly in Albanian by a team of trainers. The training team consisted of two consultants from ICF Macro and staff from the INSTAT and the IPH. Several guest lecturers from the Ministry of Health and the IPH also presented on Albania's family planning, maternal and child health, and HIV/AIDS programmes. All participants were trained on interviewing techniques and the contents of the ADHS questionnaires. In addition, participants were trained to conduct anthropometry measurements, to perform haemoglobin testing, and to take blood pressure measurements.

The training was conducted following the standard DHS training procedures, including class presentations, mock interviews, and written tests. All of the participants were trained on how to complete the Household Questionnaire, the Women's Questionnaire, and the Men's Questionnaire. The training first focused on a particular module of the questionnaire using the paper questionnaire, covering the details of the subject matter and data collection issues, and explaining how to complete the questionnaire on paper. This was followed by training on the same module using the PDA, with in-class mock-interviews, one-on-one interviews or small group practices.

In addition to in-class training, participants practiced taking anthropometric measurements and conducting anaemia testing on children at local kindergartens. Trainees also conducted three rounds of field practice to gain more experience in interviewing, anthropometry, anaemia, and blood pressure measurements, and fieldwork logistics and team dynamics. While both female and male interviewers interviewed respondents for the Household Questionnaire, only female interviewers interviewed women eligible for the Women's Questionnaire and only male interviewers interviewed men for the Men's Questionnaire. Participants selected as field supervisors were given an additional two days of training on how to supervise fieldwork and ensure the collection of good quality data.

E. Fieldwork

Twelve teams were constituted for the field. Each team was made up of a supervisor, three female interviewers, two male interviewers, and a driver. Interviewers and supervisors were selected on the basis of in-class participation, field practice and 8 theoretical assessment tests. The most experienced trainees, those who had participated in the pre-test, and those who did extremely well in the practices and the tests were selected to be supervisors.

The IPH and the INSTAT supervised all aspects of fieldwork activities. For this purpose, four quality control (QC) teams were formed with one staff person from each institution in each team. The quality control teams were responsible for between 2 and 4 interviewing teams (depending on the locality and the difficulty of accessing the teams). Selection of the quality control teams was based on full participation in the pre-test training or the main survey training and practice, thorough experience with the full ADHS questionnaire, and the ability to use and resolve problems on the PDA. ICF Macro monitored fieldwork progress with a standard set of quality control tables generated every two weeks from the most recent data. Furthermore, staff from ICF Macro visited 6 of the 12 field interviewing teams along with the QC team members, observed fieldwork, reviewed progress and checked the quality of fieldwork.

Data collection took place over a period of 6 months, from late October 2008 to April 2009. On average, each team took about 3 days to complete one PSU, taking advantage of early mornings and late evenings to find respondents at home.

F. Data Processing

Because the 2008-09 ADHS used PDAs for the data collection, data processing activities were an integral part of all survey activities. Throughout data collection, range and consistency checks were applied to the data collected, and interviewers reviewed and corrected the data as needed. At the end of each interview the data collected were backed up to secondary storage within the PDA. As soon as data collection for the day ended, the data for the completed interviews were transferred via Bluetooth from the interviewer's PDA to the supervisor's PDA, and the household, women and men's questionnaires were reconciled and automatically checked against the list of selected households.

After all interviewing was completed for the PSU, and the supervisor had received all data for that PSU, all questionnaires were checked for completeness before being prepared for transfer to the central office at the INSTAT in Tirana. The data recorded in the PDAs from the completed PSUs were downloaded to PCs and sent from the field to the INSTAT headquarters in Tirana on a regular basis, typically every one or two weeks. Upon receiving the data at the INSTAT they were checked for completeness and edited by data processing personnel who were specially trained for this task. All programs for processing the ADHS were prepared using the Census and Survey Processing System (CSPRO). Every two weeks, a set of data quality tables was prepared based on the data received centrally, and these were used to provide feedback to the field teams on their performance and to advise them of problems detected.

Following completion of all fieldwork, additional data processing was performed to aggregate all data, complete secondary data editing and date imputation, compute sampling weights, and prepare the data files for analysis. This phase of the survey was completed in late May 2009.

III. RESULTS OF THE SURVEY INTERVIEWS

A. Response Rates

Table 1 shows response rates for the 2008-09 ADHS. A total of 8,994 households were selected in the sample, of which 8,168 were occupied at the time of the fieldwork. This difference between selected and occupied households usually occurs because some structures were found to be vacant or non-existent. The number of occupied households successfully interviewed was 7,999, yielding a household response rate of 98 percent.

| Result | Residence | | Region | | | | Total |
|--------------------------------------|-----------|-------|---------|---------|----------|--------------|-------|
| | Urban | Rural | Coastal | Central | Mountain | Urban Tirana | |
| Household interviews | | | | | | | |
| Households selected | 4,894 | 4,100 | 2,501 | 2,499 | 2,493 | 1,501 | 8,994 |
| Households occupied | 4,514 | 3,654 | 2,256 | 2,322 | 2,185 | 1,405 | 8,168 |
| Households interviewed | 4,401 | 3,598 | 2,209 | 2,282 | 2,142 | 1,366 | 7,999 |
| Household response rate | 97.5 | 98.5 | 97.9 | 98.3 | 98.0 | 97.2 | 97.9 |
| Individual interviews: women | | | | | | | |
| Number of eligible women | 3,898 | 3,835 | 2,001 | 2,165 | 2,416 | 1,151 | 7,733 |
| Number of eligible women interviewed | 3,846 | 3,738 | 1,961 | 2,115 | 2,366 | 1,142 | 7,584 |
| Eligible women response rate | 98.7 | 97.5 | 98.0 | 97.7 | 97.9 | 99.2 | 98.1 |
| Individual interviews: men | | | | | | | |
| Number of eligible men | 1,695 | 1,449 | 784 | 923 | 909 | 528 | 3,144 |
| Number of eligible men interviewed | 1,655 | 1,358 | 753 | 874 | 866 | 520 | 3,013 |
| Eligible men response rate | 97.6 | 93.7 | 96.0 | 94.7 | 95.3 | 98.5 | 95.8 |

In the households interviewed in the survey, a total of 7,733 eligible women were identified; interviews were completed with 7,584 of these women, yielding a response rate of 98 percent. In a sub-sample of one-half of the households in the ADHS sample, a total of 3,144 eligible men were identified and interviews were completed with 3,013 of these men, yielding a male response rate of 96 percent. The household response rates are slightly lower for urban than for rural households. On the other hand, the opposite is true for individual interviews; the response rates are somewhat higher among urban women (99 percent) and men (98 percent) than among their rural counterparts (98 percent and 94 percent, respectively). Response rates varied little by region, with slightly lower response rates for households in urban Tirana (97 percent), but slightly higher response rates for eligible women and men (99 percent).

The principal reason for non-response among both eligible women and men was the failure to find individuals at home despite repeated visits to the household.

B. Characteristics of Respondents

The distribution of women and men age 15-49 by background characteristics is shown in Table 2. The proportions of both women and men are largest in the younger age group (age 15-19) and the older age groups (age 35-49 for women, age 40-49 for men). On the other hand, the proportion of respondents in the middle age groups 25-34 is lower, compared with younger or older age groups. This U-shaped distribution of the Albanian population is likely to be a reflection of the higher rates of emigration among the working age population.

Nearly two-thirds of women (66 percent) and more than half of men (57 percent) are married or living together. Because men tend to marry later in life than women, 43 percent of the surveyed men age 15-49 have never married, compared with 31 percent of women age 15-49. Women are slightly more likely than men to be widowed, divorced, or separated (3 and 1 percent, respectively).

Both women and men are more likely to live in rural areas than urban areas (55 percent of women and 54 percent of men). By region, the smallest proportion, about one-tenth, of women and men are from the Mountain region, while the largest proportion, 46 percent of women and 48 percent of men, are from the Central region. Looking at prefectures, the largest proportion of both women and men, about one-fourth, resides in the Tirana prefecture, which includes the country's capital. The smallest proportion of respondents age 15-49 resides in the prefecture of Gjirokastër (3 percent each).

Women and men in Albania are universally well educated, with only about 2 percent of respondents having no education or only having attended the first 4 years of primary education. More women (49 percent) finished schooling with between 5 and 8 years of primary education than men (39 percent). A greater proportion of men (47 percent) have some secondary, professional or technical education beyond the primary 8 year level than women (36 percent). More than one-tenth of respondents (13 percent of women and 12 percent of men) have a university or higher education. Table 2 shows that the main difference in educational attainment between women and men is in the progression from primary 8-year education to the secondary, professional, or technical levels. A smaller proportion of women move on to the secondary, professional, technical education than men.

Table 2. Background characteristics of respondents

Percent distribution of women and men by background characteristics, Albania 2008-09

| Background characteristic | Women | | | Men | | |
|---------------------------------------|------------------|--------------------------|----------------------------|------------------|------------------------|--------------------------|
| | Weighted percent | Weighted number of women | Unweighted number of women | Weighted percent | Weighted number of men | Unweighted number of men |
| Age | | | | | | |
| 15-19 | 19.5 | 1,478 | 1,518 | 22.2 | 670 | 672 |
| 20-24 | 12.9 | 976 | 953 | 13.0 | 393 | 383 |
| 25-29 | 11.2 | 848 | 826 | 8.9 | 269 | 274 |
| 30-34 | 11.4 | 866 | 862 | 9.0 | 273 | 275 |
| 35-39 | 14.5 | 1,097 | 1,125 | 12.3 | 372 | 363 |
| 40-44 | 16.2 | 1,232 | 1,239 | 16.6 | 501 | 496 |
| 45-49 | 14.3 | 1,088 | 1,061 | 17.8 | 536 | 550 |
| Marital status | | | | | | |
| Never married | 31.1 | 2,357 | 2,412 | 42.8 | 1,291 | 1,310 |
| Married | 64.7 | 4,910 | 4,878 | 55.4 | 1,671 | 1,650 |
| Living together | 1.2 | 91 | 89 | 1.1 | 32 | 30 |
| Divorced/separated | 1.4 | 109 | 93 | 0.5 | 15 | 18 |
| Widowed | 1.5 | 116 | 112 | 0.1 | 4 | 5 |
| Residence | | | | | | |
| Urban | 44.6 | 3,380 | 3,846 | 46.2 | 1,391 | 1,655 |
| Rural | 55.4 | 4,204 | 3,738 | 53.8 | 1,622 | 1,358 |
| Region | | | | | | |
| Coastal | 28.1 | 2,129 | 1,961 | 26.5 | 800 | 753 |
| Central | 45.8 | 3,477 | 2,115 | 47.9 | 1,443 | 874 |
| Mountain | 10.2 | 777 | 2,366 | 9.2 | 277 | 866 |
| Urban Tirana | 15.8 | 1,201 | 1,142 | 16.3 | 493 | 520 |
| Prefecture | | | | | | |
| Berat | 5.7 | 433 | 339 | 5.2 | 156 | 125 |
| Diber | 5.5 | 419 | 941 | 5.0 | 151 | 315 |
| Durres | 8.3 | 627 | 497 | 7.7 | 232 | 183 |
| Elbasan | 12.5 | 949 | 1,160 | 13.1 | 395 | 469 |
| Fier | 11.2 | 846 | 776 | 10.4 | 312 | 291 |
| Gjirokaster | 2.9 | 222 | 134 | 2.9 | 87 | 53 |
| Korce | 7.0 | 529 | 380 | 6.5 | 196 | 145 |
| Kukes | 2.9 | 223 | 727 | 2.9 | 89 | 292 |
| Lezhe | 4.1 | 307 | 283 | 4.2 | 127 | 119 |
| Shkoder | 11.3 | 855 | 494 | 11.9 | 358 | 201 |
| Tirana | 23.7 | 1,799 | 1,505 | 24.9 | 749 | 672 |
| Vlore | 5.0 | 375 | 348 | 5.3 | 160 | 148 |
| Education | | | | | | |
| No education/ primary 4-year | 1.7 | 127 | 127 | 1.8 | 55 | 58 |
| Primary 8-year | 48.9 | 3,712 | 3,579 | 39.3 | 1,183 | 1,138 |
| Secondary, professional, technical | 36.1 | 2,740 | 2,904 | 47.0 | 1,415 | 1,460 |
| University+ | 13.3 | 1,005 | 974 | 12.0 | 361 | 357 |
| Total | 100.0 | 7,584 | 7,584 | 100.0 | 3,013 | 3,013 |

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.

C. Fertility

Fertility data were collected in the 2008-09 ADHS by asking each of the women interviewed for a history of her births. The information obtained on each birth included the month and year of the birth. These data are used to calculate two of the most widely used measures of current fertility—the total fertility rate (TFR) and its component age-specific fertility rates (ASFR).

Table 3 shows a TFR of 1.6 children per woman for the three-year period preceding the 2008-09 ADHS, approximately corresponding to the period from the beginning of 2006 to the end of 2008. This means that, on average, a woman in Albania who is at the beginning of her childbearing years will give birth to 1.6 children by the end of her reproductive period, if fertility levels remain constant at the level observed in the three-year period. The survey results indicate that the crude birth rate is 10.0 births per 1,000 women.

The TFR for rural areas (1.8 births) is higher than that for urban areas (1.3 births). Figure 1 shows that this urban-rural difference in childbearing rates can be attributed almost exclusively to the younger age groups. Although peak fertility occurs sharply at age 25-29 in both urban and rural areas, the greatest absolute difference in ASFR (56 births per 1,000 women) is in the 20-24 age group.

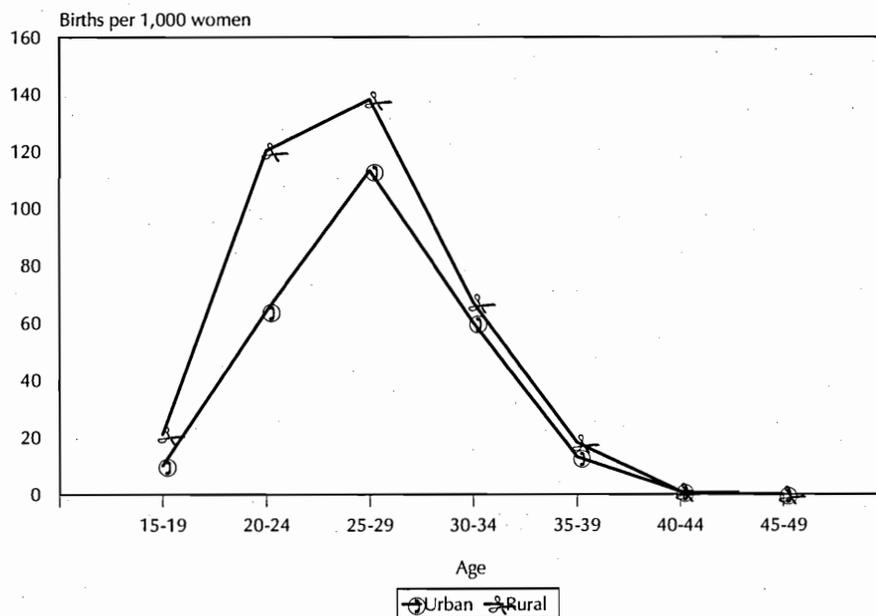
Table 3. Current Fertility

Age-specific and cumulative fertility rates, the general fertility rate, and the crude birth rate for the three years preceding the survey, by urban-rural residence, Albania 2008-09

| Age group | Residence | | Total |
|-----------|-----------|-------|-------|
| | Urban | Rural | |
| 15-19 | 10 | 21 | 17 |
| 20-24 | 64 | 120 | 95 |
| 25-29 | 113 | 138 | 126 |
| 30-34 | 60 | 67 | 64 |
| 35-39 | 13 | 18 | 15 |
| 40-44 | 1 | 1 | 1 |
| 45-49 | 0 | 0 | 0 |
| TFR | 1.3 | 1.8 | 1.6 |
| GFR | 39 | 51 | 46 |
| CBR | 8.4 | 11.3 | 10.0 |

Note: Rates for age group 45-49 may be slightly biased due to truncation.
 TFR: Total fertility rate for ages 15-49, expressed per woman
 GFR: General fertility rate (births divided by the number of women age 15-44), expressed per 1,000 women
 CBR: Crude birth rate, expressed per 1,000 population

Figure 1 Age-Specific Fertility Rates by Urban-Rural Residence



ADHS 2008-09

There has been a steady decline in fertility throughout the 1990s and into the present decade, from 3.3 children per woman in 1993-1995 to 2.6 in 1999-2002 (CDC, IPH, and INSTAT, 2005) to the current level of 1.6 children per woman in 2006-2008.

Compared with recent fertility estimates from Demographic and Health Surveys conducted in other countries in the region, fertility is higher in **Albania** than in **Ukraine**: 1.2 births per woman in 2007 (UCSR, SSC, and Macro International, 2008) but lower than in **Azerbaijan**: 2.0 births per woman in 2006 (SSC, MOH, and Macro International, 2008), **Moldova**: 1.7 births per woman in 2005 (NCPM and ORC Macro, 2006), and **Armenia**: 1.7 births per woman in 2005 (NSS, MOH, and ORC Macro, 2006). The levels of fertility are very similar to those found in surrounding countries, according to estimates from the United Nations Population Division, which give estimates of 1.4 births per woman for the period 2005-2010 in **Greece** and **The Former Yugoslav Republic of Macedonia**, and 1.6 births per woman in **Serbia** and in **Montenegro** (UNPD, 2008).

D. Family Planning

The 2008-09 ADHS collected information on knowledge and use of contraception. To obtain these data, respondents were first asked to name all of the methods that they had heard about. For methods not mentioned spontaneously, a description of the method was read and the respondents were asked if they had ever heard of the method. For each method named or recognized, respondents were asked if they had ever used the method. Finally, women were asked if they (or their partner) were currently using a method. For analytical purposes, contraceptive methods are grouped into two categories: modern and traditional methods. Modern methods include female sterilization, male sterilization, pill, IUD, injectables, implants, male condom, female condom, and LAM. Traditional methods include periodic abstinence or rhythm and withdrawal.

Table 4 shows the level of and differentials in the current use of contraception by method among currently married women age 15-49. About two-thirds of currently married women (69 percent) are presently using some method of contraception. Traditional methods are much more commonly used than modern methods; about six in ten (59 percent) married women use traditional methods, while about one in ten (11 percent) use modern methods. The male condom is the most widely used modern method (4 percent), followed by female sterilization (3 percent) and the pill (2 percent). Women in the youngest age group (15-19 years) use condoms more frequently than women in the older age groups. Withdrawal is the most popular traditional method. It is used by virtually all users of traditional methods (58 percent).

Contraceptive use levels rise rapidly with age, peaking at 75 percent in the 35-39 age group and 76 percent in the 40-44 age group, and then falling to 64 percent among women age 45-49. About one-third of women with no children use a method with around three-fourths of them relying on withdrawal, and about one in six relying on the male condom. The majority of women with at least one child (72 percent) are using contraception.

There is an eight percentage point difference in the use of contraception in urban and rural areas (74 and 66 percent, respectively); similarly, urban women are more likely to use a modern method than rural women (12 and 10 percent, respectively). There is some variation in contraceptive use by region. Women in urban Tirana are the most likely to use any method (72 percent) and any modern method of contraception (13 percent). On the other hand, women in the Coastal region are the least likely to use any method (66 percent) and any modern method (9 percent).

With the exclusion of the relatively small group of women with no education or only primary 4-year education, contraceptive use rises with level of education, from 66 percent of women with primary 8-year education to 74 and 73 percent, respectively, in the secondary, technical, professional and the university education groups. While there is no difference in overall contraceptive prevalence for these two groups, a greater proportion of university-educated women use modern methods—the prevalence of modern methods is 18 percent for university-educated women, compared with 12 percent for those with some secondary, professional, or technical education.

In terms of trends, in 2002, the contraceptive prevalence rate was 75 percent among of married women age 15-44 years, and 8 percent used modern contraceptive methods (CDC, IPH, and INSTAT, 2005). The contraceptive prevalence rate of 69 percent in the 2008-09 ADHS is slightly lower, but use of modern methods increased to 11 percent.

Table 4. Current use of contraception

Percent distribution of currently married women by contraceptive method currently used, according to background characteristics, Albania 2008-09

| Background characteristic | Modern method | | | | | | | | | Traditional method | | | | Total | Number of women |
|------------------------------------------|-------------------|----------------------|------|-----|-------------|-------------|-----|---------------------|------------------------|---------------------|------------|---------------------|------|-------|-----------------|
| | Any modern method | Female sterilization | Pill | IUD | Injectables | Male condom | LAM | Other modern method | Any traditional method | Periodic abstinence | Withdrawal | Not currently using | | | |
| Age | | | | | | | | | | | | | | | |
| 15-19 | 54.7 | 12.9 | 0.0 | 1.7 | 0.0 | 1.1 | 9.4 | 0.7 | 0.0 | 41.8 | 1.0 | 40.8 | 45.3 | 100.0 | 110 |
| 20-24 | 52.8 | 8.4 | 0.0 | 0.9 | 0.5 | 0.0 | 4.8 | 2.1 | 0.0 | 44.5 | 1.3 | 43.2 | 47.2 | 100.0 | 358 |
| 25-29 | 62.2 | 14.3 | 1.4 | 1.7 | 1.0 | 1.2 | 8.0 | 1.1 | 0.0 | 47.9 | 1.1 | 46.8 | 37.8 | 100.0 | 599 |
| 30-34 | 72.9 | 13.4 | 2.7 | 2.1 | 1.3 | 1.4 | 5.7 | 0.3 | 0.0 | 59.5 | 1.6 | 57.9 | 27.1 | 100.0 | 766 |
| 35-39 | 75.4 | 10.5 | 2.9 | 2.4 | 1.2 | 0.7 | 2.9 | 0.2 | 0.1 | 64.9 | 0.6 | 64.3 | 24.6 | 100.0 | 1,022 |
| 40-44 | 76.1 | 10.0 | 4.3 | 1.6 | 0.9 | 0.6 | 2.5 | 0.0 | 0.2 | 66.1 | 0.9 | 65.2 | 23.9 | 100.0 | 1,155 |
| 45-49 | 64.3 | 7.7 | 4.4 | 0.7 | 0.5 | 0.1 | 2.0 | 0.0 | 0.0 | 56.6 | 0.0 | 56.6 | 35.7 | 100.0 | 993 |
| Residence | | | | | | | | | | | | | | | |
| Urban | 74.4 | 11.9 | 3.1 | 2.0 | 1.0 | 0.2 | 5.1 | 0.5 | 0.0 | 62.5 | 0.7 | 61.8 | 25.6 | 100.0 | 2,145 |
| Rural | 65.5 | 9.6 | 3.0 | 1.3 | 0.9 | 1.0 | 3.1 | 0.3 | 0.1 | 55.8 | 0.9 | 55.0 | 34.5 | 100.0 | 2,856 |
| Region | | | | | | | | | | | | | | | |
| Coastal | 65.7 | 9.1 | 3.8 | 1.1 | 0.8 | 0.4 | 2.5 | 0.4 | 0.1 | 56.5 | 1.2 | 55.3 | 34.3 | 100.0 | 1,450 |
| Central | 71.1 | 10.6 | 3.0 | 1.1 | 0.8 | 0.8 | 4.6 | 0.2 | 0.1 | 60.5 | 0.8 | 59.7 | 28.9 | 100.0 | 2,383 |
| Mountain | 67.1 | 11.5 | 2.8 | 2.4 | 1.2 | 1.7 | 2.6 | 0.8 | 0.0 | 55.6 | 0.4 | 55.3 | 32.9 | 100.0 | 482 |
| Urban Tirana | 72.3 | 13.2 | 1.8 | 3.7 | 1.5 | 0.0 | 5.7 | 0.5 | 0.0 | 59.2 | 0.2 | 58.9 | 27.7 | 100.0 | 686 |
| Education | | | | | | | | | | | | | | | |
| No education/ primary 4-year | 71.7 | 18.4 | 3.4 | 1.5 | 3.6 | 2.9 | 7.0 | 0.0 | 0.0 | 53.3 | 0.0 | 53.3 | 28.3 | 100.0 | 81 |
| Primary 8-year | 65.7 | 8.6 | 2.9 | 1.0 | 0.7 | 1.0 | 2.6 | 0.3 | 0.1 | 57.1 | 0.8 | 56.3 | 34.3 | 100.0 | 2,746 |
| Secondary, professional, technical | 74.0 | 11.5 | 3.9 | 1.5 | 1.2 | 0.3 | 4.3 | 0.4 | 0.0 | 62.6 | 0.6 | 61.9 | 26.0 | 100.0 | 1,681 |
| University+ | 73.0 | 17.5 | 0.8 | 5.3 | 0.6 | 0.0 | 9.9 | 0.8 | 0.2 | 55.5 | 1.9 | 53.6 | 27.0 | 100.0 | 493 |
| Living children | | | | | | | | | | | | | | | |
| 0 | 33.8 | 7.8 | 0.2 | 1.9 | 0.0 | 0.0 | 5.7 | 0.0 | 0.0 | 26.0 | 0.0 | 26.0 | 66.2 | 100.0 | 361 |
| 1-2 | 72.1 | 10.9 | 2.2 | 1.8 | 0.9 | 0.3 | 5.0 | 0.6 | 0.0 | 61.2 | 1.0 | 60.3 | 27.9 | 100.0 | 2,680 |
| 3-4 | 71.8 | 10.4 | 4.4 | 1.3 | 1.0 | 1.1 | 2.4 | 0.1 | 0.1 | 61.4 | 0.6 | 60.8 | 28.2 | 100.0 | 1,754 |
| 5+ | 73.9 | 13.4 | 6.6 | 1.5 | 1.8 | 2.8 | 0.5 | 0.2 | 0.0 | 60.5 | 2.2 | 58.2 | 26.1 | 100.0 | 207 |
| Total | 69.3 | 10.6 | 3.0 | 1.6 | 0.9 | 0.7 | 4.0 | 0.4 | 0.1 | 58.7 | 0.8 | 57.9 | 30.7 | 100.0 | 5,001 |

Note: If more than one method is used, only the most effective method is considered in this tabulation. Other modern methods include diaphragm, foam, jelly, female condom and male sterilization
LAM = Lactational amenorrhea method.

Although it appears that contraceptive prevalence has decreased slightly since the 2002 Reproductive Health Survey (RHS), the different age range of women interviewed in the 2008-09 ADHS must be taken into account. Interviewing women age 15-49 years likely results in a lower prevalence than interviewing women age 15-44 because proportionally fewer women age 44-49 use contraception, especially modern methods.¹

E. Fertility Preferences

The survey included several questions on women's fertility preferences: whether the respondent wanted another child and, if so, when she would like to have the next child. The answers to these questions allow an estimation of the potential demand for family planning services either to space or limit births.

Figure 2 shows that there is considerable desire among Albanian women to control the timing and number of births. Among currently married women, 9 percent reported that they would like to wait two years or more before the next birth, and 73 percent do not want to have another child or are sterilized. About 8 percent of married women would like to have a child soon (within two years). The remaining women are uncertain about their fertility desires, or say they are unable to get pregnant (infecund).

Figure 2 Fertility Preferences among Currently Married Women

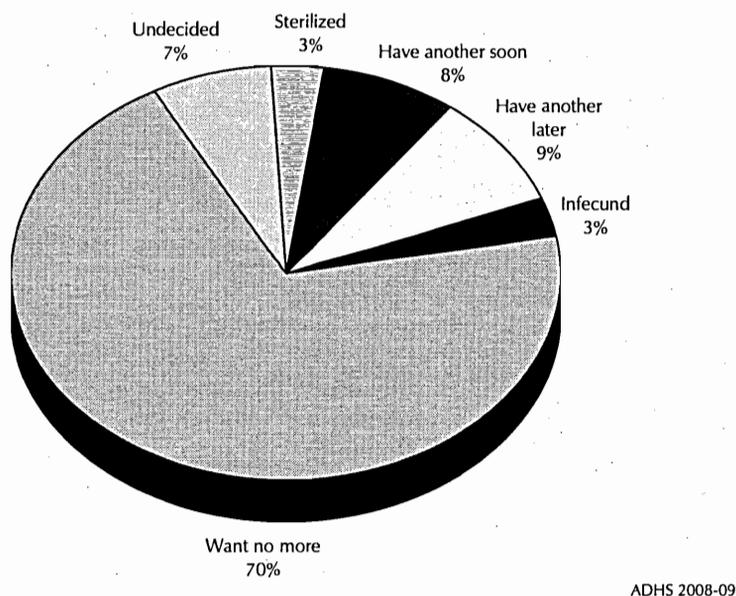


Table 5 shows that fertility preferences are closely related to the number of children a woman has. About half of currently married women without a child would like to have one soon. The desire to have another child drops quickly after the first child; only about one-fourth of women with one child want to have another child soon, more than one-third want to have another child later (after two or more years), and one-fifth do not want any more children. The proportion of women who want no more children rises from 22 percent among women with one child to 77 percent among women with two living children and to more than 90 percent among women with four or more living children.

¹ In addition to the DHS and RHS data, there have been two MICS surveys, the latter producing estimates of 60 percent overall prevalence and 22 percent prevalence of modern methods (INSTAT, 2007). However, the MICS data are likely to have underestimated overall prevalence and overestimated the prevalence of modern methods because of wording differences in the questionnaire used in that survey.

Table 5. Fertility preferences by number of living children

Percent distribution of currently married women by desire for children, according to number of living children, Albania 2008-09

| Desire for children | Number of living children ¹ | | | | | | | Total |
|---------------------------------|----------------------------------------|-------|-------|-------|-------|-------|-------|-------|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6+ | |
| Have another soon ² | 50.2 | 22.9 | 4.5 | 1.9 | 0.7 | 0.0 | 0.0 | 8.4 |
| Have another later ³ | 13.2 | 35.8 | 6.9 | 1.1 | 0.2 | 1.0 | 0.0 | 8.7 |
| Have another, undecided when | 20.3 | 9.3 | 0.7 | 0.0 | 0.0 | 0.0 | 0.0 | 2.7 |
| Undecided | 0.9 | 4.3 | 6.6 | 2.3 | 1.9 | 2.3 | 1.4 | 4.2 |
| Want no more | 1.2 | 21.8 | 76.5 | 87.7 | 91.7 | 90.4 | 89.3 | 69.7 |
| Sterilized ⁴ | 0.2 | 0.4 | 2.8 | 4.4 | 4.8 | 6.0 | 7.8 | 3.1 |
| Declared infecund | 14.0 | 5.6 | 2.0 | 2.7 | 0.8 | 0.2 | 1.5 | 3.2 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Number of women | 300 | 655 | 2,053 | 1,366 | 419 | 150 | 59 | 5,001 |

¹ Includes current pregnancy

² Wants next birth within 2 years

³ Wants to delay next birth for 2 or more years

⁴ Includes both male and female sterilization

F. Maternity Care

Proper care during pregnancy and delivery are important for the health of both the mother and the infant. In the 2008-09 ADHS, women who had given birth in the five years preceding the survey were asked a number of questions about maternal and child health care. For the last live birth in that period, the mothers were asked whether they had obtained antenatal care during the pregnancy and whether they had received tetanus injections to prevent neonatal tetanus while pregnant. For each birth, the mothers were also asked what type of assistance they received at the time of delivery. Table 6 presents the information on these key maternity care indicators.

Antenatal Care

Antenatal care from a trained provider is important to monitor the pregnancy and reduce risks for the mother and infant during pregnancy and at delivery. Ninety-seven percent of mothers reported seeing a health professional at least once for antenatal care for the most recent birth in the five years before the survey. Coverage is high among mothers regardless of background characteristics, as shown in Table 6. ANC coverage has increased substantially since 2002, from 81 percent—19 percent of mothers reported no ANC visits—as reported in the 2002 RHS to 97 percent reported in both the 2005 MICS and the 2008-09 ADHS.

Compared with estimates from recent Demographic and Health Surveys conducted in other countries in Eastern Europe and Caucasus, **Albania** is among those with the highest coverage of antenatal care by a trained provider. In the neighbouring countries, 98 percent of mothers received antenatal care from a trained provider in **Serbia**, 97 percent in **Montenegro**, and 94 percent in **The Former Yugoslav Republic of Macedonia** (UNSD, 2009).

Tetanus Toxoid

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a major cause of early infant death in many countries, often because of failure to observe hygienic procedures during delivery. Table 6 shows that 67 percent of last births were protected against neonatal tetanus. Protection against neonatal tetanus is highest for births to mothers in the < 20 age group (79 percent), urban mothers (71 percent), mothers in the Coastal region (77 percent), and mothers with a university or higher education (76 percent).

Table 6. Maternal care indicators

Percentage of women who had a live birth in the five years preceding the survey who received antenatal care from a health professional for the last live birth and whose last live birth was protected against neonatal tetanus, and among all live births in the five years before the survey, percentage delivered by a health professional and percentage delivered in a health facility, by background characteristics, Albania 2008-09

| Background characteristic | Percentage with antenatal care from a health professional ¹ | Percentage whose last live birth was protected against neonatal tetanus ² | Number of women | Percentage delivered by a health professional ¹ | Percentage delivered in a health facility | Number of births |
|------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------|-------------------------------------------|------------------|
| Mother's age at birth | | | | | | |
| <20 | 96.7 | 79.2 | 86 | 99.5 | 96.5 | 115 |
| 20-34 | 97.8 | 66.2 | 1,085 | 99.3 | 96.9 | 1,317 |
| 35+ | 93.9 | 70.5 | 139 | 99.7 | 94.8 | 144 |
| Residence | | | | | | |
| Urban | 99.1 | 71.4 | 520 | 99.9 | 99.1 | 609 |
| Rural | 96.2 | 64.9 | 790 | 99.0 | 95.2 | 967 |
| Region | | | | | | |
| Coastal | 99.0 | 76.7 | 352 | 99.2 | 98.7 | 435 |
| Central | 96.9 | 64.4 | 624 | 99.3 | 95.1 | 741 |
| Mountain | 92.4 | 59.6 | 157 | 99.1 | 95.2 | 193 |
| Urban Tirana | 100.0 | 67.0 | 177 | 100.0 | 99.8 | 207 |
| Education | | | | | | |
| No education/primary | | | | | | |
| 4-year | (96.9) | (44.5) | 42 | 96.3 | 93.6 | 54 |
| Primary 8-year | 96.6 | 66.8 | 797 | 99.2 | 95.3 | 988 |
| Secondary, professional, technical | 98.1 | 68.2 | 326 | 100.0 | 99.9 | 372 |
| University+ | 99.4 | 76.3 | 145 | 100.0 | 99.1 | 163 |
| Total | 97.3 | 67.5 | 1,310 | 99.3 | 96.7 | 1,576 |

Note: Figures in parentheses are based on 25-49 unweighted cases.
¹ Doctor, nurse, midwife, or auxiliary midwife
² Includes mothers with two injections during the pregnancy for the last live birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last live birth), or four or more injections (the last within ten years of the last live birth), or five or more injections prior to the last live birth

Delivery Care

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the infant. Table 6 shows that virtually all births in Albania (99 percent) are delivered by a health professional; similarly, almost all deliveries (97 percent) take place in health facilities. Differentials in delivery care vary little by background characteristics of the mother.

Estimates from recent Demographic and Health Surveys conducted in other countries in Eastern Europe and Caucasus show that most countries in the region, with the exception of Azerbaijan, have over 95 percent of women assisted by a health professional at the time of delivery, and delivering in a health facility.

G. Child Health

Vaccination of Children

According to the World Health Organization, a child is considered fully vaccinated if he or she has received a BCG vaccination to prevent tuberculosis, three doses of DPT to prevent diphtheria, pertussis, and tetanus, at least three doses of polio vaccine, and one dose of measles vaccine. The vaccination schedule followed by the National Immunization Programme of the Government of Albania provides all vaccinations mentioned above as well as vaccination against Hepatitis B (three doses) and against mumps and rubella. The last two are given as one injection of combined measles-mumps-rubella (MMR) vaccine. All vaccinations should be received during the first year of life, except MMR, which is given at the age of 12 months. Taking into consideration this vaccination schedule, full immunization coverage was estimated in the birth cohort 18-29 months of age, allowing a reasonable interval for children to receive the MMR vaccination.

The information on vaccination coverage was obtained for all children under five years. In Albania, child immunization records are routinely maintained in the local health facilities, however "Vaccination cards" and "Child health books" are kept in the possession of the child's parent or guardian. Vaccination cards have been available for many years, while child health books were introduced more recently in 1998. In this survey, data were collected from both sources, as well as the mother's verbal report. All mothers were asked to show the interviewer the vaccination card or the child health book used for the child's immunization. If the vaccination card or child health book was available, the interviewer copied the dates of each immunization received in the questionnaire instrument. If no vaccination card or child health book was available the interviewer proceeded to ask the mother if the child had received BCG, polio, DPT, hepatitis B, and MMR vaccines, and how many doses were received. After completing the interview in the household and collecting information about the name of the local health facility where the child's immunization record is kept, the field team supervisor visited that health facility to obtain the child's immunization information from that source. The final estimates of vaccination coverage are based on all available sources, with the information from the health centre taken as the primary source, supplemented by the vaccination card or child health book provided by the mother, and lastly by the mother's reporting of vaccinations given to the child.

Vaccination cards or child health books at home were seen for only 68 percent of children; however immunization records at the health facility were seen for almost all children (96 percent) indicating that a strong immunization programme is in place in Albania.

Table 7 presents information on vaccination coverage for children age 18-29 months, who should be fully vaccinated against the nine preventable childhood diseases. The results are based on the combined sources including the child's record at the health facility, the vaccination cards and child health books at home, and information reported by mother.

Table 7. Vaccinations by background characteristics

Percentage of children age 18-29 months who received specific vaccines at any time before the survey (according to health facility records, vaccination card, child health book, and the mother's report), percentage with a vaccination card or child health book seen, and percentage with the health facility record seen, by background characteristics, Albania 2008-09

| Background characteristic | BCG | DPT | | | Polio | | | Hepatitis B | | | Measles | All ¹ | No vaccinations | Percentage with a vaccination card/child health book | Percentage with a health facility record | Number of children |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|-------------|---------|---------|---------|------------------|-----------------|------------------------------------------------------|------------------------------------------|--------------------|
| | | 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 | | | | | | |
| Sex | | | | | | | | | | | | | | | | |
| Male | 97.9 | 100.0 | 97.9 | 96.9 | 97.9 | 97.9 | 97.9 | 97.9 | 97.9 | 96.9 | 96.1 | 95.2 | 0.0 | 63.9 | 94.4 | 131 |
| Female | 98.0 | 99.2 | 99.2 | 98.2 | 99.2 | 98.2 | 98.2 | 99.2 | 99.2 | 98.2 | 97.2 | 95.1 | 0.8 | 70.9 | 97.0 | 160 |
| Residence | | | | | | | | | | | | | | | | |
| Urban | 98.3 | 100.0 | 100.0 | 98.8 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 98.8 | 100.0 | 97.1 | 0.0 | 71.5 | 98.6 | 109 |
| Rural | 97.7 | 99.3 | 97.7 | 96.9 | 97.7 | 96.9 | 96.9 | 97.7 | 97.7 | 96.9 | 94.8 | 93.9 | 0.7 | 65.5 | 94.1 | 183 |
| Region | | | | | | | | | | | | | | | | |
| Coastal | 96.2 | 98.4 | 98.4 | 98.4 | 98.4 | 98.4 | 98.4 | 98.4 | 98.4 | 98.4 | 97.0 | 94.8 | 1.6 | 66.3 | 96.3 | 83 |
| Central | 98.1 | 100.0 | 98.1 | 96.1 | 98.1 | 97.0 | 97.0 | 98.1 | 98.1 | 96.1 | 95.2 | 93.2 | 0.0 | 71.6 | 94.6 | 145 |
| Mountain | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 0.0 | 61.6 | 96.2 | 34 |
| Urban Tirana | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (100.0) | (0.0) | (59.7) | (100.0) | 30 |
| Mother's education | | | | | | | | | | | | | | | | |
| Primary or less | 97.1 | 99.3 | 98.0 | 98.0 | 98.0 | 98.0 | 98.0 | 98.0 | 98.0 | 98.0 | 95.4 | 94.5 | 0.7 | 67.8 | 96.1 | 205 |
| Secondary+ | 100.0 | 100.0 | 100.0 | 96.7 | 100.0 | 98.2 | 98.2 | 100.0 | 100.0 | 96.7 | 100.0 | 96.7 | 0.0 | 67.5 | 95.2 | 87 |
| Total | 97.9 | 99.5 | 98.6 | 97.6 | 98.6 | 98.0 | 98.0 | 98.6 | 98.6 | 97.6 | 96.7 | 95.1 | 0.5 | 67.7 | 95.8 | 292 |

Note: Figures in parentheses are based on 25-49 unweighted cases

¹ BCG, measles, and three doses each of DPT and polio vaccine

Overall, 95 percent of children age 18-29 months are fully vaccinated, and less than 1 percent of children were reported as having never received any vaccines. Regarding coverage for specific vaccines, 97 percent or more of children have received the BCG vaccination, all three doses of DPT, polio and hepatitis B vaccines, and measles. There is a slight decline in the DPT vaccination from 100 percent for the first dose to 99 percent for the second dose and 98 percent for the third dose, reflecting a small dropout rate of less than 2 percent. The dropout rate represents the proportion of children who receive the first dose of a vaccine but did not go on to receive the third dose.

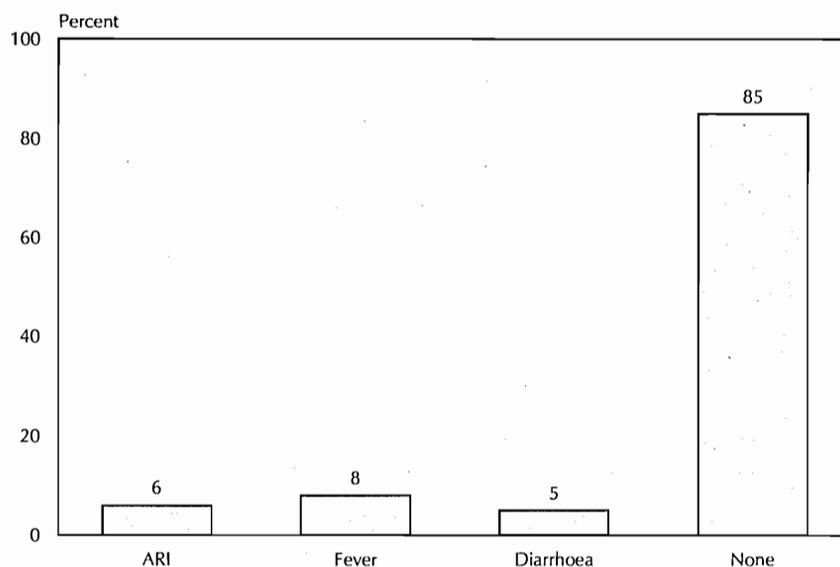
There are no significant differentials in coverage levels by background characteristics. Children residing in the Central region (93 percent) and children of mothers with primary or lower education (95 percent) have slightly lower coverage rates than other children.

Treatment of Childhood Illnesses

Acute respiratory illness, fever and dehydration from severe diarrhoea are major causes of childhood morbidity and mortality. Prompt medical attention for children experiencing the symptoms of these illnesses is, therefore, crucial in increasing child well-being and reducing child deaths. To obtain information on how childhood illnesses are treated, mothers were asked (for each child under five years) whether in the two weeks before the survey the child had experienced cough with short, rapid breathing (symptoms of acute respiratory infection (ARI)), fever, and diarrhoea.

Among children under five years, 8 percent were reported to have had a fever, 5 percent had a cough with short, rapid breathing, and 5 percent had diarrhoea within the two-week period preceding the ADHS (Figure 3).

Figure 3 Prevalence of ARI, Fever, and Diarrhoea in the Past Two Weeks, among Children Under Five

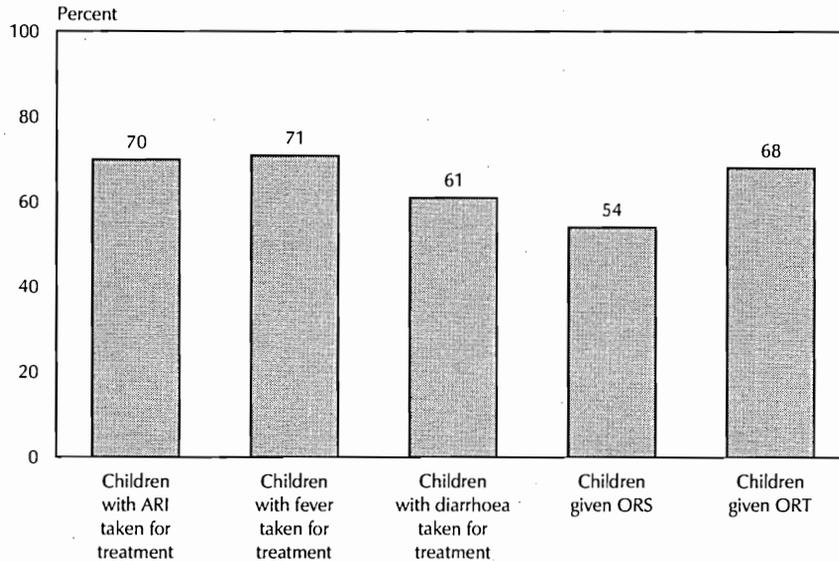


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The data show that, among children with ARI symptoms, about seven in ten were taken for treatment to a health facility or provider; and a similar percentage (71 percent) of children with fever were taken for treatment to a health facility or health provider. Six in ten children with diarrhoea in the past two weeks were taken for treatment, more than half (54 percent) were given oral rehydration salt (ORS), and about seven in ten (68 percent) were treated with oral rehydration therapy, whether as a solution prepared from ORS packets or a home-prepared solution (Figure 4).

Analysis of variation in the treatment of children under five for ARI, fever, and diarrhoea by background characteristics could not be carried out because there were too few cases to be statistically reliable.

Figure 4 Treatment for ARI, Fever, and Diarrhoea among Children Under Five



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H. Nutrition

Breastfeeding and Supplementation

Breastfeeding enhances the early bonding and socialization experience of an infant. In addition, breast milk is uncontaminated and contains all the nutrients needed by children in the first four to six months of life. Children who are exclusively breastfed receive *only* breast milk. Exclusive breastfeeding is recommended during the first 6 months of a child’s life because it limits exposure to disease agents as well as providing all of the nutrients that a baby requires. Table 8 shows the breastfeeding practices of mothers of children less than three years of age.

Ninety-six percent of children under six months of age in Albania are breastfed. The duration of breastfeeding, however, is not long; already at 12 to 15 months, only six in ten children are being breastfed. By 20 to 23 months, only one in three children (31 percent) are being breastfed.

Exclusive breastfeeding is less common, and supplementary feeding begins early. Four in ten children (39 percent) under 6 months are exclusively breastfed; 21 percent are receiving complementary foods, and the rest of the breastfed children consume water-based liquids or juice, or other milk in addition to breast milk. By age 6 to 9 months, most breastfeeding children are receiving complementary foods in addition to breast milk.

Table 8. Breastfeeding status by age

Among youngest children under three years living with their mother, percent distribution by breastfeeding status and the percentage currently breastfeeding, according to age in months, Albania 2008-09

| Age in months | Percent distribution of youngest children under three living with their mother by breastfeeding status | | | | | | | Percentage currently breastfeeding | Number of youngest children under three years |
|---------------|--------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------|------------------------|------------|--------------------|-------|------------------------------------|-----------------------------------------------|
| | Not breast-feeding | Exclusively breastfed | Breastfeeding and consuming | | | | Total | | |
| | | | Plain water only | Non-milk liquids/juice | Other milk | Complementary food | | | |
| 0-1 | (0.0) | (68.2) | (5.8) | (5.9) | (7.8) | (12.3) | 100.0 | (100.0) | 37 |
| 2-3 | 3.3 | 39.4 | 10.2 | 12.8 | 17.8 | 16.4 | 100.0 | 96.7 | 61 |
| 4-5 | (7.7) | (17.6) | (37.0) | (5.2) | (0.0) | (32.5) | 100.0 | (92.3) | 54 |
| 6-8 | 22.6 | 4.7 | 14.9 | 0.7 | 2.0 | 55.1 | 100.0 | 77.4 | 58 |
| 9-11 | 30.3 | 0.8 | 0.8 | 2.1 | 0.0 | 66.1 | 100.0 | 69.7 | 58 |
| 12-17 | 45.7 | 0.0 | 0.0 | 0.0 | 0.0 | 54.3 | 100.0 | 54.3 | 139 |
| 18-23 | 67.4 | 0.0 | 0.0 | 0.0 | 0.0 | 32.6 | 100.0 | 32.6 | 111 |
| 24-35 | 93.3 | 0.0 | 0.0 | 0.0 | 0.0 | 6.7 | 100.0 | 6.7 | 268 |
| 0-3 | 2.1 | 50.2 | 8.6 | 10.2 | 14.1 | 14.9 | 100.0 | 97.9 | 97 |
| 0-5 | 4.1 | 38.6 | 18.7 | 8.4 | 9.0 | 21.2 | 100.0 | 95.9 | 151 |
| 6-9 | 24.3 | 4.7 | 12.9 | 2.4 | 1.7 | 53.9 | 100.0 | 75.7 | 67 |
| 12-15 | 39.4 | 0.0 | 0.0 | 0.0 | 0.0 | 60.6 | 100.0 | 60.6 | 96 |
| 12-23 | 55.4 | 0.0 | 0.0 | 0.0 | 0.0 | 44.6 | 100.0 | 44.6 | 250 |
| 20-23 | 69.0 | 0.0 | 0.0 | 0.0 | 0.0 | 31.0 | 100.0 | 31.0 | 67 |

Note: Breastfeeding status refers to a 24-hour period (yesterday and the past night). Children classified as breastfeeding and consuming plain water only consume no supplements. The categories of not breastfeeding, exclusively breastfed, breastfeeding and consuming plain water, water-based liquids/juice, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus, children who receive breast milk and water-based liquids and who do not receive complementary foods are classified in the water-based liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well. Figures in parentheses are based on 25-49 unweighted cases.

Nutritional Status of Children

Undernutrition places children at increased risk of sickness and death and has also been shown to be related to impaired mental development. Anthropometry provides one of the most important indicators of children's nutritional status. Height and weight measurements were obtained for all children born in the five years preceding the 2008-09 ADHS (Table 9). The height and weight data are used to compute three summary indices of nutritional status: height-for-age; weight-for-height; and weight-for-age. These three indices are expressed as standard deviation units from the median for the international reference population recommended by the World Health Organization (WHO, 2006). Children who fall more than two standard deviations (-2 SD) below the reference median are regarded as undernourished, while those who fall more than three standard deviations (-3 SD) below the reference median are considered severely undernourished. Table 9 shows the nutritional status of children less than five years of age by selected background characteristics.

Table 9. Nutritional status of children

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Albania 2008-09

| Background characteristic | Height-for-age | | Weight-for-height | | Weight-for-age | | Number of children |
|---------------------------------------|------------------------|-------------------------------------|------------------------|-------------------------------------|------------------------|-------------------------------------|--------------------|
| | Percentage below -3 SD | Percentage below -2 SD ¹ | Percentage below -3 SD | Percentage below -2 SD ¹ | Percentage below -3 SD | Percentage below -2 SD ¹ | |
| Age in months | | | | | | | |
| <6 | 19.7 | 32.8 | 12.6 | 26.9 | 3.3 | 11.3 | 94 |
| 6-8 | (15.9) | (23.5) | (4.1) | (10.0) | (5.7) | (8.2) | 41 |
| 9-11 | 15.2 | 32.3 | 5.2 | 6.9 | 0.0 | 8.3 | 51 |
| 12-17 | 7.1 | 17.9 | 4.4 | 6.7 | 3.4 | 4.0 | 123 |
| 18-23 | 16.6 | 29.3 | 3.4 | 7.0 | 0.5 | 6.4 | 112 |
| 24-35 | 9.9 | 17.1 | 4.9 | 9.4 | 1.1 | 3.9 | 255 |
| 36-47 | 10.4 | 19.4 | 5.6 | 8.0 | 1.3 | 3.7 | 272 |
| 48-59 | 6.6 | 11.8 | 5.3 | 6.9 | 1.4 | 5.0 | 339 |
| Sex | | | | | | | |
| Male | 9.3 | 17.6 | 6.7 | 11.2 | 1.8 | 5.8 | 634 |
| Female | 11.7 | 20.9 | 4.4 | 7.1 | 1.5 | 4.6 | 654 |
| Residence | | | | | | | |
| Urban | 10.6 | 19.8 | 6.1 | 10.6 | 1.9 | 4.6 | 522 |
| Rural | 10.5 | 18.9 | 5.1 | 8.2 | 1.5 | 5.7 | 766 |
| Region | | | | | | | |
| Coastal | 9.4 | 17.9 | 4.2 | 8.1 | 1.8 | 6.0 | 382 |
| Central | 10.1 | 18.4 | 5.4 | 8.8 | 1.0 | 4.2 | 590 |
| Mountain | 16.7 | 27.8 | 3.7 | 9.1 | 4.0 | 9.2 | 144 |
| Urban Tirana | 9.3 | 18.3 | 10.4 | 12.8 | 1.6 | 3.5 | 173 |
| Mother's education² | | | | | | | |
| No education/primary | | | | | | | |
| 4-year | (23.3) | (31.2) | (5.5) | (16.9) | (1.8) | (11.0) | 45 |
| Primary 8-year | 11.0 | 19.7 | 5.3 | 8.5 | 1.3 | 5.2 | 801 |
| Secondary, professional, technical | 6.2 | 17.2 | 5.3 | 8.9 | 2.0 | 4.7 | 294 |
| University+ | 11.5 | 17.0 | 7.6 | 11.6 | 2.9 | 5.1 | 137 |
| Mother's status³ | | | | | | | |
| Mother interviewed | 10.5 | 19.3 | 5.4 | 9.1 | 1.5 | 5.1 | 1,255 |
| Total | 10.5 | 19.3 | 5.5 | 9.1 | 1.7 | 5.2 | 1,289 |

Note: Table is based on children who slept in the household the night before the interview. Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards adopted in 2006. The indices in this table are NOT comparable to those based on the previously used NCHS/CDC/WHO reference. Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight. Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Includes children who are below -3 standard deviations (SD) from the International Reference Population median

² For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire

³ Total includes 21 children of mothers not interviewed but living in the household and 12 children of mothers not interviewed and not in the household (or deceased).

Children whose height-for-age is below minus two standard deviations from the median of the reference population are considered stunted or short for their age. Stunting is the outcome of failure to receive adequate nutrition over an extended period and is also affected by recurrent or chronic illness. About one in five (19 percent) children under five years were short for their age and approximately one in ten (11 percent) were severely stunted.

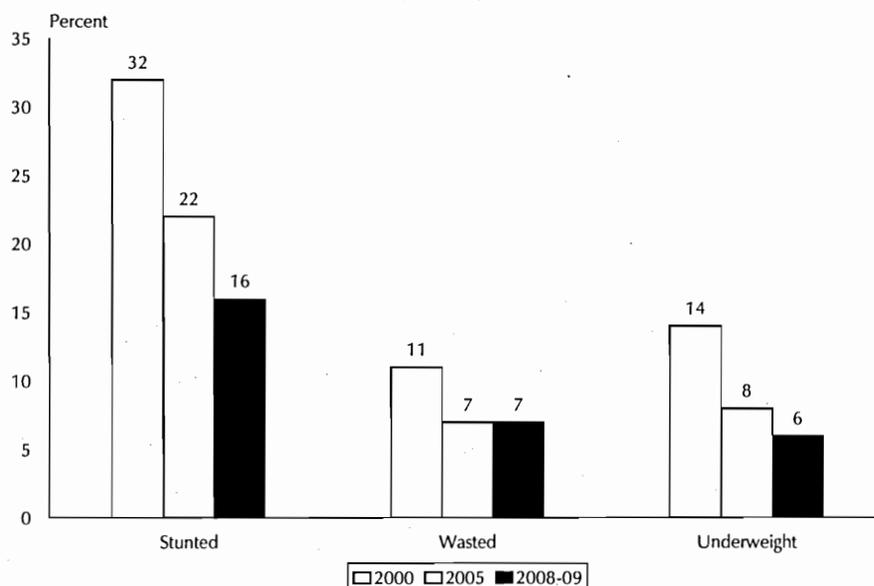
Children whose weight-for-height is below minus two standard deviations from the median of the reference population are considered wasted or thin. Wasting represents the failure to receive adequate nutrition in the period immediately before the survey and is typically the result of recent illness episodes, especially diarrhoea, or a rapid reduction in food supplies. In Albania, about 9 percent of children were wasted at the time of the survey and about 6 percent were severely wasted.

Children whose weight-for-age is below minus two standard deviations from the median of the reference population are considered underweight. The measure reflects the effects of both acute and chronic undernutrition. Approximately 5 percent of children were underweight at the time of the survey and about 2 percent were severely underweight.

Nutritional status of children under five varies somewhat by background characteristics. Stunting is relatively high among younger children under 6 months (33 percent), those 9 to 11 months (32 percent), and those 18 to 23 months (29 percent), children residing in the Mountain region (28 percent), and children of mothers with primary (20 percent) or lower education are more likely than other children to be stunted. The percentage of children who are wasted is substantially higher among children less than 6 months (27 percent) than among those in other age groups. It is also higher among male children (11 percent), and those residing in the urban Tirana region (13 percent). The proportion underweight is highest among young children under 6 months (11 percent), and children residing in the Mountain region (9 percent).

It should be noted that the 2008-09 nutritional status data are based on the WHO Child Growth Standards adopted in 2006 (WHO, 2006) and, therefore, are not comparable to those based on the previously used NCHS/CDC/WHO reference. However, to assess the nutritional status of Albanian children over time, the 2008-09 nutritional indices were produced based on the old NCHS/CDC/WHO reference and then compared with the findings from the 2000 and 2005 MICS surveys (INSTAT, 2002; INSTAT 2008) (see Figure 5). The nutritional status of Albanian children has been improving gradually over the past decade. Stunting among children under five has decreased from 34 percent in 2000 to 22 percent in 2005 to 16 percent in 2008-09. The proportion of children who are wasted has dropped from 11 percent in 2000 to 7 percent in 2005 and 7 percent in 2008-09. Finally, the percentage of underweight children has decreased from 14 percent in 2000 to 8 percent in 2005 to 6 percent in 2008-09.

**Figure 5 Nutritional Status of Children Under Five
Albania 2000, 2005, 2008-09
Based on NCHS/CDC/WHO Reference**



Anaemia

Anaemia is characterized by a low level of haemoglobin in the blood. Haemoglobin is necessary for transporting oxygen from the lungs to other tissues and organs in the body. Anaemia usually results from a nutritional deficiency of iron, folate, vitamin B₁₂, or some other nutrients. This type of anaemia, which is commonly referred to as iron-deficiency anaemia, is the most widespread form of malnutrition in the world. The 2008-09 ADHS included anaemia testing of children 6 to 59 months old and women and eligible men age 15-49. The results of anaemia testing for children and women are shown in Table 10.

Overall, about one in six children age 6 to 59 months (17 percent) in Albania has some level of anaemia, including 11 percent of children who are mildly anaemic (10.0-10.9 g/dL) and 6 percent who are moderately anaemic (7.0-9.9 g/dL). There is a higher prevalence of anaemia among children who live in rural areas than those who live in urban areas (20 and 13 percent, respectively), and more children in the Mountain (24 percent), Coastal (21 percent) and Central (16 percent) regions are affected than children in Tirana urban region (7 percent).

The prevalence of anaemia is slightly more pronounced among women than among children. Nineteen percent of women in Albania are anaemic, with 16 percent mildly anaemic and 3 percent moderately anaemic. The prevalence of anaemia in women by residence and region varies like that of children: it is more common in rural areas than urban areas (23 and 15 percent, respectively), and it is higher among women in the Central (21 percent), Coastal (20 percent), and Mountain (17 percent) regions, compared with women in the urban Tirana region (12 percent).

Compared with recent anaemia prevalence rates among women and children in Demographic and Health Surveys conducted in other countries in the region, anaemia among both children (17 percent) and women (19 percent) in **Albania** is less common than in **Azerbaijan**: 37 and 39 percent, respectively, in 2006 (SSC, MOH, and Macro International, 2008), **Moldova**: 32 and 28 percent, respectively, in 2005 (NCPM and ORC Macro, 2006), and **Armenia**: 37 and 25 percent, respectively, in 2005 (NSS, MOH, and ORC Macro, 2006).

| Table 10. Anaemia among children and women | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------------------|------------------|----------------|--------|
| Percentage of children age 6-59 months and women age 15-49 years classified as having iron-deficiency anaemia, by background characteristics, Albania 2008-09 | | | | | |
| Background characteristic | Any anaemia | Percentage with anaemia | | | Number |
| | | Mild anaemia | Moderate anaemia | Severe anaemia | |
| CHILDREN | | | | | |
| Residence | | | | | |
| Urban | 13.1 | 9.5 | 3.6 | 0.0 | 537 |
| Rural | 20.3 | 12.4 | 7.8 | 0.2 | 785 |
| Region | | | | | |
| Coastal | 21.3 | 14.2 | 6.8 | 0.3 | 385 |
| Central | 16.3 | 9.7 | 6.7 | 0.0 | 595 |
| Mountain | 24.2 | 15.7 | 8.4 | 0.1 | 161 |
| Urban Tirana | 6.5 | 6.0 | 0.5 | 0.0 | 182 |
| Total | 17.4 | 11.2 | 6.1 | 0.1 | 1,322 |
| WOMEN | | | | | |
| Residence | | | | | |
| Urban | 14.6 | 13.0 | 1.5 | 0.1 | 3,348 |
| Rural | 22.5 | 19.0 | 3.4 | 0.1 | 4,095 |
| Region | | | | | |
| Coastal | 20.2 | 17.0 | 3.0 | 0.2 | 2,101 |
| Central | 21.2 | 18.0 | 3.1 | 0.1 | 3,379 |
| Mountain | 16.9 | 15.2 | 1.6 | 0.0 | 769 |
| Urban Tirana | 11.9 | 11.0 | 0.9 | 0.0 | 1,195 |
| Total | 19.0 | 16.3 | 2.6 | 0.1 | 7,443 |

Note: Table is based on children and women who stayed in the household the night before the interview. Prevalence is adjusted for altitude (for children and women) and smoking (for women) using CDC formulas (CDC, 1998). Women and children with <7.0 g/dL of haemoglobin have severe anaemia, women and children with 7.0-9.9 g/dL have moderate anaemia, and non-pregnant women with 10.0-11.9 g/dL and children and pregnant women with 10.0-10.9 g/dL have mild anaemia.

I. Infant and Child Mortality

Information on infant and child mortality is useful in identifying segments of the population where children are at high risk so that programmes can be designed to increase their chances of survival. Childhood mortality rates are also basic indicators of a country's socio-economic level and quality of life. Data on the deaths of children were collected from women in the birth history section of the Women's Questionnaire and are used for direct calculations of mortality rates among children under age five:

- Neonatal mortality: the probability of dying within the first month of life;
- Postneonatal mortality: the difference between infant and neonatal mortality;
- Infant mortality: the probability of dying before the first birthday;
- Child mortality: the probability of dying between the first and fifth birthday;
- Under-five mortality: the probability of dying between birth and the fifth birthday;

All rates are expressed per 1,000 live births, except for child mortality, which is expressed per 1,000 children surviving to 12 months of age.

Table 11 presents infant and under-five mortality rates from the 2008-09 ADHS. The level of under-five mortality was 22 deaths per 1,000 live births for the five-year period preceding the survey, implying that around one in every 45 children born in Albania during that period died before reaching their fifth birthday. The infant mortality rate for the same period was 18 deaths per 1,000 live births. The 2008-09 ADHS also shows a decline in neonatal, post-neonatal, and infant mortality over the past 15 years. In particular, the infant mortality rate was cut in half over that period, from 35 deaths per 1,000 live births in the period 10 to 14 years preceding the survey to 18 deaths per 1,000 live births in the five years preceding the survey.

Table 11 Early childhood mortality rates

Neonatal, postneonatal, infant, child, and under-five mortality rates for five-year periods preceding the survey, Albania 2008-09

| Years preceding the survey | Neonatal mortality (NN) | Postneonatal mortality ¹ (PNN) | Infant mortality (${}_1q_0$) | Child mortality (${}_4q_1$) | Under-five mortality (${}_5q_0$) |
|----------------------------|-------------------------|-------------------------------------------|--------------------------------|-------------------------------|------------------------------------|
| 0-4 | 11 | 7 | 18 | 4 | 22 |
| 5-9 | 10 | 11 | 20 | 2 | 22 |
| 10-14 | 15 | 20 | 35 | 5 | 39 |

¹ Computed as the difference between the infant and neonatal mortality rates

Compared with the infant mortality rates (IMR) and the under-five mortality rates (U5MR) from Demographic and Health Surveys conducted in other countries in the region, the IMR (18 per 1,000) and U5MR (22 per 1,000) in **Albania** are slightly higher than in **Moldova**: 13 per 1,000 and 14 per thousand, respectively (NCPM and ORC Macro, 2006) and **Ukraine**: 14 per 1,000 and 17 per thousand, respectively (UCSR, SSC, MOH, and Macro International; 2008), but lower than in **Armenia**: 26 per 1,000 and 30 per 1,000, respectively (NSS, MOH, and ORC Macro, 2006) and **Azerbaijan**: 43 per 1,000 and 50 per 1,000, respectively (SSC, MOH, and Macro International, 2008).

J. HIV/AIDS

The 2008-09 ADHS included a series of questions that addressed respondents' knowledge about AIDS and their awareness of modes of transmission of the human immunodeficiency virus (HIV) that causes AIDS and of behaviours that can prevent the spread of HIV.

HIV/AIDS Awareness

Table 12 shows that awareness of AIDS is nearly universal among women (93 percent) and men (94 percent) age 15-49 in Albania. There is little or no variation in knowledge of AIDS by age or marital status. Women and men in rural areas, those residing in the Mountain region, and respondents with no education or primary education are less likely than other subgroups to have heard of AIDS.

Table 12. Knowledge of AIDS

Percentage of women and men who have heard of AIDS, by background characteristics, Albania 2008-09

| Background characteristic | Women | | Men | |
|---------------------------------------|-------------------|-----------------|-------------------|---------------|
| | Has heard of AIDS | Number of women | Has heard of AIDS | Number of men |
| Age | | | | |
| 15-24 | 94.5 | 2,454 | 94.0 | 1,062 |
| 15-19 | 94.9 | 1,478 | 92.7 | 670 |
| 20-24 | 93.8 | 976 | 96.1 | 393 |
| 25-29 | 92.9 | 848 | 94.9 | 269 |
| 30-39 | 93.7 | 1,962 | 95.0 | 644 |
| 40-49 | 92.0 | 2,319 | 93.6 | 1,037 |
| Marital status | | | | |
| Never married | 94.7 | 2,357 | 94.2 | 1,291 |
| Ever had sex | 99.4 | 367 | 97.9 | 580 |
| Never had sex | 93.9 | 1,990 | 91.3 | 711 |
| Married or living together | 92.7 | 5,001 | 94.0 | 1,703 |
| Divorced/separated/ widowed | 93.8 | 226 | * | 19 |
| Residence | | | | |
| Urban | 97.9 | 3,380 | 97.9 | 1,391 |
| Rural | 89.7 | 4,204 | 90.9 | 1,622 |
| Region | | | | |
| Coastal | 95.1 | 2,129 | 93.7 | 800 |
| Central | 91.7 | 3,477 | 94.5 | 1,443 |
| Mountain | 87.9 | 777 | 84.5 | 277 |
| Urban Tirana | 98.5 | 1,201 | 99.3 | 493 |
| Education | | | | |
| No education/primary | | | | |
| 4-year | 75.8 | 127 | 75.1 | 55 |
| Primary 8-year | 88.9 | 3,712 | 90.3 | 1,183 |
| Secondary, professional, technical | 97.8 | 2,740 | 96.6 | 1,415 |
| University+ | 99.9 | 1,005 | 99.8 | 361 |
| Total 15-49 | 93.4 | 7,584 | 94.1 | 3,013 |

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

Methods of HIV Prevention

AIDS prevention programmes focus their messages and efforts on three important aspects of behaviour: condom use, staying faithful to one partner, and delaying first sexual intercourse in young persons (i.e., abstinence). Table 13 shows the percentage of women and men who, in response to prompted questions, gave positive responses to specific ways to avoid AIDS.

Using condoms (74 percent), limiting sex to one partner who is not HIV positive (78 percent), and abstaining from sex (72 percent) were each recognized as ways of avoiding HIV by approximately three-fourths of women. Similarly, about seven in ten women (67 percent) mentioned both using condoms and limiting sex to one HIV-negative partner as ways to prevent transmission of HIV.

Table 13. Knowledge of HIV prevention methods

Percentage of women and men age 15-49 who, in response to prompted questions, say that people can reduce the risk of getting the AIDS virus by using condoms every time they have sexual intercourse, by having one HIV-negative partner who has no other partners, and by abstaining from sexual intercourse, by background characteristics, Albania 2008-09

| Background characteristic | Women | | | | | Men | | | | |
|------------------------------------|----------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------|-----------------|----------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------|---------------|
| | Using condoms ¹ | Limiting sexual intercourse to one HIV-negative partner ² | Using condoms and limiting sexual intercourse to one HIV-negative partner ^{1,2} | Abstaining from sexual intercourse | Number of women | Using condoms ¹ | Limiting sexual intercourse to one HIV-negative partner ² | Using condoms and limiting sexual intercourse to one HIV-negative partner ^{1,2} | Abstaining from sexual intercourse | Number of men |
| Age | | | | | | | | | | |
| 15-24 | 77.1 | 80.1 | 70.6 | 74.2 | 2,454 | 82.2 | 80.5 | 74.0 | 74.7 | 1,062 |
| 15-19 | 76.7 | 79.9 | 69.6 | 72.8 | 1,478 | 81.1 | 77.9 | 71.8 | 73.2 | 670 |
| 20-24 | 77.8 | 80.4 | 72.0 | 76.4 | 976 | 84.0 | 85.0 | 77.7 | 77.2 | 393 |
| 25-29 | 74.4 | 81.2 | 69.7 | 70.6 | 848 | 89.9 | 86.1 | 82.2 | 81.2 | 269 |
| 30-39 | 74.2 | 78.6 | 67.0 | 70.9 | 1,962 | 84.9 | 83.4 | 78.4 | 78.4 | 644 |
| 40-49 | 69.5 | 74.7 | 62.4 | 70.3 | 2,319 | 81.8 | 79.8 | 73.6 | 75.5 | 1,037 |
| Marital status | | | | | | | | | | |
| Never married | 78.5 | 81.7 | 72.5 | 75.2 | 2,357 | 84.0 | 82.1 | 76.1 | 76.6 | 1,291 |
| Ever had sex | 91.3 | 95.9 | 89.5 | 87.2 | 367 | 91.4 | 90.8 | 86.0 | 84.4 | 580 |
| Never had sex | 76.1 | 79.0 | 69.3 | 73.0 | 1,990 | 78.0 | 74.9 | 68.0 | 70.4 | 711 |
| Married or living together | 71.4 | 76.6 | 64.5 | 70.0 | 5,001 | 82.8 | 80.9 | 75.1 | 76.0 | 1,703 |
| Divorced/separated/widowed | 74.7 | 77.5 | 66.8 | 74.7 | 226 | * | * | * | * | 19 |
| Residence | | | | | | | | | | |
| Urban | 85.7 | 88.2 | 80.9 | 78.5 | 3,380 | 89.7 | 88.4 | 83.7 | 82.4 | 1,391 |
| Rural | 64.1 | 70.1 | 55.9 | 66.3 | 4,204 | 77.8 | 75.4 | 68.5 | 71.2 | 1,622 |
| Region | | | | | | | | | | |
| Coastal | 75.1 | 76.7 | 66.4 | 72.2 | 2,129 | 80.7 | 81.5 | 74.4 | 76.0 | 800 |
| Central | 69.6 | 75.8 | 62.7 | 68.8 | 3,477 | 82.3 | 79.1 | 72.8 | 72.8 | 1,443 |
| Mountain | 62.5 | 70.3 | 56.4 | 71.1 | 777 | 73.4 | 69.0 | 63.1 | 69.8 | 277 |
| Urban Tirana | 90.5 | 92.8 | 87.7 | 80.1 | 1,201 | 96.3 | 94.7 | 92.2 | 91.1 | 493 |
| Education | | | | | | | | | | |
| No education/primary 4-year | 41.2 | 50.1 | 35.1 | 46.6 | 127 | 40.7 | 37.4 | 28.9 | 42.2 | 55 |
| Primary 8-year | 61.4 | 68.9 | 53.2 | 64.9 | 3,712 | 75.2 | 73.9 | 65.8 | 68.5 | 1,183 |
| Secondary, professional, technical | 84.0 | 86.0 | 78.2 | 77.5 | 2,740 | 88.8 | 86.4 | 81.8 | 80.9 | 1,415 |
| University+ | 95.3 | 94.5 | 91.6 | 84.8 | 1,005 | 95.1 | 92.9 | 89.8 | 89.6 | 361 |
| Total 15-49 | 73.7 | 78.2 | 67.1 | 71.8 | 7,584 | 83.3 | 81.4 | 75.5 | 76.4 | 3,013 |

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

¹ Using condoms every time they have sexual intercourse

² Partner who has no other partners

Older women age 40-49 are less likely than other women to be aware of HIV prevention methods. Never-married women are somewhat more likely to be aware of ways to prevent the transmission of HIV than women who are currently married or previously married or cohabiting. Furthermore, never-married women who have ever had sex are substantially more likely than never-married women who have never had sex to know each of the specified methods of HIV prevention. Rural women are less likely than urban women to be aware of HIV prevention methods. Looking at regional variation, with the exception of abstinence, where knowledge is lowest among women in the Central region, women in the Mountain region are least likely to know any methods of HIV prevention, while women in Tirana urban region are most likely to know HIV prevention methods. There is a clear, positive relationship between respondent's education and knowledge of ways to prevent HIV. For example, 92 percent of women with a university or higher education say that the risk of getting the AIDS virus can be reduced by using condoms and limiting sex to one HIV-negative partner, compared with only 35 percent of women with no education or primary 4-year education.

Men are more aware than women of ways to avoid HIV. The most frequently cited way that men avoid HIV is by using condoms (83 percent). The two other ways of AIDS prevention, limiting sex to one partner who is HIV negative (81 percent), and abstaining from sexual intercourse (76 percent), are each mentioned by similar proportions of men. Three-fourths of men (76 percent) think that both using condoms and limiting sex to one HIV-negative partner can reduce the risk of getting HIV.

Among men, knowledge of HIV prevention methods are highest in the age group 25-29 years. Like women, marital status is not strongly associated with knowledge of HIV prevention; however, never-married men who have ever had sex are much more likely than never-married men who have never had sex to know of ways to avoid getting the AIDS virus. Furthermore, rural men and men residing in the Mountain region are less likely than other men to be aware of HIV prevention methods, while men living in the urban Tirana region are more likely. Knowledge of HIV prevention methods among men increases with level of education.

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| Report | Published | Language(s) |
|-----------------------------------------|----------------|--------------------|
| Chad 2004 | February 2006 | French |
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| Malawi 2004 | August 2006 | English |
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| Niger 2006 | August 2006 | French |
| Niger (Intervention zones) 2006 | October 2006 | French |
| Nepal 2006 | October 2006 | English |
| Uganda 2006 | November 2006 | English |
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| Azerbaijan 2006 | April 2007 | English |
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