

The Enterprise Program

TRIP REPORT: TURKEY (#1)

January 17 – February 3, 1988

AID/DPE-3034-C-5072



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PD-ARC-802

ISA 111663

**REVIEW OF POTENTIAL PRIVATE SECTOR PROGRAMMING POSSIBILITIES
IN TURKEY**

by

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January 1988



GLOSSARY

ARI:	Acute Respiratory Infection
Bakal:	Small food/provision store
CBD:	Community-Based Distribution
CEDPA:	Center for Education in Development and Population Activities
Cecekodu:	Slum or shanty town
COD:	Cash on Delivery
DFT:	Development Foundation of Turkey
Ebe ane:	Traditional Birth Attendant
Ecanze:	Pharmacy
FARTW:	Foundation for the Advancement and Recognition of Turkish Women
FHI:	Family Health International
FPAT:	Family Planning Association of Turkey
FPIA:	Family Planning International Assistance
IEC:	Information, Education and Communication
Imam:	Village religious leader
IMR:	Infant Mortality Rate
IUD:	Inter-Uterine Device
MCH:	Maternal and Child Health
MIS:	Management Information System
MOH:	Ministry of Health
Muhtar:	Village headman
Muftu:	Provincial-level religious leader
ORS:	Oral Rehydration Solution
PCS:	Population Communications Service
TBA:	Traditional Birth Attendant
TFHPPF:	Turkish Family Health and Population Foundation
Ujemli:	Turkish equivalent of COD
VSC:	Voluntary surgical contraception

THE ENTERPRISE PROGRAM
Contract No. AID/DPE-3034-C-5072
Trip Report: Turkey (#1)

Team Members:

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Dates of Trip:

17 January -
3 February 1988

Project CTO:

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Places Visited:

Ankara
Istanbul
Bursa

I. EXECUTIVE SUMMARY

This was the Enterprise Program's first trip to Turkey, an assessment visit conducted by consultants David Pyle, Ph.D. and Dennis Weeks, MBA, MPH.

During two and one half weeks in Turkey reviewing private sector family planning opportunities, several innovative strategies were identified. Three projects with two high quality, non-governmental organizations were found to offer the greatest potential for having an impact and a spread effect. The activities identified offer high probability of becoming self-sustaining after initial support from the Enterprise Program.

A brief description of the two agencies and the proposed projects under each are as follows:

A. Development Foundation of Turkey

This 19-year old organization has been dedicated to rural and agro-business development. It has become a huge operation, having gross operating revenues of approximately \$50 million in 1987. Their poultry and beekeeping businesses are particularly noteworthy successes. The DFT has participated in a World Bank-funded livestock development project and received high praise for their achievements. Their family planning involvement has been limited in recent years, but the Foundation is committed to making significant efforts in this field in the next decade. The proposed projects discussed are:

1. National Condom Distribution (Macro Project)

Utilizing DFT's experience in the mail-order business and in marketing, the Foundation is interested in developing a national condom distribution program. The effort will consist of two parts. Phase I is a large-scale market research study of both the potential clients as well as possible distributors. The practicality of innovative outlets (such as army recruits returning to their villages, petrol stations with mini-markets, grocery stores in the villages, school teachers) will be considered as local sales agents. Knowledge, attitudes, practices and

sensitivities of the client population regarding the condom will also be studied. The results will provide the information required to develop a detailed proposal for Phase II, the implementation of the national program, and will help in the development of demand-generation materials (e.g., television spots and posters). The estimated cost of Phase I is approximately \$40,000.00

2. Rural Community-Based Distribution (Micro Project)

The underserved rural areas of Turkey, especially the East and Southeast, lack education on the proper use of contraceptives and access to them. To reduce fertility to desired levels, thereby improving child survival statistics, a self-supporting CBD program will be developed, probably in Van District where the DFT has had women's development projects for a number of years. Enterprise support, primarily in the form of transport, personnel and educational materials, will enable the DFT to initiate the program which, after two years, should be well on its way to reaching economic self-sufficiency. Community workers will be the contraceptive (pill and condom) distributors and receive a portion of the revenue from sales to the villagers as an incentive. This will encourage the village agents to motivate village women to use contraceptives on a continuing basis. They might also sell such items as ORS to reduce the under-five toll from diarrhea. The estimated cost of this two year project is approximately \$45,000.

B. Turkish Family Health and Planning Foundation (Istanbul)

This two-year old foundation was started by one of Turkey's leading industrialists, and its Board consists of many outstanding business and professional leaders. In its formative stage, the Foundation has concentrated on developing its factory-based family planning operations and is in the process of establishing a network of urban clinics. Four clinics will be started in four different cities around Turkey in conjunction with the MOH. A fifth will be established in Istanbul and staffed by the University. Another will be supported by Pathfinder and serve the middle and upper economic groups of Istanbul and rely heavily on newspaper advertising to generate business.

1. Low Income MCH/FP Clinic

This proposal idea involves the establishment of an integrated MCH/FP (possibly women's) clinic near a cecekodu (slum) to serve a middle and low income population of approximately 50,000. It will rely on a cadre of local women who will serve as outreach workers and contraceptive marketers. Their salaries will come from a portion of the contraceptive sale price which they will retain. Simultaneously, these outreach workers will market clinic services, referring women to the facility for pre/post-natal care and gynecological, pediatric and general health services. The estimated start-up cost for this facility is approximately \$70,000 over the two-year period.

II. INTRODUCTION

The Enterprise Program requested that two consultants (one with private sector family planning experience, the other with business and marketing experience) visit Turkey between 17 January and 3 February 1988 to determine if programming opportunities exist and, if so, what form they might take. The scope of work for the assignment is included as Attachment I. In the course of the consultancy, a number of key actors involved in family planning were met, including officials in the U.S. Government, the Ministry of Health and private agencies (a Contact List is included as Attachment II). Our discussions, review of documents and observations make it clear that the time is right for Turkey to develop creative and effective private sector family planning programming. It is our opinion that family planning in this country has reached a take-off point and that appealing opportunities exist in which the Enterprise Program should be involved.

After a brief overview of the health and population situation in Turkey, including a review of current government policies and programs as well as private sector activities in Section II, Section III describes several exciting program possibilities which were identified with the Development Foundation of Turkey (DFT) and the Turkish Family Health and Planning Foundation (TFHPPF). The report closes with an outline of the next steps which the Enterprise Program should take in the development of the strategies presented.

III. BACKGROUND

A. Health/Population Situation

While Turkey is generally considered a semi-industrialized country with moderately high per capita incomes, the country still reports infant mortality and fertility rates which are comparable to less developed countries. The mean national figures for Turkey are varied by conditions in the more developed and prosperous western region; the numbers from the slums (shanty towns or cecekondus) in the three major metropolitan areas (Ankara, Istanbul, Izmir) and the eastern/southern regime are as serious as those found in parts of Africa. In many ways it is easier to think of Turkey as two countries -- the developed west and the underdeveloped east. The line dividing the two might be drawn from Samsun on the Black Sea coast to Adana in the South.

Among the most disturbing statistics are those that refer to the Infant Mortality Rate (IMR). Between 1979 and 1982, the average IMR for the country was 95 per 1,000 live births (according to the 1983 Population and Health Survey, Hacettepe University, Institute of Population Studies, 1987). Although this figure represents a dramatic drop from the more than 150/1000 in the mid-1970's and 134 in 1978, upsettingly high rates still exist among segments of the Turkish population. The rates are particularly high in the rural areas (125) and in the east and southeast. The further one goes in those directions, the higher the IMRs become. The

DFT^[1] found in a survey they conducted in the extreme eastern province of Van several years ago that over 25% of the infants died during the first year of life. The leading causes of death are acute respiratory infection (ARI) - especially pneumonia during the harsh winters, and diarrheal diseases, with widespread malnutrition typically being an underlying cause.

Despite rapid urbanization, almost half the population still resides in the rural areas. The 1983 Population and Health Survey states that 76% of the births in the rural areas were attended by traditional midwives or neighbors/relatives; the figure increases to 84% in the east. Studies are now being conducted to determine if neo-natal tetanus is a significant problem in this region of infant death rates and prevailing home delivery practices. Although precise figures are not given, it is conceded that a low percentage of pregnant women in the rural areas of Turkey, especially in Eastern Anatolia, receive pre-natal care.

The high IMRs are certainly linked directly and indirectly, to the high fertility rates which exist among large segments of the Turkish population. High rates of malnutrition, infection and fertility can be referred to as the "vicious triangle". The national population growth rate is 2.8% per year; this means that Turkey's population of 52 million will double within 25 years, causing it to reach the magic, but frightening, figure of 100,000,000 ten years into the next century. For this not to be achieved, the crude birth rate (of 37/1000 population) and total fertility rate of just over 4 (ranging from 2.7 in the west to 5.1 in the rural areas and 6.5 in the east) must be reduced.

Fertility-related aspects which must be considered include age at marriage, fertility preferences and contraceptive knowledge and use. The average age of marriage for women in Turkey is 17.6 and only varies slightly between urban and rural (17.8 vs. 17.2), but more between west and east (18.4 vs. 16.3). As expected, women with high school education and above is 2.5 years later than illiterate women.^[2] Counter-intuitively, the average age of marriage was lower in 1983 than in the previous survey in 1978. Polygamy is still practiced in some areas, particularly in the East.^[3]

The 1983 Population and Health Survey found that 74% of the married women of Turkey of childbearing age desired 3 or less children. The desired number of children increases as one goes east (from 7.4% wanting more than 4 children in the east to 4.3% in the west). It is encouraging that the younger women desire fewer children.

[1] In Turkish it is Turkiye Kalkinma Vakfi (TKV)

[2] Female literacy nationally is 43%, compared to 57% for the male population. As with all indicators, the rates drop dramatically in the East where fewer women (under 20%) read or even speak Turkish.

[3] The DFT had a video-taped interview with a man with four wives who had "approximately" 40 children.

Knowledge of contraceptive methods is widespread among Turkish women -- 94% of the women interviewed in 1983 had heard of at least one method of contraception and 91% knew of a modern method. The pill was the most widely known method (85%), followed by the IUD and withdrawal (75% each). Fifty-five percent of the women named condoms.^[4] In the latter method, the rate differed dramatically between urban (71.3%) and rural (37.8%) and by region (from 78.8% in the west to 36.9% in the east).

In terms of contraceptive usage, 71% of the responding women said they had used at least one method of contraception sometime during their married life. The majority of these practiced withdrawal (46%) and other non-modern methods. Of the modern methods, the pill registered 34%, condoms 16% and IUD 15%. Rates varied greatly by method in the ever-used category depending on region, place of residence and level of education:

PILL: urban (39%) vs. rural (27%)
west (40%) vs. east (21%)

CONDOM: urban (25%) vs. rural (7%)
west (22%) vs. east (6%)

Current usage of contraception was found to be 62%, almost entirely for spacing purposes. This represents an increase of over 20% in the five years since the 1978 survey was conducted. Less than half of this number, however, is using modern methods, meaning that some 27% of the married women of Turkey were employing effective methods of family planning at the time of the 1983 survey. Of the current contraceptors, almost half practice withdrawal, more than all modern methods combined. Of the modern methods, pills (14.6%), IUDs (14.5%) and condoms (8%) are most common. Usage of the withdrawal method is fairly constant regardless of educational level; however, education is directly correlated to use of the modern methods. Regionally, the rates in the west are about double those in the east (% of eligible couples):

<u>Method</u>	<u>West</u>	<u>East</u>
Pill	11	6
IUD	9	5
Condom	7	3
Withdrawal	38	14

It is interesting to note where people get their contraceptives. In the case of pills, 93% of those in the cities and 95% of those in the rural areas rely upon the pharmacies for supplies. For condoms, the percentages purchased from drug stores (eczane) drops but remains high (76.4% in urban and 66.3% in rural). Thus, while the numbers and percentage of the most common forms of temporary contraceptive methods are relatively small at present, the private sector is playing a major role in providing a source of supplies.

[4] Males were not interviewed.

Turkey has traditionally had a high abortion rate. The 1983 survey reports that 37% of ever-married women had had at least one abortion. Over 12% of all pregnancies are terminated by induced abortions. The practice is more common in the urban and western regions where the rates are double those found in the rural and eastern regions, respectively. The same is true of literate women, who have twice the rate of abortions than illiterate women.

While abortions were made legal in the 1983 family planning law and the practice has been made medically safer, the high rate indicates the need and potential for greater and more effective use of modern contraceptive methods. The high rate of failure of the withdrawal method, said to be 20%, is a concern. The common practice of relying upon breastfeeding for contraceptive purposes for more than six months is also not effective. Even among the pill users, irregular consumption can result in a failure rate close to that of the withdrawal method. Contraceptive failure results in high abortion rates; to reduce these, more modern methods must be made available while more education on how to use them is properly provided.

B. Governmental Policies and Programs

Prior to 1965, Turkey was pro-natalist. The first Population Planning law was passed in 1965 and anti-natalist policies began to be adopted to reduce fertility and lower the population growth rate. After the law of 1983 was passed, voluntary sterilizations and abortions were permitted, and properly trained nurse-midwives could insert IUDs and distribute pills. Family planning was integrated in the Ministry of Health's (MOH) MCH delivery system.

Generally, the subject of family planning has been openly discussed in the last several years although growing religious conservative factions occasionally raise objections. The Islamic authorities in Turkey view family planning favorably.

Family planning services are provided primarily through the MOH and Social Security organization. Funding, particularly for the General Directorate of MCH/FP is limited; last year they received only 4% (about \$8 million) of the MOH's budget. The infrastructure consists of the following:

MOH Maternity Hospitals:	26
MOH Hospitals	97 (2/3 provide FP)
Social Security Hospitals providing FP	14 (out of 80)
Maternity Hospitals providing FP	2
MOH Health Centers (Salik oga)	2900
MOH Health Homes or Posts (Salik evi)	8300
MOH MCH/FP Centers	116

In terms of personnel, as of mid-1986, approximately 1,500 physicians were trained in IUD insertion and 105 in laparoscopy. About the same number of midwives (out of an estimated 17,000) were trained in IUD insertion and family planning service delivery. The MOH has heavily promoted the IUD as the chosen method of contraception.

It should be noted that the President of Turkey, Mr. Khenan Evren) is known to be a strong advocate of family planning and can be counted on for support.

C. Current Donor and Private Sector Activities

There are currently eight U.S. Cooperating Agencies operating in Turkey:

- CEDPA:** Supports Childrens' Hospital (Istanbul) to fund community family planning outreach workers.
- FHI:** Works with Hacettepe Medical School on contraceptive research.
- FPIA:** Supports Turk-Is Labor Confederation and family planning in workplaces and Social Security Hospitals.
- JHPIEGO:** Assists MOH in the laparoscopy and microsurgery training of physicians.
- Pathfinder:** Funds nurse-midwife training and increasingly supports private sector family planning activities, especially with the TFHPF and with Turk-Is.
- PCS:** Has contacted the MCH/FP General Directorate about IEC activities. At present, MOH IEC activities are very limited and unprofessional. PCS also provides services to TFHFF and the Foundation for the Advancement and Recognition of Turkish Women (FARTW) to produce family planning communication strategy and materials for radio and television (including a mini-series or "soap").
- RONCO:** Trains health professionals at Institute of Child Health (Istanbul University) and provides supervisory training in MCH/FP General Directorate of MOH.
- Westinghouse:** Analyzed data from 1983 Health and Population Survey.

In addition to these U.S. agencies, UNFPA has a five-year project (1984-89) entitled, "Strengthening Integrated FP/MCH Services" with the MOH (MCH/FP General Directorate) for almost \$2 million. The project is being carried out in 17 of Turkey's 67 provinces. Its main activities include establishing FP/MCH training centers in the 17 provinces, training medical and para-medical health providers, equipping FP units in the provincial hospitals as well as in the health centers and houses, providing contraceptives and immunization support (cold chain), supplying kits to village midwives, improving supervision and providing vehicles.

Several private organizations have played a significant role in family planning in Turkey:

Family Planning Association of Turkey (FPAT) is an affiliate of IPPF and has 25 branch offices around Turkey. Its largest project provides counseling, information, training and services to 115 factories having over 150,000 employees. Several years ago the FPAT also started a Community-Based Distribution (CBD) program in an Ankara cecekodu having about 50,000 population. Eighteen women were paid about \$25/month to motivate and supply condoms and foaming tablets free of charge. After two years, 38% of the women had reportedly accepted contraception, but activities ceased as the funding came to an end.

Turkish Family Health and Planning Foundation (TFHPPF) was started in late 1985 with the support of Vehbi Koc, the leading industrialist of Turkey, who serves as the President of the Board of Directors. With funding from the Pathfinder Fund, the TFHPPF has initiated factory-based family planning in 14 factories in western Turkey (mostly in the vicinity of Bursa). It is currently developing five integrated MCH/FP clinics around the country (Istanbul-Bakirkoy; Izmir-Gediz; Diyarbakir; Mardin; Bursa). Four of these will be operated in conjunction with the MOH (which will provide the staff); the Istanbul facility will be run in cooperation with the Institute of Child Health (Istanbul University) which will provide the staff.

Family Planning Foundation has very recently been formed and is headed by the Dean of the Ankara University Medical Faculty. The type of activities it will be involved in is unknown at this point.

IV. PROGRAMMING POSSIBILITIES

Discussions regarding possible Enterprise Program activities in Turkey were undertaken with two groups, the DFT in Ankara and the TFHPPF in Istanbul. Several innovative and exciting activities were identified and are worthy of further exploration and development. Family planning in Turkey has come a long way in the last several years and appears to be at a critical take-off point. Enterprise Program funding could make a significant impact on the country's demographic situation by assisting the private sector to play a crucial role in the family planning effort.

A. Development Foundation of Turkey

The DFT is one of the biggest non-profit private development entities anywhere in the developing world; it had an annual gross operating budget of approximately \$50 million in 1987. Since its founding in 1969, the Foundation, under the creative and astute leadership of Altan Unver, has developed into one of the largest poultry producers and marketers in Turkey and now produces about 20% of the chickens sold in the country through its 12 independently operated poultry companies. This effort has received support (and high praise) from the World Bank under the Fifth Livestock Development Project, (1982-86). The production efforts are supported by veterinary and marketing services. In fact, DFT has a separate marketing company which is working to increase Koy-Tur's (DFT's brand name) share of

the poultry market. Other agricultural production efforts include the cross-breeding of cattle and sheep for generic improvement, production of cash crops and expanded veterinary services.

Another successful effort of the DFT involves bee-keeping and honey production. The Foundation supports approximately 10,000 small to medium sized bee-keepers in Turkey with the supply of bees-wax, queen bees and medicine. This is done through an efficient, self-sustaining mail-order business centered in Kazan (about 30 miles northwest of Ankara on the Istanbul highway). Last year the Foundation shipped out over 100 tons of bees wax, 40,000 bred queen bees and over 15,000,000 dosages of medication (against Varroa - a lethal parasite). Relevant articles on bee-keeping are published in the project's Beekeeping Journal. Moreover, the marketing division of the DFT assists in finding markets for the honey. In the first quarter of 1986, 300 tons of honey were exported, in addition to local sales.

The DFT now has offices in 17 provinces, mostly in the less developed eastern part of Turkey. The organization combines a community-based development approach with sophisticated and well developed business and management principles; this has proven to be a winning combination.

The DFT also has a human resource development section which includes home economists and social workers who assist women to improve their own and their families' lives. Activities include training and assisting women in several areas of eastern Turkey to produce high quality rugs and kilims (flat woven floor coverings). Over 800 women are being helped, their self-esteem and community standing improved with their increased incomes. DFT helps market the finished products, in western Turkey and abroad, and in the process eliminates the exploitive middlemen. At the same time, the women receive instruction in nutrition, child care, literacy and family planning. Attachment III provides a good sense of what the Foundation does and how they do it.

The Foundation's involvement in family planning has been limited. In the early 1970's, it carried out studies in community-based distribution (CBD) efforts in the southern provinces of Icel and Mursin. Their findings served as the basis for the Population Council-funded project in Yozgat Province (central Anatolia). In the late 1970's, DFT received 100,000 gross of condoms from FPIA which it distributed without charge to the public who responded to newspaper advertisements. The enthusiastic response to this offer convinced the Foundation that there was a large unmet need for contraceptives in the country.

Discussion regarding possible Enterprise Program activities addressed a number of different ideas. One was support for a private hospital in Gaziantep (southeastern Turkey) to develop family planning activities and initiate a CBD program. This proposal seemed to offer very limited impact and potential for replication; consequently, it was given little consideration. Two other suggestions appeared to have greater chance to contribute significantly to Turkey's family planning effort by adding a missing dimension. One deals with a nationwide effort to distribute large quantities of condoms--this is referred to as the macro aspect of the DFT

family planning program. A complementary micro element would be developed to address contraceptive education and supply issues in the rural areas of eastern Turkey.

1. National Condom Distribution

The General Director of the DFT is convinced that a large-scale, national condom distribution and mail-order effort could be developed and sustained. This conviction comes from his experience with the condom mail-order effort in the late 1970's and early 1980's as well as with the Foundation's economically self-sustaining beekeeping operation run through the postal system. DFT's marketing expertise has succeeded in developing money-making operations in such diverse undertakings as poultry and handicrafts. There is no reason why the Foundation could not succeed in a nationwide condom distribution effort.

A number of possible distribution outlets were mentioned for the marketing of the condoms:

- o conscripts: the drafted soldiers would be given a small number of condoms as they leave the service, together with education for their proper use. In addition to encouraging them to use the contraceptive, they would be given information how to order more and even become salesmen in their villages.
- o small food shops (bakals): a list of village and town bakals would be developed and sent samples by mail with information on how to get resupply.
- o gynecologists/general practitioners: a list of physicians who have extensive contact with women would be drawn-up; they would be sent promotional materials on condoms and encouraged to order supplies which they could sell at a reasonable profit.
- o tea houses: a list of tea houses would be developed; they present excellent potential as distribution outlets since they are the most common gathering places for males throughout the country; even the smallest village has one.
- o pharmacies (eczanes): a list of Turkey's 10,000 drugstores would be obtained from the National Pharmaceutical Association and, like the bakals, they would be contacted and supplied through the mail. This effort will be greatly assisted by a newly recruited senior member of the marketing division who worked for 10 years with one of the major international pharmaceutical companies in Turkey.
- o petrol stations: a list of those facilities with mini-markets attached (usually found along the main truck routes) would be obtained from the petrol companies and contacted/supplied by mail.

- o **beekeepers:** the 10,000 beekeepers already receiving services from the DFT would be informed of how to obtain condoms by an insert in the Beekeeping Journal; contraceptive users as well as sales agents in the villages can be recruited in this manner.
- o **teachers:** a list of male teachers in the villages could be obtained from the Ministry of Education; they would be provided with condom samples with information on how they could become a local sales agent to earn extra money.
- o **universities:** the health services at the universities could be provided with contraceptives so that students and employees interested in utilizing modern methods would have access to them.
- o **village headmen (muhtars):** the State Institute of Statistics publishes a list of all village headmen which could be utilized to send them orientational material and possibly condom samples.
- o **village religious leaders (imams):** would be oriented on family planning with sensitively produced promotional materials (utilizing supportive statements from the Islamic authorities in Turkey) to ensure that they do not oppose efforts in their villages.
- o **individuals:** would respond to DFT advertisements directly by mail and receive as many condoms as they ordered.

The primary justification for the condom distribution approach is that there is a reasonably widespread awareness of family planning and a desire to reduce fertility among the population of Turkey. However, there is a lack of knowledge about methods and of places to go to acquire contraceptives. In addition, there is the privacy question which in a conservative society like Turkey (especially in the less developed East) may make people reluctant to procure contraceptives publicly. This distribution/mail-order approach would address the supply issues; simultaneously, however, a demand generation effort would be required. This would include the development and production of such things as tasteful posters for display at pharmacies and bakals as well as television spots.

Such an undertaking would require a large number of condoms. A rough estimate of 40-50,000 gross of condoms has been made for the first year of the project. Although the condom is not the contraceptive of choice in Turkey or most countries, it is one with which people are familiar and one that can be sold widely without a prescription. DFT's experience with condoms earlier in this decade demonstrates that there is a market for them. They are a very effective entry or first contraceptive; gradually many, if not most, of the condom acceptors will upgrade to more reliable, more effective modern methods of contraception, such as the pill, IUD and VSC.

The first step in the condom distribution project would be a comprehensive market research study which would investigate two aspects. First, it would study the consumer or demand side--what various socio-economic classes, ethnic groups, rural and urban populations in different regions of Turkey know about condoms, their attitudes and current practices. Of special importance will be the development of sensitive marketing strategies--what approaches appeal and which ones repel? The second aspect is the distributor or supply side. It is vitally important to know if enough pharmacies, bakals, petrol stations, etc., would be interested in participating in a condom marketing effort and to determine the best method of supplying the outlets. The issue of cost would have to be addressed in both the consumer and distribution sides--e.g., determining what price the DFT would have to charge to cover costs, what profit the distributors would require, what cost the consumer would be willing and able to pay, etc.

The major constraint facing a national condom distribution program is the government's regulation that stipulates that donated commodities cannot be sold. There is, however, mounting pressure for this law to be modified. Pathfinder, with their ally Mrs. Ozal at the Foundation for the Advancement and Recognition of Turkish Women, is eager to impose a small service charge for the contraceptives they will distribute so that its community-based efforts can be supported. The FPAT has also identified the need to recover distribution costs to sustain successful activities like their cecekodu CBD program. With Mr. Tandogan Tokgoz, Under Secretary of Health, as their chairman, the FPAT plans to raise this issue at its forthcoming board meeting and urge a change. This can be done in short order if their chairman is convinced. In addition, we found that the TFHPF is very concerned about the same issue and wants to charge for donated contraceptives in several of its programs. Being the organization of the most important industrialists of Turkey, they have numerous contacts and considerable influence in the government. The DFT itself is used to lobbying for changes in regulations. They were responsible for initiating the process which resulted in the midwives being able to insert IUDs and distribute oral contraceptives. With their legal staff plus allies such as Professor Dr. Nurset Fisek (considered the father of family planning in Turkey and former Under Secretary of Health), and Dr. Ayse Akin (Professor of Community Medicine at Hacettepe University and director of the highly successful Cubuk Hospital and rural health project), the DFT could present a strong case. The final decision to change the regulation will be in the hands of the scientific committee in the MOH. This group consists of the deans of the four leading medical schools and the three general directors in the MOH; it meets every three months, although special meetings can be convened.

Currently there is no formal mechanism which brings the private family planning groups in Turkey together. Our discussion with the various groups identified the need to initiate some means to coordinate activities, exchange experience and, importantly, develop a pressure group to argue for the change in official regulations (e.g., prohibition against charging for donated commodities) which might be inhibiting the effectiveness of their programs.

The government official with whom we met also mentioned several other issues that must be considered before a national condom distribution program can be launched. First, the condoms must meet government standards. Each individual brand must receive authorization. Any condom distributed in Turkey must be approved. This approval is currently granted by the Ministry of Industry and the Institute of Standards. One solution suggested is for all U.S. brands that might be imported be given to the Ministry for testing; once approved, any one will be able to be imported without special clearance. The Ministry of Industry has recently recommended that the MOH assume responsibility for the certification of condoms, and the MOH is considering the matter at this time.

A second issue involves packaging. If donated condoms were ever to be approved for sale, they would have to be packaged so that they could be easily distinguished from the goods provided through the MOH's infrastructure at no cost. This is to preclude the leakage of government supplies into the marketplace.

Finally, we were told that condoms at present could be sold only at registered pharmacies. This will have to be confirmed since currently one can find condoms for sale at stores catering to men (e.g., tobacconists) and even sold by street vendors in Istanbul.

It was decided that the DFT would not attempt to include contraceptive pills in the mail order operation to pharmacies and private distributors (gynecologists and general practitioners). This was considered not advisable at this time since several serious constraints exist such as need for continuity of brand which demands constant availability. If a woman were to start with the imported brand provided by the doctor and then be unable to find the same type at her local pharmacy, complication and confusion might arise. It is possible that the selective mail order distribution of pills might be considered once experience has been gained in the condom effort. Contact would already exist through the condom distribution exercise.

The Enterprise Program is the most appropriate vehicle through which to initiate such a large-scale condom distribution effort. Enterprise could provide the funding to determine the viability of the strategy (see following section). If the study is positive and the distribution effort is launched, the only support envisaged from AID at this time would be contraceptive supplies. These supplies may be required for three to five years, to firmly establish a market and develop a loyal clientele. Gradually, it is hoped that prices could be raised so that local^[5] or imported condoms could be purchased and their costs recovered. The start-up costs of the distribution effort would be minimal (for such things as a warehouse to store the condoms and a computer to maintain the

[5] There has been mention of condom production in Turkey, possibly in collaboration with the Japanese. Progress on this effort has been slow, and there is no estimate when or if locally produced condoms will be available.

distribution data base). Theoretically, a loan to DFT could cover these expenditures which, in theory, would be recovered in several years from the sale of the condoms.

2. Rural Community-Based Distribution (CBD)

In contrast to the large-scale condom distribution project, a need was identified to develop a viable, self-sustaining community-based, contraceptive distribution model in the rural areas, especially in the region demonstrating greatest need (i.e., eastern Turkey).

If a pilot delivery system could be established for educational messages (on what contraceptive methods are available and how they are used) and for supplies, the approach can be replicated throughout the rural areas of Turkey. While it is true that the rate of urbanization is very rapid, approximately half the population still lives in the rural areas and are both less exposed to information on contraceptives and have less access to them. Data in the mid-1980s fertility study by Hacettepe indicates that the knowledge about modern contraceptive methods and supplies are major problems, especially in the rural areas. Just as importantly, it is the rural population that has higher fertility rates and is in greatest need of contraceptives. Unfortunately, this problem receives very little attention in Turkey today.

The Enterprise Program is a particularly appropriate vehicle through which to support a rural self-sustaining CBD effort.^[6] The major problem in most developing countries where there is a perceived need on the part of the population to reduce fertility is to develop a delivery mechanism. The system in this case depends upon and is driven by the sale of AID-donated contraceptives. Enterprise would provide support for a few start-up costs; these might include a vehicle (to supervise and support the village agents) and the salaries of the staff (supervisor and manager) until sufficient funds could be recovered to cover these costs (amortization and salaries). It is expected that all the salaries would be paid by Enterprise the first year, 50% the second year and be fully recovered the third year. In addition to this, AID funds would only be required to support the cost of contraceptives, a relatively low price to pay if the needs of the rural population are indeed met and contraceptive usage rates raised to a satisfactory level (30-40% of eligible couples utilizing a modern method). Once the CBD approach and the demand for contraceptives have been established, the cost of the contraceptives could be gradually recovered from the clientele. The Enterprise Program support would be used to establish the approach and determine its viability. The DFT is, at the same time, a particularly appropriate agency to establish such a micro-level program with its extensive experience and expertise in community and human resource development, the development of income generating activities, and its existing network.

[6] It should be noted that a self-sustaining CBD effort has not yet been attempted under the Enterprise Program.

The rural CBD effort would include the promotion and distribution of both oral contraceptives as well as condoms. It might also attempt to distribute oral rehydration solution (ORS) through the same mechanism to address one cause of the high IMR in the area.

The basic approach would be to identify one male and one female in each village who would serve as agents. It is thought that a male would be most appropriate for condom distribution since the main problem to overcome is embarrassment among the men. The "shyness" factor is something which is referred to regularly and will have to be addressed if the condom is to become widely used. The female would serve the women, resupplying pills (once the user has received a medical examination) and possibly supplying condoms to women whose husbands are too embarrassed to procure them. If the population of the village is small and only one agent can be supported, a woman might possibly be preferred and she would then have to identify the most effective means to distribute condoms (i.e., through the bakal or tea house) and sharing the incentive.

The village agents would receive a portion of the contraceptive sale price which is expected to serve as an incentive to motivate new acceptors and reinforce previous users so that the typically high drop out rates are reduced. The remainder of the contraceptive fee would go to the DFT to cover the cost of supervising, administering and managing the provincial family planning effort.

To implement such a program, the DFT would require the services of a physician at the provincial level, at least on a retainer basis, to satisfy the MOH regulation that states that oral contraceptives can only be prescribed under a doctor's supervision. The DFT would also have to train workers in how to determine if a woman is able to take the pill.

Preliminary discussions identified personnel requirements as being one technical person having knowledge and experience in family planning and the ability to speak Kurdish since a high percentage of the population in the area is Kurdish, and the women in particular are unable to speak Turkish. In addition, another person would be required at the provincial level to handle the business (financial) aspects.

An important part of DFT's work would be orienting the village headmen and imams so that they do not object to the effort and inhibit the distribution of contraceptives. The selection of the village agents is of utmost importance. The ideal candidate would have leadership abilities, an outgoing personality, ability to convince others and to inspire trust and confidence. One female possibility to consider is the local traditional birth attendant (TBA) or ebcani. The village agents must be trained in motivational techniques and in family planning. Training materials for the agents will have to be developed as well as educational information in contraceptive use for the clients to use when motivating villagers. The latter material should be produced for illiterates since such a high percentage of the population in the East cannot read or even speak Turkish.

The tentative decision was made that Van Province (bordering on Iran) would be an appropriate place to develop and test the rural self-supporting CBD approach. Demographic data for the Van area are included as Attachment IV. The DFT has carried out development activities in Van for many years

and it considers Van one of its two "mature" programs. Moreover, the director of their Van operation is a social scientist who is interested in family planning. There is also a home economist assigned to Van who is involved in women's development programs and could help launch the family planning program.

While DFT operates intensively in only 14 out of Van's 604 villages, as many of the villages Van that are approachable and interested would eventually be included in the contraceptive CBD activity. During the first two years under Enterprise assistance, it is thought advisable to start with 100 villages the first year, adding another 200 in the second. Thus, half the villages would be covered by the end of two years. The average village in Van is small, having about 600 people or 100 families. Some are scattered over a large area, hence difficult for one person to cover. For this reason, it must be advisable for the first villages included in the project to be more concentrated. To make this possible, the effort requires a vehicle for its exclusive use. the cost of the vehicle would have to be amortized (i.e., paid for over five years out of a portion of the money recovered from the sale of the contraceptives) so that it can be replaced. It is hoped that office space to house the activity (administrative and storage) would be available in DFT's building in Van.

As in the case of the national condom distribution effort, a major constraint is the ability to sell donated commodities. However, as mentioned, there is growing pressure from the private family planning organizations in Turkey to change this regulation. This will smooth the way for the DFT's micro, rural CBD effort. In the event that the law is not changed, however, the possibility of charging the DFT a nominal amount for its contraceptives might have to be considered. A small payment for "purchasing" the contraceptives would then permit DFT to recover costs by selling them. It would be a budget transaction that might satisfy the regulation.

If the initial rural experience is positive, it could be adopted in the 16 other provinces in which the DFT is currently operating and beyond. The DFT would have proven the approach works and can be self-supporting. Based upon this experience, they could borrow money for the start-up costs or develop proposals for other donors to support. The important point now is to determine that such a rural CBD approach can be effective and can recover its costs.

B. Turkish Family Health and Planning Foundation

In late 1985, Mr. Vehbi Koc, the leading industrialist of Turkey, founded a private organization to improve and expand family planning services in Turkey. Mr. Yasar Yaser, an experienced demographer who has held high-level positions in Turkey and internationally and who is extremely well connected, was appointed Executive Director of the TFHPF.

During the first two years, the Foundation has concentrated on developing its factory and clinic projects. In the former effort, 14 factories with approximately 20,000 workers have received assistance in the form of training for the existing health staff and motivation of the

employees. The second area of concentration is the development of a series of clinics. At present they are in the process of finalizing facilities and/or agreements for five clinics. Four of these clinics (Bursa, Diyarbakir, Izmir, Mardin) will be constructed by the foundation on land supplied by the local municipalities. They will be staffed by MOH personnel, hence will be unable to recover their costs since they will not be able to charge for their services. The Foundation feels it important at this early stage in their development to establish close relations with the Ministry, and these clinics provide the opportunity to assist the Ministry by providing additional resources.

The fifth clinic has been constructed in Istanbul (Bakirkoy section) on donated land. Funds for this facility have been provided by a leading businessman who is on the Board of Governors of the Foundation. The center will be staffed by the Community Medicine Department of Istanbul University Medical School.

The Pathfinder Fund has generously supported the Foundation in its formative stage. Pathfinder is currently considering a Foundation proposal for a self-supporting Istanbul clinic. This represents a sixth clinic under the Foundation's control, but is very different in that it is designed to be financially self-sufficient, something the other clinics are not capable of achieving. Other THFPF activities include the training of religious leaders. Several Turkish Islamic officials have been sent to Indonesia to observe the role of religious leaders in family planning there. Plans are to integrate family planning into imam and muftu (provincial religious leaders) training courses. Another activity is assisting in the design and testing of television and radio programs and support materials for the national family planning campaign; this is being done in conjunction with PCS.

The TFHPF is interested in expanding its operations and diversifying its sources of funding. They have one doctor (specialist in community medicine) currently working for them and plan to add another in the near future. Several of the ideas raised during the August meeting (see Pyle memo of September, 1987) did not appear to be practicable upon further investigation. One was to assist the Foundation to expand the factory-based family planning effort so that they would be able to respond to the requests from five new industrial sites. With the FPAT and the Foundation already covering close to 250 factories, the approach is well established and accepted in Turkey. In addition, the labor union Turk-Is, which represents half of Turkey's 2,000,000 workers, is fully committed to and actively promoting family planning. Any contribution the Enterprise Program could make in this regard, therefore, would be minimal and add nothing to the private sector family planning initiative in Turkey in terms of innovative approaches to fertility reduction; it would only be more of the same offering services to a small number of fertile couples. Thus, it did not seem worth pursuing.

The second idea concerned assisting doctors to establish practices in low-income residential areas (shanty towns or cecekodu). During our discussions with the Foundation and our tour of several cecekodus in the Istanbul area, it became apparent that this would also contribute little. Metropolitan areas such as Istanbul are practically saturated with doctors and more and more doctors are establishing practices in and around

cecekondus. They reduce their fees so that their services are more affordable by the local population. This is not to suggest that the needs of this segment of the population, especially in terms of family planning and MCH services, have been met, but supporting private practitioners in such areas is not something that can be justified. What may make sense, however, is a self-sustaining clinic providing a package of MCH and family planning services.

1. Urban Clinic for Low-Income Population

The previously mentioned urban clinic funded by Pathfinder would be located at a central location, strategically situated at an easy-to-reach place convenient to multiple forms of transportation (buses, mini-buses and dolmuses, ferry boats). Its services will be aggressively marketed (using newspapers extensively) and cater to an upper and middle class clientele. The proposal calls for this facility to be staffed by three doctors (gynecologist, pediatrician, general practitioner) and three nurses.

The integration of family planning and MCH services is considered essential for economic reasons. People are much more willing to pay for curative and child-related services. The funds generated from these services can be utilized to subsidize the family planning services which people are less willing to pay for. Thus, integration in this case is based primarily on economic considerations. We are not aware of any clinic providing family planning services exclusively being able to achieve fiscal independence. The market and potential for generating income is too small. In addition, clients in several other integrated clinics (e.g., Egypt and Indonesia) respond positively to multiple services being provided at one site. Arguments against integration because it reduces attention directed to family planning apparently apply more to the public sector (where cost recovery has traditionally been less the issue) than to the private sector (where economic considerations become extremely important).

The two-year budget for the Pathfinder center is approximately \$250,000. Of this amount, about \$40,000 is to be contributed by the Foundation in the form of rent, office space and overhead expenses, laboratory equipment). Staff salaries and benefits account for approximately half of the clinic's total operating costs. About one quarter of the proposed budget (or \$50,000) is allocated for newspaper advertising. The income generated through patient fees and sales of drugs/supplies is estimated to amount to over \$100,000 over the two-year period. Pathfinder has instructed the Foundation to place this amount in a separate account which will not be used until after Pathfinder support has come to an end and is then available to cover costs associated with transition to a fully self-supporting status.

The urban clinic discussed with the TFHPF that the Enterprise Program should consider funding differs from the Pathfinder-funded approach in several important regards. First, the Enterprise facility would be located so as to serve a middle and low income population (compared to middle and high income population for Pathfinder's clinic). The purpose would be to test the feasibility of establishing a self-supporting, integrated MCH/FP clinic drawing largely on the population living in and around a cecekondu. Since over half the population of Turkey's three most populous cities (Istanbul, Ankara, Izmir) reside in cecekondus, it is vitally important

that some approach be developed that responds to their needs. The doctors residing in the area are typically general practitioners who charge fairly high prices for consultations and treatment. In addition, it is in the cecekondus that we find the most recent migrants from rural Turkey, those in the midst of the modernization process and with a high unmet need for family planning education and services. If the Enterprise-developed model proves effective and financially viable, a series of such clinics could be established in the cecekondus in the other major cities of Turkey. The Foundation would have a proven model to promote, either with their corporate members or with other donor agencies. All that would be required (in addition to contraceptive supplies) would be reasonable start-up costs.

A population of approximately 50,000 would be served by the Enterprise-supported clinic. In contrast to the static Pathfinder clinic, the cecekondu-based clinic would introduce an outreach component. A corps of local residents would be recruited to serve as community workers. Selection would be based on leadership capabilities, and each worker would be assigned a specific area of about 5,000 people or 1,000 women of childbearing age to cover. These workers would be women trained in family planning motivation and service delivery as well as in simple MCH aspects. They would be supplied with oral contraceptives and condoms which would be sold to clients during monthly housecalls. They would retain all or a portion of the revenue generated as pay.^[7] This is expected to serve as an incentive to encourage effective family planning motivators, educators, counselors and suppliers. By establishing trust and confidence in the women served, the agents should be able to achieve high levels of contraceptive prevalence.

The outreach workers/sales agents will serve another very important function for the clinic. They will serve as a self-supporting marketing team for the clinic. Being in constant contact with the population of their respective catchment area, they will refer women and their children to the facility for gynecological problems, pediatric concerns, pre and post-natal check-ups, etc. Thus, while the clinic will have reduced income from the sale of temporary methods (pills and condoms), it will receive increased business through referrals. More IUD insertions should be motivated (if the community agents receive a sufficient percentage of the fee to encourage recruitment of cases). Tremendously widespread gynecological infections should also be addressed by the field workers who can inform the women about the clinic's capabilities to cure such problems at a reasonable cost. The possibility of providing the agents a small financial incentive for each qualified referral might be considered to encourage these activities.

[7] The suggestion was made that the agents should make a minimum base salary. While this may be found to be required, it is thought worthwhile to see if they would work on commission only. Those who did not perform well would not earn enough to make their time worthwhile and would, in most cases, resign. New, more effective agents could be selected in their place.

The clinic fee would be structured to fall between the virtually free government service and the higher cost private doctors. Equally important, the quality of service would be superior so that the client received totally satisfactory and sensitive care for a modest price. It is thought that a dedication to client needs and concerns will make the clinic popular. The idea of calling the clinic a "Women's Health Clinic" might be considered since the vast majority of its patients will be women and children anyway.^[8] In a culture where women receive little or no special attention or support, having a facility which caters only to their special needs may be worth experimenting with. Services for under-fives of both sexes, of course, would be provided. It is expected that excluding the men would result in a minimal loss of income since they were typically infrequent users of such facilities. If counseling of newly married couples were to be one of the services, it could be done in the homes or even in the clinic itself, without abandoning the women's health focus.

In terms of project cost, several modifications in the Pathfinder clinic budget are suggested. First, the revenue generated would be utilized immediately to defray the clinic's operating costs. This amount is expected to cover approximately half of the \$200,000 required to fund the first two years of clinic operation. Secondly, the large amount allocated for newspaper advertising can be reduced by at least 50%. Because this center is primarily designed to serve local residents in and around a cecekodu, newspaper advertising is difficult to justify. It is possible that the newspaper ads for the Pathfinder facility could include the names of the TFHPF's three Istanbul clinics (featuring the centrally located Pathfinder-funded center, the Bakirkoy and Enterprise-assisted clinics). This would add prestige and notoriety to the outlying centers even if it had minimal impact on the number of clients using them. The resources for publicity for the Enterprise-supported clinic will have to be invested in more local instruments like posters and brochures.

With the use of the generated income and a reduction in newspaper advertising costs, the need for outside funds can be reduced to approximately \$75,000 for the two-year period (if the first four months are excluded as a start-up period, operating at a lower cost for personnel).

One aspect that might be added to the Enterprise-funded facility is a management information system (MIS), featuring the introduction of a microcomputer for the clinic. Currently, the Foundation functions with manually tabulated records. With an expected large volume of patients in an individual clinic (due to outreach capacity), they will eventually be required to keep a large number of patient records. All Foundation clinics could benefit from such a system. A prototype could be developed and tested at the Enterprise center.

[8] This idea was raised but did not receive a great deal of enthusiasm. This could be because the concept has never been considered before. To date they have been thinking of a clinic opened to both sexes and restricting it to only women represents a significant shift in orientation if not in actual utilization.

As in the case of the DFT's projects, a financially self-sustaining clinic is only possible if donated contraceptives (primarily condoms, pills and IUDs) could be sold. Therefore, this effort is also dependent on the government changing the current regulation prohibiting the practice or on the nominal purchase of donor-subsidized contraceptives. After four or five years, it is expected that contraceptive usage and demand for contraceptives would be well established. When this occurs the reliance on free contraceptives could be phased out and the full market price gradually introduced. At the end of this phasing out of subsidization, the contraceptives could be purchased locally in bulk; the agents would still sell them, making a commission on their sales.

As the source of the contraceptive supplies, two possibilities exist. One is the Pathfinder Fund. Their country director in Turkey has made a commitment to the Foundation to supply all its contraceptive needs. Having one source of contraceptives may be advisable for the Foundation since it would minimize its logistical problems. However, if the Foundation thought it important to diversify its source of contraceptive supplies, alternative sources could be investigated. In any case, as the MOH informed us, any contraceptives sold by the private sector (assuming permission is granted) would have to be packaged differently from those available through the public infrastructure so that they could be differentiated from the Ministry supplies, and leakage controlled.

IV. NEXT STEPS

A. Development Foundation of Turkey (Macro Project)

Development of the "macro" project with the DFT (a national contraceptive marketing program with initial emphasis on condoms) will best be accomplished in a two-phase approach. Phase I will be a market/feasibility study in which various approaches to the market will be analyzed and costed. The overall product of Phase I will be a business plan by which Phase II will be implemented.

Phase II will be implementation of a national marketing program which will utilize a multi-faceted distribution approach to potential consumers, both through institutions and directly to individuals. The approaches to be used and the sectors targeted will result from Phase I activities.

1. Phase I

Many sectors within the overall Turkish economy hold promise for market development and distribution of contraceptives. The wholesale market includes associations of physicians (both general and specialist) and pharmacies, the armed forces, private clinics and hospitals, midwives, selected truck stops located on major transportation routes, small stores (bakals) and University-based organizations. (There are likely to be additional wholesale possibilities which will become clear during research activities of Phase I). The retail market component is simply the collective individuals that are potential users of the contraceptives

marketed through either the wholesalers already mentioned or directly by the DFT through various means (especially through newspaper advertisements).

Approaches to both wholesale and retail market components will require sensitivity to cultural, religious, political and economic aspects. For example, it is the opinion of marketing experts that Turkey is comprised of up to six discrete socio-economic cultural population groups with differences so important as to require possibly unique approaches. Major cities in western Turkey (Istanbul, Ankara, Bursa and Izmir) where rates of literacy and family planning usage are both relatively high when compared to other cities in Turkey, will allow a marketing approach that can effectively utilize mass media campaigns. At least two of those cities, Ankara and Istanbul, will need additional approaches tailored to the large portion of their populations (up to sixty percent) that live in the cecekodu. This population, more than half of which has migrated to the cities within the last five years, statistically resembles rural Turkey, with relatively high illiteracy (especially among women) and fertility rates and low rates of modern contraceptive methods utilized.^[9] IEC programs will need to be developed especially for the urban poor, and they should probably be community-based rather than mass media-based.

Moderately sized cities along the Black Sea and in the East/Southeast might require a marketing approach that reflects special sensitivities based on a religious and political traditionalism which affect attitudes toward family planning and use of modern contraceptives. The advertising campaigns for this region will differ from the mass media usage for large, western cities and will be designed to reflect historical and current customs, literacy rates, economic strata and other factors that could impact the success of a contraceptive market development campaign.

The essence of Phase I, therefore, is to develop a market research activity which will provide intelligence about national market segments. Urban populations will be segmented according to economic and locational criteria, while both urban and rural population will be segmented according to regional customs, religious beliefs, political trends and, in some cases, language differences.

In addition to defining the market demand according to prevailing demographics, various approaches to market segments will need to be determined and developed. Private clinics and hospitals, for example, represent a potentially important set of wholesale consumers to which the DFT might market significant quantities of condoms for subsequent distribution to retail consumers (patients of the clinics and hospitals). An approach to clinics and hospitals will need to be developed, based on data that reflect attitudes of clinic/hospital management and employees existence and extent of FP programs at clinics/hospitals, patients' profile

[9] According to a sample survey in a cecekodu in Istanbul, recent migrants reported 15% using the pill, 12% IUD and 7% condom.

and extent of marketing support required by the private clinic/hospital network. Additionally, purchase, transportation and storage systems will need to be understood.

A similar information-gathering exercise will need to be undertaken for other potentially important wholesale consumers, such as pharmacies and small grocery stores, private practitioners, gynecologists, nurse-midwives, the Turkish Army and associations of University students. Each of these wholesale market components will need to be defined in order to effectively develop a market for them. Urban/rural and regional factors might be important to the wholesale as much as the retail market.

A special look will be taken at the potential for a mail-order system of delivery for both wholesale and retail contraceptive consumers. The DFT, through existing businesses and with direction and assistance of a captured marketing and sales holding company, has substantial experience using the national mail systems for sales and distribution of a wide variety of products. DFT has established an extensive data base for its mail-order activities, and utilizes a large, sophisticated computer network for maximum effectiveness. In addition, a directly applicable experience was achieved through a mail-order program to distribute condoms at only marginal charge to consumers so that handling costs were covered. Although Turkey was nowhere near as ready for family planning then (late 1970's) as it is now, DFT's experience was that a huge demand existed and was stimulated through a national promotional campaign conducted in mass media (print). Several years after termination of the campaign, letters requesting free condoms were still being received at the DFT.

Methodology

Data gathering should be undertaken by local consultants, possibly with the support of the Marketing Department at Bosphorus University, through the use of questionnaires designed to reflect the different market segments already discussed. The questionnaires will be administered to population samples, and since it is assumed that in some areas illiteracy will prevent independent utilization, assistance in reading/interpretation will be provided. Focus groups will also be utilized to gather information that will describe market segments and assist in development of appropriate approaches to each market segment.

Since some market segments are clearly rural, it is assured that field work will be necessary in selected regions. There might be the possibility, however, that recent migrants to urban cecekodu can be approached for current rural data, thereby obviating the need to send teams of market researchers/focus groups to rural areas. Travel requirement will be more adequately determined once research commences and cecekodu residents are approached. It will be assumed, for budgetary purposes, that travel to rural areas will be required.

Resource Requirements

Among management personnel within the DFT complex of organizations are individuals with more than twenty-five years' experience in market development and sales. The current Chairman of the sales organization and his sales managers are well suited to coordinate the market research project already described. Assistance will be provided by market research experts with experience conducting focus groups, developing questionnaires and collating and analyzing the data. Three such people as project specialists complemented by university students at schools of business and population, the number of which will be determined after the project is further defined, will be sufficient to implement Phase I of the macro project.

Several people were identified in Turkey who could provide support and technical assistance to the DFT Marketing Group in carrying out the condom study. One is Jeanne Binstock-Van Rij, Ph.D., who has considerable experience in marketing and especially in the use of focus group technique. This is an approach the DFT marketing people are unfamiliar with and with which they will require assistance. A second person with focus group experience is Dr. Sanda Cale at the University of Antalya. Her Turkish language capability and experience in family planning would make Dr. Cale a particularly valuable asset in a condom market research study. Finally, Dr. Ahmet Koc, head of Marketing Department at Bogazaci University in Istanbul could serve as a valuable adviser to the DFT in this major research effort.

Development of a preliminary budget requires assumptions as to the number and type of people required for the study, the extent to which travel will need to be undertaken, and the costs associated with both.

Preliminary Estimates of a Phase I Budget (US dollars)

	<u>DFT^[10]</u>	<u>EP^[11]</u>	<u>TOTAL</u>
PERSONNEL	\$11,310	\$30,033	\$41,343
TRAVEL/PER DIEM		4,300	4,300
MATERIALS/SUPPLIES	500	2,000	2,500
OTHER DIRECT COSTS	<u>1,000</u>	<u>2,000</u>	<u>3,000</u>
TOTAL ESTIMATED PHASE I	\$12,810	\$38,333	\$51,143

Timing

The DFT has recently completed activities which have consumed time and attention, and the organization is now positioned to embark on family planning activities as soon as possible. The in-house legal staff is pursuing remedies to issues associated with current legal constraints imposed by the MOH. Other departments of DFT (marketing, sales) could promptly initiate activities for Phase I, and the Enterprise Project is encouraged to support activity as soon as practicable.

2. Phase II

Upon completion of Phase I, anticipated at four to five months, Phase II implementation would be clearly defined in terms of activities and resource requirements, and could commence promptly. The strength of the Phase I product is that upon its completion, Phase II will be a project ready for implementation. The product of Phase I, if the condom distribution idea is found viable, will be a full proposal with a business plan on how the strategy will be carried out. Phase II will be a project ready for implementation by Enterprise Program, if it is able and so chooses, or DFT can present it to other potential funding sources.

B. Development Foundation of Turkey (Micro Project)

If the Enterprise Program decides to pursue the "micro" community-based approach described above, in Section IV, A.2, the next step will be basic programmatic support for project implementation. It is

[10] Project Management: DFT Secretary General @ \$150/day x 30 days = \$4500; Chairman of Marketing Corp. @ \$70/day x 30 days = \$2100; National Marketing Manager @ \$70/day x 30 days = \$2100. (A 30% tax is added to all Turkish salaries over \$10,000/yr. = \$2610.)

[11] Three Turkish consultants (responsible for data collation and analysis, and Project design assistance): 1 @ \$150/day x 15 days = \$2250 + 30% = \$2925; 2 @ \$100 x 90 days each = \$18,000 + 30% = \$23,400; 30 students at \$16 each (including tax) = \$480; 1 U.S. consultant @ 12 days

expected that the DFT will provide space for office and storage activities and some office equipment within current Foundation operations based in Van. The Enterprise Program will be asked to partially support the village operation for the first several years, until enough revenue can be generated from the sale of contraceptives to sustain the effort. Enterprise would pay for the supervisor and manager of the CBD effort for the first year when the return from the sale of contraceptives was still minimal. By the second year, half their costs would be recovered and by the third, all their salaries so covered. Informational materials adequate for reaching approximately half of the rural population of Van (an estimated 30,000 families), and technical assistance for both materials development and to family planning training would also come from Enterprise Program. A vehicle for transporting both contraceptives and people to villages would be required. Initially vehicle might be partially paid for by the Enterprise Program, although it must be amortized over a five-year period and recovered through contraceptive sales if the effort is to become fully self-supporting.

Preliminary Estimates of 2-Year Project Budget (US Dollars)

	<u>DFT</u> ⁽¹²⁾	<u>EP</u> ⁽¹³⁾	<u>TOTAL</u>
PERSONNEL	\$2,200	\$ 7,800	\$10,000
TRANSPORTATION ⁽¹⁴⁾		24,800	24,800
MATERIALS/SUPPLIES(IEC) ⁽¹⁵⁾	1,500	10,000	11,500
TECHNICAL ASSISTANCE ⁽¹⁶⁾		2,400	2,400
OTHER DIRECT COSTS ⁽¹⁷⁾	<u>5,000</u>	<u> </u>	<u>5,000</u>
TOTAL ESTIMATED PROJECT COSTS	\$8,700	\$45,000	\$53,700

Timing

This project could, and the Enterprise Program team suggests that it should, commence as soon as the concept can be developed into an approved contract. The Secretary General of DFT, Mr. Altan Unver, will be in Washington in late February to discuss both the macro and micro efforts with Enterprise Program personnel.

 @ \$269/day = \$3228.

⁽¹²⁾DFT Management: Office manager @ 10% = \$650/yr; Accountant @ 10% = \$450/yr.

⁽¹³⁾Gynecologist 25% = \$1800/yr.; Nurse/Midwife @ 25% = \$900/yr; Outreach workers (2) @ \$600 each (represents half of total compensation.)

⁽¹⁴⁾Represents half the estimated cost of a vehicle (\$10,000) plus full operation/maintenance (\$2400/yr)

⁽¹⁵⁾Represents basic office supplies and light equipment (DFT) and IEC

C. Turkish Family Health and Planning Foundation

As discussed in Section III of this report, the TFHPF represents the best private sector family planning activity now functioning in Turkey. Dedicated to the provision of family planning and MCH services and products to consumers who are employees or dependents of private sector employees, the TFHPF, although only two years old, is backed and staffed by such strong individuals that it has already had a major impact on family planning programming in Turkey.

Conceptually the Pathfinder clinic proposal is an excellent model. There are, however, modifications which could be made that would substantially reduce initial two-year costs while increasing revenue and thereby reaching a self-sustaining level of operation more quickly. Should the Enterprise Program decide to support a financially self-supporting FP/MCH clinic in Istanbul for middle and low income populations, the two-year budget summary presented below would be adequate.

Preliminary Estimates of 2-Year Project Budget (US Dollars)

	<u>TFHPF</u>	<u>EP</u>	<u>TOTAL</u>
RENT	\$15,000		\$ 15,000
SALARIES ^[18]		\$108,760	108,760
TRAVEL/PER DIEM		3,050	3,050
GENERAL/ADMINISTRATIVE		2,688	2,688
EQUIPMENT(OFFICE)		8,500	8,500
IEC ^[19]		30,725	30,725
CLINICAL EQUIPMENT		<u>4,921</u>	<u>4,921</u>
TOTAL COST	\$15,000	\$158,644	\$173,644 ^[20]

booklets (EP).

[16] Training to be supplied by MDs from Turkish organizations.

[17] Space for office and storage, plus phone, mail, etc.

[18] In addition to the staffing pattern proposed in the Pathfinder model, ten community resident outreach workers, initially, would be added, at \$50/mo. each. Additional revenue would be generated by them through sales of products and referrals. An option would be to provide no salary, with remuneration being commissions only.

Revenue:		
Sales of Contraceptives/Health Care Products: ⁽²¹⁾		\$10,000
Fees for Service at Clinics/Outreach Centers		75,000
TOTAL REVENUE		\$85,000
NET COST TO PROJECT:	Approximately	\$85,000

In addition, the contraceptive commodities would be donated by AID.

Timing

The TFHPF is moving rapidly, yet professionally, to implement its longterm goal of establishing privately-owned and operated clinics. It is prepared to proceed on the establishment of this proposed clinic as soon as formal arrangements and approvals are completed. The General Director of the TFHPF, Mr. Yasar Yaser expects to visit Washington, D.C. sometime in March and would be pleased to discuss the project with he responsible officers in the Enterprise Program and, if appropriate USAID/Washington. It is hoped that some Enterprise Program action to develop a contract to proceed with this effort will be initiated subsequent to that meeting.

D. Social Security System

Time did not permit the team to investigate the potential of the Turkish Social Security System (SSK) for family planning. This huge parastatal organization provides health insurance coverage for almost half the Turkish population (over 23 million individuals). It operates 77 general and maternity hospitals and 300 dispensaries. The possibility of integrating family planning services into this elaborate system should be investigated. As in the case of Enterprise's work in Egypt with the Health Insurance Organization (HIO). The health and economic benefits of providing family planning through the SSK should be investigated by the Enterprise Program.

⁽¹⁹⁾The Pathfinder allocation of \$40,000 for advertisements has been reduced to \$20,000 plus \$3,975 for education equipment, \$4,000 for brochures and \$2,750 for leaflets, all combined in an IEC effort that would be applied to a more intensive, localized marketing approach.

⁽²⁰⁾Approximately \$20,000 of Project total is non-recurring.

⁽²¹⁾A more intensive local market efforting, using outreach workers, will increase sales and referrals, therefore revenue, significantly.

SCOPE OF WORK

Enterprise Program Assessment Visit

TURKEY

Dates and Team Members:

David Pyle Jan 18 - Feb 3, 1987
Dennis Weeks

Locations to be Visited:

Ankara (USAID, GOT, international donors, others as appropriate)

Istanbul (NGO's, business community, local government, others as appropriate)

Bursa, Eskisehir, Ismir, and other rural areas outside of Ankara (industrial facilities, NGOs, business community, parastatals, local government, elements of the rural distribution infrastructure, others as appropriate)

Objectives of Visit:

1. To assess the potential in Turkey for increased involvement of the for-profit sector in family planning promotion, product manufacturing, distribution, and/or service delivery.
2. To identify opportunities for the Enterprise Program to assist existing Turkish NGOs active in family planning to address management - and business-related issues and/or to improve or expand programming.
3. To identify new actors in the NGO or non-profit health sectors which have potential for involvement in family planning activities.
4. To assess the current situation in Turkey with respect to the provision of family planning services or information at the workplace.
5. To devise a strategy for Enterprise Program assistance to Turkey to include short - and long-term activities in the commercial sector, state-run enterprises, and NGOs.
6. To investigate the current distribution of contraceptives, considering the expansion of improvement of distribution in rural areas.

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Proposed Strategy:

1. To respond to the USAID priority concerns for Enterprise Program involvement in private sector family planning.
2. To establish contacts and define future programming and/or technical assistance possibilities in the NGO sector.
3. To establish contacts and define future programming and/or technical assistance possibilities in the for-profit, commercial sector, by targeting large employers; appropriate business, trade, professional, and employees' associations; entities in the for-profit health sector, etc.

Specific contacts anticipated include:

- a) The Confederation of Turkish Trade Unions;
- b) The Development Foundation of Turkey;
- c) The Turkish Family Health and Family Planning Association;
- d) Pathfinder Fund;
- e) Ministry of Health Department of Family Planning as appropriate.

ATTACHMENT II

LIST OF PERSONS CONTACTED

1. ANKARA

U.S. Embassy

Carl Matthews, Labor Attache (AID contact)

Ministry of Health

Tandogan Tokgoz, Under Secretary of Health
Ugur Aytac, Deputy General Director, MCH/FP

Hacettepe University

Ayse Akin (Dervisoglu), Professor of Community Medicine and
Executive Director of Cubuk Project

Family Planning Association of Turkey (Atac Sokok 73/3; 131-1878)
Semra Koral, Executive Director

Development Foundation of Turkey (Tunali Hilmi Cad.22; 131-9090)

Altan Unver, Secretary General

Ahmet Saltik, Executive Director

Sukru Kaleli, Deputy General Manager (head of Marketing)

Munir Havlioglu, Manager of Sales

Akin Atauz, Deputy Coordinator, Rural Development

Turcan Karaosmanogulu, Home Economist

Esref Yucelyigit, Project Manager, Cubuk

Other

Dr. Nurset Fisek (139-1646), President, Turkish Medical Association
and Former Under Secretary, MOH

Dr. Cevdet Aykan, Former Minister of Health

2. ISTANBUL

Pathfinder Fund (Mehtap Sokak 6/7, Goztepe; 350-1912)

Turkiz Gokgol-Kline, Country Representative

Bogazici University (163-1500)

Ahmet Koc, Dean of Business School (Marketing Specialist)

**Turkish Family Health and Planning Foundation (Istaklah Cad. 347;
143-3062)**

Yasar Yaser, Executive Secretary

Enis Bulkan, M.D., Projects Coordinator

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BURSA

Santral Dikis

Gulsen Soykan, Family Planning Nurse

Sifas

Nigar Dagli, Family Planning Nurse

Sonmez-Filament

Muruvet Cangaytar, Family Planning Nurse

Yesim

Aytan Ozpolat, Family Planning Nurse

Ideas & action

1987/3

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ffmc/action
for
development



ATTACHMENT III

4 The Development Foundation of TURKEY

— small-scale production and community development

by
Geoffrey
Tansey



It is not often a development journalist gets to go back to the same project - or the same organization. Often it is a quick visit and away never to see it again. I was lucky, then,

to find myself in Malak village, high on the plateau in Central Turkey, in spring 1987. The last time I was there was in summer 1982. Then the hillside above the village was bustling with activity. Dozens of people were working - digging the foundations for a small reservoir near a spring that would provide a new water supply.

This year the hillside is quiet. All that remains is a line on the land showing where the trench was dug and a building covering the small reservoir. The partners in this water project were the villagers themselves and an unusual non-governmental organization NGO in Turkey - the Development Foundation of Turkey (DFT).

DFT members first came to Malak in 1981, soon after the Foundation started to work in Kayseri province. They had a series of meetings with the villagers to discuss what they needed. At first the villagers did not want anything to do with DFT. They thought they were politicians and something would be wanted from them for any help they received.

I learnt this as we sat in the house of the muhtar (elected village headman) with a dozen or so villagers, discussing their relations with the Foundation. At the beginning, when DFT staff explained that they wanted to help them improve living conditions, many villagers did not believe it was that simple. Others simply expected DFT to do whatever it was that they decided needed doing.

After several meetings it was agreed that the greatest need was for a secure, adequate water supply. The existing spring often dried up in the summer and did not provide enough water. DFT agreed to help the villagers to tap a spring about a kilometer from the town on the condition that the villagers organized themselves to do the work required. They did. DFT got a water engineer to show them what to do and provided the cement, piping, etc., for the work.

Thus it was that I found them in 1982, when visiting DFT's projects in order to write a report for them. Today things have gone much further. Instead of a couple of fountains in the village, water has been plumbed into every home. DFT is now involved with a livestock improvement programme - providing improved bulls for breeding, encouraging fodder production and pasture improvement, and milk processing.

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This did not all come at once, however. The villagers were glad to see the water supply improved, but they still expected DFT to come back after it was done, for some political payoff. They decided to wait a while before getting involved in other projects. In the event, no unpleasant consequences occurred, and the villagers decided to continue working with the Foundation.

Malak is just one of many villages in the area where DFT is working. Near Malak, in Beserek village, they supply looms and yarn for girls doing rug weaving, and a market for the finished product. Elsewhere they assist with the construction and repair of communal facilities like laundry houses, irrigation and drinking water; beekeeping; family planning and mother and child care. They are also supporting village-level training extension and research, which is community-focused and involves holding meetings to discuss problems and identify projects with the villagers.

The DFT staff in the province are at pains to point out that there is more to their "village-level work" than simply an odd project or two. They want to help villages to help themselves and generally to improve their economic well-being.

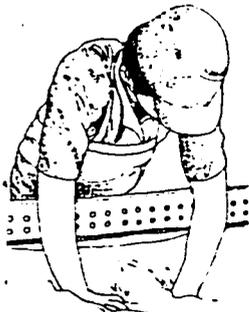
The rug work is one area where they provide a consistent source of supply for looms and yarn, give advance payments and pay up when the rug is finished. They buy in good and bad times from the villagers as well as giving support to the weavers. They started with 34 looms and are expanding to 460.

Small-scale cheese production

Livestock is however the mainstay of people's livelihood here. But improvement has to be seen in a long-term perspective, drawing together the different aspects of animal husbandry and providing markets for the produce.

Before starting work in the region, DFT did a survey that showed there were over 100 000 sheep in the villages around Kaynar. Travelling cheesemakers would come and take the milk, pay rather low prices and, even then, not pay most or all of the money due to the villagers until months later. At other times there was no market for milk from their cows, which were for subsistence.

DFT felt a modern cheese factory would provide a suitable rural industry and help in the economic development of the area. The idea was discussed with the villagers at Kaynar and it was agreed to proceed. The factory was built and came into operation in 1982. At first they only processed sheep's milk,



in the short, 40-day season. Around 650 tons per season is now processed, with the workers coming from Kaynar and the surrounding villages, of which Malak is one. They gave an advance for the milk and paid when they took it - not when they had sold it, as the travelling salesmen did.

The Foundation's long-term objective is to help bring about a greater return from livestock farming for the farmers in the area. The Government, too, is keen to see animal production increased and is promoting the purchase of high-yield breeds. But these need better feed and management than the traditional cows (which would also benefit of course).

The farmers were sceptical about investing in new cows and improving yields by better management and feeding until they knew there would be a market for the increased milk production. Before they would buy new cows, they said that the factory should be run every day for a year, collecting cow's milk. This has been done. Now, in Kaynar alone, 35 households bought 76 pure-bred cows and, in the area as a whole, some 200 dairy cows were bought. A man has been appointed in each village to collect the milk in churns, and these are taken by the DFT factory wagon every day.

The factory is still working at about a tenth of its capacity but the amount coming in is increasing and farmers are now interested in improving their milk yields. A cold store has been added to the factory so that it can keep the produce for 20 days, until it is sent for marketing.

But success has also had its problems, as the villagers in Malak explained. At first the factory gave advances early in the year to the farmers for the sheep milk purchases. But now these are getting later and later, and some do not get them at all.

The problem is a lack of working capital for the factory, as Rahmi Toprak, Manager of the Kayseri region explained. At first, when there were about 200 producers, there was no working capital problem. Now there are 2 000 producers. There is still considerable inflation - even if it has fallen from over 100 per cent at the end of the 1970s to around 40 per cent last year. In 1982 the advance needed was 20 000 lira */ for 200 producers, now it is 100 000 lira for 2 000 producers - which needs a working capital of 200 million lira - but the factory only has 90 million. He believes they will overcome the problem: but it will take time.

*/ 860.00 Turkish lira equals one US dollar.

6 But whether it is milk, rugs, cheese, or any other product, both DFT and the farmers know that just producing it is not enough. Besides having to have the skills and resources needed to produce, the farmers must sell at a price that gives them an economic return on their work and investment. It is here that what DFT calls its "village-level work" is leading to a more agribusiness approach to small-farmer development. This can be seen elsewhere in the Kayseri region.



A village starts poultry breeding

In Endürüklük village, on the slopes of Erciyas Mountain near Kayseri city, life has been getting harder for the farmers for the past years. They say the climate has been getting cooler, spring comes later, the growing season gets shorter, and vines are less productive. The village population has been falling. Nearly half of the village's 80 houses are empty in winter: they belong to workers in Kayseri whose families only come in the summer months.

Muammer Yildirim wanted to find a way to make his farming pay. He had heard about the small-farmer broiler production system that DFT had pioneered and was now being spread through many different regions in the country. He went to Kayseri to ask how he might become a broiler producer.

No broiler houses were planned in his area but he learned there would be parent stock houses. To run a parent stock house, where the eggs for the parent stock of the broilers are produced, there had to be sufficient farmers in one village who wanted to take up this activity.

He talked to various friends and relatives and got some interested in becoming parent stock producers. They met with the DFT staff, who came and looked around the village. Eight farmers applied for loans. They had to give their land title deed, or in some cases their father's, as security to the bank. The money was released to the special organization, Koy-Tur Kayseri Poultry Inc., which was set up by DFT for this purpose. It provides farmers with guidance, plans for building the poultry houses, day-old chicks, technical training and a regular veterinary and technical support service. The farmers are paid a monthly advance and provided a market for the eggs, which are taken to hatcheries for incubation.

Other villagers watched progress and later another 14 applied to get loans for the production of parent stock. Now DFT is building a hatchery at the edge of the village.

This is the first time parent stock have been produced by small farmers in Turkey. It requires careful management and many people said that DFT would not succeed in having it done by small farmers. So far, they have been proved wrong.

The origins of the DFT

The Development Foundation of Turkey is largely the brain-child of its General Secretary, Altan Unver. Son of a dentist, as a child he used to go with his father in the summer, when he shut up his practice in town and toured around the countryside, offering his services. It was good business and it provided a service to people who normally had no access to dentistry. It was Unver's first exposure to the rural population and the needs of villagers. While studying chemistry at the university he participated in an international work camp in Tunisia and then in Turkey, when the work camp movement started in 1959.

In the work camps, students worked with villagers in the summer months, building schools, small irrigation canals or roads. The materials were provided by various local and state organizations. The camps were good at motivating him and others, and in making them aware of the problems of development, but he felt they had little impact on the communities they were designed to serve.

Unver elaborated this idea still further when he did postgraduate work in chemical engineering and economics at the University of Texas: his thesis was entitled "an integrated approach for induced growth", which explored an alternative approach to rural development in Turkey. He advocated the need for a close and continual contact with villagers and commun-

ities, through which problems and possible solutions could emerge. It was in contrast with the formal extension approach then prevailing in the Turkish administration.

Back in Turkey he and his wife tried to put their ideas into action, teaching part-time and organizing a social service club among the six secondary schools of Tarsus, in south-east Turkey, near the coast. Members did all kinds of projects to promote social and economic development, from bee-keeping and small-scale irrigation to village handicrafts and family planning.

Activities proliferated and soon it was evident they could no longer remain just a social services club. In 1968 a seminar discussed how best young people could help in village development and the participants decided that a non-profit foundation should be created to carry out the activities in a more systematic way. A constitution was worked out; Professor Sonmez, one of the seminar participants, became the Chairman and Unver, Secretary General.

Funds were sought from local businessmen in Adana and also from charitable institutions overseas. The Secretary General has been busy and talented in raising funds for DFT ever since.

The Foundation gets going

The Foundation started its activities in the Tarsus area in the early 1970s, in poultry production, the field in which it has had its biggest impact on national agricultural production. The usual pattern had been for large, high-tech units, but the DFT developed a small farmer approach that has since been adopted by the Government as part of its Fifth Livestock Development Plan. Indeed the Foundation was chosen to be the implementing agency for setting up 12 poultry projects, like the one in Tarsus, in a World Bank financed programme, implemented between 1982 and 1986.

But we are anticipating. After their pioneering chicken production activities in the Tarsus area, the DFT started to work with poor bee-keepers in northern Ankara province, a project that has developed into a nationwide service to bee-keepers, with queen-bee and hive production, technical advice, a campaign against varroa and marketing.

In the mid 1970s DFT expanded to the Diyarbakir area where it got involved in earthquake relief and rehabilitation work after an earthquake in that region in 1974. It was in 1981 that it began work in Kayseri province.

By 1987 DFT has grown to a major operation with over 500 staff in the seventeen regions and the Ankara headquarters. Many new regions were brought in through a special department set up to deal with the implementation of the poultry component of the Fifth Livestock Development Plan. Three quarters of the staff work with the poultry projects; the rest work in rural and agricultural development projects funded mainly by European donor organizations like the Dutch agency HIVOS, US agencies and the Swiss Government. In all, the Foundation is working with nearly 8 000 families in 500 villages.

In 1986 DFT's grant income was 2 300 000 US dollars, and it is expected to remain at this level for the next 2 to 3 years. The agribusiness type of activities are kept separate from the Foundation's grant-aided work: dividends from the charitable holding companies are ploughed back into their operations to strengthen them. Their primary aim is to create strong farmer organizations that can stand on their own feet.



8 "With" the villagers and not "for" them

DFT's approach to rural development has changed. Gradually they have come to realize that they need to work with farmers and villagers, not for them. Only in this way could they generate the community, needs-based development they wanted to support.

This has happened through their experience and through interactions with the donors. "Initially" says Unver, "we concentrated on getting things done. For example, with a community well, if the pump broke down we felt we must press on and have it repaired. But we have evolved to believing that having community participation is more important than getting the pump mended."

A technical advisory group, appointed by HIVOS and other donors, has worked with DFT to help it evaluate its activities for a number of years. They helped pinpoint some of the problems in developing a more participatory approach and in 1984 it became more of a training group to assist staff in an internal evaluation of their activities, especially the predominantly technically qualified staff in DFT, most of who were former government employees.

About two-thirds of the staff come from the government services, usually the extension service, and one third from the private sector. There is perhaps still a need for them to get more training in the community-based approach. Recently DFT has changed its policy and staffing. Now they recruit more 20 to 25 year olds and give them an intensive training programme. In this way they are trying to produce a new generation of development workers. They have about 20 per cent drop outs, but the rest do want to stay and work.

There is another implication in taking the people's participation approach to development, according to Unver. "We must have the participation of field staff - it requires a lot of autonomy and initiative in field staff. If the organization was rigidly structured and projects dictated to the field, you couldn't expect much initiative from the field staff or between them and the farmers."

Staff get job satisfaction

DFT offers salaries not much higher than the government extension service, but the staff find the job rewarding and job satisfaction is very high. The staff choose to remain - as I know from the people I've met and seen over the years.

In Pinarbasi (Kayseri), the Director, Uzeyir Bagci, previously worked for 14 years in the cooperative section of the Ministry of Village Affairs (now merged into the Ministry of Agriculture, Forestry and Rural Affairs). His Project Director, Ismail Ozsoy was an agricultural technician in the Ministry of Agriculture for 12 years before joining DFT in 1982, while the man running the carpet developments, Ali Domanci, was an agricultural technician for 19 years before he went to the Foundation.

All the staff are much happier working for the Foundation, it appears. Uzeyir finds there is much less bureaucracy. He has lots of authority and responsibility and is not afraid to use it. He can work much more quickly than before. Ali, too, now has authority and responsibility, whereas in the Ministry he had responsibility but no authority. Then he could only do projects that came down from the Ministry. "But DFT can respond to local requirements." Also they find they can openly discuss problems with the director and with headquarters staff.

Uzeyir makes no bones about it: "I believe we are the best working organization in Turkey" he says. "We do change our ideas according to how projects are implemented. Our work in villages and experience there teaches us a lot."



Plans for the future

Over the next few years Unver sees a period of concentration and consolidation on the lines already initiated. For him their real success has not been in beekeeping or poultry projects but "in developing an analytical ability over the last two decades, an analysis of the problems of development within the Turkish rural setting and to formulate remedies". Now he feels there is a grasp of the issues among the staff, and they have some models and approaches worth developing.

There have been four stages in their work, he feels. First it was extension and training at an individual level, then credit. Then it was work in groups and the creation of organizations of farmers to get inputs for agricultural production. Now they are in a fourth stage, agribusiness activities with small farmers.

The country is littered, he says, with agribusiness investments set up by coops or worker coops or small investors that have closed after a very short life. The investment was usually unproductive, as the farmers have not got outlets to process their agricultural products. Operations folded because of lack of equity and management skills.

Over the next few years Unver hopes to focuss assistance in these areas and rehabilitate some of those enterprises. This will mean establishing an organizational base to provide equity participation in widening agricultural enterprises and management guidance.

The Holding Company set up for the existing poultry, dairy and beekeeping agribusinesses should provide the model for this. But more funds will be needed to provide working capital. It is a kind of "non-profit venture capitalism". Once the business is operating it would sell the equity to farmers who would have both an investment and capital gain.

A model for other countries?

This kind of charitable, agribusiness approach is beginning to attract attention from other countries in the Third World. Earlier this year Lalit Godamunne, Secretary General of the Mahaweli Development Project in Sri Lanka, visited DFT to see their small farmer agribusiness. He was impressed.

He liked the 'revolving fund' and holding company approach which provides initial capital and technical back-up to farmers to get them off the ground and then transfer of ownership to

them later as shareholders in the holding company. He felt this cuts through the barriers which normally prevent rural people getting access to skills and credit. 9

Godamunne plans to send some of his staff from Mahaweli to Turkey to make a more detailed analysis of the Foundation's management structure and to see if they could try a pilot project along the same lines in Sri Lanka. He may not be the only one.



For further details contact: The Development Foundation of Turkey, Tumali Hilmi Caddesi 22, Ankara. For more information on the operation of the poultry project write to the author: 4 St. John's Close, Hebden Bridge, West Yorkshire HX7 8DP, U.K.

ATTACHMENT IV

Van Province Population Data
(Number of villages, rural/urban populations by districts)

Districts (ilce)	# of villages	Population (1985 census)		
		rural	urban	total
Merkez (central)	100	59,909	121,306	181,215
Baskalc	109	35,380	12,538	47,918
Catak	26	21,889	2,932	24,821
Ercis	79	53,713	42,881	96,594
Gevas	50	36,984	9,470	46,454
Gurpinar	63	38,593	3,533	42,126
Muradiye	102	60,394	15,552	75,946
Ozalp	75	54,477	4,250	58,727
Totals	604	361,339	212,462	573,801