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A.I.D. POPULATION ASSISTANCE

OF

STRATEGIC EVALUATION

TURKEY



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EXECUTIVE SUMMARY

Since bilateral A.I.D. assistance to Turkey ended in 1976, A.I.D. has been providing population assistance to the GOT through several A.I.D. Cooperating Agencies (CAs) -- U.S. institutions operating under centrally-funded Cooperative Agreements or contracts with the Office of Population, and which tend to specialize in some subarea of population/family planning. Initially, the magnitude of these activities was low, but by 1990 assistance had grown to the point where it was necessary to hire a highly-qualified Turkish physician to coordinate overall assistance. In effect, this individual plays the role of an A.I.D. population officer in a setting where there is no A.I.D. bilateral program and no USAID mission.

By the end of 1992, AID/W deemed it advisable to carry out a "strategic evaluation" of A.I.D.'s population assistance in Turkey. **The purpose was to put in place a strategic framework within which A.I.D.-assisted population activities would in the future take place, in order to maximize their impact.** This was to be a major effort aimed both at assessing past performance and, perhaps more important, taking a strategic look at options for the future. The team was to make recommendations on program direction, areas of emphasis, specific CA interventions required, management options and, broadly, on A.I.D. assistance levels required to carry out its recommendations (see Scope of Work, Annex 1).

An eight-member team consisting of two AID/Washington officers, the Embassy's Population Officer, and five outside individuals was assembled to carry out the intended work over a five-week period in May-June 1993, including three weeks in-country. The team consisted of highly qualified and broadly experienced persons having the entire range of skills appropriate to the task: physicians, demographer, social scientists, policy and finance specialist, A.I.D. senior managers, logistics and MIS specialist, social marketing specialist, etc.

Principal findings and recommendations of the team are summarized below.

FINDINGS

- **A.I.D.-funded population assistance to Turkey has been effective in promoting appropriate strategies and programs in both the public and private sectors.**
- **While this assistance has made a difference, progress has been uneven.** Impact of assistance is unrelated to length of time in-country: some of the newer activities are already having major impact, while older ones are of lesser importance.
- **While some CAs have taken an overall systems approach, i.e., have conceptualized their activities with regard to the overall system within which they are working, others have pursued activities which seem less systematic and less systemic.**

- **The GOT appreciates and values A.I.D. population assistance**, emphasizing its role in keeping population/family planning concerns at a priority level and in stimulating appropriate response.
- Although Turkey is in many ways an advanced developing country, her demographic characteristics and family planning situation are more like those found in far less developed countries. Even so, **there is tremendous POTENTIAL for rapid advances to meet demographic goals**, due both to the extensive public and private infrastructure and to the very high "demand" for family planning services.
- **Turkey's legal and policy framework is generally supportive** of a modern family planning program. **However, neither public nor private sector channels for family planning service delivery have been adequately developed.**
- **Quality of family planning service delivery is low.** This situation is due to a number of interrelated factors: inadequate pre- and in-service training; shortage of equipment and supplies; administrative limitations on services organization; personnel practices which support very high staff turnover; poor or no supervision; weak logistical systems; no MIS; no overall strategic or implementation plans; no counseling or counselors; provider bias; no provider or client IEC materials; etc.
- Largely as a result of factors mentioned above, **client misinformation, dissatisfaction and discontinuation of modern contraception is a major problem.** While over 70% of all married and fecund couples say they want no more children, only 42% of these couples are using an effective modern method; 40% are using an ineffective method, and 16% are not using any method.
- **Abortion rates are high in Turkey** (abortion is legal up through the 10th week), so high that it appears many women may be using abortion as a principal means of fertility control. At present, no family planning counseling is given to women presenting for abortion.
- Because of the advanced socio-economic level of Turkey, **opportunities for stimulating programs which will be cost-effective and sustainable are great.**
- **Continued and intensified A.I.D. assistance will be needed for an interim period to develop sustainable programs in both the public and private sectors;** the need for A.I.D. assistance will be greatly diminished by the year 2000.
- **A.I.D. management of the program** through its in-country contract employee, its CAs, and the AID/W Turkey Working Group **has been generally acceptable, but will need significant strengthening in order to carry out recommendations contained in this report.**

RECOMMENDATIONS

General

1. **A.I.D. population assistance should be continued** and somewhat better focused on activities having catalytic and sustainable potential.
2. **A.I.D. management of the program should be strengthened** through the following actions: (a) additional in-country (contract and C.A.) personnel; (b) development of program-specific management tools; (c) establishment of standardized procedures and guidelines for all C.A.s working in Turkey; and (d) through more formalized relations & periodic program reviews involving the C.A.s and host country institutions.
3. **Coordination of C.A.s both in U.S. and in-country should be strengthened** through above procedures and through a process of treating C.A.s as "management clusters", i.e., grouping those engaged in similar or closely related activities.
4. **All C.A. activities should be reviewed** using overall systems concepts, in order to ensure they are focused on activities which are **catalytic, replicable, measurable, sustainable**, etc. All C.A.s need to ensure that their activities are focused on programs which are broadly sustainable, to enable A.I.D. to sharply reduce its population support by the year 2000.
5. In collaboration with the GOT, **phased plans should be developed** during the next six months for: (1) **commodities phasedown/phaseout** within 3-5 years; and (2) **overall T.A. phasedown** over the next 5-7 years, linked to increased contraceptive prevalence levels and overall program performance.
6. **A.I.D. funding levels should be increased** to accommodate recommended areas of emphasis...probably within range of \$5-8 million...followed by a leveling off and, after 4-5 years, a reducing level of assistance looking toward phasedown to very low levels by the year 2000.
7. **One U.S. contract technician should be recruited** to assist the Embassy Population Officer, stationed at the Embassy in Ankara. This individual could be provided through the Michigan Fellows program or other contract mechanism.
8. **Two of the C.A.s** currently without in-country representatives (JHPIEGO, JHPCS) **should hire U.S. or local Turkish professionals** to coordinate their activities in Turkey; **two other C.A.s (AVSC, FHTP) will need to strengthen their in-country presence** by hiring local professionals.
9. **Policy assistance should be provided** to the MOH's MCH/FP Directorate and to the

SSK to assist in strategic planning, goal-setting, development of implementation plans, management information systems, monitoring and evaluation, and in overall coordination of population/family planning actions by interested GOT and other agencies (MOH, by 1983 law, has overall coordination responsibility).

10. For the present A.I.D. **should not invest energies in general demand stimulation; rather A.I.D. assistance should be concentrated on stimulating the provision of high-quality services** as widely as possible, including expanding the real availability of all appropriate modern methods.
11. **Finance and cost efficiency studies should be undertaken** to assist in planning; at present needed data are lacking.
12. The A.I.D. Europe Bureau and the Office of Population should continue the close working relationships developed as a byproduct of this evaluation, aiming toward shared understanding and support of C.A. assistance in Turkey.

Service Delivery Recommendations

13. **Modern contraceptive methods**, in addition to the IUD which has long been the mainstay method, should receive much greater emphasis. Specifically, this should include VSC, orals, and long-acting hormonal methods (injectables and implants).
14. **All appropriate delivery channels should be exploited**, including fixed and outreach service rooted both in the public and private sectors. At each service delivery level, an attempt should be made to provide all methods appropriate to that level, given staff skills, plus information about and referral for other methods.
15. **Effective referral mechanisms** and other links between health units providing family planning information and temporary methods, and hospital units providing long-acting clinical methods, should be emphasized.
16. **Greater attention should be given to postpartum/perinatal and periabortion services** because this is an opportune time for service delivery; because abortions are often a proxy for undelivered FP services; and because of the very high percentage of Turkish women who do not want more children.
17. Because of the enormous potential for FP service delivery in terms of staffing and facilities (particularly, reaching the least advantaged segments of the population), **much greater emphasis should be given to strengthening MOH capacity to deliver high-quality FP services throughout its extensive network.** At the same time MOH capacity is strengthened, **specific in-service training and certification programs should target MOH physicians who have private practices and who are potential**

providers of family planning services. Since MOH-affiliated physicians represent most physicians also in private practice who could provide family planning services, this approach is doubly important.

18. Because of the demonstrated high potential of outreach services to recruit and refer clients for all FP services, **outreach programs should be greatly expanded and linked closely to fixed facility services; in the case of Pathfinder-assisted CBS programs, emphasis should be shifted to rural areas.** Issues of program cost, sustainability of results, and self-financing should be dealt with explicitly at the design stage as new outreach services are mounted.
19. **Social marketing programs should be further strengthened and expanded,** particularly as regards: (a) the introduction of new methods (IUDs, injectables, Norplant); and (b) far greater emphasis on educating pharmacists and pharmacist-assistants to provide counseling and support for hormonal methods. Provider and client education will be particularly critical factors in this process.

Other Major Recommendations

20. **Both pre- and in-service training of family planning service providers must be significantly strengthened.** FHTP should expand and intensify its effort in this critically important area.
21. **Management information systems (MIS) development and implementation should be speeded up both within the MOH and the SSK.** Insofar as possible, these systems should attempt to capture both public and **private sector** activities. Lack of an operational MIS is a severe handicap both to program management and to program planning.
22. **Information, Education, and Communication (IEC) activities need to be strengthened.** A national IEC strategy is needed, as well as an in-country IEC specialist to work across all CAs and institutions having major IEC components.

Only major recommendations have been listed above; there are numerous others which are important. These are given and discussed in Section III.A. beginning on page 41.

A.I.D. Cooperating Agencies (CAs) in Turkey

JHU - Johns Hopkins University (Baltimore)

- PCS (Population Communications Services....IEC activities)
- PIEGO (Program in International Education in Gynecology and Obstetrics...clinical training activities)

CEDPA - Center for Development and Population Activities (Washington, D.C.) - FP service delivery, training, coordination activities

The Futures Group (Glastonbury, CT)

- SOMARC (social marketing activities) -- Washington, D.C.
- OPTIONS (RAPID & other policy activities)

ISI - John Snow, Inc. (Boston, MA and Rosslyn, VA)

- FPLM (Family Planning Logistics Management Project)
- SEATS (provides comprehensive family planning assistance)

AVSC - Association for Voluntary Surgical Contraception (New York)
- Supports training and equipment for VSC and other clinical methods

The Pathfinder Fund (Boston) - supports innovative service delivery, IEC, and other projects.

D.A. - Development Associates/Family Health Training Project (FHTP) (Rosslyn, Va.) - together with subcontractor Pathfinder, provides comprehensive training assistance

MSH - Management Sciences for Health - FPMD Project (Boston) - provide policy, management, and planning assistance

Macro (Columbia, Md.) - provides technical and financial assistance to implement Demographic and Health Surveys worldwide.

I. PROBLEM CONTEXT AND RATIONALE FOR A.I.D. ASSISTANCE

I.A. ECONOMIC CONTEXT

Turkey has a vibrant, growing economy. Per capita GDP is now \$3100; the economy has consistently grown since the early 1980's with real growth in per capita GDP increasing more than 6% annually. Despite these positive trends, high interest rates and inflation (60.3% in consumer prices in 1990) continue. Agriculture remains the most important economic sector, with about 55% of the labor force. Among developing countries, Turkey enjoys a reputation as a model for economic development based on its vigorous open market system. It has recently assumed the role of donor, e.g., in providing commodities, financing, and training in finance and banking to the Central Asian Republics of the Newly Independent States.

In the health sector, however, Turkey ranks lower than many developing countries in several health indicators and consistently last among OECD nations in most health performance measures (OECD Health Data File, 1992). Health resource allocation is imbalanced, with preventive services receiving only 4% of available financing (family planning receives less than 3%).

The economic transition in Turkey has already and will continue to significantly impact on population-related issues and on the provision of family planning services. Demand for family planning services, already high, will likely increase as a result of urbanization, higher educational level, the high cost of children in urban areas, etc. Turkey's robust economy, rooted in its very active and accomplished private sector, presents an opportunity to build strong family planning initiatives which are wholly or largely self-financing, since most Turks are -- at least in theory -- capable of paying for services.

I.B. LEGAL AND POLICY CONTEXT

Turkey's leaders recognize that increased human productive capacity requires reduced population growth consistent with sustained economic growth; current legal and policy environments provide broad support for family planning services and have effectively paved the way for achieving ambitious development goals.

In 1983, the government passed watershed legislation known as the "Population Planning Law." This law supported the principle that "individuals have the freedom to decide the number and timing of their children" by lifting most legal barriers to the import, manufacture and distribution of contraceptives. Aimed at both reducing population growth and improving women's reproductive health, it legalized provision of family planning information, free or low cost distribution of contraceptives, sterilization for men and women and abortion on request up to the 10th week of pregnancy. Specific elements of the law have had significant

impact on fertility, contraceptive use, and on improving the status of women in Turkey. This law remains one of the most liberal in the world. However, certain aspects of the laws regarding family planning could be improved. The 1983 law, for example, restricts provision of tubectomy services to OB/GYNs, while GPs and even lower-level trained personnel could carry out minilap procedures as they do in other countries.

The 1983 law provided an umbrella for the provision of family planning services in both the public and private sectors. Contraceptives are available widely in the private sector through 13,000 pharmacies located throughout the country, and through private physicians trained and certified to provide at least some family planning services (usually IUDs). In the public sector, support for family planning services continues at both central and local levels of government. Dr. Yildirim Aktuna, the current Minister of Health, declared 1993 as "The Year of Mother and Child Health" with priority given to initiating new family planning approaches. Health reform legislation is awaiting Parliament's consideration. Privatization of hospitals, a central focus of this health reform package, has the potential to improve both the efficiency and quality of care. The Sixth Development Plan (1990-1995) and the First Health Project of Turkey include specific fertility reduction and contraceptive prevalence targets. At the local level, the Mayor of Ankara recently proposed a tax incentive and forgiveness scheme for couples limiting their family size to three children.

With some relatively minor exceptions, the overall policy and legal framework needed for effective family planning programs is in place. Effective implementation of these well-intentioned policies is often limited, however. The greatest barriers to increasing use of effective family planning in Turkey involve human, technical, managerial and, to a lesser extent, financial constraints. A discussion of these constraints, and ways that A.I.D. support can assist in improving modern contraceptive use, forms the bulk of this report.

I.C. DEMOGRAPHIC CONTEXT

Turkey's 1993 estimated population of 60 million persons places it 17th among the most populous countries of the world. Approximately 36 million Turks live in urbanized areas (60%) while the remainder reside in small towns and rural areas widely disbursed across the country. In area, Turkey is slightly larger than Texas. With a crude birthrate of 28 and a crude deathrate of 6 per thousand, Turkey's rate of natural increase is estimated at 2.2 percent per annum. Infant mortality is 54-60 deaths per 1000 live births. The total fertility rate is 3.4 children per married female. The Turkish population is literate (95% men, 77% women) and has a per capita income between \$3100 (GDP per capita) and perhaps \$4500 (an estimate taking into account purchasing power). This level of income implies a capacity among many Turks to pay for health and family planning services. Turkey's demographic indicators, however, are those of a developing country rapidly entering the demographic transition stage.

I.D. CURRENT FAMILY PLANNING CONTEXT¹

Turkey is a land of many contrasts, including in the area of family planning. Knowledge of modern FP methods is high (90%), but practice is low (31%). Useful knowledge may be much lower than the 90% figure, since **misinformation and incomplete information** is widespread. Potential demand for family planning is very high, based on the following three factors:

- *overall use of some family planning method is high* (63% in 1988), with 31% of couples using modern methods and 32% using traditional methods;
- *76% of ever-married and fecund women interviewed in 1988 say they want no more children*, including 84% of those having 2 children, 93% of those with 3 children, and 96-98% of those with 4 or more children;²
- *ever use of a modern method is about twice as high as current use*, suggesting that many couples have tried modern methods but have discontinued their use for one or another reason; and
- *reported abortion rates are high*, estimated at 1 abortion for every 3 live births nationally and, among some populations, 1 abortion for every live birth.

While the overall legal and policy context for family planning is permissive and quite liberal, implementation of high-quality family planning service programs is uneven in both the public and private sectors. Client and provider bias, shortage of equipment and supplies, inadequate training, poor or no supervision, lack of informational materials, inconsistent fee structures, and other such problems combine to severely limit the true availability of high quality FP services, even in large urban areas such as Istanbul (pop. 10 million) and Ankara (pop. 2.5 million). The GOT, acting through the MOH, has recently reiterated its desire to strengthen family planning service availability. Turkey's new Prime Minister, U.S. educated Tansu Ciller³ and a champion of women's rights, is likely to breathe new life into well-intentioned but ineffectively implemented family planning policies, especially since in present-day Turkey the importance of these policies to continued economic progress is abundantly evident.

¹ The 1993 demographic and health survey is just getting underway at this writing; preliminary results will not be available until Fall 1993. Information below is predicated upon findings of the 1988 DHS survey and other sources.

² Curiously, differences by educational level showed that illiterate females were just as likely -- or more likely -- to want no more children than did better educated females (Turkish Population and Health survey, 1988, p61ff).

³ Ciller, a female, was Turkey's Economics Minister

I.E. A.I.D. AND OTHER DONOR SUPPORT

A.I.D. bilateral assistance to Turkey ended in 1975. Since that time, population assistance has been provided from the Office of Population, and has been coordinated from Washington. As the level and complexity of assistance grew, in 1991 it was decided to recruit a local-hire professional to serve as the Embassy's Population Officer. This individual, a Turkish public health physician, has served admirably in this role for the past two years, coordinating the work of a dozen U.S.-financed cooperating agencies providing population assistance in Turkey. Present levels of assistance are about \$5 million per annum from all A.I.D. sources.

A.I.D. is the major external source of population assistance to Turkey. UNFPA has a country coordinator and has funded service delivery activities in the East and limited technical support. They are working through the MOH to provide improved institutional capability at both the central and local levels. The World Bank is supporting a major health care reform program which seeks to re-allocate responsibility for health care financing and service delivery from the public to the private sector. This is a huge undertaking which will be implemented in a phased manner, probably over 10-15 years. The European Community (EC) has also provided small grants to NGOs working in population. While total external support from all sources is relatively low, it has served to fill vital gaps in the system and to keep population issues visible at the highest levels of government.

I.F. CONFORMITY TO A.I.D. POPULATION STRATEGY AND TO U.S. POLICY INTERESTS

Current A.I.D. population strategy calls for assistance to countries desiring to increase the use of modern contraceptives for health, demographic, socio-economic, women's rights, and other such reasons. In the recent past, there has been the added desire to emphasize assistance to the most populous countries wherever possible, on the theory that limited U.S. resources for population assistance worldwide could have the most important global stabilizing effect if assistance were concentrated in the "large countries". In Turkey, both conditions are met: the GOT is intent on lowering its fertility through the increased use of modern contraception (see below), and Turkey's population of 60 million certainly qualifies it as a "populous nation".

U.S. foreign policy interests provide a compelling reason to provide targeted population assistance. Turkey has for two decades served as the eastern bulwark (some would say "bedrock") of NATO, performing that critical function in an exceptional manner. Now, in the post cold-war era, the U.S. has continuing ties to Turkey in trade, military, and other important foreign affairs areas, including the newly independent states of the region. Turkey has itself begun to invest heavily in the former Soviet states along its northern border. In 1993 alone, the equivalent of over one billion U.S. dollars will be channeled directly to these states by the new Turkish International Cooperation Agency (TICA). It is in both Turkish

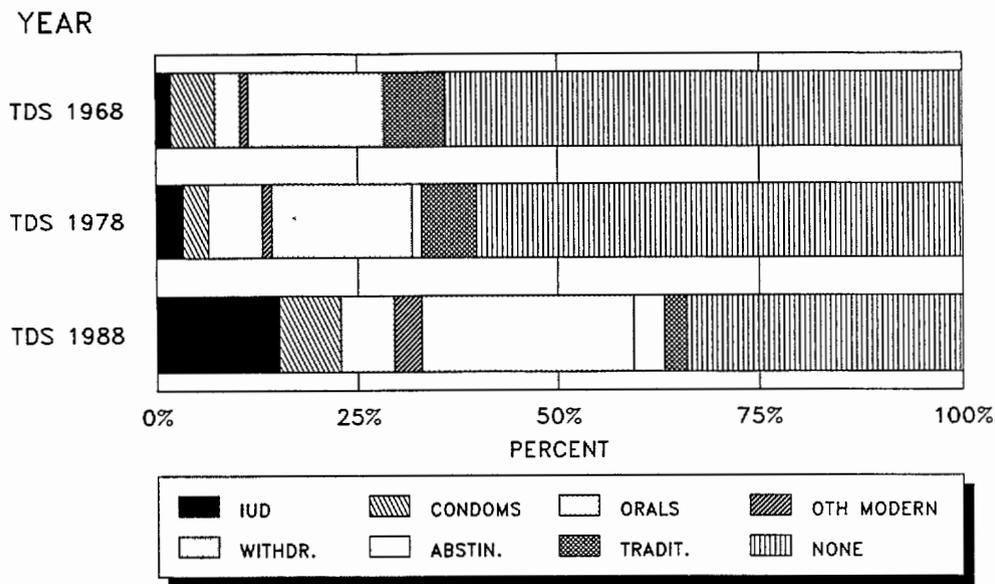
and U.S. interests that such relationships result in stabilizing and strengthening the economies of these new states, thereby helping to foster long-term stability in the region. U.S. population assistance to Turkey can be viewed, in itself, as helping to strengthen the Turkish economy in both economic and social terms.

Finally, the impact of U.S. assistance can be realized in a relatively short time period. Turkey is poised, like few other nation states, to achieve a **doubling of modern contraceptive use** in a very few years. Such a momentous demographic transition will help thrust Turkey farther into the modern world by the turn of the century.

I.G. CONFORMITY TO HOST COUNTRY INTERESTS AND PRIORITIES

Turkey is intent on reducing the population growth rate, recognizing that continued medium-to-high fertility is inconsistent with reaching her economic goals. Specific demographic and family planning objectives have been outlined for the year 2000; these objectives are consistent with A.I.D. population assistance as recommended in this document. While Turkey's overall population growth rate is just over 2 percent, urban growth is continuing at a very high rate (4.5% overall, 8-10% in some cities), fed by an exodus from the rural areas (the rural population actually **declined** at a rate of 5% during the 1985-1990 intercensal period). Newcomers to urban areas live in "squatter" areas, placing increasing demands on municipal governments for services already in short supply. A.I.D. assistance is targeted in part to these recent urban arrivals, as well as to other segments of the population less able and likely to be served by the private sector. Such assistance is in direct support of the GOT's desire to increase modern contraception use as rapidly as possible.

CONTRACEPTIVE USE IN TURKEY 1968-88 BY CONTRACEPTIVE METHOD



All Data From Turkish Demographic Survey

Figure 1 - Progression In Contraceptive Use in Turkey 1968-88

II. FACTORS AFFECTING STRATEGIC CHOICES

II.A. VERY HIGH DEMAND BUT RELATIVELY LOW CURRENT USE

Figure 1 above depicts the progression in use of contraception during the 20-year period 1968-88. Reading from the left for each year, the first four patterns trace modern contraceptive use (IUD, condom, orals, and other modern methods). In 1968, it can be seen that total modern method use was only 11-12%. By 1978, the percentage of modern contraceptive use had increased only slightly to around 15%. Ten years later, modern contraceptive use had doubled to around 34% (of married women of reproductive age). There is reason to believe that this proportion has further increased during the past 4-5 years, a hypothesis which will be supported or rejected when preliminary results from the ongoing Demographic and Health survey (DHS) are available later this year.

Oddly, however, the level of current practice is far lower than would be expected either from Turkey's advanced level of economic development (and its liberal family planning policies), or from an analysis of the existing demand for contraception. Countries much farther down both these scales have comparable or higher use of modern contraceptive methods (Bangladesh, Indonesia, Tunisia, Morocco, etc.).

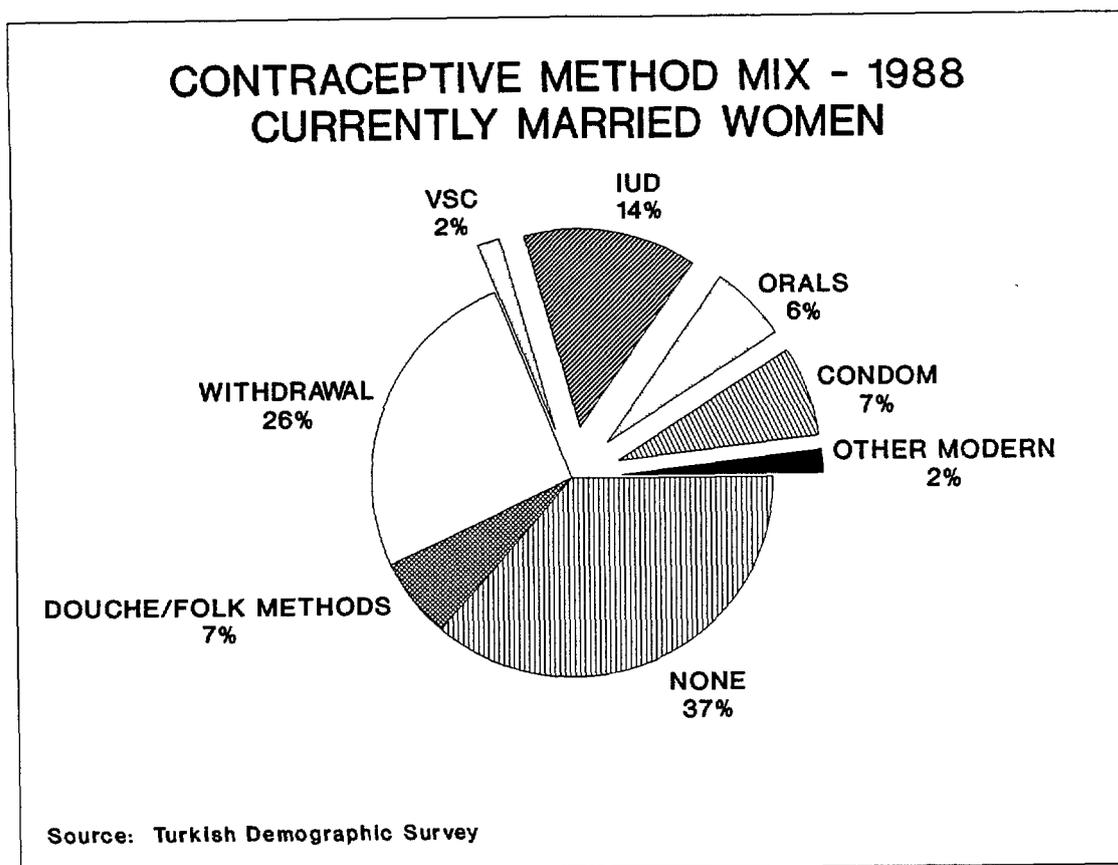


Figure 2 - Current Contraceptive Use Among Married Women of Reproductive Age

The explanation for this anomaly seems to be rooted in the manner in which modern contraceptive methods have been made available in the public and private sectors in Turkey -- a manner which favored certain methods (particularly the IUD) to the relative exclusion of other methods. Even those methods which were emphasized (IUDs by MOH, orals by pharmacies) have not always been introduced, promoted, and supported sufficiently well by either the public or the private sector. This has led to large numbers of couples who have tried modern methods, but have abandoned them due to real or imagined side effects for which there was no supportive (counseling, followup) system in place.

Figure 2 above shows the current method mix (1988). It can be seen that while modern methods (VSC, IUD, orals, condom, and other) make up 31% of use among currently married women of reproductive age, an even larger percentage (33%) of women are using withdrawal, douche, or other ineffective methods. Even among modern method users, there is good evidence to suggest that some (orals, condoms) are not being used correctly, leading to high method-use failure rates and high dissatisfaction and discontinuation. Yet demand for effective contraception remains very high, as is shown in **Figures 3 through 6**, and it is highly significant that this high demand seems to be independent of either place of residence or level of education (**Figures 5 and 6**). Note also in **Figure 4** that many couples wanting additional children are using contraception, presumably for child-spacing.

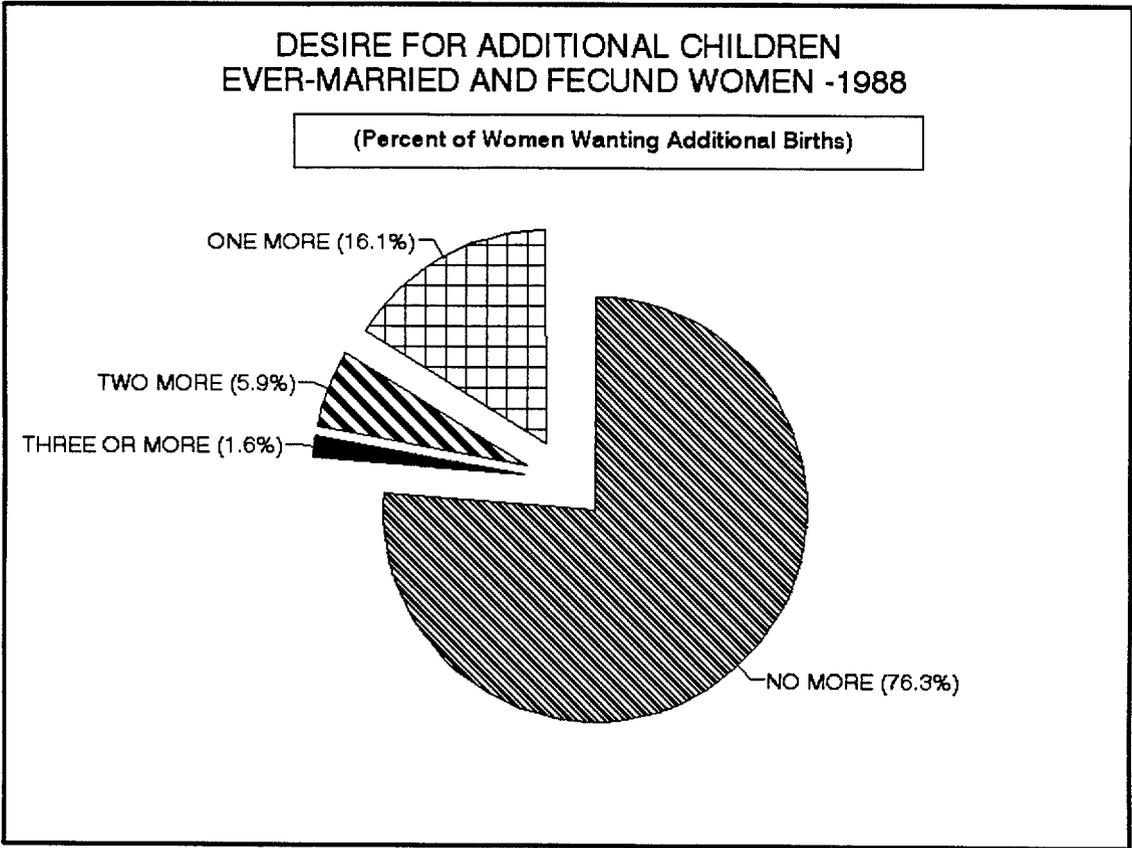
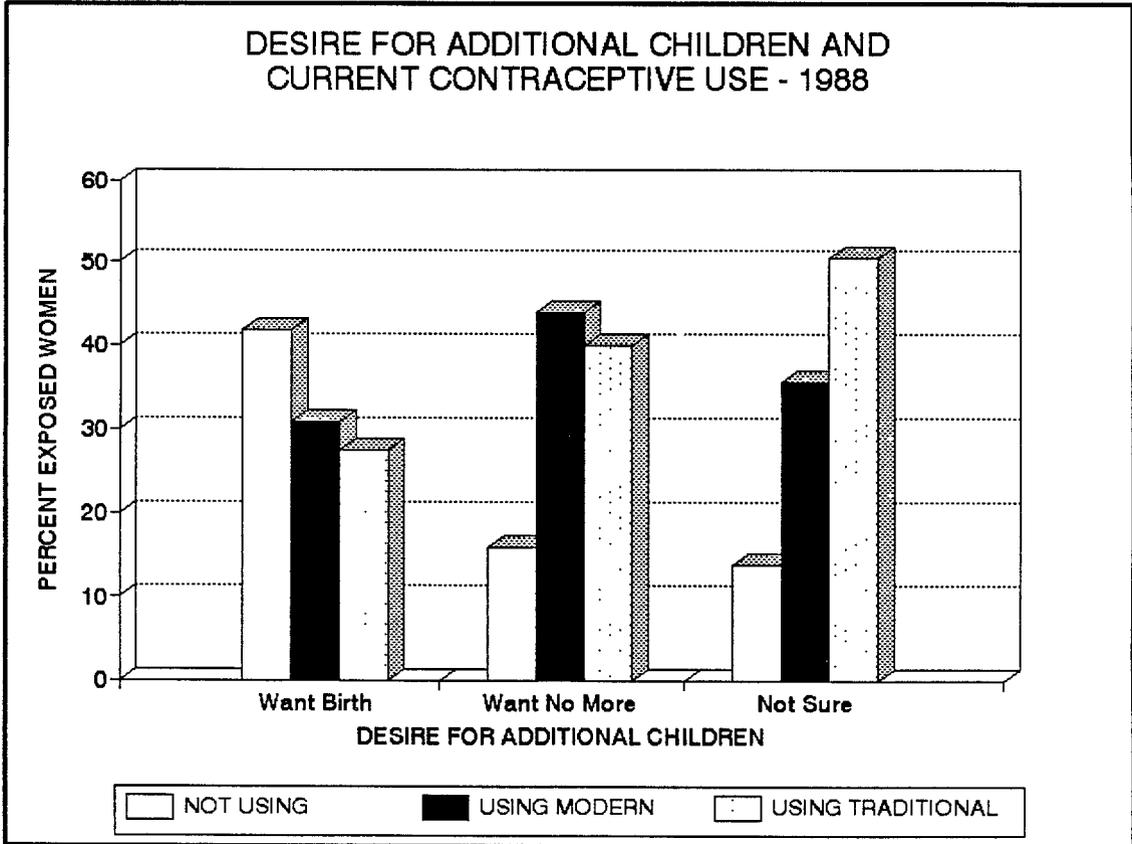


Figure 3

Figure 4



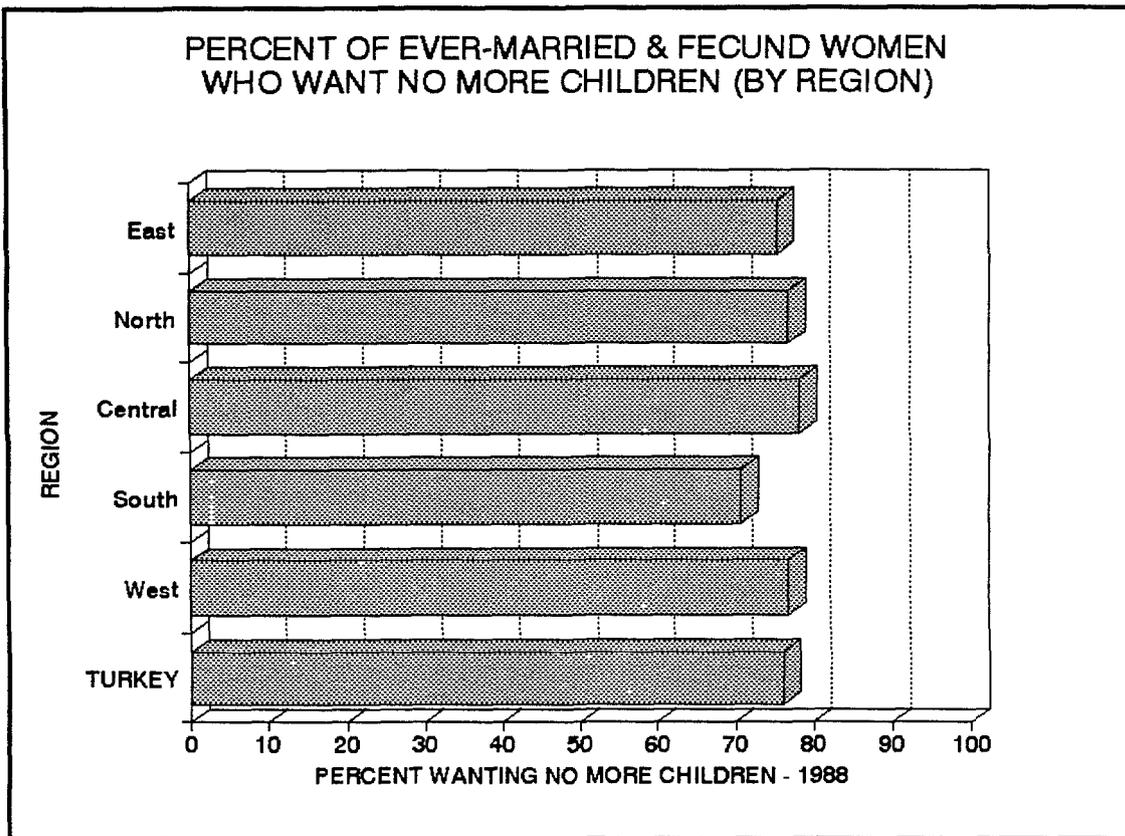
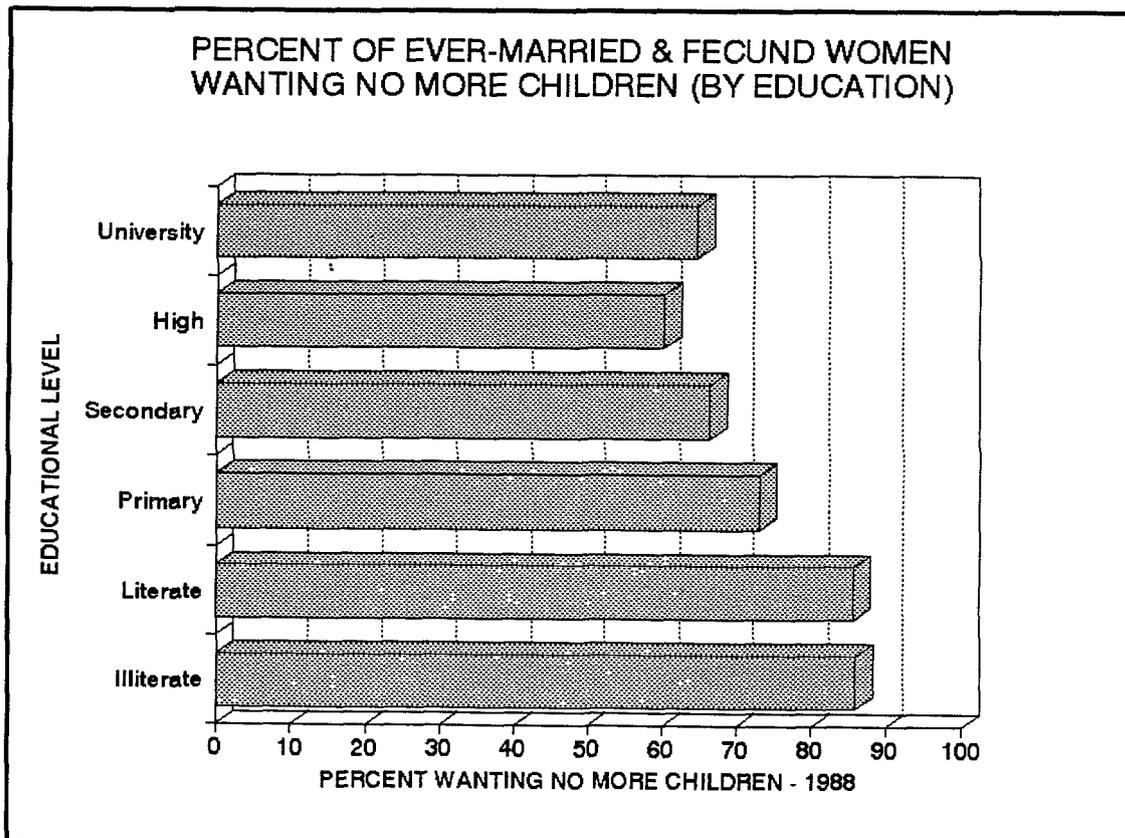


Figure 5

Figure 6



Figures 3 and 4 embody the great paradox in family planning practice in Turkey today:

- over three-quarters of ever-married and fecund women say they want *no more children* (an additional 16.1% want one more child; 5.9% want two more children; and 1.6% want three or more additional children)

YET

- only 42% of those wanting no more children are using an effective contraceptive method (an additional 40% are using an ineffective method and 15% are not using any method...Figure 4).

The explanation for this low use of modern methods among women who say they have completed their fertility is multi-faceted. Some (the team believes many or most) couples *would use* a modern method if it were to be truly available to them in terms of physical access, cost, good counseling, and followup. Some women, it seems, are now depending on abortion as a backup in the event they become pregnant. Some, perhaps most couples using a traditional method may be doing so in the false belief that they are protected from an unwanted pregnancy; the team came across many examples of misinformation both among users and clinicians. Couples using traditional methods (and abortion) are also good candidates for modern methods, given appropriate IEC and counseling. Finally, many couples not using contraceptives at all may be candidates for modern methods, particularly spacing methods.

Medical barriers, i.e., resistance among physicians and other health professionals to providing comprehensive family planning services are a widespread constraint. These barriers result from a variety of factors, including misinformation, inadequate pre- or in-service training, as well as administrative and economic factors. These are discussed in detail later in this report.

While use of modern methods is low, overall use of *some family planning method* is high (73% of currently married women use *some method of family planning*). The widespread use of abortion is discussed elsewhere. Turkish women say they want, on average 2.17 children, essentially replacement-level fertility. The Futures Group has calculated, using the new TARGCOST model, that this level of fertility could be achieved *without increasing the percentage of couples using family planning*, by shifting couples from ineffective methods to more effective, modern contraceptive methods.

For these reasons, as well as the very promising ongoing projects supported by A.I.D. CAs, the team believes Turkey is poised to undergo a very rapid transition from moderate to high use of modern contraceptive methods by the end of the decade.

II.B. UNDERUTILIZATION AND UNDERDEVELOPMENT OF CHANNELS FOR FAMILY PLANNING SERVICE DELIVERY

One way to look at family planning service delivery is to consider the various **channels** through which, potentially, services could be delivered. These include: (1) the public sector network (hospitals, health centers, clinics, outreach workers); and (2) NGO and private sector networks (women's organizations, pharmacies, private physicians and other health personnel, private hospitals and clinics, private employers). In Turkey in 1993 it appears that many of these channels are being utilized to some degree, but in no case has the potential been fully realized; in most, it has just begun to be tapped.

Figures 7 through 12 examine aspects of family planning service delivery in the *public sector*, drawing upon the only information available to the team⁴. This information pertains specifically to *new acceptors* (the team was told that new acceptors are those accepting a modern contraceptive method for the first time in a given facility). Data in this category are available for a five-year period, allowing some comparisons to be made. Note that these data for the public sector refer *only to institutions which reported their family planning activity to the MOH (about 25% of all health institutions)*; one can infer that reporting institutions were those which had some family planning activity in 1992.

Figure 7 traces the trend in new acceptors of four methods (condom, orals, IUD, and VSC) over the past five years. It can be seen that orals have increased significantly in 1992 while IUD and condom acceptors have increased only very slightly over the period. It is difficult to see on this graph that VSC acceptance (tubectomy and vasectomy) has increased more rapidly than any other method. This trend is shown graphically in **Figure 11**.

The average number of new family planning acceptors in most facilities is quite low, being about 1-2 acceptors per workday *except* for the MOH's dedicated MCH/FP centers where some 8-9 new acceptors are registered each workday (**Figures 8, 9, and 10**). The dramatic difference between the family planning productivity of these MCH/FP centers and other categories of service providers can be seen in **Figures 9 and 10**. Of the 3,460 MOH units reporting in 1992, the 192 specialized MCH/FP centers themselves accounted for one-third of all new acceptors, thus demonstrating the impact of specialized centers where family planning is a priority activity! Note that in **Figure 10** the 21 SSK hospitals (an A.I.D.-supported activity) recruited more new acceptors per facility than any other type of facility, excepting the MCH/FP centers. It is also encouraging to note that reporting institutions in the public sector appear to be providing more family planning than abortion services (**Figure 12**). Still, family planning services are available in only about a third of public sector facilities, and even these appear to do far less family planning than they could.

⁴ the generally poor availability of data was a constraint to analysis throughout the Strategic Evaluation effort; data are often unavailable, unexploited, conflicting, or of questionable quality in virtually all delivery systems examined by the team

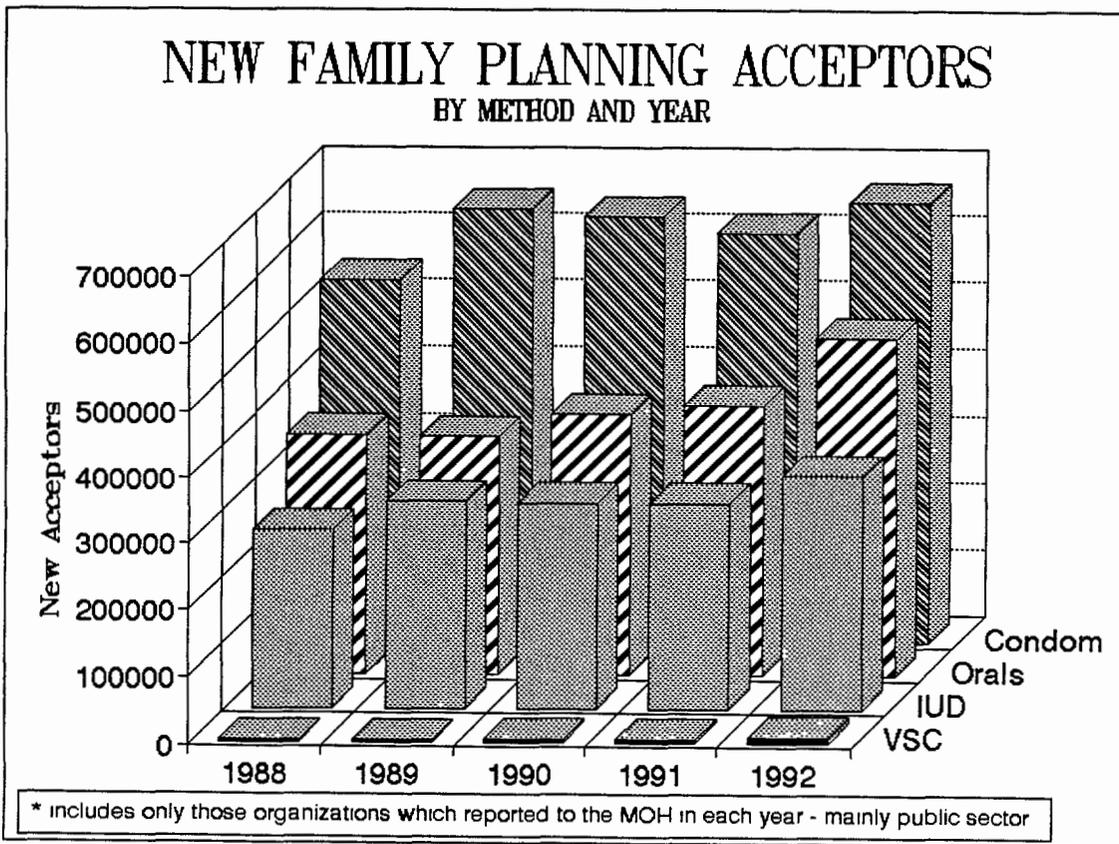
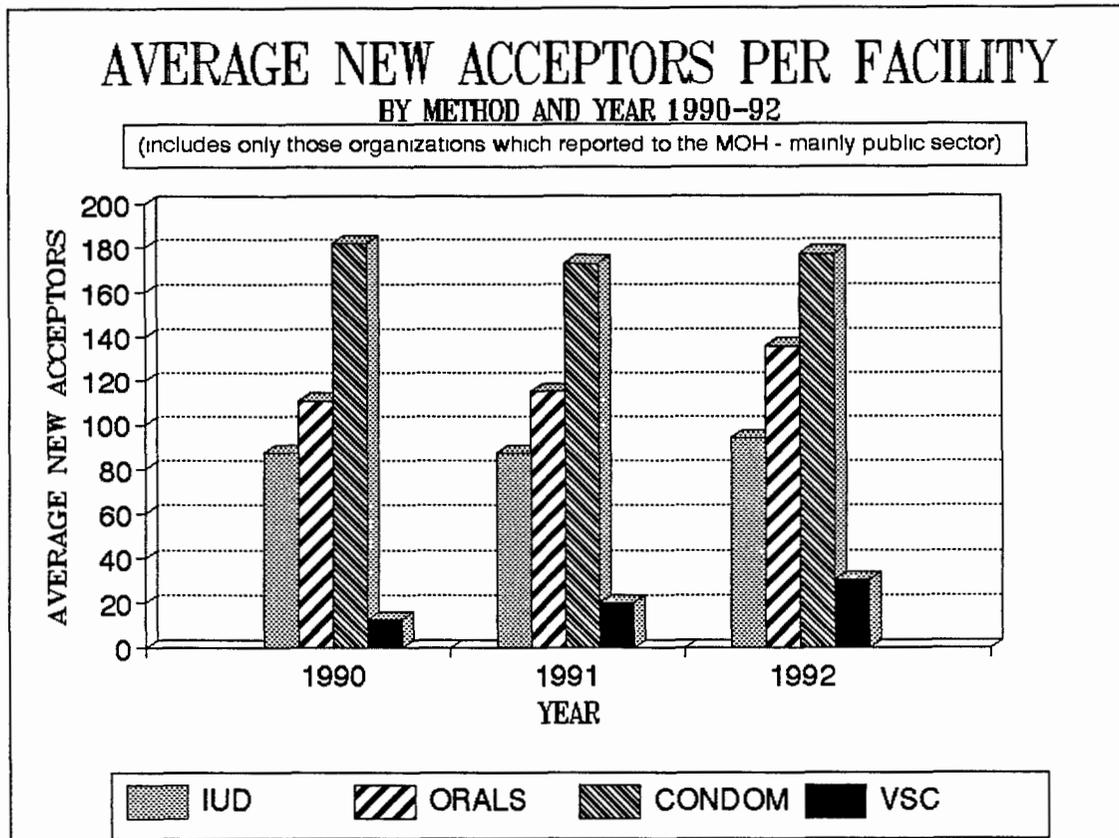


Figure 7

Figure 8



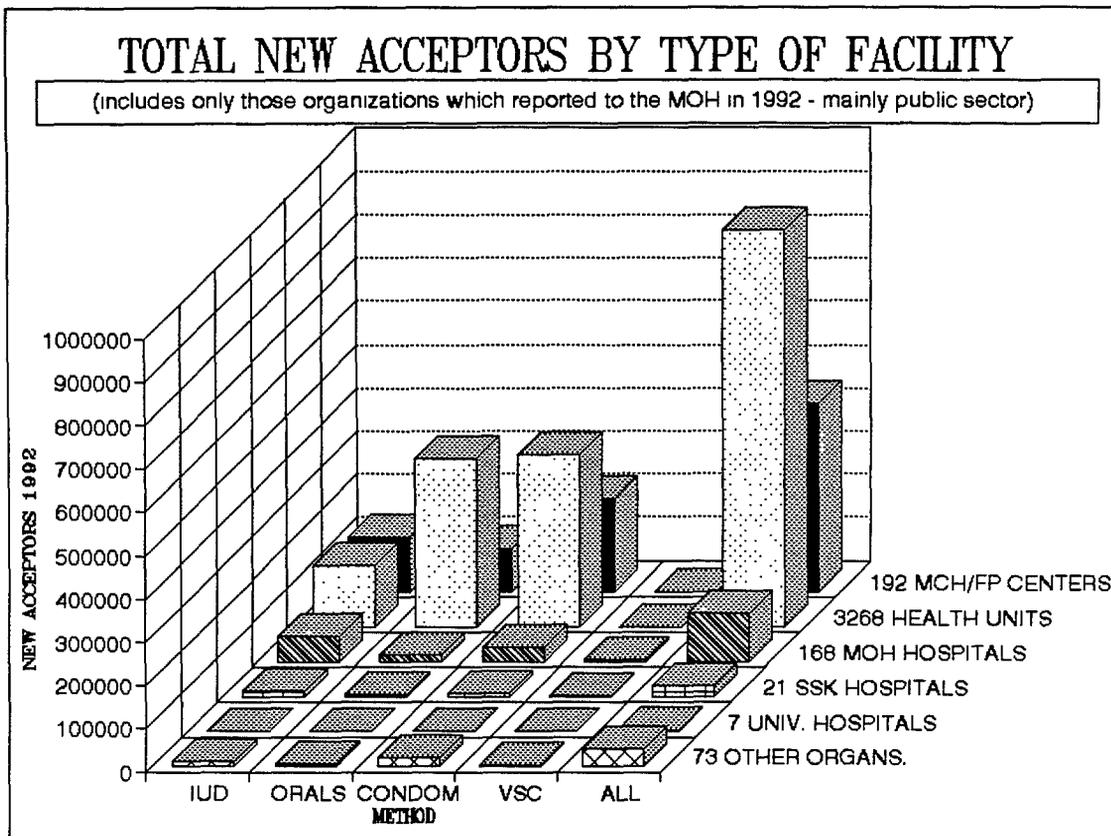
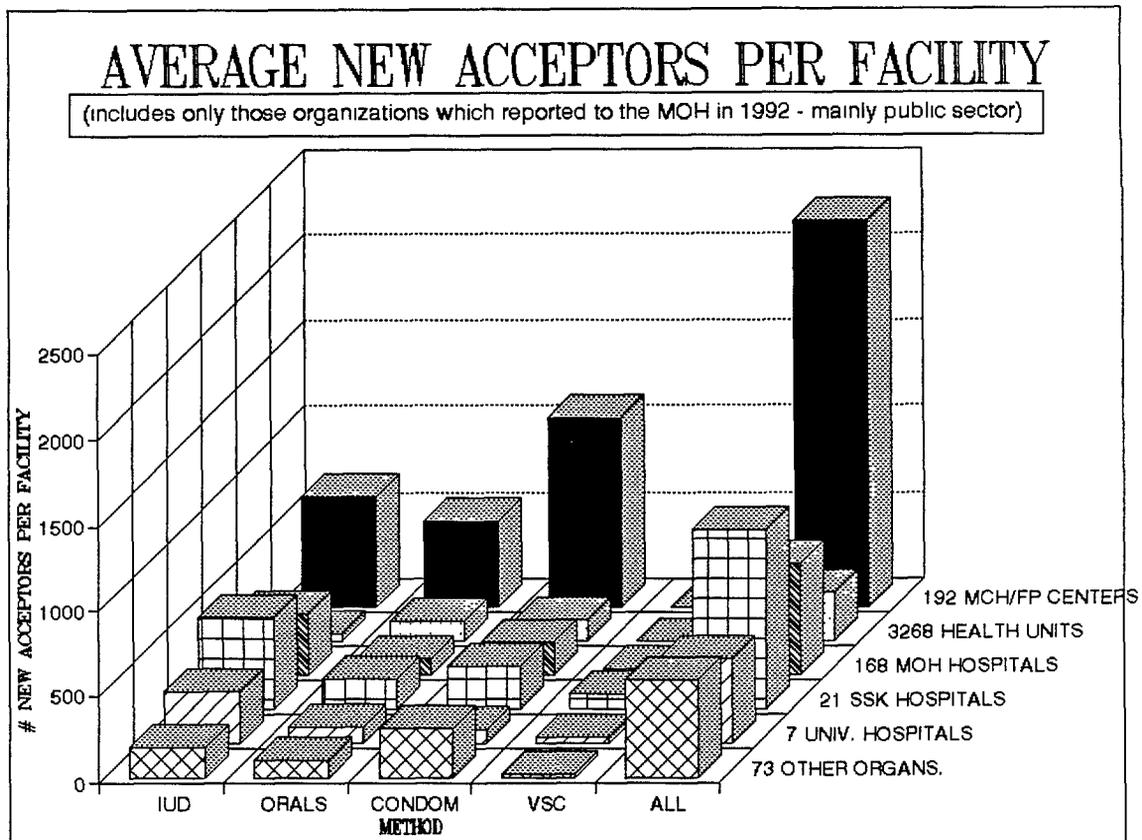


Figure 9

Figure 10



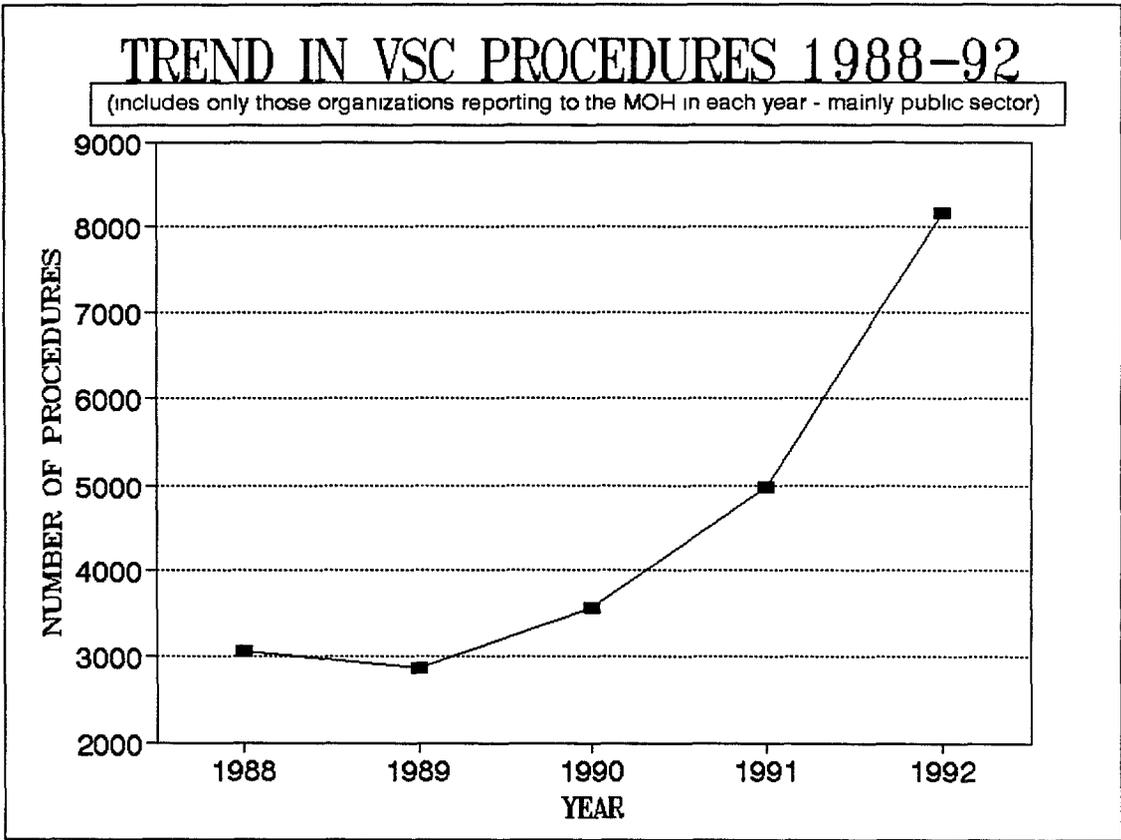
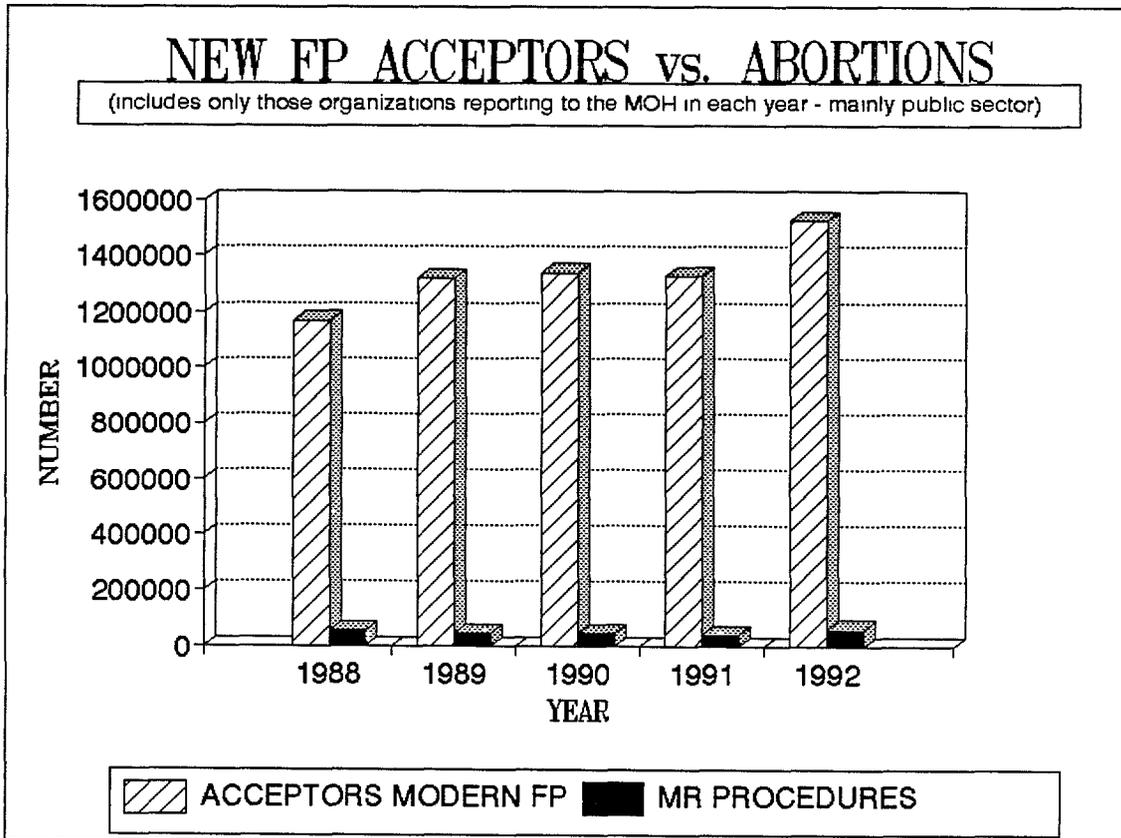


Figure 11

Figure 12



Other promising public sector channels for family planning service delivery include health insurance/social security organizations (some of which operate their own health facilities), the military, and the city municipalities (local governments). At present, A.I.D.-financed CAs are working with the SSK and its extensive health system (435 facilities, including 105 hospitals and 135 dispensaries), and with the Municipal Government of Ankara. Both of these channels appear very promising: the SSK performance has been noted above; the Ankara municipality project has also done extremely well in a pilot CBD program focused on the urban poor. This project is to a large degree self-financing, and is potentially expandable and replicable in other municipalities throughout the country. The military health system is extensive and is untapped as yet; it offers a particularly attractive channel for IEC and family planning services to young recruits.

SSK. The SSK has substantial human and financial resources: 60,000 employees and an annual budget of 7.4 billion TL, financed through mandatory employer and employee contributions. Most SSK resources are allocated to supporting its pension system; this will likely place greater financial demands on the SSK budget in the future, as adult life expectancy increases. Nevertheless, SSK also supports a health infrastructure of 465 facilities, including 105 hospitals, 135 dispensaries, and other units.

While SSK facilities now have secure financing, SSK leadership was frank with the team about management problems of the organization. They attributed this partially to the structure of its Board of Directors, composed of representatives from government, labor unions, employers, each of whom have frequently competing priorities. In particular, they cited as problematic its management structure, which is based on the government budgetary and planning system. Personnel, and physicians, working in SSK facilities, for instance, must be paid according to government salary scales and personnel decisions and appointments are made and changed arbitrarily such that many facilities lack the personnel they need.

Other insurance schemes may also have potential for provision of family planning services, although the team was unable to explore this possibility in detail. Some other schemes, such as BAG-KUR, do not themselves provide health services, but reimburse for services provided, for example, by the MOH. Note: the team learned that BAG-KUR is experiencing severe financial problems, limiting its potential at present. Additionally, the World Bank health project has just completed a study to estimate actual coverage under health insurance schemes and finds that the numbers of persons covered is far less than numbers generally touted. Within the SSK system, for example, it is difficult to see how over 22,000,000 persons can be served by a total of 435 health facilities. Nevertheless, it appears that the SSK and perhaps other insurance organizations represent useful channels through which family planning services can be provided.

NGO and Private Sector. Channels for family planning service delivery in the NGO and private sector are similarly underdeveloped. The contraceptive social marketing program has demonstrated the impact of increased availability on increased oral and condom use over the past two years. However, more has to be done in terms of educating pharmacists

and, especially, pharmacist-assistants with respect to hormonal family planning methods, since it is expected that injectables may soon be available through the network of 13,000 pharmacies and it is critical that injectables NOT follow the course of orals. Orals were made available in the private sector without prescription or even instructions, and without counseling and followup. Inevitably, this led to client dissatisfaction, misinformation, rumors, discontinuation, and an unusually low level of orals use.

In Turkey, most physicians having a private practice and who would be likely providers of family planning information and services (OB/GYNs, GPs, internists, pediatricians) *are also employees of the Ministry of Health*. That is, they tend to practice privately in the late afternoons, evenings, and weekends. Thus the MOH itself can be seen as an excellent channel to reach "private physicians" and should be fully exploited.

NGOs active in family planning in Turkey are few, and the principal ones have been established with CA assistance. One such NGO has achieved extraordinary results over the past several years in CBD programs, working principally in disadvantaged neighborhoods in urban areas. These programs carried out with Pathfinder assistance have shown that the prevalence of modern contraceptive use can be raised dramatically (from 25-30% to 60-70% of MWRA) in a period of 9 to 12 months. These programs have considerable potential for expansion and are virtual goldmines of information as yet unexploited (see section III.A. Services). They also have demonstrated the ability to organize and activate the existing public health infrastructure to improve overall family planning service availability. The potential exists for this type of impact to be realized in rural as well as urban areas.

Private-for-profit businesses often represent an additional private-sector channel through which family planning services can be extended, particularly in countries where there is no effective health insurance system. Some attempts have been made in Turkey to tap this channel, but results were reported to be disappointing, in part because of the availability of services through other channels. A worker in a factory, for example, might well be doubly covered already by virtue of his participation in the SSK -- where family planning services are becoming available in SSK facilities with SEATS assistance -- as well as additional family coverage obtained through his wife who is a government employee. Still, one has the impression that there may well be additional scope for new initiatives in the "employer channel".

In sum, the team believes it will be important to utilize both public and private sector channels to strengthen family planning service delivery throughout the country; neither sector, acting alone, will be able to reach all segments of the population in all areas of the country.

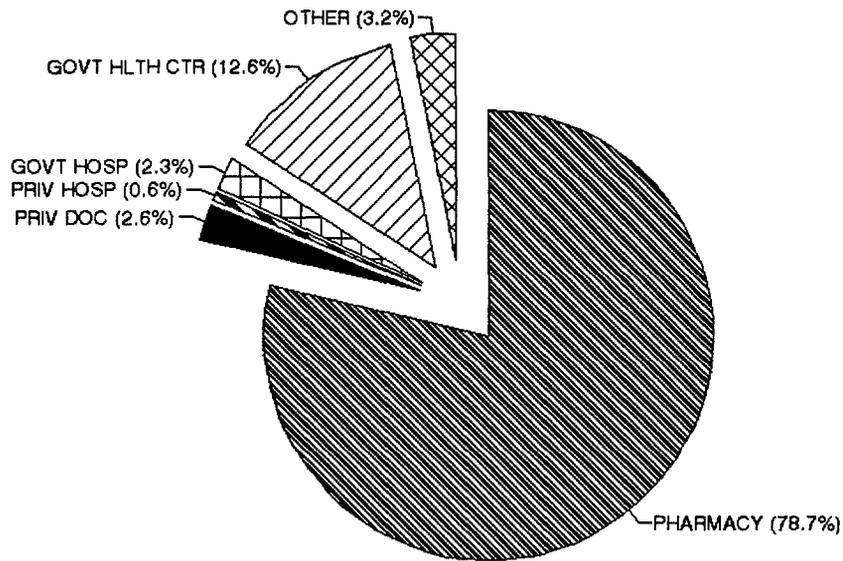
II.C. POOR QUALITY OF SERVICES, HIGH EVER-USE, HIGH DISCONTINUATION

Statistical, observational, and anecdotal evidence overwhelmingly point to the low quality of family planning services in Turkey as a major factor -- perhaps THE major factor -- limiting the numbers of couples currently using effective family planning methods. Following the team's three-week visit in-country, during the course of which there was time to observe many of the service delivery situations, gather informed opinion, and examine the statistical evidence, it was concluded that the qualitative aspects of family planning service delivery remain a high priority for technical assistance. The problem extends throughout both the public and private delivery systems. Listed below are some of the most critical factors to be corrected.

- **client misinformation and ignorance** - while over 90% of married, fecund women know of at least one modern family planning method, knowledge of some modern methods is far less generalized (e.g., only about 30-40% of MWRA know of VSC). "knowledge" may, in fact, be misinformation. The team interviewed one family planning client with two children who said she'd decided to use an IUD; when asked where she'd get one, she said she was planning to send her husband over to the next district to get one for her! Many couples believe that douche, withdrawal, and other folk methods are as efficient as modern methods.
- **provider ignorance, misinformation, and bias** - many service providers do not themselves possess adequate or accurate information on modern contraceptive methods; they are therefore incapable of passing correct information along to their clients. In the past, there has been a general public sector bias towards the IUD and against other methods, especially orals. In fact, many/most family planning training programs today are still called "IUD Training Programs".
- **poor client counseling and limited or no followup** - 79% of orals users in 1988 reported they obtained them from a pharmacy, almost always without a prescription, screening for high-risk clients, instructions, counseling, or followup for side effects, referral, etc. This is largely a *private sector* problem, since the private sector is the major source of pill supply (**Figure 13**). Similar problems exist in the public sector: there is insufficient time or staff or materials to do client counseling effectively; there is very limited supervision of service providers; there is little effective followup of clients; contraceptives are sometimes in short supply; etc. In 1988, the public sector was the major source of supply for IUDs, accounting for 53% of users (**Figure 14**).

There are numerous factors linked to the three mentioned above, including adequacy of pre- and in-service training; certification standards and procedures for family planning service delivery; availability of IEC materials for both providers and clients; logistics, supervisory, and MIS systems; operations research; counseling training; and many others. These are all addressed in following sections of this report (see also Annex 4.E., Quality of Care).

SOURCE OF CONTRACEPTIVE SUPPLY (ORALS)

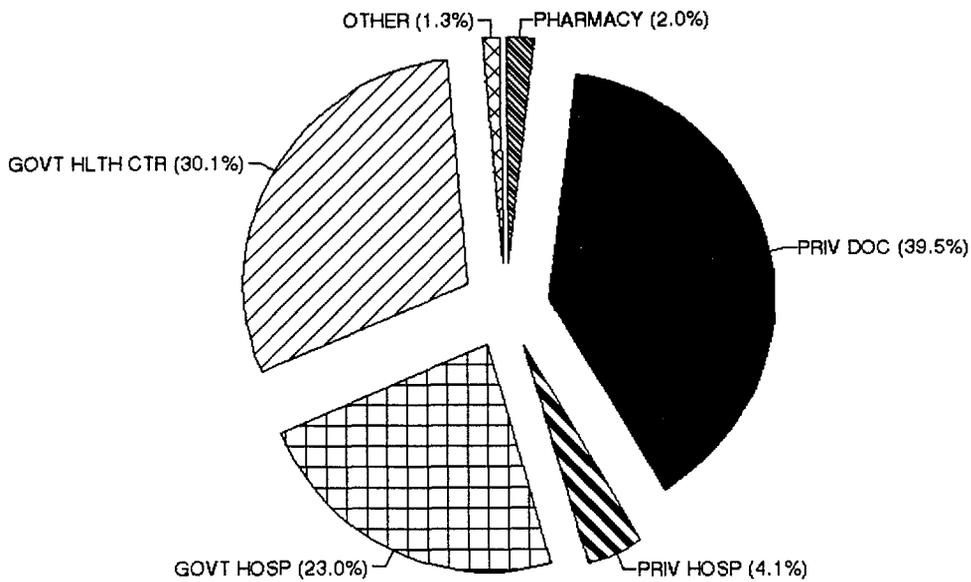


Source: 1988 TDS (reported by female users of orals)

Figure 13

Figure 14

SOURCE OF CONTRACEPTIVE SUPPLY (IUD)



Source: 1988 TDS (reported by women IUD users)

II.D. LEGAL, POLICY, MANAGEMENT, AND FINANCIAL FACTORS AFFECTING STRATEGIC CHOICES

The following section examines in more detail the policy, legal, structural, management and financial factors which influence efforts to do more effective and efficient implementation of family planning services. These factors will hinder or support the activities of A.I.D. population assistance to Turkey. The development of a strategy will have to recognize and deal with the constraining factors and support those factors which facilitate activities. The factors dealt with here are generally systemic and operate at the national level.

Legal and Policy Factors Influencing Strategic Choices

- **The pro-family planning 1983 Law.** The legal basis for providing family planning services is well established in the 1983 "Population Planning Law." The Law allows: dissemination of family planning information through appropriate channels, government provision of services free or at low cost, identifies service providers by method, legalizes VSC, legalizes abortion and mandates MOH with responsibility for developing a national family planning program. This Law is one of the most open and liberal in the region and has allowed the use of an unusually high degree of fertility control in Turkish society.
- Under authority of the 1983 law, the MCH/FP Directorate has established a multi-sectoral Population Planning Advisory Board including representatives from all MOH General Directorates concerned with family planning, plus Defense and Education, the recently formed Directorate for Women, from the academic, religious and scientific communities. MOH/FP hopes to use the influence of this Board to affect population planning and inform policy-makers directly about opportunities for effective investment in population activities.
- **Limits on who may provide certain family planning services.** The 1983 Law limits the provision of tubal ligation to Ob/GYNs. The limited number of Ob/GYNs and a lack of medical justification for preventing other physicians from providing the services represents a serious constraint to major expansion of VSC.
- **Pharmaceutical registration procedures.** The private sector claims that the MOH is slow in processing requests for registration of new drugs, and that this hinders the introduction of new methods or the importation of a greater selection of brands. Note: the review process does not seem excessive by international and U.S. standards.
- **Pharmaceutical price controls.** The Government sets the retail price on all pharmaceuticals based on the cost of production. The effect of this is to limit profits. The drug industry claims that it limits their promotion and introduction of new products. However the industry is still introducing new products, such as the high

priced low-dose pill introduced by Organon. The brand, Desollet® has captured 90% of the growth in the orals market, through effective promotion. This would suggest that the price controls do not constrain the market.

- **Age-at-marriage laws.** The legal age of marriage is 16 years for women and 17 years for men with parental consent, and 18 years otherwise. The age at marriage has been increasing in Turkey. While the minimum age of marriage could be raised, changes in the status of women, greater educational opportunities, and changing social attitudes suggest that the social factors are having a greater impact than would changes in the legal code.
- **High level Government and MOH support for family planning.** Without official support at the highest levels of the government, family planning interventions are not likely to succeed. This is not currently the case in Turkey. Strong support at the highest levels of the Government, the MOH, and the health bureaucracy are frequently expressed. Unfortunately, high turnover at the top and at most political levels can spell a change in political support in a very short time. Even among the policymakers that support the family planning program, there is little comprehension of the social impact of effective prevention of unwanted pregnancies, or the cost-benefits of providing family planning services.
- **Lack of recognition of the importance of preventive services.** Generally health care providers and health policy favors curative care at the expense of preventive services. Few medical personnel seemed to make a connection between the use of family planning, abortion and maternity caseload, and pre- and postnatal care.
- **Service-point budget allocation system.** Despite the high cost-benefit ratios associated with the provision of family planning, hospitals allocate budgets on a competitive basis between units. The family planning service must justify its procurement of equipment and drugs against all other units in the hospital. The curative bias and the crisis management approach ensures problems for preventive programs such as family planning, especially in larger multi-purpose hospitals.
- **Lack of NGO policy or formalized operating procedures.** The NGO community in Turkey has only recently started to develop so there is little historical guidance for a working relationship with the Government. The MOH has developed an informal working relationship with the NGOs involved in family planning services, but has yet to set norms for collaborative relationships. As a consequence, NGOs are limited in their ability to support MOH objectives, gain access to MOH resources and contribute to program development process. There is limited coordination between NGOs.
- **Lack of a strategic plan.** The MOH, as the legally mandated coordinator of health and family planning services, has set program performance targets. It has also

outlined some operational strategies in the new Health Reform Plan. It does not have a strategic plan, with the associated operational or implementation plans, necessary to achieve its institutional or programmatic goals. This makes implementation more difficult and hinders cooperation with other elements of the national service delivery structure.

Management and Structural Factors Influencing Strategic Choices

- **Multiple health service structures.** Turkey has several health delivery structures which can provide family planning services or medical backup (MOH, the military, SSK, NGOs, and the private sector). Each of these health structures has limitations, but they also have the potential to increase the availability of services, provide client options, and create a competitive environment which could influence the quality of services.
- **Despite high-level support, the health system is unable to provide the basic equipment for provision of family planning services to most facilities.** Such equipment as examination tables, disposable gloves, lights, speculums, etc. are available in the major facilities (often procured outside the normal government system), but are not available in the smaller facilities. Any effort at increasing quality of care will have to address basic equipment needs.
- **Low level staffing in the pharmacy system.** Pharmacies, with over 13,000 outlets spread throughout the country, have a major impact on the availability of contraceptives. Many pharmacies are owned or managed by trained pharmacists, but are operated by low level untrained assistants (*kalfas*). As a consequence, high quality family planning services through pharmacies are problematic.
- **Attitudinal and economic capabilities to pay for family planning services.** The potential for self sufficiency and cost recovery for family planning services is very high in Turkey. Clients have a tradition of payment for health services. The cash economy is strong enough so that even rural women can pay for desired services. As a consequence, there is every likelihood of developing family planning services that are self sustaining.
- **Rural-to-urban migration.** Turkey is currently experiencing massive migration out of the rural areas and into urban high density areas. About 60% of the population is defined as living in urban areas. This situation makes it difficult to get service providers into the rural areas and overburdens urban services.
- **Pharmaceutical production capability.** Turkey has the capability to produce oral contraceptives in-country. The vast majority of pills used are locally produced. There is also the potential for production of other methods, especially the IUD if a regional market of sufficient size can be developed..

- **Management and administrative skills.** The MOH is hindered in its efforts to effectively administer family planning services by a number of factors. Two of the most important are a lack of management systems and no internal human resource development structure. Management training structures are non-existent. The constant turnover in staff is more damaging than it needs to be because there are few documented and carefully thought out management systems in place (supervision guidelines, MIS, promotion, performance review, procurement, etc.). Consequently, skills are low at every level of the government structure. Anything that can be done to develop human resource development programs and help formalize informal management systems would make a significant contribution to the management constraints to effective family planning service provision and coordination.
- **Logistics management capabilities.** The MOH currently has very little logistical management capability. Commodity needs are estimated by A.I.D., which also procures and delivers the commodities. International procurement experience, and commodity management (shipping, storage, monitoring, and logistical staff training) are also areas where the MOH is weak.
- **Diffuse implementation responsibility within the MOH.** Implementation of family planning services is the responsibility of several MOH directorates. This causes coordination, resource and management problems, and it hinders the provision of services in larger MOH facilities (Directorates with overlapping responsibilities include MCH/FP, Health Education, Personnel, Curative, and Preventive).
- **Personnel Turnover.** The current personnel systems and policies result in maximum mobility of staff, often at the expense of quality of services, effective management and they result in a loss of impact for training and other human resource development activities.
- **Lack of an effective training structure.** The health system in Turkey trains thousands of physicians, nurses and midwives. Yet both pre-service and in-service training do not provide basic clinical skills in family planning or any other skills associated with the provision of quality services. This situation is beginning to improve, with assistance from A.I.D.-funded CAs (FHTP, AVSC, JHPIEGO, Pathfinder, SEATS).
- **Training duties.** In the MOH system, training is not recognized as a priority area and a legitimate duty. As a result, trainers must fit training programs in with their other duties. Trainers receive no compensation for the special efforts or specialized skills.
- **Lack of information for informed decisionmaking.** The MOH currently lacks the appropriate service and commodity reporting systems to effectively monitor and manage operations and planning. In addition research activities are insufficient in both quality and quantity to make up for the lack of traditional service statistics.

Economic and Financial Factors Influencing Strategic Choices

- **A large and active private sector.** The availability of private sector services is an important element in understanding contraceptive use in the context of a weak government program and a lack of medical service providers. The private sector is the major provider of pills and condoms and contributes a significant number of IUDs, sterilizations and abortions each year. Also notable is that the private sector operates with unsubsidized commodities.⁵ The percapita GDP in Turkey is of sufficient level to suggest that most couples are able to *pay for desired services*.
- **Inadequate budget allocation for family planning services.** Current budget allocations for the MCH/FP Directorate are 2.8% of the total MOH budget. *There is no separate line item for family planning or for contraceptives.* Most of the funds are to cover salaries and operating expenses. The other directorates which often actually provide the service receive no funding specifically allocated for family planning.
- **Physicians' economic biases.** Almost all physicians work in the Government health system (MOH, military, SSK, etc.). For example, 90% of all OB/GYNs work for the Government. Almost all also operate private practices. Maternity and abortion services are frequently a major source of income. Providing family planning is not likely to be a lucrative component of a private practice.
- **Limited technical and financial external support.** For a variety of economic and political reasons Turkey has not received as much international support for population activities as have other countries. A.I.D. and the UNFPA are the only major population donors in the country and both have relatively small programs. As a result, they have not benefitted fully from the lessons learned by the international family planning community.

II.E.1. FAMILY PLANNING EDUCATION AND TRAINING

The Turkish government has made laudable efforts to train health care providers in family planning. Nevertheless, education and training of service providers is woefully inadequate for meeting current service provision needs. A huge proportion of government facilities (MOH and SSK) still do **not** provide either family planning services or information. One estimate is that about 80% of all hospitals and 60% of all health centers do **not** offer family planning services. In addition, those facilities that do provide family planning services do not measure up particularly well on current international standards of quality of care. This is

⁵ in the social marketing program, commodities are purchased through international tenders or are locally-produced. These commodities are sold for profit with no subsidy. However, some components of the program (promotion, training, etc.) are subsidized at present.

true of nearly all facilities, even though many may score well on technical competence for Turkey's leading method, the IUD.

Many (but not all) of the shortcomings in service provision can be attributed to problems in training -- both in-service and especially pre-service. Health care providers (midwives, doctors and nurses) do not get an adequate introduction to family planning during their basic pre-service education. Once they are out working, only a portion get in-service training in family planning. This is not adequate either.

In-service training in family planning has received greater attention (from both the government and donors) than pre-service education. A distinct strength of in-service training in Turkey is that it is clearly linked to service provision (training is on-the-job in one of 40 or so health centers that also serve as training sites). Nevertheless, the in-service training courses, developed about a decade ago, are inadequate in many ways.

- **Family planning training tends to center on the IUD.** When family planning was launched as a government program in the 1960s, the IUD was identified as the most appropriate method for Turkey. Training since has consequently centered primarily on IUD insertion.
- **There is little attention to counseling and method choice,** given the long-standing view of the government and providers that this one method, the IUD, is the best for most Turkish women. The MOH's in-service training course discusses other methods, but the pill and condom are the only other methods offered by most family planning centers; since they are looked upon as inferior, there is little real counseling on method choice -- nor training for this. Introduction of new methods and stepped-up attention to counseling should go hand in hand, and happen soon.
- **Training opportunities in surgical contraception and in MR (despite the legality of abortion) are limited.**
- **MOH training capacity is extremely limited.** The numbers of persons provided the basic in-service course in most of the 40-some training sites is low. Generally, only 1 to 3 or 4 persons are trained in any one course. For example, in 1992, of the 48 centers, 38 centers trained 10 or fewer providers. In addition, given high personnel turnover rates, those trained often move on to other work. **In-service training is clearly not producing enough trained personnel to keep up with the need for services, either with respect to the public sector itself or to private sector physicians, most of whom are also MOH employees.**

Current efforts for improvement. The government (and A.I.D. CAs) have good plans for improving family planning education and training, both pre-service and in-service, and are in the process of implementing these plans. It will take time, however, before the new systems are fully in place and producing service providers in larger numbers and with

improved levels of competency. UNFPA is the other major donor, in addition to A.I.D., providing support in training, notably in the Southeast.

A.I.D. Cooperating Agencies Working in Training

A.I.D. has provided financial and technical assistance for family planning training in Turkey for many years. A.I.D. CAs have launched or supported a large number of appropriate training activities, including: training needs assessments, curriculum design and re-design, training-of-trainers, training of supervisors, training materials development, and training program evaluation. A.I.D. has done this chiefly through **two training projects: JHPIEGO** (Johns Hopkins Program for International Education in Reproductive Health) and the **PAC Project (now Family Health Training Project, FHTP)**.⁶ Both JHPIEGO and FHTP are working to standardize training and training systems, and to institutionalize these. This is crucial if Turkey is ever going to be able to train enough service providers to meet demand.

In addition, four service delivery CAs (SEATS, AVSC, Pathfinder, and SOMARC) also provide some training. In fact, all CAs are involved in some training, each in its own technical area. This is natural and should not be considered undesirable overlap per se.

JHPIEGO. Prominent among JHPIEGO objectives are:

- (1) facilitating the development of **national clinical family planning guidelines** -- very important because, if done well and disseminated correctly, they can set *uniform* standards for *quality* in both training and service delivery;
- (2) helping key medical schools to **incorporate family planning into the basic (pre-service) education** and training of all medical students, thereby helping to prevent provider bias;
- (3) developing a **standardized clinical family planning practice training network** affiliated to the regular pre-service and in-service institutions; and
- (4) training to proficiency in **NORPLANT® clinical skills** a core group of service providers, selected to lead MOH's introduction of hormonal methods in Turkey.

The national guidelines are nearing completion and should be an important contribution.

⁶ The **Family Health Training Project (FHTP)** is implemented by Development Associates with a subcontract to Pathfinder. FHTP is part of the **PAC IIB Project (Family Planning Training for Paramedical, Auxiliary, and Community Personnel)**.

It is difficult to assess what progress JHPIEGO is making, especially with regard to undergraduate education. JHPIEGO has no resident advisor but works through Turkish project directors.

The Family Health Training Project. FHTP has the following goals:

- (1) strengthening pre-service education and in-service training of family planning service providers, especially midwives, through promotion of increased technical competence related to modern contraceptive methods, post-partum contraception and counseling; and
- (2) promoting sustainability of family planning training and service delivery interventions through skills transfer to host-country counterparts, and through strengthening of communication and collaboration among various MOH General Directorates responsible for family planning.

FHTP is working in a clearly articulated *systems approach* with both MOH directorates responsible for training (MCH/FP Directorate and GD/HT). Its in-country staff work closely with Turkish counterparts in a very logically structured process that should bring good results. Most problematic, however, for institutionalizing a training capacity is the high turnover, among both trainers and trained service providers, and the fact that there is no formal position for "trainer" as distinct from any other service provider.

For further detail, see Annex 4.A., Family Planning Education and Training

II.E.2. Clinical Services⁷

General Strengths of Clinical Service Environment

- **There are no legal and relatively few governmental policy barriers** to any approved clinical family planning method.
- **There are some progressive laws and service policies**, most notably those which allow nurses and mid-wives to insert IUDs.
- **There are ample clinical facilities** (over 15,000 hospitals and other health service sites,

⁷ For purposes of this report, the terms "clinical services" and/or "clinical methods" refer to vasectomy, tubal ligation, NORPLANT®, IUDs, and injectables. "Non-clinical services" refers to provision of condoms and oral contraceptives, generally accompanied by information and referral for all methods, e.g., in community-based services. Of course, orals and condoms may also be provided in a clinical setting.

mostly of the MOH and SSK.), and a large number of health personnel (4,000 Ob-Gyns, 20,000 GPs, 39,000 midwives and an additional number of nurses.)

General Weaknesses of Clinical Service Environment

- **GOT resource allocation to family planning is inadequate** (only 2.8% of MOH budget goes to MCH and family planning; no specific line item for family planning or for contraceptives).
- **The MCH/FP Directorate has little control over service provider and service trainer personnel placement** and can do little to retard the frequent turnover of trained personnel. This exacerbates the situation at clinical service sites, a large percentage (60-65%) of which do not offer family planning services due to lack of trained personnel.
- **There is a fragmented structure within the MOH**, with five different general directorates involved directly or indirectly in some aspect of clinical services.
- **The MCH/FP Directorate**, which has the responsibility for coordinating and leading the national program, **has limited authority**. For example, of the 14,000 service sites it is "responsible for", it directly operates only 192 MCH/FP centers.
- **Services are poorly linked**, with physical and administrative separation between delivery, abortion, and family planning service delivery sites; lack of an efficient referral chain; and, consequently, poor continuity and quality of care. This weakness in management systems and structures is often mirrored by weak management of service sites, and lack of commitment on the part of service site administrators to making family planning services a priority and thus readily available.
- **There is also a systemic bias**, in terms of emphasis and resource allocation, **favoring curative rather than preventive practices**.
- **Serious medical policy and practice barriers exist**, most notably an almost universal **provider bias** against oral contraceptives in favor of the IUD, and **limitations on who can perform sterilizations** and where they can be done (only as a hospital inpatient.) These barriers to contraceptive use are exacerbated by widespread client ignorance and misconceptions about the various family planning methods and by economic incentives for providers that often work to favor abortion rather than contraception.

All of these factors lead to very **ineffective contraceptive practices**, inconsistent with the fertility intentions of users, and marked by high discontinuation rates, high failure rates, high use of traditional methods, and high abortion rates. This is striking in view of the very high potential demand for family planning services as described in section II.A. and elsewhere in this report.

Service Channel-Specific Findings

- The MOH and the SSK are the major providers of clinical family planning services. The MOH provides over half the IUDs inserted in Turkey, and most of the clinical family planning services in rural and impoverished areas of the country. The SSK, in theory at least, covers almost 40% of the population, is financially well-endowed, and is in transition to provide preventive services to its members. Consequently, the bulk of A.I.D. assistance in clinical family planning services goes to these two organizations.
- Private physicians also provide clinical services, especially the IUD. With the introduction of injectables and NORPLANT®, the role of the private sector in providing clinical methods is very likely to increase substantially.
- NGOs provide minimal clinical services at present; municipalities and the military -- both of which have their own facilities -- are not yet providing clinical family planning services to any significant degree.

CA-Specific Findings

Pathfinder

- Pathfinder has been a true "pathfinder" in terms of A.I.D.-supported service delivery in Turkey. No other CA has made a greater contribution to the initiation and diffusion of family planning approaches, and to organizational development. Pathfinder has established important NGOs (HRDF and the Turkish Family Health and Planning Foundation), supported training, introduced community-based family planning services which feature effective referral to MOH facilities for clinical methods, and has demonstrated unequivocally that high demand exists for such services.
- Pathfinder's work has been largely in the private sector.
- Pathfinder's current portfolio consists of three areas, selected according to the target-of-opportunity which each represented: (1) vasectomy support in several selected SSK facilities since 1988; (2) a large community-based services program which does not provide family planning services directly but generates a large number of referrals to MOH facilities (see section II.E.2.); and (3) work with the Turkish Confederation of Tradesmen and Craftsmen (TESK) to advance family planning. These activities are implemented through the HRDF and the Foundation for the Advancement and Recognition of Turkish Women.
- Pathfinder's work with TESK involves funding of clinics, promoting family planning to TESK leadership, and training and financing motivators and educators. TESK members as a group have higher fertility than the average in Turkey. This work was initiated in 1988 and was a promising attempt to diffuse family planning into the TESK network

since TESK has 3.8 million members (19 million including their families). However, unlike the SSK, TESK does not have its own network of facilities, and almost all of its members get services through MOH facilities, diminishing the potential multiplier impact that working in this system could have had. The team felt that this was originally another true pathfinding idea, but that the original goals are unlikely to be met and the premise they were based upon is no longer valid.

AVSC

- Since establishing a limited in-country presence in 1992, AVSC has made clear progress in a number of important areas.
- AVSC has established an effective partnership with SEATS, sharing a headquarters office and complementing and integrating with SEATS' work with the SSK.
- AVSC has played a key catalytic role in helping to introduce a number of important new clinical family planning technologies in Turkey. It has the strong support of the MOH which has designated AVSC as the lead agency to assist in the introduction of Depo-Provera and NORPLANT®. In this capacity, AVSC has provided technical assistance to the MOH to develop a strategy and plan for the phased and coordinated introduction of these methods.
- AVSC has provided both clinical and counseling training, equipment, and renovation, and other technical assistance to key MOH and SSK facilities to improve the quality and availability of tubectomy and post-partum IUD services. These have risen significantly (see **Figure 11**), and have demonstrated their acceptability and feasibility to medical opinion leaders and decisionmakers in the two systems. It is noteworthy that this is being accomplished without salary support.

SEATS

- SEATS program is entirely in collaboration with the SSK. It builds upon 1982-89 work by the A.I.D.-funded FPIA project. SEATS assistance to the SSK began in 1992 and is planned to span 2.5 years, involving \$3.5 million.
- The SEATS program involves a well-conceived, systematic approach to the rolling out of the full range of quality family planning services within the SSK, with the goal of expanded service availability to 22 million persons.
- SEATS assistance is performance-based. Commodities, management and clinical training, and other technical assistance are provided only to individual SSK units which indicate interest and commitment to providing clinical family planning services to their members. These commodities are only provided for two years, with the SSK committed to subsequent purchase with its own funds.

- There are excellent prospects for institutionalization and sustainability, particularly given the high commitment of the SSK leadership and the fact that provision of clinical family planning services is cost-effective, and in the evident self-interest of the SSK. **A quick and "crude" cost-savings study conducted by SSK and SEATS revealed a 13:1 cost savings would be realized by providing these services throughout the system. Estimates were that the total savings to the SSK would be equivalent to the annual budget of five 200-bed SSK general hospitals; it may well be that this is an underestimate of cost savings, since it only included the costs of pregnancy and delivery care, not subsequent child care for the estimated 24,000 births averted.**
- In just a short time, a number of units (e.g., Etlik SSK Maternity and Bakirkoy SSK Maternity) have demonstrated marked improvement in performance and have been designated as training centers (evidence of the good performance of SSK facilities is shown in **Figures 9 and 10**). Other CAs, the MOH, and some medical schools may use these centers for their own training centers as well. Study tours have resulted in a number of hospital directors becoming strong advocates for the provision of clinical family planning services. This is a good example of the catalytic nature of SEATS' work with the SSK.
- Quality of care, and medical policy and practice barriers have also been addressed. Counseling is better; nurses insert IUDs; GPs perform tubal ligations and vasectomies; and tubal ligations are performed as a hospital out-patient procedure in some centers. Thus there is a good prospect for the development of training centers which are also service "centers of excellence", to which "site visits" by MOH and SSK policymakers and decisionmakers can be taken to change attitudes and practices.
- There is excellent collaboration between the SEATS/SSK project and other interested CAs and host institutions: Pathfinder and AVSC; the MOH; and the Turkish labor union federations which comprise the bulk of SSK membership.

II.E.2. Nonclinical Services

A.I.D. support for non-clinical family planning services has taken two forms - social marketing (discussed elsewhere) and community-based service delivery. Currently there are three projects which fall in this category. The impact of the activities are described in more detail in annex 4.C., The Role of Nonclinical Services.

The first activity is a community-based service (CBS) project funded by Pathfinder International in the urban slums of Izmir. The project was implemented in 1986 under the management of the Human Resources Development Foundation. The Project selected two slum districts to recruit unemployed women living in the community to work as family planning promoters. The workers were trained for one month before starting on a full-time basis to identify at risk women in the community, educate through home visits, do referrals

for examinations and clinical methods, and distribute commodities. The Project has worked closely with MOH facilities in the area to ensure quality clinical back-up. **The project is notable for many reasons, but one is the success it has had in supporting and getting support from MOH. The Project is also notable for its strategy of "rolling over" communities.** The paid CBS workers cover an area for about one year, when home visits stop and the client must seek services elsewhere. The Worker can move to a new neighborhood or can leave the position. **The potential sustainability of the Project is good because of the lack of long-term commitment to the staff and clients,** which is understood by all. **The quality of service and its impact is very high (see Annex 4.C.).** In the project sites prevalence increased dramatically; modern method use went up; use of pre- and post-natal services increased; and prevalence continued to remain high long after services were discontinued.

The **replicability** of the above exercise is indicated by the fact that Project is currently providing technical support to another, second, CBS project funded by Pathfinder and operating in Eastern Turkey. The availability of family planning services in the Eastern Area of Turkey is limited by lack of infrastructure, ethnic divisions, political instability and the difficulty of providing services to a widely distributed rural population. The Foundation for the Advancement and Recognition of Turkish Women has attempted to improve the situation by providing CBS in Urfa Province with financial support from Pathfinder. The Izmir Project has provided technical support. The Project has 50 CBS workers providing services to about 7,000 active users. The Project has two clinics and mobil units which are used to augment services from the MOH. Clinical staff are contracted from private practice, MOH and the universities. Clients are technically urban residents since the project sites are in the main provincial urban centers. **However, the project comes much closer to serving rural women than any other project.** The Foundation is a general development foundation that has taken family planning as one of many activities targeted to raising the status of Turkish women.

Third, CEDPA has worked with the Ankara Municipal Authority to provide family planning services to its slum dwelling women. The Project uses CBS workers to educate, recruit, and motivate couples wanting services. The Authority has set up four clinics to provide back-up support. Clients wanting VSC or having other problems are referred to a MOH maternity hospital with which it has an ongoing relationship. This Project is notable for several reasons. **The level of political support is incredibly high.** The Municipal Authority has taken over funding of the Project with the withdrawal of CEDPA funding. The Project charges for commodities and has built up a fund which has allowed it to continue to operate. CBS workers are paid a honorarium. The Project uses the same roll-over mechanism that the IZMIR Project uses, with workers moving to new areas or leaving the project. The project has had significant impact on the status of the women involved (one of the reasons for its political and community popularity). The Project covers a population of about 400,000. It has achieved very high prevalence levels in its catchment areas. **The Project is clearly sustainable without external support and it is replicable. Several other municipal authorities have expressed an interest in providing similar services, and it widely talked**

about even in conservative areas. The Ankara Authority has even begun expanding its support for family planning by providing rebates on the cost of municipal services for family planning users. The impact of the Project is discussed in more detail in Annex 4.C.

II.E.3. Information/Education/Communication (IEC)

In reviewing Information/Education/Communication (IEC) activities in population, the team considered:

- (1) target audiences: opinion leaders, providers, clients, and other market "segments"--men, teenagers;
- (2) channels of communication: mass media, print media, professional channels for providers such as seminars, conferences, professional journals and person-to-person communication; and
- (3) specific messages: general awareness of family planning, correcting misinformation about specific methods, switching from traditional to modern methods, where to obtain services (i.e., effective access).

The 1988 Demographic Survey found overall awareness of family planning was virtually universal, but knowledge of specific methods very low and **misinformation**, especially about side effects of various methods very high. Our analysis indicates one very important source of misinformation is, ironically, from providers themselves. We have discussed medical barriers to increasing contraceptive prevalence several times in this paper; medical barriers were also identified as a major constraint in the Bryan-Senlet assessment in 1990. We attack this problem on several fronts in our strategy, through training and through consideration of non-monetary and other compensation for performance. Effective IEC activities, addressed to providers, as well as directly toward consumers, clearly form one critically important element in the multifaceted effort to break down medical barriers.

Current MOH/Donor/A.I.D. Activities

In briefing the team, MOH/FP Directorate leadership listed strengthening IEC activities as the first item on a long, comprehensive list of proposed steps to target high risk groups, reach service delivery targets and increase contraceptive prevalence. MOH/FP Directorate leadership highlighted the need to increase male involvement in family planning and has recently completed production of five TV spots promoting this message.

Several donors are now providing MOH/FP Directorate with support for IEC activities in family planning. UNFPA recently reissued and updated a flip chart (using a prototype originally developed by AVSC with A.I.D. funding) for distribution to midwives. UNFPA is emphasizing training in interpersonal communication techniques and counseling for 4,000

midwives and nurses in its two regional projects. UNFPA is also working with the Ministry of Education to introduce family planning messages into the formal education system and developing a book targeted at policy-makers. JICA is most active in mass media work and has provided the MOH/FP Directorate new Population Education Center with highly sophisticated, state-of-the-art audio-visual production studio and equipment. JICA is now training PEC staff in Japan on use and maintenance of this equipment; a JICA team was in-country at the same time as the A.I.D. assessment. MOH/FP Directorate leadership stated JICA planned to continue this support.

IEC activities form an integral component of the all A.I.D.-supported family planning activities in Turkey, in the public and private sectors. Through various A.I.D. CAs, the MOH, SSK, NGO and private commercial (social marketing) activities all produce IEC materials for educating both care providers and clients. MOH/FP Directorate and the private sector, through SOMARC, have used A.I.D. assistance to support production of mass media programs and advertising, aimed primarily at the public and consumers. A.I.D. is not now working on interpersonal skills through its IEC activities *per se*, although other A.I.D.-supported activities do emphasize interpersonal skills and counseling, particularly through training interventions.

There is also considerable research being used to develop IEC activities, in both public and private sector. Some use of focus group surveys is beginning; in general, however, research methodologies emphasize large-scale survey techniques rather than small, qualitative studies aimed at segmenting and identifying factors influencing specific target audiences. In interviews, private contraceptive producers stated that they needed more qualitative information, e.g., "we need to find out about women who are not taking the pill," and found it hard to get copies of research that was done. Market researchers stated they also wanted to do more qualitative studies to test hypotheses: whether, for instance, a Turkish brand name would be popular or unpopular or "that as women get older, they care more about the type of contraceptive they use." Researchers noted also that in the private sector, they are restricted from disseminating research results to competing firms.

Results of the 1992 Advertising Tracking Survey contracted for the Turkish Social Marketing Project found mixed results of mass media campaigns, and that personal communication for information about family planning is still important. For instance, urban men and women reported the following sources of family planning information, listed in rank order: press, friend-neighbor, doctor, television, nurse-midwife, spouse, relative. The survey also found low overall awareness of television advertising for OC's, low awareness (13%) of low-dose pills and that "one third of women who had seen pill advertising did not recall anything." This suggests that further attention to interpersonal communication and counseling skills in IEC activities could produce positive results.

General Findings

A.I.D. activities in IEC are important and integral supporting components of all other

elements of the strategy; they are catalyzing other people's success, e.g., through the dissemination of AVSC materials by UNFPA.

The A.I.D. communications strategy must include working with other donors to avoid duplication and increase coordination; it must include the private sector.

There is unused IEC capacity. As yet, the audio-visual production center of MOH is not fully utilized. MOH/FP Directorate personnel are learning how to use and maintain sophisticated JICA-provided equipment but still need training in communication techniques to make best use of the IEC equipment and resources they have. Note: We understand from MOH/FP Directorate leadership that JICA is providing this type of assistance.

There is a need for more qualitative research to segment target audiences better and develop approaches and educational materials to reach them, e.g., providers: clinical, non-clinical; users: married/unmarried, older/younger, rural/urban, higher/lower SES, etc. There is need for more attention to interpersonal communications, as these are the sources from which people get their information.

Information is being gathered, but not effectively distributed or disseminated. Private manufacturers, for instance, indicated they needed more access to family planning research to inform them about potential markets.

Constraints

Private sector commercial players may restrict distribution of IEC research and information; firms contracting for this information regard it as proprietary and do not wish to share it with competitors.

II.E.4 SOCIAL MARKETING IN THE PRIVATE SECTOR

To date the only A.I.D.-sponsored activities in the private commercial sector have been selected IEC activities and the social marketing of one condom brand and generic low dose oral contraceptives. The social marketing activity has been conducted by the Futures Group under its SOMARC Project, in cooperation with the Turkish Family Health and Planning Foundation (TAPOV) and four pharmaceutical manufacturing companies.

The follow-on marketing research has indicated that the social marketing interventions have been consistently successful. The brand name marketing for OK⁸ condoms has increased condom sales and made OK the market leader. The marketing for generic low

OK is also written as okey.

dose OCs has significantly increased sales for low dose pills and OCs generally. The OK condom is already financially self sufficient, and the marketing for generic low dose OCs will require no additional support from A.I.D. after 1993. Because purchased products are more likely to be used than commodities provided freely in the public sector, the private sector sales figures are a good surrogate for actual use levels for private sector consumption. Other social marketing initiatives are planned for injectables, implants, and IUDs.

Given its dynamism and growth along with its powerful influence on consumer and provider choices, the private sector is an appropriate strategic priority for A.I.D.-supported population activities. It also offers more potential for self-financing than do many alternative interventions in the public and non-profit sectors.

Production and Procurement

There are just over 100 pharmaceutical manufacturers and roughly 400 wholesalers in Turkey, and, by every indicator, the industry continues to develop rapidly. However, contraceptive products currently represent less than 1 or 2% of the total pharmaceutical market, and only a few manufacturers are producing and marketing them. The key managers whom we interviewed in the pharmaceutical industry felt that the major barriers to further growth of the private family planning market were: (1) a lack of government support (i.e., strong promotional policies, ranging from advertising to pricing controls); (2) cultural changes which are slow to take place and even at some risk of reversing; (3) physicians economic interests (i.e., IUD insertions, abortions, and deliveries are more lucrative); and (4) free commodities supplied by A.I.D.

Eczacibasi, the leading pharmaceutical manufacturer in Turkey, has 15% of the pharmaceutical market. Eczacibasi had little or no interest in marketing a condom, but management was persuaded by the combined forces of SOMARC and TAPOV. Once persuaded, Eczacibasi developed an excellent marketing plan for the OK condom. The procurement arrangements for the import of the condoms saved an estimated \$1.1 million dollars for commodities. The OK condom achieved sales of nearly 6 million and a market share of 41% within 2 years of its launch. Under the social marketing project agreement, the activity has accumulated an additional \$90,000 contribution to finance future promotional activities. This was well in excess of Eczacibasi's own sales projections for the product, and the success of the product has inspired Eczacibasi to apply for licensing for four oral contraceptive brands, one high dose and three low dose. Having inspired an interest in contraceptives in the largest pharmaceutical company in Turkey may eventually be seen as the greatest success of A.I.D.'s early support of social marketing with the OK condom.

The social marketing program worked with three pharmaceutical manufacturers: Schering (German), Wyeth (U.S.), and Organon (Dutch) to market low dose OCs. All three companies are among the top 20 pharmaceutical companies in Turkey, and collectively

they represent roughly 90% of the OC commercial market in Turkey. A major part of the social marketing project's success with these three companies was in persuading them to work together and share information on the collective marketing of generic low dose OCs. The TAPOV was again an important facilitator in obtaining GOT permission to allow media advertising directly to the consumer.

The Product Lines

The private sector's major contraceptive products are condoms, OCs, and IUDs, along with a few other minor products, e.g., spermicides. Condoms and OCs are the only 2 products that the social marketing program has worked with to date.

Oral Contraceptives

Roughly 80% of all OCs obtained in Turkey are purchased through the commercial pharmacy network. During the five-year period from 1987 through 1991, the private sector share of the OC market was declining, and much of this decline appears to correlate with the influx of OCs provided by A.I.D., although other undocumented influences may also explain the trend (**Figure 15**). When the data are smoothed⁹ for presumed changes in stock levels, the steady growth of the market from the 3.964 million in 1987 to over 4.816 million units in 1992 could easily be explained by the natural rate of increase in fertile women (especially young women), urbanization, other modernizing influences, and public sector wastage or leakage. Other explanations for this trend are possible, but its implications should be considered in the phaseout of A.I.D.-supplied contraceptives. This is particularly relevant because most MOH outpatients and many SSK members (and other insured groups) are now purchasing pharmaceuticals, including OCs, from the private sector either under a co-payment or full payment system.

The 18% growth in the OC market that occurred in 1992 is assumed to be primarily due to the social marketing efforts around low dose OCs. During 1992 when cooperative social marketing efforts for low dose pills were initiated, sales of all OCs rose 18%, and low dose OCs shifted from 50% of the OC market to 61%. However, an interesting aspect of this growth is that from 80-90% of the growth in low dose pills came through one product: Organon's Desollet®. Since the growth went to Desollet®, it appears that either the product itself or Organon's independent promotional efforts had enough appeal to allow Organon's product to collect a halo effect from the generic demand creation for low dose products. Despite the range of OCs available on the market, there is very little to distinguish between them, other than high and low dose. Available brands

⁹ The peak in 1989 and the trough in 1990 for A.I.D.-supplied OCs are presumed to be a function of the supply system being over-stocked one year and using up excess stock the following year. Wastage rates would also be somewhat, if not significantly, higher in the public (i.e., A.I.D.-supplied) sector than they would be in the private sector. Therefore, the apparent increase suggested by the A.I.D. supply increase is apt to be overstated.

are 21-day cycles. Pharmacy staff whom we interviewed did not think that customers were aware of high dose or low dose pills, but they felt many customers did have beliefs about brands that were less apt to have side effects.

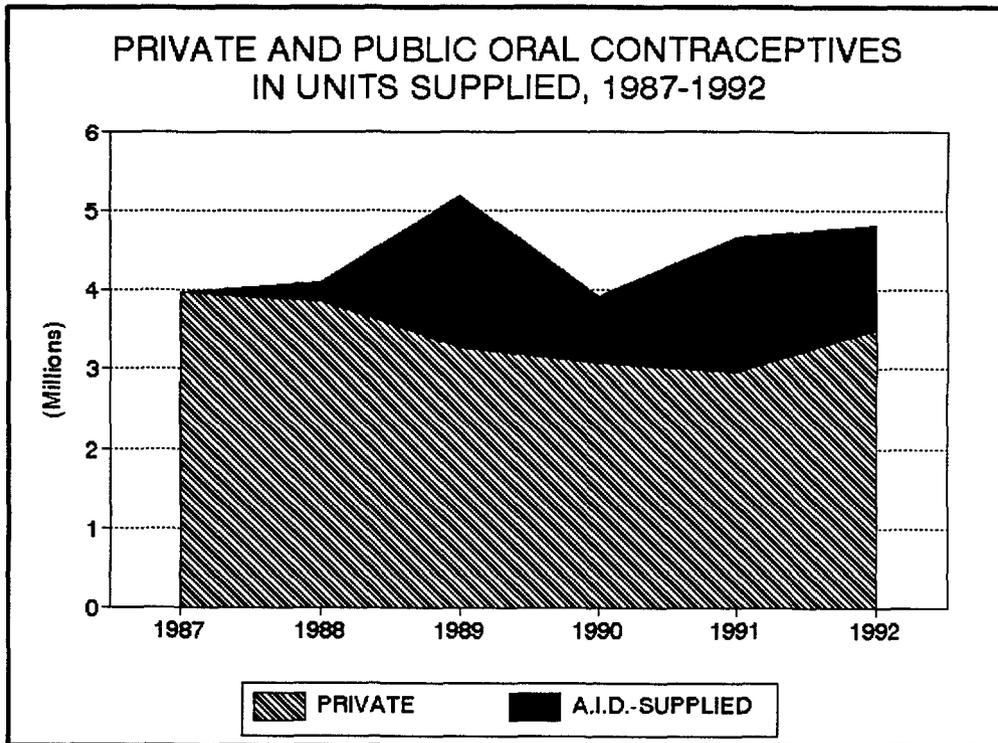


Figure 15

Condoms

Pharmacy staff disagreed about whether there had been significant changes in total condom sales; this may indicate that the rapid rise in OK condoms was largely through erosion of the market share of other brands. Those who had observed an increase believed that it was partly due to an interest in family planning, but even more to concerns about sexually transmitted diseases (STDs). The marketing techniques used for OK were also frequently cited as an unsolicited reason for the increase in demand for condoms.

Pricing Issues

Pricing issues create incentives and disincentives at various levels of the private sector supply system. The GOT exercises price control over the pharmaceutical industry. These controls impact all family planning commodities (i.e., devices and pharmaceuticals),

except condoms which are not under price control. Like most government laws and regulations there is some scope for flexibility, although the retail margin is generally around 20%.

Although there will be exceptions for the very poorest segment of the population, there is no evidence that most consumers in Turkey are price sensitive. Both for condoms and for OCs the lowest priced products are doing poorly in the market place. Desollet® is the clear market leader for OCs, and it is nearly double the price of the next highest priced brand. A 10-pack of OK is double the price of a 12-pack of Jellia condoms, the lowest priced common brand. Prior to the introduction of OK, Amor was the market leader for condoms, and most 12-packs of Amor brand sell for more than double the OK price.

The lack of end user price sensitivity within the available range is relatively typical for contraceptives and other pharmaceutical products in developing countries, and there is generally a strong association between price and quality in the consumers mind. In fact, the higher price of Desollet® could be an important element in its success in the market. Not only does the consumer equate price with quality, but, with price controls on allowable margins, the retail pharmacy network is going to be motivated to push the highest priced products in order to maximize profits. The lack of price controls for condoms allows the pharmacies to put a higher margin on inexpensive products.

Promotional Strategies

Since detailing is the major and arguably most powerful promotional tool used by the industry, more attention should be paid to what works and what is less effective. For example, Organon has a larger sales force and a much higher portion of women; and this may enhance promotional power for its main product lines (i.e., infertility drugs, OCs, IUDs, etc.), and be another partial explanation for the success of Desollet®.

Government restrictions normally prevent promotional techniques that allow a direct approach to the consumer. However, with the facilitation of TOPOV, the social marketing program was able to launch brand specific media campaigns for OK condoms and method specific campaigns for low dose pills. Channels of communication included television, radio, bill boards, and print media (e.g., magazines and dailies, pamphlets and brochures, etc.). These mass media approaches appear to have been very effective.

Market Research

Zet-Medya, with support through A.I.D. from the Johns Hopkins Center for Communication Programs and the Futures Group, has conducted most of the market research for IEC and social marketing activities in Turkey. Initially, Zet-Medya received significant technical assistance from Hopkins, but at this point the organizational capacity is well-developed, and little if any external technical assistance is required for future

work.

Much of the recent research that has been done for IEC and social marketing has been driven by the need for baseline studies and follow-on studies that can be used to evaluate the impact of particular interventions. This research has been valuable but limited in scope. In general, research has not been conducted to inform the basic design of interventions, and this should be changed in the future to make the interventions more effective.

II.E.5. RESEARCH AND MEASUREMENT

A.I.D. has played a small but important role in the area of family planning research and general measurement of fertility in recent years. Currently in Turkey, the research component -- often an important element of A.I.D. support to family planning programs -- receives relatively little attention, with the exception of the upcoming DHS. The MOH has no specific budget for population/family planning research and there is no position in the MCH/FP Directorate for a researcher or research coordinator. The team believes that some additional emphasis should be given to *operations research* activities linked directly to action programs, particularly in areas dealing with financing and sustainability questions, organizational and management approaches to service delivery in rural areas, and in relation to quality of care. Additionally, there are extensive datasets which have not been exploited (e.g., the Izmir CBS project); these should be analyzed to provide insights helpful in planning new initiatives and modifying ongoing ones.

National Demographic and Health Survey

The major A.I.D. support has been financial and technical assistance for the national demographic and health survey (DHS), the main source of nationwide data on contraceptive practice in Turkey. With A.I.D. support, a DHS will be conducted this fall (with preliminary results due late 1993-early 1994). This will be the first national-level survey of fertility and family planning since 1988. The survey has generated tremendous interest; its results are anxiously awaited and will be a major ingredient for policy and planning for the next five years. A.I.D. support will have a significant impact on the availability of data for program management and the future of survey capabilities in Turkey.

A.I.D. support is provided through A.I.D.'s Demographic and Health Surveys III Project (implemented by Macro International) to the Institute of Population Studies at Hacettepe University. This is the leading social research and survey institution in Turkey -- and one whose capabilities A.I.D. has contributed substantially to develop over the years. For this survey, A.I.D. is introducing a variety of new computer, analytical, and data collection techniques that will significantly increase the capability to do future surveys. The survey will also be the first national demographic survey in Turkey to use standard international techniques and definitions. (To date, lack thereof has been a vexing problem for persons

analyzing Turkish data and monitoring activities.) A.I.D. support has also helped generate a more open policy on access to data, which may increase analytical use of Turkish data.

Research Through Other Cooperating Agencies

A.I.D. has supported a small amount of evaluative research through CAs involved in service delivery. **SEATS** has funded some small cost-benefit studies in connection with **SSK**. **Pathfinder** has funded a number of small evaluations of its community based projects. Pathfinder has also supported the development of a very strong service statistics system in each project. Unfortunately, the data collected has exceeded the analytical capabilities of the local staff and so are under-utilized. A recent survey on provider attitudes, conducted by the **Human Resources Development Foundation** with Pathfinder funding, will be a most useful contribution, since it provides statistical evidence of the widely discussed biases and incorrect information on the part of service providers -- but results have yet to be published. The **SOMARC** Project, working with its local implementing agency, the **Turkish Family Health and Planning Foundation**, has funded a number of small studies for project development purposes. These studies are generally for internal use only.

A.I.D. projects are improving the ability to quantitatively monitor and measure program activities. This includes development of commodity management systems (**SEATS-FPLM** Project) and a management information system (**MIS**) in the **MOH (FPMD** Project). A.I.D. has also supported the translation of international research findings (e.g., through *Population Reports*) into Turkish. This is a very important contribution for facilitating improvements in family planning service delivery.

Gaps

The informal and limited nature of A.I.D. support for research has resulted in some gaps that would be notable in other A.I.D. population programs. There have been relatively few Turks trained in research. There has been no development of operations research capabilities in Turkey. The evaluation components of the service delivery and technical support activities are unusually weak for A.I.D. funded activities. Finally, with exception of analysis of DHS data, there is relatively little publication or dissemination of the research and studies that A.I.D. has funded.

Conclusion

Turkey has a long history of effective use of information in policy and management decision-making. The catalytic power of research results to influence family planning services is well established (e.g., the 1983 Population Law). The forthcoming DHS data is expected to have a major impact on policy and services. Additional qualitative and quantitative research, and more effective use of information, can also be expected to significant positive impact on such issues as medical barriers, target populations, cost effectiveness, and quality of care.

II.E.6. Contraceptive Supplies, Logistics, MIS

Contraceptive Supplies

A.I.D. has been a major provider of family planning commodities for the MOH. While the amounts provided represent a relatively small part of the national consumption of contraceptives they have been instrumental in MOH service delivery. Since 1986 commodities have represented about one-third of the total value of A.I.D. assistance to Turkey. In 1991 \$2.2 million in commodities was part of a \$5.12 million assistance package. Commodity contributions since 1986 are presented in Table 1 below (all figures are in thousands).¹⁰

ITEM	1986	1987	1988	1989	1990	1991	1992	1993	1994	Total
IUDs	0 (0)	0 (0)	233 (\$243)	602 (\$639)	296 (\$298)	289 (\$317)	384 (\$398)	403 (\$465)	252 (\$255)	2458 (\$2615)
Orals	0 (0)	0 (0)	250 (\$34)	1925 (\$261)	845 (\$130)	1684 (\$252)	1337 (\$218)	1913 (\$336)	1206 (\$224)	9158 (\$1457)
Condoms	8502 (\$369)	9702 (\$431)	7008 (\$316)	18900 (\$867)	8772 (\$408)	23634 (\$1177)	13050 (\$739)	16440 (\$848)	7140 (\$407)	113148 (\$5563)
TOTAL by YEAR	\$369	\$431	\$592	\$1768	\$837	\$1747	\$1355	\$1649	\$886	\$9752

Table 1

Note: Excludes \$117,000 for 40,000 units of Depo-Provera and 5,000 units of NORPLANT® to be shipped over next 18 months.

Contraceptive Production in Turkey

The production picture is a changing one and Turkey clearly has the infrastructure and technological capability to produce world standard pharmaceuticals. A.I.D. should keep tabs on the production situation and facilitate new initiatives which could be potential candidates for U.S. support for feasibility studies, possibly by the Trade and Development Agency (TDA). The PROFIT project knows TDA procedures and requirements and could facilitate this activity. Two developments bear watching:

¹⁰ Source: AID/R&D/POP/FPSD. Commodity levels vary by year according to a number of complex factors, including estimated past and future consumption levels, in-country stocks, stocks already in pipeline, major changes in program emphasis, etc.

- Three firms manufacture oral pills in Turkey: Wyeth, Schering and Organon. The team learned that Wyeth was closing its plant because it cannot support extensive renovations needed to introduce GMP. At the same time, Wyeth does not want to stop operating in Turkey and is pursuing contacts with local other local producers on the feasibility of making OC's with imported active ingredients and in-country compression and finishing.
- The current markets for IUD's and condoms are too small to interest manufacturers. Eczacibasi, however, is negotiating with Finishing Enterprises on the possibilities for marketing the U.S.-made Copper-T IUD in Turkey.

Impact of A.I.D. Commodity Support

The impact of commodity support has been substantial.

- Commodities support has provided the collaborative environment between the MOH and A.I.D., which has allowed ongoing cooperation and confidence in the technical support component of assistance.
- The procurement systems in the MOH are undeveloped, so that the A.I.D. commodities could not have been acquired through "normal" procurement channels.
- Control over the commodities has given the MCH/FP Directorate some influence in the other Directorates that provide family planning clinical services (Curative, Preventive, etc.)
- The only 28-day pill cycles currently available in the country are provided by A.I.D.
- While condoms are an expensive and less effective method of family planning, they have played a more important role because they are often used as a transitional method when couples shift from traditional to modern methods, and the active role of Turkish men in fertility control makes condoms a more acceptable method.
- Orals provided through the MOH constitute one of the few sources of the method where the client will also receive counseling. The private sector is the major source of supply but until recently supplies were sold without instructions.
- A.I.D.-provided injectables (40,000 doses) and NORPLANT® (5,000 units) represent the first introduction of these methods in Turkey. The injectable, because of its low cost and acceptability, holds considerable potential for being a major method in the near future. It's introduction must be carefully done, however, to avoid problems such as those experienced with oral contraceptives made available without adequate support.

- The IUD is the most popular of the modern methods. A.I.D.-donated IUDs represent a relatively small part of commodity costs and yet provide a major part of the protection provided by MOH facilities.
- Nominal amounts of foaming tablets have also been provided, but their distribution and use is limited by the small quantities provided.
- *Negative impact:* The availability of donated contraceptives has allowed the MOH to ignore alternate sources of supplies or to consider local procurement. As a consequence there is currently no institutional capability to procure contraceptives if A.I.D. were to abruptly discontinue contraceptive supplies.

In summary, A.I.D.-provided commodities have been important politically and have provided important protection to couples with limited resources or access to any source other than MOH facilities. However, a plan for A.I.D. to phase down and out of contraceptives procurement over the next few years is essential.

Logistics

As mentioned, the logistics management capabilities of the MOH are weak. To improve technical capabilities in this area A.I.D. has been working through CDC, the FPLM and the FPMD Projects. The major focus of this support has been on supporting the commodity procurement exercise and improving logistics management through workshops and training programs. The A.I.D. interventions in logistics management have been limited and in response to an expressed need on the part of the MOH. As a result the interventions have not addressed systemic issues, developed local procurement capabilities nor fully institutionalized management systems.

MIS

Turkey currently has no standardized reporting system to generate data for program management. It is only recently that the MOH has begun trying to collect and coordinate family planning information. It is hindered by the lack of standard definitions, diverse responsibility for delivery of family planning services, a large private sector program outside government control, and limited interest on the part of MOH in the day-to-day management of the national family planning program. Changes in management level personnel have recently increased interest in program monitoring for strategic planning and quality control purposes. Both the World Bank and A.I.D. have made limited technical contributions in support of the new focus on information collection and utilization. The A.I.D. FPMD Project and CDC are now in the initial stages of developing a national MIS for the General Directorate of Maternal, Child Health and Family Planning of the MOH. The MIS is being installed on a pilot basis in five provinces. The MIS is a computerized client based reporting system for use in MOH facilities. Once the pilot activities have been completed, the objective is to move to national level implementation and to consider installation in other

non-MOH facilities, like SSK. It is not yet clear how private sector family planning will be incorporated into the MIS. The initial success of FPMD in providing technical support for the development of a MIS will depend on the continued interest of the MOH in monitoring activities. Once the system is installed and operating, the local counterparts should be able to maintain and expand the system.

II.F. A.I.D. MANAGEMENT CONCERNS AND PARAMETERS

1. Strategic Management Issues

Management issues relating to A.I.D.'s population assistance in Turkey can be summarized as follows:

Hypothesis: That a limited-term, carefully-targeted, intensified program of U.S. population assistance to Turkey can achieve cost-effective, sustainable impact in terms of reducing Turkey's population growth rate in accordance with national goals.

Strategy: Analyze Turkey's current demographic situation, identify opportunities where U.S. assistance has had and can have catalytic impact and formulate an overall program that will use available resources effectively and obtain desired results.

Management Approach: Operating within personnel ceilings and related constraints, strengthen in-country management capability through a series of coordinated actions: (1) put in place an overall strategy with clearly defined priorities; (2) ensure closer CA coordination through use of new Standard Operating Procedures (see Annex 4.D.), use of cluster groups, regular exchange of information, meetings, and periodic reviews; and (3) limited additional in-country contract staff in the Embassy and in CA offices.

2. Other Issues

Specific Objectives: Identifying Opportunities and Measuring Catalytic Action

The Team hypothesizes that by concentrating population assistance in a few critical areas for a relatively short period of time, the U.S. can make a substantive difference in reducing high fertility in Turkey. The Team identified several target interventions:

- **Policy interventions**, especially strategic planning, financial and cost analysis, and information and data management, including policy-related research
- **Service delivery** in the public and private sector,

- **Training** in all sectors,
- **Communication**, again in all sectors,

Management Complexity of Cooperating Agencies

A country as large and complex as Turkey requires work on several fronts--in the public and private sectors, with many actors and counterpart organizations, using the technical resources of several CA's. In order to manage resources responsibly, programs must be streamlined to save money, avoid duplication and contribute to program depth. The Team recommends the use of "CA clusters," grouped under the headings above, to do this. We have attempted to make both the management structure and the management process as simple and transparent as possible. At the same time, within these several categories, the Team has identified a series of "new opportunities" for innovative family planning approaches.

Physical Presence

The R&D/POP Cooperating Agencies in Turkey are using a remarkable team of highly qualified Turkish national professional advisors to manage and implement their programs. The U.S. Embassy is phasing down the number of official U.S. citizens stationed in Turkey and has indicated concern over any expansion of expatriate advisors here. It is clear that any increase needs strong justification. The Team recommends that the current practice of encouraging CA's to recruit Turkish nationals for professional positions be continued as much as possible.

We have examined and propose to incorporate skills of current expatriate resident advisors into the new program plan. For those with part-time regional responsibilities, we recommend they work full-time in Turkey. We must weigh carefully any additional expatriate presence; this is critical, sensitive and must be as transparent as possible.

Evaluation/Program Assessment/Monitoring

A key component of the recommended management approach concerns the need to develop specific objectives, outputs and indicators for each CA activity, plus work on strengthening information management within implementing institutions to help document overall program success and impact. This approach includes regular, built-in assessment points, at natural benchmark points: at program build-up, mid-term and phase-down points. Small (2-3 people) assessment teams would measure progress against objectives at these benchmarks, make a go/no go decision or recommend other strategic adjustments.

Policy Dialogue/Agreement with GOT

Occasional issues will require policy dialogue with GOT representatives at a level higher than the technical/operational working team. For example, phasing out, or reducing, U.S. procurement of contraceptive commodities will likely require policy dialogue at the senior level, e.g., the U.S. Ambassador to Ministries of Health and Finance. The team introduced this issue in discussion with the U.S. Embassy and MOH. Similarly, the policy dialogue should include consideration of phasedown of overall A.I.D. technical assistance in population to reach very low levels by the year 2000.

AID/W Management

The R&D/POP country specialist, the backstop officer from EUR/DR/HS and the in-country population advisor form the primary country management team. This Team has recommended a streamlined management plan covering CA's annual workplans, reports on activities, travel schedules, etc. The Embassy has adopted this plan (see Ankara 07522 in Annex 4.D.).

Cost

The number of dollars (and CA's) flowing into Turkey should be based on criteria of need, resource availability and how resources can be most effectively deployed. Thus, the dollar value of assistance is of less concern than its effective, efficient management through the procedures and approach discussed above.

II.G. PHASEDOWN, PHASEOVER, AND PHASEOUT CONSIDERATIONS

1. Contraceptive Supply

The U.S. now provides some 90% of contraceptives for the MOH. Annual procurement value varies depending on supply, but over the past 5 years averaged \$1.5 million per year, or some 35% of A.I.D.'s total investment. The MOH is now developing strategies to introduce two important new methods, DMPA and NORPLANT®, using A.I.D. technical assistance. UNFPA is buying modest initial stocks of these products to test use under controlled conditions, but will not supply contraceptives on a large scale.

There are compelling arguments to prepare the technical assistance, management systems and financing plans needed for A.I.D. to phase out contraceptive procurement. A.I.D. is now providing technical assistance to establish MOH contraceptive management information and logistics systems to forecast supply needs and improve distribution; managing procurement, international tender and quality testing of commodities are logical next steps. The team found some evidence that the increased availability of public sector supplies has undermined market share in the private sector, i.e., that people previously paying for OC's switched to free commodities. Since people are more likely to waste free supplies, this may actually contribute to reduced effectiveness. U.S. resources may be more cost effectively

used to help improve method mix by shifting our support to the new, longer-term methods. In any case, and most importantly, as demand increases, U.S. financing will simply not be able to sustain the growing cost of contraceptive procurement.

Thus, A.I.D. needs to assist the MOH/FP Directorate now to establish and increase its own budget for contraceptives. The U.S. and GOT need to develop a timetable that will ensure the institutionalization of this process without disruption in supply. Realistically, this will require both to make considerable investment; in A.I.D.'s experience, a successful phase-over strategy may, in the short-term, be more expensive than simply continuing to donate product. MOH/FP Directorate has some preliminary views on how to assume this cost, but its current budget could not do so without major reduction in other activities.

As noted above, this essential element of A.I.D.'s population strategy in Turkey will require senior level policy dialogue. Over the long run, however, it will contribute to sustainable population activities, enabling the MOH/FP Directorate to assume full responsibility for directing its service delivery program. It will also facilitate A.I.D.'s continued effective investment in its areas of comparative advantage: the technical assistance and training needed to improve quality, expand access and increase efficiency of family planning activities.

2. Technical Assistance

As Turkey progresses towards higher levels of modern contraceptive use, full responsibility for commodity procurement, and development of effective planning, management, and monitoring capability, A.I.D.-funded technical assistance should be phased down in a manner consistent with these factors. While it is too early to say with precision how long this process should take, a good guess would be that by the end of this decade -- only 6½ years hence - - A.I.D. technical assistance should be at far lower levels than at present or in the immediate future.

II.H. POTENTIAL FOR TURKEY AS MODEL AND POSSIBLE PROVIDER OF POPULATION ASSISTANCE

If Turkey's ambitious demographic goal of achieving replacement fertility within this decade can be reached -- and there is reason to believe dramatic progress toward this goal can be made with A.I.D. assistance -- Turkey could well serve as a model for other nations aspiring to reduce their population growth rates. Other predominantly Muslim nations would undoubtedly be interested in Turkey's experience, including nations throughout the Middle East, South Asia, and North Africa.

Turkey is already beginning to assume a leadership role in providing technical, financial, and training assistance to the the former Soviet states in central asia. Private sector institutions, particularly banking, are playing an important role. A.I.D. is already planning to use

Turkey's social marketing infrastructure to market contraceptives in the central asian states. If other Turkish family planning institutions can be strengthened sufficiently, e.g., those doing pre-service and in-service training of service providers or those providing innovative service delivery, it is likely that Turkey could further extend technical assistance in population/family planning to its neighbors.

Criteria for Evaluation and Recommendations

For each component of A.I.D. (and thus CA) assistance, the Team asked a set of questions aimed at determining the relative merit and contribution of the particular component to the overall program. This was especially important in evaluating the components and the totality of each CA's program and in assessing which CA activities should be continued and at which levels of support.

The following questions were asked:

- o *Is the potential impact of a CA activity great?*
- o *Is the CA activity addressing an important problem in Turkey?*
- o *Is the activity systematic (addressing a whole system)?*
- o *Is it catalytic, or likely to have a multiplier effect?*
- o *Is it replicable?*
- o *Is it likely to be sustained?*
- o *Is it an A.I.D./CA comparative advantage?*
- o *Is it cost-effective?*

If the answer to these questions was "yes," the Team then asked, "*Is a greater effort, and more human or financial resources needed?*" If the answer was "no," the Team either recommended redirection of effort to areas more likely to meet the above criteria, or recommended that the component be de-emphasized or discontinued.

In addition to the above, the Team was consciously alert for new opportunities, i.e., for interventions not already included or contemplated in the current program. A careful reading of the following recommendations will show that these have been incorporated therein. For the most part, they involve recommendations to be implemented by A.I.D. CAs. This is both logical and expeditious, given the fact of their presence in Turkey and their very broad capabilities to provide assistance for almost any imaginable initiative in either the private or the public sectors.

III.A.1. MANAGEMENT AND POLICY RECOMMENDATIONS

A review of the family planning program management and policy environment quickly makes apparent of number of factors which both hinder and support full implementation of a national program.

The MOH and the SSK, as the major service providers in Turkey, are the organizations most in need of effective management systems in order to achieve overall program impact. The following recommendations focus on those areas where A.I.D. may be able to support the MOH and the SSK in achieving desired management and policy changes.

1. While there is strong support for family planning in the MOH, the level of awareness and support is not as strong among policy makers outside the Ministry. **It is recommended that A.I.D. provide the services of the Rapid and Options Projects to work with the MCH/FP Directorate to prepare a series of policy briefings and analyses for policy makers throughout the Government.**
2. The MOH and the SSK would also benefit from a policy review and analysis of its service delivery options. **The Options Project should help the MCH/FP Directorate and the SSK assess demographic, financial, social, personnel and health impacts of changes in MOH or national policy (especially, the new National Health Reform Plan).**
3. Responsibility for coordination and overall management of family planning services should reside at a high level in the MOH to ensure greater efficiency in program operations at the general directorate level. While the legal mandate for coordination rests with the MCH/FP General Directorate, services are provided by a number of directorates. Systems for better communication, priority setting and allocation of resources are needed, with responsibility resting at the highest level possible in the system. **It is recommended that the Embassy discuss with the GOT ways of raising the priority of family planning within the MOH and the GOT.**
4. The expanding coordination role and the problems of staff turnover have resulted in a lack of management systems commensurate with the mandated responsibilities of the MCH/FP Directorate. While individual management capabilities are high, the lack of structured and documented operating procedures are a constraint to effective and efficient operations. A.I.D., through the FPMD Project has the technical skills to provide assistance to the Directorate to develop needed management systems. **It is recommended that FPMD support the Directorates' efforts by facilitating needs assessments, coordination workshops, working groups, and by helping with basic documentation.**
5. One notable constraint to MOH and SSK efforts to increase the level of family planning use in Turkey is the lack of a strategic plan. The recently released National Health Policy, for example, includes broad goals for providing family planning services, with performance targets and some workplans; however, there has been no formal strategic planning exercise

within the MCH/FP Directorate to develop operational plans for meeting these goals. A five-year strategic plan for the Directorate and for each unit within the Directorate would greatly facilitate collaboration, personnel planning, budgeting and give the MOH a clearer picture of the future of MOH involvement in family planning. The FPMD Project has helped a number of programs carry out strategic planning exercises and should be able to help each unit develop a strategic plan, help the directorate combine the unit plans into a plan for the directorate, and institutionalize strategic planning as a staff skill and as part of the planning process. SEATS should provide similar assistance in strategic planning to the SSK. **The Embassy, FPMD, and SEATS should explore with the MOH and SSK options for development of needed plans.**

6. Recent support for improved logistics management should be expanded to reflect the immediate need for the MOH to be able to procure family planning commodities on the international market, and to more effectively manage the storage, distribution and control of the commodities in the system. This need is directly related to the pending reductions in A.I.D. commodity support. **The CDC/FPLM Project should be asked to expand their technical support in order to speed up the development of logistics management skills and the shift of responsibility to the MCH/FP Directorate.**

7. Personnel problems, inadequate trained staff and inappropriate utilization of limited personnel are constantly identified by service providers as a major constraint to the provision of quality family planning services. These constraints need to be addressed through improved and expanded training programs, a review and modification of personnel policies and a change in priorities to emphasize high quality and continuous family planning services. The training needs are already being met with support from a number of CAs (Pathfinder, Development Associates, SEATS, JHPIEGO). **A review of personnel policies should be carried out by the MCH/FP General Directorate with technical support from FPMD and Development Associates (FHTP). A similar review should be done by the SSK with the same CA support.** These reviews would address such issues as remuneration, transfer procedures, supervision, recognition, scopes of work, authority (technical, financial and administrative), promotion, access to training opportunities, technical competency, quality-of-care standards, reporting requirements and general performance standards.

8. While the MOH and the SSK are and will continue to be major family planning service providers, there must be administrative and policy recognition of the expanding importance of the private for-profit and non-profit sectors in providing services. In the future these sectors will play a major role in achieving MOH family planning objectives. **It is recommended that the Embassy and CAs explore with the GOT and MOH ways of including NGOs and private sector entities in the planning process, as well as strengthening public-private sector cooperative endeavors.**

9. The MOH currently lacks the quality information necessary for informed decision making. Several A.I.D. funded activities are working to change this situation. The DHS Project will develop a national survey to measure family planning status, which is essential in a program

with a large private sector involvement and a rapidly changing social and health environment. Support for a MIS and a logistics reporting systems are currently being provided by FPMD, CDC and FPLM. SEATS is also providing this type of assistance to the SSK. **This support should be expanded in order to speed up the process and get systems in place.** Since institutionalization is an important element of all A.I.D. technical support to Turkey, **special emphasis should be placed on training managers in the use of data in program planning and management.**

Clarifying Notes. All of the above recommendations and discussions of the role of A.I.D. in supporting the development of quality family planning services in Turkey must be considered in the context of the Team's mandate to address the issues of sustainability, comparative advantage, the catalytic nature of considered activities and the planned phase out of A.I.D. support. The policy and management recommendations focus on improving systems within the most important service systems. The activities are sustainable because their focus is on building capabilities of institutions which are already in place, and training staff whose salaries are already paid. Once systems are designed, installed and documented, they should continue to influence operations long after technical support has ceased.

Any improvement in the operations of the MOH and the SSK will influence the lives of millions of Turkish couples. Also, the MOH, as the foundation and institutional memory for all family planning activities, can ensure continuity in systems development and that changes in the system will be translated to affect every component of the service delivery structure. The efforts to work with systems implies that technical support will phase out as the systems come on-line.

10. It is important that all CAs incorporate phaseout considerations in their workplans. Most ongoing activities should phase out within five to seven years. A number of recommendations made above involve needs assessments and consultation with the MOH and the SSK before workplans and levels-of-effort can be prepared. Generally, CAs would be expected to refine their workplans based on the recommendations of the Evaluation Team, the Office of Population and the Bureau for Europe over the next 12 months. Additional short-term assistance could be provided to help maintain or institutionalize A.I.D. support or, at the request of the MOH and/or SSK, to provide limited support for new activities in the policy or management areas.

III.A.2. FAMILY PLANNING EDUCATION AND TRAINING RECOMMENDATIONS

In-Service Training:

1. **Re-design of the MOH's In-Service Training** (in which FHTP is taking the lead through standardization of MCH/FP centers). The effort to improve the quality of in-service training is essential. Training should be re-designed to give greater attention to methods other than the IUD: the pill (emphasizing that low-dose pills are a new product with fewer side-effects), condoms, male and female sterilization, and injections. NORPLANT® should also be covered, with emphasis relative to its availability.
2. **A new strategy for family planning certification should be developed, replacing the current "IUD certification," and giving greater emphasis on counseling and other methods.** Midwives and GPs in health houses and health centers should be trained to counsel in *all* methods, including those they cannot provide, and be able to give clients effective *referral* to facilities providing other methods. Some countries have found it appropriate to have a course and give a certificate in "Basic Family Planning" (covering knowledge and counseling skills for all methods and referral for clinical methods), which is subsequently followed by a "Comprehensive Family Planning" course and certificate (which includes competency in clinical methods). This might be appropriate for Turkey, too.
3. **Refresher training and training for supervisors.** A plan should be developed to institutionalize refresher training/continuing education. "Contraceptive updates" on new methods should seize the opportunity to fill in gaps concerning already existing methods and counseling.
4. **Policy-oriented research should be conducted to achieve priority changes needed to facilitate training and achieve service provision goals** (as was done in the late 1970s-early 1980s for IUD insertion by midwives). Topics might include: GPs to perform vasectomy, GPs to perform minilaparotomy, injectables to be provided by midwives, GPs, and pharmacists (not confined to ob-gyns as has been mentioned). This would help to attack medical barriers to service provision and to convince providers, especially physicians, that family planning methods can be delivered safely by more types of providers.
5. **The role of (family planning) trainer should be formalized and professionalized.** A career track should be established which includes protection from random transfer and some salary adjustment or incentive for people who take on a training responsibility. It might be possible to do this in conjunction with the "Family Practice Specialization" that was legally created a year or so ago. Other possibilities should also be tried, complemented by non-monetary incentives (e.g., "Trainer of the Year" designation.)
6. **Training CAs should provide a modest amount of equipment to assure that all trainees have the equipment necessary to provide the family planning services that they have been trained to provide.** In the past, A.I.D.'s Office of Population has not permitted training CAs

to provide equipment and/or supplies. This should be permitted, and provided.

Pre-Service Education and Training

- 1. Much more serious effort must be made to develop family planning knowledge and skills at the pre-service level.** The in-service training capacity of the MOH simply is not keeping pace with need (is described by some as a "drop in the bucket").
- 2. A primary goal of pre-service education should be to develop positive family planning attitudes and basic knowledge regarding all methods of family planning among all doctors, midwives, and nurses -- i.e., to overcome the current provider bias.** All medical, nursing and midwifery students should be taught that different methods may be appropriate for different individuals and at different stages of a woman's reproductive life or couple's life together. All students should be taught the principles and importance of counseling, both for different methods and for effective method use. Positive family planning attitudes and knowledge should be presented in a well-designed module and also included in other courses where appropriate (e.g., pediatrics). *Clinical training in IUD insertion is not enough.*
- 3. Clinical training should be provided to all medical and midwifery students where adequate clinical practice sites or opportunities can be developed.** It is not clear, however, that it is realistic to expect that all medical students should graduate with IUD insertion competency.

General

- 1. A comprehensive "Training Strategy for Family Planning Service Delivery in Turkey" should be developed.⁸** *Its goal should be to increase the number of well-trained family planning service providers in Turkey in order to meet manpower need projections.* Objectives related to this goal should be: to standardize information presented in pre- and in-service training, to upgrade the quality of this training, to improve the efficiency with which training is provided, and to identify obstacles that prevent training from being well-utilized in service delivery. All training efforts by FHTP, JHPIEGO and other CAs should be designed in accord with priorities established in the national training plan.
- 2. Personnel ("manpower") projections should be carried out** to arrive at a clear understanding of the trained personnel needed to meet Turkey's increasing demand for contraception.

⁸ This does not mean "needs assessment." Good needs assessments have been done and are also underway through FHTP activities.

3. Efforts should be made at the policy level to **remove programmatic impediments that constrain training and prevent full utilization of trainees and their skills.**

Recommendations Concerning A.I.D. CAs

1. **FHTP should be designated A.I.D.'s "lead CA" for training.** FHTP should work with the directorates for MCH/FP and training (GD/MCH/FP and GD/HT) to develop a comprehensive national training strategy (see above) and coordinate inputs of the other CAs. JHPIEGO should play a major role in the pre-service area, including with YOK and the medical schools. A.I.D.'s service delivery CAs and UNFPA should also be involved.

2. **FHTP is doing very important work with relatively limited human and financial resources.** Given FHTP's currently limited budget for Turkey, FHTP resources should be substantially increased to speed up and facilitate this work and enable FHTP to carry out the planned coordinating role. FHTP's regional advisor who now works part-time on Turkey should have her time on Turkey increased to full-time. In addition, FHTP should hire a Turkish national to work full time, based in Ankara.

3. **JHPIEGO-FHTP overlap on standardization of training sites.** FHTP and JHPIEGO should work together on standardization. FHTP should take the lead with regard to overall issues, given the systematic facility assessment and related work it has already completed and initiated. JHPIEGO should take the lead with regard to clinical procedures. JHPIEGO should not, however, be pursuing separate agendas.

4. **Resident advisor for JHPIEGO.** There is definite need for JHPIEGO to have a *full-time* resident advisor. JHPIEGO should hire, on a full-time basis, a Turkish professional who can work closely and collaboratively with A.I.D.'s Population Advisor and FHTP as well as with the medical schools and YOK. The main tasks of this advisor should be: (a) to coordinate with FHTP on standardization of training centers and training; (b) to develop and implement a comprehensive strategy for integrating positive family planning attitudes and basic knowledge into all medical school curricula; and (c) to develop the planned clinical practice sites for the first 8 medical schools. This advisor should be based in Ankara (located, ideally, in the CA office cluster).

5. **Laparoscopes.** JHPIEGO, in view of the age and problems described with the laparoscopes/laparacators it earlier provided to Turkey, should determine what the costs and benefits are for continued provision of spare parts. JHPIEGO should either terminate provision of parts or outline and implement a cost-effective plan that advances family planning objectives. For further detail, see Annex 4.A.

III.A.3. QUALITY OF CARE RECOMMENDATIONS

Quality of care is one of those important cross-cutting factors, i.e., those which need to be

considered separately but which, in fact, are intimately linked with other factors such as management, MIS, training, clinical and nonclinical service delivery, etc. Recommendations pertaining to quality-of-care concerns, therefore, are similar to those found in other sections of this report. To be as brief as possible, the following five actions are most important in regard to improving quality of care in family planning in Turkey:

1. **Expand the method mix** (according to recommendations elsewhere in this report). At the same time as providers are trained to offer new methods (injectables and NORPLANT®), use this opportunity to improve general family planning knowledge and counseling skills, especially as concerns the pill.
2. **Develop a separate strategy to resuscitate the pill.** This could include clever marketing of the low-dose pill which emphasizes that it is essentially a different product.
3. **Insofar as possible, clinical family planning services should be brought together in a single location** which offers "comprehensive family planning services", including the full range from condoms to VSC.
4. **Efforts should be intensified to expand postpartum family planning counseling and services.**
5. **All women having an abortion should be counseled,** before the procedure, on using contraception, and should be encouraged to adopt a method afterward. A modest study of abortion and quality-of-care should be undertaken (see Annex 4.F., "Contraceptive Failure and Abortion").

III.A.4. CLINICAL SERVICES RECOMMENDATIONS

Following the general set of criteria adopted by the Team for recommendations (section III.A.), the following programmatic recommendations are those which would have the greatest positive impact in the area of clinical services.

General Recommendations

1. **Strategic plan (including operational plan) for the MCH/FP.** The MCH/FP Directorate needs a well-developed strategic plan, including an operational plan, which addresses management aspects of the program and lays out goals and implementing responsibilities for different units within the MOH and for other organizations working on clinical family planning service delivery as well as for other components of family planning (see recommendations in section III.A.1.).
2. **Expansion of method mix.** While the IUD should remain an important part of the method mix in Turkey, other long-acting methods should also be made more available and

easily accessible. Sterilization and other long-acting methods (i.e., injectables and NORPLANT®), because of their effectiveness, acceptability, and under-utilization -- despite their appropriateness to the fertility intentions of the great majority of Turkish citizens -- should get much **more A.I.D. programmatic emphasis**. This means not only by A.I.D.'s service CAs, but also by CAs working in related areas such as training, IEC, and social marketing. In addition to training for clinical skills, training in counseling for these methods is critical. Also needing more attention is method-specific IEC to providers, clients, and other key groups such as journalists and medical and other opinion leaders.

3. Immediate postpartum and peri-abortion family planning services should receive greater attention. (The immediate post-partum period is an opportune time for family planning service provision; a very high number of women giving birth either want no more children or want to delay the next birth; and over 60% of Turkish births occur in health care facilities. Also, abortions are a presumptive indication of unmet demand for family planning or of ineffective contraceptive practices.)

4. Sterilization: male and female

- (a) **Sterilization, for women and men, should be made widely available on an outpatient basis.** The current welter of structural impediments, regulations, and practices needs to be changed to permit outpatient sterilization, thus making this method more accessible and affordable. Tubal ligation needs to be moved out of infertility/diagnostic laparoscopy units (where it typically requires a 2- to 3-night stay) and integrated into hospital outpatient family planning units providing other methods. Once trained, GPs -- not just OB/GYNs -- should be allowed to provide tubal ligation services.
- (b) **The current program emphasis on expansion of sterilization services within the MOH and SSK should be maintained.** Cost constraints make it unlikely that the for-profit private sector will be a significant provider of sterilization services to the general populace in the near future.
- (c) **Vasectomy services should be expanded.** Efforts to train and permit GPs perform vasectomy should continue. In most cases, it appears appropriate for vasectomy services to be provided where other family planning services are provided.

5. New methods: Depo-Provera and NORPLANT®

- (a) **It is critical that Depo-Provera and NORPLANT® be carefully introduced to avoid the unfortunate fate of oral contraceptives in Turkey.** As is currently planned by the MOH, introduction of Depo-Provera and NORPLANT® should be carefully phased in, and linked to regular and reliable commodity availability, as well as to training (and competent service provider availability for insertion and removal in the case of

NORPLANT®.) Training, good counseling, and careful, method-specific IEC to providers, clients, and opinion leaders, are critically important. Didactic and clinical aspects of both methods should be included as part of all pre-service and in-service education and training.

- (b) **Only a 3-month injectable (i.e., Depo-Provera) should be introduced**, to avoid programmatic difficulties (provider and client confusion, etc.) which often arise when two injectables with different lengths of action are available in a family planning program. (This is particularly of concern in Turkey given the abysmal situation regarding oral hormonal contraceptives. Depo-Provera has the potential to be a very important and popular method in Turkey; however, due to very common bleeding side-effects of one sort or another, it also has much potential to be misunderstood and misdelivered.
- (c) **Midwives and nurses**, in addition to physicians, should be **allowed to provide Depo-Provera** (as is safely and appropriately done in numerous other countries). This enables a program to responsibly make available a method which often becomes the preferred method of many women. Similarly, GPs as well as specialists should be allowed to provide NORPLANT®.
- (d) The MOH (and A.I.D. and its CAs) must recognize that Depo-Provera will quickly become available in the private sector, perhaps even more quickly than the MOH would prefer (or is able to control). **The private sector is an appropriate, and perhaps the most important, ultimate venue for Depo-Provera provision. Pharmacists and pharmacist-assistants must be a key target audience for IEC and training efforts. Pharmaceutical representatives should be involved in planning and implementing its introduction and expansion from the start. SOMARC and JHUPCS should ensure that these critical target audiences are appropriately covered.**
- (e) **The MOH**, to the extent that it is planning on making NORPLANT® available, should **limit NORPLANT® to a few key, high-quality institutions**. NORPLANT® has a commodity cost alone some 30 times greater than IUDs, and greater delivery costs as well. Thus the MOH should view the SSK system as perhaps the most suitable service channel for NORPLANT®, because the SSK has a greater ability to insure regular commodity supply with its own funds and procurement mechanisms. Because the SSK financing system is supported by fixed employee-employer contributions -- and because SSK must serve all members irrespective of family size - - it has a greater potential to realize the cost savings NORPLANT® offers in terms of births averted, and the attendant costs of pregnancy, delivery, and subsequent child health care. It therefore has a financial incentive to encourage use of this, and other family planning methods.

6. **Effective referral mechanisms** and other links between health units that provide family planning information and temporary methods and hospital departments that provide long-

acting clinical methods must be developed in MOH, SSK and other service systems.

Recommendations Concerning A.I.D. CAs

Pathfinder

1. Pathfinder, by virtue of its long history in Turkey and involvement in many aspects of family planning at a time when other more specialized agencies were not working in Turkey, has had a diffuse focus for its work. This was very appropriate earlier, and Pathfinder has made many important contributions. Now that other CAs have joined the effort, it is advisable that **Pathfinder sharpen its focus and concentrate on its comparative advantage**. In addition to possible expansion of its community-based (CBS) activities, there are a number of untapped areas for service delivery where Pathfinder might consider working in a holistic way.
2. To avoid unnecessary duplication and overlap as AVSC's vasectomy activities expand in the MOH and SSK, **Pathfinder should phase over its vasectomy activities and responsibilities to AVSC and SEATS** and concentrate its efforts where it has more activities and a greater comparative advantage. **A timetable for phaseover** should be devised and agreed upon by Pathfinder, AVSC, SEATS, and the Embassy.
3. **Pathfinder's support to TESK**. This should be re-evaluated by both Pathfinder and the Embassy prior to the scheduled (March 1994) renewal of the subagreement to consider whether the original premises under which support was provided are still valid, and whether the proposed activities meet the Team's criteria for judging CA activities (see III.A. above).

AVSC

1. **AVSC should increase staffing** of its Turkey Country Office to a level **adequate to achieve the challenge it faces** in making VSC and other long-acting methods of clinical contraception widely available and an appropriately expanded part of the method mix in Turkey. AVSC should continue its emphasis on expansion of services by working with the MOH and SSK in training, IEC, renovation and equipment, counseling, and quality assurance.
2. **AVSC should continue its lead role in technical assistance to the MOH for introduction of NORPLANT® and Depo-Provera**, given AVSC's recognized expertise and worldwide experience. AVSC should also assist SOMARC where necessary to work with pharmaceutical manufacturers and detailers regarding information to be given to service providers about long-acting clinical methods, particularly NORPLANT® and Depo-Provera.

SEATS

1. Because of the great potential of the sustained provision of clinical family planning services in the SSK system, and the excellent performance to date, the **SEATS project**

should continue its work expanding quality clinical family planning services there.

2. Specific and increased attention should be given to working with several leading SSK centers which demonstrate interest and commitment in providing services and training. These should be developed and designated as "**centers of excellence**," providing higher quality services than the average facility is able to do and thus providing models for system-wide improvement.

3. Multiple strategies should be used to **reinforce and acknowledge supportive individual SSK facility leaders and decision-makers**. This might include publicizing their efforts and results in newsletters and other mass media, establishing awards for leadership in delivery of quality family planning services, and so on.

4. Attention to **reorienting less supportive SSK facility leaders**, through site visits or "study tours" to more successful family planning service delivery sites is warranted, recognizing that MCH centers, and ob-gyns may be more supportive than other specialists. If the work with SSK continues to be successful, leverage with SSK leadership may be available to "encourage" this reorientation of less supportive hospital administrators.

5. SEATS should commission some more **detailed policy-oriented cost analysis studies** to present to both SSK and MOH (and other GOT) leadership to promote changes in clinical method service availability and delivery, and a greater allocation of resources to prevention.

6. SEATS would be an appropriate CA to work with the military health services system; it is one of the major public sector channels and could have a large impact. The system could provide sustainable IEC and family planning services to reach young men during the period of their military service. **Subject to funding and management concerns, SEATS should consider launching an initiative with the military health system similar to its program with the SSK.**

III.A.5. NON-CLINICAL SERVICES AND OUTREACH RECOMMENDATIONS

1. While both CEDPA and Pathfinder are supporting CBS activities, the focus of the two CA programs should be different. It is recommended that Pathfinder play a major role in promoting service delivery through CBS activities, especially in small towns and rural areas. Using community non-clinical structures and building on its considerable experience, **Pathfinder should develop service delivery models suitable for broad replicability, with special attention paid to reducing costs while maintaining project impact. CEDPA, however, should focus on converting the Ankara Municipal Project into a model demonstration project, using it as a catalyst for encouraging other municipal authorities to develop (with CEDPA TA and municipality resources) their own service delivery projects.** Note: Istanbul (pop. > 10 million) has already expressed interest in replicating the Ankara Project.

Ankara Municipality / CEDPA CBS Project:

Recommendations on the Ankara Project are based on the replicability of the current model, the high levels of political support and interest the project has generated, the potential for financial sustainability, the potential to reach otherwise underserved populations, and the opportunity to develop a major new family planning service provider with considerably greater political will and community involvement than national-level providers.

1. The Team recommends that CEDPA continue to provide technical and financial support to the Project. The Project will continue to provide services in the Ankara area, using the same approaches already in operation. However, the new focus of the Project will be to serve as a demonstration site for municipal authority family planning services. The objective will be to get other municipal authorities to introduce family planning services as part of their social development services for residents. They may use the CBS or another model, but should be aware of the issues and involved in promoting family planning in their communities.

2. CEDPA should encourage the Ankara Municipal Authority to continue its take-over of responsibility for service provision. CEDPA resources should go towards creating the demonstration project and working with other municipal authorities to transfer the political will and the service strategy.

3. CEDPA and the project staff should undertake a project design exercise which will result in a project proposal for review and approval by the Turkey Population Advisor and the Turkey Working Group in Washington. Components of the project should include:

- a strategy for continued service delivery and expansion into new areas.
- plans for the setup and structure of the demonstration project.
- plans for developing project staff technical capabilities to provide technical assistance to other municipalities.
- development of promotional and educational materials targeted towards municipal officials.
- funding for technical assistance.
- funding for study tours of the Ankara Project.
- funding for small "seed" grants to municipal authorities to help with project development.
- development and/or generalization of operating systems for easier export (esp. MIS, supervision, financial management, training, clinical linkages, site identification procedures, worker selection procedures, evaluation techniques, cost recovery management, etc.).

4. Since the objective is to create a demonstration project, the elements of operations research should be expanded. Greater emphasis should be placed on testing variations in

service delivery to the urban poor.

The Izmir CBS Project with Pathfinder and Human Resource Development Foundation

The Izmir Project is another example of a successful, appropriate family planning service delivery intervention. **The Team recommends that the project undergo a major review with the objective of modifying the Project to use community-based services to raise national contraceptive prevalence levels.** The review should lead to a project proposal for review by The Turkey Population Advisor and The Turkey Working Group in Washington. The proposal should have the following properties:

- The proposal should strive to create a project having potential for wide replication.
- The CBS Project should continue to build on MOH clinical facilities to provide the necessary clinical back-up services.
- The Project should focus on smaller provincial urban areas that have the potential to provide the foundation for moving into rural areas. **The new project should have rural populations as one of its major targets.**
- The CBS should use the strategy of initiating services and then moving to new areas. The procedures should be reviewed and documented in a project manual, and the period of intervention should be reduced as much as possible.
- The expanded Project should strive for a leaner management structure (supervision, training, MIS) to be consistent with the strategy for moving quickly from community to community. However, the structures will be more complex in the first phase as the Project begins developing new rural interventions.
- The Project should consider a two-phased approach, the first to test broad-based, more rurally-focused CBS interventions (12 to 18 months), and the second phase would expand the Project to achieve broad impact (3 to 5 years).
- Project site selection should focus on low prevalence, high fertility areas where services are limited.
- The Project should work closely with the Family Health Training Project to ensure that there are trained health providers (midwives) available to the community after the Project moves out.
- The CBS Project may wish to experiment with other types of community-based family planning interventions. Specifically, setting up commodity depots or knowledgeable community leaders with ties to the health system to continue to provide commodities/information after the Project has left the area.

- Since the Project will be working in areas where services are less available, it may wish to focus efforts on raising VSC prevalence. Efforts in support of this objective could include collaboration with AVSC, special IEC efforts, transport, and other forms of special support.
- The current Project in Izmir should continue to expand into new areas, but should begin planning for phaseout, as resources and staff focus more on broader scale programming.
- The use of local implementing organizations, as in Urfa, can still be done if the local situation justifies it. However, the goal of rapid turnover of Project sites suggests limiting the use of other organizations with their own agendas and organizational needs.

III.A.6. CONTRACEPTIVES AND EQUIPMENT RECOMMENDATIONS

A.I.D. has played a major role in providing contraceptives to the MOH, and in introducing new methods to support improved method mix. The commodity support is, in part, responsible for the positive working relationship between A.I.D. and the Government of Turkey, which has used the commodities to build relationships with health providers and to provide one of the few commodities currently available in the Government health system. However, a number of factors argue that the need for this support is diminishing. The success of SSK and the Social Marketing Project in procuring low cost commodities in the international market or through local procurement clearly indicates the financial and technical capabilities for local procurement exist in Turkey. The important service provision role of the private sector also indicates an ability to operate without donated contraceptives.

- 1. The Team recommends that A.I.D. commodity support be reassessed, with the objective being a phased and responsible reduction in funding for contraceptives. A.I.D. should phase out commodity support completely by 1999. Specific methods may be phased out earlier as discussed below.**
- 2. The MOH needs to strengthen its commodity procurement planning capability. The SEATS Project, with support from the FPLM and CDC, should continue their current demand projection support and continue to institutionalize capabilities.**
- 3. The phaseout of A.I.D. commodity support will place a further burden on the MOH planning process. The process is already complicated by a lack of logistics data. Efforts by FPMD, CDC and FPLM to set up logistics management and reporting systems should be given higher priority.**
- 4. The MOH, the CAs and A.I.D. should develop a method-specific plan for A.I.D. phaseout, procurement, budgeting and distribution.**

Condoms

Current A.I.D. condom procurement runs through 1994. The 1995 procurement should be 50 percent of average 1993/94 levels. **The need for A.I.D. condom procurement in 1996 should be reassessed in late 1994**, but the goal is to have no condoms procured for 1996. If condoms are procured the level should be no more than 25 percent of the average 1993/94 levels. The phaseout should be linked to an IEC effort to educate the general population and clients to the availability of condoms through pharmacies. This activity is linked to social marketing and general IEC efforts.

Oral Contraceptives

1. Current A.I.D. orals procurement runs through 1994. Local production of pills reduces the need for external procurement. **It is recommended that procurement levels for 1995 be 75 percent; 1996 be 50 percent; and the final procurement in 1997 should be 25 percent of the 1994 levels.** Of course, the subsequent annual reviews by MOH, A.I.D. and the commodity planning specialists may determine that the phaseout process can be speeded up.
2. **Efforts should be made to encourage the local pharmaceutical industry to package a 28-day pill cycle.** This will require the MOH to deal directly with the industry.

Injectables

1. A.I.D. is procuring 40,000 doses for a trial introduction of the injectables in Turkey. Virtually everyone believes injectables will be a very popular method and that demand will far exceed the limited quantities available. It is not yet clear what the private sector response to procurement and distribution will be once the trial period is over and the method is approved for general distribution. **It is recommended that A.I.D. significantly increase the level of injectables procurement to support the demand creation effort and speed up the process of improving the contraceptive method mix. A.I.D. assistance for injectables (and NORPLANT® -- see below) should be contingent on GOT development of a phased plan for GOT procurement of these commodities, and for introduction of these methods into the Turkish family planning program.**
2. Injectables procurement should continue and increase beyond the initial 40,000 doses. Subject to the annual review by the procurement specialists, A.I.D. procured injectable doses should increase to 100,000 doses for 1995, 200,000 for 1996, 300,000 for 1997, 200,000 for 1998 and 100,000 for 1999. By 1999 demand should be established and local production or procurement systems in place.
3. Injectables traditionally are administered using disposable syringes. There is a local production capacity that is not currently operating at maximum output. Syringes should be locally available, but a back-up stock should be planned for to deal with production problems.

4. **The injectables introduction will require logistics management support (CDC) and IEC activities (PCS).**

5. These recommendations are based on the unproven assumption that demand for injectables will be high. **Demand and private sector involvement should be monitored and injectables procurement plans be modified accordingly.** For example, if local production capacity comes on line before 1999, phaseout can begin earlier.

NORPLANT®

A.I.D. is currently (1993) providing 5,000 NORPLANT® kits for a trial introduction. The high cost of NORPLANT® is likely to prevent it playing a major role in contraceptive use in Turkey. However, there is enough private and insured contraceptive users to indicate that there is a segment of the population that would use the method. **It is recommended that A.I.D. continue to provide sufficient quantities to generate demand and train providers, about 5,000 to 10,000 per year until 1999.** It is also recommended that many of future supplies should go to SSE, since it is likely to be most able to financially sustain NORPLANT® utilization.

IUD

Even with an improved method mix, the consumer demand and provider biases will ensure the IUD's continued importance as a method in Turkey. A.I.D. procurement of IUDs is a relatively small component of assistance with a relatively high level of impact. **It is recommended that A.I.D. continue to supply IUDS at the 1994 level until the complete phaseout of commodity support in 1999.** The rationale for this recommendation is that dollar values are small, impact is high, it provided justification for continued involvement in logistics, and there is no local production capability. If local procurement were required for policy or budgetary reasons, it would be possible to phaseout IUD support in 2 to 3 years without disrupting the service delivery system.

Cost Recovery

Budgetary constraints, private sector involvement, management problems, and multiple service delivery structures clearly indicate that future Government/MOH procurement of contraceptives will remain a problem. **It is recommended that greater emphasis be placed on studying and testing cost recovery and alternate systems which will reduce the financial burdens of commodity procurement.** Several of the currently active CAs have the technical capacity to support this activity. Pathfinder, SEATS and CEDPA could support expanded cost recovery experimentation through current service delivery activities. FPMD could also support cost recovery reviews as a component of its management support to the MOH.

Medical Equipment

A constant complaint of service providers is a lack of equipment for providing OB/GYN services, including family planning. The Team's site visits support the validity of these complaints. **It is recommended that A.I.D. consider a one-time equipment procurement to upgrade facilities for providing family planning services.** The procurement would be for non disposable equipment - examination tables, sterilizers, speculums, lights, laprascopes, screens, training aids, etc. **AVSC, given its technical expertise and excellent working relationship with the MOH, would be the appropriate CA to deal with the MOH system. SEATS is already doing this with the SSK.**

III.A.7. IEC RECOMMENDATIONS

- 1. Better coordination is necessary among IEC providers in the public and private sectors and between IEC and service providers. The MOH/MCH/FP wants to play a key role in this process. One CA IEC specialist should be assigned to work across all CAs having IEC activities so as to better orchestrate overall IEC assistance.**
- 2. A.I.D. needs to find its proper niche in the possible mix of assistance, taking into account the enormous needs, activity of other donors and A.I.D.'s own comparative advantages. In the view of this Team, A.I.D.'s proper emphasis in the future should focus on non-mass media channels and on developing and strengthening interpersonal communications skills.**
- 3. Future A.I.D. assistance with mass media programs should emphasize integrating family planning messages into already scheduled programs rather than creating new ones;**
- 4. A.I.D. should assist with better dissemination and use of data, particularly Turkish language translations of studies; more use of qualitative data and qualitative research.**
- 5. General awareness is very high, but there is a need for more method-specific information, especially to counteract rumors.** There is still a major need for informing the public broadly about the NEW pill (low dose), and injectables (carefully calibrated with availability of supplies). Again, these factors argue for less attention to mass media activity, which is most useful for increasing general awareness and consciousness-raising about family planning, rather than targeted method-specific information.
- 6. To break through medical barriers, IEC targeted toward providers is also a priority.** This could emphasize new incentives, such as recognition and creative, non-monetary awards for supportive leaders, e.g., political leaders (the mayor of Ankara), performers, media producers, journalists; non-monetary incentives for high-performing service providers, e.g., conferences, congresses, etc.
- 7. There is need for a major IEC provider/client program for injectables.** This is a top priority which can have a disastrous negative impact if not handled properly.

Major IEC Recommended Actions

Because of the critical role and significance of IEC activity throughout the A.I.D. population portfolio, **there is a critical need for:**

- 1. development of a national IEC strategy for A.I.D.-funded IEC assistance.**
- 2. PCS to provide an A.I.D. advisor for population IEC activities, to serve as in-country resident expert to advise the MCH/FP Directorate, CA's and donors and the private sector.** This could be a Turkish national or U.S. citizen, based in Ankara with the MCH/FP Directorate as the primary counterpart. Qualifications would emphasize skills in interpersonal communication, counseling. This person would work as a catalyst and IEC coordinator, rather than a mass media expert.

The scope of work for this assignment needs to be carefully and fully developed, but would include the following tasks:

- direct development of the national IEC strategy for all A.I.D.-supported activities; this will include an IEC assessment involving all CA's;
- take the lead role in putting this IEC strategy into action with all relevant parties: counterparts, CA's, donors, the private sector;
- provide technical support and coordination for the IEC/Communication needs of all CA's and counterpart agencies; strengthen coordination of IEC activities between MOH and the private sector;
- look for leveraging activities and opportunities;
- develop specific strategies to overcome medical biases; work with A.I.D.-supported training programs, using materials already developed by these programs;
- develop a family planning guide for use by pharmacists and pharmacists assistants who come into contact with potential family planning acceptors, to inform them about available methods and options. This material should include method-specific information and screening questions about side effects, what to do if problems, etc.

CA-Specific IEC Recommendations

- 1. PCS and SOMARC need to coordinate their activities more closely.**
- 2. SEATS and AVSC both propose large IEC efforts and must also coordinate these activities with other A.I.D.-funded activities.**

III.A.8. SOCIAL MARKETING RECOMMENDATIONS

1. While the market research that has served as a pre and post measure of the effectiveness of an intervention has been useful, **there should be more market research on issues that will help to inform the fundamental design of IEC and social marketing programs.** For example, what is the profile of those using traditional methods? This is the group that should be most easily attracted to modern methods. Who are the withdrawers? Why are they using this method? How frequently are they using it? Who are the condom users? Are they using the condom consistently or only occasionally? What are the specific beliefs—rumors or reality—that underlie discontinuation or lack of trial for modern methods? How effective can young midwives be in introducing contraceptors to modern methods? Do people in Turkey strongly prefer injections as a route of administration? If so, will this preference hold for the introduction of new injectable contraceptives? What specific promotional techniques have been most powerful? Without more specific information on these details, both IEC and social marketing efforts will be less effective than they can be. However, **more primary qualitative research also requires that A.I.D. allow more planning time for the design of interventions.** Follow-up research should also include more extended follow-up, as advertising typically has a powerful short term impact but often only a modest portion of the impact can be sustained.

2. **Market research that has been conducted should be shared more widely.** For example, the major advertising tracking survey that was recently completed by Zet-Medya should be provided to all four of the pharmaceutical companies with which the social marketing project has been working. Research on the public sector could also be shared with the private sector. Summaries of A.I.D.-supported studies tend to be used as a promotional tool by project actors, and are naturally more broadly circulated than the studies themselves. While this is normal behavior, **A.I.D. needs to encourage summaries that highlight interesting data that are poorly understood, data that indicate program weaknesses and failures, and other facts that not only help to spread the good news but help to spread news that can make future programs even stronger.** These data can highlight the need for programmatic changes or further investigation. For example, the fact that one product represents 80-90% of the growth in the low dose OC market is as and perhaps more interesting than the actual growth in the market as it correlates with the social marketing campaign.

3. **The range of products available in the private sector should be expanded,** and the social marketing project plans to include IUDs, contraceptive implants, and injectables in future activities. **Social marketing of these products will be primarily to physicians, and this requires that the most effective use of the detailing and the sales force be well understood.**

At least one new pill should be introduced. This OC should be a low dose compound with a 28-day cycle of tablets, including iron supplements, and possibly a name that is meaningful and memorable to Turkish women. A 28-day cycle should increase compliance and therefore efficacy. Iron supplements for the additional 7 tablets would decrease anemia caused by menstruation, decreasing perceived and real side-effects and increasing efficacy.

These enhancements should gradually increase consumer confidence and ultimately demand. In time, when combined with higher use of the low-dose pills, this could improve general attitudes toward modern methods in Turkey. The brand name, along with messages and pricing options, should be pre-tested. For example, Eczacibasi might be able to use the brand recognition for ¢K condoms as a lead to introduce £K pills.

4. **The social marketing program should consider dropping both Wyeth and Schering, as they seem to be willing but not enthusiastic. Dropping these two companies could allow pursuing activities that are brand specific with Eczacibasi and Organon.** One advantage of brand specific marketing is that it can be more focused. Another more important advantage is that the marketers can better control demand to a product that has the specific attributes that the program should promote, i.e., low price, etc. Without intending to do so, the social marketing for low dose pills appears to have primarily attracted new users to the most expensive product on the market.

5. The social marketing program in particular and the A.I.D.-supported population programs more generally should **begin dialogue with the GOT and the pharmaceutical industry about potential changes in pricing policies that would create better incentives** for both consumers and the industry, from manufacturing through the retail level. Appropriate pricing incentives will facilitate an increase in the prevalence of appropriate and affordable modern methods.

6. **Social marketing and other commercial private sector development for the provision of commodities should be a strategic priority** for A.I.D. population assistance. Although it will often not contribute to equity of access, the private sector for health care services is growing rapidly in Turkey. The private sector is more efficient and effective, and more robust and dynamic than the public sector. It offers much potential for catalytic influence of both consumer and provider demand for modern contraceptive methods. **Given the importance of the private commercial sector and the linkages between IEC and social marketing, A.I.D. should consider an in-country coordinator, probably based in Istanbul, working jointly with these two activities.**

III.A.9. OPERATIONS RESEARCH AND PROGRAM IMPACT MEASUREMENT RECOMMENDATIONS

1. **The upcoming Demographic and Health Survey** should be given high priority and as much support as needed. To facilitate institutionalization, the DHS Project should direct special efforts to training Turkish researchers in data processing and analysis. MOH staff should be part of the Turkey DHS analysis team to facilitate use and understanding of the data set. The team should be larger than might be normal and should include participation from Turkish organizations in addition to Hacettepe. The team should spend maximum time possible with the DHS Project to maximize learning opportunities and institutionalization.

2. **Decisions on future DHS support** should be based on the technical needs, success of past institutionalization efforts, the political environment, and the availability of resources in 1998-1999, when the next DHS should be carried out. It should be noted that the rapidly changing demographic situation in Turkey suggests need for more regular measurement of some of the basic variables. This should be considered and can be done using existing multipurpose surveys or specially commissioned smaller surveys.

3. **Analysis and dissemination of findings.** Funding agencies should build analysis and dissemination into all research budgets. Research sponsors should disseminate findings as widely as possible. As the coordinator and primary consumer of family planning research, the MOH should take a leading role in facilitating the dissemination of research results.

4. **CAs and research.** Because the potential impact of research on services is so great, **the CAs should expand their analysis, report writing/publication, and dissemination of findings from their research activities.** All the CAs involved in Turkey have or can get the technical resources to support their own research needs and provide support to the program.

5. **Data for decision-making.** A.I.D. should consider offering a short course for service delivery managers in the importance and use of family planning data for decision-making. Participants would include MOH, provincial and NGO project staff.

6. **Translation.** The translation and dissemination of selected international family planning publications (currently undertaken by SEATS and PCS) should be continued and, ideally, expanded. Special focus should be given to materials that will help overcome the common medical barriers to effective service provision.

For further detail, see Annex 4.G., "Research and Measurement: Data for Decision-Making."

IIIA.10. FINANCE/COST EFFICIENCY RECOMMENDATIONS

Cost Analyses

Although data are insufficient for true cost effectiveness analysis, simpler cost analyses would assist decisionmakers to allocate resources more efficiently and improve services management. The World Bank sees this as a priority and is assisting the MOH to undertake a major cost analysis of the entire health service delivery system. These data will be very useful, but are not likely to be available for some time; for family planning services delivery, more specific analyses could be invaluable. They could be particularly useful at the operational level, quantifying the discrete costs of various services, e.g., VSC, within institutions, or the increased cost efficiency of providing family planning services at the same time and in the same location as maternity services, or an abortion. The proposed AVSC workplan includes this type of analysis and should be supported.

Influencing Provider Decisions/Behaviors

Team findings confirmed previous studies identifying provider bias as a major barrier to increasing modern contraceptive prevalence in Turkey. The team has identified two major interventions to attack provider bias: training, at all levels, and policy-related research particularly aimed at physicians, to convince them to overcome medical barriers. A third means of changing medical behaviors involves incentives. In the U.S., Health Maintenance Organizations use incentives to encourage and influence health care behaviors, both among their members and by physicians. These can include premium reductions for members, changes in benefit packages, and discounted or contract fees charged by physicians or hospitals in exchange for the volume business provided by the HMO. In some developing countries, CBD workers can sell contraceptives.

We found some examples of such practices among family planning service providers in Turkey, for example, one physician who agreed to a discounted fee for sterilizations referred to him through a CBD program. CA's working in Turkey should experiment with provider incentives to reinforce and reward provision of family planning services. Such experimentation will contribute both to the sustainability of the program and to increased contraceptive prevalence.

There is legitimate concern that reliance on monetary incentives would result in denial of service to indigent clients. Programs also need to experiment with non-monetary rewards, and ways to support individual leaders and opinion-makers and publicly recognize their individual contribution and to encourage emulation by others. Potential examples abound: physician of the year award, or acceptor of the year award.

FINANCING RECOMMENDATIONS

- 1. Undertake cost analyses of specific service delivery activities**, both to quantify costs, and compare service delivery options. For instance, our observation indicates higher performance at facilities offering provision of complete maternity and family planning services. Cost analysis could tell on a representative basis what it would cost to replicate such activities, distinguishing between costs for starting up a new activity and for replicating a successful intervention at a new site; replication costs should be less. Such analysis would also highlight where cost efficiencies are possible, such as in drug costs and management. AVSC's workplan includes proposals for such cost analysis and should be supported.
- 2. Introduce and experiment with competitive conditions within delivery systems** which would allocate resources (or non-monetary rewards) according to efficient performance of service units; experiment with semi-private provision of clinical family planning services
- 3. Support sensitivity analysis of user fees for services at different levels.** Currently, we know there is wide variation in user fees both public and private facilities for various

services, especially sterilization. Better knowledge of the variability of fees and their potential effect on demand would lead to more rational and equitable use of fee schedules and give administrators greater predictability of funds.

4. A.I.D.'s current efforts in VSC are appropriately directed at building up service supply, identifying targets of opportunity and increasing availability of services. Over time, as supply of services increases, the program will need to direct more attention to studying and generating demand. In this regard, the program should seriously consider **supporting market research to segment target audiences and develop strategies to address potential market demand for sterilization**. Effective market research can identify and project the dimensions of demand at all program phases, from potential, emerging and effective demand of a mature market. It can also identify excluded or at-risk populations requiring special approaches, e.g., women who have had multiple abortions.

5. **Technical assistance in insurance principles and/or actuarial science**, to appropriate officials with interest in effective health financing. Of particular concern is that adequate resources will be available in these systems to support family planning service delivery as covered benefits under insurance schemes over the long term, and ensuring that health insurance premium revenues are used for providing medical care rather than other purposes.

III.B. POLICY, MANAGEMENT, AND PROGRAM IMPACT CONSIDERATIONS AT VARYING LEVELS OF A.I.D. ASSISTANCE

One of the objectives of the evaluation Team was to review levels of A.I.D. support for consistency with both stated and potential program objectives. The Team was not given advice on whether future assistance levels should be the same, higher, or lower than at present. Rather, the stated objective -- agreed by all parties -- was to assess the current situation, identify needs and opportunities, and make recommendations for future assistance consistent with the following considerations:

- recommended program activities must be manageable within personnel and other constraints laid down by the Embassy in Ankara;
- program assistance must be focused on activities which are *catalytic, sustainable, systemic, and likely to have a major impact*;
- A.I.D.'s comparative advantage should be considered in all recommended activities; and
- A.I.D. assistance should be looked at in terms of the rapid socio-economic development of Turkey, and should be considered *short-term*; this implies that a phased and modulated pattern of A.I.D. assistance -- appropriate to programmatic needs -- should be recommended.

The phasedown/phaseout of A.I.D. population assistance should be based on the rapid economic development of Turkey, a vibrant private sector and its potential role in health care, Turkey's stage of demographic transition, and the development of institutional capability to provide quality family planning services. While Turkey is making rapid strides, as is discussed elsewhere in this report, there remain a number of major constraints to the provision of family planning services, and many opportunities for A.I.D. to have a major impact on the quality of life of Turkish couples. The following discussion of levels of assistance assumes development support will have achieved its objectives and Turkey will no longer require other than very modest population assistance by the turn of the century.

Current A.I.D. Assistance Levels

A.I.D. currently provides about \$5-6 million in population assistance to Turkey. About 35% goes for contraceptives, the remainder is used to provide technical assistance through A.I.D. CAs. A continuation of A.I.D. assistance at this level would likely have the following effects:

- most political agendas (Embassy and A.I.D.) would be unaffected;
- some refocusing of CA activities could be done to increase program impact;
- some CAs would be constrained from providing the resources needed to pursue very promising, high impact program activities (e.g., FHTP, FPMD, CEDPA, SEATS, AVSC, OPTIONS);
- a strengthening of A.I.D. management capacity would still be required (personnel, procedures, MIS);
- A.I.D. would be unable to capitalize on an excellent opportunity to engage the GOT, through the MOH/MCH/FP, in targeted policy and strategic planning actions which could impact positively on the overall program;

Reduced A.I.D. Assistance Levels

A reduction in current assistance levels would have the following important consequences:

- service-delivery elements of current assistance would be severely impacted, especially CEDPA, Pathfinder, and commodity support;
- the GOT would likely take this as a sign of reduced U.S. interest in population matters;
- program impact would be significantly reduced: A.I.D.'s place at the policy

table would be forfeited, critical CA assistance would be lost at various levels within the overall system, and much of A.I.D.'s investment to date would be undermined;

- quality-of-care issues would be unlikely to receive needed attention as the program effort was refocused on maximum coverage; and
- the speed of the demographic transition in Turkey would likely be slowed, owing to a general slowdown in the development of institutional capability to plan and implement effective family planning programs;
- reduced A.I.D. assistance levels could well prolong the time period required for outside population assistance; and
- Turkey's role as regional model and potential provider of population assistance would be significantly reduced.

Greater A.I.D. Assistance Levels

It was the Team conclusion that Turkey does not need *much* greater levels of A.I.D. assistance; that which is needed is relatively modest and is time-limited. Increases in A.I.D. assistance levels now (say, to a total of \$8-10 million per year for 2-3 years, followed by a sharp decline thereafter) could have a major impact on demographic trends in Turkey and on the development of Turkish institutions. An increase of this magnitude would likely have the following consequences:

- this level of assistance would take advantage of the strong A.I.D. and CA management structures which will in any event be put in place;
- the phasedown/phaseout of A.I.D. population assistance to Turkey would be accelerated;
- CAs would be able to take advantage of existing opportunities -- afforded by a unique political and social environment -- to overcome significant constraints to program progress, speeding the time when quality family planning services can be made available widely, and GOT institutions are capable of maintaining a high level of program impact;
- it is likely that this level of assistance would be sufficient to allow Turkey to *double the percentage of couples using modern family planning methods*, and using them more effectively than ever before, by the turn of the century; and
- a program impact of this magnitude could be expected to strengthen U.S. ties

and collaboration with Turkey, an important and stable friend in the midst of a troubled region of the world.

RECOMMENDED A.I.D. ASSISTANCE LEVELS

This Team is unable to recommend a specific assistance level. Determination of the proper level will depend upon several factors, among them: (1) the availability of ceiling and funding within existing CA contracts and cooperative agreements; (2) the actual levels of support needed (CAs will have to cost these out, based on recommendations contained in this report); and (3) exogenous factors over which this Team has no control.

What we can say with certainty is the following:

- implementation of the recommendations in this report will involve increased A.I.D. funding levels, perhaps only marginally in some cases;
- the climate in Turkey is right: A.I.D. should not miss this unique opportunity to strengthen Turkey's institutions and capability to provide quality family planning services widely;
- A.I.D.-assistance to Turkey should be *front-loaded*, i.e., increases should be effected incrementally over the next 1-2 years -- consistent with improved management capacity -- and should thereafter be maintained for 2-3 years before beginning a decline aiming at very low levels by the year 2000.
- A.I.D. should not establish artificial "ceilings" or "caps" in the level of population assistance to Turkey; these have proven to be counterproductive in the past. Rather, A.I.D. assistance levels should be determined by the factors outlined hereinabove.

Additionally, in determining A.I.D. assistance levels for Turkey consideration should be given to the following:

- agreement on the recommendations contained in this report;
- availability of funding and ceiling-space within existing CA agreements;
- redirection of CA activities along lines recommended in this report; and
- A.I.D. management capability (this factor should be only loosely considered against funding levels, since increased funding **does not necessarily imply a greater management load**); and
- the likely overall program impact due to leveraging of local resources.

EVALUATION TEAM RECOMMENDATIONS ON CA LEVELS OF EFFORT

The recommendations in section III.A.1 thru 9 provide a detailed description of activity type. Usually, activities are logically associated with specific CAs. For purposes of summarizing recommendations of level of effort, **Table 2** provides very general indications of the Team's perceptions of level of effort and magnitude of CA assistance required for the Turkey program. Recommended changes in levels of effort and in funding are related to current levels of assistance. Each is *exclusive*, i.e., it pertains to an individual CA without regard to other CA levels. For example, a major increase in level of effort and funding for a CA now having a very small presence may imply funding increases of only a relatively small amount, whereas smaller changes in LOE and funding with respect to a CA having a larger program (e.g., Pathfinder) may actually imply greater funding increases.

Team Recommendations for CA Level-of-Effort (L.O.E.) and Funding

CA & Project	L.O.E.	Funding	Comment
JHU ● JHPIEGO ● PCS	+ +	+ +	Redirect resources on systems basis. Client/provider materials & support.
SEATS ● SSK ● FPLM ● equipment inputs	same ++ ++	same ++ ++	High impact; limited absorptive capacity. More logistics mgt support for MOH. Need equip.; no other sources.
AVSC	++	++	Fastest growing method; accelerate.
PATHFINDER ● FHTP ● other projects	++ same, but redirect	++ same	FHTP activity has direct impact on quality & availability. Pathfinder needs reallocate resources towards CBS for greater impact.
FUTURES GROUP ● OPTIONS ● SOMARC	++ same	++ same	Policy work (Options). Major educ. effort needed with new methods (SOMARC).
CEDPA (Ankara Municipality)	+	+	National CBS demonstration project - high impact.
FPMD/CDC	++	++	Small cost but major expansion MIS & mgt assistance.
DHS (survey assistance)	same	same	Increase support for institutionalization.
A.I.D. Commodity Support (Contraceptives)	-	-	Phasedown/phaseout according to agreed-upon plan with GOT.

Table 2.

Legend: + = more
 ++ = much more
 - = less

III.G. MANAGEMENT PLAN FOR RECOMMENDED A.I.D. ASSISTANCE

While in Turkey, the Team worked out with the Embassy and its Population Officer an overall management approach which would be effective in implementing the recommendations listed above. This approach has the following components:

1. The articulation and promulgation of **Standard Operating Procedures for CAs in Turkey**; its purpose is to ensure a uniformity of procedures and to facilitate monitoring by the Embassy and AID/W (see Annex 4.D. -- Ankara 07522).
2. **Approval for a full-time, contract U.S. technician based at the Embassy**, to work closely with the Population Officer to develop management tools and to coordinate CA activities (see Ankara 07830, Annex 4.D.).
3. **Development of specialized management tools** to be used for monitoring and coordinating CA assistance; these will include computer-based tools designed to measure progress against identified subproject goals, making extensive use of graphics and user-friendly interfaces.
4. **Periodic meetings of the Turkey Working Group in Washington**, making use of reports and information generated by the above.
5. **Small in-country assessments of management issues** scheduled each 12-18 months.
6. **Increased in-country staff for selected CAs** to improve their planning, program concentration, and management capability.

It is believed that the above techniques and procedures will significantly strengthen overall A.I.D. management of the population assistance program in Turkey, consistent with recommended program directions.

ANNEX I - SCOPE OF WORK

April 30, 1993

TURKEY A.I.D. POPULATION STRATEGIC EVALUATION STATEMENT OF WORK

BACKGROUND

Demographics and Family Planning in Turkey

In Turkey, the demographic transition is already well underway; U.S. Census Bureau projections show Turkey's growth rate dropping from its present rate of 2.2% to 1.8% by 2001. Nevertheless, with a current population of 54.6 million people and a total fertility rate of 3.4 children, Turkey is a high priority country for assistance from the Office of Population. The young population (37% under 15) will place continued, costly demands on health, education and employment needs, and the population will continue to grow because of past high fertility patterns.

Contraceptive prevalence among married women in Turkey is 31% for modern methods (slightly less than Bangladesh). Another 32% use ineffective, traditional methods (especially withdrawal), contributing to continued high reliance on abortion. Of women using family planning, fully 76% state they want no more children, demonstrating a substantial unmet demand for greater access to longer-term, reliable methods of contraception.

In short, there is work to be done in improving family planning service delivery in Turkey. In planning it, critical questions include learning why there is an unmet demand for conception and why such low prevalence for modern method use exists. A renewed look at U.S. assistance in the population sector is warranted to determine how the U.S. can focus assistance that will solidify the Turkish population program and ensure its long term success to allow all couples access to comprehensive high quality family planning services.

A.I.D. Population Assistance to Turkey

A.I.D. has supported family planning in Turkey through centrally funded Cooperating Agencies (CAs) for over a decade, managed from the Office of Population. A.I.D. field program management is carried out by Dr. Pinar Senlet, a highly qualified Turkish physician, and since 1991 an A.I.D. personal services contractor working in the U.S. Embassy in Ankara. In addition, a number of Cooperating Agencies have resident staff to provide day to day program support in Turkey.

Over the last decade A.I.D. has made substantial contributions to the public and private sector programs in the areas of training, family planning service delivery, information, education and training (IEC), contraceptive logistics and management and enhancement of the management information system for the national program. Notable achievements include the improvement and

standardization of training curriculum for pre-service midwifery schools; expansion of the in-service training capacity of the GDMCHFP for midwives, physicians and nurses; expansion of surgical contraception; and, improvement in service delivery in urban and rural areas, including community based distribution, establishment of the social marketing program and worker and insurance based family planning services to promote wider access to family planning services.

For further details on past and current AID assistance in family planning for Turkey please refer to Attachment 1.

Interoffice Coordination and Project Management

In order to oversee management of the Turkey population assistance program, the Office of Population formed the Turkey Working Group, currently composed of a chair person (the Chief of the Information & Training Division of R&D/POP), an alternate (the Chief of the Family Planning Services Division of R&D/POP), and representatives from EUR/DR/HS. This group meets regularly to review workplans and activities for the individual CAs. It thus has the major responsibility for the combined tasks of program planning and management, while Dr. Senlet has field management oversight responsibility to facilitate project implementation in Turkey. For the past several years, the Office of Population has also hosted an annual meeting in Washington of all the CAs working in Turkey. CA staff, AID/W representatives from the Office of Population and the Europe Bureau and Dr. Senlet have participated in these meetings. This meeting usually occurs in the fall. The Turkey Working Group has decided to postpone it this year until after the evaluation.

Turkey Population Sector Assessment

After a decade of A.I.D. population assistance in Turkey, the major qualitative assessment is the EUR/DR/HR Sector Assessment completed in 1990 by Paula Bryan and Dr. Pinar Senlet. This report did not recommend program expansion. Rather, it called for consolidation and targeting A.I.D.'s resources into a set of clearly defined activities:

- Strengthening sustainable, user-financed family planning services, through existing insurance-based programs;
- Increasing contraceptive sales through the private commercial sector;
- Expanding voluntary sterilization services;
- Assisting the MOH identify alternative sources of contraceptive commodities to phase out procurements.

- Improving family planning medical school curriculum, and other activities aimed at changing behavior patterns of the medical community, (especially medical doctors)--identified as a major constraint to family planning acceptance.

The Office of Population responded to these recommendations and consolidated and oriented Cooperating Agency activities toward these recommendations. Current CA programs (as detailed above) continue to work toward the achievement of these recommendations. In order to continue the process of tailoring AID efforts to Turkey's needs and conditions, it was recommended that a team be sent to Turkey to conduct a strategic evaluation of population efforts in that country. A critical goal for the evaluation team will be to determine whether the objectives stated above will in fact meet the root causes of lower contraceptive prevalence for modern methods in Turkey, or if other interventions would be more effective.

Goals of Strategic Evaluation

During the past year, in order to achieve greater impact on population growth, the Office of Population launched the "Priority Country Strategy"--a major shift to work in fewer countries, targeting the largest countries with rapid population growth rates. These include the Asian countries of India, Bangladesh and the Philippines, but also such countries as Brazil, Mexico and Nigeria--and Turkey. In line with the "Priority Country Strategy," the Office of Population wishes to increase program, technical assistance and financial support for the Turkey population program.

In line with the consolidation of Cooperating Agency activity as recommended in the Bryan/Senlet report, the Bureau for Europe has had concerns about expanding the population assistance program in Turkey beyond its current level of approximately \$5 million per year. It is not even clear to the Bureau for Europe why this level should be sustained--are we strengthening Turkey's own ability to run its programs or are we substituting for it? These concerns center on two issues: (1) the ten year-old program has not undergone a comprehensive strategic evaluation; and, (2) whether A.I.D. has adequate resources for management and accountability requirements of a consolidated expanded program. The Bureau for Europe has shared these concerns with the Office of Population, and the two Bureaus have agreed to the following:

1. Future population programming in Turkey should be considered in light of a comprehensive, overall assistance strategy based on an objective assessment of the current environment in Turkey, the efficacy of past programs, and the cost efficacy of A.I.D. activities to date. This evaluation

should recommend a set of strategic objectives for the program and measurable indicators for their achievement.

2. Program accountability, oversight and control and management needs will be directly addressed in this evaluation, including the additional management and personnel inputs needed for program continuation and/or expansion.

A strategic evaluation is timely for several reasons. Since the 1990 Bryan/Senlet sector assessment there has been significant progress. Two major programs - Contraceptive Social Marketing and the collaboration with the Social Security Insurance Institute to incorporate family planning services into their health care system - have been launched, and favorable changes of key high level Government officials have created a very positive environment for the A.I.D. population assistance in Turkey. Also, the Office of Population reoriented several aspects of its program to address concerns and recommendations made in the report. The assessment will highlight these significant new initiatives; determine to what degree these earlier recommendations have been implemented; review and evaluate the current mix of A.I.D. program funded program interventions, the role of U.S. Cooperating Agencies and Turkish counterpart organizations; and, recommend future program interventions and funding levels relative to the management and financial capacity of the Agency.

This strategic evaluation can then serve as the foundation for planning A.I.D. assistance for the Turkish population program, help assess and prioritize the comparative advantages and roles of individual Cas prominent in the current program within an overall strategy, and suggest an appropriate funding level to carry out the A.I.D. strategy for population assistance in Turkey.

Subsequent to this assessment, and using it as a source document, A.I.D. will develop a country program strategic plan. The plan will incorporate overall objectives with measurable indicators along with appropriate supporting program interventions and funding levels. The strategic plan will also include management and financial oversight mechanisms (such as the Turkey Working Group if deemed most appropriate, use of contract and CA staff, etc.) to best facilitate the agreed upon strategy.

SCOPE OF WORK

Purpose

To carry out an objective, formal external strategic evaluation of the environment for population assistance in Turkey, document A.I.D. and other donors' historical and present population assistance activities in Turkey, analyze country or regional

socio-economic factors, assess local institutions and available resources, and make recommendations for future assistance. The strategic evaluation will also make recommendations regarding program management concerns, i.e. given that there will be no resident A.I.D. USDH in Turkey, what are the staffing needs to set overall policy directions and assure responsible oversight and control of program design, implementation and financial accountability, and how should these management limitations contribute to the focussing of program activities? Results of this strategic evaluation will support the formulation of a comprehensive, overall assistance strategy which ensures that A.I.D. resources will make a sustainable difference.

Issues for the Strategic Evaluation

In completing this assignment the team should particularly consider the questions of the impact of donor programs to date in this area, current understanding of root causes for low uses of modern contraceptive methods, marketing factors, issues of financing, and ability of various proposed interventions to meet the program's goals for Turkey. Some recommended issues for the assessment team's consideration are described in greater detail in Attachment 2.

Team Composition

The team will consist of seven people. Five external evaluation team members should have extensive knowledge and program skills in management of donor-assisted programs, financing sustainable health/family planning programs (including insurance-based service delivery systems) in both the public and private sectors, business and marketing, and evaluating family planning services. A.I.D. team members will include one representative each from the Europe Bureau and the Office of Population. Dr. Pinar Senlet will serve as a resource person for the team.

Methodology

As framed by the issues detailed in this scope of work, the strategic evaluation will involve an analysis of past program achievements and a situational analysis of present A.I.D. program objectives and supporting program interventions implemented by several U.S. Cooperating Agencies and Turkish public and private sector organizations. The evaluation will make recommendations for future program directions and A.I.D. assistance in the population sector in Turkey.

In the first phase, a recognized expert in population and social issues and an expert in health financing issues will undertake review of relevant background documents, including: (1) "Turkey: Population Assessment, Strategy and Action Plan Recommendations for A.I.D. Assistance", October 1990 by Paula Bryan and Dr. Pinar

Senlet; (2) "Assessment of Family Planning Service Provision and Training of Family Planning Service Providers in Turkey", October 1990 by Judith P. Rooks and Dr. Pinar Senlet; (3) "Health Sector Reforms in Turkey," August 1991 by Dr. George Schieber and Jeremiah Norris and, (4) select Cooperating Agency program documents. Other key resource documents include the Staff Appraisal Report for the World Bank Health project in Turkey. These individuals will prepare a briefing and background document for the full team to use in formulating its investigative approach in Turkey. In addition, the Office of Population will provide a background paper on demographic trends and target modeling in Turkey (a copy of the proposed Table of Contents for this document is attached). In the second phase, the evaluation team will conduct initial research and interviews with AID/W staff in the Office of Population and the Bureau for Europe for program overview prior to the in-country evaluation. Finally, field program review will take place in Turkey by the team including Embassy briefings and debriefing, meetings with appropriate Turkish Government officials, private sector representatives and Cooperating Agency staff.

Reporting Requirements

The team will develop a draft report in-country prior to departure. The team will return to Washington to debrief AID/W staff on major findings and recommendations and then finalize the evaluation report.

Schedule

The evaluation will take place during May of calendar year 1993, dependent on availability of consultants. The entire assignment should take approximately five weeks, including one week in AID/W for collection and review of documents, briefing and team building, three weeks in Turkey for program review and draft report preparation and one week in AID/W for debriefing and final report preparation. In addition, four weeks will be allotted for the preparation of the background document and summary of previous written materials.

ATTACHMENT 1: HISTORY OF AID FAMILY PLANNING ASSISTANCE IN TURKEY

From 1987-90, A.I.D. assistance averaged \$2.48 million annually. In 1991, this assistance increased to \$5.12 million, including \$2.2 million in commodity procurement for condoms and pills.

The current R&D/Population program has three objectives:

1. Increase program sustainability and improve access through public and private sectors.
2. Improve contraceptive knowledge, practice, and method mix.
3. Strengthen the Ministry of Health institutional capacity.

In order to achieve the above objectives, the program utilizes Cooperating Agencies funded by the Office of Population. To increase sustainability and improve access, Pathfinder and the Family Planning Service Expansion and Technical Support project (SEATS, a project managed by John Snow, Inc.) Project support and coordinate service delivery projects with two Turkish insurance-based programs (TESK and SSK), while the Family Planning Logistics Management (FPLM, another project managed by John Snow, Inc.) project assists SEATS with establishing Management Information Systems for the SSK. The Social Marketing for Change (SOMARC, a project managed by the Futures Group) project supports the social marketing programs and the Center for Education and Development of Population Activities (CEDPA) works with municipalities to support service delivery in urban slums.

To improve contraceptive knowledge, practice and method mix, Pathfinder and the Association for Voluntary Surgical Contraception (AVSC) are working on increasing access to and improving knowledge about voluntary surgical contraception and other long-term methods. Johns Hopkins University, through its Population Communications Services (PCS) Project, is taking the lead in continuing to improve the Information/Education/Communication strategy and designing campaigns to increase awareness and knowledge. Development Associates and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) continue to be involved in improving training curricula and developing training strategies for service providers while the Population Council is assisting in identifying ways to improve method-mix.

The Centers for Disease Control Division of Reproductive Health and the Family Planning Management Development (FPMD, a project managed by Management Sciences for Health) project are continuing assistance to the MOH to strengthen its institutional capability

by working with the logistics system and Management Information System. Commodities continue to be supplied to the MOH by the Office of Population.

Program Management

As is often done in countries where no bilateral program exists, the Turkey population program has been designed and managed by AID/W. Utilizing central projects through the Office of Population, program support and direct interventions have been funded to strengthen the Turkey population program. The situation in Turkey is exceptional, however, in two respects: (1) the size and complexity of the program (over \$5 million/year with eleven active Cooperating Agencies) and (2) there is no AID Representative or Mission in-country for on-the-ground supervision.

8. What mechanisms can be put in place to ensure technical, administrative and financial sustainability of these programs - rather than creating greater dependency?
9. What overall program direction will have the greatest future impact for A.I.D. assistance to the population sector in Turkey? Where and how should the U.S. Government target assistance? How can service delivery interventions be focussed to institutionalize efforts within the medical community, government and the private sector?
10. What staffing levels are needed to assure adequate program design, monitoring, and financial accountability?
11. The contraceptive social marketing program began in Turkey about one year ago. The program has already been declared an outstanding success because actual sales greatly exceeded targets. How, and on what criteria, were these sales targets established? Can immediate impact on sales, based on an intensive advertising campaign, be maintained?
12. Is the recommendation to expand voluntary sterilization services appropriate? Is current demand for these services sufficient to support continued expansion of services, or, as an alternative, should the program focus on demand generation strategies? How will voluntary surgical contraceptive services be sustained without on-going donor support?

1/25/93: R. Eskow draft

ANNEX 2. MAJOR CONTACTS

MINISTRY OF HEALTH (MOH)

General Directorate for Maternal and Child Health and Family Planning (GD/MCH-FP)

Ayşe Akin Dervisoglu, MD, General Director
Ugur Aytac, Deputy General Director
Dr. Mehmet Ali Biliker, Deputy Director
Ms. Nuran Ustunoglu, Head of Public Health Training Department
Ms. Advige Temiz Tupay, MCH/FP Section Director
Ms. Guljidan Cosar, Head of MH Department

General Directorate for Health Training (GD/HT)

Mehmet Ozden, MD, General Director
Fatma Yegen, Project Chief
Emel Narin, Assistant to General Director
Ekine Tekin, Member, Central Training Team of FHTP
Severhan Mest, Member, Central Training Team of FHTP
Gonul Denir, Member, Central Training Team of FHTP
Huseyn Ozalp

Adana MCHFP Training Center

Dr. Canan Sargin, Director
Berrin Dogon, GP, FP trainer
Sevgi Gevikoglu, GP, FP trainer

Ministry of Health, Izmir

Meltem Agzitemiz, Associate Director General
Saadet Yardin, Head MCH/FP Division

Izmir Maternity Hospital

Uzemir Kirca, Director

Numune State Hospital, Family Planning Clinic & Training Centre

Erol Alpay, Chief, Ob/gyn Department
Ali Memis, Urologist

MINISTRY OF LABOR AND SOCIAL INSURANCE

Social Insurance Institute (Sosyal Sigortalar Kurumu, SSK)

SSK General Directorate
Kemal Kilicdaroglu, General Director

Bakirkoy SSK Maternity and Pediatrics Hospital

Dr. Tahsin Berk Arsan, Head Physician

Dr. Mehmet Esber Okan, Gynecologist

Etlik SSK Maternity and Pediatrics Hospital

Dr. Berna Ozbey, Ob-Gyn

STATE PLANNING ORGANIZATION

Ismail Karaman, General Director, Social Planning Department

Nesrin Cilingiroglu, Health Economist

Samira Yener, Expert, Population Sector

Muharrem Varlik

GREATER ANKARA MUNICIPALITY

Murat Karayalcin, Mayor of Ankara

Ugur Cilasan, Director of Health Affairs

Birgul Piyal, Project Coordinator, Mamak Family Planning Services

M. Siddik Ensari, Mustesar Yardimcisi

TURKISH TRADE UNION (TURK-IS)

Salih Kilic, Secretary General for Education

TURKISH TRADESMEN AND CRAFTSMEN CONFEDERATION (TESK)

Alev Gunal, Deputy Secretary General

TURKISH RADIO AND TELEVISION (TRT)

NON-GOVERNMENTAL ORGANIZATIONS

Family Planning Association of Turkey (FPAT)

Semra Koral, Executive Director

Human Resource Development Foundation (HRDF)

Nuray Fincancioglu, Executive Director

Inci Mubarek, Communications Coordinator

Dogan Gunes Tomruk, Medical Coordinator

Ozcan Baripoglu, MD, Vasectomy Coordinator

Human Resource Development Foundation, Izmir

Tulay Gayindirli, Project Director

Bahar Torun, Buca District Office

Nevin Seckin, Bayrakli District Office

Turkish Family Health and Planning Foundation (TFHPP)

Mr. Yasar Yaser, Executive Director

Prof. Dr. Sunday Ünder, Deputy Executive Director

Nurcan Muftuoglu, Director Family Planning Department

Foundation for the Advancement and Recognition of Women

Sevgi Altinay, Financial Manager

HACETTEPE UNIVERSITY

Department of Public Health

Munevver Bertan, Director

Institute of Population Studies

Prof. Dr. Ergul Tuncbilek, Director

Asst. Prof. Attila Hanciogly, Lecturer

Banu Ergocmen, Lecturer

Faculty of Medicine

Prof. Dr. Hikmet Pekcan, Department of Community Medicine

For SOCIAL MARKETING OF CONTRACEPTIVES

Eczacibasi Pharmaceutical Corporation

Tunç Erben, Product Manager

Ayse Özger, Assistant General Manager, Marketing

Nuri Kiliç, Product Manager

Kadir Akyildif, Chief of Istanbul OTC Sales Team

Other Pharmaceutical Manufacturers

Göktuna, Halim, Promotion Manager, Wyeth

Önder, Adnan, General Manager, Wyeth

Saribay, S. Meriç, Product Manager, Organon

Schindler, Günter, General Manager, Schering

Tunali, Nilgün, Product Manager, Schering

Yörük, Sinasi, Marketing Manager, Schering

Aitinbasak, Faruk, Sales Manager, Schering

Pharmacies

Bolsoy, Mehmet, Pharmacy Assistant, Aslan Eczanesi

Aktan, Ayla, Pharmacist, Asli Eczanesi

Çolak, Mustafa, Pharmacy Assistant, Asli Eczanesi

Paksoy, Tülay, Pharmacy Assistant, Eczane Ilgi

Özok, Ibrahim, Pharmacy Assistant, Karadeniz Eczanesi

Tarhan, Sahin, Pharmacy Assistant, Eczane Sürmen
Tümer, Mdme., Pharmacist, Eczane Tümer
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**COOPERATING AGENCIES' FY 1993 WORKPLANS
RD/POP POPULATION ASSISTANCE IN TURKEY**

COOPERATING AGENCY	MAJOR ACTIVITY	TURKISH COUNTERPART AGENCY	COLLABORATING CAS	FY 93 IN COUNTRY BUDGET LEVEL (\$000's)
JSI/SEATS	Training; IEC; Logistics; VSC; TA in management	SSK; MOH Hacettepe Univ Turk-Is	AVSC PF; PCS PATH FPLM	1,265
AVSC	TA to the MOH and SSK in long-term and permanent contraception in 11 provinces; TA to MOH to introduce long-term hormonals into national program	SSK; MOH Hacettepe Dept Pub Hlth	JHPIEGO SEATS SOMARC	640
SOMARC	Oral contraceptives Social Marketing program; Initiate assessment for introduction of long-term methods	Turkish Health and FP Foundation (THFPF)	AVSC	698
PATHFINDER	Community-Based Services; VSC	HRDF; FRTW SSK; TESK	AVSC	745
JHPIEGO	Preservice Training in Medical Schools; In-service training with MOH to reduce Medical Barriers; NORPLANT/Depo Introduction	Turkish Medical Schools; MOH HRDF; Hacettepe	AVSC	205
DA	Training of midwives and trainers; Strengthen training centers	MOH		374
JHU/PCS	Mass media/IEC; 2 Population Reports	THFPF; MOH; Hacettepe		191

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COOPERATING AGENCY	MAJOR ACTIVITY	TURKISH COUNTERPART AGENCY	COLLABORATING CAS	FY '93 IN-COUNTRY BUDGET LEVEL (\$000's)
MACRO/DHSIII	Conduct national demographic and health survey	MOH; Hacettepe		210
CEDPA	Services	Greater Ankara Municipality		46
FPLM	Logistics	SSK		27
FPMD	MIS	MOH	FPLM CDC	77
CDC	MIS	MOH	FPLM FPMD	37
Population Council	Operations Research	MOH		35
Commodities	Condoms; IUDs; OCs	MOH; THFPF; SSK		1,111

TOTAL 5,661

2/8/93

Actual A.I.D. expenditures (including commodities) in Turkey for the past five years is presented below

Year	Total expenditures
1987	\$2,329,000
1988	\$2,783,000
1989	\$2,693,000
1990	\$2,598,000
1991	\$5,120,000
1992**	\$5,533,000

* Receives A.I.D. contraceptives

** Projected expenditures for 1992

FAMILY PLANNING EDUCATION AND TRAINING

DEFINITIONS: ESSENTIAL FOR UNDERSTANDING

In family planning, "training" generally means both:

- a) **in-service training** that selected health care providers receive after they are on the job; and
- b) **pre-service education** in family planning that is given to medical, nursing, midwifery and pharmacy students.

Both may include **didactic** and **clinical** components. If pre-service education includes practice in clinical skills, it is often referred to as **pre-service training**.

When family planning is first taught in a country, it is through in-service training. Later, as demand for family planning increases, family planning should be added to the curricula for the basic education of health care providers.

In Turkey, "training" is translated into expressions with several meanings that are quite different from the English word. This is frequently a source of misunderstanding between Turkish and foreign personnel. In Turkey, the term "training" may also be translated and understood as one of the following: individual counseling, group counseling, or community education or outreach. Clearly these are very different from the A.I.D. understanding of "training."¹

A.I.D. COOPERATING AGENCIES WORKING IN TRAINING

Long History of A.I.D. Support

A.I.D. has provided financial and technical assistance for family planning training in Turkey for many years. After passage of Turkey's 1983 Population Law, which specified that midwives and GPs should provide information and services for temporary methods of family planning, including IUD insertion, A.I.D. CAs helped establish the MOH in-service training courses for midwives and GPs. A.I.D. CAs have launched or supported a large number of appropriate training activities, including: training needs assessments, curriculum design and

¹ Thus, for example, when an American training specialist wants to meet with his/her counterpart in the MOH, she may end up meeting with someone who has the title "Director of Public Health Education" -- actually the "IEC" chief and **not** the MOH person most responsible for training.

re-design, training-of-trainers, training of supervisors, training materials development, and training program evaluation.²

A.I.D. has done this chiefly through two training projects: JHPIEGO (Johns Hopkins Program for International Education in Reproductive Health) and the PAC project (Family Planning Training for Paramedical, Auxiliary, and Community Personnel). Service delivery CAs have also provided training.

* Since at least 1980, **JHPIEGO** has worked in Turkey to win the support of leading ob-gyn specialists for family planning, providing ob-gyns with laparoscopes and training them in family planning and the use of laparoscopes for tubal ligation and related gynecological reproductive health purposes.

* Since at least 1984, the **PAC project** has provided additional assistance, especially for the training of midwives. INTRAH was the first of the PAC contractors. RONCO was the PAC contractor working in Turkey between 1984-1989. From 1989 through 1991, Gulf War events prevented PAC project assistance to Turkey. Since January 1992, the Family Health Training Project (FHTP), implemented by Pathfinder on subcontract to Development Associates, has been working in Turkey as part of the PAC Iib project.

CAs and Projects Currently Working in Education and Training

All CAs are involved in training, each in its own technical area. This is natural and should not be considered undesirable overlap per se. The Family Health Training Project (FHTP) has recently prepared an excellent synthesis of all CA-sponsored training in Turkey.³

Six CAs are involved in training for service provision. These are: FHTP and JHPIEGO (the training CAs), SEATS, AVSC, and Pathfinder (service delivery CAs). SOMARC is involved in training of pharmacists (and potentially physicians) via its social marketing work. Of these, all but JHPIEGO and SOMARC have resident advisors in Turkey. JHPIEGO works through Turkish project directors for each of its subprojects.

The "training CAs": JHPIEGO. JHPIEGO's current activities are based on the following set of goals:

- 1) Development of a standardized clinical family planning practice training network affiliated to the regular pre-service and in-service institutional infrastructure.

² See "Assessment of the Pre-Service Education and In-Service Training and Job Performance of Turkish Midwives" by Judith Rooks, et al. Family Health Training Project, February 1992.

³ "Summary of Family Planning Training Activities Implemented by USAID Cooperating Agencies in Turkey, January-December 1993." Family Health Training Project, March 1993.

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- 2) Development of a family planning component to undergraduate medical school curriculum, including an elective course for the undergraduate medical school curriculum.
- 3) Development of a mandatory family planning course for ob/gyn and public health post-graduates.
- 4) Faculty with proficient clinical and training skills reflecting an established uniform standard.
- 5) National clinical family planning guidelines, developed through consensus of the MOH, the SSK, relevant NGOs and universities. MOH approval of these guidelines which set uniform standards for training and service institutions.
- 6) Proficiency in Norplant clinical skills for a core group of service providers, selected to lead MOH's introduction of hormonal methods in Turkey.
- 7) Other ad hoc activities, responsive to specific AID requests. For example, technical assistance and spare parts to maintain JHPIEGO-donated laparoscopy systems.

JHPIEGO works with the following local counterpart agencies: MOH, General Directorate for MCH/FP; Hacettepe University; and the Human Resource Development Foundation

The "training CAs": the Family Health Training Project. FHTP has the following goals:

- 1) Strengthening pre-service education and in-service training of family planning service providers, especially midwives, through promotion of increased technical competence related to modern contraceptive methods, post-partum contraception and counseling; and
- 2) Promoting sustainability of family planning training and service delivery interventions through skills transfer to host-country counterparts, and through strengthening of communication and collaboration among various MOH General Directorates responsible for family planning.

FHTP's strategy in Turkey is to assist the *institutionalization of family planning training capabilities* and *promotion of quality of care* principles through systematic technical assistance and collaboration with the MOH, the largest supplier of family planning services in Turkey. The FHTP strategy maximizes the opportunities for detailed collaboration and transfer of technical capabilities to in-country counterpart organizations, therefore increasing their "ownership" of project outcomes to include:

- updated midwife job description,
- new and strengthened curricula for family planning service providers,

- standards for family planning training centers, and
- training packages on contraceptive methods.

FHTP works with the following local counterpart agencies:

- **The MOH, General Directorate for MCH/FP**, (responsible for in-service family planning training of midwives, nurses, general practitioners and other family health professionals); and
- **The MOH, General Directorate of Health Training (GDHT)**, (responsible for pre-service education of midwives, nurses and other family health professionals, and for the accreditation of all health training programs in Turkey.)

FINDINGS: GENERAL

The government has made laudable efforts to train health care providers in family planning. Nevertheless, education and training of service providers is woefully inadequate for meeting current service provision needs. A huge proportion of government facilities (MOH and SSK) still do not provide either family planning services or information. One estimate is that about 80% of all hospitals and 60% of all health centers do **not** offer family planning services.⁴ In addition, those facilities that do provide family planning services do not measure up well on current international standards of quality of care.⁵ This is true of nearly all facilities, even though many may score well on technical competence for Turkey's leading method, the IUD.

1. Much (but not all) of the shortcomings in service provision can be attributed to problems in training -- both in-service and especially pre-service. Health care providers (midwives, doctors and nurses) do not get an adequate introduction to family planning during their basic pre-service education. Once they are out working, only a portion get in-service training in family planning. This is not adequate either. The in-service courses, developed about a decade ago, have become inadequate in many ways. In addition, in-service training is not available to private physicians unless they are GPs identified to work for the MOH in family planning and are sent to the MOH's in-service course. Training opportunities in surgical contraception and in MR are limited and in family planning counseling almost unavailable.

⁴ JHPIEGO, "Reproductive Health Training Assessment, Turkey." May 1991, p. 1.

⁵ Quality of care is generally recognized internationally to consist of six elements: (1) choice of contraceptive methods; (2) information given to clients; (3) technical competence of providers; (4) client-provider relations; (5) mechanisms to encourage continuity of care; and (6) appropriate combination of services. This is often referred to as the "Bruce framework." (See publications of the Population Council by Judith Bruce and Anrudh Jain.)

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A nationwide survey in early 1992 revealed a serious lack of basic reproductive health and contraceptive technology knowledge among ob-gyns and general practitioners working at health centers, and among pharmacists. Only 22% of the gynecologists and only 13% of the GPs felt they are adequately trained in applying family planning methods.⁶

2. Current efforts for improvement. The government (and A.I.D. CAs) have good plans for improving education and training, both pre-service and in-service, and are in the process of implementing these plans. It will take time, however, before the new systems are fully in place and producing service providers with improved levels of competency.

3. Donor dependency. Provision of training by the MOH appears to have depended on availability of funding support from donors. In addition to A.I.D., UNFPA has been the other major donor in training. UNFPA's "17-Province Project" (1984-1988) placed priority on the East and Southeast. In 1988, this was followed by an "11-Province Project," scheduled to end in 1993 (now expanded to a larger number of provinces). UNFPA has been active in development of IEC and training materials (flipcharts, etc.).

IN-SERVICE TRAINING: FINDINGS AND RECOMMENDATIONS

In-service training in family planning has received greater attention (from both the government and donors) than pre-service education. A distinct strength of in-service training in Turkey is that it is clearly linked to service provision.

1. Family planning training centers on the IUD. When family planning was launched as a government program in the 1960s, the IUD was identified as the most appropriate method for Turkey. Although other temporary methods (pills, condoms, vaginal spermicides) were also introduced, conviction remained firm that the IUD was the best method for Turkey. Training since has consequently centered on IUD insertion. The MOH's basic in-service family planning training course is thus generally referred to as "the IUD course." It focuses on this method and has the goal of training participants to become competent in IUD insertion. Successful participants receive an IUD insertion certificate; with this they are considered certified family planning service providers.

2. Little attention to counseling and method choice. There has been little attention to counseling, given the long-standing view of the government and providers that this one method, the IUD, is the best for most Turkish women. The MOH's in-service training course discusses other methods, but the pill and condom are the only other methods offered

⁶ The survey, sponsored by the Human Resource Development Foundation, was conducted in Jan.-Feb. 1992 in 31 provinces, including three large cities (Istanbul, Ankara, Izmir). A total of 2082 people were interviewed: 526 ob-gyns, 540 GPs, and 1016 pharmacists and pharmacist assistants (*kalfas*). Human Resource Development Foundation, HRDF briefing document, May 1993.

by most family planning centers; since they are looked upon as inferior, there is little real counseling on method choice -- nor training for this.

For several reasons, including vocabulary, training, and general biases, distinctions between the following concepts are blurred:

- * community education
- * community training
- * group counseling
- * IEC activities (waiting-room type activities)
- * information given on need-to-know basis during service provision

Perhaps as a result of the emphasis on one method, counseling in general does not get the emphasis during training that it does in many other countries. In addition to the IUD bias, the general lack of attention to counseling during training contributes to inadequate counseling on the pill, and thus to its ineffective use (and discontinuation) by a very large proportion of those many women who have tried it.

3. Laudable emphasis on midwives and GPs. Early on, a major difficulty in promotion of IUDs was found to be the poor acceptability to women of male physicians as IUD providers. **Policy-oriented research** initiated in the late 1970s convinced the government that midwives could be trained to insert IUDs and demonstrated that they can do so as successfully as physicians.⁷ Based on this policy research, the 1983 Population Law required that midwives (along with general practitioners, GPs) be trained for IUD insertion. This was a major achievement in extending the accessibility of services, especially given the reluctance of doctors to work in rural areas. As a result, today midwives are major providers of IUD (and thus family planning) services, along with GPs.

4. MOH MCHFP Training Centers. Midwives and GPs are trained for IUD insertion (and family planning) in on-the-job type courses at MOH MCHFP Training Centers. These now number 48 throughout Turkey, the number waxing and waning from year to year. These "training centers" are MCHFP service centers with relatively good client demand for family planning. Midwives spend 4 weeks at such a center, during which time they are to perform 50 pelvic exams and 20 IUD insertions, the number considered necessary by the MOH for

⁷ These were studies conducted by Hacettepe University students of Dr. Nusrat Fisek, Turkey's pre-eminent public health pioneer who, as MOH secretary in the 1960s, was instrumental in overturning Turkey's pro-natalist policy and launching family planning services and who established Hacettepe University's Institute of Population Studies. See: A. Akin, R.H. Gray, and R. Ramos, "Training Auxiliary Nurse-Midwives to Provide IUD Services in Turkey and the Philippines," Studies in Family Planning 11:5:178-187 (May 1980); and N. Eren, R. Ramos, and R.H. Gray, "Physicians vs. Auxiliary Nurse-Midwives as Providers of IUD Services: A Study in Turkey and the Philippines," Studies in Family Planning 14:2:43-47 (Feb., 1983). This was a highly successful use of research to achieve policy changes.

IUD certification. GPs are trained for IUD insertion (and family planning) in 3-week stays at the same MOH training centers. Some GPs have a fourth week of training, which certifies successful participants in MR (menstrual regulation, or early abortion).

5. MOH training capacity extremely limited. The numbers of persons provided the basic in-service course in these centers varies. Generally, only 1 to 3 or 4 persons are trained in any one course. For example, in 1992, of the 48 centers, 38 centers trained 10 or fewer providers. Ten centers trained 30 or more. In 1992, a total of 674 midwives and GPs received IUD training, with 26 GPs receiving the additional week of MR training. This number seems substantial but must be assessed together with other statistics: (a) high personnel turnover rates, and (b) increasing and currently unmet demand for contraception. **In-service training is clearly not producing enough trained personnel to keep up with the need for services.**

6. Refresher training. The 1983 law mandates that all persons trained in family planning/receiving IUD certification should be re-certified every 5 years. This is not done. No re-certification or refresher training program exists. (FHTP is currently committed to provide technical assistance and financial support to begin this activity in September-October, 1993.)

7. Training of trainers. A.I.D. CAs and UNFPA have from time to time provided some TOT (training of trainers) trainers. Central and provincial training teams have been established. However, "trainer" is not a recognized job category. Trainers are simply service providers, academic faculty, or central MOH staff who are tasked with extra in-service training responsibilities and may or may not have received some TOT training.

8. Training for supervisors. Such courses have been offered in some centers over the years, but this is not standardized and seems to have lapsed. According to MOH statistics, the last training for nurse/midwife supervisors was in 1986. There is no special job category for supervisors.

9. Programmatic obstacles to training effectiveness and utilization. Several programmatic obstacles (which are beyond the control of trainers, training managers, and trainees) reduce the contribution training can make to improving family planning outcomes. Primary among these are:

- o "Trainer" is not a recognized job category. Trainers perform training on top of their regular service delivery work without extra compensation of any sort; nor do service delivery sites serving as training centers receive extra personnel to cope with the extra tasks;

- o Frequent turnover of GPs and midwives trained in family planning;⁸
 - o Many midwives trained in IUD insertion lack IUD kits after transfer to new posts;
 - o Lack of advancement opportunities for GPs working in family planning;
 - o Shortages of pills and condoms
 (Quote from a MCHFP doctor: "Yes, it's true many people get these from the pharmacy. But the television tells people to go to the health center for family planning. When they come to us and we don't have these, they lose faith in us and give us problems. Our job becomes hard.") xx
- In Adana, two young female GPs are among the three family planning trainers of the Adana MCHFP Training Center, which is one of the MOH and FHTP's 14 priority training centers. These two young women, Berrin and Sevgi, have been working at the Training Center for about five years each. Their eyes light up when they talk about the importance of family planning and why they like training. Both would like to continue in family planning training, but they also want to move ahead in their careers, and family planning training offers no such possibility. Thus Berrin has decided to go back to medical school to specialize in ophthalmology or physiotherapy. For Sevgi, the opportunity to be trained in MR would be incentive to remain at the center. But this is opposed by a local ob-gyn, and so she too may decide to leave and specialize in some other field.
- o In hospital-based family planning clinics and other settings with ob-gyns present, some ob-gyns do not permit midwives to insert IUDs, despite their certificates and the Population Law. Their reasons include: Clients lack confidence in midwives and prefer ob-gyns; and midwives' training and skills are variable and inadequate.

Recommendations (In-Service Training):

1. **Re-design of the MOH's In-Service Training** (in which FHTP is taking the lead through standardization of MCHFP centers). The effort to improve the quality of in-service training is essential. Training should be re-designed to give greater attention to methods other than the IUD: the pill (emphasizing that low-dose pills are a new product with fewer side-effects), condoms, male and female sterilization, and injection. Norplant should also be covered, with emphasis relative to its availability. Training should include the fact that douching (still relied on by many women and couples) does not prevent pregnancy.

⁸ Statistics on turnover rates are not readily available. FHTP is trying to determine turnover rates for the providers trained at its 14 "target" MOH Training Centers (dating from two years previous through the end of the project). In general, the high turnover is due to: (1) requests by personnel themselves, and (2) personnel being transferred by the MOH's GD for Personnel.

2. **A new strategy for family planning certification should be developed, replacing the current "IUD certification," and giving greater emphasis on counseling and other methods.** Midwives and GPs in health houses and health centers should be trained to counsel in *all* methods, including those they cannot provide, and be able to give clients effective *referral* to facilities providing other methods. Some countries have found it appropriate to have a course and give a certificate in "Basic Family Planning" (covering knowledge and counseling skills for all methods and referral for clinical methods), which is subsequently followed by a "Comprehensive Family Planning" course and certificate (which includes competency in clinical methods). This might be appropriate for Turkey too.
3. **Refresher training and training for supervisors.** A plan should be developed to institutionalize refresher training/continuing education. "Contraceptive updates" on new methods should seize the opportunity to fill in gaps concerning already existing methods and counseling.
4. **Policy-oriented research should be conducted to achieve priority changes needed to facilitate training and achieve service provision goals** (as was done in the late 1970s-early 1980s for IUD insertion by midwives). Topics might include: GPs to perform vasectomy, GPs to perform minilaparotomy, injectables to be provided by midwives, GPs, and pharmacists (not confined to ob-gyns as has been mentioned).
5. **The role of (family planning) trainer should be formalized and professionalized.** A career track should be established which includes protection from random transfer and some salary adjustment or incentive for people who take on a training responsibility. It might be possible to do this in conjunction with the "Family Practice Specialization" that was legally created a year or so ago. (How this is specialization is to be established in reality is unclear.) Other possibilities should also be tried, complemented by non-monetary incentives (e.g., "Trainer of the Year" designation.)
6. **Training CAs should provide a modest amount of equipment to assure that all trainees have the equipment necessary to provide the family planning services that they have been trained to provide.** In the past, A.I.D.'s Office of Population has not permitted training CAs to provide equipment and/or supplies. This should be permitted, and provided.
7. **The proposal for support to a comprehensive training center at Istanbul University should be considered as part of an overall country training strategy.** It has been suggested that A.I.D. support the family planning component of a proposed comprehensive MCHFP training center at Istanbul University, sponsored by its Faculty of Medicine and Institute of Child Health. (Some services are currently being provided and facility renovation is being financed by the EEC.) This center would aim to present a model of comprehensive quality care, offer in-service training to personnel whose needs and time availability do not fit the MOH's 3- or 4-week course, and become self-sustaining by charging fees for services and for training, including international training.

The financial feasibility of the proposed scheme, and its potential for contributing to overall family planning objectives in Turkey, should be evaluated.

PRE-SERVICE FAMILY PLANNING EDUCATION AND TRAINING

1. Medical students: Pre-service family planning training is inadequate and variable by school. Some 5,000 medical students graduate each year. At this point they are GPs required to do one year mandatory rural service. Most have not had a comprehensive, up-to-date grounding in basic family planning attitudes and knowledge -- let alone developed competency in IUD insertion or other family planning clinical skills.

Turkey's Council of Higher Education (YOK), which regulates Turkey's 24 medical schools, specifies that all schools include a set number of hours (25?) on family planning. The content and approach is up to individual schools, however. Some include family planning in a Department of Public of Health, others in Ob-Gyn. Some use a local MOH center for clinical training (or exposure), but most have no clinical training facilities. Universities in Istanbul and Ankara have been potential capacity for family planning training, but have not used this capacity.

2. Integrating family planning into pre-service medical curricula has been a low priority. Efforts are under way with JHPIEGO to standardize and improve family planning training in the curricula of 8 leading medical schools (after which this should take place in the remaining medical schools). This includes plans to train all medical students in IUD insertion; it is also projected that they should achieve *competency* in IUD insertion before graduation.

Of the 9 facilities chosen by JHPIEGO to become "clinical practice sites" (facilities where medical students from the 8 schools can be trained to achieve competency in IUD insertion), 7 are among the target 14 MOH MCHFP centers chosen by FHTP for its upgrading and standardization of in-service training.⁹

3. Midwifery and nursing students: More emphasis is given to family planning, but this is not standardized and there is little opportunity for clinical training. This training is carried out under the auspices of the MOH (GD/HT). Efforts are under way with FHTP for upgrading and standardizing midwifery education. The recent raising of entrance requirements for midwifery school (from 8th grade to 12th grade) should have a major impact on improving the performance of midwives. This is crucial, given that midwives are the main providers of family planning services in Turkey.

⁹ These are: in Ankara, Gulvaren Clinic and Zekai Tahir Burak (ZTB) Hospital; in Istanbul, Zeynep Kamil Hospital; in Kayseri, Kayseri Maternity Hospital; in Konya, Konya Maternity Hospital; in Izmir, Izmir Maternity Hospital and Izmir MCHFP Center. Included as JHPIEGO's two additional clinical practice sites are: Etlik SSK Hospital, in Ankara, and Esksehir Hospital in Esksehir.

Recommendations: Pre-Service Education and Training

1. **Much more serious effort must be made to develop family planning knowledge and skills at the pre-service level.** The in-service training capacity of the MOH simply is not keeping pace with need (is described by some as a "drop in the bucket").
2. **A primary goal of pre-service education should be to develop positive family planning attitudes and basic knowledge regarding all methods of family planning among all doctors, midwives, and nurses -- i.e., to overcome the current provider bias.** All medical, nursing and midwifery students should be taught that different methods may be appropriate for different individuals and at different stages of a woman's reproductive life or couple's life together. All students should be taught the principles and importance of counseling, both for different methods and for effective method use.

Special efforts must be made in pre-graduate medical education in order to counter the prevailing provider biases against specific aspects and methods of family planning. Positive family planning attitudes and knowledge should be presented in a well-designed module and also included in other courses where appropriate (e.g., pediatrics). *Clinical training in IUD insertion is not enough.* To overcome negative attitudes and provider biases, basic attitudes and knowledge need to be presented earlier than at the time (end of undergraduate education) when IUD clinical training might be made available.

3. **Clinical training should be provided to all medical and midwifery students where adequate clinical practice sites or opportunities can be developed.** It is not clear, however, that it is realistic to expect that all medical students should graduate with IUD insertion competency.

Recommendations: General

1. **Manpower projections should be carried out to arrive at a clear understanding of the trained personnel needed to meet Turkey's increasing demand for contraception.**
2. **A comprehensive "Training Strategy for Family Planning Service Delivery in Turkey" should be developed.¹⁰ *Its goal should be to increase the number of well-trained family planning service providers in Turkey in order to meet manpower need projections.*** Objectives related to this goal should be: to standardize information presented in pre- and in-service training, to upgrade the quality of this training, to improve the efficiency with which training is provided, and to identify obstacles that prevent training from being well-utilized in service delivery.

¹⁰ This does not mean "needs assessment." Good needs assessments have been done and are also underway through FHTP activities.

3. **Efforts should be made at the policy level to remove programmatic impediments that constrain training and prevent full utilization of trainees and their skills.**
4. **Greater emphasis should be placed on pre-service education than at present. In-service training alone cannot keep up with demand.**
5. **FHTP should be designated A.I.D.'s "lead CA" for training.** FHTP is working in a clearly articulated **systems approach** with both MOH directorates responsible for training (GD/MCHFP and GD/HT). It should work with these directorates to develop a comprehensive training strategy and coordinate the inputs of the other CAs. JHPIEGO should play a major role in the pre-service area, including with YOK and the medical schools. A.I.D.'s service delivery CAs and UNFPA should also be involved.

* * *

ADDITIONAL ISSUES AND RECOMMENDATIONS CONCERNING A.I.D. CAs

1. **JHPIEGO-FHTP overlap on standardization of training sites.** FHTP is engaged in a series of activities aimed at standardizing and upgrading the quality of the MOH's MCHFP Centers which the MOH uses as MCHFP Training Centers. FHTP is already at work on 14 of the 48 MOH Training Centers.

JHPIEGO has also initiated activities aimed at upgrading and standardizing 9 service delivery sites, intending that these should become clinical practice sites for students of 8 university medical schools. Of the 9 sites JHPIEGO has identified, 7 are MOH MCHFP Training Centers with which FHTP is already working.

Recommendation: **FHTP and JHPIEGO should work together on standardization. FHTP should take the lead with regard to overall issues,** given the systematic facility assessment and related work it has already completed and initiated. JHPIEGO should take the lead with regard to clinical procedures.

2. **National training strategy.** As described above, **FHTP and JHPIEGO should work together in developing a national training strategy and plan that will guide their activities and those of others involved in training.** FHTP should take the lead in this, beginning immediately, in conjunction with its ongoing standardization activities. All training efforts by FHTP, JHPIEGO and other CAs should be designed in accord with priorities established in the national training plan.

3. **FHTP is doing very important work with relatively limited resources.**

Recommendation: **Turkey, FHTP resources should be substantially increased to enable it to speed up and facilitate its work and to take on the new "lead CA for training" role.** FHTP should hire a full-time Turkish national as professional staff (based in Ankara);

FHTP's Regional Advisor who now works part-time on Turkey should become full-time for Turkey. Given that FHTP personnel currently work out of the Pathfinder Regional Office in Istanbul, but often need to work in Ankara with MOH and CA personnel, office space should be made available (full-time) in Ankara for use by FHTP personnel. This should be in or nearby the AVSC-SEATS offices, where costs could be shared for additional equipment support. There should also be more technical support visits to Ankara by the Istanbul-based staff, and more visits to Turkey by Development Associates' specialized technical staff.

4. **Resident advisor for JHPIEGO.** There is definite need for JHPIEGO to have a **full-time** resident advisor. JHPIEGO currently works through Turkish project directors for its various subprojects, but these persons often have multiple competing demands on their time. This places severe limitations on JHPIEGO's ability to achieve objectives, or means that it moves slowly in doing so.

For example, establishing clinical training sites for the 8 medical schools is not a new activity. The 8 schools (or most of the 8) were apparently identified in years previous to JHPIEGO's June 1992 designation of the 8. But changing curricula and developing clinical practice sites is a difficult task requiring substantial sensitive negotiations. To move forward with any alacrity requires more than occasional involvement and visits from Baltimore.

Recommendation: JHPIEGO should hire, on a full-time basis, a Turkish professional who can work closely and collaboratively with the A.I.D. representative and FHTP Turkey advisor as well as with the medical schools and YOK. The main tasks of this advisor should be: (a) to coordinate with FHTP on standardization of training centers and training; (b) to develop and implement a comprehensive strategy for integrating positive family planning attitudes and basic knowledge into all medical school curricula; and (c) to develop the planned clinical practice sites for the first 8 medical schools.

This advisor should also be based in Ankara (ideally, in the CA office cluster).

5. **Laparoscopes.** JHPIEGO's early involvement in Turkey centered on the provision of laparoscopes to ob-gyns potentially able to use them for female sterilization. Perhaps 100 or so are still around. JHPIEGO continues to provide spare parts and support a "RAM (repair and maintenance) Center" at the MOH for these instruments. Their use and maintenance is problematic, however. Many are now old and have fallen into disrepair and non-use. Many of the instruments are laparacators which have limited capabilities and thus are not liked by today's ob-gyns. Apparently most ob-gyns now use German-manufactured laparoscopes, which the spare parts provided by JHPIEGO do not fit. In addition, AVSC is providing laparoscopes (the German instruments, for which parts and servicing are more readily available) to gynecologists directly involved in its efforts to expand female sterilization. JHPIEGO has been asked to explain how its provision of spare parts fits into an overall strategy, but has not yet done so.

Recommendation: What are the costs, and benefits to family planning, of continued provision of spare parts for these laparoscopes? JHPIEGO should be required to answer this question. It should either terminate provision of parts or outline and implement a cost-effective plan that advances family planning objectives.

Annex 4.B. CLINICAL SERVICES

General Strengths in the Clinical Service Environment

Several characteristics make for a positive environment for the provision of clinical methods of family planning in Turkey.

First, there are few legal or governmental policy barriers to any approved family planning method. Second, there are some progressive laws and service policies -- most notably those allowing midwives and GPs to insert IUDs when trained and certified to do so.

Third, there are ample clinical facilities (over 15,000 hospitals and other health service sites, mostly of the MOH and SSK) and a large number of health care providers (4,000 Ob-Gyns, 20,000 GPs, 39,000 midwives, and an additional number of nurses).

Fourth, there is very high awareness of family planning, high use of some form of contraception (63%), even higher "ever-use," and very high demand to limit family size. (Abortion is very widespread: 35 per 100 live births, and probably under-reported; 44% of families have more children than they actually desired; 76% of all women and 74% of their husbands want no more children, going up to 84% of those with 2 children and 93% of those with 3 children.) This high demand implies great need for availability of long-acting clinical methods, and has been reflected in high and continuing use of these methods in Turkey in situations where quality services have been made available.

General Weaknesses of the Clinical Service Environment

On the other hand, there are many negative factors which result in the relatively low use of modern methods: only 31%. This is substantially below what would be expected given Turkey's relatively high socioeconomic level and ample service infrastructure. Many negative factors are especially apparent with regard to the government's role in family planning service provision.

First, the government's resource allocation for family planning does not mirror its rhetorical commitment to reducing fertility. There is not even a separate line item in the Government of Turkey's budget for family planning. As in many countries, there is a strong systemic bias, in terms of emphasis and resource allocation, favoring curative rather than preventive practices.

Second, there is no governmental body with adequate authority to coordinate work and directives of other government units whose mandates involve or influence family planning services. Within the MOH, there is a fragmented structure as concerns family planning. The highest governmental body responsible for family planning is the MOH's General

Directorate for Maternal and Child Health and Family Planning (GD/MCH/FP). But this is only one of 5 different general directorates (GDs) involved directly or indirectly in some aspect of family planning services (and sits organizationally at the same level as the other 4). Although the GD/MCH/FP has formal responsibility for coordinating and leading family planning services in Turkey, it has limited authority. For example, of the 14,000 service sites for which the GD/MCH/FP is formally responsible, it directly operates only 200 MCH/FP centers. (It is noteworthy, and perhaps not unsurprising, that these MCH/FP centers provide a disproportionately high amount of total clinical services, and a significantly higher amount of services per service site. See Annex, Graph # __)

Third, and related to the general fragmented structure, services are poorly linked, with physical separation between delivery, abortion, and family planning service sites. These are under different administrative jurisdictions, typically with no system for or thought to referral and, consequently, poor continuity of care. This weakness in management systems and structures is often mirrored by weak management of service sites and lack of commitment on the part of service site administrators to making family planning services a priority and thus readily available.

Fourth, the GD/MCH/FP has little control over personnel placement and transfers. This is very serious. It means that the GD/MCH/FP can do little to retard the frequent turnover of trained family planning personnel: family planning service providers and family planning trainers. This exacerbates the situation at clinical service sites, a large percentage (60-65%) of which do not offer family planning services due to lack of trained personnel.

Finally, in both the public and private sectors, serious medical policy and practice barriers exist. Most notably these include an almost universal provider bias against oral contraceptives (in favor of the IUD). Also serious are limitations on who can perform sterilization and where it can be done (female sterilization only as a hospital inpatient procedure). These barriers to contraceptive use are exacerbated by widespread client ignorance and misconceptions about modern family planning methods and by economic incentives for providers that often work to favor abortion rather than contraception.

All of these factors lead to very ineffective contraceptive practices, inconsistent with the fertility intentions of users and marked by high discontinuation rates, high failure rates, high use of traditional methods, and high abortion rates.

Specific Findings: Service Delivery Channels

The MOH and the SSK (social security system) are the main providers of clinical family planning services. Consequently, the majority of AID assistance in clinical family planning services goes to these two service systems.

The MOH is the largest provider of clinical family planning services. It is officially responsible for the provision of free or low cost preventive care including family planning services to persons in need. The MOH provides the majority of the IUDs in Turkey (about 55 of the some 300,000 inserted annually), and most of the family planning in rural and impoverished areas of the country.

The SSK covers 40% of the population. It formerly provided only curative services, but now, with AID assistance, some SSK facilities are providing clinical family planning services. The SSK system is relatively well-endowed, both financially and in terms of service sites (107 hospitals and 320 other service sites throughout Turkey). There is strong support among SSK leadership, and in the MOH, for making preventive services (notably family planning and immunization) available in the SSK system. The SSK system is relatively decentralized, however, so that individual hospital directors have much authority. Where the hospital director is committed to making family planning services available, service provision has risen quickly and dramatically. (See Bakirköy Case Study.)

As for other service delivery channels, NGOs provide minimal clinical services. The **for-profit sector** comprises largely the same personnel working in MOH and SSK facilities. Finally, **municipalities** and the **army**, which have facilities and varying degrees of interest in providing family planning services to their constituents, are not yet doing so to any significant degree.

Specific Findings: AID's Cooperating Agencies (CAs)

The AID CAs involved in clinical service delivery are SEATS, Pathfinder, and AVSC; these generally work well with each other, with other relevant CAs, with the Embassy's Population Advisor, and with the MOH and other counterpart organizations. There is effective collaboration and true coordination. Specifically:

SEATS

The SEATS program is totally with the SSK and represents a real partnership. It builds upon 1982-1989 work of an AID-funded project of Family Planning International Assistance (FPIA). SEATS assistance to the SSK began in 1992 and extends for 2-1/2 years (when the current SEATS contract expires.) It is well-staffed and adequately funded.

The SSK-SEATS partnership entails a well-conceived, *systematic* approach to the rolling out of the full range of quality family planning services within the SSK, with a goal of expanded service availability to 40% of Turkey's population. Commodities, management and clinical training, and other technical assistance is provided to individual SSK facilities that indicate interest and commitment to providing clinical family planning services to

their clientele, and substantiate it by demonstrated performance. Commodities are provided for only 2 years, with the SSK committed to subsequent purchase with its own funds.

There are excellent prospects for institutionalization and sustainability, particularly given the high commitment of the SSK leadership and the fact that provision of clinical family planning services is cost-effective and in the evident self-interest of the SSK. (A quick, preliminary cost savings study conducted by SSK and SEATS indicated that a 13:1 cost savings would be realized by providing these services throughout the system. Estimates were that the total savings to the SSK would be equivalent to the annual budget of five 200-bed SSK general hospitals. It may well be that this is an underestimate of cost savings, since calculations included only the costs of pregnancy and delivery care, but not subsequent child care for the estimated 24,000 births averted.)

In just a short time, a number of units (e.g., Etlik SSK Maternity Hospital and Bakirköy SSK Maternity Hospital) have demonstrated marked improvement in performance, and have been designated training centers. Other CAs, the MOH, and some medical schools may use these centers for their own training activities as well. Study tours have resulted in a number of hospital directors becoming strong advocates for provision of these services (see Bakirköy case study.) This is a good example of the catalytic nature of the SEATS' work with the SSK.

Quality, and medical policy and practice barriers, have also been addressed. Counseling is better; nurses/midwives insert IUDs. In some centers GPs perform tubal ligations and vasectomies and tubal ligations are performed as a hospital outpatient procedure. Thus there is a good prospect for the development of training centers which are also service "centers of excellence" and to which site visits can be made by MOH and SSK policymakers and decision-makers. Such site visits can play a major role in helping to change unnecessarily constraining attitudes and practices.

Finally, there is excellent collaboration between SEATS and AVSC (which share an office and work together to introduce tubal ligation) and with Pathfinder (all 3 are collaborating on introduction of vasectomy within the SSK), and with the other AID CAs working with the SSK. The MOH is strongly supportive of this effort, as are the Turkish labor union federations which comprise the bulk of SSK membership.

Pathfinder

Pathfinder has been a *true "pathfinder"* in terms of AID-supported service delivery in Turkey. No other CA has made a greater contribution to the initiation and diffusion of family planning approaches, and to organizational development. Pathfinder has established important NGOs, supported training, introduced community-based family planning services which feature effective referral to MOH facilities for clinical methods, and has demonstrated unequivocally that high demand exists for such services.

Pathfinder has also worked successfully in a number of venues to train providers and introduce services, particularly in underserved squatter areas and in the poorer regions of Turkey.

Current Pathfinder activities involving clinical services relate to 3 types of activities, selected for the target of opportunity which each represented. One is **Community-Based Services** (a large program in Izmir, and one in southeast Turkey, which do not provide clinical services directly but acts as a catalyst through counseling and referral). A second area is **vasectomy support** in several SSK facilities. A third is work with the **Turkish Confederation of Tradesmen and Craftsmen (TESK)** to advance family planning among its members. These activities are implemented through Pathfinder support to two NGOs -- the Human Resource Development Foundation (HRDF) and the Foundation for the Advancement and Recognition of Turkish Women.

Activity #1 is discussed in the section on non-clinical services and outreach (see Section ____). Activity #2, the introduction of vasectomy, began in 1988 (before the SEATS-SSK effort and before AVSC had an in-country presence in Turkey) upon the request of several urologists to Pathfinder. Pathfinder has provided training in a new technique, no-scalpel vasectomy (which has been disseminated into many national programs by AVSC). In addition to training, Pathfinder has also provided salary support and other technical assistance. During the past 2 years, Pathfinder has funded the HRDF as an NGO to manage the vasectomy program activities. Pathfinder is proposing to "expand its current program in all the SSK hospitals in Turkey in order to increase its availability and accessibility."

Pathfinder's work with TESK, Activity #3, involves funding of clinics, promoting family planning to TESK leadership, and training of male and female motivators and educators. TESK members as a group have much higher fertility than Turkey as a whole. This work was initiated in 1988 and was a promising attempt to diffuse family planning into the TESK network, since TESK has 3.8 million members (19 million including their families). However, unlike the SSK, TESK does not have its own network of facilities; almost all TESK members get services through MOH facilities, diminishing the potential multiplier impact that working in this system might otherwise have had. Thus, although this may clearly have been another true pathfinding idea at the outset, it appears that the original goals are unlikely to be met and that the premise upon which the effort was based (of being a catalyst and having a meaningful multiplier effect) is no longer valid.

AVSC

Since establishing a limited in-country presence in 1992, AVSC has made clear progress in several important areas. AVSC has established an effective partnership with SEATS, sharing a headquarters office and complementing and meshing with SEATS' work in the SSK. In AVSC's work to provide equipment, training, and technical assistance in both the MOH and SSK systems, AVSC has had a strong impact despite the presence of only

one in-country individual.

AVSC has played a key catalytic role in helping to introduce several important new clinical family planning technologies to Turkey. It has the strong support of the GD/MCH/FP, which has designated AVSC as the lead agency to assist the MOH in introduction of Depo-Provera and NORPLANT®. In this role, AVSC co-hosted (with JHPIEGO) 3 seminars to present these new methods to the leading Ob-Gyns of Istanbul, Ankara, and Izmir. AVSC also provided technical assistance to the MOH to develop a strategy and plan for the phased and coordinated introduction of these methods.

AVSC has also provided both clinical and counseling training, equipment and renovation, and other technical assistance to key MOH and SSK facilities to improve the quality and availability of female sterilization and postpartum IUD insertion. Both have risen significantly, by several hundred percent in some facilities (see Graph __), which has demonstrated their acceptability and feasibility to medical opinion leaders and decision-makers in the two systems. It is noteworthy that this is being accomplished without salary support needing to be provided.

In short, the prospects for these important AVSC initiatives related to timing (postpartum and post-abortion) and method (VSC, IUD, Depo-Provera) are excellent. Furthermore, AVSC provides valuable technical assistance in clinic management through its COPE (Client Oriented Provider Efficient) approach to service provision. These activities address in a systematic manner the need to provide high-quality clinical contraception to the 75% of the Turkish populace who want no more children.

CLINICAL SERVICES: METHOD-SPECIFIC FINDINGS

IUD

- generally a very cost-effective method
- the most popular clinical method in Turkey (14% CPR in 1988)
- associated with much provider bias against other methods
- an ideal method for post-partum and post-abortion contraception (and in some pilot programs, has been very frequently chosen)
- midwives, nurses and GPs allowed to provide (after appropriate training), thus enhancing availability
- infection prevention (asepsis) is inadequate in many facilities
- screening for contraindications is sometimes inadequate

Sterilization

- not widely available (only 1.7% prevalence)
- low awareness among women (35% unaware of tubal ligation; 72% and 58% of their husbands unaware of vasectomy)
- low skill and motivation among many providers
- potentially very acceptable, if available
- appropriate (76% of Turkish women want no more children)
- much latent demand which is actually "easy" to translate into services (In countries where trained providers, good counseling, and client outreach exist, tubal ligation statistics go way up)
- no strong cultural bias against sterilization (Turkey's population more Westernized and secular than in Tunisia or Bangladesh, both Muslim countries with much higher sterilization prevalence.)
- difficult to privatize (expensive to clients; hard to amortize)
- very cost-effective to client and system
- two serious medical-policy and practice barriers to services exist in Turkey: sterilization, particularly tubal ligation, can only be provided by specialists, and only as an inpatient service

Injectables

- only recently approved for limited introduction
- not yet a program method
- potentially very popular (from worldwide experience, from reports of injectables already being smuggled in from Western Europe and Syria, from cultural preferences for injections)
- planned to be introduced in a carefully phased way (initially in the public sector)

with AID-donated commodities)

- UNFPA does not plan to provide the method to Turkey
- if proves to be popular, will rapidly expand to the private sector since cost per dose will be low
- much potential to be misunderstood, misedelivered, etc., (i.e., "ruined") particularly since bleeding side effects of one sort or another are highly likely, and counseling is poor

NORPLANT®

- not yet a program method
- commodity cost alone 30 times greater than IUD, with greater program costs as well
- likely, because of expense, to be a relatively marginal program method (more likely in SSK, and for-profit private sector)
- carefully phased introduction planned
- introduction dependent on arrival of AID commodities
- presence in a program expands method choice
- requires good training, counseling, attention to follow-up and subsequent removal

Annex 4.C.

COMMUNITY BASED FAMILY PLANNING SERVICES IN TURKEY

Community Based Family Planning Services (CBS) are usually non-clinical outreach service that are provided outside of the traditional clinical or fixed facility. Services are usually provided by non-professional health workers in the community, the work place or in a commodity depot. CBS are most commonly used as a FP intervention when fixed facilities and health professionals are inadequate to meet contraceptive demand or where passive approaches (mass media, clinic visits, etc.) to demand creation are less effective.

Often CBS services are targeted to sub-populations that are less accessible to program services - the young, the poor, the rural, working women, the urban, etc. A number of social, cultural, economic and demographic characteristics could lead one to assume that Turkey would not be a good candidate for CBS. It has a relatively strong infrastructure of clinics and clinic based staff; demand for fertility control, and to a lesser extend modern contraception, is already high; knowledge is also high; women are relatively literate and have access to mass media; and the private sector provides some contraceptives throughout the country. In this environment, the awareness and demand creation and basic distribution of commodities generally associated with CBS would seem to be redundant. However, CBS has taken an unusual approach in Turkey and has found itself a successful niche in the program.

In Turkey, CBS activities have focused on the use of local women to educate, motivate and distribute contraceptives, using primarily NGO type structures. Currently there are four CBS projects. All four will be briefly described and a review of data will be provided to elaborate the impact of current CBS activities. The Pathfinder/Human Resource Development Foundation Project in Izmir Province (hereafter called the Izmir Project) is A.I.D. funded, as is the CEDPA/Ankara Project and the Urfa Project. The Family Planning Association of Turkey also runs a number of small CBS projects in various stages of operation. These activities are funded by IPPF and the Economic Community of Europe.

The Izmir Project was implemented in 1986 under the management of the Human Resources Development Foundation. The Project selected two slum districts to recruit unemployed women living in the community to work as family planning promoters. The workers were trained for one month before starting on a full-time basis to identify at-risk women in the community, educate through home visits, do referrals for examinations and clinical methods, and distribute commodities. The Project has worked closely with MOH facilities in the area to ensure quality clinical back-up. The project is notable for many reasons, but one is the success it has had in supporting and getting support from MOH. The Project is also notable for its strategy of "rolling over" communities. The paid CBS workers cover an area for about one year when home visits stop and the client must seek services elsewhere. The Worker can move to a new neighborhood or can leave the

position. The potential sustainability of the Project is good because of the lack of long-term commitment to the staff and clients, which is understood by all. The quality of service and its impact is very high. The project staff are currently providing technical support to the Urfa Project in Eastern Turkey.

The availability of FP services in the Eastern Area of Turkey is limited by lack of infrastructure, ethnic divisions, political instability and the difficulty of providing services to a widely distributed rural population. The Foundation for the Advancement and Recognition of Turkish Women has attempted to improve the situation by providing CBS in Urfa Province with financial support from Pathfinder. The Project has 50 CBS workers providing services to about 7,000 active users. The Project has two clinics and mobil units which are used to augment services from the MOH. Clinical staff are contracted from private practice, MOH and the universities. Clients are technically urban residents since the project sites are in the main provincial urban centers. However, the project comes much closer to serving rural women than any other project.

CEDPA has worked with the Ankara Municipal Authority to provide FP services to its slum dwelling couples. The Municipal Authority is a local government, but operates independently of the national government. The Ankara Project uses CBS workers to educate, recruit, and motivate couples wanting services. The Authority has set up four clinics to provide back-up support. Clients wanting VSC or having other problems are referred to a MOH maternity hospital. The Project is notable for several reasons. The level of political support is incredibly high. The Municipal Authority has taken over funding of the Project with the withdrawal of CEDPA funding. The Project charges for commodities and has built up a fund which has allowed it to continue to operate. CBS workers are paid a honorarium. The Project uses the same roll over mechanism that the Izmir Project uses, with workers moving to new areas or leaving the project. The project has had significant impact on the status of the women involved (one of the reasons for its political and community popularity). The Project covers a population of about 400,000. It has achieved very high prevalence levels in its catchment areas. The Project is clearly sustainable without external support and it is replicable. Several other municipal authorities have expressed an interest in providing similar services.

The Family Planning Association of Turkey (FPAT) is developing a CBS project in Umraniye a suburb of Istanbul. The area is a popular destination for new rural migrants. The project will serve a population of 350,000. Based on the project proposal, The 19,000 couple years of protection should cost about U.S. \$1.40. FPAT is also planning a similar project for Ankara. However, the focus will be on safe motherhood, with FP only one element of a series of related primary health care interventions. The EC is the proposed source for funding for a CBS project in Adana-Mersin. This project will cover a population of about 170,000 at a cost per projected CYP of U.S. \$4.00. FPAT has no currently operating CBS projects. Their last CBS project, which finished in 1989, will be the model and material source for the new activities.

Most of the projects described above have built an evaluation component into the project. As a result, most have data to support their claims that CBS is effective and

there is a role for these types of services in modern-day Turkey. Summarized below are some of the data made available to the Evaluation Team. These data were project generated and not independently verified. However the similarities in impact across projects is an indicator of the validity of the internal evaluation efforts. The data presented below are internally consistent, but are not internationally comparable because of the common practice in Turkey of using more limited base populations in calculating rates. If international standard definitions were used prevalence would be considerably lower.

IMPACT ON PREVALENCE (see Figure 1)

- In the Izmir Project population, modern method prevalence went from 34% to 73% in 2 years.
- The Urfu Project increased modern method prevalence from 17 to 63%.
- CBS seems to have a catalytic effect on contraceptive use. The data from Ankara indicate that there is significant new use in the first six months of the project, then it slowly declines as the pool of potential new acceptors is depleted. Figure 1 indicates that the strategy being used in most CBS projects, of initiation, high impact and withdrawal of services, is a rational one for maximizing impact and minimizing costs.
- In Izmir, the project did periodic follow-up of clients to see if they continued using after CBS was discontinued. In one district prevalence measured during the last visit by a CBS worker was 89%. It had declined to 84.3% after one year without project activity. In another district it dropped from 88.1% to 82.4%. These results suggest that the major hurdle in getting couples to use FP is the initial clinic visits and introduction to a new modern method - a hurdle which seems to be easily scaled by a well trained community member.

COSTS

- The Izmir Project estimates that it cost about U.S. \$25 per CYP in the first year and \$8.5 for the second year. (Note that the Project does not provide services after the second year even though continuation remains high.)
- In Urfa, Each CYP in the first year cost U.S.\$20 and dropped to \$18 in the second year.

IMPACT ON METHOD MIX (see Figure 2)

- The Ankara Project was able to achieve a major shift in method mix in one year. The drop in withdrawal and increase in oral and IUD use shown in Figure 1 is especially notable.

POPULATION SERVED (see Table I)

- CBS has been serving primarily the urban poor. Most often the clients are recent migrants from rural areas. As a consequence, CBS areas tend to have high turnover and thus provide a greater target population than the traditional baseline would measure. Table 1 below shows The client migration experience of two districts covered by the Izmir Project. Gumuspala Yamanlar experienced a 44% growth in the population of eligible women due to in migration, and a 30% drop due to out migration. These migrants are usually the least informed of service availability. They are recent arrivals from the high fertility areas of Turkey. The conclusion is that CBS projects serve a unique and needy population and that they serve more couples than traditional evaluation techniques would give them credit for.
- The Izmir Project found that the baseline survey reported that in their population of eligible women the mean age was 25, mean number of pregnancies was 5 to 6, mean number of living children 3-4 and most has finished only primary school.
- In interviews with the staff of clinical facilities that supported CBS activities, one of the contributions cited was the workers' ability to bring marginal clients in for service - those clients who would never come in alone, but who want and need service.
- CBS workers interviewed by the Evaluation Team report that husbands do not get involved until after a second or third home visit. However they are interested, willing to talk to the usually female CBS worker and have a lot of method specific misinformation.
- The Izmir Project data base keeps a tickler file of pregnant women in the community with their due dates, so that visits can be planned before and after delivery.
- CBS in most countries focuses on distribution of commodities to increase availability. In Turkey the projects, because of their short period of coverage, focus on generating demand and getting couples to clinical facilities. Data from the third quarter 1992 for Izmir shows the pattern of referrals. 8,521 women were contacted during the quarter. About 16% or 1337 were referred, as shown in Table II.

Table I - Izmir Project: Population Change During CBS Project Life

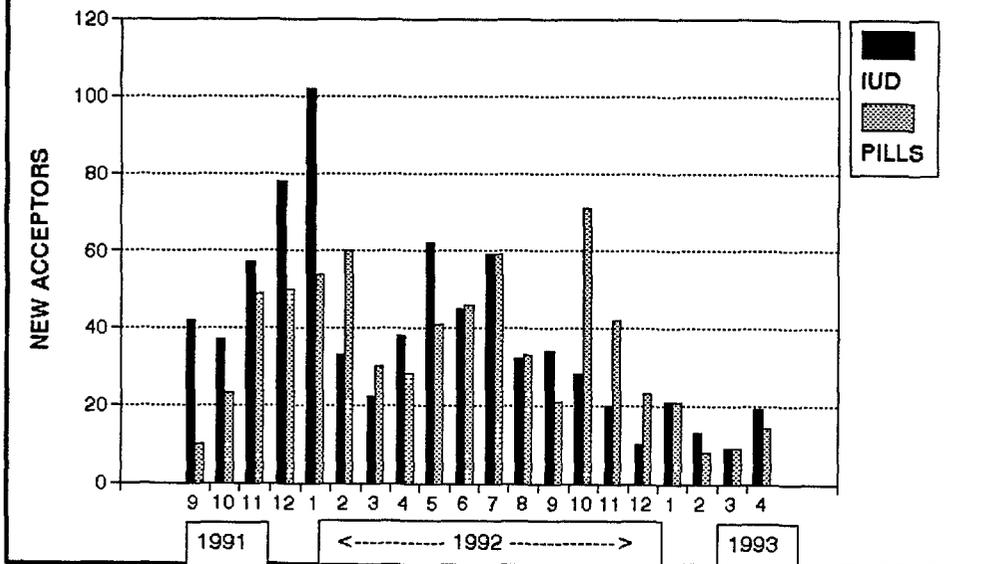
	Gumuspalc Yanular	Guzeltepe Bagrakli
Eligible women in Project Area	8,321	16,165
In-migrants during project	3,641	3,340
Out-migrants during project	2,506	2,445
Total Women Exposed to Project	11,962	19,515

Table II - Izmir Project (3rd Quarter 1992): Reason for Client Referral

	%	N
Total referred	100.0	1337
New pill users	4.8	131
Pill checkup	14.4	192
Pill side effects	0.0	0
IUD checkup	12.0	161
IUD insertion	49.0	655
Tubal ligation	14.6	195
Vasectomy	0.2	3

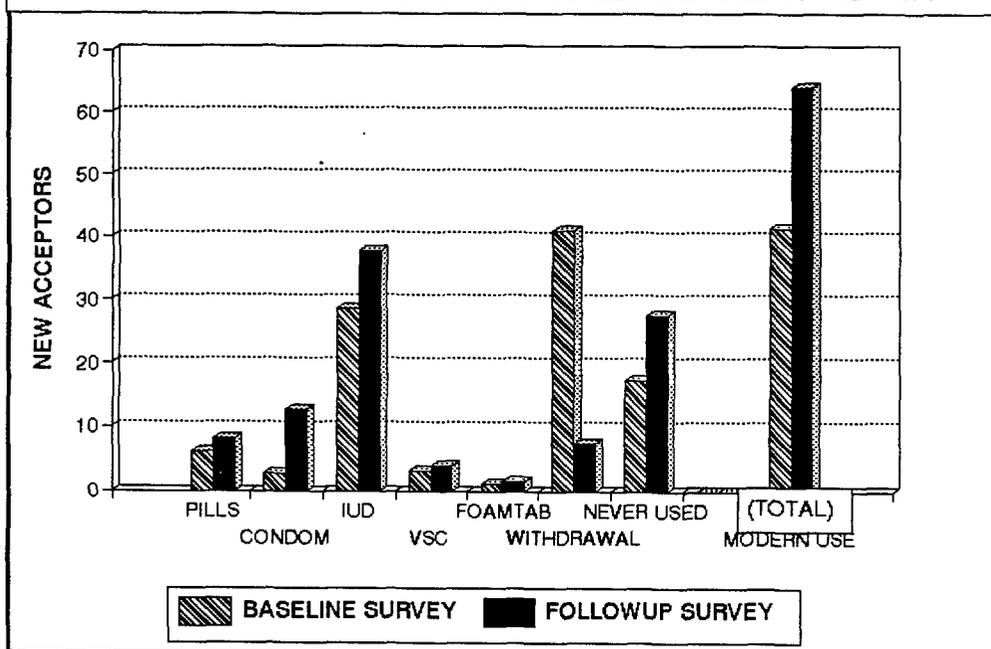
ANKARA CBS PROJECT

NEW ACCEPTORS BY METHOD AND MONTH



ANKARA CBS PROJECT

PROPORTION USING SPECIFIC METHODS IN BASELINE & FOLLOWUP SURVEYS



COPY FOR YOUR
INFORMATION

UNCLASSIFIED
AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

ROY
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ACTION AID-00

ANKARA 07522 00 OF 02 161110Z 8296 047701 AID2201

ACTION OFFICE POP-04
INFO RDA0-01 HEAL-04 HHS-09 AMAD-01 EURM-01 EUDR-03 EUDP-03
MLC-01 /027 AB 16/1528Z

THE COUNTRY WORKPLAN WILL THEN BE DISCUSSED AT A
TURKEY COOPERATING AGENCIES MEETING TO BE HELD IN
MID-NOVEMBER IN WASHINGTON WITH THE PARTICIPATION OF
THE CA REPRESENTATIVES, THE EMBASSY POPULATION ADVISOR
AND AID/WASHINGTON STAFF.

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US EMBASSY, RD/POP AND EUR/DR WILL FINALIZE AND
APPROVE THE COUNTRY WORKPLAN BY DECEMBER 15, 1993.
THE COUNTRY WORKPLAN WILL THEN GUIDE ALL THE
ACTIVITIES OF THE COOPERATING AGENCIES IN TURKEY FOR
1994.

R 161106Z JUN 93
FM AMEMBASSY ANKARA
TO SECSTATE WASHDC 1086

IF THIS PROCESS PROVES SATISFACTORY, A SIMILAR
PROCEDURE WILL BE FOLLOWED ANNUALLY.

UNCLAS ANKARA 07522

AIDAC FOR RD/POP -- ROY JACOBSTEIN
TURKEY WORKING GROUP MEMBERS
EUR/DR/HR -- KATHLEEN McDONALD
INFO FOR EUR/PDP

4. SUBPROJECT PROPOSALS: INDIVIDUAL SUBPROJECT
PROPOSALS WILL FLOW FROM THE MASTER WORKPLAN.
NONETHELESS, ALL SUBPROJECT PROPOSALS WILL BE
SUBMITTED TO THE US EMBASSY IN ANKARA IN A TIMELY
FASHION FOR APPROVAL, WITH COPIES TO THE RD/POP TURKEY
COUNTRY SPECIALIST AND THE EUR/DR/HR COUNTRY BACK-STOP.

E.O. 12356: N/A

TAGS: N/A

SUBJECT: POPULATION: STANDARD OPERATING PROCEDURES FOR
RD/POP COOPERATING AGENCIES WORKING IN TURKEY

THE EMBASSY WILL REVIEW AND APPROVE THE SUBPROJECT
PROPOSAL AND NOTIFY RD/POP BY CABLE FOR FINAL
COGNIZANT TECHNICAL OFFICER (CTO) APPROVAL, WITH
COPIES ALSO SENT TO RD/POP COUNTRY SPECIALIST AND
EUR/DR/HR COUNTRY BACK-STOP.

1. SUMMARY: DURING THE STRATEGIC ASSESSMENT OF AID
POPULATION ASSISTANCE TO TURKEY, MAY 1993, RD/POP
(OFFICE OF POPULATION) COUNTRY SPECIALIST, EUR/DR/HR
(HUMAN RESOURCES DIVISION OF BUREAU FOR EUROPE)
COUNTRY BACK-STOP AND U.S EMBASSY POPULATION ADVISOR
HELD A SERIES OF MEETINGS ON HOW TO STREAMLINE THE
MANAGEMENT OF USAID FUNDED POPULATION ACTIVITIES OF
RD/POP COOPERATING AGENCIES (CAS). THE FOLLOWING
PARAS 3 TO 9 SUMMARIZE THE OUTCOME OF THESE
DISCUSSIONS. END SUMMARY.

THIS PROCEDURE ALSO APPLIES TO ALL SUBPROJECT
EXTENSIONS AND AMENDMENTS.

5. QUARTERLY MANAGEMENT REPORTS: THE US EMBASSY
POPULATION ADVISOR WILL PROVIDE A STANDARDIZED
MANAGEMENT REPORT FORMAT TO THE COOPERATING AGENCIES

2. AS PART OF THE CONSIDERATION OF THE PROGRAM OF AID
POPULATION ASSISTANCE TO TURKEY DURING THE MAY 1993
STRATEGIC ASSESSMENT, A NUMBER OF STANDARD PROCEDURES
RELATED TO THE WORK OF THE COOPERATING AGENCIES HAVE
BEEN MUTUALLY AGREED UPON BY THE EMBASSY, EUR/DR/HR
AND RD/POP.

MOST OF THESE PROCEDURES DO NOT PRESENT A DEVIATION
FROM THE CURRENT PRACTICE. THEY ARE DESIGNED TO
IMPROVE MANAGEMENT, COORDINATION, INFORMATION EXCHANGE
AND OVERSIGHT. THEY RELATE TO THE KEY ASPECTS OF THE
WORK OF THE COOPERATING AGENCIES AND FLOW FROM THE
WISHES OF THE U.S. EMBASSY. THE INTENTION IS TO
ENSURE EFFECTIVE MANAGEMENT OF THE AID-FUNDED FAMILY
PLANNING PROGRAM, IN THE ABSENCE OF AN AID MISSION IN
TURKEY. PLEASE FAMILIARIZE YOURSELF WITH THE
FOLLOWING PROCEDURES AND PASS THE INFORMATION TO THE
RELEVANT COOPERATING AGENCIES.

FOR USE IN SUBMITTING QUARTERLY REPORTS. THIS REPORT
WILL BE DESIGNED TO TRACK QUARTERLY PROGRESS AGAINST
THE OBJECTIVES SET BY THE CA. THE INTENTION OF THIS
REPORTING SYSTEM IS TO SERVE AS A MANAGEMENT TOOL
WHICH BOTH CA STAFF AND THE EMBASSY POPULATION ADVISOR
CAN USE TO MONITOR PROGRESS AND IDENTIFY PROBLEMS
NEEDING MORE ATTENTION. ALL COOPERATING AGENCIES
WORKING ON THE TURKEY PROGRAM WILL SUBMIT THESE
REPORTS TO THE EMBASSY POPULATION ADVISOR. THE FORMAT
WILL BE DISCUSSED WITH THE CA REPRESENTATIVES AT THE
JUNE CA'S MEETING IN ANKARA.

3. ANNUAL WORKPLAN: EACH COOPERATING AGENCY WILL
SUBMIT A 1994 ANNUAL WORKPLAN PROPOSAL FOR TURKEY TO
THE US EMBASSY IN ANKARA AND TO THE RD/POP COUNTRY
SPECIALIST IN WASHINGTON BY OCTOBER 15, 1993. THE
1994 WORKPLAN WILL REFLECT THE AREA OF CONCENTRATION
INDICATED FOR THE CA DURING THE MAY 1993 STRATEGIC
ASSESSMENT.

6. TRIP REPORTS: TO FACILITATE COMMUNICATION AND
INFORMATION EXCHANGE, ALL COOPERATING AGENCIES WILL
COPY THEIR TRIP REPORTS TO EACH OTHER AS WELL AS TO
THE EMBASSY, RD/POP COUNTRY SPECIALIST AND EUR/DR/HR
COUNTRY BACK-STOP. A STANDARDIZED CIRCULATION LIST
WILL BE FINALIZED AT THE JUNE CA'S MEETING.

THE EMBASSY POPULATION ADVISOR WILL PROVIDE THE
COOPERATING AGENCIES A UNIFORM FORMAT WHICH THE
WORKPLANS WILL FOLLOW. THE FORMAT WILL INCLUDE THE
OBJECTIVES PURSUED BY THE AGENCY, THE ACTIVITIES BASED

7. IN-COUNTRY COORDINATION MEETINGS: THE US EMBASSY
WILL CONTINUE TO CONVENE AND CHAIR IN-COUNTRY
COORDINATION MEETINGS IN ANKARA EVERY TWO MONTHS.

ON THESE OBJECTIVES, THE EXPECTED OUTCOMES, LOCAL
COUNTERPARTS, AND AN ESTIMATED BUDGET THE US EMBASSY,
RD/POP AND EUR DR/HR WILL REVIEW AND AMALGAMATE THE
INDIVIDUAL WORKPLANS INTO A MASTER COUNTRY WORKPLAN

THESE MEETINGS WILL BE ATTENDED BY ALL COOPERATING
AGENCIES BASED IN TURKEY. AGENCIES WHICH ARE NOT
BASED IN TURKEY SHOULD TRY TO SCHEDULE PROJECT
MONITORING VISITS TO ALLOW ATTENDANCE AT THESE
MEETINGS. THE EMBASSY POPULATION ADVISOR WILL
CIRCULATE THE MINUTES OF THE MEETINGS TO THE CA S,
RD/POP COUNTRY SPECIALIST AND EUR/DR/HR THE RD/POP
COUNTRY SPECIALIST WILL CIRCULATE THE MINUTES TO THE
CTO'S IN RD/POP

8. ANNUAL TRAVEL PLANS: IN CONJUNCTION WITH THE

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TELEGRAM

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ANNUAL WORKPLANS, COOPERATING AGENCIES WILL SUBMIT A PROJECTED ANNUAL TRAVEL SCHEDULE WHICH RELATES TO THEIR WORKPLAN TO THE EMBASSY AND RD/POP COUNTRY SPECIALIST BY OCTOBER 15, 1993. THE TRAVEL PLANS WILL INCLUDE THE NAMES OF THE TRAVELERS, PURPOSE OF THE TRIPS, PROPOSED DATES AND LOCATIONS TO BE VISITED AND THE PRIMARY CONTACTS. THE EMBASSY POPULATION ADVISOR, RD/POP COUNTRY SPECIALIST AND EUR/DR/HR COUNTRY BACK-STOP WILL REVIEW AND APPROVE THESE TRAVEL PLANS ALONG WITH THE COUNTRY MASTER WORKPLAN.

SIMILARLY, FOR PROJECTED TRAVEL FOR THE REMAINING SIX MONTHS OF 1993, COOPERATING AGENCIES SHOULD SUBMIT THEIR TRAVEL PLANS BY JUNE 30, 1993 TO THE EMBASSY POPULATION ADVISOR AND THE RD/POP COUNTRY SPECIALIST FOR REVIEW AND APPROVAL.

9. COUNTRY CLEARANCE FOR INDIVIDUAL TRAVEL:
NOTWITHSTANDING THE APPROVAL OF THE ANNUAL TRAVEL SCHEDULES, THE EMBASSY REQUIRES CABLE REQUESTS FOR

COUNTRY CLEARANCE FOR INDIVIDUAL TRAVEL RELATED TO AID-FUNDED POPULATION ACTIVITIES. RD/POP CTO'S MUST SUBMIT REQUEST CABLES NO LATER THAN TWO WEEKS PRIOR TO THE PROPOSED TRAVEL.

IF THE PROPOSED TRAVEL HAS ALREADY BEEN APPROVED UNDER THE ANNUAL TRAVEL PLAN, THE RD/POP COUNTRY SPECIALIST AND EUR/DR/HR AND EUR/PDP DO NOT NEED TO CLEAR THE CABLE BUT SHOULD BE COPIED. IF THE PROPOSED TRAVEL HAS NOT BEEN APPROVED UNDER THE ANNUAL TRAVEL PLAN, THE RD/POP COUNTRY SPECIALIST AND EUR/DR/HS AND EUR/PDP WILL NEED TO CLEAR THE OUTGOING CABLE REQUEST.

10. THANK YOU FOR YOUR COOPERATION TO FURTHER THE USAID POPULATION ASSISTANCE EFFORTS IN TURKEY. IF YOU HAVE ANY COMMENTS, QUESTIONS OR NEED FOR CLARIFICATION PLEASE CONTACT ROY JACOBSTEIN AT 703-875-4409 OR PINAR SENLET AT 90-4-426-5470.
BARKLEY

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6. IF AID CAN AGREE TO THE STIPULATION IN PARAGRAPH FOUR, PLEASE ADVISE AND FORWARD C.V. OF SUITABLE CANDIDATES ASAP.
BARKLEY

ACTION OFFICE POP-04
INFO 1G-01 RDAA-01 AMAD-01 EURM-01 EUDR-03 EUDP-03 MLC-01
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INFO LOG-00 EUR-00 OES-09 RPE-01 /012W
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FM AMEMBASSY ANKARA
TO SECSTATE WASHDC 1264

UNCLAS ANKARA 07830

AIDAC FOR RD/POP/IT -- MARIA BUSQUETS - MOURA
-- JOANNE GROSSI
INFO FOR EUR/DR/HS; EUR/PDP

E.O. 12356: N/A
TAGS: N/A
SUBJECT: POPULATION PLACEMENT OF A MICHIGAN FELLOW

REF: A) STATE 154472; B) TRAYFORS/HOLMES MEMORANDUM OF 5/25

1 IN RESPONSE TO REFERENCES, EMBASSY CONCURS IN THE PLACEMENT OF A MICHIGAN FELLOW IN ANKARA TO ASSIST IN THE COORDINATION AND MONITORING OF POPULATION (COOPERATING AGENCY) ACTIVITIES IN TURKEY UPON SATISFACTION OF KEY CONDITIONS WHICH RELATE TO THE MISSION PROFILE AND SECURITY OF ITS PERSONNEL IN A HIGH THREAT ENVIRONMENT.

2 THE EMBASSY HAS DISCUSSED THE ISSUE WITH THE STRATEGIC EVALUATION TEAM WHICH WAS IN COUNTRY LAST MONTH, AND WITH DEBORAH PRINDLE (AID/EUR/DP). IT IS THE GENERAL CONCLUSION THAT A STRENGTHENING OF IN-COUNTRY STAFF CAPABILITY TO MONITOR AND COORDINATE PROGRAM ACTIVITIES IS NECESSARY, AND THAT THIS SHOULD BE DONE AS EXPEDITIOUSLY AS POSSIBLE.

3 THE EMBASSY REQUESTS, THEREFORE, THAT AID/W AND THE UNIVERSITY OF MICHIGAN TAKE IMMEDIATE STEPS TO IDENTIFY AND NOMINATE A QUALIFIED CANDIDATE FOR ASSIGNMENT TO TURKEY IN THE SHORTEST POSSIBLE TIMEFRAME

4 EMBASSY UNDERSTANDS THAT MICHIGAN FELLOWS GENERALLY COME WITH COMPLETE SUPPORT PACKAGES, U.S. CITIZEN WORKING REGULARLY ON THE COMPOUND WOULD BE SUBJECT TO THE SAME SECURITY THREAT AS A REGULAR USG EMPLOYEE THEREFORE, WE WOULD REQUIRE A FELLOW TO LIVE IN AN EMBASSY-PROVIDED AND GUARDED APARTMENT THIS WOULD REQUIRE THE NEGOTIATION OF A F.A.C. AGREEMENT TO ALLOCATE THE NECESSARY COSTS TO AID. ALTHOUGH THE MICHIGAN FELLOW WILL NOT REQUIRE ACCESS TO CLASSIFIED INFORMATION, ALL AMERICANS WORKING ON DIPLOMATIC FACILITIES SHOULD HAVE A SECURITY CLEARANCE POST RSO RECOMMENDS THAT THE MICHIGAN FELLOW BE CLEARED.

5. PLEASE NOTE THAT EMBASSY CONCURRENCE FOR THIS POSITION IS GIVEN ON AN EXCEPTIONAL BASIS IN VIEW OF THE IMPORTANCE AND URGENCY OF STRENGTHENING STAFF SUPPORT FOR POPULATION ASSISTANCE ACTIVITIES. THIS APPROVAL DOES NOT REPRESENT A DEPARTURE FROM GENERAL

POLICY AND INTENT TO REDUCE THE NUMBER OF OFFICIAL U.S. NATIONALS RESIDENT IN TURKEY

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Annex 4.E. - Quality of Care

Quality of care is generally recognized internationally to consist of six elements: (1) choice of contraceptive methods; (2) information given to clients; (3) technical competence of providers; (4) client-provider relations; (5) mechanisms to encourage continuity of care; and (6) appropriate combination of services. This is often referred to as the "quality of care framework"¹

It is hard to say definitively how well Turkey measures up against these standard quality-of-care criteria. The absence of a family planning management information system (MIS) means that the usual service statistics are not available which could present some data related to quality. All of the CAs working in training and service delivery have done some assessment of the quality of care being provided in the facilities with which they are working, but little documentation is available. As noted in section II.E.5., little operations research is being conducted. FHTP's 1992 needs assessment provides some insights, and FHTP is currently developing data collection instruments (questionnaires and observation guides) for situation analysis, in June-July 1993, in 14 of the MCH/FP Centers used for training. This may be the most valuable source of data on quality.

In the meantime, the following generalizations can be made. For criteria one and two, evidence is quite clear.

1. Choice of contraceptive methods. Turkey scores low here. Only the IUD, pills, and condoms are widely available. In reality, only the IUD and condoms play reasonably appropriate roles in the method mix. Pill use is very low and pill failure rates too high. Other modern methods have not yet been made available.

2. Information given to clients. In most settings, information given to clients is inadequate. Nearly every single CA, in needs assessments, trip reports, and other documents emphasizes that counseling is poor and one of the weakest parts of family planning service provision in Turkey. Information provided focuses chiefly on the IUD. Many providers believe that "Turkish women can't use the pill" and believe the IUD is the best method for them. It may be that the quality of information provided about IUDs is quite or even very good. Data are not available. It is well documented, however, that information presented about the pill is by and large very poor, and sometimes not presented at all. Information about side-effects is especially ineptly presented, often incorrectly. Furthermore, because there is little or no refresher training for providers, it is likely that many of them do not stay up-to-date on any methods.

3. Technical competence of providers. Data are not readily available -- but neither does one hear many verbal accounts (as in some countries) about incompetent providers. It may be that technical competence with regard to IUDs is fairly good, although the absence of

¹ Judith Bruce, "Fundamental Elements of the Quality of Care: A Simple Framework," *Studies in Family Planning* 21(2):61-91.

refresher training and frequent transfer of providers to facilities that lack IUD kits means that some providers surely get rusty. There are also problems with screening for IUD use. It is apparently fairly common that providers are not able to screen for and distinguish accurately between cervicitis and cervical erosion (cervical ectopy). There are two inappropriate outcomes: some women (with only cervical erosion) are denied IUDs unnecessarily, while other women (with cervicitis) are given an IUD when they should instead be treated for the infection and given an alternate method until the cervicitis has disappeared.

The fact that national clinical guidelines for training and service delivery are now being finalized should help significantly in improving and upholding standards. Just how well the guidelines will be used and followed remains to be seen.

4. Interpersonal relations. Little is documented, and a national review of this sort cannot easily get a good picture. It is said that, given providers' bias for the IUD, and authoritarianism in Turkish culture, it is a "doctor knows best" relationship in which clients' views and concerns are not given much attention. In community-based services, which rely on female fieldworkers, the relationship -- predictably -- seems much more one of mutuality and respect. The fact that the main providers of family planning in Turkey are midwives may also make for fairly good client-provider relations in many facilities.

5. Continuity and followup. Clients are asked to return to clinics and health centers for followup visits, but MIS data do not exist to give any statistical picture. It is said that many clients do not return unless they experience complications. In some CBS programs (notably Pathfinder's in Izmir), there has been good followup and high continuation rates.

6. Appropriate constellation of services. Three points merit mention. (a) Efforts are being made to promote *postpartum family planning*, especially IUD insertion. It appears however, that many women leave the hospital after delivery not even having been systematically counseled on family planning. (b) It is *not* appropriate that female sterilization is divorced from other family planning services, available only as in-patient surgery. (c) Given that abortion is legal up through the tenth week of pregnancy, and incidence is high, it is *not* appropriate that abortion also is divorced from family planning: performed in an different part of the hospital and with no systematic enquiry as to whether the woman had been using contraception or intended to do so in the future. The experience of Bakirkoy SSK Hospital shows what dramatic gains can be made in contraceptive use when family planning counseling is provide in conjunction with all abortions, and when the abortion services is located adjacent to the family planning service.

In conclusion, the major shortcomings in the quality of family planning services in Turkey are: a very limited number of methods actually available; poor information to clients (misunderstanding, poor counseling, and lack of followup and attention to side-effects, especially of the pill); and maternity and abortion clients getting services in places not linked to family planning and leaving the hospital or health facility without counseling or provision of a family planning method.

ANNEX 4.F. CONTRACEPTIVE FAILURE AND ABORTION

Abortion is an important consideration in assessing the quality of care in family planning programs. Although statistics on abortion are hard to come by and abortion is often underreported, this is an important area to investigate given the impact of abortion on maternal mortality and the importance of abortion as an indicator of unwanted pregnancy. (Repeat abortions also put women at risk for preterm labor and delivery, a major contributor to infant mortality.) Understanding attitudes and practices related to abortion is important for a more accurate understanding of factors -- cultural and programmatic -- related to contraceptive use, failure, and non-use.

Legality and Incidence

In Turkey, the 1983 Population Planning Law made abortion legal on request for medical or social reasons. Abortion is now performed on request up to the 10th week of gestation, but requires consent of the husband. Even before 1983, however, abortion was common and in fact so widespread that many people were not aware that it was not legal.

Currently it is estimated that there are about 35 abortions for 100 live births. About one of every four pregnancies is terminated by abortion (1988 TPHS; SSK 1992¹). Almost one-fourth of the women responding to the TPHS (23.6%) said they had had at least one induced abortion. Abortion was more common in the cities than in rural areas and most common among women ages 35 to 39 (TPHS, p. 111).

As of 1988, there had been no detectable decline in the proportion of births resulting from unwanted pregnancies. In 1988, 37% of most recent live births were reported to have resulted from unwanted pregnancies -- about the same as 15 years earlier. This was figure was approximately the same in each 5-year interval from 1973 to 1988 (Goldberg and Toros 1993, p.6).

The incidence of abortion is said to be increasing (PCS, Background paper; UNICEF, Situation Analysis, p.). (Or is it that reporting of abortion has increased?)

The mortality rate for abortions was calculated as 179 per 100,000 in 1990. (In developing countries on average, 20-25% of maternal mortality is attributed to abortions.)

Abortion Services

There are four main sources of abortion services:

1. Ministry of Health hospitals

¹ *Family Planning in Turkey*, by Dr. Ali Tekin Celebioglu, SSK/SEATS Project Manager, 1992/93.

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2. Social Insurance (SSK) hospitals (for workers or workers' wives)
3. Other public institutions (e.g., university hospitals)
4. Private practitioners (hospitals and physicians' clinics)

Public sector. Abortion is provided free or at a token charge at MOH and SSK hospitals. MOH hospitals reportedly provide abortion free to women who have become pregnant while using an IUD, but charge 50,000 TL (about \$5.00) to other women. Charges are waived for indigent women.

Ob/gyns are the main providers of abortion services. General practitioners are also allowed to provide menstrual regulation (MR) under the supervision of an ob/gyn if they have received training and been certified for MR. The MOH offers a specific post-graduate (in-service) training course in MR for GPs (a fourth week following the MOH's IUD training course). GPs perform many of the abortions in government hospitals.

Although abortion is legal, many staff in the public hospitals have a punitive attitude. The law requires every government facility with beds to perform abortions, but facilities sometimes offer abortion only one day a week. Public hospitals perform abortions up to 10 weeks. For an abortion after 10 weeks, women have no choice but to go to a private clinic.

Post-abortion counseling absent or inadequate. Many (if not most) doctors and hospitals fail to provide post-abortion counseling for contraception. Many doctors and hospitals simply do not link the two as related. Typically, abortion is provided in one part of the hospitals and family planning elsewhere. There has been little systematic effort to introduce post-abortion counseling for contraception.

Private practitioners. It is stated that because hospital-provided abortion services are not sufficiently available, the field is open to private physicians for profit on abortions. The price varies between \$10 to over \$100 depending on the quality of the services and the facilities. Vacuum curettage (MR) and D&C are said to be the methods commonly used by private physicians.

Results of Recent Studies ²

Recent data indicate that *the majority of unwanted pregnancies apparently occur while women are trying to use some method of family planning -- modern as well as traditional.*

² This summarizes three preliminary papers from ongoing studies on abortion: (1) "Findings from Focus Groups with Abortion Clients from Bakirkoy and Sisli Hospitals in Istanbul" (prepared by Istanbul University, Institute of Child Health); (2) *Abortion in Turkey* by Aysen Bulut; and (3) "Abortion Research" by Aysen Bulut and Olcay Neyzi.

Survey data from SSK and MOH hospitals in Istanbul

Preliminary findings from a study in one SSK and one MOH hospital in Istanbul provide insights. A sample of 302 and 246 women from each hospital respectively were interviewed on the day of the abortion and again six months later (Bulut, Neyzi, p.4). Analysis of data is not completed, but preliminary results show the following:

Among the women having an abortion:

- o 71% were using FP methods when they became pregnant,
 - 66% had been using withdrawal,
 - others were using the pill, condom, rhythm, spermicides and the IUD, in this order,
- o Nearly half (49.1%) had no previous abortion history,
- o 59% had 1 or 2 children,
- o About 17% said they wanted more children, mostly in 3 to 5 years,
- o 99.3% said they prefer contraceptives rather than abortions.
- o 22% reported they had undergone the abortion without anyone else's knowledge except for their husband's.

Among their husbands:

- o 94% had agreed to their wife's abortion, 4% had suggested it, and 1.6% objected to the abortion.

The most commonly cited reason for unwanted pregnancies was the *failure of withdrawal*. This was true for both low and high education groups. The women say they knew withdrawal is not efficient, but it was the only method acceptable to their husbands. Among them, some had also rejected the IUD and the pill because of fear, bad experiences, physician attitudes, or fear of harmful side effects.

Focus group discussions from Bakirkoy and Sisli hospitals

Most women participating in focus group discussions for this study reported at least one unwanted pregnancy during their married life. Most said they had had enough or too many children; others wanted to space their children. Most women chose public hospitals for the

procedure because of the low cost (Istanbul University, Institute of Child Health).

The majority of unwanted pregnancies occurred while the women were trying to use some method of family planning. Only a few women reported using no method. The most common reasons given for seeking an abortion were:

- o unsuccessful use of withdrawal
- o IUD failure
- o unsuccessful use of rhythm
- o using no method because of the assumption that breastfeeding protects from pregnancy
- o using no method for other reasons
- o forgetting to take the pill every day
- o not using a condom on one occasion

Women felt that the cost of abortion in terms of mental hardship is worse than the monetary cost. They also agreed that use of a family planning method is less expensive than abortion. The most expensive of all is to give birth to the baby.

Women reported some areas of dissatisfaction with the abortion services as follows:

- o Interpersonal relations
- o Counseling and information given to clients
- o Follow-up
- o Clinic setting
- o Technical competence of providers
- o Comparison with other abortion providers

Some women felt that general anesthesia is necessary to avoid a painful abortion. The women stated that abortion is regarded as a sin in Turkey; however, they felt that it was a greater sin to have a child that they could not care for. The women did not feel that abortion was a family planning method, but rather the last resort in case of accidents. A common phrase in the group was "*mecbur kaldim*" ("I had to do it, I had no other choice").

Spousal communication and husband's attitudes. Women in the high education group reported that they usually discussed the problem of unwanted pregnancy with their husbands. The husbands' attitudes, however, are divergent and complex.

In once case, one of the women covered head-to-toe in black had had 8 induced abortions. Her husband was a religious man. She said that her husband was against use of contraceptives but not against having abortions (Bulut pp.1-7).

Annex 4.6.

RESEARCH AND MEASUREMENT: DATA FOR DECISION-MAKING

In the context of family planning, research (and the research environment) typically include: basic demographic research, operations research, program and project evaluation, MIS and service statistics, analysis, empirically-based management decision-making, data utilization, informational needs, organizational and professional capabilities, and impact of past research. All of these issues are considered under the general rubric of research.

Findings and Recommendations

1. **General.** In Turkey, the research component -- usually an important element of AID support to family planning programs -- has been weak. Relatively little operations research has been done and what has been done has been under-analyzed. There has been little collaboration between AID CAs or donors on research. Differences in technical and geographic focus explain some of the failure to share data collection efforts, but there is still considerable unrealized potential for greater cooperation in data collection and utilization.
2. **Data for decision-making.** At the national level, research and evaluation have not been incorporated into planning and management. Program-level service statistics and the associated MIS are currently being developed. The MOH has no specific budget for research and there is no position in the GD/MCHFP for a researcher or coordinator. The Institute of Population Studies at Hacettepe University runs a clearinghouse for population information, but this is a passive effort and is not involved in dissemination. In this environment there is limited research, little coordination or collaboration, problems getting data for use in program planning, and limited experience in using family planning data for management decision-making.
3. **DHS.** The upcoming Demographic and Health Survey, with technical support from AID's DHS Project, represents a major step forward for Turkey. Not only will it provide absolutely vital data for planning. It will also introduce new survey and analysis technologies and will allow Turkey to start using standard international demographic definitions and analytic procedures. The latter benefit will result in greater comparability of data and more reliable analysis of program performance.

Recommendation: The DHS should be given the highest priority and as much support as needed. To facilitate institutionalization, the DHS Project should direct special efforts to training Turkish researchers in data processing and analysis. MOH staff should be part of the Turkey DHS analysis team to facilitate use and understanding of the data set. The team should be larger than might be normal and include participation from Turkish organizations in addition to Hacettepe. The team should also consider spending more time with the DHS Project to maximize learning

opportunities.

4. **Client data bases.** Several of the service delivery projects have fairly comprehensive client data bases. These data bases are **under-utilized both for research and for program management.** The existence of several under-analyzed data sets is problematic. Lack of information is the basis for many of the inefficiencies, biases, and medical barriers that characterize family planning services in Turkey. None of the projects observed have staff with experience in the analysis of family planning data.

Recommendation: Consideration should be given to developing a short course for service delivery managers in the use of family planning data for decision-making. Participants would include MOH, provincial and NGO project staff. The course should use local trainers from Hacettepe University and/or staff from current projects who have shown capabilities and could be easily trained as trainers. Some short-term technical assistance in materials development would be required.

Recommendation: The CAs should expand their analysis and report writing activities, or a researcher should be recruited to help clean up the backlog of data analysis.

5. **Poor dissemination of findings.** During this assessment, the team found research results that were not referenced elsewhere and were not known beyond the organization that conducted the research. Rumors of other data sets, never seen but heard about, were common ("I think the ___ has been doing studies in that area"). Even the CAs are guilty of limiting access to research results.

Recommendation: It is recommended that the MOH, perhaps in collaboration with the State Institute of Statistics, bring together the research community and donors to set policies on research. Traditional research policy issues -- including privacy, coordination and avoidance of redundancy, standardized definitions, access to sample frames, access to data, publication procedures, and peer review -- should be among the issues considered. The result of effectively implementing a national family planning research policy would be to make more information available and to improve the quality of Turkish demographic and family planning research. Technical assistance in setting up a research and evaluation policy workshop and in preparing the background materials (discussion of the issues and options) would greatly facilitate this process.

6. **Lack of communications among researchers and projects.** While policy development might increase access to data, part of the problem is a lack of communications within the small community of researchers and service projects. This situation is not unusual, and can be often be resolved by increased awareness and a variety of small efforts.

Recommendation: Funding agencies should build analysis and dissemination into all research budgets. Researchers should try to disseminate findings as widely as

possible. Periodic reviews of the literature and reports and the policy implications of research can be published. Research dissemination seminars can be held. As the coordinator and primary consumer of family planning research, the MOH should take a leading role in facilitating the dissemination of research results. Two ways to support increased communication and sharing of research findings are the creation of a research coordination position and support for a research network. The coordinator position could also be involved in analysis and use of the MIS data produced by the MOH.

7. **Language barrier.** The lack of local research findings is compounded for many Turkish personnel by the language barrier, which limits access to international research findings. Currently the SEATS Project and PCS have been translating and disseminating selected international family planning publications. This activity should be continued and expanded. Special focus should be given to materials that will help overcome the common medical barriers to effective service provision.

8. There is a clear need for more research to support program coordination and expansion, improve access to services, make services more efficient and effective, and reduce provider and client biases. Unfortunately AID has not previously played an advocacy role in this area and, given issues of phase out, there is little interest in initiating a new CA or starting a new program.

Recommendation: Because the potential impact of research on services is so great, the CAs should be encouraged to more fully address the informational needs of their projects and the overall program. All of the CAs involved in Turkey have or can get the technical resources to support their own research needs and provide support to the program. AID's Population Advisor in Ankara can contact the various CAs to determine their interests and capabilities and develop a brief workplan. There are some obvious matches between recommended activities and CA resources. FPMD and Pathfinder both have MIS technical capabilities. The Options Project may be working on policy issues. The DHS Project has already established its role in research. All the service delivery CAs have some evaluation capability. PCS has considerable experience in information dissemination. Most of the CAs have access to researchers, data processors, and analysts for any additional research activities identified. Some of the CAs, most notably FPMD, have training capabilities.

9. **Future topics.** Topics that appear to have been understudied and that might benefit from research include:

- The measurement of quality of care (baseline and problem identification for the MOH and SSK)
- An information/research needs assessment (management focus)

- Abortion studies
- Use-effectiveness studies (especially of traditional methods)
- Continuation rate studies (especially IUDs)
- User satisfaction studies
- Adolescent sexuality and fertility (not perceived as a major problem and some empirical support for this view)
- Cost-benefit studies

10. **Training for researchers**

Recommendation: AID should attempt to identify training opportunities for Turkish researchers and data users. Both applied training and long-term graduate training would also be helpful. (Hacettepe has one U.S. trained demographer). Examples of U.S. institutions that provide applied training include the DHS Project, University of Michigan, Management Sciences for Health, and CDC.

11. **Phase-out of AID support for research is not a problem.** Both current and proposed research and evaluation activities are linked to service delivery projects or are short-term interventions; as these activities phase out, the associated research would also phase out. **The one notable exception is the DHS.**

Recommendation: Decisions on future DHS support should be based on the technical needs, success of past institutionalization efforts, the political environment, and the availability of resources in 1998-1999, when the next DHS should be carried out. It should be noted that the rapidly changing demographic situation in Turkey suggests need for more regular measurement of some of the basic variables. This should be considered and can be done using existing multipurpose surveys or specially commissioned smaller surveys.

Conclusion

Turkey has a long history of effective use of information in policy and management decision-making. The catalytic power of research results to influence family planning services is well established (e.g., the 1983 Population Law). The forthcoming DHS data is expected to have a major impact on policy and services. Additional qualitative and quantitative research, and more effective use of information, can also be expected to significant positive impact on such issues as medical barriers, target populations, cost effectiveness, and quality of care.

Social Marketing & the Private Commercial Sector

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I. FACTORS AFFECTING STRATEGIC CHOICES

Social Marketing in the Private Commercial Sector

To date the only AID sponsored activities in the private commercial sector have been selected IEC activities and the social marketing of one condom brand and generic low dose oral contraceptives. The social marketing activity has been conducted by the Futures Group under its SOMARC Project and in cooperation with the Turkish Family Health and Planning Foundation (TAPOV) and four pharmaceutical manufacturing companies.

The follow-on marketing research has indicated that the social marketing interventions have been consistently successful. The brand name marketing for O'K¹ condoms has increased condom sales and made O'K the market leader. The marketing for generic low dose OCs has significantly increased sales for low dose pills and OCs generally. The O'K condom is already financially self sufficient, and the marketing for generic low dose OCs will require no additional support from AID after 1993. Because purchased products are more likely to be used than commodities provided freely in the public sector, the private sector sales figures are a good surrogate for actual use levels for private sector consumption. Other social marketing initiatives are planned for injectables, implants, and IUDs.

As in most developing countries, the private sector for health care services is growing rapidly. As is also typical, most of this growth is in ambulatory care services, especially private physicians offices, and pharmaceutical and lab services. From 80-90% of all ambulatory care and pharmaceuticals are obtained in the private sector. The sector will be consistently more efficient and effective—in terms of what clients want²—than the public sector. The range of choices will be greater, and the quality and motivation of human resources providing services will be better. The pharmaceutical industry in Turkey is robust and dynamic, and offers much potential for catalytic influence of both consumer and provider demand for contraceptive products. There are over 100 manufacturers, 400 wholesalers, and over 13,000 pharmacies throughout Turkey. The manufacturers promotional techniques, particularly personal selling or detailing, are the major influence on provider prescribing habits (e.g. oral contraceptives and injectables) and the choice of medical devices (e.g. IUDs). This influence is exercised over physicians in both public and private sectors. Detailing and other promotional techniques also push products out through the retail pharmacy network.

Given its dynamism and growth along with its powerful influence on consumer and provider choices, the private sector should be a strategic priority for AID supported population activities. It offers much more potential for sustainability than alternative interventions in the public and non-profit sectors. The purpose of this section is to put the AID supported social marketing activities within the broader context of the private sector in order to consider the possibilities for fine-tuning and expanding activities in that sector.

Production and Procurement

There are just over 100 pharmaceutical manufacturers in Turkey, and, by every indicator, the industry continues to develop rapidly (i.e. raw materials production and manufacturing increasing, balance between imports and exports improving, % of GNP on pharmaceuticals increasing, industry price inflation lower than CPI, etc.). As in most developing countries, local

¹O'K is also written as okey.

²Which is not always what they need from a medical perspective, but it is what motivates them.

manufacture in Turkey is still dominated by the most basic stage of manufacturing processes, i.e. converting imported compounds into tablets, capsules, and other forms of presentation. All OCs marketed under the social marketing project in Turkey are locally produced at this stage of production. The OK condom is imported. However, contraceptive products currently represent less than 1 or 2% of the total pharmaceutical market, and only a few manufacturers are producing and marketing them.

Eczacibasi³, the leading pharmaceutical manufacturer in Turkey, has 15% of the pharmaceutical market. Like other local manufacturers, Eczacibasi is working under license with a number of multi-national pharmaceutical companies. Prior to the social marketing project, Eczacibasi carried no contraceptive products, with the exception of one spermicide which was a minor product for them. They had little or no interest in marketing a condom but were persuaded by the combined forces of SOMARC and TAPOV. Once persuaded, Eczacibasi developed a marketing plan for the OK condom with a minimum of assistance from SOMARC. The marketing plan was thoughtful, creative, and comprehensive. Eczacibasi clearly has excellent in house resources to develop and implement marketing plans. Other than financial resources, the only support that Eczacibasi needed was the facilitation of TAPOV between itself and the GOT to allow the use of media to advertise the new condom⁴. The procurement arrangements for the import of the condoms saved an estimated \$1.1 million dollars for commodities. The OK condom achieved sales of nearly 6 million and a market share of 41% within 2 years of its launch. Under the social marketing project agreement, the activity has accumulated an additional \$90,000 contribution to finance future promotional activities.

This was well in excess of Eczacibasi's own sales projections for the product, and the success of the product has inspired Eczacibasi to apply for licensing for four oral contraceptive brands, one high dose and three low dose. Having inspired an interest in contraceptives in the largest pharmaceutical company in Turkey may eventually be seen as the greatest success of AID's early support of social marketing with the OK condom.

The social marketing program worked with 3 pharmaceutical manufacturers—Shering, Wyeth, and Organon—to market low dose OCs. All 3 companies are among the top 20 pharmaceutical companies in Turkey, and collectively they represent roughly 90% of the OC commercial market in Turkey. A major part of the social marketing project's success with these 3 companies was in persuading them to work together and share information on the collective marketing of generic low dose OCs. The TAPOV was again an important facilitator in obtaining GOT permission to allow media advertising directly to the consumer for a pharmaceutical product.

Wyeth carries 3 brands of OCs, and 2 of these have been on the market for from 10 to 20 years. OCs represent less than 10% of Wyeth sales. Although Wyeth has international interests in OCs, the company has limited interest in FP and OCs in Turkey. By contrast, infant formula represents from 20-25% of total sales for Wyeth in Turkey, and the sales force that promotes OCs also promotes the infant formula⁵.

Although contraceptives are also important for Shering as a multinational, they are not very important in the Turkey portfolio. Shering's 3 OCs, also with 2 on the market for from 10 to 20

³The honorary title of Eczacibasi—meaning head pharmacist—was bestowed on the father of Eczacibasi's founder, and he was later urged to adopt this honorary title as a family name. The company, now a large conglomerate, is 75% family owned.

⁴Actually the word condom is never used in any of the advertising, partially to augment the "teaser" intrigue of the approach and partially to make OK almost synonymous with condom in Turkey.

⁵This fact may raise both conflict of interest and ethical questions. However, since further activities to support Wyeth are not being recommended for other reasons, there is little point in discussing these issues here.

years, represent roughly 5 or 6% of total revenues. (Normally, they would be 30% in a typical Shering market.) Shering also carries an IUD and is in the process of getting a license for an injectable contraceptive.

Organon, a division of Akzo⁶, specializes in hormonal products, including OCs. It is the market leader for OCs within Turkey. OCs represent 14-15% of its revenues, and, although not the most important product line, OCs are important to Organon. It also carries Multiload, an IUD that comes in multiple sizes, for 8 years. It is the market leader in Turkey and Europe with a 67% market share in Turkey for IUDs. It is planning to launch Implanom (a Norplant-like product with only one piece) in other markets, but does not feel Turkey is ready for the product yet.

All of these manufacturers work with at least 100 of the 400 wholesalers, and they have strong marketing skills, particularly through their sales forces. During 1992 when cooperative social marketing efforts for low dose pills were initiated, sales of all OCs rose 18%, and low dose OCs shifted from 50% of the OC market to 61%, indicating that most of the growth in the OC market came from low dose pills. The program projects this trend increase to continue through 1993 when the activities will require no further external support.

The key managers whom we interviewed in the pharmaceutical industry felt that the major barriers to further growth of the private FP market were: 1) a lack of government support (i.e. strong promotional policies, ranging from advertising to pricing controls), 2) cultural changes which are slow to take place and even at some risk of reversing, 3) physicians economic interests (i.e. IUD insertions, abortions, and deliveries are more lucrative), and 4) free commodities supplied by AID.

Pharmacies: The Retail Distribution System

There are approximately 13,500 pharmacies in Turkey, and the pharmaceutical manufacturers described supply the products included in the social marketing activities to virtually all of these pharmacies. Since the MOH as a policy sends out-patients to the private sector to purchase pharmaceuticals, and many of the pharmaceuticals acquired by members of SSK, BAG-KUR, etc. are purchased through the private sector on a co-payment scheme, access to pharmacies should be excellent. Pharmacies tend to cluster around government hospitals in urban areas. Service is rapid in these outlets; staff are polite and motivated; and the range of brand choice is relatively wide.

Only a qualified pharmacist can establish a pharmacy, but open pharmacies are often staffed by a kalfa, i.e. assistant. These pharmacy assistants have no formal training in pharmacology, and generally from 8 to 11 years of formal education. Although they are not licensed to do so, they perform a number of medical services (e.g. injections, blood pressure checks, etc.), including giving clients medical advice.

Although legally required, the use of prescriptions is not common. SSK members, government employees, etc. present prescriptions because they only make a co-payment for the purchase when prescriptions are presented. However, this is not necessary in the case of contraceptives because the SSK does not co-pay for these products. According to recent IMS data, only 5% of OC purchases are made with a prescription slip.

⁶Akzo is the fourth largest Dutch multinational conglomerate, and Organon is one of its two pharmaceutical divisions. The other handles OTCs.

Table 1
Analysis of Sample of Istanbul Pharmacies

Pharmacy Name	Sales Class	Client Class	Condoms		Oral Contraceptives	
			Brand Variety	Weekly Sales	Brand Variety	Weekly Sales
Aslan Eczanesi	A	A-B	5	51	7	18
Asli Eczanesi*	C	C	5	7	7	15
Eczane Ilgi*	A+	B	5	9	8	17
Karadeniz Eczanesi	A	B	11	30	6	16
Eczane Surmen	B	B-C	5	20	7	11
Eczane Tumer*	A	A-B	8	7	9	12
Erdal Eczanesi	A	B-C	6	5	8	3
Eczane Oktay	B	B-C	5	7	7	5
Eczane Sibel*	B-C	B-C	7	6	9	4

*Female Staff in Pharmacy

We visited 9 pharmacies in Istanbul. (See Table 1.) Most of the pharmacies were very similar in appearance and offered a similar range of contraceptive products. Customers apparently prefer to consult with pharmacists about drugs in general, including OCs. They have confidence in their advice, and

advice from a doctor entails costs in terms of both consultation fees and time. For OCs, women, and particularly lower class women and older women, prefer to solicit the advice of female staff in pharmacies. In small towns where there are few doctors, pharmacists are consulted even more frequently.

The Product Lines

The private sector's major contraceptive products are condoms, OCs, and IUDs, along with a few other minor products, e.g. spermicides, etc.. The discussion here focuses on condoms and OCs both because they are the major products in terms of units sold, and because these are the only 2 products that the social marketing program has worked with to date.

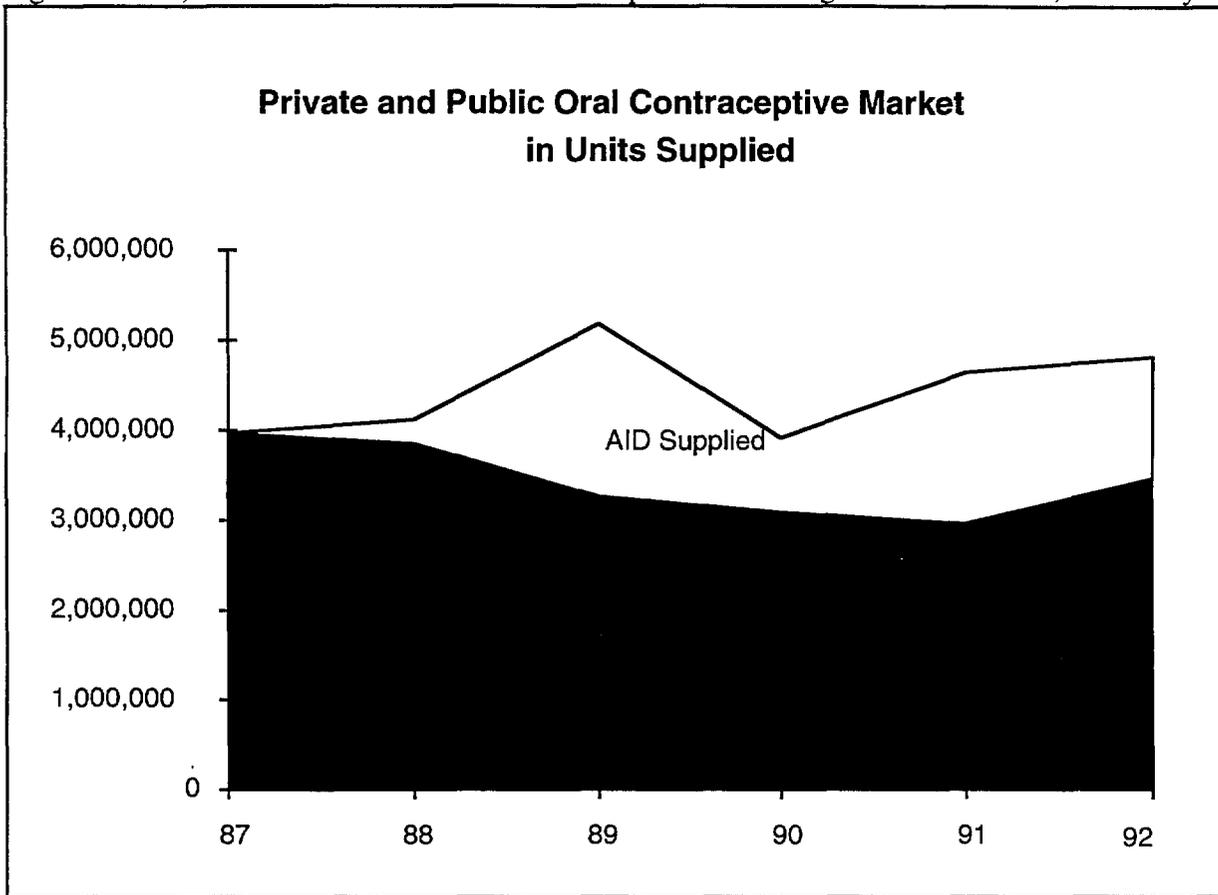
IUDs are a major choice in terms of contraceptive prevalence. The IMS does not include statistics on IUDs because they are not an ethical product, but Organon, as the market leader, estimates that sales are around 100,000 units annually for all IUDs.

As is clear from the contraceptive prevalence data, the product options for FP in both the private and public sector have been limited in Turkey. At one time injectables were available in the private sector, but they declined and then completely disappeared. The reasons for this are unclear, although some of those interviewed believed the availability of injectables was only part of a trial. This requires further investigation because some sources claim a strong general preference for injections in the Turkish population which would seem to bode well for the introduction of injectable contraceptives. Other potential attributes seen for injectables are improved compliance and potential for protecting users privacy.

Oral Contraceptives

Roughly 80% of all OCs obtained in Turkey are purchased through the commercial pharmacy network. During the 5 year period from 1987 through 1991, the private sector share of the OC market was declining, and much of this decline appears to correlate with the influx of OCs

provided by AID, although other undocumented influences may also explain the trend. (See Figure below.) When the data are smoothed⁷ for presumed changes in stock levels, the steady



growth in the market from the 3.964 million in 1987 to over 4.816 million units in 1992 could easily be explained by the natural rate of increase in fertile women (especially young women), urbanization, other modernizing influences in Turkish society, and public sector wastage or leakage. Other explanations for this trend are possible, but its implications should be included in considerations of the phase out of AID provided commodities. This is particularly relevant when one considers that most MOH out patients and many members of SSK and similar insurance groups are now purchasing pharmaceuticals, including OCs, from the private sector either under a co-payment or full payment system.

The 18% growth in the OC market that occurred in 1992 is assumed to be primarily due to the social marketing efforts around low dose OCs, and this assumption is supported by the fact that most of the growth in the market was through the growth of low dose pills. However, an interesting aspect of this growth which was not high lighted in the reports is that from 80-90% of the growth in low dose pills came through one product: Organon's Desollet. The product manager at Organon believes the market increase came through a synergy from 3 influences: 1) the social marketing promotional activities, 2) independent promotional activities used by the manufacturers (e.g. discounts, etc.), and 3) the expiration of IUDs that had been implanted

⁷The peak in 1989 and the trough in 1990 for AID supplied OCs are presumed to be a function of the supply system being over stocked one year and using up excess stock the following year. Wastage rates would also be somewhat, if not significantly, higher in the public (i.e. AID supplied) sector than they would be in the private sector. Therefore, the apparent increase suggested by the AID supply increase is apt to be overstated.

through public sector services some years before. However, since the growth went to Desolett, it is apparent that either the product itself or Organon's independent promotional efforts had enough appeal to allow Organon's product to collect a halo effect from the generic demand creation for low dose products⁸. The packaging for Desolett might be considered better quality than competing products, but the difference is slight.

<i>Brand Name</i>	<i>Manufacturer</i>	<i>Package Price</i>	<i>Tablets in Package</i>	<i>Strength</i>
Desolett*	Organon	36,000	21	low dose
Triquilar	Shering	19,000	21	low dose
Eugynon	Shering	21,000	21	high dose
Lyndiol	Organon	18,500	22	high dose
Microgynon	Shering	20,500	21	low dose
Ovral	Wyeth	20,700	21	high dose
Lo/Ovral	Wyeth	15,600	21	low dose
Ovulen	Searle	15,000	21	high dose
Cyclo-Progynova	Schering	20,000	21	high dose
Anovlar	Schering	9,000	20	high dose
Trinordiol	Wyeth	26,300	21	?

*Top Brand, with 53% of low dose market in 1992

We examined the range of OCs, prices and sales volume in the 9 Istanbul pharmacies. (See Table 2.) Female staff were more apt to have observed an increase in OC sales, and both male (unsolicited) and female (solicited) staff in pharmacies said that women preferred to talk with female staff about OCs. Pharmacy staff did not think that customers were aware of high dose or low dose pills, but they felt many customers did have beliefs about brands that were less apt to have side effects. The

specific questions that customers asked staff most frequently were about side effects, either before or after a purchase.

Despite the range of OCs available on the market, there is very little to distinguish between them, other than high and low dose. All brands are using Latin names that are appealing to the medical community, but neither meaningful nor memorable for the general public. Except for two minor brands with 20 and 22 day cycles, all available brands were 21 day cycles. None, therefore, have iron supplements, and all are less likely to encourage good compliance.

Condoms

Although some pharmacists interviewed in Istanbul pharmacies believed that sales of condoms had risen significantly during recent years, others felt there had been no significant changes. Those who had observed an increase believed that it was partly due to an interest in family planning, but even more to concerns about sexually transmitted diseases (STDs). The marketing techniques used for σ K were also frequently cited as an unsolicited reason for the increase in demand for condoms. Although Amor was occasionally the top selling brand when there were 4 or more types of Amor condoms available in the Istanbul pharmacies, σ K was most frequently the top selling brand. Jellia, generally the lowest priced brand, is not a meaningful name in Turkey, and it usually had relatively lower sales, although the packaging is attractive. (See Table 3.)

⁸It is also possible, although unlikely, that Organon's independent promotional activities were more powerful than the generic low dose promotion.

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Table 3
Condoms Available in Istanbul Pharmacy Sample

<i>Brand Name</i>	<i>Price</i>	<i>Quantity in Pack</i>	<i>Package Features</i>
OK Extra*	26,000	10	Silver package, OK symbol
OK*	18,000	10	White & silver package, OK symbol
Amor*	9,000-50,000	1-12	Brown with gold trim, or gold and silver
Eros	15,000	12	Almost naked blond couple kissing
Jellia	10,000	12	Gold box, name not meaningful
Erotim	9,000	1	Palm trees and moonlight
Erosex Black Cat	20,000	6	Black kitten on box

*Top selling brands

Pricing Issues

Pricing issues create incentives and disincentives at various levels of the private sector supply system.

The GOT exercises price control over the pharmaceutical industry. These controls impact all FP commodities (i.e. devices and pharmaceuticals), except condoms which are not under price control. Like most government laws and regulations there is some scope for flexibility. For example, at the manufacturer's level, one industry representative felt the GOT had recently become more flexible about what would be considered base costs for a contraceptive product, e.g. marketing costs, packaging costs, etc.. The retail margin is generally around 20%.

Although there will be exceptions for the very poorest segment of the population, there is no evidence that most consumers in Turkey are price sensitive. Both for condoms and for OCs the lowest priced products are doing poorly in the market place. Desolett is the clear market leader, and it is the highest priced product by a roughly 75% margin over most competing products. A 10 pack of OK is double the price of a 12 pack of Jellia condoms. Prior to the introduction of OK, Amor was the market leader for condoms, and most 12 packs of Amor brand sell for more than double the OK price. The lack of end user price sensitivity within the available range is relatively typical for contraceptives and other pharmaceutical products. There is generally a strong association between price and quality in the consumers mind. For pharmaceuticals generally this lack of price sensitivity would be enhanced when co-payment schemes such SSK membership or status as a government employee significantly reduce the out-of-pocket costs for the consumer. However, there is apparently no co-payment for contraceptives, and consumers pay the full price.

In fact, the higher price of Desolett could be an important element among the reasons for its success in the market. Not only does the consumer equate price with quality, but, with price controls on allowable margins, the retail pharmacy network is going to be motivated to push the highest priced products in order to maximize profits⁹ The lack of price controls for condoms allows the pharmacies to put a higher margin on inexpensive products.

⁹This is precisely why it is so hard to promote ORS for diarrhea treatment in developing countries. It's too cheap.

Promotional Strategies

Detailing through the sales force is the major promotional tool used by all pharmaceutical companies. Personal calls to physicians in their offices and to pharmacies are supported by special promotional offers, e.g. 10% free goods with a purchase, free samples, sales gimmicks to decorate the pharmacy, brochures, regular visits made to medical schools, etc.. The direct support that the social marketing program gave to this activity was the provision of brochures and gimmicks. However, use of other media supported the sales force indirectly.

Since detailing is the major and arguably most powerful promotional tool used by the industry, more attention should be paid to what works and what is less effective. For example, Organon traditionally has women on its sales force, and this may enhance promotional power for its main product lines (i.e. infertility drugs, OCs, IUDs, etc.). From 35-40% of the 85 strong Organon sales force in Turkey is female. Wyeth, by contrast, has a sales force of 58, with only 12 women, and Shering has a sales force of 69 with no women. Has Organon been more successful with its OCs because of the size of its sales force? because of having women on its sales force? both? or both of these factors combined with other marketing techniques?

Government restrictions normally prevent promotional techniques that allow a direct approach to the consumer. However, with the facilitation of TOPOV, the social marketing program was able to launch brand specific media campaigns for OK condoms and method specific campaigns for low dose pills. Channels of communication included television, radio, bill boards, and print media (e.g. magazines and dailies, pamphlets and brochures, etc.). We rarely saw social marketing print materials on site in the Istanbul pharmacies, although pharmacy staff were certainly aware of the campaign.

Market Research

Zet-Medya¹⁰, with support through AID from the Johns Hopkins Center for Communication Programs and the Futures Group, has conducted most of the market research for IEC and social marketing activities in Turkey. Initially, Zet-Medya received significant technical assistance from Hopkins, but at this point the organizational capacity is well-developed, and little if any external technical assistance is required for future work.

Much of the recent research that has been done for IEC and social marketing has been driven by the need for baseline studies and follow-on studies that can be used to evaluate the impact of particular interventions. This research has been valuable but limited in scope. In general, research has not been conducted to inform the basic design of interventions, and this should be changed in the future to make the interventions more effective.

II. RECOMMENDED STRATEGY AND OPTIONS

Social Marketing in the Private Commercial Sector

While the market research that has served as a pre and post measure of the effectiveness of an intervention has been useful, there should be more market research on issues that will help to inform the fundamental design of IEC and social marketing programs. For example, what is the profile of those using traditional methods? This is the group that should be most easily attracted to modern methods. Who are the withdrawers? Why are they using this method? How frequently

¹⁰This is another area where government rules are bent or ignored. Private companies are not supposed to do market research, as this is an area where the State Institute of Statistics is supposed to have a monopoly.

are they using it? Who are the condom users? Are they using the condom consistently or only occasionally? What are the specific beliefs—rumors or reality—that underlie discontinuation or lack of trial for modern methods? How effective can young midwives be in introducing contraceptors to modern methods? Do people in Turkey strongly prefer injections as a route of administration? If so, will this preference hold for the introduction of new injectable contraceptives? What specific promotional techniques have been most powerful? Without more specific information on these details, both IEC and social marketing efforts will be less effective than they can be. However, more primary qualitative research also requires that AID allow more planning time for the design of interventions. Follow-up research should also include more extended follow-up, as advertising typically has a powerful short term impact but often only a modest portion of the impact can be sustained.

Market research that has been conducted should be shared more widely. For example, the major advertising tracking survey that was recently completed by Zet-Medya should be provided to all 4 of the pharmaceutical companies with which the social marketing project has been working. Research on the public sector could also be shared with the private sector. Summaries of AID supported studies tend to be used as a promotional tool by project actors, and are naturally more broadly circulated than the studies themselves. While this is normal behavior, AID needs to encourage summaries that highlight interesting data that are poorly understood, data that indicate program weaknesses and failures, and other facts that not only help to spread the good news but help to spread news that can make future programs even stronger. These data can highlight the need for programmatic changes or further investigation. For example, the fact that one product represents 80-90% of the growth in the low dose OC market is as and perhaps more interesting than the actual growth in the market as it correlates with the social marketing campaign.

The range of products available in the private sector should be expanded, and the social marketing project plans to include IUDs, contraceptive implants, and injectables in future activities. Social marketing of these products will be primarily to physicians, and this requires that the most effective use of the detailing and the sales force be well understood.

At least one new pill should be introduced. This OC should be a low dose compound with a 28 day cycle of tablets, including iron supplements, and possibly a name that is meaningful and memorable to Turkish women. A 28 day cycle should increase compliance and therefore efficacy. Iron supplements for the additional 7 tablets would decrease anemia caused by menstruation, decreasing perceived and real side effects and efficacy. (Support from AID to purchase new equipment that would allow the production of a 28 day blister pack may be necessary.) These enhancements should gradually increase consumer confidence and ultimately demand. In time, when combined with higher use of the low-dose pills, this could improve general attitudes toward modern methods in Turkey. The brand name, along with messages and pricing options, should be pre-tested. For example, if legally possible, Eczacibasi might be able to use the brand recognition for OK condoms as a lead to introduce OK pills.

The social marketing program should consider dropping both Wyeth and Shering, as they seem to be willing but not enthusiastic. Dropping these two companies could allow pursuing activities that are brand specific with Eczacibasi and Organon. One advantage of brand specific marketing is that it can be more focused. Another more important advantage is that the marketers can better control demand to a product that has the specific attributes that the program should promote, i.e. low price, etc.. Without intending to do so, the social marketing for low dose pills appears to have primarily attracted new users to the most expensive product on the market.

The social marketing program in particular and the AID supported population programs more generally should begin dialogue with the GOT and the pharmaceutical industry about potential changes in pricing policies that would create better incentives for both consumers and the

industry, from manufacturing through the retail level. Appropriate pricing incentives will facilitate an increase in the prevalence of appropriate and affordable modern methods.

AID should consider eliminating commodity support soon. Given the current policies regarding pharmaceuticals generally in the public sector, it seems unlikely that the GOT will begin to procure contraceptives when AID withdraws commodity support. It will be the private sector that takes over the commodity supply, and, since this appears to be predictable, it is better to begin building private sector capacity now rather than potentially competing with it.

Social marketing and other commercial private sector development for the provision of commodities should be a strategic priority for the AID population program. Although it will often not contribute to equity of access, the private sector for health care services is growing rapidly in Turkey. The private sector is more efficient and effective, and more robust and dynamic than the public sector. It offers much potential for catalytic influence of both consumer and provider demand for modern contraceptive methods. It offers potential for program sustainability within a short time horizon. Given the importance of the private commercial sector and the linkages between IEC and social marketing, AID should consider an in-country coordinator, probably based in Istanbul, working jointly with these two activities.

Individuals Contacted in Turkey

Pharmaceutical Manufacturers

Özger, Ayse	Assistant General Manager, Marketing, Eczacibasi
Kiliç, Nuri	Product Manager, Eczacibasi
Erben, Tunç	Product Manager, Eczacibasi
Akyildif, Kadir	Chief of Istanbul OTC Sales Team, Eczacibasi
Göktuna, Halim	Promotion Manager, Wyeth
Önder, Adnan	General Manager, Wyeth
Saribay, S. Meriç	Product Manager, Organon
Schindler, Günter	General Manager, Schering
Tunali, Nilgün	Product Manager, Schering
Yörük, Sinasi	Marketing Manager, Schering
Aitinbasak, Faruk	Sales Manager, Schering

Pharmacies

Bolsoy, Mehmat	Pharmacy Assistant, Aslan Eczanesi
Aktan, Ayla	Pharmacist, Asli Eczanesi
Çolak, Mustafa	Pharmacy Assistant, Asli Eczanesi
Paksoy, Tülay	Pharmacy Assistant, Eczane Ilgi
Özok, Ibrahim	Pharmacy Assistant, Karadeniz Eczanesi
Tarhan, Sahin	Pharmacy Assistant, Eczane Sürmen
Tümer, Mdme.	Pharmacist, Eczane Tümer
Erdal, Derici	Pharmacist, Erdal Eczanesi
Koklay, Haydar Büyü	Pharmacist, Eczane Oktay
Kügüküydirim, Sibel	Pharmacist, Eczane Sibel

Other

Yaser, Yasar	Executive Director, TOPOV
Ünder, Professor Dr. Sunday	Deputy Executive Director
Özler, Güntaş	General Manager, Zet Medya