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**ASSESSMENT OF FAMILY PLANNING
SERVICE PROVISION AND TRAINING
OF FAMILY PLANNING SERVICE
PROVIDERS IN TURKEY**

by

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Glossary

A.I.D.	U.S. Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
BAG-KUR	Turkish organization which provides for the health care and social security needs of self-employed workers and housewives
CA	Cooperating Agency
CBD	Community-based distribution
CEDPA	Centre for Population and Development Activities
CTT	Central Training Team
DPT	Diphtheria, pertussis, tetanus
FPAT	Family Planning Association of Turkey
FPIA	Family Planning International Assistance
GDCM	The General Directorate for Curative Medicine
GDHT	The General Directorate for Health Training
GDMCHFP	The General Directorate for Maternal and Child Health and Family Planning
GDPHC	The General Directorate for Primary Health Care
GP	General practitioner
HRDF	The Human Resource Development Foundation
IEC	Information, education, and communication
INTRAH	Program for International Training in Health (program at University of North Carolina)
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCHFP	Maternal and child health and family planning
MOH	Ministry of Health
NORPLANT®	A method of contraception which releases the synthetic hormone levonorgestrel through capsules inserted beneath the skin of the upper arm

Gyn/Ob	Gynecology and Obstetrics
Pathfinder	The Pathfinder Fund
PID	Pelvic inflammatory disease
POPTECH	Population Technical Assistance Project
PTT	Provincial Training Team
PVO	Private voluntary organization
RONCO	RONCO Consulting Corporation
SSK	Social Security Institution
TESK	Turkiye Esnaf ve Sanatkarla Konfederasyonu -- a national confederation of organizations which serve members of the small-scale manufacturing and service industries in Turkey
TFHPF	The Turkish Family Health and Planning Foundation
TL	Turkish lira
TOT	Training of trainers
TURK-IS	Turkish Federation of Labor Unions
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VSC	Voluntary surgical contraception
WHO	World Health Organization
YOK	Council of Higher Education

Executive Summary

Introduction

The United States Agency for International Development (A.I.D.) spends approximately \$3 million per year to support the provision of family planning services in Turkey. As A.I.D. does not maintain an office in Turkey, this assistance is provided through A.I.D. Office of Population Cooperating Agencies (CA). Four of these CAs -- the Association for Voluntary Surgical Contraception (AVSC), the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), the Pathfinder Fund, and RONCO Consulting Corporation -- have provided significant support for family planning training in Turkey.

In an effort to determine the appropriateness and effectiveness of A.I.D. population assistance in Turkey, this assessment sought to examine the overall context of family planning services in Turkey and to identify strengths and needs in training.

Country Background

Turkey's population of 55 million people is growing at a rate of about 2.5 percent per year. However, fertility is decreasing, and most people want small families; three-fourths of reproductive-aged couples do not want to have any more children. A national survey conducted in 1988 found that 77 percent of women were using some method of contraception. Despite this degree of contraceptive prevalence, one in four pregnancies is terminated by legal abortion and 37 percent of births in the past five years were unwanted or mistimed.

A 1983 updating of Turkey's Population Planning Law legalized early abortions, removed most restrictions on surgical sterilization, and called on the Ministry of Health (MOH) to train midwives to insert intrauterine devices (IUD) and provide other temporary methods of contraception.

Family Planning Service Delivery

Turkey's health care system is complex and pluralistic. The MOH operates a massive system of hospitals and clinics (in cities) and health centers and health posts (village-based midwives) to provide primary health care to the rural population (about 45 percent of the people). A national insurance system for workers (the SSK) covers one-third to one-half of the population and runs its own system of hospitals and clinics. In addition, there is an active private sector (physicians and pharmacies), and a number of private voluntary organizations (PVO), including, most importantly, the Family Planning Association of Turkey and four private foundations that are interested in family planning. Despite this pluralism, it is an interlocking system; e.g., the MOH provides most of the midwives and physicians who run family planning clinics for PVOs. Multiple training and service delivery problems run throughout the system, affecting care in the private sector, as well as in the MOH.

Although there has been consistent policy support for family planning, frequent changes in the leadership of the MOH have encumbered full implementation of those policies. Yet, large numbers of well-educated, hard-working, and dedicated professionals are trying to improve the delivery of family planning services, and they have accomplished much. However, many problems go beyond the family planning program: There seems to

be a widespread reduction in policy-level support for public health as evidenced by declining support of medical school departments of public health (which have provided much of the leadership for family planning in Turkey). Previously successful approaches to induce young physicians to serve time in the rural primary health care system have been abandoned for less successful approaches, and there may soon be a large influx of less well-trained young physicians into the health care system as a result of the government's having opened 11 new medical schools within the past two or three years. There is no functional patient referral system. The outreach arm of the primary health care system depends on the performance of health post midwives, many of whom are very young, inexperienced, and inadequately trained. In addition, low status among urban midwives demoralizes students and may have a negative effect on the profession. Nevertheless, it appears that the MOH's primary health care delivery system works (at least down to the level of the health center), and the MOH is able to identify service and training problems and to make changes to address them.

Clinical family planning services in Turkey emphasize careful, competent, conservative IUD insertion and follow-up and the provision of condoms for those who cannot use IUDs. However, little attention is paid to oral contraceptive pills, and there is little or no counseling for patients. Other problems are that only about 35 percent of the health centers have either a midwife or general practitioner who has been trained and is certified to insert IUDs; MOH hospitals do not participate fully in the national family planning effort, most SSK hospitals do not offer family planning services, and sterilization services are not available to most women.

Training of Family Planning Service Providers

The MOH's in-service training program has trained more than 3,700 midwives and nurses and 2,500 general practitioners to insert and manage IUDs safely. Although this is a significant accomplishment, rapid turnover of all personnel in rural primary health care means that these numbers cannot be translated into assumptions about availability of care. The MOH's training capacity is limited and far less than the country needs to replace trained people who leave their posts and to ensure that all MOH hospitals and health centers have the capability to provide effective family planning services.

Other areas of need in the training effort include the following: 1) training to prepare family planning service providers to educate women regarding a range of contraceptive methods, especially to assist them to select their own best method of contraception and to manage pill side effects and support women using oral contraception; 2) voluntary compliance with a standard family planning curriculum in pre-service medical education, and the development of family planning clinical electives for sixth-year medical students who have a special interest in this subject; 3) stronger clinical training for midwifery students, including more experience with home births and learning how to manage complicated deliveries; and 4) better training and utilization of male nurses in family planning.

Contributions of A.I.D. Cooperating Agencies

The inputs of A.I.D. CAs have helped to make the entire MOH family planning training effort more effective: INTRAH helped to develop the training curriculum, RONCO trained the central training team in the use of participatory methods, and JHPIEGO helped the MOH to expand its training capacity and to develop an objective way to evaluate IUD insertion training. In addition, Pathfinder assisted the MOH in the development of the family planning curriculum intended for use in all midwifery schools;

RONCO assisted the MOH to conduct an important training of trainers (TOT) project for principals and tutors from midwifery schools that culminated in the development of a family planning training manual which is based on field needs assessments, addresses actual problems, and will be used in every pre-service midwifery school. Also, JHPIEGO has trained and equipped gynecologists to perform laparoscopic tubal sterilizations, and AVSC is training physicians to conduct minilaparotomies and nurses, psychologists, and others to educate and counsel women regarding sterilization and other methods of contraception.

Contraceptive Method Use

Withdrawal is the most popular method of contraception in Turkey, accounting for 40 percent of all contraceptive use. It is the most frequently used method among every age group, in every region of the country, and for urban as well as rural people. Although most midwives and physicians discourage the use of withdrawal, the only methods with fewer failures (as used in Turkey) are IUDs, rhythm and (presumably) sterilization. Some couples have used withdrawal successfully for many years and seem to prefer it. However, it appears that many other people use it because they believe that oral contraceptives are dangerous to women's health and they do not have adequate access to other methods.

IUDs are the second most commonly used method, accounting for 22 percent of method use. They are favored by most physicians and midwives who provide family planning in clinical settings, and appear to be a good method for many Turkish women. There seem to be few serious IUD complications, a relatively low incidence of sexually transmitted diseases (STD), and most women seeking contraception do not want to have more children. The two main problems associated with IUD use in Turkey are (1) that some women are being pressured to accept IUDs that they may not really want, and (2) that the MOH is not able to train enough midwives to make the method widely available.

Condoms are the third most commonly used method, and their use is increasing. Free condoms are provided to women through community-based distribution (CBD) programs and clinical family planning service sites. Men can buy them at pharmacies and free or low-cost condoms are provided to men through programs based at various work-sites.

Use of oral contraceptive pills is low, declining, and associated with poor continuation and a high incidence of contraceptive failure. Although 94 percent of women have heard of pills, and many have tried them, the general public and many physicians and midwives have incorrect beliefs about health risks associated with oral contraception. There is a self-reinforcing belief that Turkish women cannot learn to use pills correctly. Most women who try them buy their pills at pharmacies, where they are available without prescription; pharmacy workers make no effort to screen and/or educate the women who buy pills.

There is a very large unmet need for permanent contraception. Although three out of four couples want no more children, only 2 percent of fertile-age women have been sterilized and only 65 percent have even heard about female sterilization. However, more women are now asking for tubal ligations, but few services are available. This is due mainly to barriers other than a lack of persons who are capable of performing the surgery, including costs, institutional/organizational complexities, and the attitudes of gynecologists.

Turkish men support family planning: 89 percent of husbands approve of family planning, two male methods (withdrawal and condoms) together account for about half of all current use, and the men use these methods with more effectiveness than their wives use pills or vaginal spermicides.

Recommended Goals for Future A.I.D. Training Assistance

A.I.D. training assistance to Turkey should be directed towards six long-term goals:

1. Supporting and expanding the role of men in family planning;
2. Staffing every MOH health center with at least one midwife who is certified to provide all family planning services;
3. Making female sterilization services available in every province;
4. Ensuring the safety and overall quality of IUD insertion and follow-up care;
5. Providing unbiased information to women regarding oral contraception and improving the quality of care for women who choose to use pills; and
6. Improving pre-service midwifery education.

Because several groups of people play important roles in Turkey's pluralistic family planning service delivery system, the system would benefit from many different kinds of assistance. No single "silver bullet" form of assistance can solve the major problems and obviate the need for other kinds of help.

1. Introduction and Background

1.1 Purpose of Assessment

The United States Agency for International Development (A.I.D.) currently spends approximately \$3 million per year in direct and indirect support of Turkey's efforts to provide safe and effective family planning services to its people and to reduce the currently high level of 2.5 percent net annual population growth (based on information from the 1985 census). As A.I.D. does not maintain an office in Turkey, this assistance has been provided through A.I.D. Office of Population Cooperating Agencies (CA). Within the past year alone, 12 separate CAs have worked in Turkey. Oversight for this program of multiple discrete projects has been shared by staff of A.I.D.'s Office of Population, Bureau of Science and Technology, the Asia/Near East Bureau in Washington, D.C., and a Political Officer at the U.S. Embassy in Ankara, Turkey.

The last overall field assessment of A.I.D.'s population support to Turkey was conducted by a three-person team between September 27 and October 11, 1986. Because of the short time spent in country, this team was not able to observe the delivery of family planning services in rural areas or to investigate training and other issues in depth. Also, family planning in Turkey is a moving target: change is happening rapidly -- both in the demand for family planning and in the country's ability to respond to that demand. Thus, a timely, comprehensive assessment of A.I.D.'s entire program of population assistance to Turkey has been needed.

The over-riding goals of the overall assessment were to learn how effective A.I.D. population assistance to Turkey has been during the recent past and to plan for the most effective use of available funds during the near future. A training assessment was to be conducted as an integral part of this comprehensive assessment. (Scopes of work for the entire assessment and for the training assessment are attached to this report as Appendix A.)

1.2 Training Assessment Team

The training assessment team was composed of two Population Technical Assistance Project (POPTECH) consultants, Judith Rooks, CNM, MS, MPH; and Pinar Senlet, MD, DrPH. Mrs. Rooks is an American nurse-midwife and epidemiologist with a master of science degree in nursing education and a master of public health degree in maternal and child health. She has had extensive experience in family planning and maternal and child health services, training, and research both in the United States and in developing countries. Dr. Senlet is a Turkish physician with specialty training in public health. She has had extensive experience in family planning and maternal and child health services, training, and research in Turkey.

1.3 Methods, Scope, and Limitations of Assessment

Turkey is a large and diverse country with many separate institutions involved in providing health services and training health workers. The training assessment team was given a list of more than 40 discrete projects which have been supported by A.I.D. funds during the past year. The team divided its efforts between assessing the results of this A.I.D. support and gaining an understanding of family planning services in Turkey and of the training and performance of the people who provide those services in both the public and private sectors. The team also wanted to investigate the potential for new categories of people to become involved in family planning.

The methods employed for gathering information and gaining insights included reading and analyzing written reports and other documents, interviewing individuals, and visiting and observing maternal and child health and family planning training and service delivery sites and activities. (See Appendix B for a list of the places and institutions visited and the individuals interviewed during the assessment.)

Prior to the field assignment, one team member was briefed by officials of A.I.D.'s Office of Population and Asia/Near East Bureau, as well as by representatives of RONCO Consulting Corporation, the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), and The Pathfinder Fund. The team was not able to interview representatives of the other A.I.D. contractors with current projects in Turkey.

1.4 Socio-Economic Overview of Turkey

Although there is some incidence of malnutrition in Turkey, the country produces enough food to support its population of 55 million people. The country has serious environmental problems, however, and its leaders realize that its high population growth rate is a constraint to more rapid social and economic development. Further, Turkey's desire to be accepted into the European Community is likely to be thwarted until the country improves the health and educational status of its people. Twenty-seven percent of the women are illiterate,¹ and maternal and infant mortality rates are high: Turkey's infant mortality is nearly eight percent² (as compared to one percent in the United States³) and it has been estimated that there are currently 10 to 12 maternity-related deaths per day that could have been prevented by effective family planning.

Slightly more than half of the population live in urban areas; there are 23 million urban dwellers and 22 million rural dwellers. The western tip of Turkey is relatively modern and oriented towards a European way of life. The eastern areas are rural, traditional, and subject to long, harsh winters during which travel is difficult. People in rural areas live in small clusters of houses and use agricultural vehicles or take buses to get to market towns. There is considerable rural-to-urban, east-to-west migration within the country; currently almost half of the urban population are migrants from the rural areas. In an effort to slow migration to the cities, the government is making a concerted effort to improve rural housing and extend electricity and government services into previously isolated areas. A large-scale irrigation system is also being built to improve productivity and hasten development in the eastern region.

Newly arrived migrants to the urban areas settle on undeveloped land on the perimeters of cities, where they build simple cement houses. Communities of such squatter homes are referred to as "gecekondü" areas. The new homes are eventually provided with electricity, water, and sewers, but are without city services such as bus lines, schools, and MOH clinics. People in specific gecekondu areas often come from the same rural village, and there is some movement back and forth between the rural areas and these settlements.

¹Turkish Population and Health Survey report, Institute for Population Studies, Hacettepe University, 1988.

²World Bank Staff Appraisal Report, Republic of Turkey Health Project, April 7, 1989.

³National Center for Health Statistics, Department of Health and Human Services, provisional data for 1986.

There is also an annual seasonal migration of agricultural workers from the eastern provinces to farms in central Turkey, and large numbers of Turkish citizens have migrated to West Germany to work. However, many are returning to Turkey now that East Germans can work in West Germany. This can only add to the economic pressures in Turkey and increase the need for family planning and other public services.

1.5 Status of Family Planning in Turkey

1.5.1 Government Policy

Turkey passed its first Population Planning Law in 1965. A 1983 updating of this law removed most restrictions on surgical sterilization procedures and called on the MOH to train its midwives to insert intrauterine devices (IUD) and provide other methods of temporary contraception. It also allowed abortions through the tenth week of pregnancy. The government's policy is to provide family planning along with other preventive maternal and child health services to all Turkish citizens without charge. The 1983 law also made the General Directorate for Maternal and Child Health and Family Planning (GDMCHFP) responsible for providing family planning services through MOH facilities and for coordinating all aspects of the family planning effort.

1.5.2 Religious Support

The Turkish Higher Islamic Council views family planning favorably. In the past few years, however, there has been a slow change towards more religious conservatism in the country. If this trend continues, it could have a negative impact on political support for family planning.

1.5.3 Philanthropic Support

A long tradition of volunteerism and philanthropy among well-to-do Turkish people dates from the Ottoman Empire. There are more than 2,000 foundations, tax advantages for charitable giving, and a government directorate that regulates foundations. Four recently established foundations (with extremely limited financial endowments) are interested in family planning:

- The Foundation for the Advancement and Recognition of Women, which is run by the wives of many of Turkey's most important men and is chaired by the current president's wife, supports family planning, primary school education, and literacy for adult women.
- The Turkish Family Health and Planning Foundation (TFHPPF), whose board is composed mostly of businessmen, was established in 1985 for the purpose of improving and expanding family planning and health services in Turkey.
- The Human Resource Development Foundation (HRDF), established by a group of businessmen and scientists in 1988, seeks to address factors that hamper the social, economic, and cultural development of Turkey, especially environmental problems and the high rate of population growth. HRDF is particularly interested in playing a role in training.
- The Mothers and Child Health and Family Planning Foundation, which was established in Ankara in 1987.

The Pathfinder Fund assisted in the development of both the TFHPF and the HRDF with A.I.D. funding.

1.5.4 Mass Media Support

The mass media are interested in family planning. There are frequent newspaper and magazine articles on family planning and population, and two or three radio or television programs on the subject every month. (Television is popular and ubiquitous: television sets are in at least half of the country's homes, as well as in many tea houses and other public areas.)

1.5.5 Use of Contraception

A series of fertility/family planning surveys conducted at five-year intervals since 1963 has documented decreasing fertility and increasing use of contraception. Ever-married fertile women queried during the most recent (1988) study on average considered 2.1 children to be the ideal number -- one child less than the ideal number found during a survey done in 1978. Changes in family economics -- especially the impact of an inflation rate greater than 100 percent a year and social changes, particularly in the roles of women -- have promoted the desire for smaller families. The 1988 survey also found that about three-fourths of reproductive-aged couples do not want to have more children. Although this study found significant fertility and family planning differences between groups of people within Turkey, people in all parts of the country both want and try to limit family size.

Current use of contraception (any method) increased from 50 percent in 1978, to 62 percent in 1983, and 77 percent in 1988. Only 6.7 percent of ever-married women (5.5 percent of currently married women) in the 1988 survey were not using any method of contraception and did not want to become pregnant. (The most common reasons for not contracepting given by the women who did not want to conceive but were not using contraception were health concerns, "husband does not want," and lack of knowledge. Difficulties in access to family planning services or expense together accounted for only 12 percent of the 6.7 percent, or less than 1 percent of the total number of women exposed to pregnancy.) Even with this level of use, however, Turkish women are obviously not contracepting with enough success: almost 37 percent of women who had at least one live birth between 1983 and 1988 said that their last babies were either not wanted or mistimed. In addition, approximately one of every four pregnancies in Turkey is terminated by a legal abortion. Thus, it is clear that the relatively high prevalence of contraceptive effort is not yielding adequate results. (It should be noted that a similar study conducted in the United States in 1982 found that 38 percent of births were unwanted or mistimed; and 27 percent of pregnancies in the United States are terminated by legal abortion.)

1.5.6 Family Planning Methods Used

Half of the Turkish women who are trying to contracept use "traditional" methods. Turkish family planning leaders refer to all methods that require supplies or medical services as "modern," any methods that do not require supplies or medical services as traditional, and assume that traditional methods are less effective than modern. However, 52 percent of women surveyed in 1988 believed that traditional methods are as effective as modern methods, and, in practice, it appears that they were right. The 1988 survey found that the rate of unintended pregnancies was almost twice as high among couples relying upon pills for contraception (whose failure rate was 25.9 percent) as compared to couples using the traditional methods of withdrawal (for which the failure rate was 13.9 percent) or rhythm (11.5 percent). Table 1 presents the contraceptive failure rates associated with use of specific family planning methods in Turkey. Nevertheless, current use of modern methods is increasing -- from 18 percent of exposed women in 1978, to 27 percent in 1983, and 38 percent in 1988; this is despite an actual decline in pill use during the past five years.

The recent increase in modern methods is due to an almost doubling in current use of condoms (from 5 percent to 9 percent) and in IUD use (from 9 percent to 17 percent) between 1983 and 1988.

Although only 38 percent of currently married women were using a modern method of contraception in 1988, it was not because the women did not know about these methods: 94 percent of women knew about pills and IUDs (at least 90 percent in rural regions), and 60 percent had tried a modern method. But only about half of the couples who had ever tried a modern method were still using a modern method when they were interviewed for the latest survey.

Using data from the 1988 survey, the assessment team attempted to determine (1) what percent of those who had heard of each method had tried the method, and (2) what percent of those who had tried each method were still using it at the time of the survey. Data from women was used to calculate percentages for IUDs, pills, vaginal spermicides, and female sterilization. Because a husband's full participation is necessary for effective use of withdrawal, rhythm, and condoms, information provided by husbands was used to calculate percents for those three methods. There were some disparities between reports by men and women for almost all methods used.

Table 1 shows, for instance, that although only slightly more than three-fourths of the men knew about withdrawal, more than 60 percent of those who had heard about it had tried it, and almost half of those who had tried it were still using it when they were questioned for the survey. This is in stark contrast to the pill: although 94 percent of the women had heard of the pill, only 40 percent of those who had heard of it had tried it, and only one-fifth of those who had tried pills were still using them when surveyed.

About one in four women who had heard of IUDs had tried them, and more than two-thirds who had tried an IUD were still using it when surveyed. Continuation rates are fairly high for condoms and rhythm, but are low for pills and vaginal spermicides.

Because men are the dominant decision makers in most Turkish households, their support and active participation in family planning is essential. Fortunately, most husbands (89 percent) approve of its use by married couples. Two male methods, withdrawal and condoms, together account for 46 to 52 percent of all current use of contraception (depending upon whether the estimate is based on data provided by wives or by husbands). However, 82 percent of the husbands interviewed want to learn more about family planning, and 72 percent think that family planning services are insufficiently available. Taken together, these data imply that some men who are using withdrawal and condoms would rather have their wives use another method but feel that they do not know enough about the other methods or that those methods are not available to them.

See Section 4 of this report for a more detailed discussion of the family planning methods used in Turkey.

1.6 International Donor Assistance for Family Planning Programs

Turkey receives family planning assistance from the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the International Planned Parenthood Federation (IPPF), the Federal Republic of Germany, Japan, Canada, and a number of A.I.D.-funded private organizations. Family planning is given an unusual degree of emphasis by the UNICEF office in Turkey. In addition, the Government of Turkey is considering a World Bank proposal for a loan-funded project to strengthen the management of the MOH and improve access to basic health services for people in 10 provinces.

**Table 1
Overview of Contraceptive Use⁴**

Method used	% who have heard of the method	Of those who have heard of it, the % who have tried it	Of those who have tried it, the % still using when surveyed	% Contraceptive failure rates
Withdrawal	79.9	62.3	46.3	13.9
Pills	94.0	40.3	20.1	25.9
Rhythm	45.7	39.2	36.3	11.5
IUDs	94.0	26.8	67.9	5.0
Condoms	76.0	36.1	45.2	14.5
Vaginal spermicides	63.0	21.6	16.2	27.0
Female sterilization	65.0	2.9	100.0	not available

1.6.1 Major Contributions of A.I.D. Family Planning Training Support

Appendix C is a computer printout of activities in Turkey that were listed in the A.I.D. Population Projects Data Base as of August 7, 1989. It includes projects conducted by 12 different CAs. Four of these CAs -- the Association for Voluntary Surgical Contraception, Johns Hopkins Program for International Education in Gynecology and Obstetrics, The Pathfinder Fund, and RONCO Consulting Corporation -- have provided significant support for family planning training; their contributions are summarized briefly below and are discussed more fully throughout this report in the context of the contribution each has made to the delivery of family planning services.

Association for Voluntary Surgical Contraception (AVSC)

AVSC began to work in Turkey during the 1970s, but increased its level of effort following enactment of the 1983 law which removed many previous legal restrictions to sterilization. Currently AVSC is involved in five projects, the largest of which is a five-year (1987-1992) project to assist the GDMCHFP in strengthening the MOH's capability to provide voluntary surgical contraception (VSC) services as an ongoing part of its family planning program (see Section 2.3 for a more complete description of this project). Although one objective of the project is to develop

⁴Calculations are based on data presented in tables 11.3.9, 11.6.11, 11.6.17, 11.3.9, 11.3.10 in the 1988 Turkish Population and Health Survey.

Ankara Maternity Hospital as a training and demonstration center for outpatient minilaparotomies under local anesthesia, all procedures are still being done under general anesthesia and all patients are hospitalized for at least one and usually several days.

AVSC also has a project to develop VSC services at one or more Social Security Institution (SSK) hospitals in eight provinces (see Section 2.5.1). This is similar to the MOH project except that it does not call for the development of another training and demonstration center. The training capability being developed at Ankara Maternity Hospital is considered as a national (rather than an MOH) resource, and so is also used to train personnel from the SSK.

In addition, AVSC has a contract with Hacettepe University in Turkey to evaluate the effectiveness of two different ways to provide education and information about sterilization; it has translated its document on medical standards for VSC into Turkish (after being reviewed, the translation will be distributed by the GDMCHFP); and it is planning a conference to develop a strategy to introduce minilaparotomy training into pre-service medical education.

Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO)

JHPIEGO has maintained contact with family planning leaders in Turkey since 1973, and has included Turkish participants in its U.S.-based and regional training courses since 1980. These courses cover a broad range of reproductive health topics; most participants are master trainers or individuals in positions from which they can put into effect national family planning policies. JHPIEGO began to provide laparoscopy training in Turkey in 1984, and since then has trained and equipped more than 50 laparoscopic surgical teams in many provinces.

During 1986-1988, JHPIEGO provided assistance to the GDMCHFP's program for in-service family planning training of MOH midwives, physicians, and nurses. During this project JHPIEGO helped the GDMCHFP to develop 10 additional maternal and child health and family planning (MCHFP) training centers, conducted a 10-day training of trainers (TOT) workshop for GDMCHFP trainers from Ankara and 16 provinces, and provided support for GDMCHFP clinical family planning training courses for approximately 200 other midwives and general practitioners (GP). Through this project JHPIEGO assisted the GDMCHFP central training team to improve and standardize its training practices, to develop criteria for awarding certificates to trained personnel, to prepare a protocol to improve the effectiveness of evaluation/supervision site visits, to develop plans to objectively evaluate the knowledge and IUD insertion skills of physicians and midwives several months after they were trained, and to expand significantly their training capacity (see Section 2.2).

In 1988 JHPIEGO assisted the GDMCHFP and the Council of Higher Education (YOK) to convene a conference of the deans and gynecology/obstetrics department chairmen of all medical schools for the purpose of developing a standard family planning curriculum for pre-service medical education. Although the objective was not achieved, the meeting stimulated improvements in the curricula of several schools and increased interest in the issue of the family planning content of pre-service medical education. (See Section 3.2.2.)

JHPIEGO recently started a project to enhance the capacity of two MOH facilities to screen for, diagnose, and treat sexually transmitted diseases (STD). (See Section 4.2.1.)

The Pathfinder Fund (Pathfinder)

The Pathfinder Fund has been the lead CA in Turkey for a number of years, and has a country representative who has been instrumental in initiating important training and

curriculum development activities. Pathfinder assisted the GDHT to develop the family planning curriculum which is now being introduced into every pre-service midwifery educational program in the country (see Section 3.1.4). Currently Pathfinder is assisting the Human Development Resources Foundation to begin a program of continuing education in contraceptive technology for health professionals, including pharmacists and private gynecologists. The program's first activity was a two-day workshop for MOH and university physicians in March of 1989 (see Section 3.2.3). Translation of the international edition of *Contraceptive Technology*, by Hatcher, et al., into Turkish is under way, and other plans are being made. In addition, Pathfinder has trained various types of workers for the many community and work-site based family planning service delivery programs it has initiated and supported.

RONCO Consulting Corporation (RONCO)

RONCO worked in Turkey under an A.I.D. contract between 1984 and late 1989. (The Program for International Training in Health [INTRAH], at the University of North Carolina, worked in Turkey under a similar contract from 1980 to 1985.)

RONCO assisted the GDHT in an important project to improve family planning training in pre-service midwifery education. This complex but very successful project enhanced the skills of tutors in at least 17 of the nation's 41 midwifery training programs and culminated in the development of a family planning training manual, which will be used in all pre-service midwifery schools. The project is described in Section 3.1.4.

During 1987-1988, RONCO conducted a project to help the Family Planning Association of Turkey (FPAT) train volunteers from six of its 27 branch associations. The purposes were to assist the branch offices to become more active and effective and to increase the training capacity of FPAT's central officers and staff. Although this project increased activity in the branch offices (see Section 2.5.4), the central office of FPAT needs an in-house training team in order to realize the potential that rests in the inactive branch associations.

During 1986-1987, RONCO assisted the GDMCHFP and local MOH officials in two provinces to train local leaders in a few communities to carry out MCHFP information, education, and communication (IEC) activities, distribute MCHFP supplies, and support the work of the young midwives who were working in the target villages. The project had only a brief effect in the villages and has not been replicated (see Section 3.3.4). RONCO also assisted the Institute for Child Health, at the University of Istanbul, to conduct a course on family planning and maternal and child health for about 40 participants, and supported two meetings to bring government and private agencies together for the purposes of joint planning and collaboration.

1.6.2 UNFPA Support

UNFPA supports only government agencies, mainly the MOH. Between 1984 and 1989, UNFPA assisted the GDMCHFP in a five-year project to upgrade and expand the training of health professionals in 17 eastern and southeastern provinces. The GDMCHFP training program described in Section 2.2 has been funded primarily by UNFPA. The 17-province project is now ending and a new five-year project, to focus on 11 other provinces, is being started. Lists of provinces included in these projects are appended to the report as Appendix D. In addition to training support, UNFPA provides supplies and equipment, including some vehicles.

UNFPA's support for government action in eastern Turkey does not mean that A.I.D.'s support should go primarily to private agencies or only to programs in the western provinces. A.I.D. CAs provide a different kind of assistance than that provided by UNFPA: UNFPA mainly provides large amounts of money for large governmental programs and supports

activities that have already been successfully demonstrated somewhere else. A.I.D. provides smaller amounts of money for smaller, more localized projects and often supports innovations, demonstrations of new ideas. Thus, the two kinds of assistance are complementary and not redundant.

**2. Family Planning Service Delivery
and
In-Service Training of Family Planning Workers**

2. Family Planning Service Delivery and In-Service Training of Family Planning Workers

The MOH operates a massive health care delivery system through which it attempts to provide free preventive health care to the entire population and to provide curative services for which fees are charged (but waived for indigents). In addition, there are a variety of private hospitals, a large number of private physicians, a small number of private midwives, and 9,000 private pharmacies (mostly in urban areas). Fifty-eight percent of the population is covered by some form of pre-paid health care service or insurance on the basis of their status as employees, retirees, or as members of the military or of labor unions, etc. Many of the pre-paid health plans, however, provide curative services only, forcing their clientele to rely on MOH facilities or private physicians for family planning care.

Family planning, including sterilization operations, and prenatal, childbirth, and well-baby care are included within the preventive services that are supposed to be provided by the MOH without charge (except for hospital bed fees) to all Turkish citizens. The MOH is the major source of health care for most rural people, and for poor people throughout the country. Many urban people, however, are able and willing to buy their own contraceptive supplies and are either covered by health insurance or can afford to pay for private care. Most pharmacies carry condoms and several brands of pills, which can be purchased without prescription. The cost for a month's supply of pills is about the same as for a single pack of cigarettes (and many women smoke). The 1988 fertility/family planning survey found that 79 percent of women who use pills and 69 percent of women who use condoms buy them in pharmacies. Although MOH facilities are the main source of IUDs (for 53 percent of the women who use them), private providers (pharmacies, physicians, and hospitals) are the source for 54 percent of women who use them in the west, which is the region with the highest use of IUDs. In the two most rural regions (north and east), MOH facilities are the source of IUDs for 72 and 63 percent of users, respectively.

2.1 Services Provided through the Ministry of Health (MOH)

The MOH functions through six general directorates, four of which play roles in family planning:

The General Directorate for Maternal and Child Health and Family Planning (GDMCHFP). The GDMCHFP operates 200 MCHFP centers, and is responsible for coordinating and leading the entire national family planning effort. Its responsibilities include the setting of and planning towards the achievement of goals; facilitating coordination between various directorates within the MOH, between the MOH and other components of the government, and between the MOH and private voluntary organizations (PVO); compiling, analyzing, and using family planning service statistics; training health personnel to provide family planning services, including sterilization; and providing, storing, and distributing contraceptive supplies. At the present time, the GDMCHFP also manages the importation and distribution of family planning supplies for PVOs, as well as for all MOH family planning service delivery sites. These contraceptives are supplied by A.I.D. through a project with Family Planning International Assistance (FPIA).

The Government of Turkey works on five-year plans; it is currently developing the Sixth Development Plan for the period from 1990 to 1995. As part of the preparation of this plan, the State Planning Organization is developing long-term goals for the MOH. The

GDMCHFP, in turn, needs to develop its long-term goals and strategies in order to feed them into the MOH plan. The GDMCHFP has requested financial and technical assistance for the planning process from JHPIEGO. Weaknesses of the current plan have been identified and should be rectified in the GDMCHFP's next plan.

The General Directorate for Primary Health Care (GDPHC). This directorate is responsible for family planning services provided through the primary health care system, i.e., 1,030 urban and 2,200 rural health centers and more than 10,000 health houses or health posts, which are the worksites for village-based midwives who constitute the MOH's farthest outreach into communities.

The General Directorate for Curative Medicine (GDCM). This directorate is responsible for MOH hospitals and thus for sterilization procedures, childbirth care, and induced abortions in MOH general and maternity hospitals.

The General Directorate for Health Training (GDHT). This directorate is responsible for the schools that train most of the country's midwives and female and male nurses.

Most important decisions within the MOH are made in Ankara, although provincial health directorates (one for each of the country's 71 provinces) play important implementation roles. In the past few years, some municipalities have begun to play a limited role in the provision of local health care (due to their acquisition of additional tax revenues since 1983).

2.1.1 MCHFP Centers

The GDMCHFP provides temporary methods of family planning through 200 MCHFP centers, some of which are located in or adjacent to hospitals. Each MCHFP center is supposed to be staffed with one gynecologist, one pediatrician, two general practitioners (GP), one dentist, one dietician, one nurse (college-educated, if possible) one laboratory technician, eight midwives, and an administrator. (Actual staffing varies: one MCHFP center visited by the assessment team in Ankara has 41 staff members, including 11 physicians, 2 dentists, and 16 midwives.) MCHFP centers located in or adjacent to hospitals provide abortions. Some MCHFP centers also serve as training centers.

The assessment team visited five MCHFP centers in Ankara, Istanbul, Adana, and Diyarbakir. Those visited in the mornings were full of patients; most kept three or more physicians or midwives constantly busy examining patients and inserting IUDs. All were clean and had adequate staff and equipment, although space was often at a premium, creating a sense of crowding and pressure. Some centers have rooms that can be used for patient education, when time permits. However, none of the facilities had space or allotted time for individual patient counseling, and efforts to provide privacy were rudimentary at best. Some patients are told to come to the clinic on a specific day, but there are no actual appointments; people wait in lines, first come, first served. Thus, most come early in the morning. The clinics continue until all patients have been seen, but new patients are not expected to arrive during the afternoon. Since most of the physicians work part time, they leave the clinics during lunch or early in the afternoon to go to their private offices.

2.1.2 Primary Health Care: Health Centers and Health Houses

There are 3,232 health centers, of which 32 percent are in towns and cities and 68 percent are in rural villages. Urban health centers are supposed to be staffed with 2 general practitioners, 2 midwives, 2 nurses, 1 health officer (male nurse), 1 driver, and 2 housekeepers. Rural health centers are supposed to have 1 general practitioner, 1 midwife, 1 nurse, 1 health

officer, and 1 housekeeper, but no driver (and no vehicle). Actual staffing varies; for example, the rural center visited by the assessment team had 3 midwives. There are not enough GPs to staff all health centers in some areas; e.g., Adana Province has a shortfall of 30 percent and some health centers are operating without a physician. Health center GPs are usually new graduates randomly assigned to work in primary health care in order to pay the country back for their free medical education. Although they are assigned for two years, few GPs actually spend that long in a rural assignment. Those with connections use them to get reassigned to a town, and some can leave early to join the military.

Housing for the staff is located on the grounds of rural health centers. The centers provide primary preventive and curative health care to the people within a defined catchment area. Each rural health center serves an area with no more than 10,000 population. Urban health centers serve areas with populations of 20,000 to 50,000, including many people who have access to other sources of care. Midwives assigned to health centers manage births in the centers and provide a variety of maternal and child health services, including family planning. People with problems that cannot be handled at the health center are referred to the nearest district hospital.

The GDMCHFP conducts intensive courses to train midwives and GPs to provide family planning services, including the insertion of IUDs (see Section 2.2). However, only about 35 percent of the health centers have either a midwife or a GP who has been trained and is certified to insert IUDs. The percent is higher in the 17 provinces that were included in the special UNFPA-funded project; for example, 58 of 86 health centers in Adana Province (67 percent) have someone who is certified for IUDs. Health centers without trained personnel (mainly in small villages) provide pills and condoms and refer women who want IUDs to a center in the nearest town.

Three or more health houses (also called health posts) are supposed to be associated with each health center. If there is no health house building, the rural midwife works out of her own home. Each health house is located in a village within the health center's catchment area and is staffed by a midwife who works alone except for supervision by the GP and more experienced midwives in the health center. Lack of access to transportation renders regular supervision impossible in some areas. Health post midwives are supposed to provide a very broad array of primary health care services, including contraception and assistance at childbirth, to all families in their areas and to do this mainly through home visits. They also maintain a registry of every household in their areas (4 or 5 villages), and report and register births and deaths.

The youngest, least experienced midwives are often assigned to rural health posts, making them the weakest (sometimes missing) link in the MOH system. Of 10,585 health houses listed with the GDPHC as of October 1989, only 7,521 (71 percent) were actually staffed with midwives.⁵ Like the GPs, most health post midwives are new graduates fulfilling their obligations to the government. As the midwives are usually young (often less than age 20 when they graduate), inexperienced, unmarried, and strangers in the area where they are supposed to work, the plan for them to function as independent practitioners who walk or hitch rides to make home visits in three or more separate villages has not always worked out well.

In addition to routine services (patients coming to the health center and midwives making home visits), the health centers and their associated health post/midwives participate in periodic immunization campaigns, for which transportation is provided. These campaigns increase immunization coverage and improve overall health post functioning by providing an opportunity for

⁵Statistics provided by the Acting General Director of the General Directorate for Primary Health Care, Ankara, Turkey.

the health post staff to visit every village.

The assessment team visited Incirlik Health Center (in a heavily populated agricultural area near Adana), and Mermer Health Center (in rural Diyarbakir Province). Incirlik functions much as an urban health center, with many patients and a full complement of staff. However, because it is involved in a special Pathfinder-funded project for migrant workers, it may be benefitting from special attention and resources. On the other hand, the Mermer Health Center, which was selected at random, is typical of a rural health center in eastern Turkey. The assessment team also visited a health house associated with Incirlik Health Center and intended to visit all health houses associated with Mermer Health Center. Unfortunately, upon arrival at Mermer the team learned that only two health post midwives have been assigned to that center (two health posts per health center is average in Diyarbakir Province), and one of them had not moved there yet and the other was on maternity leave. Thus, for the time-being, there are no outreach midwives for this rural health center. The health centers themselves are clean, attractive facilities with adequate equipment and young, energetic staff who seemed interested in their work. None of the three midwives encountered were new graduates; all three seemed competent and comfortable in performing their roles.

The MOH reports that 90 percent of Turkish infants received at least one diphtheria, pertussis, tetanus (DPT) immunization in 1988, and that 77 percent of infants received all three DPT shots. As birth registration is incomplete in some rural areas, these percentages may be too high. In addition, only 11 percent of the women who had babies during the past five years received a tetanus toxoid shot while pregnant. The high rate of infant immunization is due in large part to immunization campaigns. Coverage based on the constantly available services is lower. In Adana, a primarily rural province, the MOH provides preventive health services to about 60 percent of women during pregnancy, to about 85 percent of women during childbirth, and to 92 percent of infant children.

2.2 In-Service Family Planning Training Conducted by the GDMCHFP

The MOH has been training physicians, midwives, and nurses in family planning service delivery since 1968. A more intensive program was developed in response to the 1983 law which called for midwives and GPs to be trained to insert IUDs and prescribe oral contraceptives. The GDMCHFP provides the training through the efforts of a six-person Central Training Team (CTT) in Ankara and 35 training centers which are dispersed throughout the country. The CTT trains about 100 people each year, including trainers for the other training centers, in courses which it conducts at the MOH training center in Ankara. The 35 training centers train midwives and GPs to provide clinical family planning services in MOH service delivery sites, including hospitals, MCHFP centers, health centers, and health houses. Midwives and GPs must be trained at one of these centers and must receive a certificate from the GDMCHFP in order to insert IUDs.

Most of the training centers function within a high-volume GDMCHFP service center. Only a few midwives and GPs are trained during a course; some centers train only one or two people at a time. Trainees have supervised clinical experience during the mornings, when the MCHFP centers are busy taking care of patients. Afternoons are used for didactic instruction and discussions. In some places, the numbers of students may be constrained by the availability of IUD patients; to be certified, each trainee must conduct at least 60 pelvic examinations and insert at least 25 IUDs.

Trainers for the outlying training centers are selected by members of the CTT, who visit the target provinces to select four or five individuals (usually a GP, midwife, nurse, health

officer, and health educator) to be trained to serve as the Provincial Training Team (PTT). They try to select individuals who have already been trained and are experienced in family planning. Other criteria are that the individuals like their jobs, think their work is important, want to stay in the same province for a long time, are not too young (inexperienced), or too old (close to retirement), and have strong verbal skills. Training teams from five or six provinces are trained at the same time in a four-week TOT course. The physicians are not there for the first three weeks, which are devoted to TOT; they join the group for the last week, during which the emphasis is on supervision and evaluation. After the course, the PTTs return to their provinces, where they begin to conduct their own four-week courses for midwives and three-week courses for GPs. Members of the CTT visit the provinces to help the newly trained provincial training teams teach their first two courses. A member of the CTT assists during two weeks of the first course and one week of the second course taught by each newly trained PTT.

The GDMCHF training reflects and replicates the existing pattern of clinical family planning in Turkey -- a program of careful, competent, conservative IUD insertion and follow-up; condoms for those who cannot use IUDs; little respect or attention paid to pills; and little or no counseling or informed choice for patients.

A major purpose of this training program is to train and certify midwives to insert IUDs. Midwives do not hold high prestige in Turkey, and by 1983, when the law which stimulated this training was passed, IUDs were losing favor in some countries because of the risk of pelvic inflammatory disease (PID). Thus, the idea of allowing midwives to insert IUDs was controversial, to say the least. It is not surprising then, that the training has focused heavily on the technical aspects of IUD insertion. The GDMCHF has evaluated the results of this training program on several occasions and is satisfied that the training produces careful clinicians who can manage IUD contraception safely. During field trips, the assessment team looked for evidence of IUD complications; it appears that there are few. Considering that IUDs are the second most prevalent method of contraception in Turkey and account for 45 percent of the use of modern methods, the training of large numbers of people to insert and manage IUDs safely is a significant accomplishment. On the other hand, the training does not focus on developing the knowledge, attitudes, and counseling skills required to assist patients to select their own best method of contraception or to manage pill side effects and support women using oral contraception.

The GDMCHF also trains GPs to perform menstrual regulations, trains gynecologists in laparoscopy and microsurgery, trains operating room nurses to assist during laparoscopic surgical procedures, trains midwives and nurses in supervisory skills, and provides "adaptation training" for newly graduated personnel who are beginning their first assignments in a primary health care setting. Table 2 provides information on the numbers of MOH personnel trained through GDMCHF in-service training programs since 1969. There is no consistent, centrally organized program of refresher training.

The GDMCHF's training capacity is limited and far less than the country needs. Since 1984, the GDMCHF Training Division has directed much of its effort to the 17 high-need eastern provinces that were the target for a special five-year (1984-1989) project funded by UNFPA and UNICEF. Although these provinces have the greatest proportions of high-risk, poor, rural people who have little access to alternative sources of family planning care, the GDMCHF's concentration on these provinces means that MOH facilities in other parts of the country have relatively few people with family planning expertise. Although there are many private physicians in the predominantly urban, western provinces, the MOH may be the only affordable resource for the impoverished families in gecekondu areas. Even within the 17 provinces that have been the main beneficiaries of the training program to date, many health centers are without anyone who can insert an IUD. The GDMCHF and UNFPA will field a major independent evaluation of their training program in the spring of 1990.

**Table 2
Personnel Trained through GDMCHFP In-Service Training Programs**

Topic	1969-1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989*	Total
IUD Insertions GPs	505	67	26	36	44	46	63	45	53	105	112	82	86	164	163	199	138	169	2,083
IUDs and Menstrual Regulations GPs											25	23	89	59	73	58	77	54	456
Laparoscopy Gyn/Obs										34	40	31			121	70			298
Microsurgery Gyn-Obs															5		5	5	15
Adaptation Training for PHC Services GPs											250	178	38		255				721
IUD Insertions Nurses & Midwives	38	39	49	25	124	9	76	139	223	49	143	164	217	191	394	474	883	486	3,723
Laparoscopy Nurses										77	43	22	12		44				198
Training of Supervisors Nurses & Midwives										12	25				12				49
Adaptation for PHC Services Midwives												138	137	261	1503	1231	239		3,509
Training of Provincial Trainers All Non-Physicians													20	17	33			25	95
Adaptation for MCHFP Services Male-Nurses														129	86	13			228
Totals By Year	543	86	75	61	168	55	139	184	276	277	638	638	599	821	2,689	2,045	1,342	739	11,375

* 1989 data are not complete.

More than 3,700 midwives and nurses and 2,500 general practitioners have been taught to insert IUDs. The number of midwives and nurses who received this training increased by 86 percent between 1987 and 1988, in part because of a JHPIEGO project that supported the development of 10 additional training centers. Although the GDMCHFP provided clinical family planning training to more GPs (223) than midwives and nurses (191) in 1985, more midwives than physicians have been trained during every year since then; in 1988, physicians constituted only 24 percent of those who were trained to insert IUDs. This is an appropriate trend, given the roles of midwives and of GPs within the MOH.

Rapid turnover of all personnel in rural primary health care means that the numbers in Table 2 cannot be translated into assumptions about availability of care. Once trained, however, most midwives probably continue to use their family planning skills. A much greater training capacity is needed to replace trained people who leave their posts and to ensure that all MOH hospitals and health centers have the capability to provide modern family planning services, as well as to provide refresher training.

Although A.I.D. has not supported the main cost of the GDMCHFP training program, A.I.D. inputs have helped to make the entire effort more effective. INTRAH helped to develop the training curriculum, RONCO trained the central training team in the use of participatory training methods, and several members of the CTT have participated in JHPIEGO courses. JHPIEGO helped the GDMCHFP to expand its training capacity and to develop an objective way to evaluate the IUD insertion training.

2.3 Reproductive Health Services Provided in MOH Hospitals

All 26 MOH maternity hospitals operate family planning clinics, as do about two-thirds of the other 97 MOH hospitals. In addition, MOH hospitals are important sources for tubal ligations, hospital childbirth services, and induced abortions for women who lack access to private care.

Pregnancy diagnosis. Because all legal abortions are limited to the first ten weeks of pregnancy, most women who think they may be pregnant and who may want abortions do not delay in finding out. MCHFP centers located in or adjacent to maternity hospitals inform women who come to the hospital for abortions about the availability of free contraceptive services and give them appointments or suggest that they have IUDs inserted immediately after their abortions. More could be done, however, to reach women who come for pregnancy diagnosis and learn that they are not pregnant; most of them are in need of contraception too. In addition, many abortions are done in hospitals that are not associated with an MCHFP center. In these cases, the hospital staff seems to see its job as limited to performing the abortions, while staff of a nearby MCHFP center may see their job as limited to taking care of only those women who come to the center for services. Neither group reaches out to provide family planning information and referrals to women who come to the hospital for abortions.

Female Sterilization. Tubal ligations must be performed by gynecologists in hospitals. AVSC and the GDMCHFP are collaborating in a five-year project to increase the availability of sterilization services in MOH hospitals. Major objectives are to develop Ankara Maternity Hospital as a demonstration and training center for minilaparotomy and local anesthesia; to develop voluntary surgical contraception (VSC) services, including systematic information, education, counseling, and referral, in one or more hospitals in 20 provinces; to make male VSC available at one service delivery site; and to train the personnel who will be needed to accomplish all of this. During the first three years of the project (1987-1989), the MOH trained 27

gynecologists to perform minilaparotomies and 188 MOH staff in counseling techniques (14 gynecologists, 57 GPs, 105 midwives and nurses, and 12 trainers, social workers, and psychologists).

The assessment team visited Ankara Maternity Hospital. They are currently performing 5 to 10 tubal ligations a day, mostly as interval (i.e., not post-partum) procedures. About half are done by laparoscope and half are minilaparotomies (depending on how fat the woman is). Regardless of which technique is used, all women who have tubal ligations spend at least one night in the hospital. As far as the assessment team could ascertain, no out-patient sterilizations are being done in Turkey. In Ankara, as in every other place visited by the team, there are women who want to be sterilized but cannot get appointments at MOH hospitals. See Section 3.8 regarding barriers to the provision of sterilization services.

In-hospital Obstetrics. The assessment team visited four maternity hospitals in major cities -- Ankara, Istanbul, Adana, and Diyarbakir. Most women who give birth at Ankara Maternity Hospital are given information about family planning and where and when to obtain a contraceptive method. Staff at the other three maternity hospitals, however, do not make an effort to provide information about family planning to women who are hospitalized following childbirth. Nor do staff from the nearby MCHFP centers go to the hospitals to talk to women in the post-partum wards; this could be done during the afternoons, when most MCHFP centers have few, if any, patients.

Ankara Maternity Hospital tried post-partum IUD insertions but discontinued the practice because of a high incidence of lost IUDs.

Only about 20 percent of women return for a routine four- to six-week post-partum visit.

2.4 Summary Assessment of the Role and Potential of the MOH in Family Planning Service Delivery

Although there has been consistent policy support for family planning over the past six years, the frequent changes in the leadership of the MOH have encumbered full implementation of those policies.

Also, recent national leadership favors a free enterprise approach to the delivery of health care. A decrease in the MOH's share of the government budget, from 4.1 percent in 1979 to 2.3 percent in 1986, reduced the quality of public health services. Although this was remedied in part by a budget increase in 1987, money is not the only concern. There seems to be a widespread reduction in policy-level support for public health. Medical school departments of public health have lost positions and resources and now find it hard to recruit young physicians into the field of public health. In some cases, beautiful new medical schools and university hospitals have been built on sites which are inaccessible to the average citizen, and specialize in teaching and providing highly technical care for uncommon diseases. For example, a new medical school building and university hospital were built in the countryside about a half-hour's drive from the city of Diyarbakir. It is a beautiful, modern building, but seems to have few patients. Although the medical school has a department of gynecology and obstetrics and is responsible for training medical students and specialists in gynecology and obstetrics (Gyn/Ob), the hospital has only one or two deliveries per day, never accepts a woman for uncomplicated childbirth, and has no family planning clinic (or indeed any clinic intended to resolve the most common health problems in that community).

Previous successful approaches used to induce young physicians to serve time in the rural primary health care system have been abandoned for less successful approaches. At one time, physicians who worked in rural health facilities were paid more than physicians in cities, and general practitioners who had worked in a rural area for several years were given preference for entrance into specialty training. Both of these enticements were discontinued in favor of the current approach, which requires new graduates to repay the government for their free education by spending two years in a post assigned to them by the MOH. However, current plans will reduce the young physician's obligation to only one year, and there is talk of eliminating the requirement altogether. One alternative under consideration would attempt to make MOH employment attractive by raising salaries for MOH physicians and giving a test to make entrance into government service competitive and selective. This plan anticipates a large influx of less well-trained young physicians as a result of the government's having opened 11 new medical schools within the past two or three years. Although most young physicians do not want to go to rural areas, many use their connections to get early transfers, and few stay once their obligation is over, while there most give their best effort; they make a critical contribution to health care delivery in Turkey. The current partial success of the MOH system is highly dependent on a continuing supply of such young physicians.

Because of the general de-emphasis on public health, unreliable support for family planning at the highest levels of the MOH, possible reduction or elimination of obligatory government service for physicians, and the unknown effects of the imminent influx of less well-trained young physicians, one cannot assume that the MOH will continue in the future to do as well as it is doing now. Yet, large numbers of well-educated, hard-working and dedicated professionals are trying to improve this system, and their accomplishments should not be underestimated. Overall, it appears that the system works, at least down to the level of the health center. The health post concept works in some places, but is dependent on the abilities of individual midwives, some of whom are extremely effective; however, some of them are too young and inexperienced to be positioned so far from support so early in their careers.

The GDMCHFP training program does a good job of training GPs and midwives to manage a large IUD program with a minimum of complications. The training program is, however, biased towards the insertion of IUDs and does not adequately prepare clinicians to provide family planning counseling or to encourage and support women in the use of oral contraception. In addition, lack of adequate numbers of trained midwives means that clinical family planning services cannot be offered in many MOH centers. Inadequate amounts of equipment, poor supervision, and lack of a functional referral system are also important deficiencies. Nevertheless, the MOH's ability to identify problems and its willingness to make changes to address them is impressive. This does not mean that all problems will be solved, many of them are intractable; but there is much evidence that it is a dynamic and responsive system.

2.5 Family Planning Provided Through the Private Sector

2.5.1 Services Provided by Non-MOH Hospitals

This strategy takes advantage of the existence of ongoing systems that have been developed to provide health care to large groups of people whose eligibility is based on current or past employment or membership in a union. In addition to the efficiency of adding family planning to an existing health care system, this strategy takes advantage of established patterns for utilizing health services.

The SSK Health Care Delivery System. The Social Security Institution (SSK), a national insurance system for workers, covers one-third to one-half of the population. It operates

approximately 75 hospitals, including at least two maternity hospitals, and 300 outpatient clinics, but is only responsible for providing maternity services and curative (not preventive) medical care. The assessment team was told that people who are covered by SSK insurance feel that they are entitled to something other than what the MOH provides and prefer to go to SSK hospitals.

Until the 1982 start-up of a special program operated by the Turkish Federation of Labor Unions (TURK-IS) and funded by FPIA, none of the SSK hospitals provided out-patient family planning services. The TURK-IS project now runs family planning clinics in 31 SSK hospitals, two of which were visited by the assessment team -- one in Ankara, the other in Gaziantep. The clinic at the SSK Maternity Hospital in Ankara was visited during a morning session, when throngs of patients were waiting to be seen in a space that was far too small. During September the clinic had seen 875 patients, including 160 women who had IUDs inserted and 18 who were referred for sterilization. The family planning service staff includes a young, female psychologist, who is there to provide sterilization counseling. (AVSC also has a project with this hospital.) Seeing that there is much misunderstanding about all family planning methods, she has organized group educational sessions. The assessment team could find neither patients nor staff, except for midwifery students and someone sweeping the floor, in the other family planning clinic at Gaziantep SSK Hospital, which was visited during an afternoon.

FPIA support for the SSK project is scheduled to end on July 31, 1990. TURK-IS wants to continue it but cannot use union funds, which are for a different purpose. It is unlikely that the SSK will continue the clinics on its own, as its charter does not authorize it to provide preventive health care. Unless external support is continued, the only way to bring the large resources of the SSK health care delivery system into the national family planning effort will be through negotiations between the MOH and the SSK. The 1983 Population Planning Law states that the MOH should carry out the family planning program in cooperation with the SSK, among other organizations.

Türkiye Esnaf ve Sanatkarlar Konfederasyonu (TESK) is a national confederation of organizations which serve members of the small-scale manufacturing and service industries in Turkey. The health care and social security needs of TESK members are provided through BAG-KUR, an organization that serves self-employed workers and housewives who have no other type of social security. BAG-KUR was established in 1972 and is financed through membership dues assessed at 20 percent of each member's declared income. BAG-KUR pays for health care for its members, but the care itself is provided through a variety of SSK, MOH, and private hospitals.

Through a project of The Pathfinder Fund, family planning clinics were established in two private hospitals, one in Konya Province and one in Eskisehir Province, to provide family planning education, counseling, and other services for TESK members and their families. Each clinic is staffed by one physician and two midwives. It is hoped that this project will set a precedent for the implementation of family planning services under the BAG-KUR health care system.

2.5.2 Private Practitioners

Approximately 42 percent of Turkey's 37,100 physicians conduct private practices.⁶ In addition to those who are in full-time private practice, most physicians who work for the MOH also maintain a private office. In some cases, physicians encourage patients they meet in MOH facilities to go to their private offices for some kinds of special care or to avoid having to wait

⁶World Bank Staff Appraisal Report, Republic of Turkey Health Project, April 7, 1989.

for a particular service. Most private physicians practice in urban areas. Private physician services are covered through some insurance programs, but most must be paid for by the patient.

Gynecologists/Obstetricians. There are about 4,000 Gyn/Obs in Turkey. Many work for the MOH, but also conduct a private practice. Most like to do family planning. Only Gyn/Obs are allowed to perform female sterilizations.

General practitioners. There are about 20,000 GPs, and many more graduate from medical school each year. All medical graduates are GPs unless and until they specialize. GPs must have special training and be certified in order to insert IUDs. With special training, they can also perform menstrual regulations. Some female GPs limit their practice to the care of women and children. The emphasis on medical specialization is likely to increase if the graduates of the new medical schools are as poorly prepared as many people fear they will be. If there were going to be physicians who specialize in family planning in Turkey, they might come from among the GPs.

Urologists. The role of urologists is not currently an issue, as there is almost no demand for male sterilization.

Midwives. Four percent of the country's approximately 17,500 midwives are said to be in private practice.

2.5.3 Pharmacies

There are about 9,000 private pharmacies in Turkey; the assessment team visited three in Istanbul and two in Diyarbakir. Each of these five pharmacies sold several brands of pills and at least one brand of condoms and one kind of IUD. (Women can buy an IUD in a pharmacy and take it to be inserted by a private physician.) The response to the team's request for information and advice regarding the pill was uniform: "Start on the fifth day of your period." No screening questions were asked, even in Istanbul, where a large proportion of women smoke. When asked which pill would be best, the pharmacy workers suggested that the inquiring team member try one brand and, if she felt ill while using it, she should switch to another brand. The pharmacist was not present at four of the five pharmacies visited.

2.5.4 Private Voluntary Organizations (PVO)

Turkish PVOs have undertaken three types of family planning service delivery projects: 1) providing family planning education and services through community-based workers, 2) establishing family planning education and services at work sites, and 3) opening family planning clinics that are not part of the MOH, the SSK, or any other large-scale component of the Turkish health care system. Many of these projects are funded or were started with support from A.I.D. contracting agencies. The assessment team was able to visit only a few of these projects. In general, the team found that the community-based and work-site based projects are successful, and that the free-standing clinics are not. One reason may be that people are accustomed to using certain health care facilities and it is difficult to induce them to try a new clinic.

The Family Planning Association of Turkey (FPAT). This organization, which is currently celebrating its 25th year, gets its core support (rent and staff salaries) from the International Planned Parenthood Federation (IPPF) headquarters in London. IPPF groups Turkey with the European countries; therefore, FPAT is less able than IPPF affiliates in less developed countries to compete for IPPF special project funds.

The central office of FPAT in Ankara has a professional executive director and other paid staff. Its board of volunteer directors includes several highly respected academics and health care professionals, and is extremely active. FPAT also benefits from the contributions of other volunteers, including unpaid services provided by volunteer physicians and other professionals. FPAT volunteers also raise funds; give speeches; plan and conduct public education and community outreach programs; act on behalf of the organization in matters of politics, public policy, and public relations; and totally operate the branch associations.

The central FPAT office operates a clinic and community-based distribution (CBD) project in a gecekondu area on the outskirts of Ankara; provides family planning education to 30,000 workers (and free contraceptives to 20,000) in 115 factories and other workplaces through a project conducted in collaboration with the MOH and the Confederation of Turkish Employer Unions (TISK); provides family planning education for 4,000 soldiers (although a delay in receipt of commodities provided by FPIA prevented them from providing condoms); and conducts educational programs for special audiences, including a family life education program for youth and a special program for religious leaders.

Only a few of FPAT's 27 branch associations are active; four of them operate family planning clinics. During 1987-88, RONCO conducted a project to strengthen the training skills of the FPAT central office in Ankara and to increase outreach activities in six branch associations. The assessment team visited two FPAT branches, both of which had participated in the RONCO project. One of them (Mersin) had been active before the project, and one (Adana) had not been active before the project. As a result of the RONCO project, about year ago the FPAT branch in Adana opened a clinic. It is staffed by FPAT volunteers and an MOH midwife, and is open from 9:00 a.m. to 4:00 p.m. every weekday; the clinic has only five or six patients per day.

In 1987, the Adana branch of FPAT conducted a more successful project aimed at increasing utilization of family planning services provided by the MOH. FPAT volunteers visited coffee and tea houses in five towns during evening hours to talk to men about family planning. The same towns were visited the next day by a mobile health unit which was provided by the municipal government and staffed by MOH midwives. During the project year, as many IUDs were inserted in those five towns during the days following the evening tea house sessions as were inserted in the rest of the province during the entire year. However, the demonstration project could not be continued because of an MOH policy against providing family planning except within the context of other maternal and child health care.

The FPAT branch in Mersin operates a twice-a-week clinic in a gecekondu area. FPAT owns the building, provides cleaning and maintenance, and pays for utilities; the MOH provides a midwife for two days a week and a physician for about a half hour per clinic session. Although the clinic offers free service and the people in the area are poor, only 10 to 20 patients come to the clinic each week. This clinic was in operation before the RONCO project.

The Mersin FPAT branch would like to start a CBD program like the one run by the FPAT in Ankara, but they need considerable help to get it started. They are also planning to start an outreach program in a local high school that provides instruction in homemaking skills for girls.

The Turkish Family Health and Planning Foundation (TFHPPF). Most of the support for the first projects of this new foundation has come from The Pathfinder Fund:

The Foundation started family planning services in the health clinics of 14 factories located in Bursa, Edirne, and Eskisehir provinces in 1987. More than 5,000 people who attended those clinics during the two-year project began using a contraceptive method; 3,882 of those

persons were still using their methods as of December 1988 -- 57 percent were continuing condom users, 26 percent IUD users, 13 percent pill users, and 4 percent users of foaming vaginal tablets.⁷

Staff of health units already functioning in six factories in Eskisehir and Izmit provinces were trained to conduct informational sessions on modern family planning methods for 10,000 factory workers and their spouses, and to include family planning services as part of the health care that is provided to the workers on a regular, ongoing basis. This two-year project will end in March of 1991.

In February 1988, TFHPF opened a new, well-equipped MCHFP training and service center in Baglar, a gecekondu area in the city of Diyarbakir. Although the provincial MOH agreed to provide personnel for the center, it has never been adequately staffed. At first it had two GPs, a gynecologist, and pediatrician, as well as midwives and nurses. However, the medical specialists came for only one hour each day and eventually were reassigned. The clinic had no physicians at all between April and August of 1989. One GP came in September and there are two midwives and five nurses. The midwives do not attend births at the clinic. Although the GP informed the assessment team that the clinic has about 20 patients per day, only three patients had come by 2:00 p.m. on the day of the team's visit. Sixteen midwives have been trained at the clinic since it opened; now, however, there are neither enough patients nor well-trained enough staff for it to serve as a training center. The clinic has a television, video equipment, and at least six patient-education videos; however, the young GP has never watched any of the videos. She reports that 80 percent of the women she examines have cervical erosions, which she considers to be a contraindication to IUD insertion. She neither seeks nor receives consultation from a gynecologist.

According to a report issued by the foundation, TFHPF has also established small MCH/FP clinics in gecekondu areas surrounding Istanbul, Bursa, and Izmir, as well as a family planning center on the grounds of the midwifery school in Mardin.

TFHPF provided two mobile health care vans and augments the salaries of MOH health center staff and health post midwives in order to bring MCHFP services to migrant agricultural workers during evening hours when they return from the fields to their tent camps near Adana. The project mobile vans are equipped for IUD insertions and have generators so that they can be used at night. The midwives focus primarily on family planning and visit the campsites frequently. GPs, nurses, and health officers from an MOH health center use the mobile vans to visit each campsite once every other week. The health center staff focus on nutrition, sanitation, child health and immunization, while the midwife does IUD insertions in the van. Although the Kurdish women did not welcome the midwives at first, now they like them, and many of the women are using contraception.

The Human Resource Development Foundation (HDRF). HDRF's first family planning project uses local CBD workers to provide family planning services in gecekondu areas of the city of Izmir. It is supported by The Pathfinder Fund.

The Foundation for the Advancement and Recognition of Women. This foundation has established approximately 30 family planning clinics in the eastern provinces of Turkey and operates an unknown number of family planning mobile vans. In addition, it has just started a new Pathfinder-funded project that employs young women to provide CBD services to Kurdish and Arabic-speaking women in the eastern province of Urfa. Each of the 14 CBD workers is at least 18 years old, speaks Turkish and either Arabic or Kurdish, and has at least 8 years of education,

⁷Annual Report, Turkish Family Health and Planning Foundation, 1988.

which is above average for this area. They are paid only 2,500 TLs/month (about US \$1.00), were trained by an MOH midwife trainer for two weeks, and are expected to visit an average of 10 households per day. Working in pairs and taking a special bus to and from the neighborhoods in which they work, the workers talk to women about family planning, give them pills and condoms, and refer them to the MOH health center for IUDs. They did not actually begin to work in the community until September of 1989. So far they have been well-received.

2.5.5 The Confederation of Turkish Trade Unions (TURK-IS)

In addition to operating family planning clinics in 31 SSK hospitals, TURK-IS has established 4 family planning clinics and 8 condom depots to serve workers in 16 factories. This project is funded by FPIA.

2.6 Family Planning Projects Organized by Schools of Medicine

Projects fielded by an institute or department of a medical school are more likely than those conducted by a PVO to include a major evaluation component; therefore, the results of these projects are more likely to be carefully described, analyzed, and promulgated through published papers.

2.6.1 Department of Public Health, Hacettepe University School of Medicine

This department has played an important leadership role in family planning in Turkey for many years, and has been a source of significant research and family planning service innovation.

In collaboration with the MOH, in 1965 the department established the Etimesgut Health Training and Research Area. Etimesgut is a rapidly growing semi-urban area (population 250,000) with many gecekondu settlements which lies to the west of Ankara. It has a steady influx of immigrants from various less developed areas of Turkey. Ten years later (1975), the department established a second special Health Training and Research Area in Cubuk, a rural area to the north of Ankara. This area has one town and more than 100 small villages, with a total population of 60,000. Many of its people are migrating from the villages to Ankara. Several important fertility and family planning studies have been conducted in these two areas, which have also been used to test new approaches to the delivery of family planning services.

The department has been a WHO Collaborating Center for Research and Training in Human Reproduction since 1979. This department conducted the studies that demonstrated and evaluated the training and use of midwives in IUD insertion, the training and use of school teachers and imams as family planning motivators in rural areas, and the training and use of labor union personnel for family planning motivation.

2.6.2 The Institute of Child Health at the University of Istanbul School of Medicine

This institute has conducted a number of family planning training, research, and service delivery projects. Its current CEDPA-funded outreach project serves a low-income community of about 35,000 people in a gecekondu area of Istanbul. Newspaper advertisements recruited married women over the age of 35 with at least a high school education to be trained as community health workers. Twenty-four women applied; interviews were used to select seven,

including one who is the political leader for her neighborhood. Their take-home pay is 250,000 Turkish liras (TL) per month, which is not bad for a part-time job with flexible hours; a school teacher, by comparison, makes about 400,000. Each worker visits five houses a day to educate women about all methods of contraception, show a family planning video film (women from several households gather in a home with video equipment), help those who want contraception to select a method, and accompany those who select an IUD to the clinic, using the special project bus. The workers were trained for three weeks, and had refresher training at three months and at the end of the first year. They meet with the project director (a female physician who is a public health specialist) every month; each has the director's telephone number and can call her with problems or questions. The workers keep records, which are discussed at the monthly meetings. They do not live in the area they serve and are better educated and have higher economic status than the women they visit. They think that this makes the women they talk to trust them more. The project started in July of 1988 and is due to end next year, by which time most homes in the target area should have been visited.

3. Roles, Pre-Service Training, and Performance of Current and Potential Family Planning Personnel

3. Roles, Pre-Service Training, and Performance of Current and Potential Family Planning Personnel

3.1 Midwives

MOH midwives provide most of the individual patient care in most family planning clinics -- whether run by the MOH or PVOs. Most midwives who perform this role were trained at a GDMCHFP center and are certified to insert IUDs. (Section 2.2 discusses strengths and weaknesses of this training.) Persons responsible for the GDMCHFP training programs say that the midwives often do better than the GPs and they think that this is due to motivation. Most GPs hope to eventually become specialists; thus, they do not intend to stay in a setting in which they will need to know how to manage contraception and insert IUDs. In contrast, most midwives who receive this training continue to fill positions in which they provide family planning care.

The MOH scheme for extending family planning to rural communities depends on the performance of midwives in rural health centers and health posts. Their ability to provide effective family planning services is not only related to their competence in family planning but also to their overall performance as midwives. Family planning is truly integrated with maternal and child health at the primary health care level. If the primary health care (PHC) system, including the village-based midwife, is valued and used by the women of the community, and the PHC midwives are competent in family planning, then the PHC system will be able to reach the people with family planning care. Therefore, persons concerned about family planning in rural areas must be concerned about the overall competence and job performance of midwives in PHC.

3.1.1 Pre-Service Education

Most midwifery students are rural or working-class girls (about 80 percent from villages), for whom nursing or midwifery are the most accessible routes to a profession. Almost all are trained in 41 health "colleges" run by the MOH's General Directorate for Health Training. These four-year programs take the place of high school, since students enter after only eight years of general education. In the past, some of the incoming students were barely literate and numerate; however, in recent years, entry to these programs has become competitive. Now many girls wish to enter and the schools are able to take only those who perform well on the government entrance tests. Tuition, room and board and a little spending money are provided in exchange for four years of obligatory government service after the midwives graduate; students who pay their own way have no obligation.

The GDHT also operates nursing schools which are separate from the midwifery schools. Unless they receive additional education, Turkish midwives are not trained as nurses. The term "nurse-midwife" is often used inaccurately in reports. College-level education is available in nursing but not in midwifery.

The first year of the training program is entirely academic, including subjects ordinarily offered in high school and a few special courses that are needed for midwifery. Approximately half of the second year is devoted to general high school courses and half to subjects related to midwifery. The third and fourth years are devoted entirely to midwifery work. Students spend one day a week in the hospital during their second and third years, and 28 hours per week in a hospital or health center during the fourth year of the program. Because of lack of transportation, most of the students go to urban health centers. In an effort to provide rural

experience, some schools require students to work in health centers near their home villages during the summer before their fourth year. Each student must conduct at least 25 births, including 10 with complications, before she graduates.

The assessment team interviewed three senior midwifery students from two schools in different parts of the country. All three were bright and seemed articulate and self-assured. Two (from the school in Adana) were committed to midwifery and eager to graduate and serve: one wants to work in a rural area, while the other wants more education and some kind of leadership role. She will compete for entrance into one of the nation's six university schools of nursing; if accepted, she will work as a midwife while earning a bachelor's degree. The third student (from the school in Gaziantep) is dissatisfied and wants to apply to medical school. A study conducted by the Director of the GDHT's Department of Education and Planning found that nursing and midwifery students are enthusiastic and eager when they enter school as freshmen, but tend to become disenchanted by the time they enter their senior year. As many as one-third to one-half of senior midwifery and nursing students want additional higher education, although not nearly that many actually go on to other schools.

Approximately 2,000 midwives are graduated each year.

3.1.2 Problems in Pre-service Education

Although pre-service midwifery education has improved in recent years, some of the schools are very weak in clinical training. However, some of the better schools keep classes small during the first two years in order to save space for some students from weaker schools to transfer into the better programs for their last two years of training. MOH leaders want to rapidly increase the production of midwives and nurses, and are pressuring the schools to admit larger classes. Whereas previously there had been only one program to train nursing and midwifery tutors (the Gevher Nesibe Health Institute, in Ankara), two new tutor training schools were opened in 1989. There is concern that such rapid increases will reduce the quality of midwifery training.

A longer-term problem is the lack of positive role models for midwifery students. Although midwives must have at least three years of practical experience before they are eligible for the tutor training program, selection into the program is entirely on the basis of their grades from school; the success of their performance since graduation is not considered in deciding who will be admitted to the tutor training schools. Some midwives who received good grades but do not like the practice of midwifery "escape" by becoming teachers. Such teachers cannot provide much inspiration to their students. Also, although the rural system is where midwives play their strongest and most-respected role, the schools are in cities and the students learn in hospitals. Midwifery faculty lack the authority to control the clinical environment in which their students learn. Midwifery students are being taught to deliver babies the way physicians do. They make little effort to provide support and comfort to laboring women, and cut routine episiotomies. Thus it is not surprising that many rural Turkish women prefer to use traditional birth attendants. In addition, many midwifery students do not get enough experience with home births or learning to manage complicated deliveries; yet, some complications cannot be predicted, and midwives must know how to handle them. Assisting women at childbirth is the *sine qua non* of midwifery. The rural-based midwife who manages births in a way that instills confidence and is satisfying to the women she assists will be effective in providing family planning.

3.1.3 Status of Midwives

The assessment team found many urban-based midwives to be dissatisfied and self-conscious about the status and rewards of their profession. Higher salaries are always helpful, but the salaries for midwives are not out of line with those of similar professionals, such as teachers.

Self-confidence and respect may be more important issues. On the other hand, rural midwives encountered by the assessment team appeared to be excellent practitioners who were confident and enjoyed the respect of their colleagues and patients. However, none of these midwives were brand-new graduates. By all accounts, working in a health post is often an unsatisfying and unsuccessful position for new midwifery graduates. (See Section 2.1.2. for further discussion of the problems of young health post midwives.)

3.1.4 Pre-service Family Planning Training

Several years ago, Pathfinder assisted the GDHT in developing a new family planning curriculum for the pre-service midwifery schools. Although it was intended for it to be used in all of the schools, the GDHT did not issue a clear directive with that message. It was later learned that the principals of some schools thought the new curriculum was part of a project (i.e., something temporary). During 1989, the GDHT formally instructed each school that the new curriculum is in fact part of the ongoing and permanent program. In the new curriculum, the 28 hour/week clinical experience of senior students is divided between labor and delivery, primary health care, and family planning. Each student spends every third week in family planning and is required to conduct 50 pelvic examinations and insert 25 IUDs. This plan is being followed in both schools visited by the assessment team. However, these two schools may not be representative of all schools in the country. Midwifery schools that are not close to a large-volume family planning service may find it difficult to provide adequate IUD-insertion opportunities for their students.

Between 1987 and 1989, RONCO assisted the GDHT to conduct an important TOT project for 46 principals and tutors from 17 of the 41 health colleges that prepare midwives. It was a complex project with three sequenced phases, the first of which required the participants to conduct a training needs assessment in the field. After developing tools and guidelines, one teacher from each school visited five of her school's recent graduates at their first jobs. In addition to interviewing the new graduates, the teacher/assessor interviewed the supervisors of their former students and observed the new midwives at work. The purpose was to understand the working conditions, problems, strengths and weaknesses of their former student's job performance, especially in regards to family planning.⁸

The second phase of this project was a 10-day TOT course to prepare tutors from the 17 schools to use "participatory" or "experiential" training methods. Information on problems experienced by the new graduate trying to provide family planning services on the job provided the basis for developing case studies, role plays, critical incidents, and other realistic and practical training activities, which were incorporated into the TOT program.

The last phase of the RONCO project was the development of a manual consisting of easy-to-use lesson plans to help midwifery tutors use the new learner-active family planning training methods. That manual is now being produced for use in all pre-service midwifery schools.

Faculty and students of the two schools visited by the assessment team were interested in family planning and enthusiastic about the midwife's role in providing family planning care.

⁸A formal report of the findings from this assessment is being prepared by the Department of Public Health, Hacettepe University School of Medicine. That paper, which was not available while the assessment team was in Turkey, should be of value to any party interested in improving pre-service training for Turkish midwives.

3.2 Physicians

3.2.1 General Training

Medical school in Turkey is a six-year program (including one year of internship) which is entered directly after high school. Entrance to medical school is based on grades achieved on an examination. The number of medical schools has expanded rapidly in recent years. For a long time there were only three high-quality medical schools (in Ankara and Istanbul). By 1964, there were four schools with a total enrollment of 900 students; by 1974 there were eight schools with 1,600 students. The number of schools and students has increased rapidly since then; 10 or 11 new schools were added in the past few years. Now there are 23 schools, including one which is run by the Army. Most of the new schools have very low enrollments. The new medical school at Gaziantep does not yet have either a department of gynecology and obstetrics or a department of public health. It has admitted a freshman class and adds departments as needed; so far there is faculty for only the basic science courses. Altogether the 23 medical schools admitted 3,800 new students in 1989, down 22 percent from the number (about 4,600) admitted one year earlier. The reduction was based on concerns about the quality of medical education and predictions that the country would produce more physicians than it needs. Many of the new schools have not produced graduates yet. The 15 schools which are already graduating students produced approximately 2,500 new physicians last year. That number will increase to between 4,000 and 5,000 for several years after the new schools begin to graduate their first classes, but should then level off at about 3,800 per year. There is a great deal of concern that graduates of the new schools will not be adequately trained.

The best schools are in the western part of Turkey. Some eastern schools have only part-time faculty, and it is difficult for them to keep up with the current medical literature. Professors from better schools in western Turkey travel to give lectures at some eastern schools.

All institutions of higher learning, including medical schools, are regulated by the Council of Higher Education (YOK). YOK establishes general guidelines in order to standardize medical education enough that students can transfer from one school to another. In addition, each year the Professional Council of Medical Schools (the deans of all 23 schools) develops an outline of basic lectures that must be given at each school. The basic lectures use about half of the curricular time; individual schools determine how to use the remainder. Medical graduates have to pass school examinations, but there is no national examination that must be passed in order to practice. A national examination is used, however, to screen applicants for admission to medical specialty training.

3.2.2 Family Planning Training Provided in Medical Schools

During a meeting held in 1988, the deans and chairmen of the department of public health and the department of gynecology and obstetrics from each medical school decided that every school should devote at least 15 lecture hours and some clinical practice time to family planning. The GDMCHFP and JHPIEGO had convened the meeting in hopes that it would lead to the acceptance of a national standard for the family planning content in pre-service medical education. Although this objective was not achieved, there have been improvements as a direct result of the meeting (see discussion below of improvements made in the curriculum of the University of Istanbul). Currently, however, it is up to each school to decide what and how to teach their students about family planning. Family planning is seen as being a preventive health measure that is part of primary health care and is therefore the responsibility of each medical school's department of public health. The departments of gynecology and obstetrics play much more minor roles. The Department of Public Health at Hacettepe University School of Medicine is currently conducting a comprehensive study of the family planning content in all 23 medical schools; questionnaires have been sent to the departments of public health, gynecology and obstetrics, and urology at every school.

The assessment team visited the following five medical schools:

The University of Istanbul. This medical school did not include any family planning in its pre-service curriculum until 1988. Now they have 15 hours of lecture and one week of clinical practice (as part of students' public health experience during the 6th year). Lectures provided by the pharmacology department have covered estrogens and progestins, but not oral contraceptive pills; however, a faculty member in that department is developing a new unit on oral contraceptives. During their clinical experience, students observe IUD insertions, are taught to do pelvic assessments, and see family planning patients who come to the clinic for routine or problem-oriented family planning follow-up. Depending on the circumstances, some students may get to insert an IUD, but this is neither expected nor required.

In addition, interns can take a one-month elective; a few students (six last year, four this year) chose family planning. At the end of the elective they are certified to insert IUDs. There are approximately 450 students in each class at this school, i.e., 15 to 20 percent of the total number of medical graduates.

Hacettepe University. This school's program is similar to that at the University of Istanbul, although family planning was started earlier at Hacettepe.

Marmara University. Although the Turkish Family Health and Planning Foundation equipped a family planning clinic at the University Hospital, it is not currently in operation. Medical students get one or two hours of family planning lectures from the Gynecology Department and 15 hours during their public health course.

Dicle University. This medical school accepts 200 medical students in every class. The school and its associated hospital are located among wheat fields about 30 minutes from Diyarbakir. It has no family planning clinic and does very few deliveries. The Gynecology Department does occasional sterilizations during caesarean sections or for women admitted with "incomplete" abortions. An upcoming lecture on "post-tubal ligation syndrome" will cover "the psychological, social, and hormonal changes which happen after sterilization." No member of the faculty of the Gynecology Department specializes in family planning or sterilization. (Indeed, no one specializes in cervical cancer, infertility, or any other subject either.)

Medical students at this school receive little technical family planning information. The Gynecology Department gives third-year students a two-hour lecture on family planning methods. Although the Department of Public Health devotes 10 hours to family planning, only one hour is used to provide information about specific methods; most of the time is used for a discussion of population. The Department of Public Health expects students to take care of family planning patients during their sixth-year public health experience. However, many Kurdish women do not allow male students to examine them (at least not during care at a health center located in their own communities). Therefore, female medical students (about one-sixth of the class in this school) are the only ones who get significant experience in family planning. During their sixth-year gynecology rotation, some students may also see a few patients with IUD complications.

Cukurova University Medical School. The Department of Gynecology and Obstetrics gives four hours of family planning lectures -- two during the third year and two during the fourth. The assessment team did not interview anyone from the

Department of Public Health and so did not learn about family planning lectures and clinical experience provided through that department. Although students see family planning patients during a one-month experience at the local maternity hospital, the university hospital does not have a family planning clinic. Residents in the Department of Gynecology insert IUDs for private patients and perform laparoscopic tubal ligations.

3.2.3 Family Planning Training for Gynecologists

Physicians who wish to become specialists must first complete two years of obligatory government service and then take a national examination to compete for the limited training posts. Specialty training for gynecologists and obstetricians takes four years. Gynecologists are popular and have high status. They are trained to prescribe oral contraceptives, insert IUDs, manage IUD complications, and perform sterilizations. However, most gynecology residents do not get experience in a large-volume family planning service.

Little or no continuing education is available to gynecologists. They do not have a national organization, although there are local associations of gynecologists in several cities. The 500-member Gynecologist Association in Ankara is planning to start a quarterly professional journal, each issue of which will contain at least one article on family planning. It will be distributed to association members and the gynecology departments of all medical schools.

The Human Resources Development Foundation wants to begin to provide continuing education in family planning for gynecologists. Since so little continuing education is available, more is needed. Any effort to reach private gynecologists, however, should be preceded by a careful needs assessment. Results from the pre-test given before a two-day workshop sponsored by the Foundation in March of 1989, suggests that gynecologists need additional training. That may well be true, but the low average score on this test (3.4 from a possible score of 10.0) does not necessarily document that need. Most of the 44 course participants were MOH physicians and many of them were not gynecologists. In addition, some questions on the test measured unessential information. Two of 10 questions were about methods (NORPLANT® and the Vaginal Ring) which are not available in Turkey. Gynecologists feel that they are well-trained and better trained than other categories of people who provide family planning services in Turkey. Although they might be interested in learning about a new family planning method, most probably would not accept an invitation to participate in a general family planning training program. Deficiencies in the family planning performance of Turkish gynecologists are related to attitudes as well as knowledge.

3.2.4 Family Planning Training for General Practitioners

Although most physicians want to become specialists, entrance into specialty training programs is competitive and many are not accepted. GPs have low salaries and low status.

Those GPs of most concern to the assessment team provide family planning to private patients or are employed by the MOH, mainly in health centers. Most of the latter are young physicians fulfilling their two-year obligation to the government. GPs assigned to health centers provide curative medical care and supervise the midwives and other staff who provide the preventive services, including family planning. A few of them take the three-week family planning training program and become certified to insert IUDs. Those without this training have only what they received in medical school (see Section 3.2.2). The limited capacity of the GDMCHFP training program and rapid turnover of GPs in rural posts makes it impossible to train most health center GPs in family planning. (See Sections 2.1.2 and 2.2.)

3.2.5 Public Health Specialists

Every medical school has a department of public health which is responsible for training and research related to preventive and primary health care, including family planning. Physicians who want to specialize in public health undergo three years of specialty training. In addition to the MOH and the FPAT, leadership for family planning in Turkey has come from the public health departments of the medical schools, rather than from the medical school departments of gynecology and obstetrics. Support for the departments of public health, however, seems to be declining (see discussion in Section 2.4). A further decline in support for public health may have serious ramifications for family planning, which depends on these academic departments for research, training of physicians, and medical leadership.

Currently Turkey has about 200 physicians who are public health specialists. In February of 1989, the Chamber of Physicians (in Ankara) organized a Public Health Group as a vehicle to strengthen the voice of public health within the medical profession. The group has written a job description for a public health specialist and has analyzed the tasks that are required for that job; it plans to develop a standard curriculum to prepare people to perform those tasks. In addition, the group has a UNICEF contract to plan a series of health education books for pre-school children, and has sent a group of public health specialists to visit some of the rural provinces to discuss public health management problems with leaders of the provincial health directorates. The Chamber of Physicians has provided the group with office space, but no staff.

3.3 Roles/Training of Other Family Planning Service Personnel

3.3.1 Nurses (Female)

Most nurses are trained in "health colleges" similar to the schools for training midwives. In 1988, there were 30 such schools; 20 new ones were opened in 1989. In addition, there are six college-level nursing education programs. Nursing students are given information about family planning and may have clinical experience, depending on circumstances in each school. Nursing students are not expected to learn how to prescribe and manage oral contraception or to insert IUDs. Most nurses work in hospitals. In addition, they are the generalists of the system; nurses with higher education play important management roles.

3.3.2 Health Officers (Male Nurses)

Six of the health colleges are devoted primarily to training health officers, otherwise known as male nurses. There are relatively few male nurses and they are used mainly for public health roles such as sanitation, health education, immunization, and administration. Their pre-service training provides information about family planning, but little actual experience. A male nurse has been included on most of the GDMCHFP provincial training teams; they often specialize in training for family planning outreach, especially outreach to males. It is easier for them, than for most midwives, to work alone, travel within the community, and discuss family planning with male political and religious leaders and local gatherings of men. Male nurses are an important undertrained and underutilized resource for family planning.

3.3.3 Psychologists

Psychologists are prepared in four-year university programs; there are at least five such programs in the country. Most work in education or mental health; a few are unemployed. Five psychologists have been assigned to Ankara Maternity Hospital and the Ankara SSK Hospital

has one. They are trained in educational psychology, interviewing, and counseling techniques. The psychologist at the Ankara SSK Hospital was assigned to provide sterilization counseling; she has also organized group educational sessions for the family planning clinic. If some psychologists were assigned to the GDMCHFP, they could be used to develop patient education and counseling services within family planning clinics, and to train midwives in counseling skills.

3.3.4 Family Planning Workers Based in the Community

Various kinds of community workers have been recruited and trained to provide family planning education and to distribute pills, condoms, and vaginal spermicides in special projects. Several of those projects are described in Section 2.5.4. All but one of these programs used unemployed women and paid them for their work. Only one program used men as well as women and did not pay the workers (the RONCO project described below). It is probably not realistic to expect continuing work from community volunteers. It does appear, however, that unemployed women will perform this work with enthusiasm and success, for relatively little pay; uneducated and educated women alike seem to be effective.

RONCO Outreach Project

During 1986-1987, RONCO assisted the GDMCHFP and the MOH directorates in two provinces in a one-year project to train a total of 307 people -- Imams (government-employed religious leaders), muhtars (elected village administrators), male and female primary school teachers, agricultural technicians, home economists and sewing teachers -- from 40 villages in two provinces to distribute condoms and other health-related commodities; to educate people in the community about family planning and other maternal and child health subjects; to refer individuals in need of services to the local midwife and other MOH services; and to support the local midwife in a variety of ways. The training was prompted in part by concerns that some people perceived the midwives as young, inexperienced, uneducated, and unnecessary strangers from the city who were earning a government salary without doing enough work.

An evaluation conducted shortly after the project ended found that trained teachers had distributed condoms to an average of 400 people every month since their training; referrals to midwives had increased; many of the trained people gave lectures and speeches about health topics, including some Imams who addressed family planning and child health topics during Friday prayer services. Midwives had been introduced to village leaders and had been given important information about the cultural and social customs of people in the villages they served. Each village also has "guards" who had often accompanied midwives to nighttime home deliveries, and teachers had asked school children to help the midwives find the homes of women in their villages. Muhtars, male teachers, and agriculture technicians began to offer the midwives access to transportation.

The assessment team visited one of the provinces (Icel) two years after the training had finished in order to determine how long the effects of this project had persisted by comparing family planning service statistics from health centers involved in the project with those from other health centers in the province. Data for 1987 and 1988 revealed a flurry of activity, mainly increased use of condoms, in the target areas (very large increases at one health center) during half of 1987. After that the contraceptive use levels in the target areas were not discernable from those reported by other health centers in the province.

4. Family Planning Method Use in Turkey

As stated earlier, the current Turkish population relies heavily on withdrawal, IUDs, and legal abortions (one of 4 pregnancies) to prevent unwanted births. One factor which affects the "method mix" in Turkey is the lack of an organized approach to providing group education and individual counseling for family planning patients. A current AVSC project is focused on training to overcome this lack.

The GDMCHFP looks to the United States Food and Drug Administration for guidance as to which kinds of contraceptives are safe to use. Although some long-acting progestational injections were used in the past, they are no longer used. Sub-dermal hormonal implants will not be accepted in Turkey until they are approved for use in the United States, which may occur in 1990.

Research has shown that Turkish women are most likely to obtain information about family planning methods from their friends, who are followed in influence by physicians, the women's neighbors, and midwives. Television is a source of general information on the need for family planning but does not provide information about specific methods.

A factor which may affect the method mix and contribute to the unusually high failure rates for some contraceptive methods in Turkey is what appears to be an unwritten rule among family planning service providers to give only a one- to three-month supply of any method to a patient at each visit. Insecurity about the timely delivery of new supplies surely contributes to this widespread practice.

Commonly used methods of contraception are discussed here, in order, with the most frequently used methods discussed first.

4.1 Withdrawal

Although fewer Turkish women know about withdrawal (85 percent) than know about pills and IUDs (94 percent), more have tried withdrawal (53 percent) than have tried any other method, and it is the most common method in current use in Turkey. Withdrawal accounts for 41 percent of all contraceptive use based on data provided by women and for 30 percent based on data provided by their husbands. It seems likely that the data provided by the husbands is more accurate. In addition, the estimates on current use of withdrawal may be too high based on the sequencing of questions in the recent survey; i.e., some women who had already said that they do not want to get pregnant may have said they were using withdrawal to avoid admitting that they were not using any kind of contraception. Nevertheless, the consistency of the data is impressive; withdrawal is reported to be the most frequently used method for every age group, every region of the country, and for urban as well as rural people. The only group for which withdrawal was not reported to be the most common method was women with secondary or higher education, who represent only 15 percent of women in the country.

There is anecdotal and research evidence that withdrawal is an effective method for many couples, especially in western Turkey. Data from the 1988 population and family planning survey found that the rate of accidental pregnancy was less for couples who use withdrawal (13.9 percent became pregnant in one year) than for couples using any other method except for IUDs, rhythm, and presumably, sterilization. Based on clinical experience, the director of one family planning project instructs workers not to encourage couples to change to a different method if they are 35 or older, like withdrawal, and have used it successfully for at least five years. Data

from a CEDPA-supported CBD project in Istanbul categorized 150 (27 percent) of 555 women as "good withdrawal users." Physicians and midwives report a big difference in the practice and success of withdrawal between people who live in eastern Turkey and those who live in the west, with those in the west tending to be more committed and successful users of this method.

A study conducted in the Etimesgut Research and Training Area (where access to family planning services is much greater than in almost all other parts of Turkey) found that only 17 percent of women who had ever used withdrawal were still using it and that 82 percent had switched to modern methods (including 65 percent who were using IUDs). This and other information leads to the conclusion that withdrawal is heavily relied upon because many people believe that oral contraceptives are dangerous to women's health and they do not have adequate access to other methods.

There seem to be two types of withdrawal users in Turkey, with quite different characteristics. One group are successful and satisfied users who use the method consistently and carefully; some of them may also be subfertile. Many of them prefer this method even when other methods are available. The other group of withdrawal users are neither successful nor satisfied, but they do not know enough about other methods or do not have access to them. In addition, statistics on use of withdrawal may be inflated if some people who use no method for a variety of reasons say that they practice withdrawal when they are included in a survey. Health personnel should try to differentiate between these groups of withdrawal users and treat them differently. "The number of unintended pregnancies in the last five years of method use" would be an excellent question on which to base this differentiation. It is not possible to ascertain the proportionate numbers of these groups with currently available data -- but Turkey's growth rate would certainly be much lower if the first group were in the majority.

Nevertheless, withdrawal is a good method for many couples and will play an important role in Turkey for years to come. Although it is not popular in the United States, Americans should be aware that withdrawal is a relatively important method even in some low-fertility western countries -- as of 1988, 25 percent of French women who were contracepting were relying on withdrawal. In addition, the popularity of withdrawal in Turkey highlights the fact that Turkish men are willing to play an active role in family planning. Their involvement and sense of responsibility for contraception should be supported. It would be counterproductive to create the impression that family planning is mainly the business of women.

4.2 Intrauterine Devices (IUD)

IUDs are favored by most physicians and midwives who provide family planning in clinical settings, whether they work for the MOH, are in private practice or are employed by PVOs. Practice and training reinforce each other in this regard; with few exceptions, "clinical family planning" in Turkey means managing contraception with IUDs.

This has both negative and positive implications. On the negative side, women who have another method in mind when they come to a family planning clinic may be pressured into accepting IUDs. Women may learn to associate "family planning" with being coerced to accept an IUD; if and when that happens, women who do not want IUDs will avoid going to a family planning clinic. Furthermore, experience in other countries demonstrates that adding access to more methods increases contraceptive use. Also, heavy reliance on any one method, perhaps especially IUDs, makes the program vulnerable. If IUDs lost favor with the people, there would be little resilience in this system. On the other hand, IUDs are a good method for many women in Turkey: the assessment team looked but did not find evidence of frequent problems associated with sexually transmitted infections and IUDs. Most women who need contraception do not want

more children and are not trying to protect their ability to conceive. They need an inexpensive, easy-to-use method they can rely upon for many years. The MOH has implemented an excellent program to control the quality of IUD insertion. The technical training is good and they evaluate it periodically. Only gynecologists and those GPs and midwives who have been trained and certified are allowed to do insertions. Although there is a shortage of gynecologists, in most areas there are enough to handle the infrequent complications of IUDs. Another reason for IUDs' popularity with clinicians is that they are fast and efficient: it takes less time to insert an IUD than to teach a woman to use pills, and once the IUD is in place, the woman does not need to come back for frequent visits. Most important, IUDs work; the failure rate associated with their use in Turkey is lower than that for any other method.

4.2.1 Sexually Transmitted Infections and IUDs

JHPIEGO is starting a timely program to improve the capacity of MOH facilities to diagnose and treat sexually transmitted infections. Although the physicians interviewed by the assessment team stated that there are few cases of IUD-associated pelvic inflammatory disease (PID), there may be some cases of unrecognized infection. Sexually transmitted infections may well be underdiagnosed due to lack of laboratory facilities, even in large hospitals. On the other hand, symptoms and treatment of gonorrhea, for example, are quite well known among Turkish men. A man who suspects that he has gonorrhea would prefer to go to a private physician or simply buy penicillin from a pharmacy, since gonorrhea must be officially reported (by name) in MOH clinics.

The assessment team's findings regarding sexually transmitted infections and IUD complications follow:

- Ankara Maternity Hospital has a good laboratory for diagnosing cervical pathology (Pap smears) but cannot culture for gonorrhea. Although the assessment team was told that chlamydia is the most common gynecologic infection among the population of women they serve, a study in which samples from 150 patients of the hospital's gynecologic clinic were cultured revealed that 12 percent of them had gonorrhea. (It should be noted that gynecologic clinic patients are not representative of all women in the population.) Among the women seen for IUD complications, it is more common to find perforations, pregnancies with IUDs in situ, and implanted IUDs than pelvic inflammatory disease.
- The physician who backs up the CEDPA-funded CBD project in Istanbul stated that they have had only one serious IUD complication (a pregnancy with an IUD in situ) among 285 women using IUDs. There have been no infections.
- A study of 17,699 women who had IUDs inserted at the MCHFP center in Zeynep Kamil Maternity Hospital in Istanbul between 1984 and 1987 found that 1,260 (7 percent) had experienced infections characterized by fever, tenderness and discharge. Only two or three women, however, had "serious infections." The hospital sees some cases of chlamydia but has diagnosed only three or four cases of gonorrhea.
- The chairman of the gynecology department at Cukurova University Medical School (Adana) stated that they hospitalize three or four women with IUD-associated pelvic inflammatory disease each month. However, they have few recognized cases of gonorrhea.
- A professor of gynecology at Dicle University Medical School (Diyarbakir) stated that in the past two years he has seen IUD perforations, pregnancies with IUDs in place, and "lost strings," but no infections.

Although Turkish clinicians should be cautious and conservative in selecting patients for IUDs, it appears that some may be over-diagnosing cervical pathology. In three cities (Ankara, Istanbul, and Diyarbakir) the assessment team spoke with physicians, including one gynecologist, who reported that more than half of the women they examine have cervical erosions which they are treating with creams or, in the case of the gynecologist, with electrocautery. The team did not examine any of these patients, but wondered if the physicians are not, in fact, seeing cases of ectopia, in which the more highly colored endocervical mucosa extends into the external portion of the cervix. (In the GDMCHFP manual on maternity care and family planning, the photograph depicting cervical erosion is unclear and would be hard to distinguish from cervical ectopia.) The women are asymptomatic and there is no evidence that untreated "erosions" are developing into serious pathology. Cervical cancer seems to be relatively rare in Turkey. Even so, many physicians defer IUD insertion until the condition has resolved, and the treatments are consuming a large amount of the limited resources. In addition, it must be stressful to young patients, who are typically told that there is "a wound on your uterus."

There are some misunderstandings about IUDs among the public. Many people do not understand female anatomy and think that the IUD is placed in the abdomen. People often believe that IUDs are much larger than they actually are, and some believe that they cause physical problems ranging from headaches to cancer. In rural Diyarbakir Province, some people think that a woman who has an IUD should not pray.

4.3 Condoms

Condoms are the third most commonly used method of contraception and their use is increasing -- 4.9 percent of men were using them in 1983, as compared with 8.9 percent in 1988. One reason for this increased use may be a rising awareness of sexually transmitted diseases, including AIDS, among male workers who go back and forth to Europe.

Condoms fit well into the picture of a country in which men play a major role in family planning. Most of the CBD programs, and many of the workplace-based programs rely heavily on condoms, and they are available at pharmacies throughout the country. SOMARC, an A.I.D.-funded social marketing project, is planning a large-scale program to promote condom sales through private pharmacies.

The 1988 population and family planning survey found a relatively low contraceptive failure rate (14.5 percent) associated with the use of condoms.

Some family planning projects have experienced problems with their condom supply. This encourages hoarding, not giving out as many as could actually be used. Problems related to supply must be solved so that, at every level of the program, people will feel free to move condoms out of storage to where they can be used. Since condoms are unlikely to be used for any purpose other than preventing pregnancy and sexually transmitted diseases, there is no reason to restrict the number which can be given to clients; even if recipients give them away, the purpose for which the condoms are provided will still be served. Since clinical family planning services are hard to come by and men are so willing to participate in family planning in Turkey, the country would probably make good use of a much larger supply of condoms than are currently being provided.

Women get free condoms through MOH service delivery sites, whereas men buy condoms at pharmacies.

4.4 Oral Contraceptive Pills

Use of pills increased slightly between 1978 and 1983, but has declined since then. Although 94 percent of Turkish women have heard of pills, and 40 percent of those who have heard of them have tried them, as of 1988, only 10 percent of contracepting women were using pills and the accidental pregnancy rate among those who had been using pills was very high (25.9 percent).

The general public and many physicians and midwives have incorrect beliefs about health risks associated with the use of pills. In addition, there is a self-reinforcing belief among family planning leaders that Turkish women cannot learn to use pills correctly. This is not surprising, given the lack of time, space, and effort invested in education and counseling for family planning patients. Neither general practitioners nor midwives are adequately trained to provide such counseling or to evaluate and manage the minor side effects of oral contraception. This means that there is no one to advise and support women who experience real or imagined problems while taking pills. Lacking authoritative reassurance, and in the face of widespread overestimation of danger from the pill, it is easy to imagine that many women who start to take pills are afraid to continue once they experience any problematic symptom. Only one of every five women who had ever tried pills was still using them in 1988. This dismal continuation rate only serves to reinforce the belief that "Turkish women cannot use oral contraception." What should be said instead is that Turkish physicians and midwives do not know how to counsel, teach, and assist women to be successful and confident oral contraceptors. The common practice of giving pill users only one or two cycles of pills at a time probably contributes to discontinuation and the unacceptably high rate of contraceptive failure.

As a result of the negative attitude toward oral contraception, women who go to family planning clinics are usually urged to try an IUD. Some pills are provided through MOH health centers and village-based midwives, but very few are provided through either MOH or private hospitals or by private physicians. Most women who want to use pills obtain them from pharmacies, where they are available without prescription and without any effort on the part of pharmacy workers to screen and/or educate the women who buy pills (see Section 2.5.3).

4.5 Rhythm

As of 1988, 4.3 percent of women exposed to pregnancy (and 6.5 percent of the husbands of exposed women) reported that they were using "rhythm." Based on the lower estimate (data from women), this represents a three-fold increase since 1983. The assessment team was not able to investigate the reasons for this increase.

Rhythm is most popular among more highly educated people. Although most physicians and midwives consider it to be an ineffective method and do not recommend it, according to findings from the 1988 population and family planning survey, the contraceptive failure rate associated with rhythm is lower than for any other method except IUDs.

4.6 Douche

It should be noted that 2.2 percent of exposed women said that they were douching for contraception; their husbands said the same. The misperception that douching helps to prevent pregnancy should be addressed.

4.7 Vaginal Spermicides

Only about 2 percent of women (and men) report that they are using vaginal spermicides for contraception. Use of these products has never been high and has decreased since 1983; all but 16 percent of women who have ever tried these products were not using them in 1988, and their use is associated with a contraceptive failure rate of 27 percent. In addition, it is as though no one has heard of diaphragms in Turkey. The recent survey did not even ask about them. Apparently some Turkish textbook says that normal Turkish women cannot use diaphragms, and this is a widely held belief.

4.8 Sterilization

4.8.1 Female Sterilization

Considering that there was almost no female sterilization in 1978, it is encouraging that by 1988, almost 3 percent of women who had heard of sterilization had actually been sterilized (but only 65 percent of women had heard of it). The 1988 fertility/family planning survey documented a large need for permanent contraception: 76 percent of women who believed themselves to be biologically capable of having (more) children said that they do not want many more; 74 percent of their husbands do not want more children; more than 90 percent of women in their thirties and nearly all women in their forties said that they do not want to have another child.

A major barrier is the widespread belief that sterilization would not be acceptable to Turkish men and women. In contrast, the assessment team found evidence of a growing demand for female sterilization. It is a new idea in Turkey. If there were an increase in knowledge about sterilization and in affordable access to sterilization operations for women, the demand could increase rapidly. AVSC and the Department of Public Health at the University of Hacettepe University School of Medicine are currently conducting a study to identify which of two different information and education interventions is more effective in disseminating messages about male and female voluntary sterilization.

Only gynecologists are allowed to perform sterilizations. JHPIEGO has worked in Turkey since 1980 and has trained and equipped enough gynecologists to perform laparoscopic tubal sterilizations so that they do not consider more of such training to be a priority need. Likewise, AVSC documents state that trained physicians and well-equipped facilities exist widely throughout Turkey. Although more and better training is always helpful, the lack of access to sterilization services is due primarily to problems other than lack of training.

For example, a lack of common cause between two MOH directorates -- the GDMCHFP and the GDCM -- is especially important. Family planning is primarily an out-patient activity which is run by the GDMCHFP. Most MOH gynecologists, however, work for hospitals, whose primary purpose is curative care. MOH hospital gynecologists say that sterilization is an "elective" operation, which means that it's not necessary. Although some gynecologists may be interested in performing sterilizations for private patients, they have little motivation to add to the work they do for a government salary.

Private practitioners charge 300,000 TL for a tubal ligation. For comparison purposes, a school teacher makes about 400,000 TL per month, and an abortion at an MOH hospital costs 3,000 TL (one percent of a private gynecologist's fee for female sterilization). The physicians' union sets minimum fees for minor, intermediate, and major surgical procedures. As a procedure in the abdominal cavity, female sterilization, whether done by minilaparotomy or

laparoscopy, is considered to be an intermediate procedure. In addition, most gynecologists believe that sterilizations should be done under general anesthesia and require several days of post-operative hospitalization. The assessment team was not able to ascertain to what extent local anesthesia is available in Turkey; however, it is probably more difficult to find someone to administer local than general anesthesia. Some physicians also prefer to operate on patients who are asleep.

Furthermore, there are institutional/organizational barriers to post-partum sterilizations. For instance, although most women who deliver babies at Ankara Maternity Hospital stay in the hospital for only two days, women who have a post-partum sterilization have to stay at least five days. This is partly because obstetrics and sterilizations are handled by separate services within the hospital: a woman who is going to have a post-partum sterilization has to be discharged from the obstetrics service and then admitted to the sterilization service. In addition, physicians at Ankara Maternity Hospital prefer to keep women for five days after post-partum minilaparotomies in order to "ensure wound healing." Although the MOH provides sterilization operations without charge, there is a 10,000 TL/hospital day fee; thus the number of days has economic implications.

Section 2.3 of this report describes an ongoing AVSC project to improve access to sterilization services in MOH facilities. Although this project has trained some gynecologists to conduct minilaparotomies under local anesthesia, all sterilizations are still being done as in-patient procedures done under general anesthesia.

Some gynecologists fear that women who ask to be sterilized will later change their minds. There have been requests for reversal from women who were sterilized during caesarian sections and gave "consent" in the midst of labor and an obstetric emergency. Also, it was a common practice to sterilize women after a certain number of caesarian sections; some women who wanted more children may have been sterilized for that reason. In addition, some women were told that it is sometimes possible to reverse sterilization procedures. When sterilization first became available some physicians tried to give the women the exact information they had learned -- that tubal ligations are reversible in a small percent of cases.

Another constraint to sterilization is the lack of a functional referral system within the MOH. Although there may be a referral system on paper, there is no operational system to identify and refer high-risk obstetric cases to specific hospitals.

Still another barrier to sterilization is presented by the "unwritten rules" on sterilization among gynecologists, e.g., "that a woman under 30 should not be sterilized," and "a woman with less than three children should not be sterilized." Although there are no such restrictions in the 1983 law, these "rules" are widely applied.

4.8.2 Male Sterilization

Currently there is almost no demand for vasectomy in Turkey. Obstacles to vasectomy may go back to the use of castration during the Ottoman Empire. In addition, the Turkish word for male sterilization is the same as the word for castration. Thus, many people think of male sterility as equaling impotence. It may be necessary for any effort aimed at increasing the use of vasectomies to be preceded by a public education campaign that discusses the difference between sterilization and castration.

4.9 Lactational Amenorrhea

Although breastfeeding is common in all regions of the country, the mean duration of any breastfeeding declined from 12.5 months in 1983 to 10.3 months in 1988. The average

duration of lactational amenorrhea is not known. The average time for return of post-partum menstruation was found to be 4.9 months in a study done in the Cubok Family Planning Service and Research Area in 1979. A study currently under way at the Institute of Child Health, at the University of Istanbul School of Medicine, will provide more recent data on the length of lactational amenorrhea. A decline in the average length of lactational amenorrhea will tend to increase fertility.

5. Recommendations for Future Directions

This assessment focused not only on A.I.D.'s support for family planning training and service delivery in Turkey, but also on the country's entire family planning and service delivery system. The recommendations based on this assessment address problems and gaps in the system as a whole. As previously discussed, it is a complex and pluralistic system in which many agencies and organizations play important roles. Although the Government of Turkey plays the largest and single most important role, non-governmental organizations (NGO) are also important. A.I.D. and other bilateral and multinational donor agencies make significant contributions, in most cases through their support of the programs and projects of either the Government of Turkey or one or more of the NGOs.

All of the above is to say that the following recommendations are not addressed solely to A.I.D. This broad assessment led to the identification of many problems and possible (if sometimes partial) solutions. A.I.D. is not in a position to implement all of the possible solutions. The assessment team is hopeful that the Government of Turkey and some of the other partners in Turkey's family planning effort will be interested in these suggestions.

5.1 Long-term Goals

This section suggests six long-term goals for family planning training and service delivery in Turkey. Projects that would further these goals should be given priority.

- Efforts should be made to support and expand the role of men in family planning in Turkey by 1) supplying men with accurate information about specific family planning methods, including male and female sterilization; 2) providing opportunities for men to discuss family planning with an empathetic and informed person who can answer questions and address concerns; 3) facilitating the distribution of adequate numbers of free and low-cost condoms to men; and 4) supporting and reinforcing the important role of men in fertility control.
- Every MOH health center should be staffed with at least one midwife who is certified to provide all family planning services.
- Female sterilization services should be made available in every province.
- The safety and overall quality of IUD insertion and follow-up care should be ensured.
- Women should be provided with adequate, accurate, and unbiased information regarding oral contraception, and pills should be provided in a manner that will increase continuation of use and decrease contraceptive failure.
- The quality of pre-service midwifery education should be improved.

5.2 Recommendations

5.2.1 General

This section describes a variety of specific projects that would help to 1) protect or improve the quality of family planning services provided in Turkey, 2) make those services more effective and efficient, 3) enroll additional numbers and categories of people into Turkey's family

planning effort, or 4) strengthen institutions that train family planning service providers. Most but not all of these projects would contribute to one or more of the six priority goals listed above. Most but not all call for training. Some of them are aimed at strengthening A.I.D.-supported projects that are already planned or under way. Some quite specific suggestions are included in order to share ideas developed during the course of the extensive training assessment. Some of these recommendations are not relevant to the GDMCHFP, some could be supported by A.I.D. Office of Population CAs, and others could be supported by any of several agencies.

Several of the suggested projects call for planning meetings involving representatives of the many government agencies, private organizations, and international donor organizations that are involved in family planning in Turkey. Coordination and collaboration between these numerous components are serious unmet needs.

The use of video tapes has been proposed in several instances. This medium has several advantages:

- Television sets and video equipment are widely available and people are accustomed to using them.
- Video tapes can be reproduced in large numbers for relatively little cost.
- Video tapes can be mailed or otherwise delivered to people who need to have the information they contain; because they are of some value, it is likely that the people who receive them will watch them and save them.
- Viewing a video cassette does not require much effort, time or money on the part of the potential "learner", and it can be done privately. This is in contrast to attending a training event, which may require a one- or two-day commitment of time, transportation, and financial costs.
- Going to a training event implies that one needs training. Some of the people who need training may not think that they need it, or may not want to be seen by others as in need of training. Those who need the training most are often the least motivated to attend.
- A video tape can be reviewed over and over again by the same learner, and can be shown to new people who rotate into a particular job.
- Since the "training" only has to be given once, i.e., to produce the tape, great effort can be made to make it very good -- to use the most prestigious and influential people, and it can be pilot-tested and edited to ensure maximum effectiveness. In contrast, a training event that has to be repeated over and over for many people cannot use the most prestigious and influential people, and may not be as effective.

When practical, it would be useful to implement projects through the medical school departments of public health. These departments need support; if they fail to thrive, the entire family planning effort will be diminished.

5.2.2 Recommendations for Reaching Men with Family Planning Information and Supplies

The role of male nurses in outreach to village leaders, religious leaders, groups of male workers and informal groupings of men within the community (e.g., in tea houses) should be

given much more attention and support, and their training should be expanded and strengthened. If Turkish family planning leaders support this recommendation, it is suggested that the GDMCHFP 1) convene a series of working meetings to expand and strengthen the family planning component of the job description and the pre-service curriculum for male nurses, and 2) plan in-service education in family planning for male nurses currently employed in health centers throughout the country. The working group should consist of representatives from the GDMCHFP, GDPHC, GDHT, Gevher Nesibe Health Institute, the six schools that train male nurses, UNFPA, and two male nurses with different but extensive and successful experience in family planning.

The use of male nurses to run the health posts (health houses) in some isolated rural areas should be considered. A working group convened to improve the training and use of male nurses in family planning might also discuss the advantages, disadvantages, and other implications of training and using male nurses to fill health post positions in areas where it has been hard for midwives to work. It should be noted, however, that there are not enough male nurses in the country to make this change except in a few of the most isolated rural areas.

Persons providing condoms should ensure that much more generous supplies are dispensed.

5.2.3 Recommendations to Increase the Number of Midwives Who Are Trained and Certified in Family Planning

The GDMCHFP's training capacity should be expanded. There should be a training center in every province.

5.2.4 Recommendations to Make Female Sterilization Services Available in Every Province

At least one hospital in each province should be developed as a source of both laparoscopic and minilaparotomy tubal ligations. This will require training of physicians to perform the procedures and of nurses, midwives, and counselors (perhaps psychologists) to counsel women who are considering sterilization. Structural and institutional barriers need to be identified and eliminated, and referral channels need to be developed, maintained, and periodically evaluated.

A major university, probably Hacettepe, should be encouraged to consider a pilot project to train GPs to conduct minilaparotomy sterilizations. The 1983 law does not allow GPs to perform female sterilizations, probably because it was based on laparoscopic procedures. A pilot project might lead to a change in this regulation.

A study of "sterilization regret" should be carried out to determine how common this has been and to analyze the circumstances related to the phenomenon. The results of such a study should be promulgated through the publication of articles in professional journals and should be used to dispel any inaccurate beliefs about the incidence of and reasons for regret, and to provide a basis for developing safeguards to minimize future cases.

The current AVSC projects are important and should be continued.

5.2.5 Recommendations to Protect the Safety and Overall Quality of IUD Insertion and Follow-up

Care should be taken to ensure that training units are not overtaxed with new demands to the extent that the current high level of quality control for IUD insertion training is

compromised. See Section 5.2.9 regarding a recommendation for development and distribution of a video cassette for refresher training on safe use of IUDs.

5.2.6 Recommendations Related to Oral Contraception

Research should be conducted into how to effectively educate and counsel rural Turkish women to use oral contraception. One or two "focus groups" consisting of successful rural pill users could be recruited (and perhaps paid) to help researchers understand the beliefs, motivations, practices, and problems that underlie the low continuation and high failure rates of pill use in Turkey, and to develop and test methods to educate other women about oral contraception and how to use pills effectively. Insights gained through this process should be used to develop a video cassette for use in training family planning workers, and effective printed materials about oral contraception to give to women who are not literate in Turkish.

Physicians and midwives should be taught to provide more than one cycle of pills at each visit. Two cycles should be given at the first visit, with instructions to return after starting the second cycle; four cycles at the second visit, with instructions to return after starting the fourth cycle; seven cycles at the third visit, with instructions to return after starting the seventh cycle. A one-year's supply should be given at each subsequent annual visit unless complications or a change of circumstances intervenes.

A training video and IEC materials should be provided to pharmacists and their employees. The following activities should be undertaken to prepare pharmacists and pharmacy workers for their roles in the distribution of pills: 1) production of a video that provides information on the role of pharmacies in supplying Turkish men and women with contraceptive supplies (condoms, pills, IUDs); risk screening of women who want to buy pills (brief, covering only the essential points); and how to advise people on the effective use of pills and condoms; 2) production of a small wall poster that provides brief, clear instructions on pill risk screening and instructions for pill users, to be placed where it can remind the pharmacy workers; and 3) production of another poster that announces that this pharmacy sells pills and that provides brief but clear information on contraindications and the types of women for whom pills are a particularly good method of contraception, for elective use on the inside of the pharmacy window.

All three of these items should be mailed to the pharmacist responsible for each of the nation's more than 9,000 private pharmacies, with a cover letter from the director of the provincial ministry of health in which each pharmacy is located. The cover letter should request that the pharmacist watch the video, require each person who sells products in his pharmacy to watch the video, and save it to show to any new workers in the future. This should be done by the Human Resource Development Foundation instead of producing a shortened (150 to 200 page) version of a Turkish translation of Contraceptive Technology for pharmacists and instead of conducting a one-day optional family planning workshop in conjunction with the next annual pharmacists meeting.

Other recommendations intended to improve the ability of physicians to provide accurate, unbiased information on oral contraception and to support women who want to use pills as their family planning method are included in Sections 5.2.8.

5.2.7 Recommendation to Increase the Quality of Pre-service Midwifery Education

The field needs assessment activities and TOT components of the RONCO project with 17 schools should be replicated with the other midwifery schools and the faculty of the three tutor-training programs.

5.2.8 Other Recommendations Regarding the GDMCHFP

A.I.D. should support a comprehensive planning process for the GDMCHFP. The State Planning Agency (SPA) is currently developing long-term (five-year) goals for the MOH. When this process is finished, the GDMCHFP will need to plan how to put into effect the policies and long-term goals established by the SPA.

The GDMCHFP has requested support for a comprehensive planning process. An earlier planning process undertaken by the GDMCHFP with assistance from RONCO was limited to training and does not meet the GDMCHFP's current planning needs.

JHPIEGO papers on this subject emphasize that the GDMCHFP plans to involve private sector organizations in the planning process. Other governmental organizations also need to be involved, including other directorates of the MOH (the General Directorate for Primary Health Care, the General Directorate for Health Training, and the General Directorate for Curative Medicine) as well as YOK, the military, the SSK, and the Ministry of Education.

The planning group should be asked to address a number of specific problems and possibilities:

- The lack of collaboration between family planning (which comes under the GDMCHFP) and the in-hospital services which are responsible for obstetrics, abortions, and sterilization procedures (which come under the GDCM). (Information and communication about family planning should be provided to women who are hospitalized following childbirth. Women who come to hospitals for pregnancy diagnosis or to schedule abortions must be informed about methods of contraception and where and when to go to get started on a family planning method. Midwives and physicians who provide family planning services in health centers and MCHFP centers must know how to arrange appointments for sterilization counseling for women who want tubal ligations.)
- Whether and how to expand the role of male nurses in family planning outreach.
- Whether and how to train and use psychologists to play roles in family planning counseling, especially in the MCHFP service and training centers.
- How to incorporate long-acting hormonal contraception (i.e., NORPLANT[®], once it is approved by the US FDA) into family planning training and service delivery programs.
- How to combine family planning with immunization campaigns. (Babies need vaccination and their mothers need contraception; there could be a joint campaign.)
- How to bring the SSK health care delivery system into the national family planning effort. (Consider a cost-benefit analysis of family planning services currently being provided at 31 SSK hospitals through a special project.)

The Turkish consultant for the planning project should be a public health specialist. The Public Health Group of the Chamber of Physicians is a potential source of expertise and could possibly handle much of the technical support through a subcontract.

The GDMCHFP should develop a shorter, more appropriate family planning course for MOH GPs. The Central Training Team (CTT) should be responsible for developing this less-

than-one-week course. The course should focus on the importance of family planning for maternal and child health; supervision and evaluation of the MCHFP services provided by midwives; and screening, diagnosis, treatment, and referral for complications associated with the use of pills and IUDs. The CTT should conduct a series of courses to prepare the provincial training teams to teach this course, which could then be given to large numbers of GPs.

Manuals published by the GDMCHFP should be updated and revised. After the GDMCHFP planning process is complete, a workshop or series of workshops (it would require a significant amount of work) should be held to revise at least two (the one on maternal health and family planning and the one on IUD insertion), if not all three of the manuals used during the GDMCHFP's training courses and by MOH workers in the field. The revised manuals should reflect any changes that result from the GDMCHFP planning process (ideally these would include an expanded role for male nurses and for psychologists), and should have much stronger units on patient education and counseling, oral contraception, and sterilization. Results from research into more effective ways to educate rural women about the pill should be made available to the people making this revision, and it should include a short section on hormonal implants, which will probably become available while the revised books are in use. In addition to GDMCHFP trainers, participants in the revision workshop should include a physician public health specialist and a gynecologist, both of whom should be experts in family planning, and appropriate representatives of the GDPHC, GDHT and the Gevher Hesibe Health Institute. An A.I.D. contractor should support the workshop with a collection of resource documents. Enough copies of the revised manuals should be produced so that one can be sent to every health unit, health center, and MCHFP center in the country; to supply the midwifery and nursing schools, and to make them available for use during the GDMCHFP in-service training sessions.

Continuing education should be provided for members of the GDMCHFP central training team. Although this team is functioning at a high level, three of its six members have not had the benefit of special family planning TOT. The value of such training is demonstrated through the dynamic leadership of the other members of the team. The three new members of the team should each be invited to participate in an appropriate international family planning TOT course. All members of the central training team should be invited, on an occasional basis, to participate in international courses intended to update family planning trainers in contraceptive technology and training methods.

5.2.9 Recommendations for the Human Resources Development Foundation

There are several suggestions for distribution of the Turkish translation of Contraceptive Technology: The Human Resources Development Foundation should revise its current distribution plans in order to provide approximately 5,000 free copies as follows: 20 to each medical school; 10 to each midwifery school; 5 to each nursing school; 5 to each health officer school; 10 to each institution that prepares nursing and midwifery school tutors; 2 to each MCHFP center; and 1 to each health center. Books sent to the schools should be accompanied by a letter requesting that some of the books be given to appropriate faculty members and that others be placed in the library for use by students. Books sent to MCHFP centers should be accompanied by a letter indicating that one copy is for the use of physicians and the other is for use by midwives. The book sent to each health center should be addressed to the GP in charge of the center, who should be instructed to share it with the midwives and to leave it at the health center when he or she leaves the post.

The other 10,000 copies of the first printing should be available for sale at an attractive price, and at a reduced price to medical, midwifery and female and male nursing students. Advertisements announcing sale of the books should be mailed to the offices of all gynecologists, and to all schools along with the schools' free copies of the book.

Instead of convening a series of large training meetings for private gynecologists, the Human Development Resources Foundation should produce three family planning continuing education video cassettes and distribute them to a variety of family planning service providers, as follows:

A well-planned and edited cassette of a discussion among a group of international experts in family planning including several well-known Turkish gynecologists

The conversation should raise and provide authoritative information regarding the following problematic issues: the risks and safety of oral contraception; over-diagnosis of cervical erosion; contraindications to IUD insertion; the practice of "resting the uterus" for a few months between removal of one IUD and the insertion of another; research findings regarding the safety of IUD insertion by MOH midwives; unmet demand for female sterilization in Turkey; administrative barriers to providing sterilization operations; appropriate anesthesia and hospitalization for female sterilization operations; how to provide clear information and counseling about female sterilization; the circumstances under which Turkish women have requested reversals of sterilization operations; the benefits (from studies) of offering a choice of contraceptive methods; and how to help a woman determine which method is best for her own use. This cassette should be from Turkish gynecologists to Turkish gynecologists, and should be mailed directly to all gynecologists registered with the Chamber of Physicians.

A video cassette for refresher training on use of IUDs

The cassette should address counseling, selection of clients, diagnosis and treatment of cervical erosions, diagnosis and treatment of vaginal and cervical infections, IUD insertion technique, sterilization of IUD insertion equipment, and diagnosis of complications, including which can be managed by a GP and which require referral or, in some cases, immediate transfer to a gynecologist. The video should show gynecologists, GPs and midwives involved in the care of women who use IUDs for contraception. Copies of the cassette should be sent to each medical school (the department of gynecology and obstetrics and the department of public health), each midwifery school, each school that prepares tutors for the midwifery schools, each MCHFP center, as well as copies for other use and distribution by the GDMCHFP, the GDPHC, The Pathfinder Fund, the Turkish Family Health and Planning Foundation, and the HRDF should produce and keep extra copies to meet other unforeseen needs.

A video cassette on how to educate and counsel women in order to help them decide which contraceptive method to use

This cassette should have the same distribution as the previous cassette, with the addition of schools of nursing (including the health officer schools).

A model family planning service and training center should be established. Turkey needs a model of excellent family planning service delivery. A model family planning service center should provide excellent patient education and counseling; a full range of contraceptive methods which are explained and offered to patients without bias; and time, space, and privacy for counseling. Its staff should demonstrate respect for patients and their right and ability to choose their own best method of contraception. It should be operated by a multi-disciplinary team (midwives, male and female nurses, general practitioners, and gynecologists) with the ability to diagnose and treat genital infections; manage contraceptive complications; and provide outpatient female sterilization. The full-time staff should include at least one male nurse for outreach to men and a psychologist to provide a model of excellent family planning counseling and to train others in the methods of counseling.

An existing GDMCHFP service and training center in Ankara or Istanbul should be selected to be developed into such a model center. Its staff (at all levels) should be selected on the basis of a strong commitment to family planning and personal leadership characteristics which have led to success in their past professional roles. Recruiting the right people is critical because they will serve as role models for others to observe and follow. The center should collaborate with the nearby hospital obstetric units in order to establish family planning information and referral services for women recovering from childbirth and for women who have come to the hospital for abortions or pregnancy diagnoses, and to facilitate referrals for sterilization procedures. In addition, it should be accessible to professors in nearby universities. Trainers assigned to this unit should be trained in participatory training techniques. The model center should be used for training all types of personnel, but should be seen particularly as a place for training the GPs who will be in charge of MOH health centers.

5.2.10 Other Recommendations and Suggested Projects

Research findings relevant to family planning training and service delivery should be summarized, reviewed, and analyzed, and the results used to improve training and planning for family planning service delivery. The Department of Public Health at Hacettepe University School of Medicine⁹ should be contracted to inventory, review, critique and analyze published and unpublished reports of research studies and of well-designed program evaluations conducted by Turkish researchers during the past 5 to 10 years and to summarize and synthesize those findings that are valid and significant. An analysis of the research findings should take study size and design into account and look for consistency, or the lack thereof, in findings from different studies of similar subjects, and should note time trends and differences in the subject populations. This information should be used to improve family planning services and training.

Some areas of research that should be reviewed and summarized include 1) studies of the use of withdrawal, 2) selected findings from the 1988 fertility survey (because the large published report is not available to most family planning workers), 3) research on the training, role, and effectiveness of midwives, and 4) the role of traditional birth attendants.

This process should result in a detailed and completely documented report and one or more papers suitable for publication in an appropriate Turkish professional journal. Such article(s) would probably also be of interest to international family planning professionals. When the comprehensive report is finished, a meeting or meetings should be convened to communicate the findings to those who are in positions to apply them to improve family planning service delivery and training. In addition, the report should be completed in time to be available for use during the GDMCHFP's planning process.

Individuals with special interest and expertise in some aspect of family planning services delivery should be encouraged to publish articles in professional journals and to present papers at professional meetings. To assist in this effort, inventories should be developed, and mechanisms to update each of them regularly should be established:

⁹Hacettepe Medical School Department of Public Health is recommended because it has been the source of much of the relevant research and expertise and because of its proximity and good relationships with the MOH. It is understood that this department, however, is already short-staffed for its present responsibilities. Much of the actual work could be performed by public health specialists from other medical schools, perhaps taking advantage of the network that is being established through the Public Health Group of the Chamber of Physicians. An A.I.D.-contracted CA should also provide some direct technical support.

1) an inventory of individual Turkish researchers and leading physicians and other professionals who are interested and have expertise in a specific subject with direct relevance to the delivery of family planning service delivery;

2) an inventory of upcoming professional meetings for general practitioners, gynecologists, urologists, subspecialty medical groups such as endocrinologists, midwives, male nurses, nurses, and psychologists, with information on the dates, location, and person responsible for developing the scientific program for each meeting; and

3) an inventory of professional journals that reach these same groups of professionals, with information regarding rules on how to submit an article to be considered for publication.

Once developed, these inventories should be shared in such a way as to promote papers on family planning subjects being presented at professional meetings as well as articles on family planning subjects being published in Turkish journals. Where it would be helpful, funds should be made available to support travel of these experts to present papers at professional meetings and to pay for secretarial and other expenses (e.g., production of graphic illustrations for an article or of slides for an oral presentation at a meeting). People are more likely to attend the regularly scheduled meetings of their professional associations than they are to attend a special training session devoted only to family planning. In addition, this approach is more cost-effective than holding special training meetings.

A.I.D. should continue to support PVOs to design and conduct innovative outreach projects to provide family planning information, education and communication (IEC) and services to particular, special-need subpopulations within Turkey. Outreach to men should be built into these projects whenever possible. In most instances, the A.I.D. support should focus on providing IEC, pills and condoms in the community and the work-site, or to providing special means to make the MOH clinical family planning services more accessible, either by bringing MOH personnel to the women in need of services (e.g., through the use of a mobile van) or by providing transportation to help women from a target population get to existing MOH family planning and maternal/child health services. A.I.D. funds should not be used to build clinics or to provide services which are available in the same area through the MOH.

If a PVO, such as Pathfinder, funds such projects indirectly, i.e, through a Turkish foundation, it should play a continuing role in their evaluation. About six months before the end of the project period, representatives of the funding organization should meet with the local project directors and local MOH and community leaders to determine how the needs of the population being served by the project can continue to be met when the project is over. A careful field evaluation of the project should precede such meetings; a representative of the local MOH and a leader of the community being served by the project should be invited to be full participants in a team to conduct the evaluation.

The Turkish foundations involved should try to raise true philanthropic funds to replicate proven projects in new areas. Since these are interesting and attractive projects, it should be relatively easy to raise funds.

The Pathfinder/TFHPF project for seasonal migrant workers in Adana Province seems to be meeting a significant need. It should be replicated to serve more seasonal migrant workers in Adana Province, and perhaps in other areas of the country. The local MOH should be able to continue such projects (once they have been seen through start-up expenses and experiences) by giving the project staff time off (for instance, during the afternoons, when most MOH health facilities have few patients) to compensate for evening hours spent at the project.

Leaders of the three Turkish foundations should be offered a training opportunity.

The executive director and one or two key board members of each of three new foundations involved in family planning (the Human Resources Development Foundation, the Turkish Family Health and Planning Foundation, and the Foundation for the Advancement and Recognition of Turkish Women) should be offered a training opportunity to enhance their ability to function effectively, to provide exposure to positive role models for leaders who may not be experienced in the world of large-scale philanthropy, and to develop a further commitment to the foundation for key board members.

The Council on Foundations, an American organization devoted to improving the performance of philanthropic foundations, holds an annual meeting every April and conducts various workshops and training meetings irregularly throughout the year. Leaders of these new Turkish foundations could certainly be invited to any of these training sessions. In addition, the Council would most likely be willing to develop a special program of training and visits to give the Turkish philanthropists an opportunity to meet and discuss issues with leaders of American foundations. Foundation board members who attend these sessions should be expected to pay their own expenses as part of their personal contribution to the foundation.

The Family Planning Association of Turkey (FPAT) should be helped to develop a central training team. FPAT needs additional technical and financial support to develop the capacity to help its 27 provincial branches become strong, effective organizations that are able to carry out their own projects. FPAT has already carried out some projects with men (e.g., FP education for 4,000 soldiers in a project with UNFPA), and is leading the way in family life education for youth. With adequate training and encouragement, volunteer members of provincial FPAT branches could replicate these projects in their local areas.

FPAT needs two or three additional full-time paid staff (two trainers and a secretary) to serve as a central training team, plus financial support to allow the trainers to travel. They have requested funds for a training team from IPPF, but so far this has not been granted.

An A.I.D. contractor should assist and support FPAT to develop and operate a central training team for two years, and to provide partial support for a third year, with such assistance dependent on an agreement that IPPF London will provide partial support during the third project year and then will continue support for at least two additional years.

FPAT should be encouraged to focus its energies and creativity on outreach to men.

Family planning training in pre-service medical education should be strengthened.

It appears unlikely that YOK will mandate a standardized family planning curriculum for medical schools. However, faculty members from some medical schools could get together to review the curriculum developed during a similar meeting in 1988, to revise it as necessary, and to plan how to encourage schools to adopt the revised curriculum voluntarily. Each school should be invited to send one representative from its public health department and one representative from its gynecology department to a two- to three-day meeting for this purpose. Funding and technical assistance could be provided through the Hacettepe Medical School Department of Public Health, which is in the process of completing a survey of current family planning training practices in every school of medicine in Turkey. Information from that survey should be used to identify individual schools that have developed good curricula and persons who should play leadership roles in such a workshop.

Participants at this meeting should also develop guidelines for a one-month family planning elective to students with a particular interest in this area. Medical schools should not be

encouraged to provide IUD-insertion training to all medical students. This would waste resources because many medical students will never be in positions to need this skill. Instead, schools should be encouraged to organize and offer a family planning elective.

Appendices

Appendix A
Scope of Work

Appendix A

Scope of Work

(Entire Population Assessment and Training Assessment)

Attachment 1

POPULATION ASSESSMENT TURKEY

Objective:

Conduct an assessment of population activities in Turkey and use the information generated to update AID's strategy for population assistance to Turkey.

Background:

Since 1965 the Government of Turkey has followed a policy of making family planning services available throughout the country. The most recent population assessments, undertaken in Turkey by AID and UNFPA in late 1986, concluded that Turkey was at an important threshold in its population program with appropriate policies in place to support the expansion of family planning services.

Twelve Cooperating Agencies (CAs) are engaged in the implementation of population projects in Turkey with AID funding. The emphasis of this work is on service delivery in the NGO and commercial sector and includes pre-service and in-service training for health care providers and program managers, family planning service delivery, increasing the availability of contraceptives, and increasing public awareness and acceptance of modern family planning methods. The CA program approximately \$1 million per year, funding which comes from ST/POP and the ANE Regional Population Project. The geographic focus of AID assistance is largely urban and concentrated in the Western part of Turkey.

A team visited Turkey in 1986 to review AID funded population activities. This assessment has guided subsequent AID funding. Recommended as highest priority was expansion of services, especially those which enable couples to move from less effective to more effective methods, and information and training projects which support these services. Since this assessment there has only been minimal monitoring or evaluation of AID funded population activities. The activities have continued over this period and there is now a significant body of information, including a recent contraceptive prevalence survey, that needs to be analyzed. The purpose of this assessment is to take a new look at population programs in Turkey (by the Turkish Government, AID, other donors, and indigenous PVOs) and develop a strategy that will provide a basis for AID funding over the next five years.

The AID Cooperating Agencies are: the Pathfinder Fund, the Futures Group, RONCO, Family Planning International Assistance, JHPIEGO, Johns Hopkins - Population Communication Services, Centre for Development and Population Activities, Association for Voluntary Surgical Contraception, Family Health International, Enterprise (John Snow Inc. and John Short and Associates), and the Centers for Disease Control.

SCOPE OF WORK

The contractor will assist AID in conducting an assessment of population activities in Turkey, and contribute to the development of a strategy for future AID support to the population sector. This exercise will start with the review and interpretation of population data that is available in the U.S. The contractor will field a consultant who will be part of the assessment team going to Turkey. This team will spend approximately three weeks in Turkey during September-October 1989. Upon their return the team will submit a report containing a revised strategy for population assistance. Specific aspects of the work to be performed are as follows (those to be accomplished under funding provided in this PIO/T are underlined):

1. Initial review in the U.S.

A. Data available from various sources in the U.S. and elsewhere will be compiled by the Futures Group (CSM II) using other funds. The contractor (POPTECH) will assist with this data gathering. This will include information available through all of the CAs, as well as information that can be obtained from Universities, International Organizations such as UNFPA, bilateral donors, and NGOs. The data gathering stage should take approximately four weeks.

B. The Futures Group, using other funds, will then conduct an analysis of the information that has been collected. This analysis will cover:

- current status of population policies
- current legal and administrative framework
- availability of family planning services in the public and private sectors, including both for-profit and not-for-profit organizations
- quality of these services
- use of these services
- training capabilities and needs
- trends in any of the above
- current method mix and future projections

C. A day long meeting will be organized in Washington to review the results of this analysis. In preparation for this meeting (POPTECH) and the Futures Group will develop a background paper that covers the results of the preceding analysis. Illustrative topics are: current policy environment, service program coverage and utilization, application of local and external resources available to these

programs, preliminary assessment of services provided through AID CAS with associated costs and their effectiveness in meeting the goals of the past AID strategy for Turkey, gaps in the program where AID support might be useful, areas where sufficient data is not available, and recommendations on how the September assessment team might go about locating that information.

2. Review of activities in Turkey:

In September a team will visit Turkey for two to three weeks in order to review first hand the status of family planning programs that are underway. This team will be following up on questions that emerged from the data analysis, looking at the program from a broad perspective of Turkey's population sector, and the overall A.I.D. population assistance effort. The most important task will be to review the effectiveness of past AID funded activities and develop the information needed to formulate a strategy for future funding.

POPTECH will provide a consultant member of the team. This individual will have a background in program management and clinical skills for family planning and maternal and child health. The consultant will have extensive experience in the planning and evaluation of such programs. It is anticipated that there will be two Turkish members of the team, with similar or complementary expertise. These individuals will be funded through POPTECH.

The POPTECH consultant(s) will focus particularly on an assessment of training needs for family planning program management and clinical skills. Included in the assessment will be a quantitative and qualitative assessment of training activities undertaken with A.I.D. assistance since 1985. This will include training of physicians and midwifery personnel, as well as paramedical, auxiliary and community workers who are active in family planning service delivery programs.

While the focus of this assessment will, to a certain extent, be retrospective, the primary purpose should be to develop a plan for responding to priority training needs over the next 3-5 years. The training plan will build on accomplishments to date, and make recommendations for coordinated and complementary roles for the cooperating agencies which undertake extensive training activities aimed at the expansion and enhancement of family planning service delivery programs.

The Turkey team will, at a minimum, review the following:

A. Turkey's demographic objectives for the year 2000, current national (and regional if appropriate) population policies plus the strategies of major contributors to the population sector, and available national, bilateral, and multi lateral resources currently directed towards population related programs.

B. Identify potential actions necessary to achieve stated sector objectives, with a special emphasis on increased government and private contributions.

C. Identify impediments to improved performance of family planning services in both the government and the private sector and possible ways to overcome these constraints.

D. Assess the activities of each of the AID funded CAs and how their efforts have contributed to the objectives in the 1986 assessment in (relation to the costs of its programs). Also, how its activities have contributed to the overall population program in Turkey. There will need to be a specific review of each of the major areas of activity, e.g., training of providers and managers, approaches to service delivery development, increased availability of contraceptives, and increased awareness of and acceptance of modern methods of contraception. Relative cost-effectiveness and sustainability of the activities will need to be addressed.

E. Based on these reviews of policy, resources and proposed strategies, recommend areas for AID assistance and an implementation strategy that will complement other efforts and will be consistent with AID population policy. Also recommend timing and budget levels for this assistance.

F. Suggest potential innovative approaches to implementing the recommended interventions, taking into consideration the mechanisms through which AID can contribute to family planning programs in Turkey. These recommendations should take into consideration the strengths of the various CAs and institutional relations that have, or could be established between CAs and Turkish institutions.

3. Preparation of a revised AID Population Assistance Strategy for Turkey:

After returning from Turkey the team will draft a revised AID Population Assistance Strategy. The POPTECH consultant will assist with drafting the strategy. It will include, at a minimum, the following sections:

- executive summary
- background on country policy, available resources and proposed strategies; program targets and objectives for the next ten years
- review of actions and resources needed to meet these objectives
- recommended AID assistance over the next five years.

This report will be based on the results of the trip to Turkey. ST/POP and ANE/TR/HPN will develop the report's outline. The draft report will be submitted to AID within five weeks after returning from Turkey. Based on comments from AID the report (strategy) will be finalized and 25 copies provided to AID.

LEVEL OF EFFORT:

POPTECH will provide the following services:

- data gathering 10 days
- preparation of background/issues paper 3 days
- consultancies in Turkey:
 - data analyst/planner 17 days
 - Turkish consultants (2) 30 days
- strategy development 16 days

TECHNICAL DIRECTION:

This work will be performed under the direction of ST/POP and ANE/TR/HPN. The individuals will be Elizabeth Mcguire and Paula Bryan.

PERIOD OF PERFORMANCE:

The work described will be completed over the period July 1989 through January 1990.

Expanded Scope of Work
for
Training Assessment - Turkey

PURPOSE: To determine the extent to which health personnel (physicians, nurses/midwives, paraprofessionals) in Turkey are trained to meet needs for the provision of family planning information, education, counseling and services.

I. A. Quantitative assessment

Types/Numbers/percentages of personnel trained in family planning
Types/Numbers/percentages of institutions providing training (see World Bank, Turkey Health Sector Review 1986)

B. MOH, General Directorate for MCH/FP

Analysis of national planning/coordination of health manpower training with program needs

(See RONCO document Trip Report No. 24, 2 week program planning workshop assisting GDMCH/FP with development of 5-year training plan for MCH/FP)

-to what extent did this guide training activities;
what other factors determined implementation of training activities

-Linkage between training and expanded service delivery

II. Nurse/Midwives and Family Planning

A. Midwifery training

1. Extent of institutionalization of family planning in the curriculum of midwifery reeducation programs. (1987, 17/39 schools covered - current status ?)

2. Contributions of AID assistance
RONCO - types of assistance, accomplishments
Pathfinder - types of assistance, accomplishments

3. Contributions of other donors, e.g. UNFPA in training of midwives in FP

B. Role of midwives, effectiveness in FP service delivery (1988 DHS - p.94 Source of contraception - in Health Center/House, is provider likely to be a physician or midwife?)

Opportunities - points of contact, ect.
Obstacles, e.g. competing demands and priorities, contraceptive supply, supervision by physicians who are not trained in family planning

Approaches: Are any contraceptive methods preferred, recommended more than others?

- C. Additional training needs, recommendations
 - general
 - AID-assisted

III. Physicians

- A. Status of physician training in family planning
 - Medical Schools
 - In-service

Sources: AVSC, Pathfinder, JHPIEGO
Accomplishments of AID assistance

- B. Policies affecting FP in Medical School curriculum?
- C. What is the extent of need for more in-service i.e. continuing medical education in family planning
- D. What are the priority needs
- E. Recommendations for AID assistance

IV. Volunteers, Paraprofessionals and Family Planning Service Delivery

Role of volunteers in Family Planning Assoc.
What is the role of volunteers in IEC and service delivery.

Do the FPAT branches know how many clients are being served by volunteers?

How are contraceptive supplies managed, distributed, tracked, resupplied?

Appendix B

Places and Institutions Visited and Individuals Interviewed

Appendix B

Places and Institutions Visited and Individuals Interviewed

United States Agency for International Development, Washington, DC

Asia/Near East Bureau

Paula Bryan

Office of Population, Bureau for Science and Technology

Dawn Liberi, Chief, Family Planning Services Division

Charlotte Ureksoy, International Training Division

Earl Lawrence, International Training Division

RONCO Consulting Corporation, Washington, DC

Dr. Oluremi Sogunro, Program Manager for Turkey

JHPIEGO Corporation, Baltimore, MD

Clayton A. Ajello, Dr PH, MPH, Associate Director for Asia & Near East

Embassy of the United States of America, Ankara

Carl Matthews, Political Officer

Carolee Heileman, Economic Officer

Marc Grossman, DCM

Ozkaya Ozdemir, Economic Officer

United Nations Children's Fund (UNICEF), Ankara

Dr. Claudio Sepulveda Alvareg, Country Director

Gary R. Gleason, PhD, Senior Project Officer

United Nations Fund for Population Activities, Ankara

Dr. Turgut Denizel, Country Representative

Chamber of Physicians, Public Health Group, Ankara

Prof. Zafer Oztek, MD

Ministry of Health, Government of Turkey

General Directorate for Maternal and Child Health and Family Planning (GDMCHFP), Ankara

Guler Bezirci, MD, Pediatrician, General Director

Ugur Aytac, Deputy General Director

Gulfidan Cosar, Midwife, Chief, Family Planning and Mother Health Division

Kadriye Yurdavok, MD, Pediatrician, Child Health Department

Public Health Training Division

Nuran Ustunoglu, Chief,

Zubeyde Ozonozu, Midwife, Trainer

Nesrin Tilmog, Nurse-Midwife, Trainer

Observed one morning of Training of Trainers course being given by GDMCHFP staff for development of provincial training teams for 6 additional provinces

MCHFP Training and Service Centers

MCHFP Center #3, Ankara

Ali Ramiz Kucuk, MD, Gynecologist

Kutbettin Oguz, MD, Pediatrician

Seza Imamoglu, MD

Belma Biliker, MD, in charge of training

**MCHFP Training Center, Ankara Maternity Hospital
Yuksel Bakkan, MD, Gynecologist**

**MCHFP Training Center, Zeynep Kamil Maternity Hospital, Istanbul
Asuman Karaman, MD, Gynecologist
Sadiye Eren, MD, Gynecologist**

**MCHFP Training Center, Adana
Sevinc Bilen, MD, Gynecologist**

**MCHFP Center, Diyarbakir
Dr. Serdar Sarac, Director
Necla Turker, Head Nurse**

**General Directorate for Primary Health Care (GDPHC), Ankara
Bilgin Gozum, Acting General Director**

**Incirlik Health Center (HC), Adana Province
General practitioner
Health unit (midwife's home) associated with Incirlik HC**

**Mermer Health Center (HC), Diyarbakir Province (rural)
Duran Sinaci, MD
Hulya Dalli, Midwife
Narin Ogut, Nurse
Sibel Yigitalp, Midwife**

**General Directorate for Curative Medicine (GDCM), Ankara
Aykut Veziroglu, Chief Nurse**

**Ankara Maternity Hospital
Tuncay Alaybeyoglu, MD, Acting Doctor-in-Chief
Perran Moroy, MD, Gynecologist
Yuksel Bakkan, MD, Gynecologist**

**Zeynep Kamil Maternity Hospital, Istanbul
Asuman Karaman, MD, Gynecologist
Sadiye Eren, MD, Gynecologist**

**Adana Maternity Hospital
Gynecologist**

**Diyarbakir Maternity Hospital
Dr. Unal Okcal, Gynecologist**

**General Directorate for Health Training (GDHT), Ankara
Fatma Uz, Nurse, MEd, Director, Department of Education and Planning**

**Gevher Nesibe Health Institute, Ankara
Ali Riza Gozler, Director**

Adana Midwifery Training School
Leman Karahan, Midwife, Director
2 senior students

Gaziantep Midwifery Training School
Sukran Pat, Midwife, Director
1 senior student

Provincial Directorate for Adana Province, Adana
Nafiz Bozdemir, MD, DrPH, Deputy Director

Provincial Directorate for Icel Province, Mersin
Dr. Yusuf Z. Ozsahin, Director for MCHFP

Provincial Directorate for Gaziantep Province, Gaziantep
Dr. Serafettin Ozemir, Deputy Director
Ugur Goren Genc, Director of MCHFP

Provincial Directorate for Diyarbakir Province
Dr. Seyfettin Sonmez, Director
Ufuk Aytac, MD
Sengun Senol, Nurse, Health Educator
Dr. Tevfik Istanbuluoglu (immunization program)
Huseyin Kesiktas, Health Officer (male nurse)

SSK Hospitals

SSK Hospital in Ankara, Family Planning Clinic supported by TURK-IS
Gynecologist
Hulya Ucek, Psychologist

SSK Hospital in Gaziantep
Midwife students in family planning unit and gynecology clinic

Family Planning Association of Turkey (FPAT)

Central Offices, Ankara
Dr. Semral Koral, General Director
Dr. Tandogan Tokgoz, Secretary General
Prof. Dr. Sema Kut, member of Board of Directors

"Woman-to-Woman" project in a gecekondu area, outskirts of Ankara
gynecologist in FPAT clinic
Katibe Unlu, community leader
Ceuriye Cakir, community leader
30 year-old mother of two children, client
Ulker Elgin, social worker, field supervisor

Adana Branch Association
Sevinc Bilen, MD, Gynecologist
Mersin Branch
Ms. Necmiye Kirmizier
Ms. Senay Yurekli
3 other members of board of directors

YOK (Council of Higher Education), Ankara

Uygur Tazebay, Vice President

Member of Board of Directors responsible for community colleges

Hacettepe University, Ankara

Institute for Population Studies

Prof. Dr. Aykut Toros, Deputy Director

Dr. Mahir Ulusoy, Professor of Economics

Department of Public Health, School of Medicine

Ayse Akin, MD, Gynecologist, Professor of Public Health

Munever Bertan, MD, Professor of Public Health and Social Pediatrics

Nesrin Cilingiroglu, Health Economist

Marmara University, Istanbul

Department of Public Health, School of Medicine

Osman Hayran MD, PhD, Assoc. Prof. of Public Health

University of Istanbul

Institute of Child Health, School of Medicine

Aysen Bulut, MD, DrPH, Associate Professor Public Health

CEDPA-supported project in gecekondu area of Istanbul
7 community workers

Department of Pharmacology, School of Medicine

Lutfiye Eroglu, Professor of Pharmacology

Halil Sagduyu, Professor of Pharmacology

Florence Nightingale College of Nursing

Dean of the college

Aysel Kavakli, PhD, Department of Pediatric Nursing

Member of maternal and child health nursing department

Cukurova University Medical school, Adana

Department of Gynecology and Obstetrics

Nihat Aridogan, MD, Gynecologist, Chairman

Dicle University Medical School, Diyarbakir

Department of Gynecology and Obstetrics

Ali Ceylan Erden, MD, Prof. of Gynecology & Obstetrics

Department of Public Health

Prof. Dr. Ersen Ilcin, Chairman

TURK-IS, Ankara

Mustafa Basoglu, Executive Director

Turkan Kuzey, Nurse-Midwife, supervisor for the Turk-Is family planning projects in SSK hospitals

The Pathfinder Fund, Istanbul

Turkiz Gokgol, PhD (interviewed in Washington, DC)
Demet Gural, MD
Mine Turkmen, Treasurer
Ayse Tunaligil, Secretary

Turkish Family Health and Planning Foundation

Migrant worker project, Adana Province
Nafiz Bozdemir, MD, DrPH, local medical director
Muhsin Akbaba, MD, Associate Professor of Public Health, Cukurova University
Medical School
Kezban Guler, Midwife
Another midwife

FP/MCH Center in Baglar area of the city of Diyarbakir
Fatma Kalkan, MD

The Human Resource Development Foundation, Istanbul

Sunday Uner, PhD, Executive Director

Pharmacies, pharmacists, and pharmacy workers

3 pharmacies in Istanbul (no pharmacists present)
2 pharmacies in Diyarbakir (one pharmacist, Bekircan Gelen, owner of Can Eczanesi)

Private gynecologist

Ferruh Adali, MD, Istanbul

Appendix C

**Population Projects Database:
A.I.D. Population Activities in Turkey,
August 7, 1989**

Population Projects Database
 U.S.A.I.D. Population Activities by Country
 Subproject Level Activities (expenditures in \$1000s)

Run Date: 08/07/89
 Run Time: 09:51:24
 Page: 64

Region: Asia / Near East
 Country: Turkey

Central S+T/POP:

Grantee	Title	Host Institution	Contact Person	Begin Date	End Date	Fiscal 1988	Fiscal 1989	Life of Project
AVSC	VSC Program	MONSA/GD FP-MCH	Dr Guler Bezirci	07/01/89	06/30/90	\$0	\$16	\$39
CEDPA	Promotion of FP in Urban Areas	Institute of Child Health	Turken Kutluay	12/19/87	07/14/91	\$10	\$25	\$140
FHI	TCU-380A vs LLD	Macettepe U/Institute of Pop	Kisnisci Musnu	04/01/85	09/30/89	\$1	\$1	\$4
FPPIA	FP Comm Dist Record/Report Proj	MONSA/GD FP-MCH	Dr Guler Bezirci	04/01/85	12/31/88	\$7	\$20	\$61
FPPIA	FP Info & Ed Mat For Turk Wkrs	TFNPP	Yasar Yasar	12/15/88	05/15/89	\$0	\$7	\$7
FPPIA	Workers Health & FP Project	TURK-IS	Kaya Ozdemir	08/01/82	03/31/89	\$28	\$27	\$462
Futures	CSM Project-Implementation	TFNPP	Yasar Yasar	02/01/89	09/30/94	\$0	\$0	\$720
JHPIEGO	Equipment Maintenance Center	MONSA/GD FP-MCH	Dr Guler Bezirci	07/01/88	06/30/89	\$0	\$12	\$12
JHPIEGO	Equipment Maintenance Center	MONSA/GD FP-MCH	Dr Tandogan Tokgoz	09/01/81	03/30/88	\$0	\$0	\$68
JHPIEGO	FP Training Program	MONSA/GD FP-MCH	Dr Guler Bezirci	08/01/86	01/31/88	\$0	\$0	\$219
JHPIEGO	Turkish National Endoscopy	MONSA/GD FP-MCH	Dr Tandogan Tokgoz	07/01/81	01/31/88	\$0	\$0	\$630
JHU-FIP	Pop Rpts--Turkish Translation	Macettepe U/Institute of Pop	Dr Ergul Tunchilek	03/01/86	12/31/87	\$5	\$0	\$75
JSI-ENTERPRISE	Turkish Fam Health & Plng Fdtn	TFNPP	Yasar Yasar	10/01/88	09/30/90	\$0	\$48	\$105
Pathfinder	Booklets to Newlyweds	Childrens Homes Foundation	Selim Kazak	03/01/87	03/31/90	\$32	\$20	\$141
Pathfinder	CBD FP Svc Cumhuriyet District	Lioness Clubs	Talay Bayindirli	05/01/86	02/28/89	\$29	\$5	\$78
Pathfinder	CBD of FP Services in Izmir	Human Resource Dev Foundation	Talay Bayindirli	01/01/89	02/28/91	\$0	\$57	\$122
Pathfinder	Cont Tech Update Workshop	MONSA/GD FP-MCH	Dr Guler Bezirci	03/15/89	11/15/89	\$0	\$15	\$15
Pathfinder	Core Support Fam With Plan	TFNPP	Yasar Yasar	01/01/86	02/28/90	\$29	\$141	\$337
Pathfinder	Creation of Turk Fam Health	TFNPP	Yasar Yasar	01/01/86	02/28/90	\$20	\$78	\$337
Pathfinder	Dev Sup System FP Kirsehir RRV	MONSA/GD FP-MCH	Dr Guner Unal	06/01/86	06/30/89	\$6	\$20	\$70
Pathfinder	Est of FP Center in Baglar	TFNPP	Yasar Yasar	09/01/87	08/31/89	\$16	\$25	\$59
Pathfinder	Estab of TFAPP's FP Clinic	TFNPP	Yasar Yasar	06/01/88	05/31/90	\$32	\$71	\$171
Pathfinder	FP Curr Devel for Midwifery	MONSA/GD FP-MCH	Dr Tandogan Tokgoz	02/01/86	09/30/88	\$23	\$48	\$177
Pathfinder	FP Ed & Services in Urfa Prev	Pathfinder	Semra Ozal	12/01/88	11/30/90	\$0	\$38	\$129
Pathfinder	FP Serv for Seasonal Migrant	Pathfinder	Semra Ozal	11/01/88	08/31/89	\$0	\$49	\$49
Pathfinder	Impact FP & Nith Prog Squatter	Institute of Child Health	Dr Olcay Haysi	08/01/86	05/10/89	\$16	\$2	\$55
Pathfinder	Provision Of FP Ed+ Svcs - Tok	Turkiye Esnaf Ve Sanatkarla K	Musanettin Tiyannan	02/01/88	01/31/90	\$38	\$48	\$101
Pathfinder	Provision of FP Info+Svc-15WP	TFNPP	Yasar Yasar	11/01/86	10/31/88	\$10	\$3	\$104
Pathfinder	Provision on FP Svcs & Wkshp	TFNPP	Yasar Yasar	03/01/89	02/28/91	\$0	\$22	\$38
Pathfinder	Senegal Akcar- CEDPA Workshop	CEDPA	Suzanne Theroux	05/08/89	06/09/89	\$0	\$8	\$8
Pathfinder	Trn in FPS Svc Deliv Trabson	Karendis University	Prof Aydin Inal	06/01/87	11/01/88	\$0	\$0	\$30
Pathfinder	Tur Islam Ldrs Visit IndotEgyp	TFNPP	Altikulak Tayyar	10/01/87	11/30/87	\$24	\$4	\$28
Pathfinder	Voluntary Vasectomy Svcs Ankar	Ankara Social Svcs Hospital	Dr Sedat Unal	05/01/89	04/30/91	\$0	\$50	\$90
Pathfinder	Wkplace FP & Child Care Educ	Confed of Tradesmen & Craftsme	Kaya Ozdemir	05/01/85	10/31/88	\$0	\$0	\$74
RONCO	Coord of FP Activities-MGA/MON	FP Association of Turkey	Semra Koral	05/01/89	09/30/89	\$0	\$15	\$15
RONCO	Strengthening FP Trn Skills	MONSA/GDPT	Ibrahim Becer	10/19/87	03/30/89	\$29	\$0	\$81

AID. Population Activities in Turkey, August 7, 1989

Appendix C

Population Projects Database
 U.S.A.I.D. Population Activities by Country
 Subproject Level Activities (expenditures in \$1000s)

Run Date: 08/07/89
 Run Time: 09:51:24
 Page: 85

Region: Asia / Near East
 Country: Turkey

Grantee	Title	Host Institution	Contact Person	Begin Date	End Date	Fiscal 1988	Fiscal 1989	Life of Project
RONCO	Strg FP Activities of FPAT	FP Association of Turkey	Senra Koral	04/01/87	07/31/88	\$0	\$0	\$39
						\$355	\$875	\$4,890

Mission/Region Buy-Ins:

Grantee	Title	Host Institution	Contact Person	Begin Date	End Date	Fiscal 1988	Fiscal 1989	Life of Project
AVSC	OR For Effective I&E Initiati	Hacettepe University	Prof Savinc Oral	01/01/89	06/30/90	\$0	\$20	\$40
AVSC	VSC Program	SSK	Erdal Uresin	01/01/89	12/31/89	\$0	\$16	\$21
Futures	CSH Project-Implementation	TFNPF	Yasar Yasar	02/01/89	09/30/94	\$0	\$20	\$800
JHPIEGO	Equipment Maintenance Center	MONSA/GD FP-MCH	Dr Tandogan Tokgoz	09/01/81	03/30/88	\$0	\$0	\$9
JHPIEGO	Turkish National Endoscopy	MONSA/GD FP-MCH	Dr Tandogan Tokgoz	07/01/81	01/31/88	\$0	\$0	\$88
JHU-PCS	Turkish FP Campaign 87-88	TFNPF	Yasar Yasar	05/01/87	02/28/89	\$163	\$86	\$265
JHU-PIP	Pop Rpts-Turkish Translation	Hacettepe U/Institute of Pop	Dr Ergul Tunchilek	06/01/89	05/31/90	\$0	\$30	\$30
PRB	Pop Policy Project-Turkey	Environmental Problems Foundat	Dr Engin Ural	11/15/86	05/15/88	\$17	\$0	\$45
RONCO	Trg: Streng Community Network	MONSA/GD FP-MCH	Dr Tandogan Tokgoz	11/01/85	12/31/87	\$0	\$0	\$33
						\$180	\$172	\$1,331

Mission/Region Contracts:

Grantee	Title	Host Institution	Contact Person	Begin Date	End Date	Fiscal 1988	Fiscal 1989	Life of Project
AVSC	FP VSC Training for Interns	MONSA/PC-GOB	Zaman B Chowdhury	02/01/89	01/31/90	\$0	\$27	\$40
RTI	Pop-Educ-Emp1 Training & Model	State Planning Organization	Ilhan Dulger	08/01/86	03/31/88	\$26	\$0	\$96
						\$26	\$27	\$136

Country Total: \$561 \$1,074 \$6,357

Population Projects Database
 U.S.A.I.D. Population Activities by Country
 Project Level Activities (expenditures in \$1000s)

Run Date: 08/07/89
 Run Time: 16:21:05
 Page: 61

Region: Asia / Near East
 Country: Turkey

Central S+T/POP Projects:

(Includes funds expended for in-country subproject activities; excludes non-subproject commodities, technical assistance and training)

Project #	Project Title	Fiscal 1987	Fiscal 1988	Fiscal 1989	Fiscal 1990	
932-0955	FPPIA	\$29	\$0	\$0	\$0	
936-3000	DDD	\$54	\$35	\$54	\$0	
936-3031	FP Training PAC II	\$65	\$0	\$0	\$0	
936-3032	Population Information Program	\$202	\$29	\$15	\$0	
936-3034	ENTERPRISE PROGRAM	\$60	\$5	\$0	\$0	
936-3037	EXPAND FPS THRU WOMEN HQRS	\$0	\$0	\$18	\$57	
936-3041	Family Health International	\$0	\$10	\$25	\$35	
936-3042	Family Health International	\$1	\$1	\$1	\$0	
936-3042	FPS PATHFINDER	\$323	\$275	\$704	\$502	
936-3045	Training Reproductive Health	\$13	\$0	\$12	\$0	
936-3049	AVSC Program	\$0	\$0	\$16	\$23	
		\$755	\$355	\$875	\$617	Central S+T/POP Total
		\$755	\$355	\$875	\$617	Country Total

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Appendix D

**Provinces Included in the UNFPA/UNICEF 17-Province Program
(1984-1989), and New 11-Province Program**

Appendix D

Provinces Included in the UNFPA/UNICEF 17-Province Program (1984-1989), and New 11-Province Program

UNFPA/UNICEF 17-Province Program

1. Kars
2. Agri
3. Van
4. Hakkari
5. Siirt
6. Bitlis
7. Mus
8. Binigol
9. Diyarbakir
10. Mardin
11. Adiyaman
12. Maras
13. Tunceli
14. Urfa
15. Erzincan
16. Elazig
17. Gumushane

New 11-Province Program

1. Corum
2. Erzurum
3. Kastamonu
4. Malatya
5. Sinop
6. Hatay
7. Gaziantep
8. Tokat
9. Manisa
10. Cankiri
11. Amasya