

TIME OF CHANGES IN TURKEY

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Turkey has gone through a comprehensive health transition. Enhancing and scaling up services and adopting continuous quality improvement at all levels are milestones of this transition, in the context of health systems reform. Since the foundation of the Republic of Turkey, health has always been a priority, but health indicators did not immediately reflect economic progress.

I would like to present a summary of some of our latest achievements. With the aim of unifying our resources and mainstreaming services, we brought together all public health facilities under the roof of the Ministry of Health, giving priority to second level hospitals, but excluding universities.

We developed a performance based payment model for the health staff. Regarding the physician per number of population ratio, we are lagging behind European countries, according to the World Health Organization (WHO), but we are taking action in order to increase the number of physicians.

An important basis of the transition programme is the introduction of General Health Insurance, which is in its final stage. We will start implementation on 1 January 2008. In addition to this, family physician pilot projects have been initiated in 21 of the 81 provinces.

We have also introduced new employment models for health staff. We are employing contractual staff and midwives where we have health staff shortages. In this way, our services have been strengthened and their quality improved.

Reproductive health services are among the main priorities of our Ministry. In line with the definition and scope of reproductive health services, we extended maternal health and family planning services. We adopted the WHO framework and in accordance with it we integrate a life cycle reproductive health approach in the overall health care system. We have

also widened the scope of our services, that originally only targeted women of reproductive age, to cover adolescents, young people, elderly people and men.

I would like to share with you some results in Turkey shown by reproductive health indicators:

Our infant mortality rate, which was 200 per 1,000 in 1960, progressed to 20 per 1,000 now. We decreased our maternal mortality rate from 200 per 100,000 in 1970 to 28.5 in 2006. We can now provide antenatal care for more than 80% of pregnant women, whereas this was only 43% fifteen years ago. Similarly, 83% of deliveries are currently performed under healthy conditions.

While noting our achievements, I would like to state that reproductive health services will continue to be our priority until no preventable infant or maternal mortality is left.

The contribution of the Reproductive Health Programme in Turkey, funded by an EU grant under the MEDA Programme and in-kind contributions of our country, is apparent in the realisation of our national objectives. Our cooperation with the civil society organisations, supported with a grant of 20 million Euro, facilitated our job through increasing awareness within the community and stimulating the demand for services.

We are determined to scale up service delivery, sustain the new approaches and meet the increased demand for services generated under this Programme.

Prof. Dr. Recep Akdağ,
Minister of Health of Turkey





Reproductive health services in Turkey date back to the foundation of the Republic itself. The services, then marked by pro-natalist policies, were delivered through vertical channels by Maternal and Child Health Centres in the 1950s and Health Centres in the 1960s. In the 1980s, efforts were introduced to reduce high fertility and mortality through integrated family planning (FP) programmes which were determined by anti-natalist policies. In the past three decades, the MCH/FP General Department was established, and fertility and mortality declined, to which both routine services and specific projects and programmes contributed, although issues of regional discrepancies, quality and access remained.

Turkey attended the International Conference on Population and Development in 1994 in Cairo and adopted its Programme of Action. Turkey then developed the National Strategic and Action Plan for Women's Health and Family Planning and thus extended the range of maternal health and family planning services. The plan covered service delivery, in-service training, IEC, management, logistics and improving women's status. Similarly, a "Population and Development" chapter with broad topics on sexual and reproductive health and rights was included in the 8th 5-Year Development Plan (2001).

The National Strategic and Action Plan was reviewed and updated within the framework of reproductive health. Following an evaluation process which took into account the post-Cairo conference country programmes of action, millennium development goals and international perspectives such as the 21 goals in health together with national objectives and priorities, four main reproductive health topics were selected as the intervention areas of the Reproductive Health Programme:

1. Maternal mortality rates are still high despite the declining trend,
2. Unintended pregnancies continue to be a problem,
3. Sexually transmitted infections and HIV/AIDS: The diseases are increasing.
4. Sexual and reproductive health and rights of young people: The young population which is quite big can not adequately utilise sexual and reproductive health services.

Within the framework of the "Health for All" approach of the Ministry of Health, reproductive health, coverage of services, reducing regional discrepancies and dealing with gender issues have become visible in the Ministry's perspectives in the 1990s. Parallel to this, negotiations with the EU, which was willing to directly invest in the civil sector, were started in the first half of the 1990s. As parties finally agreed on a two-strand (i.e. public

and civil sector) programme, RHP was launched in 2003.

The main idea adopted for the conceptualisation of RHP is very simple and clear: The Programme should be conducted through service provision and community information activities that will affect and develop each other. The Programme, based on this dual structure, improved service quality through activities targeting infrastructure and service providers on one hand and on the other hand it promoted services for the disadvantaged groups who are not aware of their own service needs or have difficulty to reach services. It encouraged these groups to seek services and help them utilise preventive reproductive health services.

The Programme ensured that central and provincial level units of the Ministry enhanced their experience of working with civil society in harmony, in-service training in the field of reproductive health was institutionalised, youth health centres were strengthened and increased in number, pilot implementations of pre-service reproductive health curricula were finalized, the Turkish Demographic and Health Survey 2003 was supported, researches were carried out such as on STI surveillance, health seeking behaviour and maternal mortality.

Considering its short implementation period, the RHP in Turkey has provided important contributions, as expected, to the process of achieving reproductive health targets stated in the National Strategic and Action Plan of Turkey. I would like to extend my thanks to all parties, organizations and those who made great efforts to initiate and implement the Programme.

M. Rifat Köse
Director of the Department of MCH/
FP of the Ministry of Health

PERSPECTIVES IN HEALTH - REPRODUCTIVE HEALTH PROGRAMME IN TURKEY



The European Commission (EC) is the major international donor in the health field in Turkey. EC support began in the early 1990s with a policy aimed at poverty reduction and reflecting a clearer understanding of the links between health and poverty. It focussed on a number of key issues including improving access to reproductive health services, reduction in maternal mortality rate and in the incidence of HIV/AIDS.

Within the scope of this policy, several projects in Turkey were supported between 1992 and 1997 from the special budget lines of “HIV/AIDS” and “Population Actions”. The volume of health related EC funding increased substantially from 1995 with the adoption of the Euro Mediterranean Partnership (MEDA) which stressed the human aspect of the relation between the two regions. After becoming a candidate country from 2002 onwards, Turkey started to benefit from pre-accession funds.

As a result, EC’s health portfolio in Turkey evolved from thematic and individual projects to sector wide programme under social development with MEDA and to institutional building with the pre-accession funds.

The Reproductive Health Programme in Turkey (RHP) was one of the main recipients of MEDA funding in Turkey, with an EU budget of € 55 million over a six year period. The objective of the programme is to improve the sexual and reproductive health (SRH) of the population in general, but particularly of women and young people. The programme takes a two pronged approach by improving the quality of health services on the one hand and boosting demand and utilisation of these services on the other.

In its drive to improve the health services on offer, the programme has directly supported the activities and policies of the Ministry through several components which provide technical assistance, training, equipment, as well as support to research and policy development through 10 service, 19 supply contracts signed within the scope of 11 service and 8 supply tenders.

The Ministry of Health (MoH) has

been supported by a technical assistance team (TAT)¹, both at central and local level, attaching great importance to strong management capacity in the efficient and effective provision of health services. Equally important for the efficient use of resources has been the cooperation fostered by this programme between the Ministry and all stakeholders, including civil society organisations (CSO) and with international organisations, UNFPA, UNICEF and WHO.

Major Programme Components

Training has been a cornerstone of the programme in order to build institutional capacity and equip health care personnel with adequate knowledge and skills on SRH issues, thereby enhancing the quality of services on offer.

A pool of trainers created at central level² of the MoH have disseminated at local level the skills and knowledge they have acquired, through a network of Regional RH Training Centres and Provincial RH Training Centres³. A service model is developed for basic/comprehensive emergency obstetric care (EMOC) and effective first aid/referral⁴, incorporating the standards recommended by WHO. This model has now been included in the Health Ministry’s 2005-2015 SRH Action Plan and will be disseminated gradually throughout the country.

The training component also accelerated efforts to harmonise SRH education offered by medicine, nursing and midwifery departments of universities⁵ with the EU curriculum, emphasising the “higher education quality management” principles of the Bologna Declaration. In the long run these efforts will result in converting Ministry’s current long-term

in-service training programmes to short-term refresher trainings and will lead to significant savings in the amount of resources allocated for that purpose.

Due to the importance of timely and regular utilisation of health care services in the prevention of maternal mortality, all activities related to improving service provision have been coupled with measures aimed at increasing demand for the services⁶. This has constituted a high-profile awareness raising not only in the public at large, but also in the media on maternal and infant mortality issues.

Under the supply component of the programme 15 million worth of medical supplies and equipment have been provided to support the improvement in the quality of services. This has included the refurbishment of units offering youth-friendly services as well as the provision of training aids and equipment for the centres where in-service and pre-service training is carried out. The provision of the supplies and their distribution to the end users has been performed by 12 companies under different contracts⁷.

Among the surveys carried out to provide comprehensive and reliable data on SRH, the programme has co-funded the “Turkish Demographic Health Survey 2003 (TDHS2003)”⁸. The findings of the survey are reflected in the 2005-2015 SRH Action Plan of the Ministry.

A survey conducted in cemeteries on burials of female deaths⁹ gathered information on maternal mortality which makes comparisons on an interregional, urban/rural as well as international level possible. The study has resulted in a shift to a permanent, systematic and sustainable registration and reporting system for the future. Whereas the findings of

a qualitative study on health seeking behaviour¹⁰ has provided meaningful replies to the “whys” and “hows” raised by the quantitative data from the “TDHS 2003” and “National maternal mortality survey”. And finally, a second generation surveillance study on sexually transmitted infections¹¹ was conducted in coordination with the EU-funded Project on the “Control of Communicable Diseases and Strengthening of the Surveillance System”, as a basis for the restructuring of the response mechanism to potential health threats as foreseen in WHO “International Health Regulation”.

In order to boost demand and utilisation of health services, direct financial support of 20 million has also been granted to Civil Society Organisations (CSO). Funding to CSOs has followed competitive procedures through well publicised “open calls” inviting a wide range of organisations to submit innovative projects which respond best to the priorities of the programme as well as to local needs. Following stringent evaluation procedures of two successive calls for proposals, the best projects were selected and 88 grant contracts were signed to conduct nation-wide information, education and communication activities. In the process the CSOs have been encouraged to establish effective strategic relations with local authorities and other stakeholders, and to institute intersectoral and multidisciplinary approaches in addressing health issues. The results so far indicate that durable and fruitful collaboration between the public sector and civil society is set to continue in this field with the CSO network built under the programme.

Conclusion

In the long run, the Reproductive Health Programme is expected to reduce maternal mortality rates and eliminate regional disparities in reproductive health indicators. It has focused on measures that are replicable, realistic, and cost-effective and specific in terms of gender, age group, geographical regions and local conditions.

The programme has shown the

necessity to prioritize improvements in the overall management capacity of the Ministry of Health through training of health personnel at different levels so that policies can be effectively converted into action plans.

The studies undertaken have filled in the information and data gaps in the fields of organization and management of health services. Their findings and resulting proposals will provide a sound basis for decision making and for the more effective use of resources.

An effective cooperation has been established with the CSOs in terms of increasing public demand for reproductive health services. Mass media has been effectively used to inform public opinion, raise awareness of public health services and influence patterns of behaviour and demand.

At the macro level, the RHP has aligned measures undertaken in Turkey with the mother-child, health care and family planning targets established at the Cairo International Conference on Population and Development (ICPD) as well as at its subsequent ICPD +5 and +10. The ambitious and multi faceted RH programme has succeeded in placing sexual and reproductive health firmly within the sphere of fundamental health rights.

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THE REPRODUCTIVE HEALTH PROGRAMME IN TURKEY: OVERVIEW AND APPROACH

By Ibrahim Acikalin, Mehmet Ali Biliker, Robert Gaertner, Demet Gural, Patrick Krause

At the mid-term date for achieving the Millennium Development Goals (MDGs), the goals and targets set by 189 states in September 2000 are high on the agenda again. A survey recently conducted by the European Commission (EC) among European Union (EU) citizens showed broad public support to the achievement of the MDGs and EU's assistance in the process. The EU funded Reproductive Health Programme in Turkey (RHP), which commenced activities in January 2003 and came to an end with a final conference in September 2007, contributed directly to four of the eight goals identified. Gender equality and women's empowerment, maternal and child health, and combating STIs and HIV/AIDS were at the core of its aims and objectives.

A grant from the EU of € 55 million and a contribution of an additional € 8 million from the Ministry of Health (MoH), makes the RHP not only the largest EU funded intervention in the health sector in Turkey, but very likely the most comprehensive of its kind in the world. Nearing EU standards and levels of development have been the guiding principle for the MoH throughout the implementation of the Programme, fostered by the start of the accession negotiations between the EU and the Government of Turkey in October 2005 and the built up to it.

MDG 3: Promote Gender Equality and Empower Women

MDG 4: Reduce Child Mortality

MDG 5: Improve Maternal Health

MDG 6: Combat HIV/AIDS, Malaria and Other Diseases

This article provides an overview of the Programme, explaining the need for reproductive health in Turkey, the choices made during its implementation and the main activities and results to date, pointing at other contributions in this Special Issue. We are ending on main challenges ahead for sexual and reproductive health and rights (SRHR) in Turkey.

Priorities of the Programme

The RHP was designed to raise commu-

nity awareness of sexual and reproductive rights, increase service utilization and enhance the existing infrastructure in order to improve service delivery. The expected outcomes of the Programme include:

- Increased use and scope of services
- Increased service accessibility (geographical, economical, cultural etc.)
- Increased quality of RH services
- Increased sexual and reproductive health awareness among adolescents
- Increased awareness among decision makers, parliamentarians and policy makers in order to support reproductive health and rights
- Reduced geographical discrepancies in reproductive health indicators.

“The Millennium Development Goals ... cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning.”

(UN Secretary-General, Kofi A. Annan, Bangkok, December 2002)

The Programme aimed to contribute to a reduction in maternal deaths by 75% by the year 2015, a reduction in the age specific fertility rate and most importantly a reduction in the regional discrepancies within the country by increasing the utilisation of sexual and reproductive health services.

To achieve its purpose the Programme followed a two-fold strategy. Through direct support to the MoH, it aimed to strengthen institutional capacity and quality of services on the one hand, including training of health personnel, upgrading of health facilities and the introduction of quality management mechanisms and service standards. On the other hand, the Programme aimed to advocate for reproductive rights, increase awareness and strengthen appropriate behaviour patterns and demand for health services among the population through support to interventions and activities of civil society organisations (CSO).

Four main areas were selected as Programme priorities, i.e. safe mother-

hood (SM), family planning (FP), STIs-HIV/AIDS and youth friendly sexual and reproductive health services (YFS). The focus on a reduction of maternal mortality, as a long-term objective, required attention to the availability of antenatal care, skilled attendance and emergency obstetric care (EmOC). Increased access to a wide range of contraceptive choices aimed to improve birth spacing and reduce frequency, better meeting current preferences of women and couples. Investments in the quality of care had to be accompanied by major interventions to raise awareness among women and their families about available services (See article in this issue of *Entre Nous*; hereafter referred to as “See article”).

According to MoH data, 1,123 people were infected with HIV in 2003. In recognition of inadequate case detection and reporting, the Programme targeted to improve the available data, as the basis for effective prevention and treatment efforts. Wider and deeper public knowledge about STIs and HIV/AIDS across all layers of Turkish society was aspired to. The National SRH Strategy document of the MoH clearly recognises young people in need of particular attention especially with regard to protection from STIs and HIV/AIDS. The Programme has given due importance to addressing the needs of young people regarding access to information about SRHR and appropriate counselling and health services (See article).

Summary of Main Results

With a separate research budget, the initial design of the RHP gave due importance to the collection of accurate data as a prerequisite for policy development and advocacy, the definition of appropriate interventions and most importantly to monitor and evaluate results from the process. Research priorities of the Programme were: the TDHS, maternal mortality, STIs-HIV/AIDS and health seeking behaviour (See summary of HSBS on page 9).

While estimations of maternal mortality at the national level have been



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made at several points in time, different methods were used and results were not comparable over time or internationally. The National Maternal Mortality Study conducted under the Programme, is the first of its kind in Turkey estimating the maternal mortality ratio at 28.5 per 100,000 live births in 2005, with the highest levels in Northeast Anatolia and East Black Sea (See article).

Lacking data on STIs and HIV/AIDS was addressed by initiating a consensus building process on surveillance and conducting an operations research on key STIs and HIV/AIDS in Turkey. The project developed tools for second generation sentinel surveillance and applied these in five major cities in Turkey (See article). A comprehensive qualitative study, targeting health seeking behaviour of women in relation to pregnancy, was finalised in March 2007, clearly recording facts obtained through focus group discussions and in-depth interviews (See article).

A training needs assessment, conducted in the inception phase of the RHP, acknowledged that almost all internationally recognised SRH services are currently available in Turkey, but pointed to the absence of nationally binding standards. Based on these findings the RHP developed the Framework for SRH Services in Turkey, providing an agreed structure against which responsible senior, mid and line managers can target improvements in SRH services, manage performance by providers, improve facility standards, and increase overall access and utilisation of services. Based on the priorities set by the Programme, the Framework sets out primary activities and the associated competencies (knowledge, skills and attitudes) required by a wide range of service providers, with an emphasis on primary care.

The document provided the basis for the subsequent development of all training activities, the development of service standards, assessment of equipment needs, quality improvement, the revision of job descriptions, and the introduction of performance management.

Service standards were adjusted to the Turkish context from the Client Oriented Provider Efficient (COPE) approach by

Engender Health and applied to more than 40 facilities in the North-eastern provinces of Turkey with remarkable results (See article). Quality of care and provider needs are taken seriously at the facility level after the introduction of service standards. Through client orientation in the process a dialogue is initiated, which leads to a better exchange and understanding, and ultimately to services better targeted to the needs of clients.

In accordance with the service standards, the provision of training at all levels to built capacities of managers and service providers, and more importantly the strengthening of training systems have been a major priority for the MoH. 12 in-service training modules have been developed and applied under the RHP (see overview on pages 30/31). More than 9,000 service providers and managers were trained, focusing on in-service training in primary care, EmOC services, YFS, the introduction of service standards and quality oriented health care management training.

Particular importance was attached to provide a structure and ensure the sustainability of SRH trainings in order to ensure high quality services. In that sense, in-service trainings were institutionalised in provincial and regional training centres, providing sustainable and continuous training of trainers, and training of service providers, accompanied by effective supervision and monitoring systems (See article). Also 19 Youth Counselling and Health Service Centres (YCHSCs) catering for special needs of young people in the age group 10 – 24 have been established, with RHP support.

Furthermore a project was conducted for 3 groups of health professionals (physicians, nurses and midwives) with a view to developing pre-service SRH curricula and adapting these curricula to the schools education programmes (See article).

Almost 15 million were spent on upgrading of health facilities and pre-service training institutions. Equipment was procured for 500 health centres, 161 hospitals, 75 MCH/FP centres functioning as training centres, 19 youth centres and 9 faculties and health schools of 3 universi-

ties. Furthermore, a pilot project was conducted to organize EmOC services and support hospitals with necessary supplies and equipment, which is expected to have a major direct impact on maternal deaths.

The RHP envisioned increasing demand for SRH services mostly through the CSO component. CSOs had already prior to the Programme proven to be able to successfully develop innovative programming in awareness-raising, community based activities, advocacy, research and training, targeted particularly at hard to reach groups. Under the RHP two calls for proposals were conducted, contracting a total of € 18.94 million to 88 CSO projects, involving 107 CSOs. Additionally to the EU funding, CSOs have added another € 3 million of their own resources. The guidelines developed for the calls clearly outlined the main priority areas of the Programme for which proposals were welcomed. CSOs were active in 55 out of 81 provinces, reaching almost every corner of the country. The figure below shows that the largest part of the resources, i.e. € 9.6 million, was spent on the three Western regions, followed by the three Eastern regions with € 6.7 million and very little in between. The CSO component has contributed tremendously to the overall visibility of the RHP, putting SRHR issues on the agenda across the country (See article).

Challenges Remain

Overall, the Programme has delivered remarkable outputs, fully matching the remarkable resources provided. The Programme contributed well to the establishment of national standards for SRH in Turkey. Short-term results can be observed with a view to improved knowledge and skills among service providers and managers, the sustainability of training and youth centres, attracting clientele and conducting trainings, increased awareness and understanding of SRHR issues among vulnerable groups. The co-operation between CSOs and the public sector is on an unprecedented level. This, however, needs to be transformed into changes in behaviours and access of the most vulnerable groups in Turkish society to quality services.



Patrick Krause



Robert Gaertner



Figure 1: Distribution of CSO Grant Scheme in Million

It is too early to talk about the impact of the Programme. Even though the time span between the previous TDHS in 2003 and the one scheduled for 2008 covers almost exactly the RHP implementation period, the data gathered in 2008 will not yet assess the full impact of the Programme. The success of the Programme also needs to be judged against the ability to keep SRHR on the political agenda and mobilise resources as there are major challenges ahead:

1. Management

According to the National SRH Strategy one of the weaknesses in the Turkish health care system is limited management capacity. The RHP has contributed with its activities in this respect, but more

attention and investment is necessary. Senior and mid-level managers at central and provincial level need to be further strengthened in their capacity to prioritise, convert policies into strategies and action plans and implement them.

2. Public – CSO Partnership

The Programme has greatly contributed to bridge the gap between public and CSO sectors, working jointly on the achievement of a common goal. Especially for vulnerable groups this partnership needs to be continued and intensified. Also the provision of quality health services to hard to reach groups by CSOs should be further explored.

3. The Gender Gap

Even though its gender gap has been

closing, Turkey will be most unlikely to meet the MDG for gender equality by 2015. Gender continues to be a major cause of inequality in reproductive health, with large variations in human development levels between men and women. The health sector alone cannot achieve a marked improvement on this issue. It requires attention to legislation, political empowerment, economic participation and educational attainment, fostered by inter-sectoral collaboration.

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HEALTH SEEKING BEHAVIOUR STUDY

The study was designed as a qualitative study to explore and describe the perceptions and health-seeking behaviours related to pregnancy and childbirth in selected urban and rural sites in Turkey, in order to design interventions contributing to increased utilisation of antenatal care (ANC) and skilled birth attendance. It was conducted in Adana, Afyon, and Van provinces (in parts of these provinces where problems regarding ANC and skilled birth attendance are observed) among pregnant women who have never attended or discontinued ANC services, and relevant others. The study group was selected by purposive sampling and snowball method.

Data were collected through in-depth interviews and focus group discussions with 239 participants, of whom 111 were pregnant women, the remainder (128) being peers, relatives, health care personnel, and community leaders. 60.4% of the pregnant women were in the 20-29 age group, 59.1% resided in urban areas, and 98.2% were either illiterate or elementary school graduate. Furthermore, 57.4% were from extended families.

Perception of pregnancy

Pregnancy was perceived as a natural process, even as a process giving a sense of happiness and fulfilment in general and it was found unnecessary to attend a health care institution in the absence of any severe complaint. Concern and anxiety observed in some pregnant women were related to childbirth and the health of the baby rather than the pregnancy itself.

A feeling of 'shame/embarrassment' was present in almost all pregnant women interviewed and it is understood that this feeling negatively affects obtaining information and accessing ANC services.

Symptoms like vaginal haemorrhage, immobility of the foetus, severe pains and nausea increased risk perceptions as did previous experience of miscarriages, stillbirths, babies with deformities, and babies with serious diseases, in their proximity.

Although pregnant women and their relatives stated that attending ANC is a good thing, they could not give satisfactory explanations as to why it was.

Barriers to ANC services

According to pregnant women and their relatives, there were many and serious obstacles impeding access to ANC services. The most common and highly-rated obstacle was 'lack of interest and negative behaviour of the health personnel'. Inattentiveness, bad practice, and miscommunication at health care institutions were important determining factors of under-utilization of existing ANC services.

Other common obstacles were lack of health insurance and economic problems. These emerge along with lack of education, and gender problems. Low education level and living in an extended family, where permission of the mother-in-law and husband is required, seriously impeded women accessing information and services.

Inadequate ANC at primary health care institutions, insufficient personnel, and the occurrence of organizational and administrative problems, were important obstacles in the utilization of services.

Osman Hayran MD, Professor, HSB Team Leader



The National Maternal Mortality Study has proven that despite good progress, making pregnancy and childbirth safer is still a priority for Turkey (1). Special attention was required for the north-eastern part of the country, where the maternal mortality ratio (MMR) was 68.3 compared to a national average of 28.5 per 100,000 live births. Based on the three-delays model the Programme aimed to increase quality of care and awareness and utilisation of services.

In 2004-2005 detailed situation analyses were conducted in five pilot provinces of Agri, Ardahan, Erzurum, Iğdir and Kars. The focus was on infrastructure, supplies, human resources, knowledge and skills of staff of primary health care (PHC) facilities, basic and comprehensive emergency obstetric care (EmOC) facilities, blood centres and emergency services. The key findings were:

- (1) Some north-eastern provinces lack basic 24-hour EmOC services. Issues included staff shortages, especially of midwives at PHC level in rural areas; limitations in clinical skills; lack of equipment and supplies; weak team work and management capacity.
- (2) The blood transfusion services required standardisation of blood collection, care and storage.
- (3) Referral protocols were not in place and emergency services (112) needed upgrading.
- (4) Difficult topography and weather conditions produced delays in accessing services.
- (5) Low levels of awareness due to poor female literacy rates and a lack of empowerment reduced access to maternal health services.

Acting on the findings and utilising the three-delays model as a framework, the Programme aimed to:

1. Increase awareness and utilization of SM services.
2. Increase the quality of SM services.
3. Provide essential equipment and supplies.

Delay 1 - in recognising a complication and seeking help.

Delay 2 - in reaching appropriate health care centres.

Delay 3 - in receiving appropriate care and treatment at the facility.

PHC Training

A training module for SM was developed covering antenatal care (ANC), delivery and postnatal care. The module was used for the training of approximately 3,500 service providers in PHC in 67 provinces. It was also shared with Civil Society Organizations (CSOs) for additional trainings and briefings.

EmOC Training

EmOC in-service training modules were developed. A systems' perspective, the team approach and clients' rights/providers' needs were at the core of these modules, which targeted PHC service providers, first aid and referral, basic and comprehensive EmOC facilities and the management level equally. The modules include clinical practice updates and standards, emphasised a teamwork approach and inter-sectoral cooperation. Extensive trainings in EmOC within the five pilot provinces are completed under the Programme and will be further expanded (Table).

Clinical Protocols

Clinical protocols for pre-marriage counselling, preconception, ANC, birth, postnatal care and EmOC were prepared,

together with IEC materials. The MOH developed a website providing information on the first, second and third trimesters of pregnancy. Danger signs and changes to be expected are extensively publicized (2).

Mass Media Campaign

In February 2007 the Ministry of Health (MOH) started with the development of a national mass media campaign, with some specific activities in 15 provinces with similar demographic backgrounds. The campaign aims to increase awareness on EmOC and to boost utilization of SM services. Local women were actively involved in the creation of appropriate messages. Women did not want to hear messages from well known female artists, but they wanted messages from 'women just like them'. They also did not want to involve their mothers-in-law or their own husbands, because they felt that "Pregnancy and related conditions are special to the mother and no other persons have to be involved if women are empowered". In a 'Road Show' a van displayed a poster showing well known national figures stating: "Regular antenatal visits - healthy mother and healthy baby - prevent deaths" or "My baby stay alive, a baby's

Table: EmOC Training

Type and Target Group	Focus
Health managers training: central and provincial health administrators, health group heads; hospital administrators, hospital head nurses	Facilitative management Supportive supervision Teamwork
1st level health services personnel: doctors, nurses, support staff, 112 emergency personnel, ambulance drivers, safe blood technicians.	Awareness of EmOC and SM Teamwork Roles and responsibilities
Clinical training: obstetricians/gynaecologists, paediatricians, anaesthesiologists, emergency service personnel, blood drive personnel, midwives, nurses	Competency based clinical training Patients' rights/providers' needs Teamwork
Neonatal resuscitation: Doctors, paediatricians, anaesthesiologists, midwives and nurses	Cardio pulmonary resuscitation



Ece Abay



Mohammed Mustafa



Selale Özmen



Ferit Saraçoğlu

life is connected to the mother, the mother's life is connected to baby”

Educational Materials

A variety of IEC materials were designed by the MOH to enhance utilization of SM clinics. The handouts state that antenatal visits decrease mother and newborn mortality and increase postnatal survival. The message is based on evidence from the Turkish DHS 2003 data (3), that the frequency of ANC has an impact on where the mother will deliver. If the mother attends ANC four or more times, 96% of deliveries will be in a hospital, compared to only 50% of mothers who have not attended ANC.

CSOs

15% of the CSO projects awarded under the Programme's grant scheme aimed at increasing awareness and utilization of SM services. The projects in the eastern provinces of Turkey were mainly focusing on increasing literacy, providing information about reproductive rights and emphasizing the importance of ANC and facility delivery. Literacy trainers provided SRH knowledge and information. In many cases the change in women's attitudes could be seen immediately after the training.

I never received ANC for any of my pregnancies, but I will definitely guide my daughters and daughters-in-law to have proper ANC

Trainee in Erzurum

If women are not cared for properly they refuse to go for another visit.

CSO trainer

Local CSOs gained excellent support from provincial governors, the health directorates and other sectors such as the military during the implementation of their projects.

Representative of a National CSO

Inter-sectoral Collaboration

The Programme effectively initiated inter-sectoral collaboration mechanism under the leadership of the MOH. The process commenced with the active participa-

tion of Provincial and District Governors and Mayors, Religious Affairs, Rural Affairs, National Education, Population and Citizenship, Turkish Armed Forces, Provincial Private Administration, Highways Administration, Electricity and Agriculture administrations and Provincial Health Directorates in the five pilot provinces. Based on the three-delays model, action plans and reports were developed, followed up on a 3-monthly basis. The co-ordination has resulted in new and innovative approaches, including the following:

- (1) To overcome the harsh winter conditions the councillors from Ağrı and Iğdır created a winter guest house project for expectant mothers and one accompanying family member. The guesthouse is used for the last four weeks before delivery.
- (2) In Ardahan a statement is being printed at the bottom of electricity bills: "The interval between deliveries should be at least two years and the maternal age at delivery should be 20 – 35 years old."
- (3) In religious gatherings the importance of ANC is emphasised.
- (4) Local TV Kars region has broadcast a programme about EmOC.
- (5) The military offered to clear snow covered roads and provide assistance by specialized vehicles or helicopter if ambulances fail due to weather conditions.
- (6) 112 emergency services will include SM in their routine training.

Conclusion

Multi-sectoral approach is already bringing results. The case study below demonstrates how improvements in EmOC services are already in place and saving women's lives.

A lady was admitted 'fitting' at 36 weeks of pregnancy; she was immediately diagnosed as having eclampsia. The midwife prepared an infusion of Magnesium Sulphate, having been taught about the benefits of this treatment during her training. When the doctor arrived he prescribed Diazepam. The midwife refused to administer the Diazepam and explained the use of Magnesium Sulphate. She had to convince the doctor, but in the end the Magnesium Sulphate was

administered. The woman was immediately taken for caesarean section. Both she and the baby survived.

The implementation of national service standards for EmOC is scaled up by the MOH, including further development of referral protocols in line with international guidelines.

WHO recommends one comprehensive and 4 basic EmOC units for every 500,000 population. The north-east of the country is sparsely populated. High altitude and limited road access in winter time means low demand for EmOC and a high MMR. To increase coverage, every province is establishing one comprehensive and two basic units, although their populations are below 500,000.

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INSTITUTIONALISATION OF SRH IN-SERVICE TRAINING

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During the last decade the Ministry of Health (MoH) worked towards developing sustainable and effective SRH training programmes in all provinces of Turkey. In 2005-2007 comprehensive and complementary work was done by MoH staff, national and international experts, within the RHP framework, in order to further strengthen the system. The main project objectives are presented in Box 1.

Box 1. Overall and specific objectives

Overall Objective

To improve MoH in-service SRH training capacity nationally both in training skills and SRH programme areas and ensure the sustainability through institutionalisation of in-service trainings

Specific Objectives

- To strengthen the training centres;
- To develop and revise training materials on the basis of sound pilot testing;
- To strengthen SRH training capacity of selected trainers in training skills and SRH programme areas (safe motherhood, emergency obstetric care, family planning, STIs, HIV/AIDS, and SRH services for young people);
- To strengthen SRH training capacity of selected trainers in advanced training, TOT, follow-up, and M&E skills;
- To establish/strengthen a monitoring and evaluation system for SRH in-service training;
- To ensure dissemination of the in-service training results to policy makers and planners.

Strengthening of training centres

At the end of 2004, 75 Reproductive Health Training Centres (RHTC) were strengthened in 67 of the 81 provinces. In 2005-2007 all centres were equipped as shown in box 2

According to sustainability plans of the MoH, 75 general (provincial) RHTCs will be responsible for SRH in-service training of service providers. This includes 12 Regional RHTCs that will also provide training of national trainers (TOT). Training sessions were organized according to the needs per province, as identified by Provincial Health Directorates (PHD), in collaboration with the MoH MCH/FP General Directorate. The cen-

Box 2. Training equipment and models

- Female Pelvic Organs Model
- Master Set of Human Reproduction
- Gynaecological Model (Zoe)
- Childbirth model
- Episiotomy Suturing Simulator
- Embryo/Foetus Development Poster
- Pregnancy Cards with Apron
- Empathy Pregnancy Apron
- Baby Examination Model
- Female Condom Model
- Breast Self Examination Model
- Testicular Self Examination Model
- Penis Model for Condom Training
- Blood Pressure Training System
- Arm model for intravenous injection
- Intramuscular injection simulator

tres are responsible for selecting training participants according to predetermined criteria, collecting participant information, preparing the courses, revising as necessary, preparing materials and equipment, selecting trainers, preparing the rooms and carrying out the sessions.

SRH in-service training modules and materials

Prior to 2005, in-service training for clinical health personnel focused mainly on family planning. The new training programme is the first experience for the MoH in developing and introducing integrated national SRH trainings country-wide. Training modules were developed jointly by national and international experts. Eight different modules cover the areas of Reproductive Health General Issues (RH), Family Planning Counselling (FP), Safe Motherhood and Emergency Obstetric Care (SM/EmOC), STI/HIV/AIDS, SRH for Youth, Training Skills (TS), Advanced Training Skills (aTS) and M&E Skills. All modules are tested, revised and published.

Strengthening SRH training capacity of national trainers and RHTCs

In 2005-2006, integrated training courses on the above-mentioned modules were

organized for national trainers and service providers. As a strategy, 5 candidate trainers from regional RHTCs and 3 from general RHTCs were selected for a TOT. Priority was given to volunteers (midwives, nurses and physicians with experience). Candidates were trained during a 20 days course by master trainers (5 modules and TS together), using modern methodologies. They acquired knowledge and training skills on clinical approaches, adult learning techniques, creating a positive atmosphere, interactive techniques, preparing and using audio-visual tools, facilitation, demonstration and coaching, developing sessions and action plan. By the end RH trainers were fully equipped with all the necessary modules, CDs and relevant materials for conducting trainings at the provincial level. In total 247 RH trainers were trained and are MoH certified "RH trainers". They have started to work as trainers in RHTCs and regional RHTCs. In total 6159 primary level RH service providers were subsequently trained in RHTCs and regional RHTCs on the different modules, selected according to the needs in each province.

Majority of participants were either midwives (41.8%) or doctors (39.0%). At the end of training, participants were tested on professional knowledge and training skills, using special multiple choice test forms. The results demonstrated high achievements in all 5 modules reaching on average a 93.8 ± 7.8 score as shown in Graph 1.

After the training sessions participants were evaluated on their learning ability, active participation, knowledge on the subject, and their communication, coaching and facilitation skills. In general, participants demonstrated a high motivation and high personal evaluation scores. Training skills and attitudes of master trainers were anonymously evaluated by participants and the former demonstrated high quality job performance.

Advanced and M&E trainings

One hundred and sixty most successful trainers, who had gained training experience at field level, were selected for



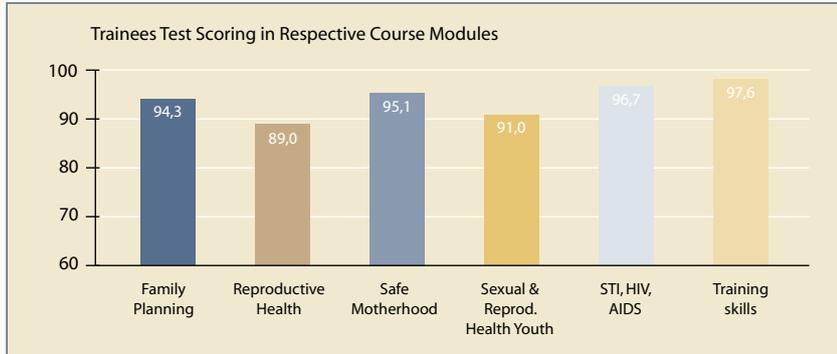
Şevkat
Bahar-
Özvarış



Güneş
Tomruk



Gayane
Dolyan-
Descornet



Graph 1

additional 5-day course on “Advanced Training Skills”. They acquired more skills in course facilitation, group dynamics, problem solving, dealing with difficult situations and all aspects of developing training modules, thus becoming “Advanced Trainers”. Sixty RH trainers were trained during 5-day “M&E Skills” course, where the main steps for training activities were introduced and exercised, including guidance and support to trainees before, during and after the training, and skills on performance evaluation.

During follow-up activities, master trainers provided support to regional and local RHTCs at all levels of training. In the first follow-ups conducted of newly trained health personnel, the aim should be for both supporting and strengthening health personnel’s skills acquired during the trainings and early detection and solving of problems that might prevent successful implementation. Some RH trainers stated that after initial support in two trainings they could carry out the third one on their own.

Monitoring and evaluation

Recognizing the importance of continuous M&E for sustainable and effective in-service training institutions, an M&E strategy, tools and guidelines were developed, tested and fully implemented at field level. Before field visits, a one day orientation meeting was held for the M&E Team and visits were standardized. In total 12 visits were made to the 12 Regional RHTCs by master trainers and MoH representatives. In general five main components of training were evaluated:

sustainability of centres, activities, atmosphere, materials, and capacity.

Most of centres were sustainable, but 36% needed additional support to become sustainable. During the visits some field training sessions were also evaluated and facilitative supervision was provided. Results, including short-term and long-term recommendations, were shared with MoH, PHDs and RHTCs.

Dissemination of in-service training results

Publication and dissemination of the activities is important for continuation; it sets examples for the future activities; sheds lights on new studies and helps the contributors of the project recognize their share in the success. Hence results of this project were disseminated in a conference organized with participation of central MoH and provincial managers, training institutions and other public agencies.

Conclusion

Fully equipped and trained health personnel must receive periodic follow up to integrate new advancements in health, self-evaluate and remain motivated. Follow-up then becomes part of an activity between master trainers and SRH in-service trainers. It helps trainers use the lessons they have learnt during training more effectively. Within the evaluation process, “corrects instead of wrongs” and “achievements instead of failures” should be focused on. It should not be forgotten that “acknowledgement and approval” is the most powerful approach that makes people and teams effective and sustain-

able. A “team approach” should be encouraged, because if local managers own the training and realize the importance of it, usually the activity is carried out more successfully. Managers’ awarding systems and events (e.g., acknowledgment letter, remembering special days -midwifery and nursing week, festival of medicine and organizing business meetings) motivate trainers to improve their performance in training courses. In-service trainings require an effective and sustained system. The in-service training project established important benchmarks for the future: an efficient physical infrastructure, master trainers; relevant materials and a supportive M&E process.

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RESPONDING TO YOUNG PEOPLE'S SRH NEEDS

Young people's SRH is one of the main intervention areas of the Reproductive Health Program (RHP) in Turkey. The main focus has been the establishment of 20 Youth Counselling and Health Service Centres (YCHSCs). These comprehensive youth-friendly centres provide quality clinical and non-clinical services for young people. Service delivery has begun, but the centres still need more guidance from the Ministry of Health (MoH), intensive youth-adult partnerships and support of other stakeholders in order to become more effective and sustainable.

Why youth as an RHP intervention area?

The MoH of Turkey puts a high priority on safeguarding young people's health and rights, promoting gender equality and supporting the transition of youth to adulthood. The recommendations of the International Conference on Population and Development (1) are reflected in the targets and strategies of Turkey's 8th Five Year Development Plan, which provides opportunities for young people to receive information, education and services related to sexual and reproductive health (SRH) and rights.

In 2002, the MoH established a National Service Provision Model to improve adolescent health. In the following few years, with the cooperation of MoH, UNICEF, UNFPA and various Civil Society Organisations (CSOs), 18 YCHSCs have been established.

The importance of youth SRH was strongly emphasized in 2005, in the National Strategic Action Plan (NSAP) of the MoH, where young people were defined as one of the five priority areas in SRH (2). This NSAP provides a systematic overview of analyses, strategies and objectives during the period 2005-2015. A key recommendation on youth in the NSAP is:

"Access to Youth Friendly SRH services will be increased to have one unit providing these services for every 150,000 young people by the year 2015"

Increased demand and supply of SRH

services for young people, aged 10-24, also became one of the priorities of EU-funded RHP in Turkey. It not only increases the number of youth friendly centres from 18 to 38, but it particularly improves the skills and expertise of the staff, in line with international standards.

What does the data on youth in Turkey tell us?

In the past decade several studies on youth SRH were completed. Box 1 summarises major outcomes of the 2003 Demographic and Health Survey.

Box 1: Basic facts on youth and SRH in Turkey (3)

- Young people aged 10-24 years make up one third of the country's population.
- One in every five women reaching the age of 19 is either mother or pregnant.
- One quarter of all pregnancies under the age of 20 do not receive any antenatal care.
- One sixth of these births are not attended by health personnel, and one fifth take place at home.
- Contraceptive prevalence of married women within the youth age group is only 44%.

In 2002 a study among first year university students was conducted by Hacettepe University, Department of Public Health, a WHO Collaborating Centre (4). Health personnel who should provide services to this group found that their SRH knowledge and experience was rather insufficient. 71% had not received any training on adolescents; only 33% of those who had some training felt competent to work with adolescents. The study was the starting point for the creation of the very first university based students SRH centres, of which there are already 13 now, partly created as a result of the CSO component of RHP.

In 2006, another study was conducted by the International Children's Centre (ICC) among first year students of eight universities. The data shows 12.4% of students had sexual experience with intercourse and 6.8% without (5). Experience with intercourse was 6% among females and 33.1% among males. It should be

noted that almost all these sexually active students were unmarried. Every 9 out of 10 students claimed they either needed or wanted to receive SRH services.

How did we achieve what we did? The process

In the initial RHP it was planned to open 16 YCHSCs under the MoH; however, upon request from many young people and Provincial Health Directorates, actually 20 centres were established.

Implementation of the RHP Youth Component began in 2004 with a Situational Analysis that provided a more accurate picture of the real needs of youth (6). The first part identified gaps in the provision of information for youth, their level of SRH knowledge, and an updated demand for services. The second part was an evaluation of 27 health facilities, that were potential candidates for establishing youth-friendly services. Box 2 presents some views of young people from the Situational Analysis.

Box 2: Opinions of Youth as Stakeholders of Centres

"Turkish society doesn't have much awareness. They don't know about prevention. Girls and boys get married before accessing correct SRH information" (22 years male).

"Will it provide a continuous service where I can ask for help for a psychological problem that I can't discuss with my parents? Usually, people in such places only work two days a week" (21 years male).

"They should provide counselling and also examinations. Eye contact is good but I think the main issue is examination and treatment. (22 years male)

"My family wants to learn what is happening; I should trust a doctor that s/he does not tell anything to my family, otherwise I won't go there ever" (22 years male).

"It should not look like a hospital; then young people might not want to come" (22 years male).

"It should have computers, internet etc., so people will come to see each other apart from seeking treatment" (21 years male).

"If it is free of charge, quality of services will be poor. There should be a price for services, but it should be low" (22 years female).



Ayşegül Esin



Emel Özdemir Şahin



Ayşe Akın



Hilal Özcebe



Evert Ketting

Comprehensive training programmes on youth-friendly services

Two different training curricula were developed. The first module is for health professionals working in general primary health care services, and aims to raise awareness on SRH and young people.

The second, comprehensive module was for service providers, and this is largely based on the “RAP rule”:

- Rights-based approach,
- Acceptance of young people’s sexuality, and
- Participation of young people.

The training topics intend to stimulate providers to reconsider their attitudes and approaches to young people.

An overall theme of this training is to create greater trust and understanding between youth and health care providers. Towards this end, the trainings also share experiences of both sides, best practices and lessons learned by YCHSCs.

It was one thing to train health care providers, but quite another to draw in managers on a continuous basis. They too are very important owners. A Management Guide for Youth Friendly Services has therefore been developed (7). The aim of the Guide is to explain to managers of YCHSCs in more detail the purpose of establishing a youth centre, the variety of youth related services, how to publicly promote the centre, share the functions of the centre and the “Services Framework for Youth” with personnel, inform them on registration and reporting forms and provide instructions for their use in the centre.

In the interest of sustainability it was planned from the start that the centres will be part of existing primary level health facilities, and not be separate organisational structures. The ultimate objective of the MoH in this respect is to ensure that all health facilities acquire skills for a youth-friendly approach through a common policy and service delivery standards.



Picture 1: Outreach work by young volunteers

Outreach activities and youth participation

An “Outreach Guide” for youth-friendly service provision was developed with the aim of giving practical advice on planning activities, reaching out to target groups in the community and creating more demand for the services offered at the centres (8). Providers have also learned in practice that they can better reach young people if they work outside their centres in places where young people hang out, like youth and sports clubs, café’s and fairs, or schools and work places.

Box 3: Various initial activities of YCHSCs

Outreach activities are the main part of the work of YCHSCs!

1-Opening ceremony: This was organised with painting and composition competitions. Brochures, posters and T-shirts were distributed by service providers and young people. A concert was given by young people during the ceremony.

2-Working with police department: A YCHSC’s psychologist is working with the police department, doing interviews during interrogations. She has meetings with suspect criminal youth beforehand. She also works with adolescents in the prison or police department.

3-Ideas box and client exit survey: Almost all YCHSCs have placed an ideas box for young people to write down and deliver their thoughts about youth centre.

4-School activities: YCHSCs prepared and gave presentations which were used to promote their centres during school visits.

5-Centre promotion on a tourism festival: Service providers of one YCHSC produced 3000 caps, T-shirts, brochures and posters together with young people, which were exhibited in a youth stand on the Alanya Tourism Festival. The centre worked with a young professional group. News about the youth centre was published in local and national newspapers and television stations. A video clip was made, to be used as a good outreach example for other centres.

Youth participation in all phases of the Programme is not an option but a necessity, if the needs of young people are really and truly to be met. Service providers have learned about the importance of engaging youth wherever they can, and managers must ensure that the practice is kept up beyond RHP.

Youth component of RHP goes international

A major success has been the hosting of an International Symposium on “Youth Friendly SRH Services”, in Ankara, 2006 (9). More than 200 young people, specialists from national and interational agencies, health policy makers, and some parents joined forces to discuss how SRH services can be made more accessible, acceptable and relevant to young people. Representatives of Turkish CSOs, WHO, UNFPA, UNICEF, ICC and IPPF also provided expert advice and practical examples of youth friendly services. A major result of the symposium has been that youth-friendly SRH services are now firmly on Turkey’s health agenda and this agenda has the full support of many active youths. The Proceedings of the symposium include more than 200 recommendations on various aspects, which are planned to be followed up by the different participating agencies. Keeping in mind the “RAP rule” these recommendations focus mainly on:

- Ways and means to lower barriers to youth friendly health services,
- Priorities for developing information and education materials for young people,
- Methodologies and utilisation of peer education,
- Identifying the main stakeholders for inter-sectoral collaboration and coordination.

It should be stressed that CSO projects have strongly contributed to putting youth SRH firmly on the agenda; more than 30 CSO projects addressed this subject!



Achieving youth-adult partnerships

In this component youth, parents, service providers, managers, CSOs and the MoH embarked on a journey together. In this travel they acted, re-enacted, learned and achieved together. Some important achievements have been:

- Increased awareness in society about needs and rights of young people.
- Services are delivered in a non-judgmental manner by health personnel who care about privacy and confidentiality.
- Physical and other infrastructure features of the 20 centres comply with internationally accepted standards of youth friendly outlets.
- Service providers use youth participation in outreach activities with great success.

Box 4: Quantitative Results

Overall output achievement of the Youth Component within RHP:

- A situation analysis on SRH YCHSCs and a Service Delivery Framework.
- A module for training primary health care providers, and 785 of them trained.
- A comprehensive training module on youth friendly SRH services for YCHSC staff and 122 of them trained. Follow-up trainings were completed.
- An Outreach Guide and a Management Guide for YCHSCs.
- 20 new YCHSCs established.
- An International Symposium on "Youth Friendly SRH Services", in 2006.
- Number of clients in 38 YCHSCs was 26,332 in 2006, and 12,474 in the first half of 2007.
- 75% of clients were pupils and students, and 8.5% were working adolescents.
- 44% of clients were 10-14, 38% were 15-19, and 18% were 20-24 years old.

Future challenges

It is to be expected that in the next decade, the issue of "Adolescent SRH" will become much more pronounced and pressing in Turkey. In order to meet the rapidly changing SRH needs of young people, and to sustain the momentum created by the RHP Youth Component, it

is essential that:

- Issues related to youth stay on top of the health agenda of Turkey;
- Number of youth centres is increased according to the targets of the SRH NSAP;
- Intersectoral cooperation and multidisciplinary approaches are employed;
- In all programmes youth involvement is ensured;
- New researches and studies on adolescent/youth sexuality are done and the results are shared with relevant agencies, communities and the media;
- International collaboration and cooperation is continued.

One of the most critical issues is to prepare youth more consciously for the future. Turkey has to attach special importance to describing the problems and risks for youth, and subsequently develop effective strategies and action plans accordingly and implement them.

We have overcome many obstacles, there are still several barriers, but the Youth Component of RHP has been a very good start in taking youth SRH serious in Turkey.

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SECOND GENERATION SURVEILLANCE OF STI/HIV/AIDS IN TURKEY

By Peyman Altan, Levent Akin, Raphael Baltes, Kevin Fenton, Catharine Taylor

Second generation surveillance (SGS) of HIV/AIDS is the regular, systematic collection, analysis and interpretation of information used in tracking and describing changes in the HIV/AIDS epidemic over time. It gathers information on risk behaviours, using it to explain changes in infection rates. In addition to HIV surveillance and AIDS case reporting, SGS includes surveillance of Sexually Transmitted Infections (STIs), to monitor the spread of STIs in populations at risk of HIV and behavioural surveillance to observe trends in risk behaviours over time. These different components are more or less significant, depending on the surveillance needs of a country, determined by the level of the epidemic: low, concentrated or generalized level (1). In low HIV prevalence countries like Turkey, where relatively few HIV-cases are found in any group, surveillance systems focus largely on high-risk behaviours, looking for changes in behaviour which may foster a rapid spread of the infection (2).

Steps taken to introduce SGS in Turkey

A number of different project activities were implemented from 2005 to fulfil the requirements for SGS in the ongoing surveillance system. A series of workshops were conducted in 2004 as part of the National AIDS Action Plan and a joint work plan of the Ministry of Health, RHP and UN Theme Group on HIV/AIDS. The workshops were conducted in the areas of surveillance, laboratory practice, diagnosis and treatment of HIV and groups at high-risk of STI/HIV. The workshop had two outputs: providing an opportunity for policy makers, practitioners and academics to discuss issues and creating a basis for a situation analysis on STI/HIV/AIDS. As recommended for the establishment of SGS, a situation analysis was carried out in 2004 as part of the STI surveillance component of the RHP (3).

A Rapid Assessment (RA) of sub-groups including unregistered commercial sex workers (CSW), men having sex with men (MSM) and intravenous

drug users (IDU) was conducted as part of the RHP in November 2004. The RA aimed to identify groups most at risk of STI/HIV and to determine which behaviours commonly put them at risk and to determine the links between these high-risk groups and the general population. Results suggested that there was a need to continue efforts to improve knowledge, raise awareness and promote safe sexual practices among the high-risk groups.

In February 2005 a National Consensus Building Meeting (NCBM) was conducted with the participation of major and relevant stakeholders in the field. The NCBM discussed the results of the previous workshops and the situation analysis, including the RA. Speakers and panellists alike agreed that STI/HIV surveillance needed improving and that an effective surveillance system required the use of existing tools and mechanisms, in addition to behavioural studies and sentinel surveillance.

Operations Research on Key STIs and HIV in Turkey (ORKSH)

Following the recommendations of the NCBM an Operations Research on Key STIs and HIV in Turkey was designed. The study aimed to contribute to the epidemiological knowledge of key STIs and HIV among the general population and among high-risk groups, and to assist in the development of a national SGS system.

The research enabled the MoH to prepare specific interventions concerning sentinel surveillance in the field of STIs and HIV. The research was implemented by a consortium, consisting of ICON Institute Public Sector GmbH, Public Health Department of Hacettepe University and Royal Tropical Institute in Antwerp, starting in March 2006 and finalized in April 2007.

The cities of Ankara, Istanbul, Trabzon and Gaziantep were selected as sentinel sites in order to develop the methodology for establishing future SGS programmes. It aimed to estimate the prevalence and associated demographic and behavioural correlates of key STIs (syphilis, gonor-

rhoea, chlamydia, Hepatitis B) and HIV among pregnant women attending antenatal clinics (ANC). In addition, the cities of Ankara, Istanbul and Izmir were chosen as sentinel sites for MARPs (Most at Risk Populations).

Implementing the ORKSH

Key ORKSH activities were:

1. Preparation of research documents (protocols, questionnaires, forms)
2. Meeting with the Provincial Health Directorates staff to establish local coordination and collaboration
3. Review of training modules for: counsellors, laboratory experts, peer recruiters
4. Identification of NGOs and peer recruiters to work with groups at risk
5. Training of peer recruiters to mobilise target groups
6. Training of counsellors, on voluntary counselling and HIV testing (VCT), and laboratory staff
7. Pre-testing of questionnaires
8. Ordering and supplying tests and laboratory materials
9. Data and sample collection of ANC patients and MARPs
10. Laboratory testing of collected samples
11. Quality control
12. Data entry & analysis
13. Final Conclusion Meeting with all participants
14. Dissemination of the results

The selection of the sentinel sites was on the basis of convenience (accessibility) rather than on the recommended representative sample for the country's target population. Given the anticipated low HIV prevalence rate (below 1%), the planned number of HIV tests to be conducted within the research was too low to have reliable confidence intervals. Therefore, the research findings only provided information on some aspects of the current situation related to STIs, including HIV, in pregnant women and some of the MARPs. The epidemiological value of the expected results of the study is limited.



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Table 1: HIV and STI incidence among MARPs and ANC clients

	CSW		MSM		IDU		ANC	
	Number	%	Number	%	Number	%	Number	%
HIV	2	0.8	3	1.8	1	1.5		
Hepatitis B	6	2.4	6	3.6	2	2.9	4	2.3
Syphilis	19	7.5	18	10.8	1	1.5	3	0.1
Gonorrhoea	7	2.8	5	3.0	1	1.5	10	0.5
Chlamydia	3	1.2	4	1.8	2	2.9	19	0.9

Antenatal Clinic Findings

The educational level of many of the pregnant women participating in the research was low; most of them were unpaid family workers/housewives. Their low social status was an important barrier in obtaining information on health and health care services in general. Out of 2,089 women approached in ANC clinics, only 29 refused to participate in the study.

Knowledge related to condoms and their use was lower amongst the pregnant women, than expected. 13.8% stated they had not heard of the male condom, while the majority of the participants (75.3%) had not heard of the female condom. During last sexual intercourse 81.4% of pregnant women had not used a condom. The major reasons for not using condoms were stated as: “thought it was unnecessary (20.8%)”, “their partner did not want to use it (19.9%)”, and “used another method (13.4%)”. Women who had not used a condom during last sexual intercourse responded that they considered the condom as a contraceptive, which indicates that they are not aware that condoms can protect against sexually transmitted diseases. Those who use condoms mainly obtain them from pharmacies, followed by primary health care units.

As is commonly found in Turkey (4), AIDS awareness was higher than HIV awareness within the study population. Only 28.6% participants replied as having heard of HIV, whereas 93.2% indicated having heard of AIDS. The laboratory results of HIV and STIs testing through VCT with MARPs and ANC clients are presented in Table 1.

MARPs findings

Among MARPs, the refusal rate to participate in the study was highest in the group recruited in health care settings at 33%. Within the MARP groups, 0.8% were found to have HIV positive status among CSWs, 1.2% among MSM and 1.5% among IDUs. Only 29.5 % of MSM declared always using a condom during sexual intercourse, while this was 36.1% among CSWs and 44.1 % for the IDU group. Pharmacies were most often used by MARPs to receive services (condom, medicine, injectors, etc.).

Conclusion and Recommendations

Since Turkey is still considered a low prevalence country, there is no need yet for SGS on HIV to be introduced in the general population. However, SGS can be considered appropriate for the most at risk populations. This would provide an early indication of the magnitude of the risk factors for HIV transmission. Therefore, both sentinel and behavioural surveillance in selected sentinel sites should be periodically carried out. Furthermore, more sentinel sites should be in place based the location and size of the MARPs population.

Due to limited numbers of MARPs and pregnant women included in the ORKSH, information was collected on only some aspects of the current situation related to STIs, including HIV, in pregnant women and some MARPs. Therefore, to carry out surveillance effectively, the numbers of members in each risk group, as well as their distribution in the country and the way to access them has to be estimated. On the basis of this information, reliable sentinel surveillance studies for risk populations should be planned.

Moreover, implementation of a well developed surveillance system should be completed and quality control should include systematic information about quality. This process should start with the diagnostics of the disease through improved reliability of the reporting process at all stages until the data entry and processing.

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STRENGTHENING SRH PRE-SERVICE TRAINING CAPACITY

By Iffet Renda and Ayla Albayrak

The two-year project in Turkey had two aspects: to strengthen pre-service SRH education in medical faculties, and in nursing and midwifery departments of Schools of Health; and to harmonise SRH education in line with EU regulations. The universities were motivated to adopt revised SRH curricula, improve their skills laboratories, focus on the teaching skills of their academic staff, and to realise the significance of feedback from in-service graduates for their programmes. The project resulted in a catalytic and continuous reform for the universities.

The needs assessment survey (2003) for RHP in Turkey, by the Ministry of Health (MoH), revealed weaknesses in SRH with regard to pre-service education. It made recommendations for the improvement of curricula formats and contents, training of teachers, standardisation and harmonisation with international standards, and for monitoring and evaluation of the overall SRH curricula.

This article describes the response by the project for strengthening SRH pre-service training capacity that ended in August 2007 (Fig.1). The overall objective of the project was to contribute to strengthening pre-service SRH education in line with EU regulations in medical faculties, and in midwifery and nursing departments of Schools of Health (SoH), in universities.

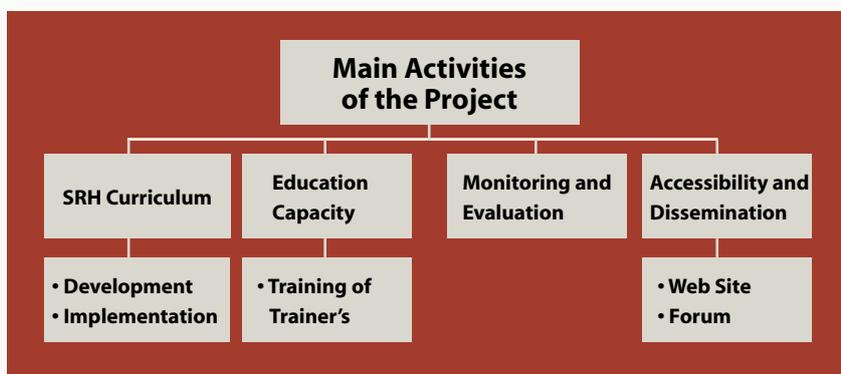


Figure 1. Key activities of the projekt

The medical, nursing and midwifery coordinators of the Technical Assistance Team (TAT) of the project visited 8 universities and selected 9 departments (medicine, nursing, and midwifery) of Istanbul, Mersin and Kayseri (Erciyas) Universities for a pilot project.

SRH curricula

The TAT assessed the SRH curricula of the pilot universities, and established core and advisory expert working groups to revise the curricula for the three disciplines and establish comparative standards. The content ensured consistency between the pre- and in-service components of the RHP and harmonisation with EU directives. The SRH subjects of violence, sexual abuse, gender issues, vulnerable groups, and SRH needs of the elderly were also included to provide comprehensive coverage.

The integration of the revised SRH curricula into the programmes of the pilot schools revealed numerous cases of repetition of the same topic in different courses and years. Learning objectives and assessment techniques were identified. Schools moved several SRH subjects to earlier years of study, and they ensured vertical and horizontal integration of subjects. The approach to teaching from illness to health and from an understanding by the students of his or her personal SRH needs to an understanding of the family and the community was adopted. The actual SRH content of the curricula was already well covered in the programmes of the schools; the project then offered an opportunity for

the schools not only to examine the SRH component but also to review their complete curricula.

The integrated SRH curricula of the pilot schools were approved by the university senates, and recommended for adoption by the Inter-university Health and Medical Sciences Education Council. The midwifery curricula were used as a reference document during the development of core curricula for the midwifery schools. The revised SRH curriculum for midwifery was promoted at the midwifery annual national conference.

Competency-based training

The project trained 53 instructors from the three pilot universities in competency-based (learning by doing) training courses. These trained academics on return set up clinical skills training courses in their schools for the other staff. Some schools established multidisciplinary new-skills laboratories to support the training of students in clinical skills and others increased the capacity of their laboratories.

Monitoring and Evaluation (M&E)

To assess the integrated and implemented SRH curricula of the pilot schools, an M&E model was developed in line with the Bologna process (on academic degree standards throughout Europe) and the university strategy plans. TAT gave regular technical assistance and designed two workshops where schools shared experience and exchanged information. The implementation of the M&E model made it feasible for schools to measure



Iffet Renda

the response of students and staff to their integrated SRH curricula. The schools also realised that taking up contact and strengthening relations with their graduates will provide valuable information concerning the credibility of their programmes.

Measurement techniques that the model offered had a high acceptance rate. Focus group meetings were used extensively to measure attitudes of staff and students with regard to SRH curricula. The SoHs started testing both the validity of examination questions and developed question banks with a view to sharing these with other SoHs. This process will gradually contribute to the standardisation of education in nursing and midwifery.

Staffing problems in Schools of Health

Schools of health are overwhelmed with long hours of teaching and a shortage of trained senior staff. Table 1 shows the distribution of senior staff in SoHs compared with medical faculties in the pilot universities. Since 1996 midwifery education is mainly the responsibility of academic nurses. There are just three MSc programmes for midwifery and only 15 midwives have MSc degrees in Turkey. The training of senior staff for SoHs should be priority for the policy makers, the Higher Educational Council (HEC), and the MoH. Unless urgent steps are taken, the quality of SRH education in Turkey will be seriously undermined.

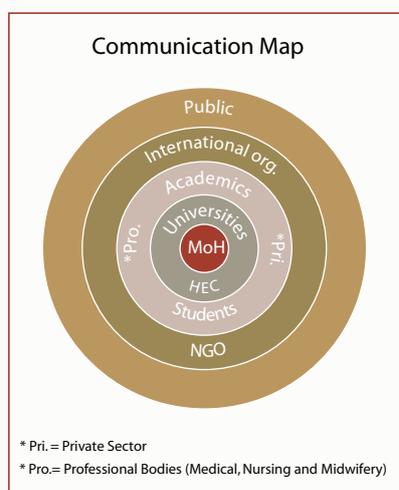
Dissemination visits

In the extension period of the project, TAT made presentations at a further 9 selected universities to outline the project, its results and distribute relevant documents and CDs. Almost all of the universities set up curricula study groups to examine their SRH curricula. They also started looking into ways of initiating or extending their competency-based training programmes and investing in skills laboratories. Twenty four instructors from six SoHs of the 9 universities visited were trained in clinical skills. Presentations contributed further to the institutionalisation of the SRH project outputs.

Communication strategy

The communication map shown in Figure 2 places the MoH at the centre, and its closest partner at the interface with the health sector is the HEC.

Figure 2



The HEC is an autonomous body with legal authority governing all higher education activities. For the newly developed SRH curricula for medical faculties, nursing and midwifery schools to have a national impact, consistent support of both the HEC and MoH is paramount. Such support is not at a desirable level at present for various reasons. The project therefore offers an alternative for improving and strengthening communication and relationships with the other layers of stakeholders in order to overcome difficulties.

The TAT's interaction with the management of the 17 universities visited for pilot project selection, pilot work, and dissemination purposes, and with professional organisations, was positive. No contact was established with the private health sector that is claiming a larger share of service and is progressively becoming a desirable employer of health workers.

A website of the project, www.tuspmoe.gen.tr, was activated in April 2007. A forum now exists for the use by all the contributors and participants in the activities of the project. The discussion forum has not yet been used, possibly because it is a new medium or because SRH education is not yet a subject of great interest.

Conclusion

The project was not designed as a one-time reform of the SRH programme in the universities but as a motor of ongoing change. Its value will be apparent if it motivates universities in Turkey to evaluate regularly all aspects of their SRH programmes and introduce appropriate changes. The curriculum, clinical skills of the academic staff, evaluation of their programmes, and incorporation of feedback from former students working in SRH fields will all play their role.

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Table 1

Number of students per senior staff member in Medical Faculties and Schools of Health

Pilot University	Medical Faculties	Schools of Health
Pilot University 1	5,8	92,1
Pilot University 2	3,8	74,1
Pilot University 3	2,2	49,8

FORGING A POWERFUL PARTNERSHIP IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN TURKEY

The article explores the creative potential of moving from an international co-operation to establishing a national partnership between the Ministry of Health (MoH) and Civil Society Organisations (CSOs) within the Reproductive Health Programme (RHP) in Turkey. The dynamics between two different sectors; the natural conflicts, the underlying interests of funding a portfolio of 88 projects, co-ordinating 107 civil organisations within a multi-stakeholder programme is analysed as a resource in itself. The result is a doorway into a rich and transformative opportunity for change and future growth in the provision of quality SRH services in Turkey.

TURKEY AT THE CROSS ROADS OF THE HEALTH MILLENNIUM

Neither a revolution nor a counter revolution

From the late 1980s to the mid 90s there were the winds of health reform and a variety of multi-lateral, bi-lateral and non-governmental donors co-operated with the public health sector and civil society. As the donors moved on or downsized, Turkey was left with many documents that the public had only rare access to. Within the hierarchy of public institutions only a select few managers understood these co-operative documents, many of which contained progressive ideas and know-how. Between ICPD Programme of Action (1994) and Millennium Development Goals (2000), there have also been shifting perceptions regarding quality of care and the added value of a rights based perspective to sexual and reproductive health (SRH). In the many interpretations that have followed these international agreements and translations that were done, people applied their own reductions. The end result - there was no collective ethos on the subject of SRH. The CSO Situational Analysis for Turkey (2004) shows that many women's groups do not equate gender equity and empowerment to sexual and reproductive rights (SRR).

From confusion to evolution

A decade long set of circumstances in Turkey created the present public – CSO co-operation and some of the perils and opportunities of economic co-operation and the social development of a country

underscored the potential partnership:

1 Turkey had become a middle income country: "Feminisation" of the bureaucracy and rapid private service sector development including health were taking place.

2 Crisis in health and successful advocacy: RH indicators were beginning to plateau. The Group for Establishing Support for Women (KIDOG) with strategic support from MoH convinced the government to fund contraceptives from the general budget.

3 'The Force' of the Acquis: The objective of this crucial EU accession document made it possible that a €5 million grant was provided by the EC for SRH; 36% (or €0 million) of which was earmarked for direct funding to CSOs.

4 New Regime Creation in SRH: The National Strategy for Women's Health and Family Planning provides the framework within which the RHP operates. A financing agreement was reached in 2001. From then on, the negotiation was episodic until implementation began in early 2003. It culminated with the National Strategic Action Plan of the MCH/FP Directorate (2004).

Dynamics of the civil society strand of RHP

There are two main components (or strands) of the RHP in Turkey: the public health sector, committing itself to improving the quality of service and strengthening institutional capacity (Strand 1) and CSOs committing themselves to increasing demand and utilisation of public health services (Strand

2). The two Programme strands were divided into 9 interlinked result areas, of which the CSO strand is Result 6. A CSO Team was established within the MoH to oversee the CSO Grant Scheme. The Team worked in collaboration with the Technical Assistance Team (TAT).

There were two calls for CSO project submissions, in 2004-5. Twenty seven proposals were contracted in the first call. Financial support was given for a period of 12-24 months, and approximately €1 million was committed and distributed. Under the second call another 61 projects were awarded. The maximum project duration was 12 months and the funds committed were approximately €12 million. The Grant Scheme represents involvement of 107 organizations, which also included CSO-CSO co-operation.

Dynamic 1: state of affairs

A civil sector review of Turkey (2004), using a Situational Analysis Model, was conducted. The Review casts a wide net through an inventory of 330 CSOs, notes their perspectives and elaborates on how these organisations have and can contribute to SRHR in Turkey.

This was followed by a Stakeholder Analysis (2004) which identified 24 potential partnerships among 3 sectors (public, CSO, private) and analysed them according to characteristics, interests and expectations, sensitivity to and respect for SRHR and capacity to resolve anticipated problems.

The Strategic Choices (2004) document of RHP facilitated a mapping route for the Grant Scheme using the 3 level

development concepts in Turkey; regional disparities in access to services, migration areas and other issues. The consultative process showed a willingness to learn and exchange opinions about a possible future together for the two sectors. This did not mean there were no obstacles or difficulties in the process.

Dynamic 2: Transforming the support for RHP into a ground swell

Key Message:

“Protecting mother and child is in the Constitution of the State... Turkey has made great strides in health... but some provinces have started from behind... Some women say ‘no more’ and they get pregnant... this is our collective failure... Fertility planning is not fertility limitation...”

General Director, MCH/FP, MoH

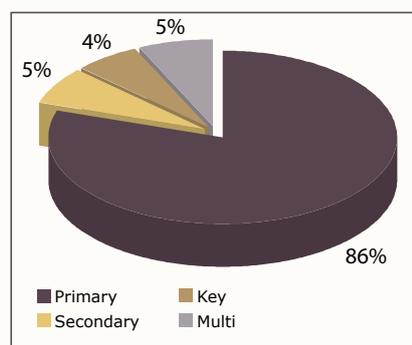


Fig 1 Distribution of CSO projects by stakeholder groups

The 88 Grant Scheme projects closely reflect the Strategic Choices as illustrated by Figure 1. It shows that reducing inequalities effectively meant CSO projects worked directly with a variety of stakeholders but mostly with primary beneficiaries i.e. the end users of services, many of whom are vulnerable and disadvantaged women, men and youth and high risk groups. Thirty percent of the projects are located in North Eastern and South Eastern Turkey and 50% in high migration areas where poor indicators for RH are found in women with low education level, irrespective of their residence (but mostly residing in gaecokundu or urban squatter settlement). The 88 projects of the CSO Grant Scheme also makes a statement in

terms of giving priority to Programme intervention areas by working with 68 lead CSOs. Figure 2 represents the resource distribution.

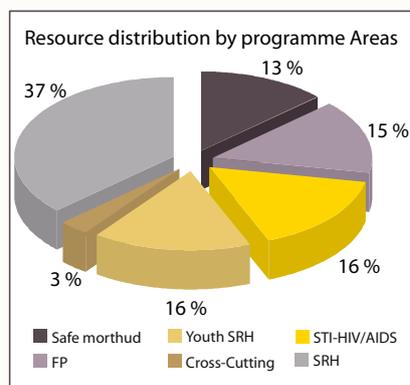


Fig 2

Dynamic 3: Dilemma of duality

There is recognition within MoH that there are no legal barriers to CSOs becoming involved directly in service delivery. The RHP design that is based on the public sector being involved solely on the supply side and civil sector only in creating demand was seen as a policy shortcoming, an artificial division and an example of a top-down approach by some, especially CSOs.

“...when creating the demand, MoH should think how much of this demand CSOs can meet. People move from the state hospitals to the private sector. I believe that there are important gaps in public service delivery; they (MoH) should have made an internal plan. Most of the people in the field complain ...”

National CSO

For the MoH, however, there was also an over-riding responsibility for improving the status of SRH, increasing demand for its services, strengthening its RH centres and assuring their quality, continuity and sustainability. Furthermore, the state could only take responsibility for quality standards of its own service delivery institutions and not that of CSOs. On the other side, initial criticism from CSOs did not manifest itself as a resistance to the supply and demand model; there was no concerted effort on their part to provide alternative strategies to the design or distribution of the Grant Scheme. At the

same time Provincial Health Directorates (PHDs) had doubts and questions about CSOs and whether resources should be given directly to CSOs or to themselves.

“Co-operation is uncommon and CSOs are not strong as a sector... They are too different... two conflicting... CSOs have their own independence... Concepts are also different... Civil society is nascent and MoH should view the co-operation as a mentor... will they accept? We would like CSOs to promote what we believe in... Civil society is not obliged ...”

Representatives of Provincial Health Directorate

Dynamic 4: Getting over stereotypes

Key Message:

“We bring the power we have in being together to reach all our objectives in the Programme. We are grateful for the support received from MoH. CSOs are taking seriously their responsibility to the Ministry and themselves. We underscore expectations on all sides ...”

Representative of ECD

In the interest of creating a balance between two critical forces the following was decided by MoH. For reasons of cost-effectiveness, work proceeded with PHDs; for efficiency in finding clients for health centres and dealing with sensitive SRH issues, a great variety of CSOs were included. The CSOs in the Grant Scheme were represented by foundations (43%); associations (41%) and the remaining ones were unions, clubs and chambers. Nevertheless, a palpable opposition from both PHDs and CSOs continued, but MoH and TAT advocated appropriately at this stage. The Grant Scheme ensured that awarded projects would maintain co-operation. Capacities were built through joint public – CSO meetings and continued during the process of implementation in forming partnerships as shown in figure 3.

“Third party mediation often works... Local representative of CSO asked to invite health staff to a training programme and

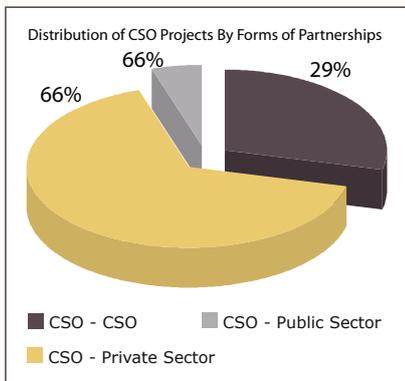


Fig 3

was turned down by PHD. Such refusals happened often and I had to act as a bridge more than a few times. We organised many confidence building meetings between the two parties... for relationship that is beneficial now and in the future....”

TAT staff, Field Office

Dynamic 5: On the threshold of a partnership

A Sustainability Initiative aimed at empowering CSOs within the Grant Scheme to understand, support and practise sustainable development of their organisations was organised in 2006-7. The Initiative demanded the energy, commitment and creativity of the CSOs, as well as the support and encouragement of the CSO Team, TAT and ECD throughout the conduct of four building block workshops. Support was sought from international experts who specialise in CSO fundraising beyond grant schemes, with knowledge of unique circumstances of EU accession and experiences of emerging markets such as Central and Eastern Europe.

Initially the CSOs had a limited understanding of the role and function of a network. Most of them had not worked together before, and many had incomplete knowledge of the practices of fellow organisations working in the field, or MoH for that matter. Through team-building exercises, analysis of case studies, simulation activities, role-play and real-life fund raising exercises the workshops unlocked the potential for effective co-operation between CSOs and potential partners in the public and private sectors.

Key Statement:

“The Network (of CSOs) seeks to strike a balance between a healthy sexual and reproductive life and sustainable development. The Network will organize itself to promote knowledge and training skills; building capacities both at home and abroad to actively generate different funds from a variety of sources to carry out activities in the interest of its mission and members.”

Interim President on behalf of Network Founding Members

By moving beyond the grants/donations paradigm to experience a huge range of funding ideas and examples from around the world, CSOs began to visualise the network as a “philanthropic exchange” and vibrant marketplace for CSOs, donors and investors. At the close of the training, a constitution was established and a three-year action plan developed. The establishment of “A€Cevap”, (in English: Net - Response) therefore represents a leap of faith on the part of the “founding fourteen” to develop their own partnership among each other, with MoH and other interested partners. Will the network live on to tell its own success story? Only leadership, endeavour and time will tell.

Dynamic 6: In the interest of accountability

The RHP has a Monitoring Plan (Progress Report, February 2005). A formal mechanism to follow-up CSOs during the implementation phase was not fully discussed and negotiated and accepted within the Programme Unit (MoH, TAT and ECD). Since mid 2005, monitoring responsibility reverted solely to ECD as part of contract management. There have in the last two years been attempts at monitoring by TAT on a limited scale. There have also been joint meetings between MoH and ECD with CSOs in Izmir and other provinces. In a novel way the MoH has made it beholden for CSOs to increase their visibility beyond the contract requirement. A qualitative Monitoring Map has been prepared.

The gap in monitoring has been leveraged by a call from MoH and TAT for an independent process evaluation. This evaluation limits itself to assessing the execution and implementing role of Programme Unit in the implementation of the Grant Scheme and response of the CSOs in adapting to the process. Preliminary findings from the evaluation show the following:

- A wide agreement among interviewees that the areas of intervention, methods and selected projects were relevant and in balance. Many also agree that it is too early to comment on the benefits of the Grant Scheme for the people of Turkey.
- 95% of the allocated funds are contracted to CSOs showing a high level of efficiency in the disbursement of funds. There is criticism (not from CSOs) that human resources (national and international) were not appropriately allocated for capacity building and were under-utilised for field monitoring during the implementation phase.
- A general agreement that the Grant Scheme made an effective contribution to the expanding SRH process and enhancing individual CSO capacities. Many CSOs state that they were not made fully aware of the complimentary roles of Programme Unit in execution, implementation and management.
- Most respondents noted that while methods of intervention were traditional to many other parts of the world, they were innovative to Turkey. As SRH is now easier to discuss, many other sensitive issues can be better integrated in the future.
- Some CSOs have integrated SRH into their core programme but require new funds for sustainability of project activities within the Programme. It is still too early to speculate on the development of the Network. CSOs in Turkey largely remain within a charity model, anticipating grants rather than pro-actively generating their own products and services; income

through diversified sources and social enterprise investments.

The process evaluation takes careful consideration of the recipient of ECD funding, namely the CSOs at large. It is however unable to speak confidently about the impact of the RHP on those 86% primary stakeholders (the end users of services) that were beneficiaries of the CSO funded activities. The amalgamation of voices summarizes the basic and initial process in terms of public - CSO co-operation and the tensions in setting priorities, understanding quality service and client rights, developing partnerships, sustainability of CSOs and health centres becoming client magnets.

“By coincidence, I saw an advertisement for maternity and new born training at home by a CSO in a private hospital. A midwife... came to me to give 4 weeks training after delivery. It was free of charge and very good quality. I learnt about infant food...she asked about me... showed how to breast feed properly without using the scissor method...things my mother and grandmother don't knowhow to sit on the chair (not the bed) and nurse... I was told about maternal care and psychology...I mean everything...The free service ended last year...”

Client of CSO Project, Izmir
“After checking the web address it was learned that a private company had started providing the same service and charging fees”.

Expert, CSO Evaluation

CONCLUSIONS: STEP BY STEP

Key Message:

“... you see how the Programme was born ... we did not speak about CSOs in the beginning ... we only spoke of what Ministry did/could do...we had full rooms...half empty rooms in our meetings...there were many questions...many experiences...and today we speak of our partnership.”

General Director, MCH/FP, MoH, 2006

The RHP in Turkey allowed the following:

- Mainstreaming opportunities for various CSOs to get into SRH sub-sector.
- Programme integration and the practical SRH link between demand and supply.
- Emphasis on public standards that highlighted importance of skilled quality services.
- Human resource development in project development and management.
- Importance of bilingualism was stressed in all documents and interaction.
- Becoming a ‘stakeholder’ without knowing and then consciously transforming.

In moving from an international financial co-operation (or collaborative aid) to a national partnership (joint venture enterprise) it was normal that as a first step, MoH would look at RHP and CSOs from their own perspective. Understanding through practical experience, the difference between power over civil society and power to civil society was the second step. Instead of seeking to control, the CSO Team became facilitator of CSOs overtime. This experience needs to resonate further within the public health sector and beyond.

CSO partnership with the public sector emphasises two parts – firstly, it has its own importance in advancing the collaboration and providing mutual support. Secondly the partnership enhances the role of CSOs in democracy as they are increasingly engaged in the reform process, building awareness on several issues on several fronts. The Programme may end but a form of partnership exists and will continue to play a valuable role in catalysing new reforms and policy innovations in health.

“Not just SRH CSOs or just the big ones but the whole sector was mobilised. Although we cannot say now whether mainstreaming activities will be sustained

or not, it is good to know that many NGOs from various sectors were able to think, develop and implement SRH projects”.

Director, Willows Foundation,
Member of RHP Consortium

As Turkey boldly enters the Accession process for European Union (EU) membership, we continue to witness remarkable transformations in society with unpredictable results in upholding sexual and reproductive health and rights. The international development policy of the EU, including health, provides vital leadership in the face of increasing opposition to SRR from different directions. The more precise fulfilment of ICPD Programme of Action continues to remain a challenge. The pace of more change in future SRH programming within Turkey can create new predicaments for the public sector as reflected in some parts of Europe but RHP will have made the possibility of finding appropriate solutions that much easier.

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A YOUTH STORY

from left to right: Selen Örs, Tunga Tüzer, Gökhan Yıldırım kaya, Fatma Hacıoğlu, Nezih Tavlas, Zeynep Başarankut



UNFPA Turkey launched Turkey's first youth-to-youth advocacy web campaign for young people's sexual and reproductive health (SRH) and rights. The campaign aims to increase awareness of SRH among young people and create demand for sexual health education.



Poster

"Before I visited your site, I did not know how to cope with my sexual health problems. Many thanks ..."

"I would like to learn how we can overcome the problems during adolescence, especially the psychological ones."

Boy of 16 and girl of 15 express their feelings on the web - (www.birgenclikhikayesi.com) "A Youth Story".

Background

Serious efforts have been made in Turkey to meet the SRH information and service needs of young people through UNFPA's technical assistance since 2000. The Ministry of Health took the lead role, with support of international donors, in developing a youth friendly health service model and integrating it into the existing maternal and child health and family planning centres. Simultaneously, a similar model was developed for students in selected universities.

Previous efforts, targeting the education system, show that only through effective advocacy, SRH education would be integrated in school curricula. A potential action could only be successful if young people themselves demanded such a policy change; however, most of them are not aware of or empowered to advocate for their SRH rights. UNFPA believes youth-adult partnership must be an integral part in programmes targeting youth, we have decided to work with and for young people to attain this goal.

A unique initiative

An advocacy campaign was launched on 12 April 2007 by UNFPA in collaboration with Levi's, MTV Turkey and the Youth for Habitat Association. The short-term goal is to create awareness and demand among young people for sexual health education. In the long run it aims to

reach policy makers and create an enabling environment for the integration of comprehensive SRH education in school curricula.

The campaign includes remarkable elements, which make it unique in Turkey. Firstly, "A Youth Story" is the original national youth SRH advocacy campaign, being implemented by true youth-adult partnership. Young people have been involved since the planning phase and a young coordinator under the direct supervision of UNFPA is currently implementing it. Secondly, UNFPA's technical expertise was united with Levi's and MTV Turkey's popularity among young people and with a national network, one of the biggest NGO working for young people's participation in governance at local level.

The website was chosen by a bank as one of the best corporate social responsibility projects in Turkey and they wanted to sponsor the campaign. Another innovative approach was to work with celebrities as role models. The lead singer of the Turkish rock band "Kargo", Koray Candemir, and popular TV presenter Defne Sarısoy kindly accepted to become spokespersons for two years.

Wherever young people are, "A Youth Story" is there...

Website: "A Youth Story" created a virtual setting for youth, enabling them to spend their leisure time with interesting interviews and quizzes, fun videos, games, and music while they are learning about SRH. The website was developed to help young people find answers to their questions without compromising confidentiality.

Events: "A Youth Story" has been carried to 30 universities during the spring fests and to three international music festivals in 2007.

Training: In order to create demand

and awareness on SRH at local level, "A Youth Story" will empower young people through a number of advocacy trainings. These trainings will be carried out in seven cities with participation from 30 provinces. These young people will act as advocates and reach their peers, policy and decision makers to create awareness on young people's SRH and rights.

Hungry for knowledge

After the launch of the website, we realized how much young people care about their sexual health and how many questions they have that they could never ask out loud. The diversity and content of the questions reveal the need for comprehensive and in-depth research to better understand the socio-cultural factors affecting young people's knowledge and attitude on SRH.

In the first three months, "A Youth Story" showed us how hungry young people are for SRH knowledge. An integrated approach including appropriate information in formal education supported by behaviour-change techniques like peer education and widespread youth-friendly health services providing necessary counselling and treatment are needed. "A Youth Story" is expected to be an important step forward to this approach by mobilizing young people and creating an enabling environment for necessary policy change.

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SERVICE STANDARDS IMPLEMENTATION (SSI)

Service Standards Implementation (SSI) is a model developed to increase service quality. It aims to build capacity in sexual and reproductive health (SRH) programme management; developing and implementing policies, service standards and job descriptions for service management. SSI tools enable clinicians, policy makers and clients to make health care more uniform, reliable and efficient. SSI was initiated in 2004; evaluation activities were carried out in 2006 and based on its outcomes scaling up activities started throughout the country in 2007.

For SSI, the period 2004-2007 was marked by planning and implementation. The planning stage included development of service standards, development and testing of SSI tools and selection of 2 project provinces and 19 health facilities. It also included the development of an External Facilitators (EF) training programme and practice. The project implementation year in the provinces was 2005, when the service standards, SSI tools and EF training programme were revised in line with local needs and national policies. In 2007 roll-out activities started in 7 provinces.

What is SSI?

The SSI Model, inspired by COPE (Client Oriented Provider Efficient), originally developed by Engender Health, focuses both on client's rights and staff needs. These are, client's right to information, access, choice, safety, privacy and confidentiality, comfort, dignity and expression of opinions and continuity of services. Staff needs include facilitative supervision and management, information, training and development, supplies, materials and infrastructure.

SSI is characterized by problem solving approaches, teamwork, and self-assessment. There are four SSI Tools used in this process:

1. Self-Assessment Guide, used by service providers to assess their own strengths and weaknesses. There is a standard list of questions and adapted to the "SRH Service Framework" developed under the RHP.
2. Client Record Checklist Form used by

staff to define whether the information on clients is accurately recorded and whether the clients receive appropriate services.

3. Client Interview Form, has questions on clients' rights that the staff use to learn about opinions of clients on the services provided.

4. Action Plan: a written plan developed by the staff on solving problems identified during the SSI process.

An EF, internal facilitator (IF) and a SSI committee play crucial roles in the introduction and institutionalisation of the process. The EF is the key person in the process and s/he is a health professional that has a role outside of, and higher than, the facility level (preferably a manager in a Health Directorate). S/he takes care of the introduction and guides the facility in institutionalisation, supporting and follow-up, and trains the internal facilitator. The IF ensures the internalisation and institutionalisation of the process within the facility, under the supervision of the EF. The Committee consists of staff from all units, representing all professional groups, follows up and supports the implementation of the Action Plan through regular meetings.

The exercises are completed in 3 days on average, and consist of: 1. Preparations in the facility, 2. Introductory meeting, 3. Group exercise, and 4. Action plan meeting.

Implementation steps

The following steps were taken to develop service standards:

1. COPE project experiences in Turkey in 1993-1994 were reviewed.
2. SSI Self-Assessment Guide was developed according to "SRH Service Standards" and in line with the "SRH Services Framework".
3. Self-Assessment Guide was tested in health facilities in Ankara, Erzurum and Kars (North-East Turkey).
4. SSI EF course programme was developed.
5. Ten health facilities in Erzurum and 9 facilities in Kars were involved.
6. All managers from all levels were oriented about the topic in the provinces.
7. Candidate EFs were selected.

External facilitator training courses

The first SSI "External Facilitator" training courses were conducted in June 2005. In Erzurum, 12 staff, including one participant from the Ministry of Health (MoH) and 11 participants from the province. In Kars 11 health staff were trained as EFs. "Follow-up and Subsequent SSI" exercises of EFs were carried out in Erzurum and in Kars. Due to staff reassignments and some personal reasons, a total number of 15 EFs (65% from the initial cohort) participated.

Following the agreement on initiating scaling up activities, in total 21 participants from Ağrı, Ardahan, Artvin, Iğdır and Erzurum were trained as EFs. In İzmir, where staff turnover is low, health staff with previous training skills were selected and 20 EFs were trained in 2007. The total number of EFs trained has been 64, which means a viable critical mass nationally.

Pilot implementation

EFs initiated pilot implementation of SSI in 19 facilities in Erzurum and Kars. Three exercises have been conducted in each facility during the first year. At the end of it, 9 EFs (39% of the initial cohort) continued their role as EF. High levels of attrition in the two provinces is a concern, but with national roll-out, these staff can be re-activated as EFs later in other places, and are not lost to the system.

Evaluation activities

SSI data collection activities were conducted in 10 health facilities twice at the beginning and end of the project to measure the effectiveness and efficiency of project exercises. During data collection, the Quality Measurement Tool, Client Interview Form, and Health Statistics Form have been used. In addition to these, Focus Group Questions, another tool, developed for the focus group discussions with managers and service providers.

Achievements

Reliable tools: Through a rigorous design, Turkey now has locally relevant and applicable SRH quality assurance tools. A Self-Assessment Guide was adapted to the SRH Framework Document, 5 train-



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ing modules were prepared for priority intervention areas of RHP and a “Client Interview Form”, covering all questions about client’s rights was developed. The evaluation process led to changes in the tools, making SRH care more uniform and more reliable and sustainable in the project provinces and facilities.

Sustainable and tested quality management process: The Programme produced the following experiences and adaptations to the process used worldwide:

- 1 Integrating “SWOT” into problem assessment process,
- 2 Developing a (monthly, quarterly and annual) “SSI Evaluation Pack”,
- 3 Using clinical protocols and flow charts developed for intervention areas in SSI,
- 4 Developing an SSI External Facilitator Training Module,
- 5 Developing and piloting alternative durations for EF courses (5 and 7-days),
- 6 Developing a standard “Facility SSI Guide”, and
- 7 Integrating SSI into the quality oriented “Health Care Management Training” of RHP.

The SSI experience in Turkey has demonstrated that it is possible for quality management, adapted to local needs and priorities, to be incorporated into existing and possible new programmes of care at a cost and in a manner that allows quality services to be sustainable without further external inputs. The processes of quality management will not always be problem-free, but managers and staff now have an understanding of the process of maintaining quality standards.

System-wide ownership of quality: The quality issue is now embedded within the service. The Programme has demonstrated that a sensitive issue like quality assurance can be successfully tackled sector wide, and with early positive results. Based on these results, the MoH has decided to roll out the SSI exercise to all SRH facilities across the country. Moreover, the rapid roll-out of the quality management system has implications for health programmes beyond the remit of RHP.

Enabling performance management: The larger reform agenda in Turkey requires that health service managers work

towards both short-term and long-term results. The tools and processes within the SSI initiative mean that managers can work with service providers (and clients) in delivering more reliable and more efficient services throughout the country. The evaluation revealed that one year after the introduction of SSI, the following improvements were observed: 1. better team work, 2. more cost-effective resource utilization, 3. better problem identification and solving, 4. increased motivation, and 5. improved ownership of staff roles and responsibilities.

Valuing client and provider empowerment: Although initially some unease was created about centring the client within SRH services, the tools and processes have actually stimulated service managers and service providers to work on this. This is a value shift which has been achieved without displacing key managerial functions, and it is consistent with the wider sector reforms being promoted nationally. The shift towards a client focus is not just about clients’ rights, but also about more emphatically giving clients a ‘voice’. Clients now are realizing that they will be heard, and that services can become more responsive to their needs, but it also means increased client responsibilities.

Constraints

Inevitably there are some problems associated with the introduction and maintenance of any quality assurance system. The process requires time, new advocacy skills, fresh attitudes and a willingness to change established roles and practices. The Programme, however, encountered the usual and universal problems that have to do with management change (resistance from ‘late adopters’), conflicting priorities, and inadequate resources. Turkey also experiences persistent problems with staff mobility, which renders new skills acquisition frustratingly inefficient as staff moves away before new practices have been institutionalised. However, these are not insurmountable problems. They can be managed within the framework of management change and managers’ support. Staff enthusiasm is perhaps the key to achieving the results seen so far.

Conclusion

SSI is a service model that increases SRH service quality. In spite of some constraints in practice, SSI as a human oriented approach, proved to be useful for clients, providers and managers at all levels. However, it has been noticed that the SSI process should be supported by all managers for its efficient, effective and sustainable implementation. The MoH, in addition to showing its willingness to institutionalise SSI, has foreseen that it should be integrated within the facilities’ job descriptions and has decided to scale up SSI throughout the country, after some arrangements reflected both in EF training and practice and in the SSI process that have been ongoing in 7 provinces by the first half of 2007.

Recommended reading

EngenderHealth. COPE® Handbook: A Process for Improving Quality in Health Services, Revised Edition. 2003. <http://www.engenderhealth.org/res/offc/qi/cope/handbook/index.html>, (accessed 1 July 2004).

EngenderHealth. Self-Assessment Guide for Reproductive Health Services. 2003. http://www.engenderhealth.org/res/offc/qi/cope/toolbook/pdf/cope_toolbook_self_assess.pdf, (accessed 16 June 2004).

SSI reports and training manuals in this issue of *Entre Nous*

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In 30 years, three estimates of pregnancy-related mortality were used in Turkey but each had drawbacks. The Turkish National Maternal Mortality study (2005) established the MMR at 28.5 per 100,000 live births, but there are significant rural-urban and regional differences.

Most maternal deaths in Turkey are considered avoidable and closely linked to underlying socio-economic factors and equity issues. Reducing maternal mortality ratio (MMR) is one of the MDGs; yet it is a difficult indicator to monitor (1). Death underreporting is a countrywide problem. The medical and underlying socio-economic causes were not precisely known prior to 2005 and the robustness of the existing information was questionable. While registration of vital events is compulsory, the system is unsatisfactory.

For 30 years, information on MMR in Turkey was based on three estimates of pregnancy-related mortality. The national MMR was 208 per 100,000 live births for the 1974-75 period (2) and 132 in 1981 (3). The last of the 3 estimates comes from a hospital-based study conducted in 1998 by the Ministry of Health (MoH), which was an estimate of 49 pregnancy-related deaths per 100,000 live births (4). There were several drawbacks to these estimates. The first two were estimated through indirect methods and the latter one had the disadvantage of not covering all hospitals and home deliveries.

An up-to-date and accurate National Maternal Mortality Study (TurkeyN-MMS) was funded by the EU as part of the RHP. The study was undertaken by a consortium composed of Hacettepe University Institute of Population Studies (HUIPS), Icon Institute Public Sector (Germany) and BNB Consulting (Turkey)

(1).

The study was conducted between October 2004 and December 2006 and the objectives were to:

1. Determine MMR and ratios at the national level; for the 12 regions of the country and for urban and rural areas;
2. Identify medical causes and underlying socio-economic factors and specify high risk categories with regard to maternal conditions;
3. Contribute to an improved registration and reporting system for pregnancy related deaths;
4. Increase awareness of administrators and health personnel on the importance of collecting uniform and reliable information as a precondition to improve MMR

Several targeted approaches were used. A prospective maternal mortality field study was carried out; comparative analyses of existing recording and reporting systems were accomplished. A model-based estimation of maternal mortality indicators was made; and a qualitative study for understanding the problems related to the data collection system was carried out.

Prospective field study

The results of the 12 months prospective field study are presented for 29 provinces that were sampled by using a weighted, stratified probability sampling method. The study covers 54 percent of the total population. The Reproductive Age Mortality Study (RAMOS) (5) data collection method was used. Information on burials at cemeteries of all urban and rural settlements was collected by using primary informants (cemetery officials in urban areas and village/section headmen in rural areas). Then, information on the death of women aged 12-50 years was collected, using two methods. If death occurred in hospital, the health records of the deceased woman were reviewed and information was transferred to a "health facility form". If death occurred at home, a "verbal autopsy questionnaire" was applied to the closest relative/friend of the deceased woman in order to identify the

medical causes of death and underlying factors related to the community/family, health facility and health personnel.

First review of response data was done by two physicians, followed by an evaluation from an epidemiologist. Final decisions on the causes of death were reached by a "Central Review Committee" of relevant experts. Definitions of WHO/ICD-10 were used.

Outcomes

The two indices that are presented in this paper are the MMR (number of maternal deaths per 100,000 live births) and the lifetime risk of dying from a maternal cause (accumulated risk by the end of the reproductive period).

Table 1: MMR and Lifetime Risk (1 in ...) in Turkey

Region/ Urbanisation level	MMR	Life-time Risk
Turkey	28.5	1536
Urban	20.7	2391
Rural	40.3	869
Region		
Istanbul	11.0	4876
West Marmara	42.1	1560
Aegean	31.5	1764
East Marmara	21.7	2549
West Anatolia	7.4	6947
Mediterranean	25.1	1737
Central Anatolia	11.9	3067
West Black Sea	26.8	1956
East Black Sea	68.3	883
Northeast Anatolia	68.3	439
Central East Anatolia	36.9	755
South East Anatolia	38.9	626

The MMR for Turkey was 28.5 per 100,000 live births but there were sub-



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stantial residential and regional differences (Table 1). The lowest ratio was found in West Anatolia (7.4) and the highest ones in Northeast Anatolia and East Black Sea (68.3). A similar pattern in maternal mortality ratios was observed with regard to the lifetime risk of dying from maternal causes. The risk of maternal death in Turkey was 1 in 1536 women, but the risk in rural areas was 2.8 times higher than in urban areas.

The MMR differs strongly by age. The age structure of maternal deaths follows a J-shaped pattern. In line with the international trends, the oldest and very young women are high-risk groups. The lowest ratio was observed at 20-24 years (10.2) and the highest one at 45-49 years (146.7).

Medical causes of maternal deaths were classified and the direct causes in order of importance were: haemorrhage (24.9%), oedema, proteinuria and hypertensive disorders (18.4%), other specified direct causes (15.7%), unspecified direct causes (10.1%), pregnancy related infections (4.6%) and suicide (3.2%). Indirect causes were responsible for 21.2 percent of maternal deaths; about half were diseases of the circulatory system (47.8%), and 13 percent were malignancies.

With regard to the time of maternal death, 37% occurred during the ante-partum period, 9 % died at delivery and 54% in the post-partum period. Twenty one percent of maternal deaths were at home and about 8% died in an accident. Sixty percent of deaths occurred at secondary and tertiary level health facilities and 10.4 percent died on the way to one.

Four categories of avoidable factors (61.6%) contributing to all maternal deaths were:

1. Household and community factors - 36.2%,
2. Health service providers - 13.7 %
3. Health service supply factors - 2.1%.
4. Other risk factors - 9.6%.

Problems of the reporting system

In-depth interviews and focus groups were held with province project teams who were using the existing recording

system. They were in close contact with the people working in the mortality recording system. The qualitative study was revealing about social structure and process. For instance, the job descriptions of the persons responsible for registration and reporting of deaths needed a thorough review. The high turnover rate of personnel and their lack of interest in record-keeping and partial coverage of the causes of death are major problems. Another significant finding was lack of coordination and cooperation between health institutions and various government organizations.

Needed interventions

The national MMR in 2005 is lower than the earlier estimates but significant rural-urban and regional differences remain. Multidisciplinary and multi-sectoral prevention approaches are required in Turkey.

Household and community play an important role in avoiding maternal deaths. Health education, particularly in reproductive health is essential to change behaviour. Such education must start at an early school age and continue throughout life. Awareness in the community of maternal health must be increased, using different channels of communication. The MoH has the primary responsibility for both. Appropriate and evidence-based policies must be developed and applied. Planned parenthood, high quality antenatal, delivery and postnatal care at all health service levels must be provided in every region. Special programmes should be developed for high-risk regions and for rural and peri-urban areas and underprivileged high-risk groups.

Accurate, complete and continuous surveillance system for all vital events must be made operational. Furthermore the provision of high quality health services asks for special programmes on training, supervision and appropriate distribution of health personnel at all levels of the health care delivery system.

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5. Maternal Mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA. WHO, Geneva, 2004.

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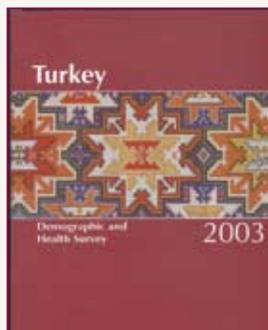
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SELECTED RHP PUBLICATIONS

Research and Symposium Publications



Turkey Demographic and Health Survey (TDHS - 2003) Hacettepe University, Ankara 2004

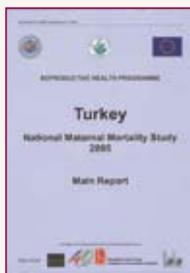
www.hips.hacettepe.edu.tr/tnsa2003eng/index.htm

Provides information on levels of fertility, mortality, marriage patterns, FP, maternal and child health, nutritional status of women and children, and reproductive health. Results are presented at the national level, by urban and rural residence, and for each of the five regions in the country. Based on interviews with 10,836 households and with 8,075 ever-married women of reproductive age.



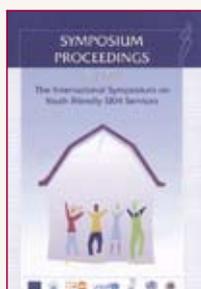
Operational Research on Key STI's and HIV in Turkey ICON-Institute, Hacettepe University, ITM Antwerp, Ankara 2005

The main objective of the research was to assist the development of a national second generation STI/HIV surveillance system. For this purpose the necessary tools and methodologies were developed and piloted in Ankara, Gaziantep, Istanbul, Izmir and Trabzon, targeting pregnant women as a proxy for the general population, and groups at increased risk in Ankara, Istanbul and Izmir.



National Maternal Mortality Study Hacettepe University, ICON-Institute, BNB, Ankara 2006

Looks into main causes of maternal death, avoidable factors, verifying high risk population groups. Presents recommendations for the improvement of existing vital registration system. Data was collected by using Reproductive Age Mortality Study (RAMOS) data collection approach. The Maternal Mortality Ratio for Turkey was 28.5 per 100,000 live births; 20.7 for urban and 40.3 for rural areas.



International Symposium on Youth Friendly SRH Services – Symposium Proceedings EPOS Health Consultants, Options, Willows Foundation, Ankara 2006

<http://www.gopa-group.com/prod/Documents.173.0.html>

This International Symposium was held in Ankara on 1-3 March 2006, under the leadership of the Ministry of Health, MCH/FP General Directorate, and in co-operation with ICC, UNFPA, UNICEF and WHO. The Symposium Proceedings provide a summary including opening speeches, presentations, reports of working groups and recommendations for improving SRH of young people.



Health Seeking Behaviour Study Conseil Santé, Sofreco, EDUSER, Ankara 2007

A qualitative study exploring health seeking behaviour related to pregnancy and child birth, revealing perceptions at individual, family and community level. It also looks at responsiveness of primary care and MCH/FP services and needed interventions to increase utilisation of antenatal and delivery care. Inattentiveness and bad treatment by health service personnel and inadequacy of services are important service barrier factors.



Training Manuals and Practical Guides

All publications are available in Turkish at: <http://sbu.saglik.gov.tr/tusp/index.asp> or <http://epos.eusrhp.org>

English versions are not available for all publications.

5 Training Modules on:



- Introduction to Reproductive Health
- Family Planning Counselling
- Safe Motherhood
- Sexually Transmitted Infections
- Youth Reproductive Health Services

These guides are developed for in-service trainings of service providers in primary health care.

Youth Pack, Including 3 Publications:



Sexual and Reproductive Health Training Module for Youth Counselling and Health Services Centres;



Management Guide for Youth Counselling and Health Service Centres, developed for the Provincial Health Directorates and managers of youth centres established by the MoH.



Outreach Guide for Youth Counselling and Health Service Centres, aiming to provide guidance in the planning and implementation of youth outreach activities.



Service Standards Implementation External Facilitators Training Module

These guides are developed to train facilitators who will first undertake and then coordinate implementation of the standards at health facility level. The term service standard is used to define decisions relating to service delivery and organization. Standards are used

as a criterion to describe basic and desired comparisons. These descriptions emphasize clients' rights and staff needs.

9 Pre-service Training Documents:



- Three SRH training curricula for the medical, nursing and midwifery fields.
- Each of these three curricula for pre-service education consists of:
- SRH Medicine Curriculum; SRH Midwifery Curriculum, SRH Nursing Curriculum
- SRH Evaluation Guide and SRH Learning Guide for Medical Education, Nursing Education & Midwifery Education.
- Framework for Monitoring and Evaluation.

Emergency Obstetric Care (EmOC) Pack, Including:



Emergency Obstetrics Care Clinician Training.

This training module was developed for EmOC in-service training for physicians, midwives, nurses, anaesthetists / anaesthesia technicians and "112" emergency care providers.

Manager Facilitator Orientation Training.

The aim of this module is to inform health care managers on the specificities of EmOC and ensure that they acquire necessary knowledge and skills to plan, implement, coordinate and monitor provincial activities.

Support Personnel Orientation Training.

The module is developed to train support staff in first aid / referral facilities about the main issues in the provision of EmOC services at their respective levels.

Reproductive Health Programme in Turkey: Programme Booklet and CD-ROM



The Programme Booklet is divided into three sections. The first section provides a summary overview of the Programme, explaining the need for reproductive health in Turkey, the choices made during its implementation, the approach taken and the main activities and results to date. The second section is an annotated bibliography of publications, tools and resources produced under the Programme. The third section comprises a list of the large number of contributors to the RHP. The Booklet is accompanied by a CD-ROM, which contains all the publications mentioned in section two of the Booklet as electronic pdf-files. With the Booklet and the corresponding CD-ROM the Programme aims to share and disseminate the knowledge created during its 5 years of implementation as widely as possible.

Entre Nous

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