

Pathways to Contraceptive Security Workshop Report

By

POLICY Project

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Acknowledgment

The workshop, *Pathways to Contraceptive Security*, October 31–November 1, 2002, in Konya, Turkey, was organized by the Ministry of Health General Directorate of Maternal and Child Health and Family Planning (GD MCH/FP) and the POLICY Project. Many organizations and professionals contributed not only to this workshop but also to previous policy analysis and dialogue initiatives that have guided the National Family Planning Program in Turkey to achieve contraceptive self-reliance. The workshop embodied the strategic thinking that drives the National Family Planning Program and reflected the visions of the many policy champions, planners, and service providers who share responsibility for public health in Turkey.

In particular, leaders within the GD MCH/FP deserve broad recognition for their dedication, namely: Dr. Rifat Köse, General Director; Mr. Ugur Aytac, Deputy General Director; Dr. Ibrahim Acikalin, Head of the Maternal Health and Family Planning Department; and Mr. Abdulhadi Atac, Budget Unit Head. The workshop was enriched by the active participation and the sharing of knowledge and experiences across leaders from 18 provincial health directorates and among public, NGO, and private commercial groups. Special appreciation also goes to Dr. Cigdem Bumin and Dr. Hakan Satirgoglu from Ankara University Medical School, who co-chaired the two-day event. Several experts made notable contributions and delivered informative presentations that provided the basis for fruitful and thought-provoking discussions about addressing unmet need, examining traditional method use, and identifying pathways to contraceptive security in Turkey. In order of presentation, the experts included Dr. Zerrin Baser, POLICY Country Director; Dr. Rifat Köse, Deputy Under Secretary and General Director of MOH/MCH/FP; Dr. Nese Nohutçu, MCH/FP Division Head, Izmir Province; Mr. Ugur Aytac, Deputy Director MOH/MCH/FP; and Dr. Fahreddin Tatar, Pfizer Health Policy Manager. The workgroup discussions were well guided by two professionally trained facilitators, Mr. Cevdet Yilmaz and Mr. Kemal Medenoglu from the State Planning Organization, who so ably facilitated the sessions ensuring each participant's voice was heard. We also acknowledge the contributions of Ms. Maureen Clyde and Dr. Jeffrey Sine, POLICY Project staff, who participated in planning and conducting this workshop. The administrative support provided by POLICY staff Mrs. Nurgan Giray and Ms. Ozlem Isli as well as the services provided by Adim Travel Agency were invaluable for making the workshop a productive and comfortable environment.

We are indebted to the many other collaborators who gave so generously of their time to participate in the workshop and brought with them years of experience in helping to illuminate new pathways. These collaborating organizations included local branches of the Health and Social Aid Foundation, UNICEF, Family Planning Association of Turkey, and Hacettepi School of Public Health, as well as the commercial pharmaceutical companies of Shering, Organon, Pfizer, and Tataroglu. The multisectoral, participatory approach to policy dialogue and strategic planning has served the Turkish Family Planning Program well. The success of the program is rooted in the dedication and commitment of many people and institutions that share a common pride in serving the common social good.

Pathways to Contraceptive Security Workshop Report

I. Workshop Objectives and Rationale

The Turkish Ministry of Health (MOH) and the POLICY Project conducted a national workshop, *Pathways to Contraceptive Security*, October 31 and November 1, 2001, in Konya, Turkey. Forty-four policymakers and leaders from the health sector participated, including representatives from the central MOH's General Directorate for Maternal and Child Health/Family Planning (GD MCH/FP), provincial health directorates (PHDs), local branches of the Health and Social Aid Foundation (HSAF), nongovernmental organizations (NGOs), and the commercial pharmaceutical industry. Participants convened to

- Review progress to date toward achieving contraceptive self-reliance (CSR) and identify challenges for completing the process; and
- Identify challenges for transitioning from self-reliance to contraceptive security (CS) and establish strategies and responsibilities to complete the transition.

This national workshop marked the end of nearly seven years of collaboration between the GD MCH/FP and the POLICY Project, during which time the primary focus was achieving CSR objectives in the face of donor phaseout. On the eve of POLICY's conclusion in Turkey, the GD MCH/FP leadership recognized the need to look beyond CSR by maintaining the status quo of the national FP program to planning how to achieve CS. In Turkey, achieving CS means fully addressing the unmet needs for FP countrywide through a multisectoral approach involving the commercial, NGO, and public sectors. Hence, *Pathways to Contraceptive Security* was designed to provide an opportunity to document the process of achieving CSR and to clarify a vision of the future; to build bridges toward a new focus on CS program needs; and perhaps most importantly to provide a first-ever opportunity to incorporate PHD leaders from around the country into policy dialogue and planning processes (see Appendix A: Workshop Agenda and Participant List).

II. Summary of Workshop Sessions

Day 1: Contraceptive Self-reliance

A. Overview of CSR Accomplishments and Identification of Challenges

Day 1 of the workshop focused on a review of progress toward achieving CSR, documenting the challenges ahead to maintain progress made, prioritizing the importance of challenges identified, and strategizing to address priority challenges. A panel of four experts presented the progress and challenges according to four broad topics: CRS strategy overview, public sector budgeting and spending, field perspective on donation policy implementation, and

performance and use of the monitoring and evaluation system. Below is a synopsis of each panelist's presentations

Dr. Zerrin Baser, POLICY Project Country Director, provided an overview of the national CSR strategy after summarizing the progress toward CSR in Turkey in the past five to six years:

- Resources required to procure an adequate supply of contraceptive commodities for the public sector program are from central government budget allocations to the GD MCH/FP's line item 400 and from the GD MCH/FP's donation policy, whereby public sector clients who are able to pay for contraceptives make a voluntary donation to the HSAF.
- The donation policy is operational in 18 of Turkey's most populous provinces, covering 35 million of the total population.

Dr. Rifat Köse, General Director, GD MCH/FP, made a presentation on public sector budgeting and spending:

- Allocations from the central treasury for contraceptive commodities are made to the GD MCH/FP budget line item 400. In budget year 2002, the amount allocated to this line item was US\$ 4.8 million, of which about US\$2.5 million was intended for contraceptive procurement. This will permit about 80 percent of the public sector program's need for contraceptive commodities to be purchased from this line item, an increase from 10 percent of the program's need in 1997.
- In 1997, spending for contraceptives from the line item 400 allocation was about US\$500,000, increasing to US\$2 million in 2000. Due to an economic crisis, spending for contraceptives declined to US\$1 million in 2001, rebounding to about US\$1.9 million in 2002.
- Procurements are generally completed at the central level. However, when administratively necessary funds are released to PHDs for local procurement, unit prices obtained by PHDs are higher than unit prices obtained by larger procurements made by the central GD MCH/FP by a factor of three times or more.
- Current MOH contraceptive stock levels are 11 months for condoms, 13 months for oral contraceptives (OCs), and 10 months for IUDs.
- The donation policy contributed 15 percent of the resources needed to procure contraceptives for the public sector program. In 2002, this is expected to increase to 25 percent. The GD MCH/FP's objective is to increase this proportion to 35 percent by 2005, which will close the gap between funds needed to fully supply the public sector contraceptive pipeline and funds allocated from the central treasury. Advantages to spending from donation revenue include more flexibility, a less bureaucratic process, and lower transaction costs to vendors.

Dr. Nese Nohutçu, Director of MCH/FP, Izmir PHD, provided a field perspective on donation policy implementation:

- Implementation of the policy has not resulted in any deleterious effect on the volume of FP services provided. Demand for OCs appears to be increasing, despite implementation of the policy. Demand for condoms and IUDs is undergoing a small decline; however, its relationship to the donation policy has not been established.

- In exchange for their donation, some clients request a greater volume of commodities (e.g., more cycles of pills or more condoms) than are typically provided during one resupply visit.
- Some civil servants have been requesting that they be exempted from making donations, even though they are able to donate. Staff at some clinics are more lenient on this issue than others, resulting in some unevenness in the application of the policy's guidelines and undermining the policy's intentions.
- Staff at some clinics have expressed a desire to set their own donation levels rather than follow the nationally set guidelines.
- Proper orientation is key to successful implementation of the donation policy at the service delivery level. Proper orientation reduces the incidence of issues noted above (e.g., exempting civil servants and failure to follow donation-level guidelines).
- In some clinics, staff are not comfortable holding receipts and donation revenue and local adjustments to operational guidelines have been required.
- The proportion of clients making the full donation increased from 50 percent in 2001 to 60 percent in 2002.
- The monitoring and evaluation (M&E) system established for the donation policy has been helpful in identifying health centers that are having implementation problems. It has also given the program a better tool to track demand for FP services and has strengthened working relationships within the PHD and among other public and NGO organizations.
- Local universities have been critical of the donation policy, and the health directorate has found it difficult to respond adequately to these criticisms.
- There is a looming shortage of OCs, and to a lesser extent, condoms. It appears that the problem lies in the logistics supply system. There is concern that stockouts will undermine clients' support for the donation policy, as the message given to clients when requesting a donation is that by doing so, they are helping to ensure a steady supply is available.
- Izmir has just recently initiated its first procurement using donation revenue; it is too early to speak about outcomes.

Mr. Ugur Aytaç, Deputy General Director, MOH/MCH/FP, spoke about performance and use of the M&E system:

- The M&E system allows the monitoring of the donation policy at both the province and national levels. Both levels of monitoring are important. This system assists in helping to understand the client base better than ever before.
- Donation revenue is compared across provinces. For IUDs, across the provinces where the donation policy is operational, 61 percent of clients make the full donation, 11 percent make a partial donation, and 28 percent are exempted. The highest exemption level occurs in Antalya (about 40 percent). The lowest exemption level occurs in Trabzon (about 18 percent).
- For OCs, exemption levels across provinces range from 24 to 48 percent.
- Fifty-eight percent of condom clients make the full donation, 6 percent make a partial donation, and 36 percent are exempted.

- Across all methods, nearly two-thirds of clients are willing to make a donation for their contraceptives. Fifty-seven percent of all clients make the full donation, 10 percent make a partial donation, and 33 percent are exempted.
- Total donation revenues are increasing quickly. In 2001, it was TL 108 billion (US\$68,000), and so far in 2002 it has been TL 230 billion (US\$144,000).

Dr. Fahreddin Tatar, Pfizer Health Policy Manager, summarized challenges described by the panelists and added additional challenges to the list. These sessions set the stage for afternoon workgroups when challenges were prioritized and strategies to address them were outlined. Box 1 summarizes challenges identified during the Day 1 morning session. The top three priority challenges, as designated by the workgroups, are highlighted in bold font.

Box 1
Challenges to Contraceptive Self-reliance in Turkey

Public Sector Budgeting & Spending	Donation Policy Implementation	Monitoring and Evaluation	Management of Donation Revenue
<ul style="list-style-type: none"> • Maintain central budget allocations to MCH/FP line item 400 at least at its current level. • Maximize purchasing power for both budget and donation revenue resources by using central procurement as much as possible. • Conduct timely central procurement to ensure that all funds allocated to the GD MCH/FP for contraceptives are spent. • Overcome budget shortfalls during periods of public budget crises, such as experienced in 2001. • Develop better mechanisms to pool donation revenue at the central level. • Increase cushion stock levels for each contraceptive commodity type back to an 18 month supply. 	<ul style="list-style-type: none"> • Establish an ongoing orientation program to accommodate provincial staff turnover. • Standardize and ensure consistent implementation of major aspects of the policy according to the national guidelines. • Communicate national CSR strategy to provincial health and nonhealth leaders and other important national and provincial stakeholders. • Expand implementation to all non-GAP provinces. • Allocate sufficient financial and human resources for expansion activities. • Allow for local flexibility on implementation of some operational details. • Establish active communication channels between field staff and central management. 	<ul style="list-style-type: none"> • Ensure integrity of the M&E system chain of communication. • Implement retraining programs for the M&E system to ensure continuity of the system through provincial staff turnover. • Integrate M&E information into policy and program management decision making. • Institutionalize use of the M&E system at both central and provincial levels to maintain awareness about changes to the public sector client base. • Ascertain demand effects of the policy and distinguish those from other factors that influence demand services. • Expand the national health and population research agenda to explore new and emerging issues about self-reliance and contraceptive security. 	<ul style="list-style-type: none"> • Centralize donation revenue so that procurement results in maximum buying power. • Ensure transparency in procurement process using donation revenue. • Standardize procurement processes, especially those currently occurring at provincial HSAF branches. • Define role of central HSAF in donation revenue management and spending. • Institutionalize a mechanism for spending foundation donation revenue for contraceptives. • Conduct trial procurement process using donation revenue. • Adjust national, regional, and local logistics mechanisms to account for how foundation-purchased commodities are distributed to MOH warehouses and points of service.

Box 1
Challenges to Contraceptive Self-reliance in Turkey (cont)

Public Sector Budgeting & Spending	Donation Policy Implementation	Monitoring and Evaluation	Management of Donation Revenue
	<ul style="list-style-type: none"> • Assist PHDs in responding to criticism about the policy, particularly criticism from influential sources such as universities. • Develop a systematic and consistent approach to provincial procurement, one that reduces the high unit cost currently being experienced in many provinces that have completed contraceptive procurement. • Ensure consistent and adequate stock flows to provinces in order that support for the donation policy at the clinic level is maintained. • Adjust policies and donation levels as needed to reflect changes in consumer donation patterns, wholesale prices for commodities, and changes in MOH's client base. • Ensure there is no conflict between the donation policy and official policy that public sector FP services are to be provided free-of-charge. 	<ul style="list-style-type: none"> • Document behavior of former MOH FP clients who stopped using MOH FP services after implementation of donation policy. • Monitor changes in donation patterns and estimate expected impact on revenue collection. • Assess impact of the donation policy on private sector FP services. 	<ul style="list-style-type: none"> • Maintain the flexibility of the current donation policy (i.e., money can be spent at either provincial level or national level, no time constraint, funds are not co-mingled or tied to other funds, unlike the revolving drug fund) • Increase the amount of money collected through the donation policy to the 35 percent goal.

B. Summary of Day 1 Morning Plenary Discussion

Participants discussed how to handle criticism about the donation policy coming from local universities. While the donation policy has successfully garnered support among public sector FP clients and health staff, little effort has been made to explain the FP program dilemma to a wider group of stakeholders. Participants agreed that the donation policy has resulted in an increased perception of the value of FP services among clients. Participants also agreed that a targeted campaign is necessary to explain the FP program dilemma to influential university leaders and political leaders at national and provincial levels.

Participants broadly agreed that provincial contraceptive procurement systems need to be systematized. Lack of guidelines and assistance has resulted in highly variable unit costs obtained across provinces during procurement processes. It was generally felt that greater central guidance would improve the efficiency of procurement processes and help provinces obtain more favorable unit prices from vendors.

Some provincial participants expressed discomfort in asking clients to make donations for contraceptive commodities dispensed to them. Dr. Rifat Köse responded by stating that political choices made at the most senior levels of government in Turkey necessitate the donation policy. Financing contraceptive commodities for the public sector program is neither a budget priority nor a priority for coverage in health insurance plans. Since the MOH is obligated to purchase contraceptives, it is therefore required to identify funds from other sources. Participants were asked for their ideas about how funds could be mobilized, while keeping in mind that there are still substantial underserved populations in Turkey with needs for subsidized FP services. Ideas were solicited on how the FP program could be expanded to serve these groups without funds being raised through the donation policy. Dr. Köse stated that the maintenance of a strong public sector program in light of national political priorities requires that such a donation policy be put in place. This discussion suggests a need for continued dialogue and awareness raising between the central level, where policymakers and program managers have been coming to grips with these difficult choices during an eight-year period, and provincial health sector leaders for whom these issues are relatively new.

There was some discussion about revolving health funds that are being put in place in provinces to finance certain recurrent expenditure needs. Some participants suggested that tapping these funds might be an alternative to the donation policy as a source of funds for contraceptive procurement. This suggestion was made in recognition of persistent problems with spending donation revenue through HSAF provincial branches. It was noted that there are also bureaucratic problems with the revolving funds and that using these funds would not result in lower unit prices for contraceptives. Participants agreed that it is better to stay with the donation policy and work out problems with this new system rather than to switch to another new system, which is not designed with the FP program needs in mind.

C. Day 1 Workgroup Outcomes

Four workgroups were formed to prioritize challenges to the national CSR strategy and to outline strategies to address high priority challenges. Priority challenges are listed for each

workgroup in bold font in Box 1 (above). Descriptions of these challenges and strategy recommendations for priority challenges are listed below. (See Appendix B: Draft Notes on Day 1 Workgroup Proceedings.)

Workgroup 1: Public Budget and Spending

Priority Challenge 1: Maintain central budget allocations to MCH/FP line item 400 at least at its current level

- Members of Workgroup 1 felt that inadequate awareness about the importance of preventive programs in general and the FP program in particular contributes to the low priority placed on these programs. Thus, they recommended that an advocacy strategy be developed to inform decision makers about FP program needs. They also recommended that the proportion of FP users who live near or below the poverty line be established and that this information be used in an advocacy strategy to encourage greater budget support.
- The members suggested that GD MCH/FP investigate ways to make more efficient use of its existing resources in order that more can be set aside for contraceptive procurement.
- They recommended that GD MCH/FP reexamine the option of creating a separate line item for contraceptive commodities under line item 400, to make it transparent of how much is being allocated for contraceptive procurement. It was noted that there are both potential benefits and risks to the separate line item approach.
- The MOH currently serves substantial numbers of clients who are Social Security Institute (SSK) beneficiaries and public servants. Thus, the members recommended that means be identified to encourage institutions charged with providing health care benefits to cover FP services and commodities as well.

Priority Challenge 2: Maximize purchasing power for both budget and donation revenue resources by using central procurement as much as possible

- Provincial procurements pay a much higher unit price for contraceptives compared to larger volume central procurements, thereby reducing the total quantity of commodities available to the program. The workgroup recommended that central budget funds be used as much as possible for bulk procurements and that the amount of money directed to PHDs for contraceptive procurement be minimized.
- They noted that budget funds are directed to PHDs when the central GD MCH/FP is unable to initiate procurements in time to meet end-of-year spending restrictions. Noting also that the GD is constrained by the timing of the release of budgeted funds from the treasury, the workgroup recommended that, to the extent possible, large procurements be initiated as early in the year as possible.
- They also noted other bureaucratic delays in the procurement process and suggested that agreements be sought to reduce these delays.
- The workgroup also recommended that agreements be made with the private sector to offer the same unit prices to PHDs as they offer to the GD MCH/FP for contraceptive procurement.

Workgroup 2: Donation Policy Implementation

Priority Challenge: Establish an ongoing orientation and training program

- It was noted that turnover at PHDs and health care facilities is significant. Workgroup 2 members recommended that a program be established to accommodate orientation for new staff that will have a role to play in donation policy implementation and to retrain existing staff as needed.
- Members also recommended that provincial training teams be established and given primary responsibility to conduct orientation for new staff and retraining of existing staff.
- They recommended that training material should emphasize the importance of FP, the importance of the donation policy to sustenance of FP services, operational policies and procedures of the donation policy, and communication skills for staff who interface with clients. In addition, they recommended that at least one manager be present at all training sessions conducted, and that manager be selected based on his/her having had prior management experience.
- The workgroup suggested that inter-province workgroups be established to manage deployment of training teams and monitor results of training activities.
- They also noted that proper orientation and training will motivate staff to implement the donation policy properly, with the expected outcome that donation revenue collection will be increased.

Workgroup 3: M&E System

Priority Challenge 1: Ensure integrity of the M&E system chain of communication

- A recommendation was made that all forms in the current system be reviewed to ensure that all necessary M&E information is being captured and that forms be revised as necessary.
- Currently, donation receipt booklets and forms are not transferred from health care facilities until an entire booklet has been used. For facilities with low volumes of FP clients, more than one month may elapse before a booklet is completely used. This results in less than monthly reporting. Workgroup members recommend that monthly reporting be required of all participating facilities, even if an entire receipt booklet has not been used in a given month.
- Better feedback mechanisms between M&E managers are needed at the central GD MCH/FP, provincial HSAF branches, and health care facilities. Adequate and constructive feedback will improve motivation of staff at health care facilities, will improve effectiveness of implementation of the donation policy, and could result in increased donation revenue collection. Members recommended that a feedback report include information that would allow facilities and provinces to compare their performance against other facilities and provinces.
- They also recommended that the proportion of donation revenue retained at health care facilities be increased.

Priority Challenge 2: Implement retraining programs for the M&E system to ensure continuity of the system through provincial staff turnover

- Workgroup members recommended that training teams be established at health units and that these teams also be responsible for M&E activities at units. Teams should be established at each level in the system, including the central GD MCH/FP, PHDs, and health care facilities.
- Training should be made available to M&E team members.
- Sufficient resources need to be made available in order that M&E team members can make necessary visits to health care facilities.

Workgroup 4: Donation Revenue Management

Priority Challenge: Centralize donation revenue in order that that procurement results in maximum buying power

- This workgroup's recommendations were similar to those of workgroup 1 with regard to promoting procurement advantages to large, central procurements over smaller provincial procurements. In this case, workgroup members recommended that HSAF establish a mechanism to centralize donation revenue from province HSAF branches in order that central procurements can be conducted. Such a mechanism will need to specify individuals/positions within the HSAF organization that will be responsible for each component of managing the transfer of funds from province branches and for implementing procurement processes.
- Workgroup members also recommended that central HSAF and MOH develop a joint protocol for using donation revenue.
- They recommended that HSAF conduct twice a year procurements using donation revenue and that they seek provincial input prior to initiating each procurement.
- They further recommended that HSAF establish an auditing board to oversee use of donation revenue.

Day 2: Contraceptive Security

A. Overview and Plenary Discussion of CS Issues

Dr. Fahreddin Tatar opened the session on CS with a presentation entitled *From Self-reliance to CS: Challenges Ahead for completing Turkey's Successful Transition*. (See Appendix C: From Self-reliance to Contraceptive Security). In his presentation, Dr. Tatar first distinguished between CSR and CS:

- **Contraceptive self-reliance** is the national assumption of responsibility for the FP program. This has been a clear and widely recognized success in Turkey.
- **Contraceptive security** is a program condition whereby all who want and need contraceptives have access to them, including those who want FP but are not yet employing it. It was noted that few countries have achieved this state.

Two general groups of potential modern FP method users who are not currently being served by the national FP program are traditional method users (mostly withdrawal users) and

those with an unmet need for FP (not wanting a child at this time but currently not using any FP method). According to the Turkish Demographic and Health Survey, conducted in 2000, traditional method users comprise 26 percent of all married women of reproductive age (MWRA) or 3.1 million women in Turkey. Another 10 percent of MWRA (1.2 million women) have an unmet need for FP. It is estimated that an additional US\$1.5 million would be needed to procure the contraceptives required to serve new modern method users who would likely seek services from public sector providers, 35 percent more than MOH's estimated current annual need to finance contraceptive commodities. The presentation concluded by posing the following two questions:

- What groups should be targeted first to expand the national FP program on the road to CS?
- What strategies would be most appropriate to successfully integrate priority target groups into the national program?

B. Summary of Day 2 Morning Plenary Discussion

A plenary discussion of the presentation followed. There was considerable debate about whether a sufficiently strategic approach had been taken with respect to encouraging traditional method users to switch to a modern FP method. Some participants believed that among certain groups in Turkey, the choice of traditional methods is deeply entrenched and that past efforts have not succeeded in changing this choice. Some expressed the opinion that traditional method use is a well-conceived choice among some users and that efforts to encourage switching to a modern method should focus on groups for whom the choice of a traditional method was made without adequate information or access to modern method services, such as rural users. Other participants, representing the prevailing opinion, stated that no systematic strategy has ever been implemented to address withdrawal users. They noted that since so much of abortion demand is driven by failure of withdrawal to prevent unwanted pregnancies, a compelling case is easily made to develop a concerted strategy. Some felt that education should be a key component of a strategy. Additional rationales for developing a systematic campaign to encourage switching to modern methods were stated as follows: (1) urbanization and education levels are increasing in Turkey; (2) people are initiating sexual behavior at an earlier age; and (3) STDs are an increasing problem. It was suggested that consideration of CS issues, such as encouraging more modern method use, should be done within the broader context of the reproductive health agenda.

There was a similarly adamant discussion about unmet need. Some participants expressed the opinion that adolescents and young adults are a key subgroup among people with an unmet need for FP. There was also a call for a more rigorous, systematic analysis of different subgroups of women with unmet need and what it is that they need. Participants felt that education would be a key tool to address unmet need and that effort should be made to link with the Ministry of Education to develop an educational approach. One participant expressed the opinion that the concept of FP should be transformed into a concept of healthy sexuality, one which gives Turkish women a greater say in matters related to their sexuality.

Service delivery issues were discussed from the perspective of their potential contribution to CS. Insufficient numbers of midwives and nurses in some places limits the consultation time

providers can spend with clients, decreasing the amount of information clients obtain during the encounter. An inadequate supply of staff also inhibits their ability to conduct home visits where they would be able to identify and work with women who do not attend FP clinics.

Continuity of contraceptive supplies was another issue discussed. In order to ensure that contraceptives are available each time a client seeks them at health care facilities, the MOH will need to procure considerably more contraceptives than is presently the case. Current resources are barely ensuring such continuity for the MOH's current FP client base; they are not sufficient if that client base expands to accommodate traditional method users who switch to modern methods or women with unmet need who become new clients. One participant called for development of a financial as well as technical strategy to expand FP services to underserved groups.

One participant cautioned about interpreting the fact that 40 percent of women with an unmet need who say they do not use an FP method because they consider themselves to be low risk of becoming pregnant. She cautioned that while this may be the woman's self-perception, it may not be medically true. She also pointed out what is described as a contradiction in Turkey's funding priorities for the health sector. While policymakers have failed to allocate sufficient funds to purchase the contraceptives needed to fulfill demand in public sector health care facilities, abortions are heavily subsidized.

A private sector representative estimated that to serve all FP needs in Turkey would require US\$80 million. He noted a pervasive contradiction, however, which is particularly evident in the SSK health care system. Contraceptives are not provided or reimbursed at anything near the needs of their beneficiaries. Yet these policies result in considerably higher expenses for pregnancy care, abortion, childbirth, and health care for children than would otherwise be the case if FP services were provided or reimbursed. He noted that a similar contradiction exists with immunizations, which are generally not covered, and care for childhood diseases, which if covered.

C. Day 2 Workgroup Outcomes

On Day 2, workgroup sessions occurred in two segments. The first segment occurred in the morning after the plenary discussion of CS issues. Two workgroups were formed, one which considered target groups among traditional method users and the other which considered possible target groups of women with an unmet need for FP. Each group was charged with identifying subgroups in their topic area, determining criteria to rank these groups, and designating their priority status. High-priority status was meant to reflect the need to develop strategies to encourage that group to become modern method users (traditional method user workgroup) or to begin using a FP method (unmet need workgroup). A second workgroup session was conducted in the afternoon and workgroup members were asked to consider strategies to address the FP needs of high-priority target groups identified in the morning workgroup sessions. Box 2 summarizes the subgroups identified and shows those subgroups that were considered to be of high priority.

Box 2
Possible Target Groups for FP Program Expansion in Turkey

	Traditional Method Users	Women with Unmet Need
Priority Target Groups	<ul style="list-style-type: none"> • Adolescents and young adults ages 15–29 • Abortion clients who experienced method failure • Adults with low educational attainment (rural and urban) 	<ul style="list-style-type: none"> • Adolescents and young adults • Men (partners of women with an unmet need) • Rural residents
Other Subgroups	<ul style="list-style-type: none"> • Urban slum residents • Low SES urban residents • Primary school graduates in urban areas • Users without social insurance • Users in rural, eastern areas • High SES users • Users with high educational attainment • Users who want no more children • Users who switch between traditional and modern methods • Modern method discontinuers • Users being seen at a health center for reasons other than FP • Adults ages 30–39 	<ul style="list-style-type: none"> • Women without social insurance • Women with low educational attainment • Women in eastern and southeastern provinces • Women with poor knowledge of FP methods • Women closest to health facilities • Newlyweds • Women with more than three children • Groups opposed to FP • Sexually active single women

Workgroups presented strategy outlines for creating demand for modern FP methods (traditional method users) or for creating demand for use of any FP method (women with an unmet need). These are summarized below.

Workgroup 1: Traditional Method Users

Priority Target Group 1: Adolescents and young adults ages 15–29

- Young people were considered a high-priority target group because they may be more easily persuaded to change attitudes and behavior and because they are more likely to be members of social groups that are more easily reached, such as schools.
- Men in military service and couples applying for marriage registration were mentioned as particular subgroups worthy of special attention.
- Information and education was recommended as a key strategy to create demand for modern FP methods, targeting venues such as schools (especially universities), health centers, NGO youth centers, marriage counseling centers, Internet cafes, hotlines, and mass media.

- Workgroup members recommended that a comprehensive training about healthy sexuality be developed.
- The workgroup recommended that broader service delivery options be considered, including nontraditional sites such as adolescent clinics (which should be expanded nationwide), schools, youth centers and youth camps, services sites for the armed forces, workplaces, and Ministry of National Education (MoNE) clinics to supplement more traditional sites, such as primary health care facilities and hospitals.
- Service delivery strategies should also incorporate education through peers and through new technologies such as Internet websites popular with young people.

Priority Target Group 2: Abortion clients who experienced method failure

- Workgroup members believed that abortion clients who were traditional method users could be easily encouraged to switch to a modern method through adequate education and counseling by health care providers. They recommended that health care staff who perform abortions be better trained about the importance of modern method FP use and in effective client education and counseling.
- A broad-based provider education program was recommended, targeting students, staff, and faculties of medicine at universities, vocational colleges, and high schools where future health care staff are trained and there are residency programs, postgraduate in-service training programs, medical associations, and PHDs.
- Encouraging NGOs to participate in education and counseling was also a recommended strategy to generate demand for modern FP methods among abortion clients who were traditional method users at the time they became pregnant.
- Other avenues that could be used for messages to encourage modern method use among traditional users are clergy, media, the private sector, and NGOs.
- Workgroup members also recommended that husbands be required to witness their wives' abortion as a means of encouraging use of a modern FP method in the future.

Workgroup 2: Women with an Unmet Need for FP

Priority Target Group 1: Adolescents and young adults

- Strategies for generating demand for FP and for service delivery were similar to those proposed by workgroup 1. Education was recommended as key to a strategy to encourage those with an unmet need for FP to begin using a method. Target locations for education initiatives included schools, health care facilities, marriage counseling centers, the media, and hotlines.
- It was recommended that educational initiatives be implemented in partnership with universities and municipalities. Members also recommended that special training teams for adolescents be established in PHDs.
- They recommended that premarital medical reports be required to stipulate that the couple has received FP counseling.
- They recommended that FP methods be covered under Mediko-Sosyal, a health insurance plan available to students.
- Establishment of special adolescent units should be a priority in primary care facilities.

Priority Target Group 2: Men (partners of women with an unmet need)

- Strategies recommended by the workgroup to generate demand for FP methods among male partners of women with an unmet need included improved counseling during premarital medical workup; improved reproductive health education in schools (including high schools, vocational schools, and apprenticeship schools); and education about FP during military service, in correctional institutions, at professional chambers, in the workplace.
- The workgroup recommended that male health workers be trained in methods that would help them to reach male clients, specifically targeting misperceptions about religious prohibitions against FP.
- They called for additional activities to inform the clergy, community leaders (such as village administrators and teachers), parliamentarians, local administrators, media managers, academicians, and Ob–Gyn physicians. Once well informed, these leaders can be solicited for support in efforts to reach other men.
- The workgroup called for greater effort to provide education and counseling to men during prenatal care visits by their wives, during delivery or abortion, and during postnatal care visits.

Participants discussed these target groups and strategies. It was noted that the strategies suggested by the workgroups need considerably more planning. They also expressed concern about the ability to mobilize adequate resources to implement these strategies.

III. Concluding Perspectives

Contraceptive Self-reliance

The workshop, *Pathways to Contraceptive Security*, sought and helped to clarify remaining tasks required to solidify Turkey's transition to self-reliance of its national FP program in the aftermath of three decades of heavy donor support. Much of the effort during the seven-year transition to CSR has been focused on maintaining the national program; that is, not losing ground. By any measure, these efforts have been successful. The workshop also sought to lay the foundation for the work ahead as Turkey strives to meet the need for FP among women and men who are currently either underserved or beyond the reach of the current program. These efforts will move Turkey toward CS. (For participant's evaluation of the workshop, see Appendix E: Workshop Evaluation Results.)

Key issues emerged on both CSR and CS fronts. Sustainability of public sector budget allocations to MOH for contraceptive procurement emerged as a concern of the highest order. While budget funds allocated to date have prevented major supply interruptions in MOH/FP services, it was noted that these funds are not sufficient to meet all the MOH needs for contraceptive procurement for its current client base. They are clearly not going to be sufficient to reach the many more women and men who need FP services; however, for one reason or another, they have yet to access them. Raising the level of priority of FP services within the scope of government programs remains an important challenge.

Workshop participants noted that allocation of budget funds is insufficient to ensure adequate contraceptive supplies. The MOH has experienced difficulties in obtaining and spending those funds, and these issues were also of great concern. Seeking earlier release of a larger percentage of MOH's annual allocation for commodity procurement and reducing bureaucratic delays in the procurement process will help to improve the proportion of allocated funds that are actually spent for contraceptives. Ensuring that a greater proportion of allocated budget funds are spent on large, central procurement will also help minimize the proportion of funds directed to PHDs for local procurement, a process that results in considerable loss of purchasing power.

Much consideration was given to the MOH's new donation policy for FP commodities. This policy, whereby clients who can afford it make a voluntary donation to the HSAF branch in return for the contraceptives they receive for free from MOH clinics, is critical to closing the gap between the resources the MOH needs for contraceptive supplies and the money allocated by the government. Participants noted broad support for this policy both among health care providers and among clients. Some perceive an added value in that donations appear to have increased the sense of value some FP clients place on FP services. The policy is now in place in 18 provinces, covering about 70 percent of the national population, and it will continue to be expanded until it includes all provinces outside the 25 GAP provinces.

The monitoring and evaluation system in place to monitor implementation is working well, providing both central and provincial program managers, planners, and policymakers with better information about MOH's clients than they have ever had before. Greater concern was expressed about tracking and reporting donation revenue, and participants called for a second look at the forms and operating procedures. Other important concerns about the donation policy regard the ability of the MOH to mobilize the resources required to complete the expansion process and maintain monitoring efforts, including assistance to province and facility staff, on an ongoing basis. An additional concern was raised with respect to spending donation revenue. Participants urged MOH and HSAF managers to define mechanisms to centralize donation revenue in order that larger volume procurements can be conducted, thus reducing unit costs and increasing the amount of goods procured.

Contraceptive Security

While participants lauded their collective success in leading Turkey from donor dependence to self-reliance, they clearly recognized that much greater effort is required to broaden the program's reach. Until all women and men who need and want FP goods and services receive them, the goal of CS will not be attained. Two major groups remain underserved: traditional method users and women with an unmet need for FP, comprising more than four million MWRA in the country and possibly more if the needs of unmarried women are considered.

Participants identified numerous subgroups for each of these two groups. They recognized that, due to the size of the underserved population, a phased approach is necessary. Adolescents and young adults emerged as the highest priority group to target by the national FP program (among the unmet need and traditional user groups). This conclusion was drawn out of

practical recognition that young people are perhaps more amenable to new messages, more likely to change their behavior based on new information, and provide a wide range of opportunities to reach them, from schools to Internet cafés, from youth groups to military institutions.

Significant resources will be required to design and implement information and education campaigns, to put the appropriate human resource base in place to run campaigns and to provide services and to finance the contraceptive supplies required to serve them. Participants recognized that the public sector could not accomplish its objectives on its own. It will need to develop partnerships with community leaders, NGOs, and the commercial sector. Given the broad range of stakeholders represented at the workshop, those partnerships are well on their way to being formed and strengthened. The evolving partnership between the MOH and the commercial pharmaceutical industry was demonstrated by the participation of representatives of the top companies during this workshop. Their participation enriched the policy dialogue and strengthened the understanding of issues from both sides of the coin. There is a growing potential market niche for the commercial sector in the contraceptive commodity sales and in partnership with the MOH, the commercial sector continues to play an essential role in policy dialogue, planning, and serving the FP needs of Turkish men and women.

One partnership in particular should be pointed out. PHD representatives formed the biggest block of participants at the workshop, perhaps the largest such showing at a national policy dialogue forum on CS issues. Participation of PHD staff showed that their ground-level experience and knowledge are indispensable not just to program implementation but also to strategy development as the national FP program reaches for new heights past self-reliance. The opportunity to involve PHDs in the national workshop arose out of the GD MCH/FP's successful efforts to rollout its donation policy to the 18 most-populous provinces. PHDs are now integral and indispensable to the national CSR strategy, and their voice will critically enrich the ongoing process of maintaining progress and pushing toward new CS frontiers.

Appendix A: Workshop Agenda and Participant List

Objectives

1. Review progress to date toward CSR
2. Identify challenges for completing process of achieving self-reliance
3. Distinguish between CSR and CS
4. Identify challenges for transitioning from self-reliance to CS and establish strategies and responsibilities to complete the transition

Day 1: Thursday, October 31, 2002

8:30-9:00am	Registration
9:00-9:25am	Welcome, Introductions, Review Agenda Dr. Harry Cross, Director, Policy Project/Futures Group Dr. Rifat Köse, Deputy Undersecretary and General Director of MOH/MCH/FP Dr. Sefer Aycan, Undersecretary, MOH
09:25-09:30am	Review Agenda, Dr. Cigdem Bumin, Chair
9:30-10:10am	Panel: Progress Towards Contraceptive Self-reliance and Remaining Challenges Ahead Dr. Zerrin Baser, POLICY Country Director—Contraceptive Self-Reliance Strategy Overview Dr. Rifat Köse, Deputy Under Secretary and General Director of MOH/MCH/FP—Public Sector Budgeting and Spending
10:10-11:30am	Coffee/Tea Break
10:30-11:10am	Panel (continued) Dr. Nese Nohutçu, MCH/FP Division Head, Izmir Province—Donation Policy Implementation: A Field Perspective Mr. Ugur Aytac, Deputy Director MOH/MCH/FP—Performance and Use of the Monitoring and Evaluation System
11:10-11:50pm	Plenary Discussion, Prof. Dr. Çigdem Bumin, Chair
11:50-12:00pm	Policy Perspectives on Self-reliance Challenges, Fahreddin Tatar
12:00-12:10pm	Guidance on Workgroups, Prof.Dr. Çigdem Bumin, Chair
12:10-1:15pm	Lunch

1:15-3:15pm	Workgroups (Facilitators—Kemal Madenoglu and Cevdet Yilmaz) Workgroup 1—Donation Policy Implementation Workgroup 2—Public Sector Budgeting and Spending Workgroup 3—Performance and Use of Monitoring and Evaluation System Workgroup 4—Managing Donation Revenue and Procurement
3:15-3:30pm	Coffee/Tea Break
3:30-4:30pm	Workgroups (continue)
4:30-5:30pm	Workgroup Reports and Discussion, Prof. Dr. Çigdem Bumin, Chair
5:30-5:40pm	Wrap up

Day 2: Friday, November 1, 2002

8:50-9:00am	Welcome, Day 1 Recap, and Review Agenda Prof. Dr. Hakan Satiroglu, Chair
9:00-10:00am	From Contraceptive Self-reliance to Contraceptive Security Dr. Fahreddin Tatar
10:00-10:40am	Summary of Challenges and Discussion Prof. Dr. Hakan Satiroglu, Chair
10:40-11:00am	Coffee/Tea Break
11:00-11:10am	General Workgroup Guidance Prof. Dr. Hakan Satiroglu, Chair
11:10-12:30pm	Workgroups—Part 1 Workgroup 1: Unmet Need—Facilitator Mr. Kemal Madenoglu Workgroup 2: Traditional Users—Facilitator Mr. Cevdet Yilmaz
12:30-1:30pm	Lunch
1:30- 3:10pm	Workgroups—Part 2 Workgroup 1: Unmet Need—Facilitator Mr. Kemal Madenoglu Workgroup 2: Traditional Users—Facilitator Mr. Cevdet Yilmaz
3:10-3:25pm	Coffee/Tea Break
3:25-4:15pm	Workgroup Reports and Plenary Discussion Prof. Dr. Hakan Satiroglu, Chair
4:15-4:45pm	Next Steps and Closing Ms. Maureen Clyde, Regional Manager for Europe/Eurasia, Policy Project/Futures Group Dr. Rifat Köse, General Director of MOH/MCH/FP

Appendix B: Draft Notes on Day 1 Workgroup Proceedings

Contraceptive Self-reliance

Prepared by: Facilitator

1. List of Challenges

Workgroup 1: Implementation of the Donation Policy

Training and Motivation of Staff (28)*

- Training of staff who will explain to potential contributors the importance of donating
- Adequate emphasis on the importance of family planning
- Good communication of health care staff with the public
- Thorough knowledge of health care staff about the donation policy
- Development of communication skills in service delivery
- Better enlightenment of the midwives and nurses involved
- Emphasis on the importance of donations and the role of NGOs in the restructuring of health services
- Staff resistance to the policy
- Practices that encourage staff

Political/Administrative Determination and Its Sustainability (20)

- Clarification of the procedures for redemption of the collected donations as supplies
- Failure of foundation branches to do their job
- Determination of agencies, administrators, and individuals to sustain the common goal
- Surmounting political and administrative pressures and obstacles
- Experiencing disjunctions with foundation branches in case of ambiguity over the role of the HSAF headquarters

Informing the Public and Other Stakeholders (13)

- Attention to informing agencies such as the Inspection Commission, Legal Consultancy Department, Ministry of Finance, State Planning Organization, and Undersecretariat of the Treasury
- Thorough briefing of medical associations, faculties, and Ob-Gyns
- Potential differences in verbal communication in informing the public
- Inability to fully elucidate the donation policy in time

Inadequacy of Supplies (11)

- Inability to meet the needs of contributors due to lack of supplies on their second visit

* Figures in parentheses indicate the score for the relevant card.

Proper Service Delivery (7)

- Some individuals who do not make payment may leave the health care facility without getting services
- People finding out that fees are being charged for FP services may quit demanding these services

Situations Encountered Because of the Donation Practice (8)

- “Service first, money second” perception may lead to no donations being collected
- Disinclination to contribute on the part of even those who can afford the fees because donation is voluntary
- Absence of FP statement on the donation receipt
- Economic capacity of the public
- Description of donation as a fee and the low amount set for partial payment
- Low-income groups representing the majority of the clients of health center may prevent fulfillment of expectations
- Setting the donation amounts based on interregional differentials
- Limits set on the amount of donations
- Tendency to undervalue something received in return for nothing
- Ensuring contribution, no matter how small, without coercion
- Existence of three different payment levels; reluctance to contribute when the exempt are noticed

Purchase of Supplies (5)

- Purchase of supplies with the accumulated donations
- Delays in the conversion of donations to supplies

Different Practices across Units and Facilities (4)

- More difficulty faced in implementation at primary health care facilities
- Donation policy does not work well in villages
- Different approaches to donation exercised in different facilities
- Important for donation policy to involve not only primary, but also secondary health care facilities
- Appointments of staff who are unfamiliar with the policy from outside health centers

Workgroup 2: Use of the Monitoring and Evaluation System

Improvement of the Data and Flow Systems, Ensuring Enforcement, and Feedback (23)

- Establishing a self-controlling flow mechanism
- Disruptions in the flow of forms from facilities
- Interpretation of interregional differentials and study results
- Forms that include all data necessary for monitoring and evaluation need to be developed
- Long intervals in the transfer of donation reporting forms, or no transfers, from some facilities
- Facility reporting forms not based on a monthly cycle

- Enforcement of evaluation results
- The desired benefits cannot be obtained unless feedback on evaluation results is provided
- Forms designed for monitoring and evaluation may take up staff time and disrupt work
- A monitoring form can be designed to illustrate the participation status of all facilities in the donation policy
- Constructive use of feedback
- Lack of adequate funds for site visits

Clarification of Roles and Responsibilities Related to HSAF (21)

- Involvement of MCH/FP branch managers in the foundation management
- Alleviating the lack of confidence in foundations
- Forming public opinion for sustainability
- Explaining the importance of the issue to all media

Designation of Monitoring and Evaluation Teams and Responsible Person(s) (15)

- Establishing training teams at each health unit, conducting monitoring and evaluation
- Development of the monitoring and evaluation system
- Establishment of the central monitoring and evaluation team
- A staff member knowledgeable about the matter should be in place at each unit on a permanent basis
- Evaluators should have received training
- Ensuring standard monitoring of facilities
- Over-frequent staff movements
- Existence of monitoring standards across health care staff
- Shifts among staff
- Combining monitoring and evaluation with other forms

Organization of the Receipt Dispersal, Collection, and Money Transfer System (12)

- Problems related to loss of Foundation receipts
- Delays in transfer of receipts by health centers
- Maintenance of the money collected in return for receipts
- Difficulty in consumption and transfer of receipts to the center in outlying areas
- Movement of staff responsible for issuing receipts
- Identifying which facility uses up receipts at what intervals

Use of Monitoring and Evaluation for Effective Management (8)

- Measures for ensuring sustainability
- Projection of future income from donations

Study of Monitoring and Evaluation Data (3)

- Use of new methodologies in FP research (qualitative)

Competition Created by the Anticipation of Greater Revenues

Workgroup 3: Public Sector Budget and Expenditures

Increasing the Budget on a Sustainable Basis (24)

- Preventive health care services should be high priority and indispensable in budgeting and expenditures
- Sustainability of budget line 400
- Ensuring a sufficient budget and its utilization
- Increase of the budget share according to national needs on a sustainable basis
- Increasing budget resources required for contraceptives
- Ambiguity in the general budget share
- Continuity of the budget allocation for contraceptive commodities
- Under-budgeting
- Budget-related continuity

Central Procurement (20)

- Procurements should be made centrally according to the annual plan
- Establishment and sustainability of central procurement
- Purchases should be made centrally to avoid higher costs incurred in provincial purchases
- Distribution of the purchased supplies should be handled centrally
- Overcoming certain legal procedural challenges in securing additional budget resources
- Greater share for commodity procurement in the general budget (establishing commodity-specific quantities)

New Policy Recommendations

- Contraception may be included in the budget implementation instructions (9)
- The fund should be reengaged in commodity procurement
- Shares may not be received from the budget line 400
- Identifying additional resources
- Reform in the health policy (3)

Timing of Procurements (21)

- Allocations transferred by the ministry and their expenditure
- Timely transfer of allocations to provinces for procurement
- Timing of expenditures
- Expenditures should take place at the time planned well in advance
- Central purchase and distribution to provinces of adequate supplies at an appropriate time
- Postponement of provincial purchases to the end of the year
- Adequate stocks and appropriateness of timing

Other

- General directorates requisitioning supplies and making the procurement are different (1)
- Adaptable to changing conditions (early warning system) (4)
- Thorough examination of the budget prior to procurement
- Provincial needs or conditions should be taken into account in budget expenditures (3)

- Ambiguity of stock levels in absence of additional resources
- Are there legal arrangements for the expenditure of allocated funds elsewhere?

Workgroup 4: Management of Donation Revenues and the Procurement Process

Central Procurement (35)

- Central procurement with donation revenues
- Prompt initiation of central procurements in concurrent action with foundation centers
- Establishment of central procurement and ensuring its sustainability
- Donation revenues and central procurements
- Increased cost in provincial procurements
- Job descriptions should be specified for central donation revenues management
- Central and provincial differences in procurement

Transparency (15)

- Procurement process must be transparent
- Transparent management of donation revenues
- Problem of who is accountable for foundation resources

Standardization of Procurements (13)

- Nonstandardization of procurement processes
- Procurement processes should be prearranged

Political Support

- Failure of decision makers to adopt (MOH managers)
- Donation revenues may be terminated by politicians

Monitoring and Evaluation

- Operationalizing the monitoring and evaluation system

Staff Training and Motivation

- Systematic training of staff who will provide training on the donation policy
- Encouragement of staff who will collect the donations
- Standardization of donation practices

MOH–HSAF Relations and Role of the Foundation

- Ensuring prompt procurement of commodities through agreement with the Foundation
- Acceleration of procurements and adequate commodities

Other

- Adaptation to changing circumstances
- Ensuring sustainability of donation revenues
- Prolongation of the procurement processes
- Provincial-based coordination across branches (MCHFP–HSAF) (8)

- Disadvantages of the foundation by-laws
- Staff shortages caused by heavy workload, and responsibilities of managers
- Resupply of receipts in case of problems identified in handover of receipts

Recommendations

- Issuance and collection of FP receipts should be handled by MCH/FP branches
- Support for management should be central, and for procurements, provincial
- Separate budgets should be established (transformed to conditional donations)
- Donation revenues should not be limited to clients
- Procurements should be made centrally, at regular intervals of maximum four to six months
- When and how will expansion to other provinces take place?

2. Recommendations for Strategies to Address Priority Challenges

Workgroup 1: Utilization of the Monitoring and Evaluation System

Challenges	Strategies for Solution	Responsible Agency	Parties Involved	Roles and Comments
Ensuring Data Flow	Preparation of form 102 and monthly reporting (conformity of payment statuses with the donation system) Monthly evaluation of foundation receipts; Organization of the receipt distribution, collection, and money transfer system	MOH Data Processing Department Provincial MCH/FP branch Provincial HSAF branch	PHD GD MCH/FP PHD Primary Health Care Facilities	Collecting data Preparation of forms, collection of data and transfer to the ministry Creating a common sharing and reporting environment
Feedback	Encouragement of health care staff Training Certification	MOH MCH/FP Primary Health Care Services Curative Services	MOH Health Directorates	Feedback and evaluation from the center to the field

	Enforcement Steady data flow from the center	PHD Primary Health Care Facilities		
Clarification of Roles and Responsibilities Related to HSAF				
Creating Public Opinion				
Establishment of Monitoring and Evaluation Team				
Evaluation of the Effect of the Donation System on Clients				

Workgroup 1: Donation Policy Practices

Challenges	Strategies for Solution	Responsible Agency	Parties Involved	Roles and Comments
Staff Training	Informing provincial health managers	MOH; Governorship; PHD; MCH/FP Branch Directorate	HSAF Provincial Branch; Other units of PHD	MOH Relevant memo; training guidelines; Visit to the province by the ministry manager
	Establishment of provincial training teams and visit to the province	MOH; PHD	Governorship (approval); Other units of PHD	Training of health directorate training teams; Provision of training materials; Identification and deployment of the team; Planning and implementation of the training

	Participation and support of at least one manager from the provinces with experience during training	MOH; PHD	PHD	Sharing of experiences and participation in the organization and implementation of training; Sharing of local experiences and recommendations
	Establishment of joint inter-provincial working groups	MOH; relevant PHD	PHD	Deployment; Creating the working environment; Monitoring of results
Staff Motivation	Increasing facility shares of donations Use of facility shares in FP rooms Sharing and monitoring of implementation through evaluation meetings	MOH; Health Directorates; Health Group Departments; Primary Health Care Facilities	Foundation branches; Health Directorate	
Political and Administrative Determination and Its Sustainability				
Informing the Public and Other Stakeholders				
Situations Encountered Due to Donation Practice				
Ensuring Continuity of Supplies				
Service Delivery as Should Be				

Note: The criteria used by this group in defining priorities are listed below.

- Temporal priority
- Phased priority
- Number of persons affected
- Shortest path to the goal
- Its solution requires least effort
- Socioeconomic level is high
- Its sustainability (training, etc.)

Workgroup 2: Public Sector Budget and Expenditures

Challenges	Strategies for Solution	Responsible Agency	Parties Involved	Roles and Comments
Increasing and Sustaining the Budget	Advocacy with decision makers to increase the budget on a sustainable basis	MOH	NGOs Media International organizations Academicians	Advocacy will target TGNA* and the Ministry of Finance
	Ensuring a specific line for funds allocated for contraceptive commodity purchases under budget line 400	MOH	Ministry of Finance NGOs Media International organizations Academicians Private sector	
	Ensuring allocation of a sufficient portion of the budgets of other public agencies (SSK, Ministry of National Education, Universities, etc.) for contraceptive commodities	SSK MoNE Higher Education Council	MOH Ministry of Finance NGOs Media International organizations Academicians	

* Turkish Grand National Assembly

Workgroup 2: Management of Donation Revenues and Procurement

Challenges	Strategies for Solution	Responsible Agency	Parties Involved	Roles and Comments
Central procurement	<p>HSAF and MOH officials to urgently sign a long-term protocol</p> <p>Based on the agreement, semi-annual central purchases made by MOH and supplies distributed to the provinces, who will handle the accounting</p> <p>Premeditation and agreement by parties in order to cut down on all bureaucratic procedures that may delay commodity procurement</p>	<p>HSAF</p> <p>GD MCH/FP on behalf of the MOH</p> <p>Foundation Officials in the Provinces</p>	<p>Private sector</p> <p>PHDs</p> <p>Auditing Units</p>	<p>Deposit of 60% foundation share of the donations in a separate bank account as remittent to the headquarters</p> <p>Quality assurance of the goods by the MOH</p> <p>Control of the goods by the MOH</p> <p>Guarantee by the private sector that factory prices and special discounts will be applied in the bids</p>
Transparency				
Standardization				

Note: The principal criteria used by this group in defining priorities are listed below.

- Continuity (of supplies)
- Institutionalization/sustainability
- Budget savings
- Political support
- Time
- Management's support
- Productivity (minimum input, maximum output)
- Conformity with procedures

Appendix C: From Self-reliance to Contraceptive Security Challenges Ahead for Completing Turkey's Successful Transition

Prepared by: POLICY Project
Presentation Slides

Slide 1

From Self-reliance to Contraceptive Security:

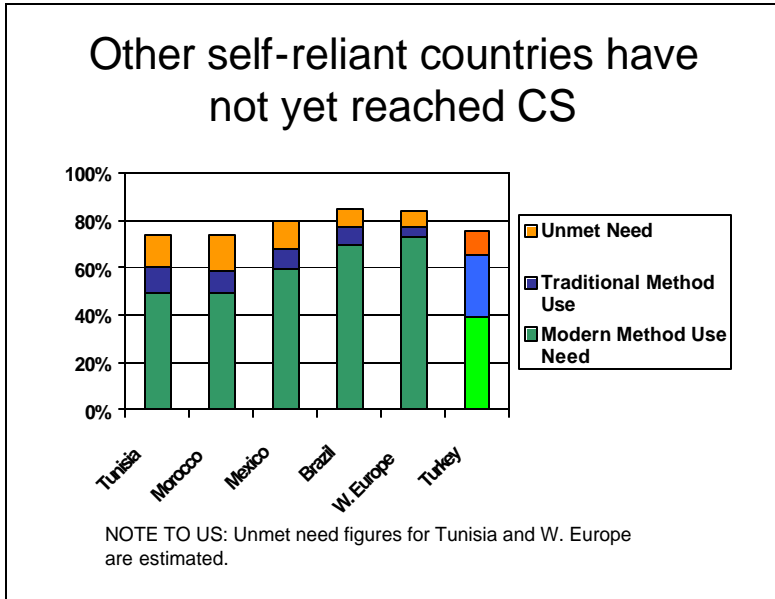
Challenges ahead for completing
Turkey's successful Transition

Slide 2

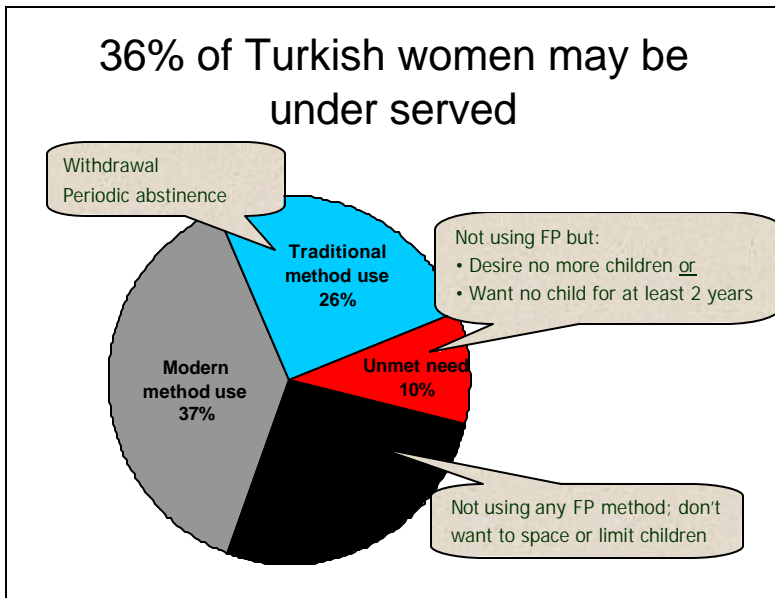
An important distinction

- **Self-reliance** – is the national assumption of responsibility for the FP program.
 - A clear and widely recognized success in Turkey.
- **Contraceptive security (CS)** – a program condition whereby all who want ***and need*** contraceptives have access to them.
 - Includes those who want FP but are not yet using it.
 - Few countries have achieved this goal.

Slide 3



Slide 4



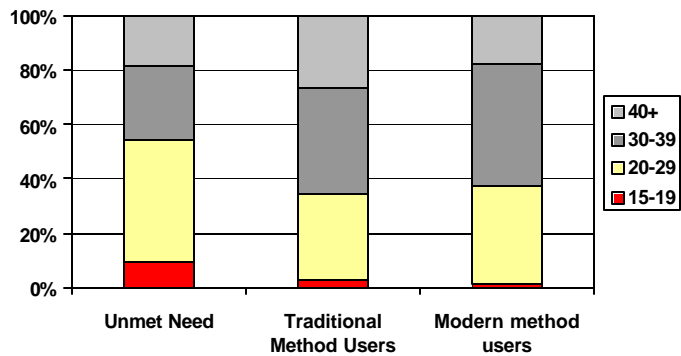
Slide 5

Turkey's CS Challenge

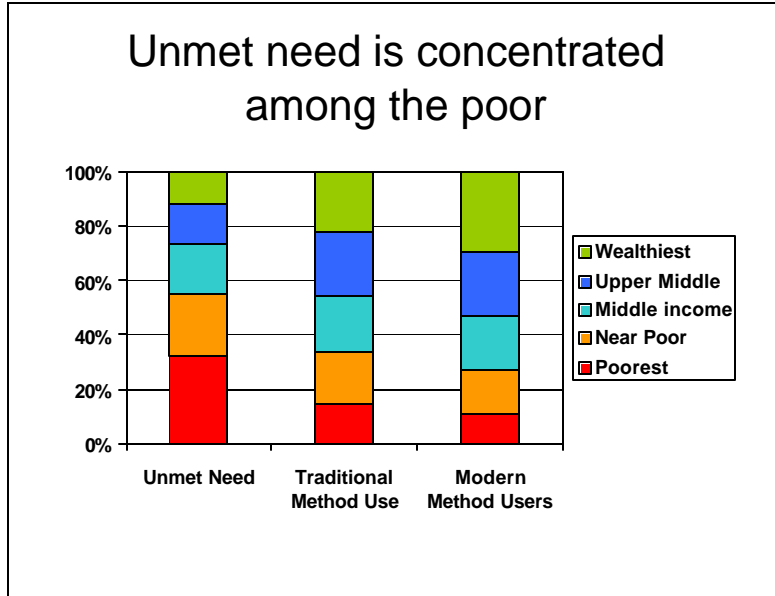
- Define the profile of each group of potential new users.
 - Demographic
 - Socio-economic
 - Geographic
- Define strategies to serve each group.
 - How to encourage them to seek services?
 - Who will serve them?
 - How will their use be financed?

Slide 6

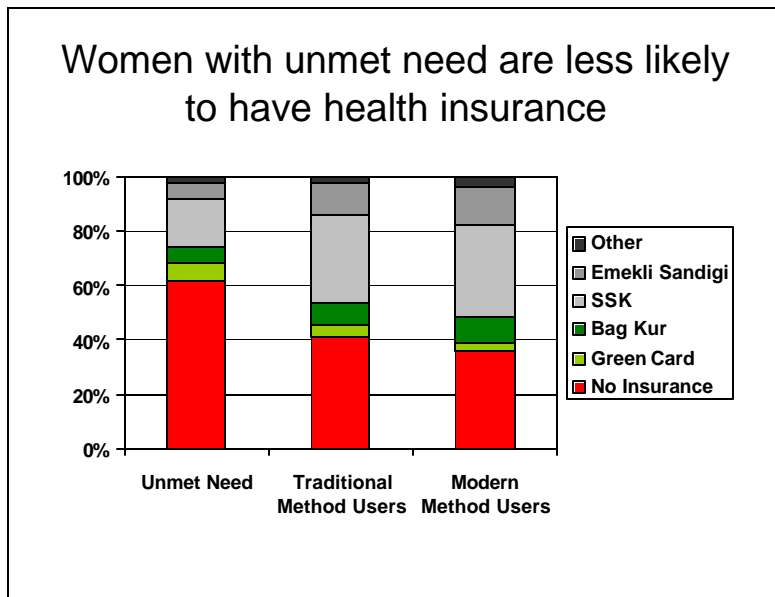
Women with unmet need are younger



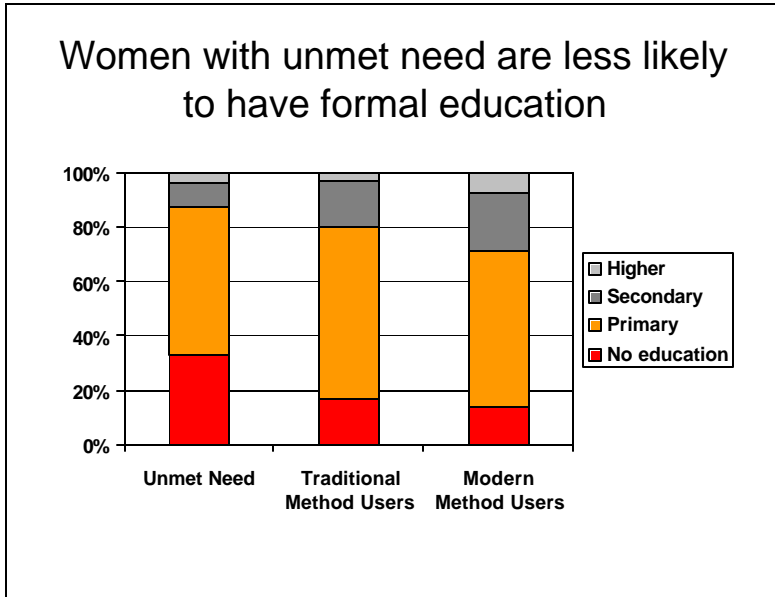
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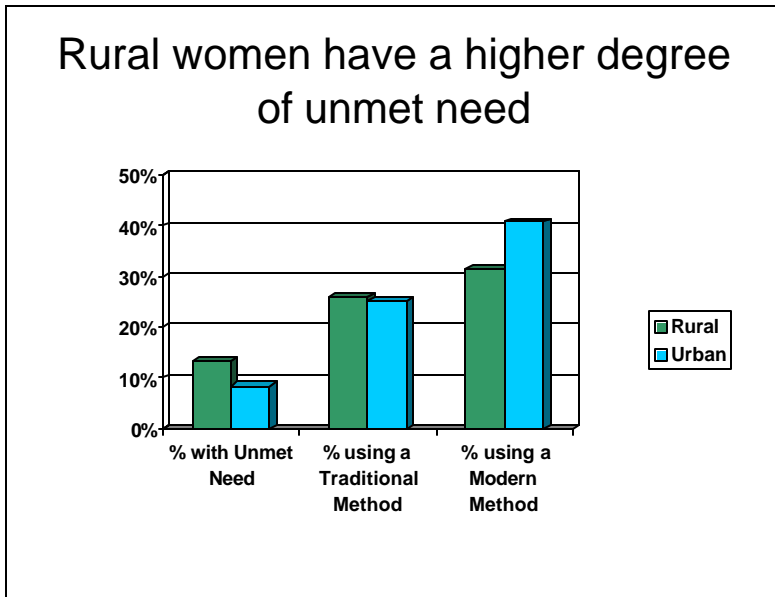
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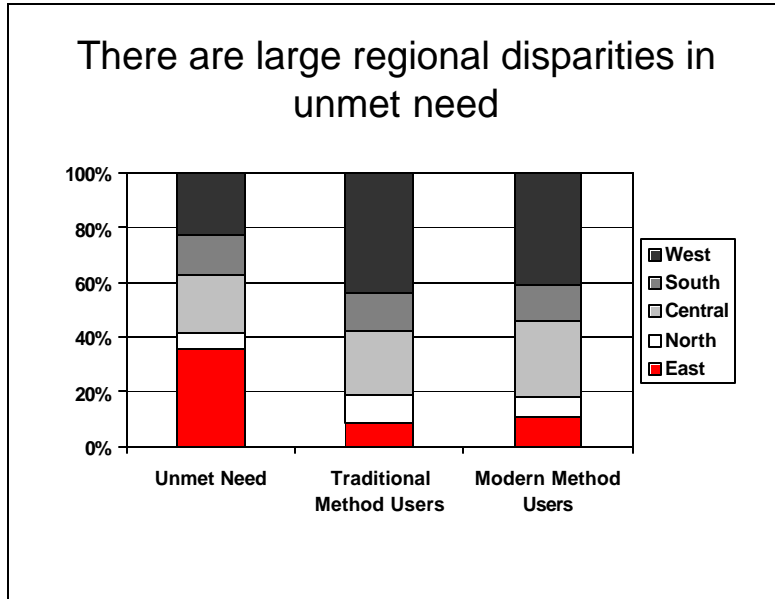
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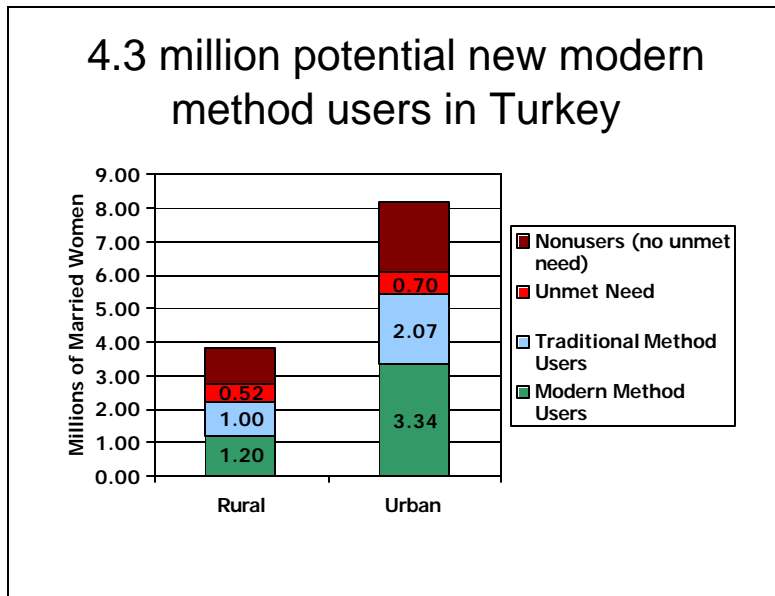
Slide 10



Slide 11



Slide 12



Slide 13

There are 1.2 million women with an unmet need for FP

- They are more likely to:
 - be poor
 - have no formal education
 - live in Eastern Turkey
 - have no health insurance
- They are also younger than FP users.
- Nearly half live in rural communities.

Slide 14

There are 3.1 million traditional method users

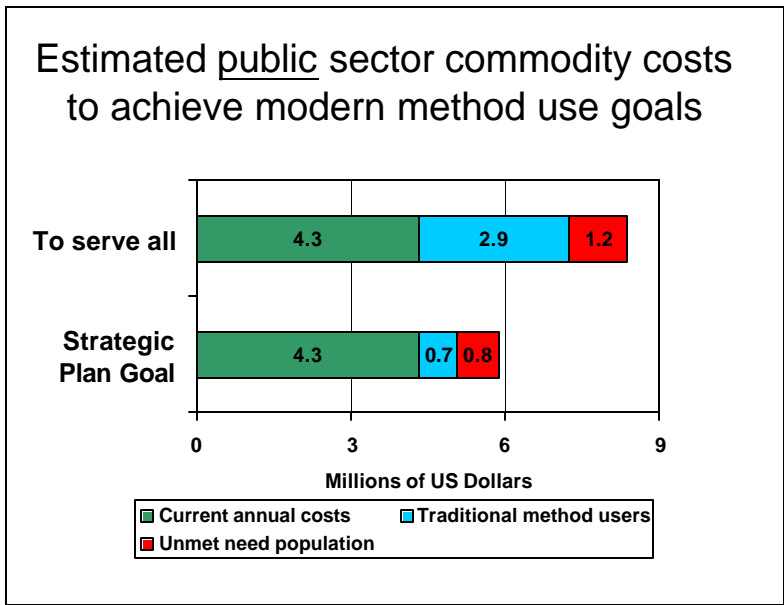
- They are similar to women who use a modern method on almost every dimension.
- 1 million live in rural communities.
- 2.1 million live in urban areas.

Slide 15

How much will it cost to serve these groups?

- Assume:
 - Method and source mix the same as other spacers and limiters.
 - 70% of all users will be modern method users.
 - Commodity costs same as MOH costs for public sector users.

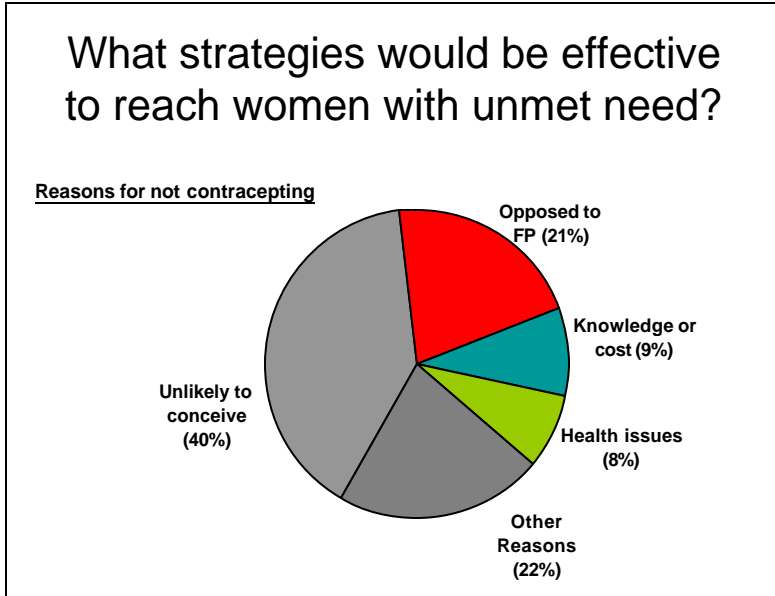
Slide 16



Slide 17

Points for priority setting and strategic planning

Slide 18



Slide 19

Should there be a phased approach?

- Whose needs should be address first?
 - 36% of women are potential new users.
 - 45% of all unmet need is in rural communities
- There are subgroups of women with unmet need
 - Opposition-based nonuse
 - Non-use due to lack of information
 - Health reasons for nonuse

Slide 20

What unique strategies will be required?

- How to encourage these new clients to use services?
- Which new clients should the public sector target?
- How should the increased demand be financed?
- How long will it take reach these new clients?

On to contraceptive security

- Turkey has achieved contraceptive self-reliance.
- Like most countries, Turkey is striving for contraceptive security.
- To achieve it, new challenges must be faced; choices must be made.
- What is the most feasible pathway?

Appendix D: Draft Notes on Day 2 Workgroup Proceedings

Contraceptive Security

Prepared by: Facilitator

1. List of Potential Target Groups

Workgroup 1: Unmet Need

Adolescents (26)*

- Adolescents
- Low educational status of 15–19 year olds
- Adolescents 15–19 years old
- Youths attending high school and university
- Students at various schools

Men (20)

- Education during military service
- Male education at the workplace
- Special education for men

Rural Areas (18)

- Rural population
- Needs of rural population should be prioritized
- Portion of rural population who are unaware of what to do, where to go for services
- Families living in rural areas
- New methods in approaching rural areas
- Young, uneducated and poor women in rural and migration areas
- Migrant agricultural workers

Group Opposed to FP (9)

- Group of 21 percent opposed to FP
- Those who consider it “improper” in traditional thinking, “sinful” in religious belief
- Those whose reason for opposing FP is unknown
- Those who think it is in conflict with religious beliefs

Those with Low Educational Status (5)

- Slum dwellers
- Low-income groups

* Figures in parentheses indicate the score for the relevant card.

Easily Accessible Groups (3)

- Easiest group to reach (population in physical proximity to health care facilities)
- Those who attend courses at public education centers

Lack of Knowledge (2)

- Those who lack knowledge
- Those who are educated, but are reserved or undecided because of uncertainty about, or because they think they know the side effects of modern methods

Others

- Newlyweds
- Those with more than three children
- Eastern and Southeastern provinces (8)
- Those without social insurance
- Sexually active singles

Workgroup 2: Traditional Method Users

15–29 Age Group (33)

- Youths in the 15–29 age bracket
- First-time users in the 15–29 age bracket
- Young women of age 15–29
- Withdrawal users of age 20–29
- Young women living in periurban areas
- Withdrawal users who are sexually active
- Young females and males of age 15–19

Women Who Became Pregnant During Traditional Method Use and Had a Voluntary Abortion

- Traditional method users who had a voluntary abortion
- Traditional method users who recently had D&C
- Traditional method users who have frequent MR or multiple children
- Those who have had a D&C

Those with Low Educational Status (12)

- Those with no education, or primary school graduates
- Primary school graduates

Urban Slum (9)

Those Who Vacillate Between Methods and Resort to Traditional Methods Due to Indecision (8)

Traditional Method Users Who Consult a Health Center for Any Reason (4)

- Everyone who consults a primary health care facility
- Traditional method users who demand counseling services
- Traditional method users who have had a hospital delivery

Those With High Socioeconomic Status Who Use Withdrawal (4)

All Women and Men of Reproductive Age (3)

30–39 Age Group (2)

The East, Traditional Rural Areas (1)

Those With High Educational Status Who Use a Traditional Method (1)

Primary School Graduates in Urban Areas (1)

Those Without Social Insurance Coverage (1)

Traditional Method Users Who Do Not Want Any More Children

Urban Dwellers of Low Socioeconomic Status

Those Who Previously Used a Modern Method but Quit

2. Recommendations for Strategies to Address Priority Target Groups

Workgroup 1: Adolescents (Traditional Method Users: 15–29 Age Group)

Priority Target Group	Strategies to Create Demand	Service Delivery Strategies	Funding
Adolescents			
Age 15–29	Information and Education Media Public Relations Political Determination Accessibility	Primary Health Care Facilities; Hospitals; Adolescent Clinics Schools Adolescent Health Centers Youth Centers Public Education Centers Domestic education Youth camps Media MoNE clinics	State Private Sector NGOs Municipalities Foreign Resources

		Peer education New technologies	
Age 20–29	Information and Education Media Public Relations Political Determination Accessibility	Armed Forces Workplaces Universities During Application for Premarital Medical Report Media New technologies (Internet, etc.)	State Private Sector NGOs Municipalities Foreign Resources Community

Workgroup 1: Women who Became Pregnant While Using a Traditional Method and Had a Voluntary Abortion

Priority Target Group	Strategies to Create Demand	Service Delivery Strategies	Funding
Women who Became Pregnant While Using a Traditional Method and Had a Voluntary Abortion			
	Emphasizing the importance of FP in the training of health care staff	Faculties of Medicine Vocational Colleges/High Schools of Health Residency Training Postgraduate IST* Medical Associations Health Directorate	State Budget Private Sector
	Public education on FP	Health Directorate Other Provincial Health Directorates Provincial Clergy Private Sector	State Budget Private Sector

* IST=In-service training

		Media NGOs	
	Informing couples visiting health care facilities for MR	Primary, Secondary, and Tertiary Health Care Facilities	State Budget Individuals
	Ensuring participation of NGOs	Cooperation with service providers	NGOs Private Sector

Workgroup 2: Adolescents (Unmet Need)

Priority Target Group	Strategies to Create Demand	Service Delivery Strategies	Funding
Adolescents	<p>Education</p> <p>FP education at schools</p> <p>Education and counseling provided to adolescents at health care facilities</p> <p>Expansion of marital counseling centers</p> <p>Joint activities with universities and municipalities</p> <p>Providing fundamental FP information and motivation on the media (printed & electronic)</p> <p>Direct motivation through brochures and printed materials in private and official institutions</p> <p>Toll-free phone line</p>	<p>Establishment of special training teams for adolescent education in the provinces</p> <p>Provision of group or individual education and FP methods in youth counseling centers</p> <p>Provision of FP counseling for premarital medical report</p> <p>Coverage of FP method provision in university <i>Mediko-Sosyal</i>*</p> <p>Establishment of separate units in primary health care facilities as an essential step</p>	<p>General Budget</p> <p>Foreign Assistance Projects</p> <p>Donors</p> <p>Provincial Semi-private Administration Budget</p> <p>Municipal Resources</p> <p>NGOs</p>

* Special health insurance coverage available to students.

Workgroup 2: Men (Unmet Need)

Priority Target Group	Strategies to Create Demand	Service Delivery Strategies	Funding
Men	<p>Counseling during premarital medical report stage</p> <p>Reproductive health education during schooling</p> <p>Education at vocational and apprenticeship schools</p> <p>Education during military service</p> <p>Education in correction institutions and prisons</p> <p>Education at professional chambers</p> <p>Education at the workplace</p> <p>Education of male health care personnel</p> <p>Informing the Clergy</p> <p>Education of community leaders (village administrators, teachers)</p> <p>Informing decision makers (Parliamentarians, local administrators, bureaucrats)</p> <p>Media managers</p> <p>Academicians</p>	<p>Counseling (at health care facilities) by health care providers (trained)</p> <p>Education by trained teachers during health information classes</p> <p>Same as above</p> <p>Institutionalization of the Land Forces Model</p> <p>Trained health care providers (training of prison physicians in FP counseling)</p> <p>Inclusion of FP education in the workplace medicine education curriculum</p> <p>Same as above</p> <p>See 1</p> <p>MOH and Religious Affairs Department collaboration (particularly for addressing the issue during sermons and homilies)</p> <p>With trained health care providers</p> <p>NGOs, pressure groups, media</p> <p>MOH, universities, professional organizations,</p>	Not required

	<p>Ob-Gyn</p> <p>Education for both the client and the person(s) accompanying her during and after pregnancy, delivery, or abortion</p>	<p>Actors/Entertainers</p> <p>Trained FP counselors</p> <p>Same as above</p> <p>Health care staff providing the service, through revisions in the procedures</p>	
Rural Areas			

Note: The criteria taken into account by both groups in identifying priorities are as follows.

- Estimated size of the group (in terms of cost and sustainability)
- Unwanted pregnancy risk level of the group
- Geographical position/place of the group
- Reaction of the group to motivation efforts oriented to modern method use
- Appropriateness of service delivery systems in terms of meeting the group's needs
- High-risk groups for pregnancy

Appendix E: Workshop Evaluation Results

An evaluation of the workshop was conducted upon its conclusion. For Day 1, 41 participants completed the form, and for Day 2, 42 participants completed the form. The evaluation form included open-ended questions on the organization of the workshop. With the exception of those participants who traveled by bus to Konya (rather than by cars or planes), the results showed high satisfaction with the venue, accommodation, food, and overall organization.

The following quotes shed light on the views of participants:

- “I wish we had participation from MOF.”
- “I wish MOH organized such fruitful and well designed meeting frequently.”
- “The workshop program was very tight, but I benefited from it.”
- “The methodology for the working groups resulted with successful outputs, I hope we can see them in action.”
- “It was very important to have voices from the 18 provincial health directorates and MOH, so we had chance to discuss many issues.”
- “This meeting was a benchmark for the RH program in Turkey.”

Day 1

Panel: Progress Toward Contraceptive Self-reliance and Remaining Challenges Ahead			
<i>A. Panel subject and coverage</i>			
Very well planned and covered	Sufficient	Would be better	Insufficient
12	29		
<i>B. Panel presentations</i>			
Well prepared and presented	Sufficient	Would be better	Insufficient
31	9	1	
<i>C. Content of the working groups</i>			
Well prepared	Sufficient	Would be better	Insufficient
18	14	9	
<i>D. Facilitation of the working groups</i>			
Facilitation skills were high	Sufficient	Would be better	Insufficient
15	21	5	
<i>E. Management of the chair</i>			
Very well managed	Sufficient	Would be better	Insufficient
27	12	2	

Day 2

Presentation: From Contraceptive Self-reliance to Contraceptive Security			
<i>A. Presentation</i>			
Well prepared and presented	Sufficient	Would be better	Insufficient
33	9		
<i>B. Content of the working groups</i>			
Well prepared	Sufficient	Would be better	Insufficient
22	14	6	
<i>C. Facilitation of the working groups</i>			
Facilitation skills were high	Sufficient	Would be better	Insufficient
21	18	3	
<i>D. Management of the chair</i>			
Very well managed	Sufficient	Would be better	Insufficient
30	11	1	