

The POLICY Project in Turkey:
Overview, Results and Lessons Learned

By

**Zerrin Baser
Maureen Clyde
Susan Richiedi
Jeffrey Sine
Fahreiddin Tatar**

February 2002



POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

Contents

| | |
|--|-----------|
| Abbreviations | v |
| I. Introduction | 1 |
| II. Contraceptive Self-reliance | 2 |
| III. National Strategies for Women’s Health and Family Planning | 8 |
| IV. NGO Strengthening and Advocacy | 11 |
| ANNEX | 17 |
| Bibliography | 20 |

Abbreviations

| | |
|-----------|---|
| CA | Cooperating agency |
| CMS | Commerical Market Strategies |
| CPT | Contraceptive procurement tables |
| CSR | Contraceptive self-reliance |
| FP | Family planning |
| FPMD | Family Planning Management Development |
| GD | General Directorate |
| GOT | Government of Turkey |
| HSAF | Health and Social Aid Foundation |
| ICPD | International Conference on Population and Development |
| KIDOG | Turkish NGO Network for Women |
| MCH | Maternal and child health |
| MCH/FP GD | Maternal and Child Health/Family Planning General Directorate |
| MOH | Ministry of Health |
| NGO | Nongovernmental organization |
| PCS | Population Communication Services |
| RH | Reproductive health |
| SEATS | Service Expansion and Technical Support |
| SOMARC | Social Marketing for Change |
| SSK | Social Security Institute |
| TA | Technical assistance |
| TOT | Training-of-Trainers |
| TFR | Total fertility rate |
| USAID | United States Agency for International Development |

I. Introduction

The purpose of this paper is to summarize POLICY's assistance in Turkey featuring results and lessons learned to date. In addition to this introduction, the paper is organized in three parts representing technical components of POLICY's work in Turkey: Contraceptive Self-reliance, National Strategies for Women's Health and Family Planning, and Nongovernmental Organization (NGO) Strengthening and Advocacy. This paper reflects experiences through December 2001 and will be updated at the close of the project in December 2002.

Setting the Stage

For three decades, the Government of Turkey (GOT) has been committed to improving the family planning and reproductive health (FP/RH) of women and men. For nearly as long, the United States Agency for International Development (USAID) has provided assistance in these efforts. Since 1983, Turkey's total fertility rate (TFR) has decreased by almost half, from 4.1 to 2.6. Still, there is a high unmet need for family planning. Sixty-two percent of married couples do not want any more children and an additional 13 percent want to wait at least two years before their next child. Also, while overall contraceptive prevalence is 64 percent, only 38 percent of married women use modern contraceptive methods.¹

In the early to mid-1990s, several factors contributed to USAID's decision to phase out assistance for family planning in Turkey. As a middle-income country, Turkey reached a point in its economic development that signaled USAID to evaluate its foreign assistance program. The U.S. and Turkish governments developed and agreed to a new strategy. This strategy called for a five-year program from 1995–1999 emphasizing expanding access to and improving quality of FP/RH services in both the public and private sectors; development of NGO networks; and the phaseout of contraceptive donations.

Then, in 1998, USAID conducted a strategic assessment and the program was expanded to cover the years 1999–2003. The assessment proposed a planned phasedown of annual assistance from peak levels of \$6–7 million in 1995–1996 to approximately \$2 million by 2001. In 1999, however, unanticipated budget reductions led to a 50 percent decrease in funding for the Turkey population assistance program and USAID's decision to phase out completely by 2001. Although the phaseout was originally scheduled for 2001, cooperating agencies (CAs) supporting the Turkey program secured brief extensions for their work to continue through March 2002. POLICY, however, secured an extension to continue work until December 2002.

Within the context of USAID's strategic framework, since 1996 POLICY has aimed "to create a favorable policy environment for family planning and reproductive health through a participatory policy process that responds to client's needs." In support of this overall goal, POLICY began its program with three key objectives to:

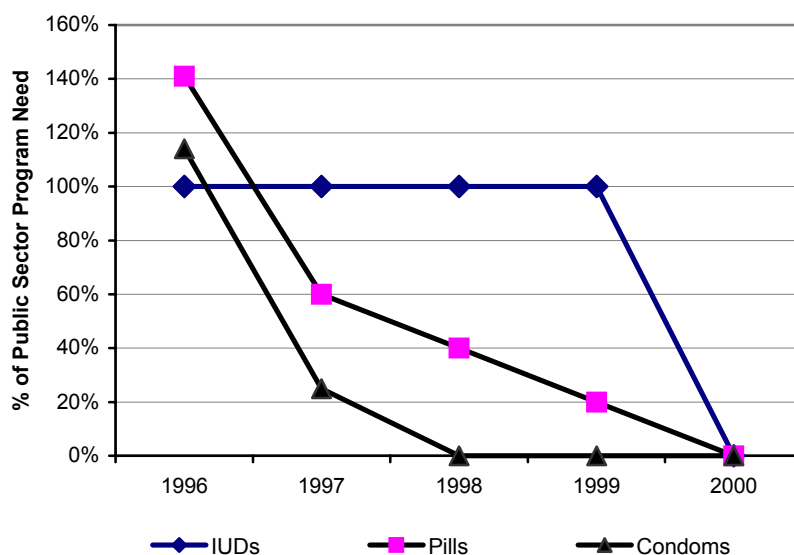
- achieve contraceptive self-reliance in the public sector;
- foster efficient resource use for family planning; and
- ensure greater participation of non-governmental, commercial, and governmental organizations in the policy process.

¹ Turkish Demographic and Health Survey 1998.

II. Contraceptive Self-reliance

Historically, USAID has donated contraceptive commodities to meet nearly the full requirements of the Turkish public sector family planning program. Annually, USAID prepared contraceptive procurement tables (CPTs) to determine Turkey's program needs and supplied the Ministry of Health (MOH) from its global procurement stock. In 1994, USAID and the GOT agreed on a schedule to phase out these donations over a five-year period between 1996 and 2000. During the first year of the phaseout, USAID agreed to satisfy 80 percent of program needs for condoms and pills, and 100 percent of needs for IUDs. Condom and pill donations were to decrease in 20 percentage point increments each year thereafter, until they reached zero in 2000. IUD donation levels were to remain at full program need until 1999, when they were to decrease to 50 percent of the program need; they were to decrease to zero in 2000. The actual pace of that phaseout, which differed somewhat from the plan, is shown in Figure 1.

Figure 1. Actual USAID Donation as a Proportion of Annual MOH Requirement During Phase-out Period



Throughout the USAID phase-out period, the MOH's Maternal and Child Health/Family Planning General Directorate (MCH/FP GD) has faced numerous challenges related to contraceptive self-reliance, including to:

- overcome barriers to allocating government budget funds required to meet the new financing needs of the public sector family planning program;
- expand and deepen the sense of national responsibility for the public sector family planning program among a broader constituency inside and outside the MOH;
- change the pervasive sense of entitlement to free family planning services; and

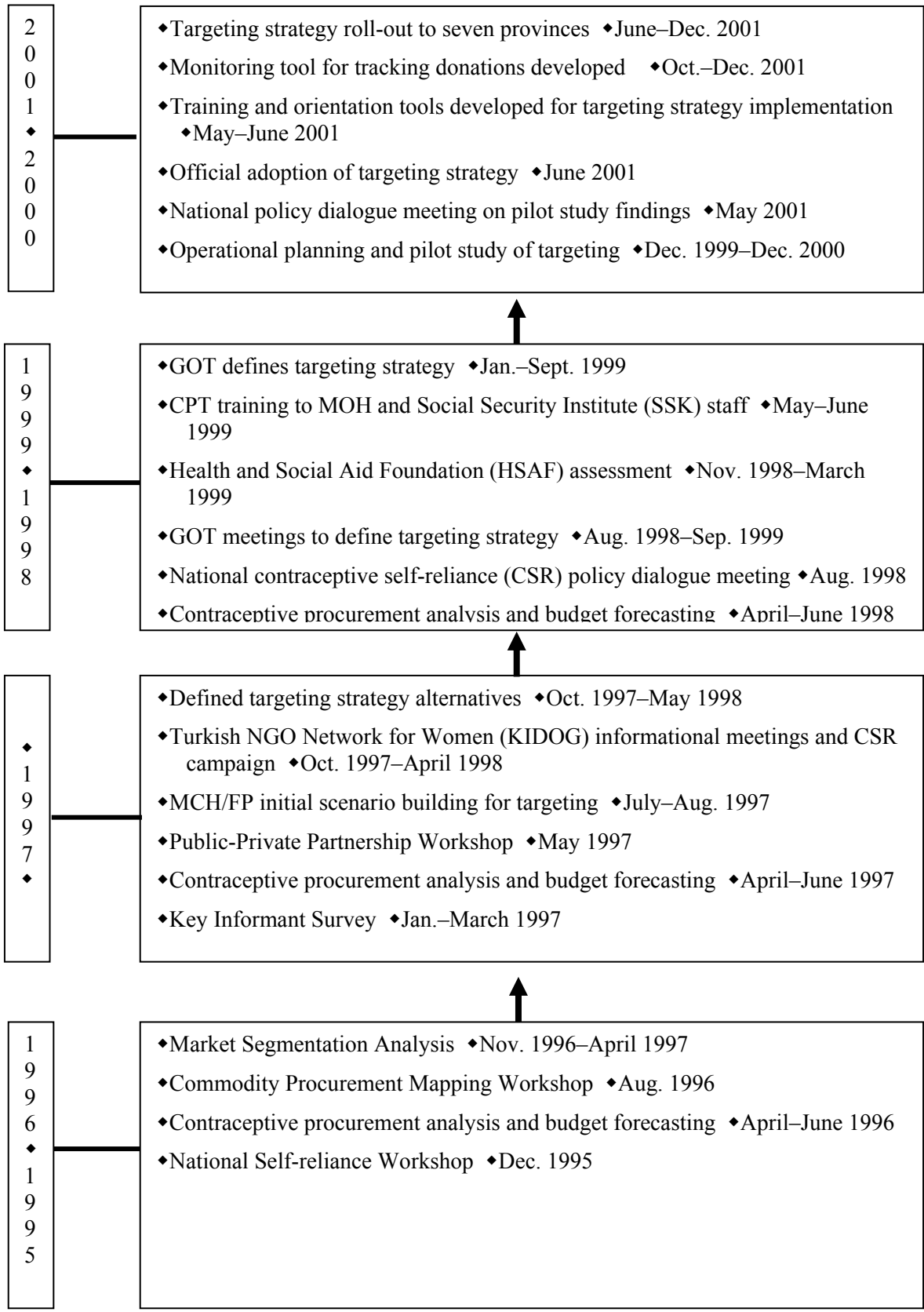
- shift strategic thinking about the national program by determining how to match scarce resources with population subgroups in greatest need of subsidy (signaling private sector opportunity to serve the less needy).

The POLICY Project and its predecessor project (OPTIONS II) worked in partnership with the MCH/FP GD to address these challenges and to fulfill the phase-out agreement. POLICY-supported activities can be classified as awareness raising, development of technical skills and an information base, and advocacy. The objective of awareness raising efforts was to create and maintain broad awareness about the phaseout and the GOT's response. Broad awareness was critical to ensuring support for GOT action, particularly on budget allocation, procurement, and targeting issues. POLICY supported MCH/FP staff development during the transition from USAID-led forecasting activities to MCH/FP GD assumption of this annual responsibility. POLICY also worked with the MCH/FP GD to prepare annual budget requirement estimates based on CPT information until the GD completely assumed this responsibility. POLICY also assisted the MCH/FP GD to reinforce skills to track stocks and procurement, define market structures, identify beneficiaries of MOH commodity subsidies, and to assess strategic options for procurement and targeting.

Advocacy efforts supported development of a contraceptive self-reliance strategy and served to strengthen the ability of public officials to act as necessary to implement the strategy. The MCH/FP GD leaders became policy champions, promoting their financing and program support needs within the MOH and among other public sector agencies. POLICY supported capacity building at KIDOG, a network of NGOs focused on women's issues. This network developed a high profile advocacy campaign designed to bring greater visibility to self-reliance needs to the public, public officials, and political leaders who are more difficult for civil servants to reach.

In such a paper, it is impossible to catalogue all POLICY activities related to contraceptive self-reliance. In order to impart a sense of the complexity of the process, a list of selected activities and related benchmarks is provided in the diagram on the next page. The Annex contains additional descriptive information.

Figure 2. Main POLICY Contraceptive Self-reliance Activities and Benchmarks

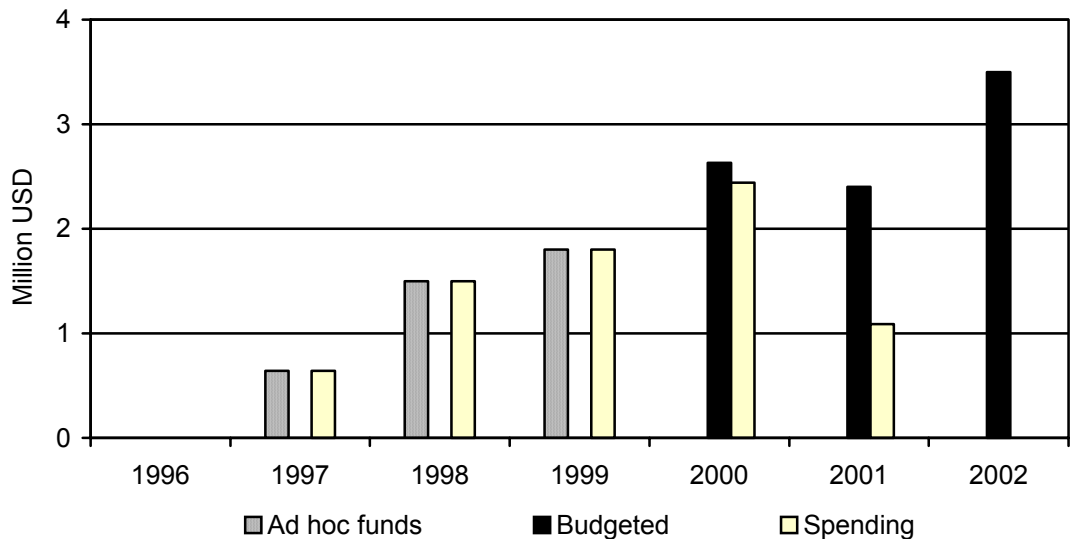


Results

Budgets and Procurement

A budget analysis conducted at the beginning of the phase-out process estimated that the GOT would need to procure \$4 million worth of contraceptive commodities annually to sustain the public sector program when all donor contributions ended. The MOH is making steady progress toward this goal. Jumping from zero public spending on contraceptives in 1996, the GOT spent \$643,000 in 1997 and more than \$1.5 million in 1998 (Figure 3). The amount spent in 1998 represented 40 percent of what was needed to achieve the GOT's financing goals that year. For the third consecutive year, spending increased in 1999, reaching \$1.8 million. The year 2000 marks the highest spending to date—\$2.4 million—meeting more than half the need for that year. Although 2001's allocation was nearly the same as 2000, spending fell as a consequence of the deepest economic crisis in Turkey's history. Private sector firms have either been hesitant to enter into bids with the public sector, or have responded to MOH tenders at high prices. In the short term, MOH stocks are sufficient to ensure a steady flow of commodities through its system. Meanwhile, in 2002 the MOH has secured the highest ever allocation to its budget for contraceptives commodities—\$3.5 million.

Figure 3. MOH Funds and Spending on Contraceptives



The 2002 budget outcome represents success on two fronts. It is indicative of the progress that has been made on forward planning for commodity stocks and budgets. The GD recognizes the value of cushion stocks and the need to replenish that cushion when drawn upon in a time of crisis. Perhaps more importantly, the outcome of the 2002 budget process resulted from efforts undertaken entirely within the MOH. No technical assistance (TA) was provided to forecast commodity and budget requirements, and budget advocacy was conducted entirely as an intra-government process.

The budget allocations from the Ministry of Finance (MOF) are for the expressed purpose of meeting the needs of the poor. The funds have been earmarked under the MCH/FP GD budget line item 400, with a long-term commitment to continuation. However, these allocations fall short

of meeting the full needs of the current public sector program. From 1997 to 1999, additional funds were obtained from the “Minister of Health’s Special Fund.” The long-term plan is to mobilize additional resources through the targeting strategy currently being put in place.

The MOH now has capacity to forecast contraceptive commodity needs, has established an effective procurement process, and has learned the value of initiating procurement early enough in a given program year to avoid the risks of stock-out. Several impediments to self-reliance have been overcome and a trained, four-person team is now in place to ensure that critical information is produced on time each year.

Partnerships

Partnerships between the MCH/FP GD and commercial pharmaceutical firms were firmly established during the phase-out period. Representatives of commercial firms had a consistent presence at most self-reliance policy dialogue forums, and routine communication presently exists outside of those formal settings. As evidence of emerging healthy public-private partnerships, one respondent who contributed to POLICY’s *Case Study of Contraceptive Self-reliance Efforts in Turkey: Prospects and Lessons Learned, November 1999* told of an agreement whereby a pharmaceutical firm agreed to assist the MCH/FP GD with financing for a family planning education campaign. As the MOH became more comfortable having these representatives at the policy dialogue table, it also became more open to participation from other stakeholder groups.

Collaboration among and within government agencies improved, as well. Case study respondents pointed out that inclusion of other GDs and government agencies in policy dialogue and planning on the subject of self-reliance was a welcome departure from the standard, more closed policymaking and planning mechanisms that prevail in Turkey’s public sector.

The success of partnerships with NGOs deserves special attention. In particular, KIDOG, the Turkish NGO Network for Women, provided a tremendous boost to self-reliance advocacy. The network developed a highly supportive relationship with the MCH/FP GD, successfully reaching high administrative and political levels to increase awareness and to lobby for action.

Targeting

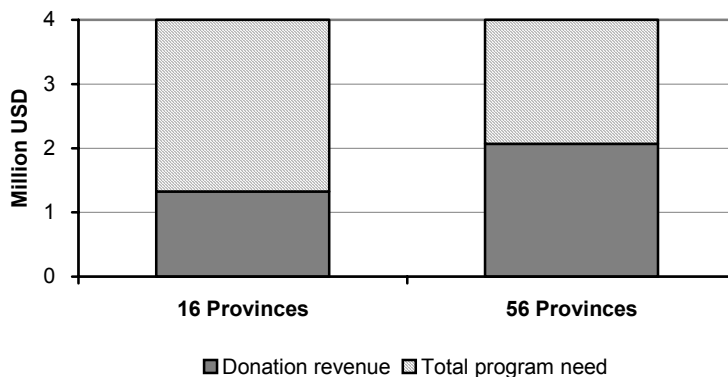
The targeting strategy was officially adopted on June 20, 2001. A guiding principal of this approach is that the MOH will maintain its long-standing commitment to serve all who seek family planning services; no one will be turned away. According to the plan, poor clients will continue to receive their contraceptive method for free, while non-poor clients will be asked to contribute to the cost of contraceptives supplied to them by making a donation to the HSAF.

The targeting strategy offers two tiers of voluntary donations and exemption, allowing flexibility for clients to donate an amount with which they are comfortable. Analysis of pilot study results indicates that expansion of the strategy to additional provinces could close the gap between program needs from contraceptive commodities and public budget allocations. The MOH is now pursuing short-term expansion to the 16 most populous and better-off provinces (including the pilot provinces where only selected districts participated in the pilot study). By the end of December 2001, POLICY had helped expand the targeting strategy to seven provinces, and, so far, \$81K in donations has been accumulated.

An important part of the expansion involves orientation and training of health facility personnel, who are the primary contact points with clients. More than 50 trainers and nearly 3,000 staff persons at health facilities in seven provinces have been oriented about the targeting policy and trained to implement its system for donation collection and processing

Looking to the future when the policy is implemented in the selected 16 provinces, donations are projected to reach \$1.1 million per year. This would leave the public sector with a budget need of approximately \$2.9 million per year to meet the requirements of the current family planning program. The level of donations will climb to \$2.1 million when implemented in the 56 provinces outside the Southeast region (Figure 4).² A growing number of policymakers and health personnel now realize that revenue generation is an important dimension of public sector self-reliance in the family planning program.

Figure 4. Contraceptive Donation Revenue Projections



There is evidence that the new, targeted approach to distributing free commodities will impact the private sector as well. During the pilot study, demand for pills and condoms decreased at public sector facilities. The proportion of family planning clients that were exempted from paying a donation indicates that it was not the poor who stopped using public sector facilities. Additional information is needed to confirm that it was the non-poor who left the public sector and to determine where they went. However, it appears that donation prices narrowed the public-private price gap for contraceptives and acted as signals to some non-poor clients to shift their demand to a private source. In effect, the targeting policy may be reducing the “crowding out” phenomenon and setting the stage for private sector expansion.

Lessons Learned

Self-reliance is in sight. Continued vigilance on the part of the MOH will be required to implement the targeting strategy to the non-Southeastern provinces of Turkey and to maintain the commitment for ongoing public budget support. Along the road to self-reliance, many lessons have been learned, all of which are valuable for donor phaseout in any country.

² 25 provinces have been designated as a high priority target area and all family planning clients will continue to receive free contraceptives upon demand. This aspect of the MCH/FP GD’s targeting policy is in line with broader GOT policies regarding public services in this region.

A minimum of two years lead time before the actual phase-out period is recommended to allow enough time for stage-setting activities. The achievement of public sector CSR is more complex than reaching agreement for the phase-out schedule itself. The approach to CSR should be conceptualized as part of the phase-out strategy. This requires adequate lead time to allow for requisite awareness raising, capacity building, policy dialogue, and advocacy, as well as for generating the information base required for sound decision making. Stage-setting activities include: forecasting future commodity needs and commensurate financial requirements; requesting and obtaining government funding as part of annual fiscal planning; and procuring, inspecting, and distributing contraceptives to health facilities.

Policy analysis, dialogue, and participatory planning are essential to facilitating change. For example, preparing for the phaseout required shifting from a sense of entitlement to a targeted approach for distributing public subsidies for contraceptives. Policy analysis was required to define and quantify the growing gap between funds available for contraceptive procurement and the amount required to provide full subsidies to all public sector clients without regard to need. This and results of other analyses were essential inputs to a multifaceted and lengthy policy dialogue process. Participatory planning translated consensus and commitment that emerged from policy dialogue into operational policies and strategies. Additional analysis supported the planning process as alternative options were considered.

Phase-out schedules and dates need to be clear among all parties from the outset. The phase-out agreement in Turkey called for a gradual, annual reduction in commodity donation levels. Given differences between USAID and GOT assumptions about budget and program cycles, however, confusion ensued over the starting point for the first reductions. USAID had planned according to its fiscal years (October to September), while the GOT planned according to its program years (January to December). This hampered early progress.

Donors need to send consistent messages about their intent to host-country governments by abiding by the phase-out agreement. In the initial years of the phaseout, USAID provided more contraceptive supplies than were scheduled. While some may view this action as helpful, it sent a mixed signal to the GOT, delaying budget action on the part of the GOT. Also, the unexpected donation instilled in some a belief that perhaps GOT inaction on budget and procurement fronts might reverse the decision to phase out.

A phase-out plan designed to create a sense of urgency earlier might be as effective as providing a longer TA lead time. The sense of urgency about contraceptive supplies certainly increased as the phaseout proceeded and as stock levels receded. The question raised is whether this sense of urgency could have been created earlier without jeopardizing the program, thereby increasing incentives to take stronger action earlier.

III. National Strategies for Women's Health and Family Planning

In the mid-1990s, the MOH recognized that the job of ensuring women's health extended beyond the services provided by the ministry itself. Other ministries (e.g., Education, Women's Affairs, and Finance), the private sector, and NGOs shared responsibility for women's health. Myriad activities were being implemented around the country in the absence of a comprehensive strategy, and it was commonly believed that duplications of effort, gaps in services and education,

and inadequate coordination were underlying causes of the inefficient use of resources. In the face of economic plight and imminent USAID phaseout, the MOH decided to develop the *National Strategy for Women's Health and Family Planning* and reached out to other directorates within the MOH and other sectors to strengthen collaboration.

In 1994, the MOH solicited support from the USAID-funded OPTIONS II Project and its follow-on POLICY Project to provide assistance in the development of a strategic plan for family planning. From the outset, the MOH embraced a participatory process in coordination with the State Planning Organization, key social sector ministries, selected NGOs, and commercial organizations. Six working groups were formed, representing the priority areas of service delivery, women's status, public education, infrastructure and management, staff training, and logistics and finance. All USAID-funded cooperating agencies participated in the working groups, including Population Communication Services (PCS) Project, EngenderHealth (formerly AVSC), JHPIEGO, Family Planning Management Development (FPMD) Project, Social Marketing for Change (SOMARC) Project, and the Family Planning Service Expansion and Technical Support (SEATS) Project. The working groups, convening periodically over a two-year period, first took stock of the principal resources to illustrate the current situation and analyzed opportunities and constraints to bring focus to the most critical issues. The groups defined their visions and targets for the primary areas and prescribed strategies. These strategies were ratified at the January 1996 meeting of the National Family Planning Council and were incorporated by an Editing Committee into the *National Strategy for Women's Health and Family Planning*.

Furthermore, a detailed activity plan was prepared, once more drawing on a participatory process. The working groups convened regularly through 1997 to prepare an activity plan that delineates tactics for strategies, including who, what, when, where, and how activities would be implemented (Turkish only—*Kadin Sagligi ve Aile Planlamasi Ulusal Startejileri Aktivite Plani*; available in English—*Activity Plan for National Strategy for Women's Health and Family Planning*).

The MOH, with support from POLICY, conducted a dissemination seminar for policymakers from all sectors in May 1998 to appeal to leaders to live up to their responsibility. The Minister of Health opened the seminar with a speech lauding the multisectoral planning process and encouraging continued collaboration. The seminar marked a proud time for the many professionals who contributed so generously of their time and intellectual energy to the initiative.

Results

Turkey achieved an important milestone in its FP/RH policy environment in January 1996 when it ratified the *National Strategy for Women's Health and Family Planning*. The strategy addresses a broad range of women's reproductive health issues in pursuit of the spirit of the International Conference on Population and Development (ICPD) *Programme of Action*, and is intended to foster collaboration and policymaker support to improve women's status and the quality of health services nationwide. The strategy is a comprehensive document that includes 48 strategies and 303 activities to be implemented in a five-year period. It was disseminated to all provincial health directorates, donors, the private sector, and NGOs who have a role in implementation. The *National Strategy for Women's Health and Family Planning* is the first of its kind prepared through a multisectoral planning process. It is a living document that is used regularly by the respective ministries and organizations as they undertake their programs.

Furthermore, the UNFPA and the European Union (EU) have used the *National Strategy for Women's Health and Family Planning* to guide development of their foreign assistance. Also, in November 2000, the MOH issued an order to provincial health directors to follow up locally.

In November 1998, 1999, and 2000, POLICY monitored the status of selected strategies and activities. Due to limited resources, only the strategies and activities integral to USAID's program were tracked. Fifteen of 49 strategies were selected, covering service delivery, public education, infrastructure, staff training, and logistics and finance. Twenty-eight corresponding activities of 106 were then selected. POLICY conducted face-to-face interviews with key partner representatives responsible for implementing the selected strategies and activities.

The November 1998 tracking interviews also included questions to assess the respondent's opinions of the process used to develop the strategy. Several findings emerged. Interviewees mentioned that, while the *National Strategy for Women's Health and Family Planning* was widely distributed, the activity plan was not. Also, the multidisciplinary approach was generally believed to be "somewhat useful" in achieving a consensus on national goals. In a related question, respondents generally reported that the multisectoral participatory process was also "somewhat useful" for developing each organization's initiatives. Regarding in-depth knowledge of the *National Strategy for Women's Health and Family Planning*, the MOH personnel were thoroughly knowledgeable, whereas other respondents' knowledge was limited to the strategies pertinent to their specific domain of responsibility.

In November 1998, 1999, and 2000, information was gathered on (1) whether selected strategies and activities were still valid; and (2) if so, the status of the activities was rated as either in the planning phase, in progress, or completed. In 1998, five activities were in the planning stage, 18 were in progress, and five were fully completed. By 1999, four new activities had started, 10 were in progress, and 14 were fully completed. By 2000, three activities had started, six were in progress, and 19 were fully completed. Tracking the status of activities was intended to monitor the progress of implementation over time rather than to evaluate change. Notable progress was demonstrated over this three-year period.

Lessons Learned

When engaging in a multisectoral participatory planning process, careful consideration should be given to the trade-offs between too little and too much inclusiveness, both in terms of technical scope and participants. The lengthy time taken to produce the strategy document was extraordinary, due in large part to the participatory nature of the process as well as the necessity of obtaining approvals from all social sector agencies.

A multisectoral planning process is valuable for creating awareness of and establishing key linkages among various sectors that share responsibilities for women's health and family planning.

To get the most out of multisectoral planning, it's necessary to establish working groups whose participants are fully dedicated and authorized to invest the time required to complete the process. Over the time when the national strategy was being developed, the working group participants rotated, which made consensus building an endless task. Participants experienced frustration, causing some to lose interest. Consequently, the burden of producing the final document rested on a few people on the Editorial Committee.

Should the MOH wish to update the National Strategy for Women’s Health and Family Planning, consideration should be given to including a monitoring and evaluation plan as well as establishing a task force to ensure implementation. Family planning policies must also include mechanisms to ensure that plans and programs are carried out as intended. While Turkey’s *National Strategy for Women’s Health and Family Planning* can be commended for its inclusiveness, it lacks a monitoring and evaluation.

IV. NGO Strengthening and Advocacy

The USAID phase-out strategy compelled new and diverse partners to address priority policy issues related to contraceptive self-reliance and improved access to and quality of family planning services. Recognizing the contributions of individual NGOs in related areas, USAID believed that NGOs “could play a strong advocacy role with Turkish decision makers at the national, provincial, and municipal levels...to strengthen the commitment to increased funding of population activities and...[to achieve] program sustainability.” USAID was eager to provide technical and organizational assistance to local NGOs to help them develop capabilities in family planning interventions. At the same time, USAID-supported policy work in Turkey was shifting from the OPTIONS II Project to the newly designed POLICY Project that included a specific participation element devoted to creating and strengthening policy advocacy networks. POLICY’s commitment to participation assumed that NGOs have a tremendous, largely untapped potential to become powerful advocates and that NGO involvement will lead to the development of sound policies that accurately represent the expressed needs of the people.

In 1995, a confluence of developments, both domestic and international, resulted in the early stages of network building and coordination among a small group of NGOs in Istanbul. Until that time, most Turkish NGOs had functioned as independent entities that were typically non-collaborative. Advocacy was the purview of foreign organizations such that civil society was reluctant and unprepared to venture into the policy arena. In July 1995, just before the start of the POLICY Project, a group of 11 NGOs gathered at an advocacy workshop organized by OPTIONS II. The goals of the workshop were to introduce the concept of advocacy, reach consensus on a Turkish-language definition of advocacy, and develop a mechanism for ongoing communication among NGOs. The organizations represented at the workshop were active in such diverse fields as sociology, family planning, law, child welfare, education, and women’s rights. Workshop participants expressed interest in forming an advocacy network that could be launched at the U.N. Conference on Human Settlements (Habitat II) and NGO Forum scheduled for May 1996 in Istanbul. By the time POLICY established a presence in Turkey, the 11 NGOs had submitted a request for TA in networking, advocacy, and strategic planning to help them prepare for Habitat II.

Ultimately, the UN Habitat II Conference and NGO Forum provided the 11 NGOs, which have since become known as KIDOG, with their first and immediate opportunity to galvanize their advocacy efforts. POLICY made substantial technical contributions to ensuring KIDOG’s readiness for the conference. Habitat II proved to be a driving force in bringing together the NGO members into a loose but formalized network. KIDOG members considered their participation at Habitat II a major success—its members worked collaboratively on an international platform and attracted the attention of policymakers.

From that time until 2002, POLICY has provided TA, training, and mini-grants to KIDOG. KIDOG’s name, *Kadin İçin Destek Olusturma Grubu*, conveys a new and complex concept that is

still foreign to many Turks—advocacy. The literal translation of the network’s name is “Group of Women to Create Support,” or “The NGO Advocacy Network for Women.” KIDOG’s mission is to “raise the status of women in Turkey” by advocating for laws and policies that promote improvements in women’s health, education, and legal rights. POLICY’s support for KIDOG was integrated into the other areas of POLICY’s work related to achieving public sector contraceptive self-reliance: strengthening public-private partnerships and developing national strategies for women’s health and family planning.

Through a series of skills-building workshops conducted by the POLICY and FPMD projects and ongoing TA for generating information and analysis as well as advocacy strategy planning and implementation, POLICY and KIDOG built an effective partnership. POLICY’s staff provided day-to-day assistance and encouragement. POLICY also mobilized assistance from several local subcontractors for focus group research, advocacy materials production, and workshop facilitation. Foreign expert assistance was provided for training and advocacy campaign development. Training sessions addressed a wide range of subjects. These workshops included:

- March 1996 – Advocacy Seminar (POLICY)
- July 1996 – Strategic Planning Workshop (joint POLICY and FPMD)
- October 1996 – Media Communication Workshop (joint POLICY and U.S. Information Services (USIS))
- February 1997 – Project Development and Resource Generation (joint FPMD and POLICY)
- May 1997 – Advocacy Implementation Planning Workshop (POLICY)
- June 1997 – Meeting Skills Building Workshop (joint FPMD and POLICY)
- October 1997 – Media Communications Workshop II
- February 1998 – RH/FP Orientation Seminar
- April 1999 – Conflict Management Workshop (joint FPMD and POLICY)
- July 1999 – Strategic Planning Workshop
- January 2000 – Sustainability Workshop
- March 2001 – Sustainability Workshop II
- August 2001 – Basic Training Skills Workshop (joint Commercial Market Strategies [CMS] and POLICY)
- September 2001 – Advocacy Training-of-Trainers (TOT) Workshop

As KIDOG planned and executed its various campaigns from 1996 to the present, the POLICY Project has served as the group’s primary technical and financial resource in developing and promoting the network and undertaking policy advocacy activities.

Results

Since 1996, KIDOG has implemented four distinct advocacy campaigns. The first campaign focused on the UN Habitat II Conference and NGO Forum (Istanbul 1996) and was the catalyst for the founding NGOs to meet and form KIDOG. It also provided the forum for testing the network’s structure and collaborative style of work. The positive reactions to KIDOG’s initial products and approach convinced the members to devote renewed energy and greater resources to their network.

KIDOG’s second advocacy strategy was and is designed to support the international declarations and national commitments made at the ICPD, held in Cairo in 1994, and the United

Nations' Fourth World Conference on Women, held in Beijing in 1995. The strategy achieves several objectives—it involves members from KIDOG's three 'Issues Working Groups' and creates opportunities for KIDOG's Istanbul-based membership to reach and mobilize local and grassroots NGOs throughout Turkey. More importantly, the Network's Cairo and Beijing strategy serves to monitor and push the GOT to follow through on its commitments to improve reproductive health, legal rights, and education for women in Turkey. POLICY provided a small grant to KIDOG (October 2001) to conduct advocacy training in selected provinces for local NGOs that support women's empowerment. KIDOG conducted the training sessions and shared its experiences to shed light on how NGOs can translate international declarations to which the GOT is a signatory into action at the local level.

KIDOG's third and most successful foray into advocacy materialized as an extension of POLICY's technical analysis of USAID's contraceptive phase-out plan. KIDOG's campaign targeted policymakers and the mass media, calling for immediate government budget support and procurement of contraceptive commodities for the public sector. The campaign yielded favorable media coverage and spurred action by former President Demirel to direct the MOH to mobilize funds. With these activities, KIDOG contributed to the allocation of resources from MOH's Special Fund for the purchase of contraceptive commodities required for 1998. The call to action dove-tailed well with other POLICY TA related to contraceptive forecasting, budgeting, and consensus building.

KIDOG's fourth campaign was mounted in direct response to another key issue and USAID priority: creating consumer demand for high quality FP/RH services and encouraging decision makers to respond. KIDOG directed its advocacy and awareness-raising activities to clients, service providers, and policymakers at several clinics in Istanbul with the following objectives: to foster client demand for high quality treatment and services; to collaborate with policymakers, service providers, and administrators to improve the quality of family planning services; and to influence MCH/FP to operationalize quality of care through responsive protocols and regulations.

Beyond its association with POLICY and FPMD, KIDOG has also developed ties with international donors. The network has received funding from the Global Fund for Women in response to a proposal for providing network members with communication equipment and has submitted a proposal to the European Union to support the network's Cairo and Beijing campaign. Also, a new partnership is budding between KIDOG and Planned Parenthood of Utah through the International Planned Parenthood Federation's Global Partnership Program. This is a partnership based on exchanging ideas and sharing experiences. It provides a unique opportunity for KIDOG to strengthen itself beyond the support of USAID.

Over time, POLICY's responses to KIDOG's needs have progressed from generic to specific. The level and nature of POLICY support in the creation, development, and daily work of KIDOG is revealing. Civil society organizations that wish to work through new and unconventional channels—such as advocacy networks—require significant levels and specific types of support, which, as is the case in Turkey, are not always available domestically. The POLICY Project has been well positioned to nurture and support KIDOG's networking and advocacy capabilities and to forge a partnership with the network. POLICY has provided continuous, committed, professional, and unique support.

Most recently, KIDOG completed the translation of the POLICY Advocacy Training Manual into Turkish. This translation was used at a TOT workshop on advocacy conducted by POLICY. The workshop and the translation of the advocacy manual helped build KIDOG

members' confidence levels and technical capacity as trainers. KIDOG will apply its skills in future training sessions for other NGOs and will share its experiences and shed light on how NGOs can translate international declarations, of which Turkey is a signatory, into action at the local level. Sustaining training, TA, and, ultimately, a partnership is a costly and long-term process that in this particular case has produced positive results.

Lessons Learned

KIDOG has broken new ground and stimulated a new type of relationship between the public and nongovernmental sectors in Turkey. It has carved out a space for itself at the policy table and has yielded significant changes in the FP/RH policy arena. Collaboration with key policymakers has led to acceptance of civil society as an important stakeholder and a valuable partner in strengthening, not undermining, the policy process. The challenge to KIDOG and all NGO networks is to sustain their early efforts and successes while surpassing the difficult hurdles posed by financial constraints, changing policy players, and competing loyalties. KIDOG's experiences and its evolving relationship with POLICY have proven to be fertile ground for valuable lessons.

Promoting Participation and Partnerships

Promoting the participation of civil society in the policy process is a time-consuming, costly, and complex process. It is particularly challenging to create a network and carry out advocacy in environments that are closed and resistant to collaboration. Yet, as KIDOG has demonstrated, with the proper mix of skills, knowledge, and determination, participation can work in almost any environment.

In the POLICY/KIDOG alliance, both parties learned that true partnerships require commitment, compromise, and patience. It is important that partners base their expectations on local realities, including the openness of the policy environment, the levels of experience and sophistication of the network, and the technical, human, and financial resources available to the network. Productive partnerships are also based on trust and mutual respect.

Donors and projects that exert too much influence on a network's advocacy agenda risk weakening the network's independence, internal structures, and credibility. Conversely, the network must assert its commitment to its own mission and priorities and not feel an overriding dependence on or obligation to the donor or project. POLICY and KIDOG have learned the value of maintaining balance between the interests and priorities of the donor, the project, and the network.

Membership/Shared Leadership

Members are the most important asset of a network. Adopting procedures for recruiting organizational members helps ensure an adequate pool of resources for the network. The KIDOG members are highly skilled and well-respected professionals. Striking a balance between organizations with strong reputations for technical excellence and organizations that are willing and able to do the work proved challenging.

A successful network is by nature democratic and participatory. Responsibility and authority should be distributed evenly and rotated routinely. When the burden falls on or is

assumed by a small group of elite, the network risks member dissatisfaction, “burn-out,” and eventual disintegration. KIDOG witnessed this to some extent and is taking steps to address member workload, recruitment, and retention.

To operate effectively, member organizations need to absorb their network responsibilities into their organizations’ work. Leaders in the organizations must commit resources—human, financial, in-kind—to making the network successful, and must incorporate advocacy responsibilities into job descriptions of staff members.

Capacity Building

Increasing a network’s capacity and ensuring its sustainability demands a long-term investment of human, material, and intellectual resources from a variety of sources. Building KIDOG’s capacity as a network and as a policy advocate has relied in large part on POLICY inputs, such as small grants and training and TA in advocacy, fundraising, strategic planning, and management. Other cooperating agencies and donors have made valuable technical contributions as well.

Network TA plans should be developed jointly by the network and its outside donor(s) to ensure that the priorities and needs of both bodies are adequately addressed. POLICY’s past technical experience put the project in the position of identifying the knowledge and skill needs of KIDOG. While this assessment was generally on target, there were instances where KIDOG identified different needs and interests.

Sustainability

POLICY and KIDOG learned that networks, like organizations, need structures, systems, and procedures for financial, programmatic, and institutional sustainability.

Financial Sustainability

Approaches that support financial sustainability include a financial management system to ensure accountability and transparency and a fundraising strategy to develop a diverse and adequate funding base. Networks require simple budgeting, accounting, and reporting systems to keep members informed of the network’s financial status and to direct internal decision-making. Generating a diverse funding base gives a network the freedom to select issues that address its mission and priorities and reduces the “donor-driven” phenomenon. In KIDOG’s case, the relationship between the network and POLICY resulted in an advocacy agenda that over-emphasized FP/RH at the expense of women’s education and legal rights and led to member dissatisfaction. At the same time, the POLICY connection strengthened KIDOG and helped it gain credibility and enough success to pursue broad-based financing and, eventually, financial independence. Network conflicts can be minimized when decisions about allocation of network resources reflect the interests of all members. Financial independence will allow this.

Programmatic Sustainability

Programmatic sustainability requires a process for monitoring the policy environment, an inventory of member skills and resources, and access to relevant technical information and data. To achieve programmatic sustainability, it is important to establish clear and agreed upon priorities for advocacy and to develop or recruit the knowledge, skills, and resources to support those priorities.

Networks require computers and Internet service to facilitate internal communication and to access current information on programmatic priorities

Promoting local ownership of network goals, activities, and success is vital. KIDOG's close and sometimes dependent relationship with POLICY led to challenges in portraying KIDOG as an independent organization in Turkey. The network's public profile is centered on its FP/RH work, not as an organization whose mission is to improve the general status of women. With clear programmatic goals and systems for identifying advocacy opportunities, KIDOG can become more active in selecting non-FP/RH issues and not limiting its activities to one domain.

Institutional Sustainability

Networks need to design and implement systems and procedures to govern decision making, communication, and membership. These include a clear organizational chart to define leadership functions and technical committees or teams; a communication tree to facilitate dissemination and collection of information; a membership plan for recruiting, developing, and retaining members; and job descriptions to clarify member roles and responsibilities.

ANNEX

Contraceptive Self-reliance Activities and Benchmarks

December 1995—National Self-reliance Workshop: This workshop served to increase initial awareness of the USAID phaseout and its implications for the public sector family planning program, as well as generate options for a self-reliance strategy and commitment to solving the dilemma.

April to June 1996 (annually thereafter)—Contraceptive procurement analysis and budget forecasts: A CSR team was formed to formalize key information gathering and analytical skills for forecasting commodity needs and financial requirements. These analyses were conducted each year and synchronized to the GOT budget process. Annually, from 1996-99, POLICY provided TA for forecasting and budgeting, and conducted training to build capacity within the MOH. In 2000, full technical and financial responsibility shifted from USAID to the GOT.

August 1996—Commodity Procurement Mapping Workshop: This workshop generated an understanding of the contraceptive procurement process and procurement alternatives in Turkey, and established key linkages among actors and stakeholders.

November 1996 to May 1997—Market Segmentation Analysis and Public-Private Partnership Workshop: POLICY conducted a quantitative analysis that described the structure of the family planning market in Turkey, examined the degree to which MOH commodities were targeted to “high-need” groups, and examined commercial sector market niches and their potential growth. It established a vision of family planning in Turkey that helped policymakers and planners better understand the big picture. The analysis was the centerpiece of discussion at the Public-Private Partnership Workshop in May 1997. The workshop opened policy dialogue to a range of public, private, and NGO audiences, resulting in a consensus about the potential of targeting to contribute to self-reliance and the ability of the private sector to absorb clients not targeted for subsidy. The MCH/FP committed itself to more clearly define its high-priority target populations.

January to March 1997—Key Informant Survey: The MOH was keen on broadening the participation of private sector physicians in policy dialogue on CSR and strategic planning initiatives. POLICY, through a local research firm, conducted a survey to identify physician leaders and facilitated their involvement in subsequent policy dialogue forums, beginning with participation in the Public-Private Partnership Workshop.

Summer 1997—MCH/FP initial scenario building for targeting: The staff of MCH/FP began to explore possibilities for targeting that would not conflict with the prevailing mindset of providing free family planning services to all who sought them. Interpretation of the Turkish constitution vis-à-vis the government's responsibility for health service provision became an issue of debate and subject of ongoing policy dialogue.

September 1997—New MCH/FP GD comprehensively briefed by POLICY staff: Ongoing policy dialogue was an important aspect of mounting broad-based consensus in Turkey's dynamic political environment. POLICY also assisted the new GD in delivering a

presentation on CSR to the Minister of Health's senior staff. Henceforth, the GD evolved into a true and very effective "policy champion."

October 1997 to May 1998—Defining targeting strategy alternatives: A spreadsheet-based tool was developed by POLICY to assess financing and logistic implications of targeting strategy options. This tool included transparency in its assumptions, some income and insurance variables, and graphics templates for policy presentations and communication. Using the targeting assessment tool, the MCH/FP GD and POLICY identified a broad range of targeting options, which included targeting (1) to certain facilities, (2) for contraceptive methods, (3) to geographic regions (such as rural and southeast parts), and (4) for the uninsured and to those least able to pay.

October 1997 to April 1998—KIDOG informational meetings and CSR campaign: POLICY provided KIDOG technical information and assistance for developing an advocacy campaign to alert policymakers of a potential family planning program crisis and to influence public officials to allocate and use resources to purchase contraceptives.

August 1998—National CSR policy dialogue meeting: Policymakers from the MOH, including the primary care, curative care, and MCH/FP GDs (national and provincial), convened a meeting to review the targeting strategy alternatives and to discuss legal issues related to Turkey's constitution.

August and November 1998; January and September 1999—GOT meetings to define targeting strategy: These critical meetings broadened the participation among MOH leaders in decision making, generated support among relevant government agencies, and resulted in the selection of a preferred targeting strategy (a multitiered voluntary donation policy).

November 1998 to March 1999—HSAF assessment: This assessment determined that the HSAF, providing support equal to that of the MOH, was a potentially good mechanism for mobilizing resources from MOH family planning clients for MOH contraceptive procurement.

May-June 1999 Contraceptive Procurement Training for MOH and SSK staff: POLICY invested in building capacity to forecast, plan and budget required for effective management of contraceptive supplies. Due to staff turnover in the public sector, however, re-training was required. POLICY conducted this training, which included a broader set of participants to ensure sustainability.

December 1999 to December 2000—Initial operational planning and pilot study: MOH and POLICY developed a plan for implementing the targeting strategy (based on a multitiered donation policy), and designed and garnered consensus for a pilot study. The pilot study was conducted in Mersin and Tarsus districts of Icel Province and Seyhan and Yuregir districts of Adana Province. Izmir Province served as a control area.

May 2001—National policy dialogue meeting: The findings and outcomes of the pilot study, along with recommendations on expansion, donation prices and retention levels, and administrative procedures, were documented and presented to a key group of policymakers including provincial health directors, their deputies, MCH/FP Unit heads of all provinces, the HSAF provincial branch accountants, and the HSAF General Director and his deputy. The significance of this policy dialogue is the growing consensus among key stakeholders for accepting the targeting strategy not only within the pilot test provinces, but also other provinces.

June 2001—Official adoption of targeting strategy: The Minister of Health reviewed the outcomes of the pilot study and agreed that the study's success was definite enough to justify expanding the strategy to larger, more populated provinces. The Minister signed a letter officially approving the donation policy and expansion to the selected provinces, specifying that money should be collected through the HSAF.

May 2001 to June 2001—Training and orientation tools developed: POLICY produced a TOT manual for provincial orientation that includes: (1) the orientation program and schedule; (2) the pilot study summary report; (3) a section on most frequently asked questions and answers; (4) transparencies of presentations; and (5) speakers' notes for presentations. Based on the implementation schedule for each province, meetings were held with provincial health directors and MCH/FP branch leaders to foster local ownership.

June 2001 to December 2001—Targeting strategy roll-out: The team of MOH trainers and POLICY staff conducted TOT programs in seven provinces, where the strategy is now fully operational. More than 50 people have since conducted orientation sessions throughout their respective provinces, instructing about 2,800 facility staff on administration of the new donation policy (Table 1). The TOT groups comprise staff from MCH/FP and HSAF provincial branches. The TOT approach not only fosters local ownership, but also enables a rapid and cost-effective way to scale-up the new policy.

October 2001 to December 2001 — Monitoring tool developed: POLICY developed a monitoring tool achieve the following: (1) to ensure that all facilities in each province that has begun implementation actually do implement the plan; (2) to ensure that facilities implement the plan in the way prescribed to them in the orientation session as well as in the Implementation Guidelines; (3) to monitor the implementation and progress of the targeting plan in the facilities for each province; and (4) to evaluate some specific outcomes and to undertake reporting activities. Provincial health directorates have been provided a simple checklist tool to use in their facility visits, and provinces have been provided a computer model for monitoring. This Excel spreadsheet model is highly practical for storing the data from the reporting forms and for monitoring and evaluating some critical aspects of the implementation and its outcome. Once data are entered, the provincial managers can automatically have, for example, the donation rates by facilities, districts, and type of facilities. This tool was first tested in the pilot provinces, and the final version was installed with the consent of the GD of MCH/FP.

Bibliography

Cakir, H.V., and J. Sine, J. 1997. "Segmentation in Turkey's Family Planning Market." Washington, DC : The Futures Group International, POLICY Project.

Cardenas, S., and S. Richiedei, S. 2000. "Participatory Policy in Turkey: A Case Study on the NGO Advocacy Network for Women (KIDOG) 1995–1999." Washington, DC: Center for Population and Development (CEDPA), POLICY Project.

Forecasts of Public Sector Budget Requirements for Contraceptive Commodities in Turkey: 1998–2000. August 1998. Ankara, Turkey: The Futures Group International, POLICY Project.

"Kadin Sagligi ve Aile Planlamasi Ulusal Stratejileri Dokumani." (*National Strategies for Women's Health and Family Planning*. Planning Document only in Turkish) September 1996.

KIDOG. 1996. *Women in Turkey: Education, Legal Status, Reproductive Health*. (Türkiye'de Kadın: Eğitim, Yasal Haklar, Üreme Sağlığı.) Istanbul, Turkey: KIDOG.

KIDOG. 1998. *In Light of International Declarations: Women in Turkey*. Istanbul, Turkey: KIDOG. (Turkish Language. *Uluslararası Sözleşmeler Işığında Türkiye'de Kadın*. Istanbul, Turkey: KIDOG.)

Ministry of Health, Government of Turkey, and POLICY Project. 1998a. *National Strategies for Women's Health and Family Planning: Activity Compendium*. Ankara, Turkey: Ministry of Health in collaboration with POLICY Project. (Turkish version: Kadın Sağlığı ve Aile Planlaması Ulusal Stratejileri. Aktiviteleri. 1998.)

Ministry of Health, Government of Turkey, and POLICY Project. 1998b. *National Strategies for Women's Health and Family Planning: Strategy Document*. Ankara, Turkey: Ministry of Health in collaboration with POLICY Project. (Turkish version: Kadın Sağlığı ve Aile Planlaması Ulusal Stratejileri. Strateji Dokumani 1998.)

OPTIONS. 1993. "Turkey Obstacles to Turning Population Policy into Effective Action." Washington, DC: The Futures Group International, OPTIONS.

OPTIONS. 1994a. "Family Planning Challenges in Turkey." Washington, DC: The Futures Group International, OPTIONS Project.

OPTIONS. 1994b. "USAID and Turkey: A Model Partnership in Population and Family Planning." Washington, DC: The Futures Group International, OPTIONS Project.

POLICY Project. 1995. "Forecasts of Public Sector Budget Requirements for Contraceptive Commodities in Turkey: 1995–1999. Final Report." December 1995. Washington, DC: The Futures Group International, POLICY Project.

POLICY Project. 1996a. "Advocacy Training II: Habitat Strategic Planning Exercise." Report. March 1996. Washington, DC: The Futures Group International, POLICY Project.

POLICY Project. 1996b. "Commodity Procurement Policy Workshop." Report. July 9, 1996. Washington, DC: The Futures Group International, POLICY Project. (Turkish version: .Aile Planlamasi Malzemeleri Alim Politikasi Toplantı Raporu. July 1996.)

POLICY Project. 1996c. "Forecast of Public Sector Budget Requirements for Contraceptive Commodities in Turkey 1995-1999 (June 1996 update)." September 1996. Washington, DC: The Futures Group International, POLICY Project.

POLICY Project. 1996d. "NGO Advocacy Network for Women (KIDOG) on its Participation in United Nations Conference on Human Settlement Habitat II NGO Forum, May 30–June 14, 1996." Report. July, 1996. Ankara, Turkey: The Futures Group International, POLICY Project.

POLICY Project. 1996e. "NGO Advocacy Network for Women (KIDOG) Strategic Planning Workshop." Report. July 12–13, 1996. Ankara, Turkey: The Futures Group International, POLICY Project.

POLICY Project. 1997a. "Forecasts of Public Sector Budget Requirements for Contraceptive Commodities in Turkey: 1995–1999. June 1997 Update." October 1997. Ankara, Turkey: The Futures Group International, POLICY Project.

POLICY Project. 1997b. "Public and Private Partnership Workshop Report." May 1997. Washington, DC: The Futures Group International, POLICY Project.

POLICY Project. 1999a. "Case Study of Contraceptive Self-Reliance Efforts in Turkey: Prospects of Lessons Learned." Washington, DC: The Futures Group International, POLICY Project.

POLICY Project. 1999b. "Forecasts of Public Sector Budget Requirements for Contraceptive Commodities in Turkey: 1999–2001." June 1999. Ankara, Turkey: The Futures Group International, POLICY Project.

POLICY Project. 1999c. "Meeting on Development of a Sustainable Financing Policy for the National Family Planning Program." Meeting Report. September 1999. Ankara, Turkey: The Futures Group International, POLICY Project. (Turkish language: Ulusal Aile Planlamasi Programi icin Surudurulebilir bir Finansman Gelistirme Toplantisi. Report. September 1999.)

Tatar, F., Z. Baser, and J. Sine. 2001. "Towards Contraceptive Self-Reliance in Turkey: Results from a Pilot Test of a Cost-Sharing Mechanism." Washington, DC: The Futures Group International, POLICY Project. (Turkish version of its summary report.*Kontraseptif Malzeme Kendine Yeterlilik Politikasi Pilot Calisma Ozet Raporu.* Summary Report. May 2001)

Tatar, F., and J. Sine. 2000. "Client Donations for Contraceptives: An Innovative Approach to Sustainable Financing in Turkey." Ankara, Turkey: The Futures Group International, POLICY Project.

Turkey's Health and Social Assistance Foundation Feasibility Study of its Role in Raising Resources for Contraceptive Commodity Procurement. February 1999. (Turkish version Fizibilite Raporu: Kontraseptif Malzeme Alimlari icin Kaynak Olusturmada Saglik ve Sosyal Yardim vakfinin Rolu.) Ankara, Turkey: The Futures Group International, POLICY Project.