Integration of Gender Perspective in Health Policy in Turkey: A CASE STUDY

Hacettepe University
Research and Implementation Center
on Women's Issues
(HUWRIC)

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Project Report

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Preface

The purpose of gender mainstreaming is to identify, analyze and act upon inequalities that arise from belonging to one sex or the other, or from the unequal power relations that between the sexes.

Since inequalities in society most often disadvantage women, “gender analysis” is a valuable starting point for addressing the issues of achieving equality for women, but also brings men into the picture.

In the field of health, including reproductive health, there has been growing recognition of the need for a comprehensive gender perspective that acknowledges the different health experiences and health care needs of women and men. This has been a prominent feature of a series of world conferences – notably Cairo (1994) and Beijing (1995).

Although “gender mainstreaming” theoretically is an accepted strategy for promoting gender equality in Turkey, so far this issue has not been studied in details, especially in the area of developing health policy.

The study presented in this “Report” has been initiated as a part of WHO/EURO research activities in 7 countries namely, Ireland, UK, The Netherlands, Tajikistan, Kyrgyzistan, Croatia and Turkey and it has been carried out in two phases. The first phase of the study aimed to analyze 5 major legislations of Turkey to find out the context and the extent of integration of a gender perspective in reproductive health policy in Turkey. In the second phase, research reached out into the community to identify the real implementation and the needs in the area of family planning and unwanted pregnancies in regard to applying health policy into practice, to make the connection between the laws and their implementations.

We “the study team” believe that the results of this exercise revealed so much valuable information about the investigated topics that deserve attention by all the interested parties to improve RH in Turkey.

Hacettepe University Research and Implementation Center on Women’s Issues (HUWRIC) would like to thank to the WHO-EURO Regional Office for their technical and financial support for the first phase of the study and also thank to the UNFPA – Ankara Office for providing financial support for the second phase of the study. The principal investigators would also like to thank to each member of the study team for their sincere and hard work and contributions.

We hope that similar studies will continue and the results will be taken into consideration by the decision makers to improve RH of women and men in Turkey.

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INTRODUCTION

Mainstreaming a gender perspective in all types of interventions is a globally accepted strategy for promoting gender equality. Mainstreaming is not an end in itself but a means to the goal of gender equality. It involves ensuring that gender perspectives and attention to the goal of gender equality are central to all interventions-policy development, research, advocacy/dialogue, legislation, resource allocation, and planning, implementation and monitoring of programs / projects.

Mainstreaming was clearly established as the global strategy for promoting gender equality through the Platform for Action at the United Nations Fourth World Conference on Women in Beijing in 1995. Ensuring that men and women are given equal opportunities to realize their potential for health is an important goal of the UN. A crucial strategy to achieve this goal is the gender mainstreaming of national health policies. This entails integrating attention to sex and gender differences in all stages policy development: problem definition and agenda setting; policy design; decision-making; policy implementation and monitoring.

A comprehensive approach to reproductive health necessitates analysis and response to the needs of women and men in their sexual relationship and reproduction. Consequently a holistic view of women lives and their needs is essential for such an approach. This demands that reproductive health care policy not only be based on the biomedical model which tends to look at individuals out of context, and is often insufficient in its analysis of the causes of ill-health, but move beyond it to take into account and respond to the many faceted life-cycle needs of women and men (WHO, 1998; WHO, 1999).

As a member state of the WHO in the European Region, Turkey participated and signed all the recommendations of ICPD and Beijing platform for actions (Akin 1994). After ICPD and Beijing; a national strategic plan for women's health and RH was prepared and UNFPA 3rd Country Program has been prepared on R/SH by gender perspective. Although "Gender Mainstreaming" theoretically is an accepted strategy for promoting gender equality in Turkey, so far the issue has not been studied in details, especially in the area of developing health policy.

In Turkey, programs have been initiated to improve the status of women, which is a crucial determinant of their reproductive and sexual health.

The General Directorate on the Status and Problems of Women (GDSPW) established in 1990 has collaborated with relevant government agencies and NGOs to carry out advocacy activities and to modify the existing legislation, which leads to discriminatory practices against women. Similarly, the Social Structure and Women Statistics Department of the State Statistical Institute, established in 1993, makes gender specific statistics available in the country. In 1996 the General Directorate of MCH/FP of the Ministry of Health prepared "A National Strategic Plan on Women's Health". Nonetheless gender inequalities continue to be apparent in areas related to reproduction and sexual issues in Turkish society.

Some Statistical Information on Reproductive Health in Turkey as follows:

Turkey is a Middle East Country it has relatively large land with over 67 million of population and it is among the 20 most populous countries of the world and the most populous in the region. It has young population, around 50% of the population is under the age of 20 (SIS, 2000).

Despite of all improvements, Reproductive and Sexual Health including Family Planning are major concern in the country, The total fertility rate (TFR) is 2.2 per women, annual population growth rate is 14 per thousand, and crude birth rate is 19.7 per thousand while crude death rate is 6.7 per thousand (HUIPS, 1999, 2004). Life expectancy at birth is 66.2 years for males, 70.9 years for females (SIS, 1997).

The infant mortality rate (IMR) is 29.0 for the year 2003. Unfortunately, perinatal causes of infant mortality are still common in the country and perinatal mortality rate is 24 per thousand total births, which indicate the needs of improvement in reproductive health of mothers (HUIPS, 2004). According to a research carried out in 1997-98 in 615 hospitals in 53 provinces of Turkey investigating the causes of maternal deaths; 5% of total female deaths aged 12-55 were maternal deaths. The rate of maternal mortality in this hospital-based survey was found to be 49.2 per 100.000 live births in 53 provinces in Turkey. Hemorrhage was the first and toxemia was the second most prevalent final cause of maternal deaths According to this study 4 out of 5 of maternal deaths were due to preventable causes (Akin et all, 2000; Akin et all, 2001).

By the years the coverage of antenatal care (ANC) has been increased being 81% of all pregnant women in 2003 ((HUIPS, 2004). The likelihood of a mother receiving ANC increases

markedly with the increase in the mother's education (Akin and Bertan, 1996; Akin and Ozvaris, 2002). The proportion of safe delivery is 83% in 2003, which means approximately one in six pregnant women delivers without any medical help (assisted by traditional births attendants at home) in Turkey (HUIPS, 2004). The prevalence of safe delivery increases by the increase in the level of education of women and the husbands (Akin and Bertan, 1996; Akin and Ozvaris, 2002).

Age at first marriage for female is 20.0, for male 23.6 years. Early age of marriage is one of the common problems in Turkey. Unwanted and high-risk pregnancies are common in Turkey (i.e. 63.4% of currently married women who don't want any more children; 20.1% of births in the last 5 years were unwanted; 13.9% of births were mistimed; 39.0% of births in the last 5 years were in high risk category) (HUIPS, 1999, 2004). Contraceptive prevalence is 71%; modern contraceptive prevalence is 42.5% while traditional contraceptive prevalence is 28.5%. Unmet need for family planning is still high in the country (HUIPS, 2004). After legalization in 1983, the rates of induced abortion first increased, due mostly to better reporting, but after 1990s the rates have started to decrease and the downward trend is still continuing (Akin and Enunlu, 2002; Akin, 1999).

All indicators related to reproductive health indicate that Reproductive Health is one of the major health concerns in Turkey besides that regional, rural/urban differences are very marked (HUIPS, 1999, 2003; MoH, 1997; MoH 1997; Akin and Ozvaris 1999, Akin 2001).

Some Health Indicators by Gender in Turkey

Sex disaggregated data is collected in Turkey since 1927 by State Institute of Statistics. Neonatal mortality rate is 32.0 per thousand for boys while 23.6 per thousand for girls. Then post neonatal mortality rate is higher for girls than boys, which 19.2 per thousand for boys; 21.9 per thousand for girls (HUIPS, 1999).

Violence against women is a serious problem in Turkey. 30% of women have violence from husband. Physical violence by husband is 22% (1992). 86% of household where violence is exist (GDSPW, 1999). Unfortunately, 70% of women believe that men can beat their views; 50% of women believe that women should not argue her husband; 80% of them believe that people who are subject to violence there is nothing for them to do (TDHS, 1994).

Cardio-vascular disease is the first most common cause of death among the eight causes of death for both sexes in the country (38.5% for female, 35.8% for male). Percentage of cancers as cause of death is higher for males than for females. But, cerebra vascular diseases as cause of death is higher for females (10.1%) than males (7.3%) (GDSPW, 1999).

Percentage of chronic diseases is almost same number for both sexes (6.8%; 6.1%). 20% of female was in bed during last six months, while 14.3% for male. Disability rate also higher for females (21.0%) than males (14.6%). 6.4% of females perceive their health as “poor” while 4.2% of males, 17.8% of female perceive as “moderate” while 14.9% of males (GDSPW, 1999).

Tobacco use is a serious health problem In Turkey, 63% for males, 24% for females. In fact percentage of tobacco use is still increasing among females. Pulmonary system malignancy is first the common health problem among males (89% of total) while 11% for females.

But breast malignancy is first the common problem among females (95% of total) while only 5.0% for males (GDSPW, 1999).

Some Examples on Gender Inequalities in Turkey

Women obtained many rights in the field of education, law, politics and other social fields after the foundation of Republic of Turkey in 1923. The social rights gained in this period had also positive influences on women’s health. But, still gender inequalities exist in many sphere of life.

The literacy rate by years has still lower for females than males since 1935. Proportion of population graduated from primary education is 43.6% for males, 26.6% for females. Proportion of male who graduated from secondary school is 2.1 times higher than female, while high school graduated is 1.8 times higher than female. Proportion of population graduated from university is 10.2% for males, only 5.4% for females. These differences indicate the gender discrimination, which in turn affect the utilization of health care services by women (GDSPW, 1999; SIS, 2000).

Women's political under-representation in Turkey is one of the main facts of gender inequalities. When we consider the world's figures of women's representation in parliaments, Turkey rated as the 101st among 174 countries, with 4.2% figure.

Therefore the lowest level of women's participation is in the political decision making in the country (Inter Parliamentary Union Database, 2000).

When we observe the highest rate of women's participation in professional jobs in Turkey, it will be much more obvious that the gender inequality to imply and perceive the importance of female under-representation rate in the political decision making process (UN, 2000).

Turkey remains at 48% globally, when rated to the Human Development Index (HDI) and Gender Development Index (GDI), but stands at 91% when analyzed within the scale of Gender Empowerment Measure (GEM) (UNDP, 2000).

As seen from all the available data that mentioned above on women's status and health; reproductive Health (RH) is an area for concern in Turkey, therefore we wanted to study "Gender and Health Policy Development in the area of RH" as Hacettepe University Research and Implementation Center on Women's Issues (HUWRIC). However, because of the time limitation, "Family Planning" and "Unwanted Pregnancies" were selected among other issues of the RH. Therefore it was planned to study "gender mainstreaming" in developing policy on family planning and unwanted pregnancies in Turkey, with the collaboration of the WHO and the UNFPA. The study was planned to carry out in two phases: The first phase of the study; to examine and analyze the legislators for the gender mainstreaming for the issues mentioned above. The second phase of the study to collect data from the field to find out in what extent the policies related to FP and unwanted pregnancies are implemented and what are the barriers and enabling factors at the provincial levels for the implementations.

(FIRST PHASE OF THE STUDY)

A CASE STUDY ON THE INTEGRATION OF A GENDER PERSPECTIVE IN REPRODUCTIVE HEALTH POLICY IN TURKEY

AIM OF THE STUDY

The aim of the study is to perform a gender analysis of national policy on the family planning and unwanted pregnancies in Turkey.

To achieve this aim, the main documents related to health policies were listed and five legislations were examined for the gender mainstreaming.

Objectives of the case study;

- To provide baseline information on the formal adoption of a national gender sensitive policy,
- To assess the extent to which gender specific considerations had been taken into account in specific health policies.
- To analyze the health policies related to RH (Family Planning and Unwanted Pregnancies) in terms of gender perspectives.
- To provide recommendations for future work or policy options for Turkey as well as for the WHO.
- To evaluate the method which was used in the study

METHODOLOGY

The main questions for the analysis that was carried out in the first phase of the study:

- How have women's and men's needs been considered in development, implementation and monitoring of the policies related to family planning and unwanted pregnancies policy?
- What were obstacles for paying attention to men and women's needs?
- What were possibilities for paying attention to women and men's needs?

To address the objectives of the study, the main policy documents related to RH were examined and analyzed for the gender mainstreaming in the issues of family planning and unwanted pregnancy.

- Main Constitution,
- The Law on General Hygiene (# 1593). Health Law on Socialization of the Health Care Services (# 224),
- First Population Planning Law (# 557),
- Second Population Planning Law (# 2827).

First, a study team was formed which consists of 5 people being 3 with medical/public health background and 2 social scientists.

The following 2 topics were selected to be examined "the integration of a gender perspective in health policy". Namely;

(1) Unwanted pregnancies

(2) Family planning

All these 5 documents were shared among the team members and a questionnaire has been used which was developed by the WHO/EURO with some minor modifications **(See Annex I).**

Weekly meetings were organized to discuss the collected data and its interpretation, procedures and progresses with the members of the team. The overall findings were discussed among the study team and a preliminary report was prepared in Turkish first, then it was translated into English.

Each legislation was examined according to the questions under the main topics (problem analysis, policy formulation, implementation, monitoring, and evaluation) of the guideline. **(Detailed information of this analysis is attached as Annex II).**

Finally a matrix* was formed in order to present a summary for the overall analysis of the documents based on the following topics that was suggested in the WHO-guideline for case studies:

- Which gender considerations are included in the policy?
- What were the enabling factors to do this?
- Which available information about gender was not included in the policy?
- What were barriers to include this information?

Because of the time constrain only 2 interviews with the key informants were carried out by using the original WHO-guideline for the interviews **(See Annex III).** Both interviews were carried out by one of the social scientists of the team who is also skilled on deep interview procedures.

Sources of Epidemiological Data that are used in this report:

1. Data used in policy papers

∗ Some data from the several DHS of Turkey, statistics made available by the State Institute of Statistics (SIS) and MoH and findings of researches carried out by the universities were used while analyzing the selected policies.

2. Data used in this report

- Percentage distribution of use of contraceptive methods and induced abortion by married couples in Turkey.
- Maternal mortality rates.
- Crude birth rates.
- Unwanted pregnancy rates and induced abortion rates.
- Infant mortality rates.

* The matrix is given as a part of the findings of the first phase.

(1963, 1968, 1973, 1978, 1983, 1988, 1993, 1998, 2003 Turkish Demographic and Health Surveys).

3. Other available data

• The SIS has since 1927 been collecting and publishing age-disaggregated data.

• There are qualitative and quantitative researches conducted by the universities.

• Relevant data published by the Ministry of Health.

• Population Census data.

• Five Year development plans of the State Planning Organization (SPO).

The study consists of a document analysis on selected policy documents using a questionnaire for the information/data collection to find out whether a gender sensitive policy exists or not in all stages of policy development like problem analysis, policy formulation, and also policy implementation, monitoring and evaluation. To analyze gender sensitive policy development the questionnaire is designed to consider gender equality and gender equity in each steps of policy formulation.

After completion of the document analysis interviews were made with key informants for information about unanswered questions and some other details. A separate comprehensive questionnaire was developed to interview the key informants.

In addition to the data, which was collected from the first phase of the study at the central level on gender sensitive policy development on family planning and unwanted pregnancies, information also collected from the peripheral levels, which is more highlighting the issues of the implementation of a gender sensitive policy on RH. The full report on the second phase is given as a separate section of the report.

The Main Findings of the First Phase of the Study

(A Case Study on the Integration of a Gender Perspective in Reproductive Health Policy in Turkey)

It was found that, **The Main Constitution of the Republic of Turkey** (1982) includes references to gender issues in terms of both gender equity and gender equality perspectives. Although the frequent usage of terms such as “all” and “none” may be the indicators of equality that was mentioned, this equality is not specifically underlined as gender equality. It is non-discriminatory for socio-economic status, gender, age etc. However, specifically gender, as a term also appears in some of the articles with reference to both gender equity and gender equality. Further amendments that were made later were also positive steps towards achieving a gender sensitive legislation. In conclusion, The Main Constitution concerned gender equality and gender equity in general including its overall approach, and also positive discriminative items for women the constitution has **(See Matrix I and Annex II).**

The second law, which was analyzed, was **The Law on General Hygiene** (1930). It focuses mainly on general health issues and some of its articles are sensitive to gender equality whereas some others have gender discriminative profile. Some of the articles seem to consolidate women’s traditional gender role in society, but when the days that this law took effect were taken into consideration, pronatalist policy’s influence may be argued to be the reason for this. The special feature of this policy is its obligation to educate people on health issues and to incorporate health courses at schools **(See Matrix II and Annex II).**

Another analyzed law is, **The Law on Socialized Health Care Services** (1961). Its rationale is mainly ensuring social justice in access to and delivery of health services. Therefore, the basic principle of this law points to gender equality by eliminating discrimination between men and women. It provides all citizens with equal rights regardless of their gender, age, religion and such considerations. There are also some articles related to gender equality within this law. However, on the other hand, those articles are also said to remind patriarchal norms that emphasize traditional gender roles of women especially by their reproductive roles.

With the new regulation, equity rather than equality became as the core notion and took place of equality pointing to the importance of providing services according to people's needs.

Later amendments also targeted all women but not only mothers, by which women are begun to seen as a special risk group because of their fertility but not instruments of raising healthy generations. Despite this providing a new perspective in terms of equality and equity, it can still be said that in general this law limits the role of women with being mothers and housewives who are responsible for child care and family health and put special emphasis on health problems related with fertility **(See Matrix III and Annex II).**

The fourth legislation examined is **The First Population Planning Law** (1965) that was implemented on national level. This law specifically addressed maternal mortality that was caused by induced abortions and unwanted pregnancies by stressing the adverse impact of population growth on national economy. Although with this law the practice of contraception was introduced except surgical sterilization, pregnancy termination was still forbidden if it were not done for medical reasons. This law was found to be insufficient in satisfying gender related targets. While preparing this policy, the findings of the survey on fertility and health that was conducted by Ministry of Health in 1963 was taken into consideration. This policy aimed to extend knowledge on contraception, provide people with contraceptives and train health service providers. The monitoring mechanism of this law was established by the reporting system of Ministry of Health, five-year development plans of the SPO and statistics published periodically by the SIS. Due to the statistics, crude birth rate was found to be decreased 12 % between the years 1960 and 1978. In addition, maternal mortality rate was found to be decrease from 208 in 100.000 live births to 132 from 1974 to 1981. Sex disaggregated data can be obtained from the records of the Ministry of Health and the Population Censuses as well as from Population and Health Surveys which provided data for only married women. These data can be said to act as a guide for some authorities and decision makers **(See Matrix IV and Annex II).**

The fifth law examined is **The Second Population Planning Law** (1983) that is also implemented at the national level. Mainly Ministry of Health has the responsibility of implementation but it cooperate universities, social insurance institutions, Radio and Television Corporation, other relevant governmental agencies, professional

organizations and nongovernmental organizations. This law addresses population planning including fertility regulation, providing and producing contraceptives, termination of pregnancies and surgical sterilization. The law was found to partially satisfy the targets of gender and health. Although the earlier policies associated women with their biological reproduction, with this policy the decision for abortion is given mainly to women. The law does not allow discrimination in terms of marital status in terminating pregnancies. With this policy termination of pregnancies were set free under safe conditions with the attendance of physicians. Surgical sterilization was also not restricted for both men and women who are above 18 years of age. The policy targeted decreasing the ratio of high risky pregnancies, maternal mortality and reaching at least 5% of couples each year for effective contraceptive methods.

The mechanisms that are responsible for the follow-up of this policy are the Advisory Boards of Family Planning and Women's Health of the Maternal Child Health – Family Planning GD of the MoH, Population and Health Surveys, Population Censuses and Five-Year Development Plans that are prepared by State Planning Organization. The General Directorate of Women's Status and Problems, a standing commission of the Turkish Parliament, The State Planning Organization, The Women's Health Commission (KASAKOM) and Women Research and Implementation Centers in 14 universities (including Hacettepe University Research and Implementation Center on Women's Issues – HUWRIC) are mechanisms that ensure the incorporation of gender issues to the health policy. In the context of selected policy, the data in terms of gender distribution can be gathered from The State Institute of Statistics, the universities that conduct research related with this issue, Ministry of Health. While drafting this policy, data gathered from DHS of 1978, from SIS and MoH and researches carried out by the universities especially. The findings of the "Operation Research" jointly carried out by the Public Health Department of Hacettepe University (which is also a WHO-Collaborating Centre for FP since 1979) and WHO were used in formulating the rationale of 3 important articles of Law no. 2827 related with induced abortion, authorization of trained nurses-midwives for the provision of IUD services and authorization of trained general practitioners for termination of pregnancies **(See Matrix V and Annex II).**

CONCLUSIONS AND DISCUSSION

Turkish study where five major laws are examined for gender mainstreaming in terms of reproductive health and its specific sub topics of “unplanned / unwanted pregnancies and family planning” revealed that in general, attention to sex differences in problem definition and agenda setting; policy design has been given. However, further investigations are needed to explain that based on the current legislations in what extend the decisions are made and policies are implemented and monitored. Only examining the legislation is not enough to decide whether “gender perspective is integrated in real life or not”. It is important to collect information from the peripheral levels that will be more informative to see the actual implementation of a gender sensitive policy on RH.

From the first phase of the current study the followings are general observations;

- Concept of gender equality and gender equity were not defined in the past so that it was not emphasized and in general gender perspectives (gender specific considerations) were missed in the old legislations.
- Differences between sexes and disadvantages of one sex were emphasized and some preventive measures were foreseen in the examined laws.
- For reproductive health; that was usually considered for females and in the old legislations reproductive role of women were overemphasized whereas in recent laws that was not the case. i.e. in the past women were seen as an object for demographic purposes, her fertility was pushed without her consent. However, in the recent laws she was given right to decide about her fertility regulation.
- Always women were targeted. Male involvement in reproductive health has been neglected in all stages of policy development although the reproductive health in the country can be improved by involvement of men more into family planning and by equally and equitably meeting the reproductive health needs of men and women.

The main limitations of the study are as follows;

- Language of the old/new legislations was quite difficult to interpret / understand even in Turkish (1930). In addition the background information of the legislations were sometimes missing or were not easily accessible.
- Extensive number of policy documents related to the topics under the study are exist however the time allowed the team to examine only 5 legislations.

- The time allocated to the study was rather short therefore, some extensions/ continuations should be considered, in fact in Turkish study it is planned to carry out the next phase of the current study with the support of the UNFPA to see to what extend gender equality and equity is implemented in practices even it exists in the legislations. In addition, the work was first prepared in Turkish and then translated into English. Therefore it took more time. Also because of the time constrain only a few key experts were interviewed.

RECOMMENDATIONS

For Turkey:

- Advocacy activities should be continued on consideration of gender issues for policy makers, related sectors who design and develop the policies related to reproductive health, especially for the jurists / law faculties.
- MPs of the Democratic parliamentary system prepare the legislations therefore all of them should be educated & sensitized in gender perspectives / consideration of gender issues. Also proportion of female MPs with sufficient knowledge on gender perspectives at the parliament should be increased.
- In order to integrate gender perspectives into the development of health policy accurate data on gender issues is needed.
- Sex disaggregated data are sometimes mixed with gender. So, the confusion between meaning of sex and gender should be taken into consideration.
- Gender mainstreaming even it exists on the theory its implementation should be examined therefore, 2nd phase of the study is needed.
- Dissemination of the information to the relevant stakeholders, such as policy makers (including MPs), health personal, NGOs, women/men in the community and media, are very important so that various types of policy dialogues should be undertaken.
- In the analysis and policy formulation not only gender equality but also gender equity should be considered.
- The existing laws should be screened in terms of gender blindness and gender sensitivity. While developing new legislations, the incorporation and integration of gender issues to the policy should be ensured and considered.
- In all stages of the reproductive health policy, male involvement should be taken into consideration.
- This study where five major laws are examined for gender mainstreaming in relation with reproductive health and its specific sub topics of “unplanned / unwanted pregnancies and family

planning revealed" that in general, attention to sex differences in problem definition and agenda setting; policy design has been given. However, further investigations are needed to explain that based on the current legislations in what extend the decisions are made and policies are implemented and monitored.

For the WHO:

- The time allocated to the study was rather short therefore, some extensions/ continuations should be considered, as in Turkish study it is planned to carry out the next phase of the current study with the support of the UNFPA.
- Dissemination of the information to the member states, international organizations, and other relevant stakeholders including NGOs are very important. Thus, a dissemination meeting should be organized by the WHO.
- Standard definitions related to gender issues are not clear. The terminologies should be standardized first, and then adapted to local / country / region specific terminology. Definitely "Definitions & Indicators of Gender Issues" should be developed and tested. (This is another study for the WHO). The criterion that will be used to decide whether a specific health policy is gender sensitive or not should be defined clearly.
- WHO should communicate the results of this exercise (study) with other UN health agencies including World Bank and the European Union.
- How to analyze the health policies for "integration of a gender perspective" is not a straightforward topic therefore the methodology should be simplified / standardized with clear indicators.
- The report should officially be sent to the Member States by the WHO.
- WHO policies and programs should also be studied as "case" whether they are gender sensitive or not.
- Every effort should be made to integrate "gender issues" in all global and regional WHO programs.
- WHO should organize at least 2 inter-country dissemination meetings to publicize the findings of these case studies carried out in 7 Countries.
- WHO should allocate budget for the studies on gender.
- Regional activities should be closely communicated and collaborated with the WHO / HQ as "One WHO" even "One UN" principle has been accepted.
- There are many more legislations and regulations related the issue under the study, therefore the countries, if they like, should continue this exercise, which doesn't cost much.

Comments on WHO – Guidelines

- The guidelines were well developed / well prepared, facilitated the task effectively. They were very helpful and

made the analysis easier. It would be better to include them in the tool kit.

- The matrix facilitated to summarize the findings but in some ways it should be modified or further explanation should be provided, as it was not easy to fill in.
- Indicators to assess gender issues should be developed in the near future

MATRIX 1. Title of the policy: Constitution of the Republic of Turkey, 1982				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	1980 Constitution considers the reassurance of individuals' rights and freedom. However the main gender consideration can be seen specifically in the items.	The development level of the state.	No specific gender approach is seen.	The term gender was not that much taken into account at that time.
Stages of policy development • **Problem Description**	The problem was described as: "1961 Constitution had some gaps with regard to its items about individuals' rights and freedom. In addition, realizing and practicing all the requirements that parliamentarian regimen necessitates in terms of execution and legislation should be met. Execution should be strengthened and the control of justice should be done legally." Again, there is a general consideration including men and women.	The same.	--	--
• **Planning**	In general equality is mentioned including all people regardless of their language, race, color, sex, political opinion, philosophical belief, religion and sect, or any such considerations (Article 10). Some gender issues on equality and equity were considered specifically to a point in some of the articles. Another equality consideration is mentioned in Article 42, which stresses the importance of approaching boys and girls equally for education. Equity was also another factor that was taken into account. Women were said to enjoy special protection in terms of working conditions. Especially the protection of mothers was addressed. Further amendments and provisions also removed some gender discriminative expressions from the law about the issues related with the citizenship status of a child born to a Turkish mother and a foreign father and political parties' rights to organize units as female branches.	Equality is defined as one of the three indispensable principles of democracy. The discrimination is strictly prohibited and the state bodies and administrative authorities were determined to be responsible for providing this equality and non-discrimination. The provisions that were done later about the constitution were influenced by the adoption of CEDAW and 4th World Women Conference.	Women are classified under "Persons Requiring Special Protection in the Field of Security" heading with people who are physically and mentally disabled. This may be argued to lower the status of women. It is also unfair as it only targets female widows of martyrs, married women and mothers but not all women.	Gender was not a term that was addressed and stressed in the 1980's in Turkey.
• **Implementation**	This point is going to be investigated and examined further at the second phase of the study.	--	--	--
• **Monitoring**	This point is going to be investigated and examined further at the second phase of the study.	--	--	--
Process Characteristics • Gender experts included in policy development	Not available	NA	NA	NA

MATRIX 2. Title of the policy: Law on General Hygiene, #1593, 1930				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	Partially	General poor health and needs of population	A legislative framework was to define the duties and responsibilities of all institutions in the field of health and to introduce up-to-date provisions and arrangements to respond to current health needs.	There was no gender perception at that time
Stages of policy development • **Problem Description**	Women's health was considered mainly for their fertility, which was supported by pronatalist policy. Specifically Article 169 can be taken as a special protection by stressing childcare courses for schoolgirls to prepare them for future motherhood as women are under risk during pregnancy. From another perspective Article 169 can be argued to be a negative one in terms of gender equality as it stresses childcare courses for schoolgirls to prepare them for future motherhood.	The "Law on General Hygiene" is an instrument exclusively focusing on health issues. It has many articles pertaining to male and female health. Some articles in this law imply gender equality and some others are reflecting gender discrimination.	It has articles regarding female and male health, which reflect gender discrimination. Some of its articles favor motherhood but not women in general. Some articles introduce women's body and fertility as an instrument.	There was no gender perception at that time and culture and traditional gender roles can be said to be barriers.
• **Planning**	No information	No information	No information	No information
• **Implementation**	An equitable approach prioritizing for risk groups; but any positive discrimination here actually favors not the women but motherhood, which further consolidates women's traditional/gender role in society.	General attitude of the policy makers	-	-
• **Monitoring**	The Law on General Hygiene establishes a reporting system whereby health facilities and health workers are obliged to report on certain issues. The law also makes it compulsory to incorporate health courses to school curricula and to launch programs for training public at large on health issues. The law also provides for fines and imprisonment for acts of breach. The items encourages excessive fertility have been changed later.	The new legislation come into force (224, 557)	-	There was no gender perception at that time
Process Characteristics Gender experts included in policy development	-No	NA	No such experts	There was no gender perception at that time

MATRIX 3. Title of the policy: Law on the Socialization of the Health Care Services in Turkey, #224, 1961				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	Partially the objectives of this law were to provide unpaid/free and equal health services to all citizens. Men and women were accepted as equal citizens by the state.	Health indicators of the country were led to this law. New, comprehensive and inclusive health services were necessary to improve health situation of men and women.	Only equality between sexes was included because of absence of current understanding of "gender" concept at that time.	• Lack of understanding of gender issues • Cultural barriers like education, working status and gender roles in the family and in the society
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Stages of policy development • **Problem Description**	Regional disparities were considered important priority by the state. Women were accepted as the first agent for improving family health especially children's health. In these stage women was accepted and treated as mainly "mother", "wife" and "housewife".	Level of social status of women and their poor reproductive health was recognized.	Policy makers protected traditional women roles. On the other hand, the target of the policy was uneducated women and women who has several children. They wanted to improve women's health knowledge and attitudes for developing healthy and happy family life.	Similar to above.
• **Planning**	Women were accepted as health care provider in solving family's (husband, children and close environment of family) health problems.	A large number of women were at home as a housewife. Thus, selection of women as the target group could lead to improve family's health status as well as their RH.	Women were accepted as a "mother", "wife", and "housekeeper". In this frame, their first role was defined by the traditional/patriarchal values	Similar to above.
• **Implementation**	Women were accepted as health care service provider in solving family's (husband, children and close environment of family) health problems.	A large number of women were at home as a housewife. Thus, selection of women as the target group could lead to improve family's health status as well as their RH.	Women were accepted as a "mother", "wife", and "housekeeper". In this frame, their first role was defined by the traditional/patriarchal values	Similar to above.
• **Monitoring**	Less developed region of country was selected for implementation. The Ministry of Health monitored Mother and child health steadily.	Established mechanisms for data collection on level of women's education and MCH.	Not included	Infrastructure, Patriarchal values and partial implementations of the law.
Process Characteristics • **Gender experts included in policy development**	There was no gender perception at that time. However, health care professionals emphasized disadvantages of women and their poor reproductive health.	NA	Only RH of disadvantaged women were accepted as and their reproductive health were accepted as important health issue by the policy makers.	Unavailability of such experts.

MATRIX 4. Title of the policy: Population Planning Law No: 557, 1965

	Gender considerations included	Enabling factors	Gender considerations not included	Barriers
Objectives	• Partially (+). However after pronatalist law, the state has adopted an anti-natalist population policy and promulgated the first population planning law	• Effects of excessive fertility on women's health	• Partially (+).	• Gender issue was not recognized in the country at that time
Stages of policy development **• Problem Description**	• Partially (+) - Unfavorable outcomes of unwanted pregnancies have been mentioned in the statement of law - Different needs of men and women are taken into consideration	• Increased maternal death due to induced abortion • High prevalence of unwanted pregnancies • Advocacy activities by the NGOs	• Partially (+).	• Conservative and traditional approach on abortion • Lack of information on surgical contraception • Demographic concerns were more influential
• Planning	• Resource allocation • Government support	• Negative economic impacts of over-population	-	-
• Implementation	• Resource allocation • Government support	• Importation and selling the contraceptives were legalized • Government support all contraceptives as free of charge	Difficulties in implementation of the gender consideration	• Personal acceptance • Insufficient health education on contraceptives • Lack of trained staff • Social constraints
• Monitoring	• Partially (+); sex specific qualitative data was collected but not issues related to gender issues were specified	• Results of Turkish Population and Health Surveys • Results of MOH records • State Planning Org. Reports	Difficulties in monitoring	• Lack of routine periodic and gender specific data, because gender issue was not recognized in the country at that time • Also poor recording and reporting system
Process characteristics **• Gender experts Included in policy Development**	No	-	-	• Conservative and traditional approach on women participation to policy making

MATRIX 5. Title of the policy: Population Planning Law No: 2827, 1983				
	Gender considerations included	**Enabling factors**	**Gender considerations not included**	**Barriers**
Objectives	• Partially (+) Abortion and FP method choice is up to woman	• Results of the scientific studies, which guided the objectives of law	Partially (+)	• Gender issue was not recognized in the country at that time
Stages of policy development **• Problem Description**	• Maternal deaths remained high • Unwanted pregnancies Were continued to be a problem	• Results of the scientific studies on maternal mortality related to unsafe abortion • Advocacy activities by the university	-	-
• Planning	• Partially (+) special resource allocation for contraceptive methods	• Resource allocation • Government support	-	-
• Implementation	• Partially (+) Abortion and FP method choice is up to woman	• Resource allocation • Government support	Difficulties in implementation	• Personal acceptance • Insufficient health education on contraceptives
• Monitoring	• Partially (+); sex specific qualitative data was collected but not issues related to gender issues were specified	• Results of Turkish Population and Health Surveys • Results of MOH records • State Planning Org. Reports	• Partially (+); last two- DHS take gender consideration into account (unmarried women & men were included into the survey)	• Lack of systematic and gender specific data • Conservative and traditional approach on woman's health
Process characteristics **• Gender experts included in policy Development**	**• Partially (+); only gender sensitive scientists included in policy development**	• Dept. of Maternal /child heath and FP • Women's heath commission and study groups • CEDAW • University Research Centers on Women's Issues	-	-

(SECOND PHASE OF THE STUDY)
GENDER MAINSTREAMING ON THE GROUND:
PERSPECTIVES AND ISSUES ON THE IMPLEMENTATION OF THE TURKISH REPRODUCTIVE HEALTH POLICY

Background

This study was conducted as a follow-up to the case study conducted by the Hacettepe University Research and Implementation Center on Women's Issues (HUWRIC) with the collaboration of WHO/EURO Regional Office. The case study explored the context and the extent of integration of a gender perspective in reproductive health policy in Turkey based on the World Health Organization (WHO) European Region guidelines. Two reproductive health topics, unwanted pregnancies and family planning were examined in terms of health policy in Turkey. For this purpose, five major legislations of the Turkish Republic were closely scrutinized for their content in terms of their considerations for gender effects. The five legislations were 1) the Turkish Constitution; 2) the "Law on General Hygiene" (law on preservation of health and prevention of diseases); 3) the Law on Socialization of Health Services; 4) the first Population Planning Law of

1965; and 5) the renewed Population Planning Law of 1983. The results of the case study were presented at the 2004 WHO European Region meeting and also included as the previous chapter of this report (Akin and Bahar-Ozvaris 2004).

Very briefly, the case study revealed that with the new amendments and changes to the constitution a more equitable legislation for men and women is in effect to protect and promote health in general in Turkey. It was also true that the legislation sometimes provided positive discrimination for women. However, the definition of women in the legislations in between the lines were found to be problematic from a gender perspective because of the emphasis on married women and portraying women as mostly through their roles as mothers and housewives. It is also important to note that the legislations about women's health mainly stressed problems related to fertility and only few citations were made to non-fertility related problems (Akin and Bahar-Ozvaris 2004).

The preparation of the case studies stimulated another major question about the actual enactment of the health policies on the ground. A good legislation

did not always guarantee good practice, and while the legislation could allow opportunities and freedoms in reproductive health issues, the actual procedures and the barriers women face could have been different, or vice versa. While this is a very comprehensive and difficult question, the HUWRIC team decided to conduct interviews in different sections of Turkey with the support of the UNFPA-Turkey, to plot the kind of issues in regard to applying health policy into practice, to make the connection between the laws and their implementation. This report was prepared based on the interviews with policy makers and health service providers. The study focused on family planning and pregnancy termination utilization and services. However, during the course of semi-structured interviews, other topics in reproductive health were also brought up and some of these important topics as they relate to the whole research question are reported here.

The main research problems that we have tried to address through interviews with key informants are as follows:

1. In the context of gender mainstreaming in reproductive health, what are the perceptions about “reproductive rights” in Turkey? What is the context of reproductive rights for Turkish women and how do they experience it?

2. According the revised Law on Population Planning, all contraceptive methods and safe abortion services should be made readily available to those who want to use them. How is the current situation in Turkey? Are the promises of this law really working in the field? Can women or men who want to use these services realistically access to FP and to abortion services? If not, what are the barriers?

3. How does health policy play into the availability of family planning and abortion services? How are some of the barriers created by the health policy acted out in real life in the field? Are there any other procedural discriminatory practices or bias through institutions or through health practitioners that cannot be justified with the health policy and legislation?

4. What is the cultural context of gender issues in reproductive health that may pose barriers, regardless of the policy and legislation?

The responses to the above four points do not have clear cut boundaries as several factors act synergistically to bring out an impact. In this report, we have arranged the following sections to provide a general picture of the contraceptive environment in Turkey with special emphasis on the research questions. The main implications of this research and the visions and scope for the future are provided in the conclusion section.

METHODS

Thirty semi-structured in-depth interviews were conducted with key informants in Istanbul, Ankara, Diyarbakir and Mardin (See Annex IV). Key informants were selected from a variety of different institutions, and they included: representatives from women's NGO's, representatives from family planning NGO's; family planning program directors in Public Health Departments of universities; family planning and abortion clinic directors in Obstetrics and Gynecology Departments in universities; service providers and clinic directors from the Ministry of Health Clinics (MOH); local Maternal and Child Care and Family Planning Branch administrators of the MOH; and two congress people with an interest in women's health. Three of the NGOs who participated in this research were specifically working in the area of family planning, reproductive health and reproductive rights, and the four others NGOs included women's health in their agenda, but were mostly dealing with women's rights issues. The two family planning NGOs were functioning to cover a wide geographical area of Turkey, and they had programs running in all regions including the Eastern and South Eastern regions. The other family planning NGO was a local branch and was serving a province of Diyarbakir. Three of the women's NGOs were based in Istanbul. One of them was serving different regions including Eastern Turkey, but the other two were mainly focused on women living in Istanbul. One women's rights NGO was locally based in Diyarbakir. Representatives of NGOs were mostly directors or program managers of their NGOs. However, interviews were also conducted with field personnel, their supervisors and service providers at the local level.

Diyarbakir and Mardin are in the Eastern Region of Turkey were chosen to reflect the situation in the East. Both of these provinces, but especially Diyarbakir had received huge migration waves from other Eastern and South Eastern rural areas and they both have very low development indicators. These regions are also populated with ethnic minorities speaking Kurdish, Zaza, Arabic or other languages as their first tongue. In Istanbul and Ankara, service providers of slum (gecekondu) regions were interviewed. Both of these big cities are heavily populated and cosmopolitan and local differences even within the same province exist. Additionally, most of the headquarters for women's NGO's are either in Istanbul or Ankara. The four cities and the key-informants were chosen to reflect different aspects and geographies of the issue. All interviews were conducted at the places of the respondents and site visits were also

conducted within these localities (to clinics, service sites, community gathering places, literacy course, etc.) as appropriate. This study did not intend to be representative, but rather tried to cover a wide array of perspectives related to issues in Eastern, rural Turkey and in the cities and slums of metropolitan areas. Among all interviews, 23 were tape-recorded. Respondents did not want to be tape-recorded in 7 interviews (2 with the congress people, 3 interviews in Mardin and 2 interviews in Diyarbakir) and notes were taken during these interviews. All tape-recorded interviews were transcribed. Although most interviews targeted one key informant, some of the interviews were conducted with a group of respondents, such as the cases with service providers in Ankara, Diyarbakir and Mardin and NGO representatives in Istanbul and Diyarbakir. The settings were favorable for such group interviews, and it also enabled interviewers to challenge contesting views. A semi-structured interview guide that was specifically developed for this study by the HUWRIC team was used for the interviews **(See Annex V)**.

The HUWRIC team also developed a list of statements on family planning services as a pilot testing tool to develop further based on the results of this study. This statement list included 27 items about gender perspectives in reproductive health and was administered to respondents after the completion of in-depth interviews. The results of this survey is not integrated into this report, but both the list of items and the range of responses are represented (See Annex VI). However, one interview was conducted with a group of women in Diyarbakir and women were asked about their reproductive life stories.

This interview provided valuable insights on women's lives and decision-making processes (or lack of it) about having children.

Excerpts from this interview are used to highlight or support some of the issues included in this study. All data was analyzed based on the themes appearing in interviews and direct quotes (which were transliterated) were used in presenting the data. In addition, the results of the most recent Turkish Demographic and Health Survey (TDHS) were also used to clarify and discuss some of the issues (Hacettepe University Institute of Population Studies and Turkish Ministry of Health General Directorate of MCH/FP 2004).

FINDINGS AND DISCUSSION

Before moving onto the findings of this study, it will be useful to review Turkey's current situation in fertility and contraceptive use levels. The contraceptive environment has always been favorable in Turkey, since the first population law of 1965 and abortion was legalized in 1983. Turkey has been running a very successful fertility reduction program for almost forty years, as indicated by the rapidly declining total fertility rates (TFR) from 4.3 in 1978 to 2.2 in 2003 (Figure 1). However, there are significant geographic differences.

While Western, Northern and Central Regions had a TFR of 1.9 in 2003 and the TFR was 2.3 in the Mediterranean Region, it was in contrast to the 3.7 TFR figure in South and South-Eastern Regions. Overall, 42.5% of all married women aged 15-49 were using a modern (medical) contraceptive method based on the 2003 TDHS, and again South and South-Eastern Regions lagged behind in contraceptive use rates. Probably the most striking contraceptive use characteristic in Turkey is the very high usage of withdrawal. As shown in Figure 2, as of 2004, it is still the most popular method among married couples with 26.4%, followed by intrauterine device (IUD) (20.2%), condoms (10.8), tubal ligation (5.7%) and pills (4.7%) (Hacettepe University Institute of Population Studies and Turkish Ministry of Health General Directorate of MCH/FP 2004). Another significant characteristic is the frequent use of induced abortion for family planning. Based on 1998 TDHS results, the induced abortion rate per 100 pregnancies were calculated to be 15.3% for all Turkey with relatively higher rates among educated women living in urban areas (Akin and Enunlu 2002).

Turkey has been indicated to complete the fertility transition by some experts (Behar 1995), and below the replacement level TFR in some regions can be interpreted as a sign of this transition. However, unmet need (defined as the proportion of women who do not want to have children but yet not using effective contraception) is still very high in Turkey, even in the slum areas of big cities like Istanbul. The issues about Turkey's reproductive health situation require from providers of different sectors and background to bring forward unique solutions. The following points should be read within such a backdrop of Turkey.

The Concept of "Reproductive Rights" in Turkey

When one looks at the issues of gender mainstreaming in reproductive health, the concept of "reproductive rights" invariably emerges as how it is experienced in the daily lives of women besides how it is approached in the health legislation. Several respondents, especially those affiliated with women's NGO's and working on women's rights issues in Turkey stressed that one can not talk of "reproductive rights" if a woman is not considered as an individual. Early and forced marriages, which are still prevalent in rural and mostly Eastern and South-Eastern Regions of Turkey were important examples of how women are not allowed to have an identity to decide for themselves. Both service providers and NGO representatives from Mardin and Diyarbakir emphasized that most women in the region were seen to be "responsible" for reproduction, rather than having and being able to exercise "reproductive rights".

Thus, if a woman did not fulfill the expectations of her family and the society about bearing children (and in some cases bearing sons), it was considered as her failure as a woman. How women perceived their bodies was defined by an NGO representative as:

"Here, women do not have the perception that their body belongs to them…Idea is that it belongs to their husband, their family. When we do education, we start with women's body, basic physiologic functions…Then they slowly understand that it is their body and they can decide about it…It takes time…" (FP NGO Volunteer, Diyarbakir)

Thus, the concept of "reproductive rights" was irrelevant for several women. It is important to note that women's NGO's and family planning NGO's always stressed "reproductive rights" within any of the programs they were running. The general trend within women's NGO's was that health appeared as a major theme and issue that brought women together even when it was not one of the missions. Respondents from women's NGO's indicated that they had to adjust and re-organize their activities based on the needs expressed by women, and issues about fertility control and domestic violence usually surfaced after working with a group of women for a while. This need lead to some successful collaborations between family planning NGO's and other women's NGO's, such was the case in Diyarbakir. In this case, women's NGO supported by the local municipality but still had an independent standing did not have the expertise to communicate and solve reproductive health needs, but their members

received training from a family planning NGO about how to address these issues. The second round of training was in effect during the time of the interviews for this study. Family planning NGO's, on the other hand, always made a strong emphasis on "rights" when working with women from the community or when training trainers. Two of the larger FP NGO's included routine sessions on women's rights and reproductive rights for their health education programs in the community. This was seen as more of a "consciousness raising" effort by the NGO's rather than meeting a demand. The efforts to increase the demand for effective contraceptives and helping families to use contraceptives effectively were regarded as part of the women's empowerment process. NGO representatives from Istanbul and Diyarbakir also made the point that "even the most educated people may not know about reproductive rights". As one NGO representative phrased it:

"Maybe some groups of women know about CEDAW (Convention on the Elimination of All Kinds of Discrimination Against Women)…But overall very few women's groups know or conduct programs about it…Go ask "Mother's Organization", they won't know it. The White Violets or Daisies, whatever, they don't know about it either…Even the lawyers do not know that international conventions are above the constitution". (FP NGO Director, Istanbul).

Related to "reproductive rights" and "control of fertility" by women, the value attached to women's fertility still seems very dominant in the Turkish culture and may still hold implications for women's fertility levels. Both respondents from the public sector service provider group and the NGO group have mentioned that, for some women, high fertility may be "the only way to express themselves", and that they may actually want to have several children, because they feel powerful. While it is desirable and "normal" for most Turkish women to have children, it is not clear how big an effect the desire to "hold more power" may have on the number of children a woman bears.

"A woman who delivers 8-10 children could think 'See I am still young, and I can still bear children…My sexuality is important…I am not old…My husband will not marry another women, because I am still young, I can still bear children for him…' This may be a woman is feeling, maybe the only way she can express herself to her husband. This is what I think…" (Nurse, Public Clinic, Diyarbakir)

Son preference, which is also related to perceived "power" of both the man and the woman in the society, may also cause some women to bear more children than they would prefer, as exemplified in the interview with a woman, who continued to having children after having 3 girls, because her husband wanted a boy. She eventually ended up

with eleven living children, where her ideal number of children was 4, “two boys and two girls”. The full story of this woman can be found in the **(Annex VII).**

During the interviews, questions about a “gender sensitive approach” in implementation of reproductive health policy and “mainstreaming a gender perspective” appeared to be problematic, because one just could not ask them as they were. First of all, most family planning and abortion service providers and public administrators did not know the specifics of the current legislation (the revised population planning law of 1983) and confusions existed in issues such as: whether it was legal to distribute pills by non-medical personnel; whether “husband’s signature” requirement should be enforced or not; or what to do if a single person or a person in religious union applied for abortion.

The public institutions seemed to have standard family planning procedures that slightly varied in cases of abortion or emergency contraception. Most of the time, the public clinics served clients who came to them and although it is defined in Socialization of Health Services Law as such, reaching out to others who cannot come to the clinic or increasing the demand did not seem as a primary concern. On the contrary, there were complaints of insufficient numbers of personnel and overwork. Thus, when directly asked about the implementation of the reproductive health legislation, it did not yield fruitful answers. Without specific indicators of “gender-sensitive” approach, it was also difficult to ask if the procedures were taking into account the specific needs of women. The translation of the word “gender” into Turkish (*toplumsal cinsiyet*) is also problematic, which is close in meaning to “social sex”, and the direct questions about gender mainstreaming did not work well with health professionals at all levels, such as midwives, nurses, physicians, and OB/GYN’s. This was in contrast to women’s and family planning NGO representatives and respondents from university Public Health Departments, where they could use and describe the aspects and problems about gender mainstreaming in their work comfortably. In at least two occasions, health professionals voiced that they did not have any training about “reproductive rights” or gender issues, but they would like to.

In the following sections, the specifics about the gender related aspects of family planning and abortion services are explored based on the perspectives of key informants. First, we define the main “gender” issue for women about family planning as whether they are able to access and use contraceptive methods

when they want to. The same is also true for men. The key point in the analyses was whether the legislation and policies made it easier for men and women to get the contraceptives they needed, or whether either the legislation, or the way it was implemented posed barriers. A similar approach was used for abortion services and a hypothetical client-provider transaction was deemed successful if it allowed women to decide whether or not she wants an abortion and to get it without much suffering and delay. The data is presented also to show the cultural context of reproductive health environment in Turkey.

Are contraceptive services realistically available for those who need them?

The short answer to this question was "No", based on the interviews and also based on the high figures of unmet need. However, respondents from both the public sector and the NGOs generally also agreed that women could get and use a contraceptive method in almost anywhere in Turkey if they were really determined to do so. This was reflected as:

"It is not incredibly difficult to get a contraceptive. If a woman really wants to get a contraceptive method, she can do so in Turkey." (FP NGO volunteer, Istanbul)

In fact, this seemed to be the summary statement of contraceptive services in Turkey as seen by most service providers. It seemed kind of okay and acceptable, within the circumstances of Turkey, if a woman had to go 2-3 times to get an IUD inserted, or be flexible enough to purchase pills from the pharmacy when they were not available free of charge from the public clinics. We defined "realistic access" as being able to get contraceptive for an affordable price and with a reasonable effort. It is clear that the definition of "affordable price and reasonable effort" may vary, and in the literature, "access" has been mainly defined in terms of physical distance to a health clinic or sometimes it is used interchangeably with the availability of the service and/or commodity (Ross 1995). In this study, the respondents were asked to use their subjective assessments of the level of difficulty in access. While the problems of physical access and cost was not indicated as major problems for contraception (whereas cost was an issue for abortion), the problems with service provision and issues related with the demand from the clients appeared as main themes. The different problems of access are discussed under subheadings below.

Contraceptives not available in the public clinics

Several respondents from different sectors emphasized the problem with the "materials", that is, the discontinuation of the availability of contraceptives for some periods as a major break down of services. This was especially true for the pills and condoms.

"When we are totally on track as a FP clinic, everything seems to be just in order, we run out of materials…It takes us back by two-three months…" (Physician, FP Clinic, Diyarbakir)

"For instance, we bring pills, for 3-4 months, we make people get used to it. People get used to it, we tell them 'See we are distributing pills free of charge, we have a card (record-keeping) system, and bla bla…' Then for 3 months, 4 months, no pills…That is terrible!… Then we go back to where we were". (Midwife, Public Hospital, Diyarbakir).

"*It takes at least 2-3 months to get one woman to use pills…She may forget, she may not take them correctly…For the first couple of months she may make mistakes in using pills, she may misunderstand…But when you explain for the third time, she understands and corrects herself…But then we cannot give her pills (after she gets used to them) for a month, or we don't have them for 2 months. Then she uses for 2 months, but no pills for the next 2 months…The woman is not thinking (only) about pills anyway…(That is not her priority)…Then everything gets mixed up…"* (Midwife, Public Hospital, Diyarbakir)

Thus, the service providers seemed frustrated about the breaks in supplies provision, which was especially the fact for the pills. When they wanted to provide high quality services and tried to set up good record keeping and establish good relations with the community they were serving, all their efforts seemed to "go down the drain" with the breaks in services which were beyond their control. The public they were serving, the providers reported, held them responsible for almost any problem related to the availability and use of contraception and they could not explain that, when the pills were not available in a public clinic, it was not their fault. This situation added to the frictions between providers and clients in some regions.

The unavailability of the pills and condoms were also observed during field trips in Diyarbakir and Mardin. In the large city of Diyarbakir, pills were available at only one public/NGO facility that was the local branch of a FP NGO. In all other public health clinics visited, including two maternity hospitals and one maternal and child health clinic, the pills were not available for distribution. The reason was that the Ministry of Health had to finalize a purchase of the pills, but due to some delays in bureaucracy, the

pills would not be available at public clinics for another two months. They were, however available at pharmacies and were sold for a price between $4-12. But because most pill users were in the habit of providing the pills free of charge from the public clinics, several service providers from different sectors agreed that unavailability of the pills at public clinics could cause disturbance in regular pill use for some women.

Bias of the health personnel

Another topic mentioned especially by the FP NGOs about the barriers to good service was the bias of the health personnel towards hormonal contraceptive methods, particularly the pills. One FP NGO representative pointed the bias of health personnel as one of the major reasons of underutilization of the pills in Turkey. Another respondent from another NGO supported this view by indicating:

"When we work with women, we screen them for everything. If the woman wants pills and if eligible to use the pills, we refer her to a health post. But then the nurse midwife at the health post says "Pills are not good for you, they contain hormones, they may cause infertility". Same with the injections. [They say that] it will cause amenorrhea, it will do this, do that…We are having a lot of resistance about this…" (FP NGO volunteer, Istanbul)

Additionally, health personnel's wrong information or misconceptions about contraceptive methods was also indicated as a reason for high discontinuation rates in Turkey. One respondent suspected that "recommendation by health personnel" was an important reason to discontinue any method in Turkey. Another prejudice was about the women with law socio economic status that they were not capable of using the pills correctly:

"Physicians know everything and they decide for woman…It is very interesting…Deciding for woman…that she will use incorrectly…that she can not use pills" (FP NGO Program Director, Istanbul).

"After sending the woman back to her home, this young doctor [in Eastern Turkey] said, 'I did not mention the pills…She can't use them'…A young doctor, a well meaning doctor. Can you imagine? (FP NGO Program Director, Istanbul).

The points made by the NGO respondents about the bias of the service providers and the failures in service provision are contested during the interviews with service providers and respondents from the public sector that will be presented in the following sections. On the other hand, not FP NGO's, but women's rights NGOs seemed to have misconceptions themselves about the "harmful effects" of

contraceptives in Turkey. “Is the spiral inserted in Ağrı a good one? Or is it inserted in a healthy manner?” asked a respondent. She also made the point that a friend living in Europe told her that the pills that are withdrawn from the European market are used in Turkey. While it may or may not be true for other pharmaceuticals used in Turkey, the pills have always had a “disciplined market” in the private sector, with almost all brands available. The pills distributed by the public clinics were low dose and high quality, and they were made in the USA and FDA approved.

As one FP NGO respondent explained, in the past the market about condoms was not well marked and cheaper and lower quality condoms were widely sold. However, the case with the pills was quite different and there has never been a real case of “low quality pills”. One problem identified with pill users prior to a study conducted by the Turkish Family Health and Planning Foundation (TFHPF) was that women were buying and using high dose pills, and almost 60% of pill users were on high dose pills. Women usually chose their brand by asking other women around them, and once the high dose was in the market, most women picked them up, because others were doing so. Through a social marketing campaign by the TFHPF, the trend in high and low dose the pills were reversed. Thus, the rumor that the pills in Turkey could be more harmful than the ones in European or American markets does not have a sound basis. The mistrust for the contraceptive methods seems to have its roots in the Western feminist model, which criticizes the “masculine medical system” for disregarding women’s bodies and needs.

Are services provided for groups other than “married women”?

One of the key points in terms of the gender aspects of reproductive health was the design of services for men and women. In all interviews and site visits it was clear that the whole domain of contraceptive and abortion services were designed for women clients who were married. The two exceptions were the adolescent reproductive health units within the University health care system in Diyarbakir and Ankara. When public sector service providers were asked about the specifics in their provision system or design that was gender sensitive, they made the point that they were working almost exclusively with women, and that it invariably made them gender sensitive. Thus, providing services only to women alone was perceived as conducting a gender sensitive approach. It is true that the services were designed to meet the needs of women, and it did benefit several women.

However, from a gender perspective, other groups who were left out of the service provision system in practice, namely men, unmarried women and the adolescents conflicted with the reproductive health policy which did not have any restrictions as to who could use the services and who could not. For the health legislation about family planning services, the general understanding is that anybody who needed the services, regardless of age, gender and marital status could use the services.

It should be noted that, despite the design of services for married women, service providers did not usually ask the marital status of the person asking for contraception and they did not turn down men or unmarried people. Service providers from all groups and geographic regions indicated that it was mainly due to social and cultural reasons that men and unmarried women did not use the public services. Most respondents believed that men would be shy to come to a public clinic and ask for condoms and they would prefer to use private services and pharmacies. Unmarried women rarely visited public clinics, and when they did, it was to get contraceptive advice soon before they got married. The social norm for most part in Turkey today is that sex has to be initiated with marriage. Therefore any indication of premarital sex is highly stigmatizing for women. Under these circumstances, it is understandable why the unmarried people, especially women would not prefer the less confidential environment of the public clinics, even to get information.

The methods that men can use are limited. However, in Turkey, the high rates of withdrawal can be interpreted as significant male contribution in the desire to limit fertility. It is reported in a qualitative study form Istanbul that both men and women may prefer withdrawal as a “natural” and “harmless” method in contrast to the “artificial” medical methods (Cebeci-Save, Erbaydar et al. 2004). Yet, failure rates with withdrawal are estimated to be high and increasing male participation in modern method use was strongly supported by respondents from all categories. It was also indicated that there are no legal or procedural barriers for providing services for males. In reality, none of the public FP clinics offered vasectomy. Some of these FP clinics were conducting tubal ligation operations, so the logistics were already there to conduct the simpler vasectomy procedure. Lack of trained personnel was reported as the main reason for not offering vasectomy.

Cultural barriers were also indicated as men’s unwillingness to use modern contraception. Several examples were

given, especially in Eastern Turkey about how men would strongly reject to use contraception even when their wives cannot use the methods due to health problems and medical contraindications:

"There is a woman who frequents our laundry room. She has very serious health problems. She cannot sit down, her legs get numb when she sits down…Her husband has to use contraception. That is what the doctor told her. She used to use pills, injections are not good for her, she cannot use the IUD and so on and so forth. Her husband has to use a method. When she told this to her husband, he said "I will kill both you and the nurse who told you that". I mean, some men make it an issue of honor and they threat their wives. Never would they use any method. It is the wife who bares children, so she could use a method. This is the logic, a straight logic" (FP NGO worker, Diyarbakir)

"None of the men are using contraception in this district. For example there is a woman who cannot use pills, she has heart disease and hypertension…I told her a lot [that her husband should use a method]…And every time she said, "No, he will never use [any method]". I wanted to talk with her husband. She said "He will never agree to talk with you". Men apply violence to their wives, too. You can see at least 4-5 women a day with purple eyes…" (FP NGO volunteer, Diyarbakir)

Other respondents, especially those working in NGOs and have direct communication with the community felt that for some regions, especially in the Eastern Turkey, times were still ripe for such a social change to occur.

"I think it is still too early for this district [to conduct programs with men]. There is a very strict feudal structure. It has been very difficult for us to base ourselves in that district for the last one year. Because, according to them we are people from the outside with good Turkish and outfits. Several men were asking behind us 'What are these girls doing over there?' They were suspicious. Only recently people have started to understand that we are not doing anything bad or harmful. They have just started to show respect. Now, at this level, when we are trying to preserve our own space and relationship with them, if we get into the talk of vasectomy and the stuff, we won't be able to keep the conditions to stay in that district. Maybe after some time…That district is very complex and diverse. I am not sure how you can keep the balance when you try to include men at this point" (Women's NGO director, Diyarbakir)

Within the favorable environment of Turkey, most men support the use of contraception for their wives and they see it as women's responsibility. And even the use of withdrawal and acceptance of condoms are high, surgical methods for men are not favored. All of respondents in this research favored increased male participation and had plans to run programs with men.

Availability of Emergency Contraception

The availability of emergency contraception (EC) is another issue where conflicts between health policy and procedures exist. EC was not widely publicized until the marketing of two preparations recently. Public FP clinics usually saved this method for condom failure and the general practice was that women were given appropriate number of oral contraceptives outside their packaging, but they were not given the information that the tablets they were taking was regular contraceptive pills. The idea was not to allow women know that they were using easily and freely available contraceptive pills for EC. The justification was that women could abuse it, use EC very frequently and endanger their health.

From the interviews, it became clear that the respondents from the public sector and NGOs had different perspectives on expansion of the knowledge and use of EC. Even though there were exceptions, the general perspective of the public sector was that the information and the EC should be reserved for special cases. It was usually meant that educated women could act responsibly with EC, but it was believed that especially for uneducated women, it was best to keep the information to the service providers. The only thing the woman should know about EC was to come to a clinic within 72 hours of unprotected intercourse.

"If we explain it (emergency contraception) as a method of family planning, she will use it continuously. I mean, she won't use it properly, say, just one time but she will use it all the time…" (Physician, Public Hospital, Diyarbakir)

"Yes, I have serious concerns that she won't be able to use it correctly. There are women who use pregnancy tests as a form of family planning…For example, she comes and has a pregnancy test every month…" (Nurse, FP Clinic, Diyarbakir)

"We tell women who are using condoms, if a break happens in the condom… We don't give her emergency contraceptive pills with the condom… We tell them to come to us immediately; the next day…I don't think you should give this information to anyone besides the ones using condoms…" (Midwife, Public Hospital, Diyarbakir).

Public sector providers also believed that the preparations for emergency contraception were advertised falsely in Turkey as if they could be used anytime after having sex.

Through the ads, women had the impression that, rather than taking a pill each day, they could simply use emergency contraception after each time they had sex.

A respondent from a FP clinic of the NGO also verified this misrepresentation of emergency contraceptives.

The perspectives of the NGOs, on the other hand was more liberal and they believed that is was imperative to make the EC information widely available to all people. The representatives from FP NGOs also were complaining about the "resistance" of the public service providers about making EC known.

"It is our organization who first brought this concept [EC] to Turkey. We started to inform each and single women in our programs. We have had incredibly difficult times with the physicians with EC. "How dare you give information about it? Then women will start using it as a method. Women will not understand'. And they were giving the pills secretly. "Do not tell what these pills are, do not tell!"…Thank God, now we have the EC preparations and we are saved…we really made it our mission. We put a lot of effort in it…we are talking about 500-600 thousand women. We gave them a totally new concept. We tell it to each women we visit. Even when she is not in the risk group, even when she is in menopause; for her sister, for her neighbor…" (FP NGO program director, Istanbul)

Even before the availability of special preparations for EC and before the misleading advertisements, health professionals still had reservations for making EC information widely available. The concern of the public providers that women may abuse the method and have health hazards needs to be verified. And because EC preparations are very new in the market and EC was not used by married women in the past according to the 2003 TDHS, we need to make careful observations and studies about its use in Turkey.

EC can be a preferred method by young and unmarried women who may not have regular sexual lives, and in that case unbiased information about patterns of use and any side effects would be very crucial.

Availability of surgical sterilization

The regulation about giving consent for tubal ligation and vasectomy is the same and equitable under the Turkish law, because it requires both genders to give consent to the other. The law was based on family union, and honored the decision making about sterilization to both sides at the same time. However, in practice men and women are differently influenced by this requirement to give consent for two reasons. The first reason is that men and women do not hold equal powers in the family. Even though FP is seen as women's business and responsibility, in cases of sterilization decision, women may be less likely to persuade their husbands to have a

surgical sterilization, and they will be less likely to deny such consent in the unlikely event of a man wanting to have sterilization. The second point relates to the rareness of vasectomy in comparison to tubal ligation. The rates of tubal ligation are increasing among women and it could further increase if the procedural barriers are removed.

Another barrier for tubal ligation comes from the medical personnel as a medical barrier. As exemplified in the women's interview, women may be denied tubal ligation even when both they and their husbands give consent on the grounds that they are too young for the procedure or they have too few numbers of children. The general information given at one Diyarbakir Public Hospital was that tubal ligation could not be done to women younger than 25. This was totally arbitrary, as the legislation had no limitations for age.

The cultural context that does not favor vasectomy for men, and parallel to it, the almost total unavailability of information and services for vasectomy also tilt the balance against women. Therefore even if this law was meant to protect the family and give equal rights to both men and women, in reality women are disadvantaged in terms of surgical methods.

The Public Sector Perspectives

The respondents from the public sector who participated in this research were either directly providing women reproductive health services or they were running programs through the Ministry of Health or through public health departments of universities. Several times, the universities collaborated with MOH, and local municipalities also provided services in Istanbul and Diyarbakir.

Overall, the administrative level program planners in universities and the MOH had a broader understanding of women's rights, women's health and contraceptive access issues in Turkey, while direct service providers were mostly informed through daily practices and interactions and provided more local descriptions. It seemed that the two levels of providers, direct providers and indirect providers, held somewhat different views about the main reasons for the persistence of high "unmet need" in Turkey. We define direct providers as those providers working in FP clinics or hospitals and in direct contact with the clients (i.e. physicians, nurses, nurse-midwives and the like). These direct providers were inclined to think that the primary reason for women not to use modern contraception properly was a "lack of

education" of the women, and not being able to use the available services.

"If (a woman) has high education, she will demand services. When she is not educated, she does not demand a service. The people cannot use effectively even the services that are currently available. The service is provided, but it is not reflected full-blown on the public. They cannot use even the existing services". (OB/GYN in public and private practice, Diyarbakir)

Lack of education of women was also seen as a primary barrier to prevent women from visiting the FP clinic in the first place:

"*I think education is paramount important… The [uneducated] woman can not talk about her concerns, problems…She feels shy…She thinks "what if I am scolded", "what if I cannot explain what my problem is"…Then she cannot come to visit us, she feels shy and reserved".* (Nurse, public clinic, Diyarbakir)

Thus, according to direct providers, who believed that they were overworked and that they were doing almost everything within their capacity, the uptake of services, or the demand for them was not enough. The direct service providers seemed to have two different images of their clients, when they were asked why there were still women who were living in close vicinity to the clinic, but still were not using the clinic for contraceptive services. The first such image was of a woman who was simply "lazy and procrastinating" as indicated by a group of nurses and nurse midwives in Mardin. These types of women could never bring themselves together to go and get a contraceptive on time and they end up with pregnancy. The other image of women who could not use the services was of a very busy woman with some children who is the main caregiver and bread earner in her home, and who at the same time has to struggle with a husband and mother-in-law. This second group of women is imaged as very stressed out and not being able to have the time or the means to go get the services they need.

Another point emphasized by the direct providers as interfering with FP services was the performance system that was recently enacted by the MOH. The providers felt that it was not a fair system when preventive services such as FP were in question. With the new performance ratings that intended to improve productivity, each procedure was allocated a certain score. For instance, injections and pelvic exams had high performance scores, but initially family planning counseling or any other form of health education did not have any score. The performance scores were reflected in the salaries of workers, and a

person with high score was to receive a higher salary. Family planning service providers spent most of their time for counseling, health education and training but they did not get any performance score for the services they were performing. There were concerns that this could have caused some providers to cut corners with giving comprehensive counseling or health education and prefer those procedures (such as injections or IUD insertion) those had higher performance score. Although recently "counseling" was also given a performance score, the service providers felt that it was low and did not reflect a just salary increase for their efforts.

"*You sit down and explain breast feeding to a woman for hours…It is so important…But with the injections, you just do it, and you don't have to explain anything*…" (Physician, FP clinic, Ankara)

Are Safe Abortion Services Realistically Available for those who need them?

Provision of abortion was found to be a sensitive issue, more so financially and legally than religiously. Abortion up to 10 weeks of gestation has been legal in Turkey since 1983 and it is being highly resorted to as a means of family planning. Because pre-marital parenthood is socially unacceptable in Turkey, it is estimated that a major proportion of pregnancies among unmarried women end up in abortions. Later pregnancies of elder married women who have completed the number of children they would like to have may also end in abortions, especially for those women living in the West and having higher socio-economic status. In more traditional and rural pockets, some women may never consider abortion and deliver all her pregnancies, with the expression of "Allah who has granted the children will also provide for them". Some other women may definitely consider abortion, "because it may be more sinful to bring a baby on this earth and not being able to provide for her", but may not have access to a doctor or a clinic or may not have abortion due to its cost. With these different perceptions and intentions about abortion, no abortion provider has ever been attacked or accused in Turkey nor has there been a strong religious opposition to abortion by the state, religious clergy or by the people. Resorting to abortion or not is highly perceived as a family's own business by many of the actors, and hence the problems related to access usually are tied up to three major factors. The first two factors are related to each other and these are: 1) use of abortion as a highly profitable procedure by the private practitioners, and 2) realistic unavailability of no-cost or low cost abortion services in public clinics.

The third factor is the interpretation and implementation of the law which states that "husband's signature is required" for the performance of an abortion.

We found that even in a single province, such as Diyarbakir, where the pool of service providers from public, private and NGO sectors is small and these people know and frequently interact with each other, there are different practices in regard to interpreting the requirement of husband's signature. A nurse at an NGO clinic, who sets up abortion appointments interprets the law quite liberally and easily signs up the woman for the service when she brings in a signed form, without requiring the husband to be present at the clinic for the signature. A woman usually visits a clinic three times for an abortion. The first visit is to get an appointment, the second one for the abortion and the third one for a post-abortion follow-up. With this implementation of the law, she takes the form during her first visit and brings back the signed form when she comes in for the procedure. The same nurse also gave appointments women "under really difficult conditions", where the woman in question absolutely does not want the pregnancy, but unable to get a signature from her husband, or when she is not legally married but in a religious union. "All I want to do is to help women", the nurse indicated. "Sometimes the woman's husbands are away, sometimes they are drunk and they don't even know or care that their wives are pregnant… and sometimes women beg… They say "Please, please, I can't take care of this child"…It is very difficult…I try to help…"

A midwifery student doing internship in the FP clinic of a hospital in Diyarbakir, at the other hand, believed that it was absolutely necessary to have the husband or someone from the husband's family present at the time of the procedure to give the signature.

"Even if a woman is married, we have to see the certificate of marriage…We don't do abortion without her husband's signature…She comes here with her husband…The husband gives the signature…The husband can come on a day when he is free, and we will take his signature in five minutes…If the husband is not available, then her brother-in-law or mother-in-law must come…Just someone from the husband's family." (Midwifery student 1, public FP clinic, Diyarbakir)

The other midwifery students shared this view during the interview and they also supported that the law should be continued as it is.

"I think it is a good practice [to ask for husband to be present to give signature]. In my opinion, a woman should not have abortion without the consent of her husband. I don't think that it (the law) should be

changed…I am against pre-marital relationships…I don't think these things should happen…" (Midwifery student 2, public FP clinic, Diyarbakir)

"It (the procedure of getting signatures) should continue as it is…A husband has responsibilities in a marriage. It is only 5 minutes that he can come and give signature. It is not like we are asking him to stay here for hours or we are asking him to do this or that…We have to see him…That's all…I don't think it is a big deal to give a signature…It will take him only 5 minutes…" (Midwifery student 1, public FP clinic, Diyarbakir)

The perception that it will take "only 5 minutes" for the husband to come to the clinic to show him and sign the papers was an interesting one. We think it is much more burdensome then "only five minutes" for a man to make the arrangements to accompany his wife to the clinic. By interpreting the law in this way, service providers are increasing the barriers for women.

Some other service providers were also strongly opposed to doing abortions without the signature of the husband and they feared that they may get into trouble if they do not follow what the law indicated about husband's signature:

"We never do the procedure without the signature of the husband. We do not do abortion to women in religious unions either. I believe this procedure should continue as it is; because this is the responsibility of both women and men. I have been doing abortions for seven years and I have never met a husband who says he wants to keep the baby. In this region, it is usually women who do not want to have an abortion. Usually it is women who opt out. Promiscuous relationships are very common in this region. For instance a woman becomes pregnant (from her lover), she gets an abortion, then her husband learns about it and comes to our clinic. What is going to happen then? These types of events have happened in the private clinics. We had a few similar cases too. We, only with good intentions to help the woman did the abortion when she told us that her husband was away. Later we have learned that the child was from another man. There is no law or director here who will support me under these circumstances. I won't do it here, and you are not supposed to do it anyway." (OB/GYN, Public Hospital, Diyarbakir)

Other service providers also supported the idea of getting husband's consent based on mutual responsibility and sharing of decisions between the couple:

"Actually, if the father is opposing abortion, he may, the sperm comes from him. Doesn't he have any right over the unborn child? In my opinion it should be a mutual decision. It may change in the future. But according to be both sides have to decide together." (OB/GYN, University Hospital, Diyarbakir)

Another interesting approach to the interpretation of the requirement for

husband's signature came from an OB/GYN:

"One should look at the social circumstances of a person when you are deciding about the indications for pregnancy termination. For instance, if a woman has 10 children and wants to have an abortion for her eleventh pregnancy, the father should not have much to say, because it should be mostly the woman's decision. Even if the husband does not give consent, mother's consent in such a case should be taken as sufficient. On the other hand, if the couple has no children, and if everything is all right with the baby, and the mother does not want the pregnancy, then the father's decision can be given the priority to save a life. I think generalizations are wrong…I believe that the consent of the husband should not be compulsory" (OB/GYN, Public Hospital, Diyarbakir)

On the other hand, a midwife made a very strong point that it was women's right to have abortion up to 10 weeks of gestation without any limitations when asked why abortions were not provided in a large Public Hospital in Diyarbakir:

"The reason that it is not provided in the clinic is that MR is not seen as a family planning service. It is not seen as a FP method, or some service people should have easy access to. Actually, it is women's right. To terminate a pregnancy up to 10 weeks is a woman's right if she does not want the pregnancy. It is just as her right as her rights for the condom or the IUD just like her mother's milk. But people cannot realize this right. Unfortunately, not here" (Midwife, Public Hospital, Diyarbakir)

It seems unlikely for most unmarried women to prefer to go to a public clinic for an abortion. Private clinics run by OB/GYNs can do abortions without asking for signatures because there is no legal enforcement or follow-up of private records. However, the cost of an abortion in a private clinic in Diyarbakir is usually in the range of ten times more than the cost at a public clinic. When questioned about the practice of asking signature for unmarried women, the reply was:

"They (unmarried women) go to private. Most of them go to private…Because we don't do it (abortion) (for unmarried woman). This is not something we can handle…" (Midwife, Public Hospital, Diyarbakir)

"If a woman is not married, I am against abortion or any other contraceptive method for her. I am particularly against abortion. I am responsible for conducting the services provided by the state, but I am not entitled to clean the dirt of others. I think we should provide information about family planning services and if an unmarried girls is having sex, she should know a method to prevent pregnancy" (OB/GYN, Public Hospital, Diyarbakir)

The insistence on asking for husband's signature was explained as possible problems with the father (legal or otherwise) if he finds out that his wife had

an abortion without his consent. Some of the service providers were afraid that the father could raid the clinic and hold service providers responsible for doing the abortion, because he wanted his wife to deliver the child. The fear of the possibility of having problems in the future with the father seemed to have a strong influence on service providers' practices. However, it was not clear whether these fears were really grounded by self-experiences or from the experiences of others. It sounded more like rhetoric as none of the service providers could remember a direct experience of themselves or others in the same clinic in this regard.

One other implementation law in regard to abortion services was that, most respondents from public and NGO clinics indicated that abortions, where provided, were done up to 8 weeks of pregnancy. The abortion law puts the limit at 10 weeks, but service providers were concerned that women could give false dates about the first day of their last menstrual period. Thus, the service providers believed that the two weeks could serve as a safety net for those abortions in which the fetuses could be older than indicated by women. One service provider stated:

"It has two reasons. First, the complications are increased, and secondly you should not make your clients to the comfort. You can do abortions up to 8 weeks easily and practically". (OB/GYN, Public Hospital, Diyarbakir)

There is not good data on abortions about their timing and complications and there is almost no data on abortions conducted in the private sector where a great proportion of abortion services are provided. On the other hand, there is no indication that abortions between 8-10 weeks would have increased risk of complications. Therefore, it is not clear at this point how using 8 weeks as the cut off for abortion services may affect its accessibility and results. This implementation is certainly conflicting with the abortion law in Turkey and further studies should be conducted to elaborate this point.

Another problem related to the availability of abortion services was that some large public institutions such as the OB/GYN Departments of University Hospital and the large urban MCH/FP Center in Diyarbakir and Maternity Hospital in Mardin did not provide elective abortions as a routine service. The service providers, of whom all were OB/GYNs voices beliefs that once abortion is made easily accessible, several women will resort to it as a means of family planning. This belief was used as a justification not to provide

easily accessible abortion services in the public clinics.

"If the public institutions routinely provide abortion services, women may abuse it. I mean paying for it is a way to discourage people, when they pay out of pocket. But when the patient can have it in a public hospital without paying for it, especially those patients who have lower educational status, she may use it as a method of contraception…It should not be done routinely and very easily. They will abuse it. They will say, even if I get pregnant, I will get an abortion and the problem will be solved. How good is this for women's health?" (OB/GYN, University Hospital, Diyarbakir)

"No, I am against abortion being very accessible. We should continue as it is. It should only be done under hospital conditions where (OB/GYN) specialists are available. Additionally, there should be surgical rooms ready" (OB/GYN, Public Hospital, Diyarbakir)

Among our respondents, there was only one OB/GYN who did not share the view that making abortions easily accessible in public clinics will cause women to use abortion as a family planning method. On the other hand, the same OB/GYNs who were against provision of "easy" abortion services in public clinics did provide abortion services in their private clinics.

"The OB/GYNs do not see abortion as a family planning method. They do not make it in easily accessible, comfortable environments. They limit it by 6-8 weeks. The reason they are not providing it as an FP method is, because they are making money in their private clinics, yes, the rumors are right. And abortion is not an FP method, we all agree. At school we were taught to save lives. I do abortions at my private clinic but ethically I have concerns. Not due to religious reasons, but due to ethical reasons I do not feel comfortable." (OB/GYN in private and public practice, Mardin)

The "rumor" that the OB/GYNs were preventing the provision of services at a lower cost in the much accessible public hospitals and clinics to make money from abortion in private practice was resonated through several respondents.

"Unfortunately we can not provide it [abortion] at the moment. Actually we do have a doctor [general practitioner] who had the course [and certified in providing abortions]. We could do it…Can I explain? But the specialists [OB/GYNs] are not looking favorably at this. Because if MR is done here, it will destroy some of their business outside [in the private sector]" (Midwife, Public Hospital, Diyarbakir)

Overall, it could be said that there are certainly important problems with the provision of safe and low-cost abortion services despite the liberal law. The barriers in provision of abortion services in Turkey seem to have very important different aspects which warrant further investigations.

The shape of unmet need in family planning in Turkey

Related to the above discussions about the problems in getting access to contraception is the extend and context of "unmet need" in Turkey. It is especially important to identify the characteristics of this group, who, for reasons of access or other barriers do not use effective contraceptives even though they do not want to have any more children or space their pregnancies. According to the 1998 TDHS data, 62% of all married women did not want to have any more children, and 13% wanted to space and have children later (Unalan and Kurtulus 1999). The unmet need was calculated to be approximately 37% among married women of 15-49 years old, when modern contraceptive use was 37.7% among this group. It is important to note that 24.4% of couples who were using withdrawal was also included in this unmet need figure.

Although the "unmet need" has a more or less standard definition, the women who fall into this category present a different outlook in different parts of the world. Dixon-Mueller and Germain had previously critiqued that the standard definition of unmet need was inadequate because it did not count a woman who is using a contraceptive method that is ineffective or inappropriate for her (Dixon-Mueller and Germain 1992). Within international health, unmet need is usually used to categorize those women who do not have access to contraceptives for several reasons. Most prominently, it is meant to say that there is "unmet need" because women cannot find contraceptives, or because they cannot afford to buy them, or because simply they are not available to them. However, the story is quite different for Turkey. Within the Turkish context, an important proportion of women with "unmet need" are mostly described as women who accessed and tried different methods, but did not like them or experienced side effects that made them stop using the method. All of the respondents agreed that the perceived fear and side effects of contraceptive methods, mainly hormonal methods were disproportionately high when compared with the real medical risks. In Turkey, withdrawal seems to be a fall back method for those couples switching from one method to the other, as 63% of married couples have tried withdrawal in their contraceptive history (Hacettepe University Institute of Population Studies and Turkish Ministry of Health General Directorate of MCH/FP 2004). This observation is supported by a recent study in Istanbul about the patterns of use of contraception.

The authors of this study reported that "most of the families changed the method they use several times, and some of them turn to natural methods, particularly to withdrawal as a method of 'their own'" (Cebeci-Save, Erbaydar et al. 2004). The same study also concluded that the resistance was not for contraception, but it was against the contraceptive methods, many based in wrong information and misperceptions about the methods, which demonstrates another dimension of unmet need in this population.

These groups of women with "unmet need" were described as "free floaters" by an NGO representative, as the most typical and large group of women who needed help. These women typically completed the number of children they wanted to have (with usually a few more) and were sure that they did not want to have any more. They were also very motivated to use contraception and had more or less access to contraceptives. Due to a combination of several factors, these women try almost all available methods to them, and thus become "glossary of contraceptives". However, an important portion of them falls through the cracks and end up with unwanted pregnancies, which then may be delivered or terminated with abortion. From anecdotal evidence, contraceptive failures, especially with the pills are very high in this group, too. Those who are successful may prevent further pregnancies, but several do not have a peaceful relationship with the method they are using. These women are said to "free-float", because they could not find just the right contraceptive for them. Or maybe they could not find just the right service, which would make them feel comfortable with the method they are using, despite the occasional side effects. Thus, they go from one method to the other and one provider to the other, until one day when they have their menopause. They are so determined about not having another child that most of them would try any method they run into. The translation of an interview with a group of women conducted in Diyarbakir provides excellent insights into how things may go wrong, even when women see doctors and nurses, use many different methods, in the example of a woman who ended up with 11 pregnancies, when all she wanted was 4 children.

The above elaboration of the characteristics of the "unmet need" group is important for two reasons. First, it resonates with the general sentiment of service providers that "it is not incredibly difficult" to get and use contraceptives in Turkey. The "free-floaters", by definition, were able to get and use different methods, but discontinuation and method switch rates (how many % of withdrawal

users have used a modern method in the past?) were very high with significant failure rates. Secondly, this characteristic of the contraceptive user population, especially because they are the ones who are most frequently seen by public and NGO service providers (because others, who really do not have access do not have a chance to go to a clinic, and hence they are not seen by service providers) who create the image, that women will surely misuse or abuse certain methods if they were made readily available. The perspectives of public service providers and NGOs on distribution of pills by non-medical personnel and on distribution of information of how to use emergency contraception are discussed in the other sections of this report. The desire to control the contraceptives and information about them finds their justifications in the group of "free-floaters" who seem not to stick with a method and do a lot of wrong things in the eyes of the providers (forget to take the pills; insist that they became pregnant when they were using the pills correctly; believe that their husband can feel the strings of IUD and that it hurts, etc.). The further questions to pursue here are: 1) What proportion of the total unmet need in Turkey is consisted of "free floaters"; 2) The correlation between the perception of service providers of women and the actual practices and experiences of women; and 3) To what extend do service providers contribute to the "free floating" pattern and unmet need through biased and wrong information and practices? This last point is especially important; anecdotes prevail about service providers' causing to stop using a method based on wrong information. The two prominent examples from the interviews were: a) A woman's IUD was removed by an OB/GYN, because the doctor said the "uterus had to rest" (and she became pregnant meanwhile), and b) Nurses did not give contraceptive injections to a woman because she had had typhoid fever, and the doctor said "she had too much worries and injections were not good for her health".

The Commitment of the Government to Improve Women's Health

Key informants provided a wide array of responses in regard to their assessment of Turkish governments' commitment to improve women's health. A high level politician who was interviewed, a congressman from the political party in power in Turkey indicated that women's health issues were important and that the current government was actively trying to improve contraceptive access for all women. The liberal abortion law of 1983 was unchanged during the long and hot debates on the revisions of the Turkish Penalty Law. This congressman, who

was a physician, cited the improved family planning indicators in Turkey as a sign of the government's commitment. On issues of abortion and making it more accessible through government health clinics, the congressmen was concerned that the physicians themselves were acting unethical by trying to make money out of abortion in their private clinics. On the other hand a congresswoman from the leading opposition party was not convinced that the current government was really committed to solve women's health and women's rights problems. This person identified herself as a self-dedicated women's rights spokesperson, who also sought collaboration with other institutions, such as universities to strengthen her cause in the Turkish Parliament to improve women's status. According to her, the government did not pay enough attention to these issues and the Islamic tendencies of the current government made it more difficult to bring up such topics as women's rights. She cited an example from herself, indicating that she was prevented to give her speech about prevention of early marriages in the Parliament, with the excuse that there were too many out-of-the-agenda talks and not enough time for her. The recent marriage of the Prime Minister's son at an early age to a 17-year-old bride, which was covered extensively by the Turkish press, the congress woman indicated, was a good indication of the tendencies of the leading political party. Also based on viewing the TV Channel broadcasting full time and live from the Turkish Parliament, those parliamentarians who touched upon the issues about women's health during their speeches seemed to be all women. At the time of the conduct of these interviews, maternity leave for women government employees were also being discussed. One speech made by a congress woman of the leading party was especially interesting after the acceptance of increasing paid maternity leave to a total of 16 weeks (8 weeks before due date plus 8 weeks after the delivery of the baby). She started her speech to other congress members indicating that Turkey is falling short of producing a new generation of healthy young people. Because, she reasoned, Turkey needs to increase the number of young people for a more prosperous future, mothers should be given the proper conditions enabling them to take care of their children. However, this expression should be viewed as an exception and as a way of responding to a minority of voter groups, rather than being real threats to FP or abortion legislature. Still, respondents from women's rights NGO believed that the Turkish governments never paid enough attention to women's issues. One responded indicated:

"None of the governments has bee concerned with women's rights. For example no statistics are being kept about violence against women, we don't know the situation in Turkey…No prime minister, no minister of internal affairs or no minister of justice until know has condemned the honor killings in Turkey, none of them…But almost everybody, including Ecevit has said something about the head scarf…Is head scarf the only problem of Turkish women? Is it that important?" (Women's NGO director, Istanbul)

Combining the two perspectives about the government's commitment, it can be concluded that the government is committed to a certain level, within the current framework or reproductive health and women's rights. However, a lot still needs to be done in terms of bringing new perspectives, expanding the services and ensuring the participation of all related actors and women from all walks of life.

NGO Programs for Reproductive Health

From the interviews, it became clear that as the definition used for women (i.e. that they were "like a glossary/history of contraceptives") by an NGO representative was also applicable to the NGOs themselves that, over the course of their history, they have tried several different programs, with different approaches and that they became a "glossary/history of FP programs".

The FP NGOs mostly funded by foreign aid, in which USAID was the largest donor, usually ran programs for a pre-determined period. At the end of this funded period, even the very successful programs eventually decayed, once resources were withdrawn. Additionally, with each new funding resource, a new model or approach had to be tried. Because the previous approaches were already "done", regardless of whether they were successful or not, there is the notion that "a new approach" has to be tried, and most likely in a new location. Thus, several different programs, usually in collaboration with the Ministry of Health were run by the NGOs with such different models as social marketing, community based distribution, franchising and peer education.

Because sustainability of programs had been an issue, a reproductive health NGO based in Istanbul, which was established in 1997 was running a program that targeted to change reproductive behavior of women through the use of volunteers in the community. In this program, women from the community was selected and trained as field trainers, with a nominal incentive to cover their transportation and lunch worked for duration of about two years.

Then, these trained volunteers conducted regular and intensive visits to the homes of women (usually 1000 women per trainer), and interacted with them about the issues of safe pregnancy, contraception, safe delivery, other reproductive health issues also to include reproductive rights and gender issues, depending on the need of women. "Because it is illegal for volunteers to distribute hormonal methods", indicated the program coordinator, volunteers referred those women who want to use the pills to a government clinic. If, as in not so rare cases, the government clinic did not have the pills, the volunteer could give the first pack of the pill to a health professional in that clinic to give to the woman who asked for it. But this NGO program also tried to raise awareness among women that using contraception was not a luxury, and they had to find their own ways to pay for them as they were not provided free of charge by the government any more (which was a practice for over 40 years in Turkey, until the year 2000, when USAID decided to cut contraceptive donations to Turkey). All three FP NGO respondents indicated that cost of contraceptives (specifically of the pills) was not usually an issue for the users, so this approach seemed to have its merit for Turkey. (On the contrary to this view, respondents from the public sector stressed that cost would be an issue for an important number of women. The volunteers also functioned as "a bridge between women and the health institutions" and sometimes even walked a woman to a clinic and stayed with her during the procedure, on the request of women. The program is reported to increase modern contraceptive use by 100% in the provinces that it was serving, and usually aimed a modern contraceptive prevalence of 65-70%.

One important future of the program, which may make it difficult to replicate in rural areas is that it is based only in city and town centers, where some form of contraceptive and reproductive health services (public or private) is available. This program is currently undergoing evaluation and is planned to reach a total of 3 million women (aged 15-49, with their husbands and household members aged 14 or older) in city and town centers all around Turkey.

An important reason voiced by both FP and women's rights NGOs for women not being able to make an informed choice about the method she will prefer to use were the failures of the health service system. This theme came up several times within different contexts during the interviews. One concern raised by NGO groups was that it was very hard to find a good referral center for the women they were working with, which would provide high quality and affordable services. The government clinics were criticized of

being highly ineffective, several times short of supplies and not being able to establish good relationships with the people in their catchment's areas. Several interviewees emphasized bad treatment of women at government clinics, such as disrespect for patients' rights and not providing enough information. One responded phrased: "It is even worse to create a demand, because you can't meet it. Then they (people) lose their trust in you and your program".

Until recently, evaluation has not been a significant part of the FP programs run in Turkey and most decisions about funding and running programs were based on logistics, personal opinions or subjective assessments rather than evidence based on evaluation reports or impact measurements. Therefore it is very difficult to assess the impact of the past and several continuing programs, or how well the models fit the structure and conditions of Turkey.

However, evaluation is becoming a more important aspect of programs and currently one of the FP NGOs who participated in this research and who works at national level is undergoing evaluation. It was also the impression of the FP program planners in the universities and in the MOH that NGOs worked side by side, but did not collaborate with each other. That trend seems to be changing, and especially in smaller cities like Diyarbakir and Mardin, several examples of information sharing and collaboration among NGOs were identified.

CONCLUSION

This second phase of the study has identified some important issues related to the implementation of reproductive health policy and legislation in Turkey. While the first phase of the study looked at five major legislations in Turkey in terms of their reproductive health content and policies, the second phase was designed to understand what was really happening in the field.

One of the findings of the first phase of this study was that the legislations were adopted to changing development and social needs in the community, such as moving from a pronatalist policy in the 1930's to a "population planning" perspective in 1960's and then moving on to "family planning" and "reproductive health" aspects after 1980's. Turkey has been running family planning programs for nearly four decades and overall they have been quite successful in controlling fertility. Another finding from the first study was that in reading between the lines, women were mainly attributed a motherhood role. The reproductive roles and responsibilities of women were in the forefront of "reproductive health" of women.

The value attributed to the fertility of women and the low status of women, especially in Eastern regions of Turkey appeared as some of the cultural factors that had an impact on the uptake of contraceptive methods. Language also appeared as a local factor and those service providers who could speak Kurdish or other local dialects had better chances of working and cooperating with the community they were serving.

From the interviews, it was not clear how "gender" could be better mainstreamed into reproductive health services and how a gender sensitive approach could become the norm of practice. Especially the public sector providers did not have a good understanding of gender issues, and how they could become barriers to providing good services. The different aspects of gender discrimination, from the bias of the (male and female) health personnel about sexuality of women, to the provision of services only to married women warrant further investigation of the topic. The specific gender-discriminatory attitudes, practices and procedures should be quantified to demonstrate the extent of the problem. The impact of these on reproductive health of women should also be documented in detail.

Several factors in service provision prevented family planning services to reach its audience.

Failure to provide a continuous supply of commodities was among the most

important problems and finding a pack of contraceptive pill was a challenge for most public clinics in Eastern Turkey. It was also clear from the interviews that the urban and rural Turkey had different access problems. In Turkey, according the public service models, the health professionals in the rural areas are expected to reach out to their population. However the urban model of the socialized health services has not been fully functional in terms of reaching out to the community and public clinics have usually been serving the population who came to them. It was interesting to note that respondents from Istanbul mentioned that, especially in the slums of Istanbul it may be as much or more difficult to access abortion services as it would be in rural Turkey. On the other hand, the staff of the three large family planning centers, two in Ankara and one in Istanbul reported that any women who was living in their catchments areas, and even other women who have heard about the clinic would easily get almost any reproductive health service for free or for a minimal fee within their low-income district.

The two large FP NGO's who participated in this research mainly functioned in cities. The priority was given to poor and underserved city sections, which, in the case of Diyarbakir and Mardin had a high proportion of recently migrated population. Thus, while the two NGO models worked well with the population in the cities, the rural areas, which probably had more serious access problems, were not given high attention. Therefore there was little outreach incentive by both the public and the NGO sector for women living in rural Turkey, especially in the Eastern and South Eastern regions.

In this research, bias of the health personnel appeared as their perceptions about the clients, such as who could use the pills and who could not. A further dimension is having wrong information and opinions about certain methods. As the methodology of this research aimed at provider perspectives, these latter points could only be touched through women's interview. Hormonal methods seemed to be the "step children" of health personnel and the general belief was that, if given the chance, women would very probably use them wrong in a way to put their health at risk. Provider bias is identified as one of the six medical barriers by Shelton et al. (Shelton, Angle et al. 1992), and several studies around the world demonstrate some kind of bias, especially for contraceptive pills (Bossyns, Miye et al. 2002; Stanback and Janowtiz 2003). Some of the ways to remove this barrier would be to provide training for health personnel, standardization of services so

they are not provider dependent and enabling an environment where health professionals will feel safe to change their own behaviors.

Despite the definition in the legislation that “all people” who need primary health care services (to include family planning and abortion services) should be able to get these services in the public sector free of charge, the interviews showed that almost all of the programs run by NGOs or the public sector and universities are primarily targeting married women. The two exceptions were the Adolescent Reproductive Health Clinics within the university health care system in Ankara and Diyarbakir. Some NGO programs did try to include husbands through their wives, but in general male participation in the reproductive health programs was very low. Men also did not contribute to using modern methods of contraception, despite the fact that withdrawal use is very high in Turkey.

It can be argued that the design of fertility regulation services in Turkey reflects the general cultural background. Pre-marital and extra-marital sexual relations for women are still strong taboos. In a survey conducted among university students in 1992, 85% of the males indicated that a girl’s virginity status would be one of the things they would consider for marriage. More recent studies confirm the value attributed to the virginity status of the girls, albeit with somewhat lower proportions [(Akin and Bahar Ozvaris 2004) and also see (Gursoy 2004)]. In this environment, tailoring the services for the most susceptible and highly demanding group (that is married women) was an initial logical step. However the changing norms are reflected in the adolescent study which found that young and unmarried people have important needs in the area of reproductive health (Akin and Bahar Ozvaris 2004). The more reproductive health services are provided only for women, the more men will see it as women’s responsibility and the more unmarried people are left out, the more traditional cultural norms will be reinforced. All of the respondents in this research were favoring increased participation of men and program designers from different sectors (MOH, universities and NGOs) and near future plans to involve men.

Adolescents and unmarried people were the other groups that have been left out of the reproductive health services provided by the public sector. Regardless of age, unmarried women may be denied abortion services at some public clinics due to the requirement of “husband’s signature”.

Some service providers were also opinionated about unmarried women getting into sexual relationships and did not approve of any form of premarital sexual life. Because pills and condoms are easily available over the counter in the pharmacies young people may still have a certain degree of access albeit with cost issues. Abortions could also be provided in the private sector without the "husband's signature". Young people are thus pushed to secrecy and to private sector where it is not the norm to provide sufficient information and cost-effective ways. However, the developments and changing perspectives in providing information and services for adolescents were promising and the two Reproductive Health Clinics for university students in Ankara and Diyarbakir and other local programs run by NGOs can serve as models to expand these services to cover more young people.

The responses to the question about the availability of emergency contraception (EC) demonstrated that the FP services in Turkey, to a great extend are medicalized. From an outside perspective, it is difficult to understand the control that especially public service providers would like to have over distribution of EC materials. Even the idea of distribution of detailed EC information enough to allow women to act on their own, if they needed EC was not supported by many providers, in contrast to the views from the NGOs. However, from an insider perspective, the many problems faced by service providers may give them a certain degree of justification in trying to control some methods and the people who should provide them. Before moving on to a more liberal and less medical contraceptive environment, the concerns of the FP providers about women not being able to use them effectively should not be dismissed easily. The different structure of the "unmet need" in Turkey also should warn the policy makers that the conditions in Turkey may require unique approaches and solutions. If anything needs to be changed, it has to be done through collaboration and participation of all concerned.

Provision of abortion services was problematic for several reasons. Even though the abortion law permits the services to anyone up to 10 weeks of gestation without any limitations about age or marital status, the interpretation of the requirement for "husband's signature" for married women brings several barriers. There were providers in some clinics, especially in Diyarbakir and Mardin, who would not do an abortion without bringing the husband in for his signature. The unavailability of abortion services in major Public Hospitals and FP clinics could not be explained

logically. The only justification came from the OB/GYNs who implied that women would have too many abortions if they had it for free. The quantitative data for abortion numbers, the financial gains of OB/GYNs from abortion in private practice and the implications of the difficulty of availability of services on women's fertility should all be explored in detail.

Also, the 8-week cut off for abortions by many providers should be seen as an other barrier and both women and providers should be informed about keeping the legal limit of 10 weeks.

This research tried to provide an overall view of the contraceptive environment in Turkey, the health policy about reproductive health and more specifically about fertility regulation and the problems in its implementation in the field. Most of the specific issues outlined in this report have not been studied in detail and while service providers find themselves in their routine, program planners and policy makers usually have to operate in a blurry and uncertain environment due to lack of specific figures and data. Turkey has been successful with her methods since now, but the new millennium brings new challenges and greater expectations for gender mainstreaming. Improvement of the current situation and success will come through detailed analyses and understanding of different perspectives. Related information about use of contraception and FP methods İN Turkey is presented as **(Annex VIII).**

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Annex I.

Guideline for Conducting Case Studies on the Integration of Gender Considerations in Health Policy Development in Countries in the WHO European Region
(Modified Guideline by Turkish Group)

Objective 1: Global Assessment of General Policies

Topic lists for global assessment of documents of general policies

A. Questions pertaining to documents on national general policies
(The Main Constitution)

1. What is the title of the policy?

2. What is the date of implementation (start and finish if mentioned)?

3. What was the political orientation of the government that formulated and enacted the policy?

4. Referring to the state level where the policy was enacted: Can you give the percentage of female ministers ascabinet members at the time of policy enactment?

5. What is the overall aim of the policy?

6. Does the policy include references to women's health, men's health or gender and health?

7. If so, summarize these references.

• Is there any gender issue-on equality-taken into account?

• Is there any gender issue-on equity-taken into account?

B. Questions pertaining to documents on national general (gender and) health policies (the Law on Prevention of Health in General (Law on General Hygiene) # 1593 and the Law on Socialized Health Care Services # 224).

1. What is the title of the policy?

2. What is the date of implementation (start and finish if mentioned)?

3. What is the overall aim of the policy?

4. Does the policy include references to women's health, men's health or gender and health?

5. If so, summarize these references.

6. What are the proposed measures (activities) for implementing the policy?

7. Who are the key actors in implementing the policy? (Health services, social services, education, other)

Objective 2: Focused assessment of one or more specific health policies
(The First # 557 and the Second Population Planning Law # 2827)

Topic list for assessment of policy documents on selected health policies.

In assessment to each policy, any evidence on gender equity and equality

(about FP/unwanted pregnancies and abortion) has been taken into account.

1. Name of the selected policy.

2. Date of implementation (start and finish if mentioned)?

3. What are the main problems that policy wants to address?

4. What are the objectives of the policy?

5. Do the policy objectives specify what the policy seeks to achieve in relation to men's health, women's health or gender equity?

The next questions are focused on the different stages of policy development.

Problem definition (statements of related laws have been studied)

6. Has the problem analysis for this policy assessed health status, risk profiles, health problems, health behavior, health needs or use of health services by gender, age or social groups?

7. Has the problem analysis for this policy assessed any other qualitative or quantitative evidence on sex and gender issues pertaining to the policy?

Policy formulation:

8. What are the target groups for the policy?

9. Have any potential sex or gender differences been taken into account in the definition of the target groups?

10. What are the proposed measures (activities) for implementing the policy?

11. Do any of these measures (activities) take differential needs of men and women into account? If yes, describe.

12. What are resources available for the implementation of this policy?

13. Are there any financial provisions for targeting men and/or women? If yes, describe.

Implementation

14. At which level is the policy implemented: national, regional, local?

15. Who are the key actors in implementing the policy? (health services, social services, education, other)

16. What are the criteria for success for the policy (targets)?

17. To what extent are these engendered?

Monitoring

18. Does regular progress monitoring of the policy take place?

19. If yes, do the results allow for actions to be modified?

20. Do the monitoring reports include gender specific quantitative and/or qualitative information? If yes, describe.

Evaluation

21. Do you know how well the success criteria of the policy have been met? (Describe successes and problems)

22. Do you have any data on the effects of the policy on men and women?

The last questions are focused on the process of policymaking; answers may be found in the documents. If not, they may be found by interviewing key informants.

23. Is there a department, committee or focal point present with responsibility for ensuring the inclusion of gender concerns in this policy?

Other data to review

Sex disaggregated data

24. Is there any quantitative or qualitative sex disaggregated data available that are relevant for the selected policy? If yes, describe. (Answers to these questions can be found by consulting national health databases)

25. Have these data been used in drafting the policy?

Annex II.

Detailed Information on
"Case Study on INTEGRATION OF Gender Perspective
in Health Policy in Turkey"
(FIRST PHASE)

In this section each of the five legislations are presented according to the questions of the WHO guideline. Each legislation is also summarized in the " Matrix for reporting results of assessment of the attention to gender considerations in the development of specific health policy"

1. **What is the title of the policy?**

CONSTITUTION OF THE REPUBLIC OF TURKEY, 1982

2. **What is the date of implementation?**

Date of Adoption by the Constituent Assembly: 18.10.1982; Publication in the Official Journal for popular referendum: 20.10.1982-17844; Date of Adoption by referendum: 7.11.1982; Official Journal declaring the adoption of the Constitution at popular referendum: 9.11.1982, no: 17863, Law no: 2709

3. **What was the political orientation of the government that formulated and enacted the policy?**

In Turkey, a military government took power in September 1980 and suspended the existing Constitution. The military government issued the "Law on Constitutional Order" and set up a "Constituent Assembly." This Constituent Assembly consisted of a 5-member National Security Council (NSC), where members were all from the military, and a 160-member "Consultative Assembly." 15 members of this Consultative Assembly were selected and assigned to prepare a new constitution. This commission drafted a new constitution, which was adopted by the Consultative Assembly. The draft was finalized after some modifications made by the National Security Council. In the referendum, the draft constitution was accepted by 91.4 % of popular vote (91 % participation) and gained official status as the "Constitution of the Republic of Turkey" upon its publication in the Official Journal no. 17863, dated 9.11.1982. This constitution, which is still in effect, consists of 7 chapters, 177 principal and 16 provisional articles.

4. **Referring to the state level where the policy was enacted: Can you give the percentage of female ministers as cabinet members at the time of policy enactment?**

There was no female among the 15 members of the Commission set up to draft a new constitution. The draft was finalized by the National Security Council, which had no female member.

5. **What is the overall aim of the policy?**

Preamble: The Constitution of 1982 was prepared by the Commission basing mainly upon the idea of "filling in some gaps of the 1961 Constitution in the field of rights and freedoms; introducing all mechanisms of parliamentary regime to improve the relationship between legislative and executive powers and ensuring that judicial supervision is exercised within the confines of legal system."

6. **Does the policy include references to women's health, men's health or gender and health?**

Yes there is.

7. **If so, summarize these references.**
   - Is there any gender issue-on equality- taken into account?
   - Is there any gender issue-on equity- taken into account?

Examined in regard to gender equality, the 1982 Constitution generally gives a positive profile. However, rather frequent appearance of such words as "all" and "no one" hints that equality is regarded as an approach covering all without any specific gender reference. The term gender appears first in "General Principles" (Chapter I) when Article 10 about "Equality Before Law" states, "All are equal before law regardless of language, race, color, **gender,** political ideas, philosophical commitment, religion, sect, etc." In the justification of the Article, equality is defined as one of the three indispensable principles of democracy. It is further stated that discrimination based on any qualification or criterion is strictly prohibited; that this non-discrimination should be equally valid in judicial processes including law enforcement; and that state bodies and administrative authorities are obliged to observe this principle of equality and non-discrimination. Another reference to gender equality appears under the heading "Right to Education and Training" (In Chapter 2, "Principal Rights and Duties"; Part 3, "Social and Economic Rights and Duties") when Article 42 reads, "primary education is compulsory for **all male and female citizens** and is provided free by the State." (See, Article 42). In this article whose content dates back to the Law on the Unification of Education dated 1924, education is qualified as a social right. There is emphasis on need to approach boys and girls equally especially in the field of learning and teaching. The same part of the Constitution includes the heading "Working Conditions and Right to Rest",

where it is stated, “no one can be employed in work unfit to his/her age and **sex;** minors, **women** and persons with physical and mental disabilities shall be accorded special protection in terms of working conditions.” (See Article 50). These may be taken, to a certain extent, as positive discrimination. However, another interpretation is also possible. It may be noted here that it was the final modification by the National Security Council, which added “women” to the phrase originally consisting only of “minors and persons with physical or mental disabilities.” This intervention may be found as “lowering the status of women.”

A similar dilemma also appears under the heading “Those who are in Need of Special Social Protection” where it is stated, “The State shall protects the widows and orphans of wartime and mission martyrs and persons injured in such action and provides them a satisfactory level of living within the society.” (See Article 61) The Constitutional Commission had originally drafted separate articles for the widows and orphans of martyrs, the disabled and elders and children in need of special protection. Later, however, the National Security Council brought them together under the same article on the ground that these persons were all in need of special social protection. The dilemma here is that while there is clear intention to adopt an equitably approach to women, this intention ends up in placing women in the same category with the disabled and elderly as far as need for special protection is concerned. On the other hand it can also be argued that the article is unfair since it accords special protection not to all but only the female widows of martyrs.

In Article 66 headed “Turkish citizenship” (In Chapter 2, “Principal Rights and Duties”; Part 4, “Political Rights and Duties”) it is stated that, “All persons who are the citizens of the Turkish State are Turks. A child born to Turkish father and mother is a Turk. The citizenship status of a child born to a **Turkish mother and a foreign father** is arranged by law.” (See Article 66) This article clearly manifests gender discrimination. Nevertheless amendments introduced in 2001 removed this expression from the text of the Constitution and thus a positive step was taken towards equality.

In Article 41 (In Chapter 2, “Principal Rights and Duties”; Part 3, “Social and Economic Rights and Duties”) there are provisions observing gender equality and have protecting women. The expression, “Family is the basis of Turkish society” was supplemented with the expression “…and family itself is based on the equal status of spouses.” It is also important in terms of protective and equitable

approach that the same Article (Article 41) states, “The State takes all relevant measures and introduces necessary organizations to safeguard the well being of families, including mothers and children in the first place, and to ensure that family planning methods are learned and practiced.” The article is based on the rationale that since family constitutes the basis of the society, the State should protect and ensure the well being of family. It was the Constitutional Commission of the NSC that introduced parts relating to family planning. Nevertheless, for any article to be fully sensitive to gender equality, it is necessary to have an approach covering all females regardless of social and economic status, ethnic origin, religion, etc. Therefore, this article, despite its protective expressions, embodies some germs of gender discrimination since it tends to consider women consisting of those who are “married and mothers.”

In the first draft of the 1982 Constitution, Article 68 (In Chapter 2, “Principal Rights and Duties”; Part 4, “Political Rights and Duties”) under the heading “Provisions Relating to Political Parties it is stated: “Political parties cannot organize party units abroad, introduce such privileged side organizations as ‘youth’ or ‘female branches’ and establish foundations.” It was the NSC that added this provision upon its review on original draft coming from the Commission. Considering that women were already excluded from political and public spheres under the pressure of established traditions and norms, this provision further aggravated the situation by placing barriers on their possible political mobilization by entering into solidarity and getting organized as women. A new amendment introduced in 1995 removed this provision from the Constitution.

Article 56 (In Chapter 2, “Principal Rights and Duties”; Part 3, “Social and Economic Rights and Duties”) under the heading “Health, Environment and Housing” refers to health services and protection of the environment.

It should be noted that currently the Grand National Assembly of Turkey (GNA) is working on new constitutional arrangements and amendments. The most debated issue in this context is related to the introduction of a new Constitutional article allowing positive discrimination to improve gender equality. Currently, two parties in the GNA are in dispute over the proposed text that reads, “Men and women have equal rights. The State is obliged to give practical effect to this equality.” While the Republican People’s Party (CHP) in opposition insists on the incorporation of the relevant provisions of the CEDAW (Convention on the Elimination of All

Forms of Discrimination Against Women" to which Turkey is a State Party, the AKP, which is in power, us standing against this proposal.

In sum, the Constitution of 1982 can be classified as a gender sensitive instrument considering its overall approach, some expressions that may imply positive discrimination and the fact that some expressions invoking gender-based discrimination have later been cleared. It must be stressed here that positive amendments and clearances in the Constitution have been largely influenced by the instrument CEDAW adopted by the UN in 1979 and ratified by Turkey in 1985 as well as the resolutions of the 4th World Women Conference held in Beijing in 1995 with the participation of 189 countries including Turkey, to which Turkey committed herself without any reservation. However, safeguarding gender equality in basic documents such as constitution does not automatically bring along equality in actual social life. Thus, researches and inquiries on how this equality in principle finds reflection in actual life and initiatives for improvement are crucial for any progress in this field.

1) **What is the full title of the policy?**

LAW ON GENERAL HYGIENE

2) **Date of taking effect**

Adopted: 24. 04.1930

Law No: 1593

Published in the Official Journal no 1489, dated 06.05.1930.

3) **What are the main objectives and rationale?**

Some general and specific provisions of the existing Penal Code and some arrangements dating back to the Ottoman era were insufficient in regard to the delivery of health services and solving problems in the field of public health. A legislative framework was thus needed to define the duties and responsibilities of all institutions in the field of health and to introduce up-to-date provisions and arrangements to respond to current needs.

4) **Does the policy have any reference to female and male health or gender and health issues?**

Since the "Law on General Hygiene" is an instrument exclusively focusing on health issues, it has many articles pertaining to male and female health. However, while some articles in this law imply gender equality, there are others reflecting gender discrimination.

5) **Please shortly explain if the policy has any reference to female and male health or gender and health issues (see question 4).**

Following are the chapters of the “Law on General Hygiene” that consists of 15 chapters and 309 articles:

Chapter 1; Organization of Health Services

Chapter 2; Control of infectious diseases and epidemics (malaria, trachoma, venereal diseases, tuberculosis)

Chapter 3; Arrangements relating to sex workers

Chapter 4; Health issues relating to migration

Chapter 5; Health issues relating to ships, railways and other means of transportation

Chapter 6; Child health

Chapter 7; Workers’ health

Chapter 8; Foods, drinks and some items used

Chapter 9; Mineral water and spas

Chapter 10; Cemeteries, sepulchering, de-sepulchering and transfer.

Chapter 11; Drinking and use water; water springs; removal of wastes; residences; inns and hotels, towns and cities.

Chapter 12; Non-sanitary enterprises

Chapter 13; Health statistics

Chapter 14; Punitive provisions

Chapter 15; General provisions

Passed in the 30s, the "Law on General Hygiene" has specific stress on malaria, trachoma, tuberculosis and venereal diseases as the leading public health problems of the time. When venereal diseases are concerned, any person contracting to any of these diseases is obliged to seek cure (Article 103) and each health worker is obliged to report any such case (Article 103). Treatment is given free in public health facilities (Article 105). It can be considered as equalitarian in terms of gender and health issues.

Another way that the Law on General Hygiene envisages in combating sexually transmitted diseases is pre-marital health examination. It is established as compulsory that all couples have their medical examination before marriage (Article 122) and no official grant for marriage is to be given unless proper cure is given to patient(s) (Article 123). These too can be considered as equalitarian in terms of gender and health issues.

In case contracted to any infectious disease, women engaged in prostitution will be banned from performing (Article 129) and such women will be given free medical treatment against sexually transmitted diseases (Article 131)

The law reflects the influence of pronatalist policy adopted following the First World War and War of Liberation to encourage population growth. As a matter of fact there are specific provisions encouraging child bearing: Deliveries in sanitary conditions with the attendance of

health workers (Articles 153-154); paid leave to working women before and after childbirth (Article 155); encouragement of having more children (Article 156) and ban on abortion (Article 152) can be cited as examples. These articles may sound as reflecting an equitable approach prioritizing for risk groups; but any germ of positive discrimination here actually favors not the woman but motherhood, which further consolidates women's traditional/gender role in society. It is even possible to assert that some articles actually regards woman's body and fertility as an "instrument." Nevertheless, the recognition of women's presence in the public sphere and entitlements for paid leave before and after delivery can be seen as significant steps forward. The significance of these steps can be grasped better if one considers the overall environment back in the 30s when traditional gender-based division of labor heavily prevailed and women's participation to labor force was extremely limited.

Article 169 is unique in displaying a rather biased approach to gender. This article establishes for the incorporation of childcare courses in curricula for schoolgirls to prepare them for future motherhood, which is seen as the principal duty of women. Article 169 is thus a negative one in terms of gender equality in the sense that it further consolidates gender-based roles in society.

The Law on General Hygiene establishes that children under age 12 cannot be employed and male and female children in the age group 12-16 can work no longer than 8 hours a day. (Article 173). As such this article conforms to the principle of gender equality. Article 177 deals with arrangements relating to working conditions abs well as general and breastfeeding leaves of pregnant women and new mothers. This can be considered as a positive attitude towards groups in risk. The sale law states that types of work that children in the age group 12-16 and women cannot be employed will be identified in the Labor Law (Article 179). This can be interpreted in two ways: It implies gender discrimination from an angle, but may also be taken as according special protection to women whose situation is riskier during pregnancy and childbirth.

6) What criteria/measures are suggested for the accomplishment of these targets?

The Law on General Hygiene establishes a reporting system (Article 276) whereby health facilities and health workers are obliged to report on certain issues (Article 279). The law also makes it compulsory to incorporate health courses to school curricula (Article 281) and to

launch programs for training public at large on health issues (Article 280). The law also provides for fines and imprisonment for acts of breach. . (Chapter 14)

7) What are the government units, agencies or person(s) in charge of ensuring the enforcement of the legislation?

The tasks specified in the Law on General Hygiene are to be performed by the Ministry of Health and health staff employed in municipalities (Article 305). The ultimate responsibility for enforcement rests with the Council of Ministers (Article 309)

1. Full title of policy: LAW ON THE SOCIALIZATION OF THE HEALTH CARE SERVICES IN TURKEY.

Law no: 224

Adopted: 05.01.1961; **Published in the Official Journal:** no. 10705, dated 12.01.1961

2. Taking effect: The law no. 224 was adopted and put into effect in an environment shaped by the military intervention of 27 May 1960. The "National Unity Committee", which held power at that time endorsed the draft on 5 January 1961, the last day of its term in power and the text of the law was published in the Official Journal on 12 January 1961

3. Government in office when the policy took effect:

Military Government

4. Proportion of female parliament members when the policy gained the status of law:

5. Objective/rationale of the policy:

Article 1 – "Medical services shall be socialized under a program to be designed within the framework of the present law in order to ensure social justice in access to and delivery of health services, which are recognized as a right in the Universal Declaration of Human Rights."

6. Does the policy have any reference to female and male health or gender and health issues?

Law on the Socialization of Health Services consists of 35 articles relating to the objective of the legislative act; general provisions addressing terms used and basic principles adopted; institution and tasks of service delivery units; implementation and coverage of socialization; specific duties of relevant institutions, local health councils and health workers and financial aspects of socialization. The law no 224 was later followed by a series of regulations and other circulars to detail and clarify the system and practices envisaged in the

main law. Both the main law itself and other documents supplementing it include phrases related to gender equality and equity.

7. **Please shortly explain if the policy has any reference to female and male health or gender and health issues**

a) Articles in the "Law on the Socialization of Health Services" relating to gender equality and equity. In **Article 2**, while the meaning of socialization is explained, it is stated: "Socialization of health services envisages **equal** access to and utilization of available health services by all citizens either totally free or by partially sharing the cost of these services." Thus, the basic principle is equal access and use of services concerned.

Article 28 says: "In case it is impossible to post married couples employed in socialized services to two different facilities in then same locality, they may be assigned to the same facility." This provision rules out any room for gender discrimination since it does not imply any priority to the status and assignment of the male.

b) "Regulation on the Delivery of Services in Regions Where Health Services are Socialized", Adopted by the decision of the Council of Ministers No. 6/3470, dated 17.08.1964. The Regulation aims at helping and guiding health workers overcome various difficulties involved in this unique and critical service and explaining ways to deliver services in their integrity in areas where they are socialized.

There are some points relating to gender equality and equity in this Regulation. The essence of Article 2 in the Law no. 224 appears in the Regulation once again. Here, the term socialization is elaborated in more detail and emphasis on equality is maintained. While dwelling on socialization, health services are elaborated as those services that "aim at protecting the health of all citizens through according equal opportunities and wire range of facilities, eliminating or rehabilitating disabilities from birth or in later life and maintaining the well being and good health status of citizens." Here, equality is envisaged for all citizens regardless of any difference with respect to sex, age, health status, religion, language, rave or ethnic origin.

The Regulation also includes references to equity. In Article 3, while explaining the benefits of socialization in health services, paragraph (d) states the following: "especially uneducated women in urban and rural areas will be trained in childcare, household affairs, personal hygiene and nutrition of children and

adults to enable them to raise well cared and healthier generations." This sentence on benefits expected from socialization can be interpreted both positively and negatively in terms of its gender stance. The positive side is that it envisages training of uneducated women in health, nutrition and hygiene. However, benefits thus accruing will be more for "future generations" then women themselves. In other words, the education and information status of women is regarded as an "instrument" rather than an end in itself. Moreover, the emphasis on the right of women as citizens is overshadowed by women's role as mothers.

Finally, stresses on "maternity", "breast milk", "child health" and "family health" are made in a way to remind patriarchal emphasis on the reproductive role of women. .

The second part of the Regulation is devoted to health institutions and their tasks. This part also includes explanations on the status and tasks of Maternal and Child Health Department. This part rears as follows: "The tasks and services of MCH facilities include the following: Systematic awareness building, guiding and informing of people in matters relating to maternal and child health; keeping pregnant, post-natal and lactating women under medical control; informing mothers about appropriate childcare practices and, in sum, reducing maternal and infant/child mortality as much as possible by safeguarding the health status of mothers and helping them raise healthy children." Here again, dual interpretation is possible. It is reasonable and quite fair that pregnant women and women who have just given birth are taken as a special risk group to be accorded special health protection. On the other hand, assigning the task of raising healthy children and generations solely to mothers can be interpreted as an approach further consolidating traditional gender roles by reducing the status of being women to motherhood.

Paragraph (g) in the text defines the tasks of dispensaries as identification of pregnant, post delivery and lactating mothers (a); provision of most suitable conditions for delivery (b); post-delivery monitoring (c) and periodic check ups (f). A similar analysis as above can be made at this point. It is important that the reproductive role of women is taken seriously as exemplified in efforts to combat related risks, establishment of special dispensaries for this purpose and detailed elaborations on the services of such facilities. On the other hand, the very title of these facilities points out that maternal health is regarded as an instrument for child health and that the mother is seen as the only person responsible for child's health status.

Paragraph(k) in the same regulation deals with services delivered by health centers. Here, health training is among the tasks of health centers. Specific reference is made to rural women: "(…) living conditions in rural areas may directly run counter to norms of hygiene. It is, however, possible to eliminate unhygienic conditions and practices by training rural women in household management, nutrition and hygiene. Again, a positive attribution may be made here considering that importance is assigned to the role of women in improving health and hygiene along with their training in these areas.

Yet, since a clear demarcation is made between the public and private sphere and women are placed solely in the private sphere, it may be interpreted as the consolidation of traditional gender role, which is mainly reproduction.

The Regulation also has a part devoted to health houses and their functions. In this part, the primary function of health houses is stated as delivering MCH services and training of people in the fields of hygiene, nutrition, household work and childcare. Here, the approach is very clear and women are addressed mainly in the context of their roles as "housewives" and "mothers", which may again be seen as contributing to the consolidation of traditional gender roles.

Summing up the essence of the Regulation no. 154 adopted to inform the enforcement of the law. No.224, it is possible to conclude that it has an approach reducing women to their roles as mothers and housewives.

c) Regulation on the Conduct of Health Services (2002)

This Regulation was prepared in 2002 basing on the Law no. 224 on the Socialization of Health Services, Article 43 of the Law no. 181 on the Organization and Duties of the Ministry of Health and provisions of the Regulation on the Delivery of Health Services in Regions Where Services are socialized.

The objective of this Regulation is to bring clarity to how various levels in the peripheral organizations of the Ministry should deliver their services, ensure harmonious and integrated delivery of health services and to guide and help health staff in this regard. It will be appropriate here to give some space to amendments to the Law no. 224 and the Regulation no. 154 that we have mentioned above.

Part 5 in the Regulation deals with services given by inpatient health facilities. In Article 194, paragraph (a) a general hospital is defined as an inpatient health facility where "all cases of urgency and all patients regardless of

age and sex who have health problems relevant to the existing specialization areas of the facility are admitted for medical examination and inpatient services." The qualification "regardless of age and sex" may be noted in terms of equality.

As to points relevant to equity, the following may be stated: In article 4 where definitions are given, the definition of socialization is repeated. However, in paragraph (c) where this definition is made it is stated that "Basing upon the premise that the provision of health services is the duty of the State, socialized health services may be defined as the extension of such services to the remotest places where citizens live in a way to allow **equitable** utilization; joint delivery of protective, rehabilitative and curative services and improvements in public health by ensuring the participation of people to health services." Earlier, it was stated that both article 2 in the Law no. 224 and the Regulation no. 154 included the phrase 'equally by all citizens" and this laid the basis for the principle of equality. In the present text, the term "equitable" replaced "equal." We think that this is more than a simple and ungrounded choice for terms. Many detailed comments of social, economic and ideological nature can be made to explain the background of this choice. Still, since our aim in this paper is restricted to a specific topic, we will suffice with a general one

Whereas the principle of "equality" was dominant and widely accepter in the overall environment of the era when the law no. 224 was drafted, the notion "equity" came to the fore leading to the premise that "services should be provided to the extent that there is need for." It may therefore be concluded that the new Regulation bases socialization on equity rather than equality. The former in principle embodies some level of inequality.

As mentioned above when discussing the Regulation no. 154, delivery of MCH services is also among the tasks of local health centers. Earlier, women in the service coverage were taken as those "who are married and having a family" whereas the Regulation adopted in 2002 introduced a wider service coverage. As a matter of fact, Article 62 of the new Regulation relating to services to be delivered by health centers addressed MCH services as follows: "Maternal health services cover all women, regardless of their marital status, in the age group 15-49 and all pregnant women and women who have just given birth regardless of their age." It is therefore possible to conclude that elimination of the earlier clause on marital status is a

positive step forward. It is also important to note that women are no longer seen as "instruments" of raising healthy generations but as a special risk group as a result of their fertility.

Article 64 defines reproductive health and family planning services. The article states that, "people from low socio economic status are given priority in family planning services (Paragraph c); that "training in family planning should cover not only to women but also to husbands and other household members like in-laws and close relatives who may be influential on fertility behavior (Paragraph d); and that "training in family planning should give priority to those who are not informed about contraceptive methods and others using traditional methods of contraception" (Paragraph f) These provisions approach the issue in a more equalitarian and equitable manner by prioritizing groups in need of services and covering all parties who may have influence on fertility behavior.

In Chapter 2, MCH services are addressed in Article 109 under the heading "Conduct of Services by Health Houses." According to this Article, it is within the service domain of health houses to "monitor pregnant women, ensure that births take place as attended by trained health personnel and to monitor post natal period as well." Here, women in prenatal, natal and postnatal periods are addressed a special risk group distinct from others. Paragraph (j) of the same Article takes women experiencing miscarriage as another group in need of special care, monitoring, referral and training in family planning. It is again possible to consider this approach as having broken apart from traditional stress on marital status, "role in bringing up health generations" or "uniqueness of motherhood."

Article 129 defines the status and duties of nurses. These duties include "extension of consulting services on family planning in both premarital and post-marital periods and engage in relevant applications including IUD if they are certified for this application." Paragraph (d) in Article 130 defines the duty of midwives as "identifying pregnant women at ages 15 to 49 and monitor their status in pre-determined periods."

It is important that, while defining the duties of nurses and midwives, the target group is taken as all women at fertile ages without any regard to marital status and pregnancy is considered as a critical period that requires close monitoring and care.

The following can be stated making an overall evaluation the new (2002) Regulation on the Conduct of Health

Services and the earlier one, the Regulation no. 154 whose basic framework was drawn by the Law no. 224:

- Existence of an approach that reduces the status of women to their roles as mothers and housewives,
- Progress and modernization are regarded as paramount instruments in improving health standards,
- A demarcation between production and reproduction whereby women are associated with the latter in their roles as housewives and persons responsible for childcare and family health,
- Lesser stress on health problems other than those related to fertility,
- Another demarcation between public and private spheres whereby women are placed within the confines of the latter,
- Failure in defining the public sphere in a way to cover women as well,
- Existence of some practices that may strengthen traditional gender roles.

8. What criteria/measures are suggested for the accomplishment of these targets?

Article 17 states, "The plan for socialization will be suspended in any specific region until facilities, residences, materials, equipment and staffs needed for the appropriate delivery of services are provided to that region." In Article 20, it is stated that "Socialization will cover the whole country 15 years after this law takes effect, the latest, and health workers employed by facilities cited in Article 19 will be subject to the provisions of the present law before the expiration of the time period given above." Upon the decision of the Council of Ministers, the first practice in socialization took place in Muş in 1963. According to the article quoted above, socialization should have been completed in geographical terms in 1976 (15 years from 1961). After realizing that it was impossible to reach this target, the date for full socialization coverage was first postponed to 1982 upon a legislative amendment introduced in 1969 and then to 1992.

To keep track of progress towards targets, many forms were developed and sent to provincial branches to be filled up regularly and sent back to the Ministry. There were quite detailed descriptions, as a part of the legislation concerned, on which forms were to be filled in by whom and how. These forms included the

following: Household Members Registration Form; Personal Health Slip; Pregnancy Check up and Monitoring Slip; Child Monitoring Slip; Daily Work Schedule for Physicians, Nurses, Midwives and Health Technicians; Patient Referral Form; monthly reports by health centers; weekly reporting form for contagious diseases, etc.

9. **State unit, institution or person(s) in charge of enforcement:**

Article 35 of the law no. 224 states that the Council of Ministers is authorized to give effect to this law. A special department for socialization was envisaged (Article 21) to plan for socialization steps and ensure the cooperation of the Ministry of Health in this process with other relevant ministries and units. A General Assembly would be formed to evaluate socialization steps and practices and ensure cooperation between government units and the people at large. The assembly comprises representatives from universities, State Planning Organization, Social Security Institution, Turkish Medical Association, Association of Pharmacists and Association of Veterinaries. The assembly convenes once a year and it authorized to set up advisory committees on various issues (Article 22)

EVALUATION FOCUSING ON LAW NO:557 AND RELEVANT REGULATIONS

(While examining legislation in effect, special attention will be paid to check whether there is gender awareness in such issues as family planning, unwanted pregnancies and abortion)

Questions:

1. **What is the full policy title?** Law no. 557 on Population Planning
2. **Date of taking effect? (And annulment, if annulled later)**

Date of Adoption: 1 April 1965. Took effect upon publication in the Official Journal on 10 April 1965. Annulled on 27 May 1983 upon taking effect of the Law no. 2827 on Family Planning.

3. **What are the major problems that the policy is intended to address?**

The preamble stresses the negative effects of rapid population growth on national economy and points out to the need to prevent unacceptable rates of maternal mortality that significantly derives from abortions attempted as a result of unwanted pregnancies.

4. **What are the main targets and rationale?**

The law gives a definition of population planning and stresses its importance. The practice of contraception is recognized with the exception of surgical sterilization. However, pregnancy termination is still

banned except in cases where it is medically indicated.

5. **Do specific policy targets fully overlap with overall policy targets in female-male health, gender and health in general?**

No. The law suffices with defining population planning and pointing out to its importance. Contraception is allowed except for surgical sterilization. The latter is possible only when medical indications point out to its necessity. As such, it is far from satisfying above stated targets.

(Questions to follow focus on various steps in policy development).
Definition of the problem (Preambles of relevant laws will be looked up during this assessment):

6. **When problems implied in this policy were analyzed, was there any gender, age or region based evaluation of such headings as health status, risk profile, health problems, health behavior, health needs and utilization of health services?**

An overall assessment is given in the preamble. Following the devastating effects of the First World War and War of Liberation, population growth was supported through pronatalist policies. However, as technological advances reduced the need for plain manpower, population growth started to pose some problems. It is stated in the preamble that earlier ban on contraception brought along some health problems. When women fall pregnant to additional child whom they think they can't care they resort to abortion and relevant sanctions are not dissuasive enough for such an act. While it is stressed that abortion is unlawful once the women is pregnant, it is also stated that it is the duty of the State to help women who want to avoid pregnancy and husbands who don't want their wives to get pregnant. The text also states that the country has rather high rates of child mortality, which can be explained, at least partly, by families making more children than they can properly care for.

7. **When problems implied in this policy were analyzed, was there any consideration of other quantitative and qualitative data relating to sex and gender?**

In Turkey, the first survey on fertility and health was carried out in 1963 by the Ministry of Health. The findings of this survey clearly showed the negative effects of excessive fertility on the health status of both mothers and their children. In preparations for the present law, this survey and its results were taken into consideration. The new policy line was also influenced by rather frequent cases of "criminal abortus" as reported by hospitals.

Policy Formulation:

8. **What are the target groups of this policy?** Males and females in the age group 15-49.
9. **When identifying target groups was there any consideration of sex and gender related differences?**

In the preamble it is stated that abortion is unlawful, but it is the duty of the State to help women who want to avoid pregnancy and men who don't want their wives to get pregnant.

10. **What criteria/measures are suggested for the accomplishment of these targets?**

Dissemination of information on contraception and importation of contraceptive devices and medicines were left free. Also, the target is to have the State providing such devices and materials free to citizens when necessary. Another target is to train health workers on this issue.

11. **Did any of these criteria/measures pay attention to different needs of men and women? If yes, please explain**

In the preamble it is stated that abortion is unlawful, but it is the duty of the State to help women who want to avoid pregnancy and men who don't want their wives to get pregnant. It is thus possible to conclude that needs of both men and women were taken into account.

12. **Have resources been allocated to give effect to this policy?**

Resources include the budget of the Ministry of Health Maternal-Child Health and Family Planning (MCH-FP) as well as contributions made by international donors (US-AID, UNFPA, etc.) and NGOs.

13. **At present, is there any financial resource that is directed to women and/or men in specific?**

One can mention the budget of the Ministry of Health, Directorate General of Maternal-Child Health and Family Planning (MCH-FP) as well as contributions made by international donors (like US-AID, UNFPA) and NGOs.

Implementation:

14. **At which level the policy is implemented: national, regional or local?**

The policy is implemented at national level.

15. **Who plays significant role in the execution of the policy? (Health services, social services, others)**

Article 2 identifies the Ministry of Health as the authority in charge of education, training and implementation and it was considered to cooperate with military, governmental and voluntary organizations in this field.

16. **Have criteria of success for the policy (targets) been identified? What are they?**

It is free to spread contraceptive information and to import and market contraceptives. The target is to have the State providing free access to such contraceptives when needed. Another target is to their health workers on this issue.

17. **To what extent these criteria were satisfied?**

Annual statistics about contraceptive methods used by adults, induced abortions, crude birth rates and infant mortality rates give some idea about this issue (Tables1 and 2).

Table 1: Use of Contraceptive Methods and Induced Abortion by Married Women at Fertile Ages in Turkey, Percentage Distribution.

Method	**1963**	**1968**	**1973**	**1978**
IUD	0	1.6	2.3	3.5
OCS	1.0	2.2	4.8	4.9
Condom	4.3	4.4	4.7	3.6
CI	10.4	18.0	23.6	19.4
Other	12.0	12.9	10.1	12.7
Total protection	22.0	32.0	38.0	44.1
Not protecting	78.0	68.0	62.0	55.9
Is	8.0	11.0	12.0	17.0

Crude birth rate, which was 44 in thousand in 1960 dropped to 32 in 1978. Maternal mortality rate was 208 in 100,000 live births in 1974 and dropped to 132 in 1981.

Table 2. Infant Mortality Rates (IMR) in Turkey

Years	IMR (In 1000 live births)
1945-50	270
1950-55	235
1955-60	212
1960-65	178
1965-70	156
1970-75	130
1975-80	102

Monitoring:

18. **Is there a regularly working monitoring mechanism for the policy?**

These include the records of the Ministry of Health, five-year development plans of the SPO and statistics published periodically by the SIS.

19. **If there is, does this follow-up system allow for modifications in policy implementation?**

Yes, as long as decision makers considering all these hold their posts.

20. **Do monitoring reports include qualitative and/or quantitative information in regard to gender? Please explain if it does.**

Monitoring reports include qualitative information with respect to sex. Quantitative information regarding gender is quite rare.

Evaluation:

21. **To what extent criteria set to measure the success of the policy could be attained? (Describe problems and achievements)**

Looking at percentages of contraceptives given in Table 1 by years, we observe a significant increase especially in the first 5 years and that the percentage of women using contraceptive methods doubled in 15 years. In the same period, there were also significant falls in both maternal and infant mortality rates. Although it was illegal to terminate pregnancies in the country, the number of induced abortions has also doubled in the same period.

22. **Do you have any data on the impact of the policy on men and women?**

Yes. There is data relating especially to fertility regulations (contraception and abortions), crude birth rate, infant mortality rate and maternal mortality rate.

23. **Is there any unit, commission or focus group in charge that may ensure the incorporation of gender issues to this policy?**

There are the Directorate of Maternal-Child Health and General Directorate of Population Planning. But these are not units directly involved in work towards gender related targets.

Review of other data:

Gender based data:

24. **In the context of selected policy, is there any quantitative or qualitative data showing gender distribution? Please explain if there is.**

Records of the Ministry of Health and population censuses may give some idea about this issue. Population and Health Surveys (PHSs), on the other hand

provide data relating only to married women.

(Answers to these questions can be gathered from national health database).

25. **Were these data used while drafting the policy?**

Yes. Especially the findings and results of PHSs and population censuses were inputs guiding well-informed authorities/decision makers.

EVALUATION FOCUSING ON LAW NO. 2827 AND RELEVANT REGULATIONS

(While examining legislation in effect, special attention will be paid to check whether there is gender awareness in such issues as family planning, unwanted pregnancies and abortion)

Questions:

1. **What is the full title of the policy?**

LAW NO. 2827 ON POPULATION PLANNING

2. **When did it take effect? (Date of annulment, if annulled)**

Took effect upon its publication in the Official Journal dated 27 May 1983 and is still in effect.

3. **What are the main problems that the policy is intended to address?**

The law includes provisions specifying principles for the delivery of family planning services; procurement and manufacturing of contraceptive devices as well as measures to regulate fertility behavior and related sanctions.

4. **What are the main objectives and rationale?**

Article 1: "The principal objective of this legislation is to lay down the principles of population planning and arrange for such relevant issues as termination pregnancies, surgical sterilization, cases of urgent intervention and identification, procurement and manufacturing of contraceptive methods."

5. **Do specific policy targets fully overlap with overall policy targets in female-male health, gender and health in general?**

Partly; in earlier legislations, women were regarded as instruments of birth to increase population. Under the new legislation the decision for abortion primarily rests with the woman

(Questions to follow focus on various steps in policy development).

Definition of the problem (Preambles of relevant laws will be looked up during this assessment):

6. **When problems implied in this policy were analyzed, was there any gender, age or region based evaluation of such headings as health status, risk profile, health problems, health behavior, health needs and utilization of health services?**

Yes.

In the Preamble of the legislation, it is stated that despite the elapse of 15 years since the adoption of the Law no.557 on population planning desired decrease in the rate of population growth could not be achieved. The number of induced abortions and infant deaths increased and many women/ mothers each year either died or remained with various disorders and disabilities only as a result of illegal abortions. It is also stressed that since legal abortion is not possible, many women resort to extremely harmful methods or leaving themselves to the hands of some untrained back street abortionists, which explains the high maternal mortalities.

7. **When problems implied in this policy were analyzed, was there any consideration of other quantitative and qualitative data relating to sex and gender?**

The primary reference was the results of population and health surveys conducted in every five years. According to information collected by these surveys, a half of women who were pregnant when the survey was being conducted stated that their pregnancy was unwanted. Objection to another pregnancy get stronger if the woman already has the number of children she wants.

Policy Formulation:

8. **What are the target groups of this policy?** Males and females in the age group 15-49.

9. **When identifying target groups was there any consideration of sex and gender related differences?**

No discrimination based on marital status is made in practices relating to termination of pregnancies or to female health in general.

10. **What criteria/measures are suggested for the accomplishment of these targets?**

Article 3

The article emphasizes inter-sect oral cooperation as follows: “Efforts to inform the society about the importance of family planning as well as education, training and practical services in this area shall be delivered by the Ministry of Health in line with principles laid down by relevant Regulations, which is to be prepared, under the coordination of the Ministry of Health, jointly by the Ministries of National Defense, National Education and Social Security and take effect upon

the decision of the Council of Ministers. The Ministry of Health shall perform its tasks in this area in cooperation with universities, social insurance institutions, Radio and Television Corporation, other relevant governmental agencies, professional organizations and voluntary organizations."

"The Ministry of Health and Social Assistance is authorized to set up special organizations, to procure or manufacture contraceptives, provide these devices free or at low cost to those who are in need and to take relevant measures for the marketing of these means and devices. Private sector manufacturing or importation of pharmaceutics and devices is subject to the permission of the Ministry."

"The Ministry is also authorized to decide on the type and quality of pharmaceutics and devices to be used in contraception by soliciting the written opinion of a special commission, which comprises academics from schools of medicine. Any medicine or device not duly authorized by the Ministry cannot be used or tested on people by any facility including medical schools."

"The Ministry issues Regulations regarding the establishment and procedures of above-mentioned commission, methods of contraception, and training of health workers, including physicians, midwives and nurses, on practices of contraception. Physicians, nurses and midwives provide contraceptive services in conformity with these Regulations."

11. **Did any of these criteria/measures pay attention to different needs of men and women? If yes, please explain**

Earlier, unwanted pregnancies used to be terminated by unsafe methods of abortion illicitly. Now it can be done legally under safe conditions with the attendance of physicians. Further, both sexes can undergo surgical sterilization above age 18.

12. **Have resources been allocated to give effect to this policy?**

Resources include the budget of the Ministry of Health Maternal-Child Health and Family Planning (MCH-FP) as well as contributions made by international donors (US-AID, UNFPA, etc.) and NGOs.

13. **At present, is there any financial resource that is directed specifically to women and/or men?**

Resources include the budget of the Mother and Child Health and Family Planning (MCH-FP) GD of the MoH, as well as contributions made by international donors (US-AID, UNFPA, etc.) and NGOs.

Implementation:

14. **At which level the policy is implemented: national, regional or local?**

The policy is implemented at national level.

15. **Who plays significant role in the execution of the policy? (Health services, social services, others)**

It is stated in Article 3. According to this article: The Ministry of Health shall perform its tasks in this area in cooperation with universities, social protection institutions, Radio and Television Corporation, other relevant governmental agencies, professional organizations and voluntary organizations."

16. **Have criteria of success for the policy (targets) beer identified? What are they?**

Yes. These criteria include the following: Ensuring that at least 5 % of couples will be reached in each year to use effective contraceptive methods; lower rates of high risk pregnancies and lower rates of maternal mortality.

17. **To what extent have these targets been attained?**

Table 1: Use of Contraceptive Methods and Induced Abortion by Married Women at Fertile Ages in Turkey, Percentage Distribution.

Method	**1983**	**1988**	**1993**	**1998**
IUD	8.9	14.0	18.8	19.8
OC S	9.0	6.2	4.9	4.4
Condom	4.9	7.2	6.6	8.2
Tubal ligation	1.3	1.7	2.9	4.2
C.I.	30.1	25.7	26.7	24.4
Other	4.4	2.0	1.3	1.1
Total protection	61.5	63.4	62.6	63.9
Not protecting	38.5	36.6	37.4	36.1
Induced abortion	12.1	12.9	18.0	14.5

Follow-up:

18. **Is there a regular mechanism of follow-up for this policy?** There is. The elements of this mechanism include the Advisory Boards of Family Planning and Women's Health of the MCH-FP GD of the MoH, Population and Health Surveys (PHS) carried out in Turkey quinquennially since 1963, Population Censuses and Five Year Development Plans prepared by the State Planning Organization.

19. **Does this follow-up system allow for modifications in policy implementation?**

Yes. This is possible especially through five-year development plans and strategic plans of the Ministry of Health.

20. **Do monitoring reports include qualitative and/or quantitative**

information in regard to gender? Please explain if it does.

The concept "gender" is being grasped and elaborated more and more. But reports presently contain information mostly related to sex.

Evaluation:

21. **To what extent criteria build in to measure the success of the policy were satisfied? (Please describe problems and successes).** Data obtained in 1983, 1988, 1993 and 1998 PHSs were compared (See Table 1).

22. **Is there any data on the impact of the policy on males and females?** The PHSs in 1993 and 1998 gathered date not only on women but also their husbands. There were also further analyses of PHSs in 1993 and 1998.

23. **Is there any unit, commission or focus group in charge that may ensure the incorporation of gender issues to this policy?**

Yes. Turkey signed the CEDAW in 1985 and it was ratified by the GNA and took effect in 1986.

The General Directorate of Women's Status and Problems (WSP) established in 1990 is in charge of following up new developments in the context of CEDAW.

Further, the GNA has a standing commission to follow up developments in the same context.

The WSP is also responsible for following up Turkey's commitments at the 4th World Women Conference held in Beijing.

The State Planning Organization (SPO) is a focal mechanism in following up Cairo-ICPD recommendations.

The Women's Health Commission (KASAKOM) established by 17 civil society organizations and Women Research and Implementation Centers existing in 14 universities (HUWRIC is one of them) are also mechanisms and bodies engaged in advocacy and monitoring-evaluation activities in this field.

Review of other data:

Gender based data:

24. **In the context of selected policy, is there any quantitative or qualitative data showing gender distribution? Please explain if there is.**

- The State Institute of Statistics (SIS) has since 1927 been collecting and publishing gender specific data.
- There are qualitative and quantitative researches conducted by universities.
- Relevant data published by the Ministry of Health
- Results of Population Census.

25. **Were these data used while drafting the policy?** Some data from the PHS of 1978, statistics made available by the SIS and MoH and findings of researches made by universities (*) were used while formulating the Preamble of the law.

* The findings of the "Operation Research" jointly carried out by the Public Health Department of Hacettepe University and WHO were used in formulating the rationale of 3 important articles of the Law no. 2827.

Findings used were related to:

1. Induced Abortion
2. Authorization of trained Nurses-Midwives for the provision of IUD services.
3. Authorization of trained General Practitioners for termination of pregnancies.

Annex III.

Criteria for successful planning and implementation of gender sensitive health policies

Questionnaire to the resource persons in the Member-State

Gender Mainstreaming and Women's Health Program, GEM
Family and Community Heath Unit
WHO Regional Office for Europe
Focal Point:
Dr. Joke Haafkens Email: JHA@who.dk;
Tel: 45 3917 1253

Before you answer the questionnaire please try to give an answer to the following questions:

- How many gender sensitive health policies exist in the country?
- In which stage of development are those policies: planning, implementation, consolidation?
- If there are no gender sensitive policies has the country ever tried to develop or implement one and failed?
- In order to answering the following questions, please choose one key policy and motivate your choice.

1. Specification of Policy

1.1 Please give the official title of the policy you are referring to, when answering the questions. If possible, state the national title as well as its official English translation.

Title in national language:
……..
……..

Title in English translation:
……..
……..

1.2 What is the legal status of the policy (Classification below follows EU-System, please apply to the Member-States legal system)

1. Law
2. Directive
3. Recommendation
4. Guideline
5. Other……..
6. Don't know

1.3 Specify the area of public policy that the policy addresses. Multiple responses are possible.

1. Public health/health promotion
2. Employment and job promotion
3. Public and personal safety (including domestic violence)
4. Education and research
5. Social security
6. Environmental issues
7. Nutrition
8. Health services
9. Another area (please state in your own words):……..

1.4 Please indicate the mission, goal and objectives of the policy:
……..
……..

1.5 Are qualitative or quantitative targets defined by the policy?

1. No
2. Yes, qualitative
3. Yes, quantitative
4. Yes, both
5. Don't know

If yes, please attach them in the Annex

1.6 Is the selected policy the only gender-sensitive, health-related public policy in the country?

No Yes Don't know

1.7 If the policy is not the only gender-sensitive public health policy, please give reasons for, why this policy was selected to answer the questionnaire.
……..

1.8 On which state level was the public enacted?
1. National level
2. Regional level
3. Municipal level

1.9 Question 9: In which year was the policy enacted by the decision making institution?
Year: ……

1.10 Question 10: Please state the decision-making institution adopting the policy?
1. Executive power/government
2. Legislative power/parliament
3. Ministry/Administration
4. Voluntary agreement between private institutions
5. Other……..
6. Don't know

1.11 Question 11: In which year did the implementation process of the policy begin?
1. Year: ……
2. Beginning of the implementation cannot be specified by year
3. Implementation has not begun yet

1.12 Question: Was there a staged implementation process? Yes/No

2. Policy Background

Question 12: Is gender equality and/or equity defined as a principle within the national constitution of the Member-state?
Yes No Don't know

Question 13: Does the policy follow global (e.g. Beijing, ECOSOC) or regional (e.g. EU, WHO/EURO) strategies or recommendations?
Yes No Don't know

Question 14: Had the Member-state a ministry for gender equality and/or equity, at the time of policy enactment?
Yes No Don't know

Question 15: How was the issue of the policy brought in to the political agenda, what caused government's interest in the enactment/implementation of the policy? (more than one answer possible)
1. Lobby-groups
2. An official report, which revealed deficits
3. Media
4. A judicial ruling
5. Recommendations from policy experts
6. An original initiative from within governmental administration
7. Other……..
8. Don't know

Question 16: What was the political orientation of the government that formulated and enacted the policy?

1. Left-wing
2. Right-wing
3. Centre
4. Other
5. Don't know

Question 17: Referring to the state where the policy was enacted: Can you give the percentage of female ministers as cabinet members at the time of policy enactment?

Percentage of female cabinet members: …….

Question 18: Can you give the percentage of female members of parliament at the time of policy enactment?
Share of female members of parliament:…….%

3. Phase of Policy Planning

Question 19: How long did the planning phase, from the first political initiative until the official enactment of the policy, last?

1. Less than ½ a year
2. Between ½ a year and 1 year
3. Between 1 and 2 years
4. Between 2 and 4 years
5. More than 4 years
6. Don't know

Question 20: Which of the following actors participated actively in the planning process?

1. Ministry of Women/Gender Mainstreaming
2. Ministry of Health
3. Ministry of Social Affairs
4. Ministry of Justice
5. Other Ministries: ……
6. Health professionals
7. Women rights groups
8. Patient rights groups
9. Other social rights groups: …….
10. Donors
11. Trade unions
12. Employers associations
13. Others: ……..
14. Don't know

Question 21: Which ministry had the overall responsibility for the policy planning process?
Ministry of…….

Question 22: Were actors from outside of government officially invited to comment on the policy proposal?

1. Never
2. Once

3. More often
4. Don't know

Question 23: Was a special institutional structure created for policy planning (e.g. commission, department, working group, etc?
Yes No Don't know

Question 24: If yes, please describe:
……
……

Question 25: Have resources been specially allocated for the planning process?
Yes No Don't know

Question 26: If resources had to be specially allocated for the planning activities, what were the sources of financing? (Multiple responses are possible)

1. State level government
2. Regional government
3. Local government
4. Budgets of targeted institutions/organizations
5. Private funds/donors
6. Others
7. Don't know

If possible, specify in annex the level of human and financial resources

5. Phase of Policy Implementation

Question 27: What was the political orientation of government, when implementation of the policy began?

1. Left-wing
2. Right-wing
3. Centre
4. Other
5. Don't know

Question 28: Have resources been specially allocated for the implementation process?
Yes No Don't know

Question 29: If resources had to be specially allocated for implementation, what were the sources of financing? (Multiple indications are possible?

1. State level government
2. Regional government
3. Local government
4. Budgets of targeted institutions/organizations
5. Private funds/donors
6. Others
7. Don't know

If possible, specify in annex the level of human and financial resources

Question 30: On which state level was the policy implemented?

1. National level
2. Regional level
3. Municipal level

Question 31: Who is responsible for the implementation of the policy? (Multiple indications are possible)

1. National ministry: Ministry of……
2. Regional administration
3. Municipal administration
4. Special agency
5. Health institution/hospitals
6. Employers
7. Trade unions
8. Others…….
9. Don't know

Question 32: Are these specific instruments used to monitor the implementation of the policy?

1. Yes, ……
2. No
3. Don't know

Question 33: Which is responsible body for monitoring the implementation of policy?
…….....

Question 34: If commission/working group has been set up, please state the professional background of the members and frequency of meetings……
…….....

Question 35: To complement the policy, were any institutional structures reorganized, or did any structural changes occur during the implementation phase?(e.g. new department, agency, focal point, working group, inter-ministerial commission)

1 Yes, (please specify the structural changes occurred): ……...
2 No
3 Don't know

Question 36: Please give number of full-time employees working on gender and health at the ministry of health or implementing agencies.

Number of employees: .....…….

Question 37: Which of the following actors participate actively in the implementation process?

1. National governmental administration
2. Regional/district administration
3. Local/municipal administration
4. Health professionals/hospitals
5. Women rights groups
6. Patient rights groups
7. Other social rights groups……..
8. Trade unions
9. Employers associations

10. Others……..
11. Don't know

5. Policy Success and Institutional Change

Question 38: Does the policy define any instruments and/or indicators to evaluate the policy outcomes?
Yes No Don't know

Question 39: What are the instruments and/or indicators?
……..……
……..

Question 40: Could you finally describe how the situation has changed after the implementation of the policy?
……..
……..
……..

6. Annex to the Questionnaire

Please use the space that is provided under the each question to comment on the information given under the same question within the questionnaire.

Question 1
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Question 2
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Question 3
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Question 4
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Question 5
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Question 6
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Question 7
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Question 9
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Question 10
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Question 11

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Question 12

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Question 13

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Question 14

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Question 15

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Question 16

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Question 17

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Question 18

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Question 32

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Question 33

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Question 34

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Question 35

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Question 36

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Question 37

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Question 38

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Question 39

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Question 40

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Annex IV.

List of Participants in the Second Phase of the Gender Mainstreaming In Reproductive Health Study

Province	Affiliation	No. of people interviewed
1. Ankara	Turkish Parliament	2
2. Ankara	Hacettepe University Faculty of Medicine Department of Public Health	1
3. Ankara	Gulveren MCH/FP Clinic	3
4. Ankara	No 9 MCH/FP Clinic	6
5. Istanbul	Turkish Family Planning Association Headquarters	1
6. Istanbul	Istanbul University Women's Problems Research and Implementation Center	1
7. Istanbul	Willows Foundation Headquarters	2
8. Istanbul	Women for Women's Rights Project – New Ways	2
9. Istanbul	Marmara University Faculty of Medicine, Department of Public Health	1
10. Istanbul	Istanbul Bar Women's Rights Commission	
11. Diyarbakir	Laundry and Tandoori Room (Diyarbakir Women's Problems Research and Implementation Center and Diyarbakir Municipality)	1
12. Diyarbakir	Midwife in a MOH Health Post	1
13. Diyarbakir	Diyarbakir Women's Problems Research and Implementation Center Headquarters	1
14. Diyarbakir	Midwives in MOH FP/MCH Center	7
15. Diyarbakir	Willows Foundation Local Branch	1
16. Diyarbakir	Dicle University Faculty of Medicine Department of Public Health	1
17. Diyarbakir	Dicle University Faculty of Medicine Department of OB/GYN	1
18. Diyarbakir	Turkish Family Planning Association, Local Branch	1
19. Diyarbakir	Health Directorate, FP/MCH Branch	1
20. Diyarbakir	SSK Hospital Department of Obstetrics and Gynecology, Private Practice	1
21. Diyarbakir	SSK Hospital Reproductive Health Unit	1
22. Diyarbakir	MOH Health Group Administrator	1
23. Diyarbakir	Maternity Hospital Department of OB/GYN, Private Practice	1
24. Diyarbakir	Midwife, Maternity Hospital	1
25. Diyarbakir	Midwifery Students, Maternity Hospital	5
26. Diyarbakir	Women (Patrons of the Laundry and Tandoori Room	7
27. Mardin	MOH Health Directorate, FP/MCH Branch	1
28. Mardin	MOH Central FP/MCH Clinic	6
29. Mardin	State Hospital Department of OB/GYN, Private Practice	1
30. Mardin	Willows Foundation Local Branch	1

Annex V.

Women's Health and Gender Study Interview Form

(Used for the 2nd Phase of the Study)

Introduction: We are coming from Hacettepe University Department of Public Health. We want to interview you about your perspectives on reproductive health and family planning services in Turkey. We will use the information and perspectives you provide to get an overview of the services. We appreciate your time for this interview. We would also like to tape this interview. Whatever you say is very important for us and we would not like to miss any part of it or any details. If you agree, I will turn the tape on.

Personal Information:

1. The name of the person: …….
2. The institution/affiliations and titles: …….
3. How long have you been with this institution? ……..
4. Where have you worked previously (the institutions and provinces)……
5. How long have you been working in this province? …….
6. What is the total time (in years) that you have been working on reproductive health issues? ……..

Information Regarding the Services:

7. What do you think the priority of health problems related pregnancies and abortions in the health agenda of Turkey in 2004?

8. What is your assessment of the contraceptive use rates in your district (This question will be asked as "In Turkey" for people who have worked in different parts of Turkey)? When you consider the districts and regions you have been working in, what are the factors that influence the contraceptive use rates?

   Probes:
   - How effective are cultural factors (language, women's status, etc.)?
   - Economical reasons
   - Level of education
   - Type of health insurance

9. What is your assessment of the contraceptive pill use rates in your district (in Turkey)?

10. What is your assessment of the vasectomy/tubal ligation rates in your district (in Turkey)? What is the procedure about getting the signature of the spouse?

11. What is your assessment of the withdrawal rates in your district (in Turkey)?

12. How do you evaluate the health legislation number 2827, which regulates family planning and abortion services in Turkey?

Probes:

- What are the advantages and opportunities presented by this legislation?
- What might be some of the points to change and/or improve in this legislation?

13. In terms of service provision, what are your perspectives on current procedures about family planning services? What are some of the effective applications and what are some of the areas to improve?

Probes:

- The extent of the services
- Health personnel
- The infra structure of the facilities
- Administration of services

14. What could be the different needs of men and women in reproductive health? And what do you think about the extent which the health legislation addresses the different needs of men and women? Can you explain and cite examples?

15. What are some of the arrangements you are making in the service delivery system you have to address the different needs of men and women?

16. When you consider the personnel working in institutions (public, private and NGO) in your district, what is your assessment of their level of care for gender issues? Are they gender sensitive? Can they approach sensitively and responsibly to different reproductive health needs?

17. Can you tell us about the services for the prevention of unwanted pregnancies and abortion that your institution is providing?

Probe: Do you ask for husband's signature for abortion? If yes, how do you think that might effect women who are coming in for abortion?

18. When you look at the issue from a client perspective, do you think people who need the services in your district (in Turkey) can get contraceptives for an affordable price and with a reasonable effort? Can you explain?

19. Again, from the client perspective; can a woman or a couple who wishes terminating a pregnancy can get abortion services in your district (in Turkey) for an affordable price and with a reasonable effort? Can you explain?

20. What are some of the opportunity areas that will help expand contraceptive services and enable more people to use them? Where do you think lies the most important opportunities?

Probes:

- An important proportion of married women are not using contraception even though they do not want to have any more children. What may be some of the opportunities to resolve this issue?
- What are your perspectives about the use of contraception among adolescents and young people?
- What are your perspectives on increasing contraceptive use among men?
- What are your perspectives about increasing access and contraceptive use for unmarried people?

21. In Turkey, both married and unmarried women may still face several barriers when they want to have an abortion. What are your perspectives on this issue? How can the barriers be overcome?

22. What are some of the future plans of your institution? What kinds of reproductive health programs are you planning to emphasize in the future?

23. Now I would like to ask your personal opinions about some contraceptive access issues:

a) What is your opinion about community volunteers distributing contraceptive pills? Would you approve of trained volunteers (not health professionals) to work as such? What may be some of the problems related to it?

(Probe: For those responses, who indicates that it is not legal: “You know, anyone who wants an oral contraceptive can purchase it over the counter from the pharmacies. So, what are the different types of issues you would consider between buying it from the pharmacy or getting it from a volunteer?)

b) What is your opinion about selling contraceptives in units other than health clinics, especially in the rural regions? How realistic and feasible is it for Turkey to sell condoms, pills or injectables in the bazaars, food markets or shops?

c) Lastly, I would like to get your opinions about the “morning after pill” or emergency contraceptives. What do you think on making the information on emergency contraceptives widely available? Such as through the internet or through other media?

24. About Gender:

a) How do you assess the implementation of health legislation in areas concerning gender issues? Do you think what the health legislation brings as gender perspectives are reflected in the everyday practices and procedures of

reproductive health services? Can you explain?

b) How do you integrate the concepts of "gender" and "reproductive rights" to your own work and in the projects/services you are working? Do you enact a gender sensitive approach? Can you explain?

c) What is the perspective on the roles and responsibilities of men and women in terms of the reproductive health services provided in your district/by your institution? Can you explain?

25. Thank you very much for sharing information and your perspectives with us. Are there any other issues that you would like to talk about that we have not mentioned?

26. What are some of the other people who would be informed about these topics? Could you tell us some names to conduct this same interview with?

THANK YOU VERY MUCH. Our interview is finished now.

Turn the tape off.
Hand out the attitude scale to service providers and ask them to complete with their consent.
Attention: After turning the tape off, continue taking down notes. It is very important to catch the important points which may come after the completion of the formal interview.

Annex VI. Opinion Questionnaire on FP Services and the Results (Used in the 2nd Phase of the Study)

Below are some statements on family planning services. Please specify your opinion in regard to these statements.

Thank you.

1. I agree
2. Not sure
3. Disagree

	%		
	1	**2**	**3**
1. Family planning services should be provided for those under age 18.	97,1	2,9	-
2. No intervention should be made to a male applying for vasectomy unless his female partner's consent is taken.	74,3	14,3	11,4
3. In case of unwanted pregnancy, curettage should be available for a woman without the consent of her husband.	42,9	11,4	45,7
4. Unmarried persons should also be able to benefit from family planning services.	94,3	2,9	2,9
5. All family planning services must be free of charge.	77,1	14,3	8,6
6. Information on emergency contraceptives, morning-after pills and their use must be widely disseminated.	82,9	5,7	11,4
7. Sexually transmitted diseases should be an important part of family planning services.	97,1	2,9	-
8. For the dissemination of information on family planning, the Ministry of Education should be involved as much as the Ministry of Health.	82,9	5,7	11,4
9. For unmarried women, IUDs should not be seen as a family planning method even if there is indication.	29,4	35,3	35,3
10. When providing family planning methods to women with low education, the health care providers should decide the best method for them to be used.	54,3	5,7	40,0
11. Low level of education is the most important factor explaining the under-utilization of family planning services.	77,1	14,3	8,6
12. New family planning methods to be developed should be more male-focused.	65,7	25,7	8,6
13. Service providers have the responsibility if family planning services offered are not sufficiently used by unmarried males and females.	28,6	17,1	54,3
14. The political will is a determinant factor in making family planning services more effective.	42,9	25,7	31,4
15. Curettage should be considered as a method of family planning.	14,3	8,6	77,1
16. Pregnancies with definite birth defects should be terminated without any consideration of pregnancy duration.	68,6	17,1	14,3
17. The fact that family planning services are used more by women is an indicator that women have the control over their bodies.	17,1	22,9	60,0
18. The reason why traditional FP methods are still used is the failure of service providers to fulfil their responsibilities.	22,9	28,6	48,6
19. Delivery of health services including family planning is one of the most important duties of the State.	94,3	2,9	2,9
20. Religious leaders should be actively involved in advocacy for the adoption utilisation of the family planning effectively.	68,6	20,0	11,4
21. No intervention should be made to a female requesting for tubal ligation unless her spouse's consent is taken.	74,3	8,6	17,1
22. Male partner's consent must be obtained for an unmarried woman asking for curettage.	14,3	17,1	68,6
23. Low service quality is an important factor explaining why family planning services are not used at a satisfactory level in Turkey.	48,6	25,7	25,7
24. "The fact that family planning services are used more by women is an indicator that responsibility regarding reproductive health is mainly undertaken by women."	85,7	5,7	8,6
25. Primary level public health facilities fully perform their duties in family planning services.	51,4	20,0	28,6
26. Family planning services are private issues of the individuals/couples.	82,9	2,9	14,3
27. Family planning services should mainly be provided by the private sector.	20,0	8,6	71,4

Please do not write down your name. Just specify your age, sex and occupation.

Age: .....

Sex: .....

Occupation:.....

Table. Statement 1 "Family planning services should be provided for those under age 18."

	Agree		Not sure		Disagree		Total	
	N	%	N	%	N	%	N	%
Age (n=33)								
29 or under	10	90,9	1	9,1	-	-	11	33,3
30-39	16	100,0	-	-	-	-	16	48,5
40 or over	6	100,0	-	-	-	-	6	18,2
Sex (n=34)								
Male	5	83,3	1	16,7	-	-	6	17,6
Female	28	100,0	-	-	-	-	28	82,4
Occupation (n=33)								
Nurse-Midwife	21	100,0	-	-	-	-	21	61,8
Physician	8	88,9	1	11,1	-	-	9	26,5
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**33**	**97,1**	**1**	**2,9**			**34**	**100,0**

Table. Statement 2"No intervention should be made to a male applying for vasectomy unless his female partner's consent is taken."

	Agree		Not sure		Disagree		Total	
	N	%	N	%	N	%	N	%
Age (n=34)								
29 or under	10	90,9	-	-	1	9,1	11	32,4
30-39	11	68,8	4	25,0	1	6,3	16	47,0
40 or over	4	57,1	1	14,3	2	28,6	7	20,6
Sex (n=35)								
Male	7	100,0	-	-	-	-	7	20,0
Female	19	67,9	5	17,9	4	14,3	28	80,0
Occupation (n=35)								
Nurse-Midwife	14	66,7	3	14,3	4	19,0	21	60,0
Physician	8	80,0	2	20,0	-	-	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**26**	**74,3**	**5**	**14,3**	**4**	**11,4**	**35**	**100,0**

Table. Statement 3 "In case of unwanted pregnancy, curettage should be available for a woman without the consent of her husband."

	Agree		Not sure		Disagree		Total	
	N	%	N	%	N	%	N	%
Age (n=34)								
29 or under	5	45,5	-	-	6	54,5	11	32,4
30-39	6	37,5	3	18,8	7	43,8	16	47,0
40 or over	3	42,9	1	14,3	3	42,9	7	20,6
Sex (n=35)								
Male	1	14,3	-	-	6	85,7	7	20,0
Female	14	50,0	4	14,3	10	35,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	11	52,4	-	-	10	47,6	21	60,0
Physician	1	10,0	4	40,0	5	50,0	10	28,6
Health Technician	1	50,0	-	-	1	50,0	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**15**	**42,9**	**4**	**11,4**	**16**	**45,7**	**35**	**100,0**

Table. Statement 4 "Unmarried persons should also be able to benefit from family planning services**.**"

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	10	90,9	-	-	1	9,1	11	32,4
30-39	15	93,8	1	6,3	-	-	16	47,0
40 or over	7	100,0	-	-	-	-	7	20,6
Sex (n=35)								
Male	6	85,7	1	14,3	-	-	7	20,0
Female	27	96,4	-	-	1	3,6	28	80,0
Occupation (n=35)								
Nurse-Midwife	20	95,2	-	-	1	4,8	21	60,0
Physician	10	100,0	-	-	-	-	10	28,6
Health Technician	1	50,0	1	50,0	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**33**	**94,3**	**1**	**2,9**	**1**	**2,9**	**35**	**100,0**

Table. Statement 5 "All family planning services must be free of charge."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	10	90,9	1	9,1	-	-	11	32,4
30-39	11	68,8	2	12,5	3	18,8	16	47,0
40 or over	5	71,4	2	28,6	-	-	7	20,6
Sex (n=35)								
Male	7	100,0	-	-	-	-	7	20,0
Female	20	71,4	5	17,9	3	10,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	18	85,7	2	9,5	1	4,8	21	60,0
Physician	7	70,0	2	20,0	1	10,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	-	-	-	-	1	100,0	1	2,9
Worker	-	-	1	100,0	-	-	1	2,9
Total	**27**	**77,1**	**5**	**14,3**	**3**	**8,6**	**35**	**100,0**

Table. Statement 6 "Information on emergency contraceptives, morning-after pills and their utilization must be widely disseminated"

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	10	90,9	1	9,1	-	-	11	32,4
30-39	12	75,0	1	6,3	3	18,8	16	47,0
40 or over	6	85,7	-	-	1	14,3	7	20,6
Sex (n=35)								
Male	6	85,7	-	-	1	14,3	7	20,0
Female	23	82,1	2	7,1	3	10,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	18	85,7	2	9,5	1	4,8	21	60,0
Physician	8	80,0	-	-	2	20,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**29**	**82,9**	**2**	**5,7**	**4**	**11,4**	**35**	**100,0**

Table. Statement 7 "Sexually transmitted diseases should be an important part of family planning services."

	Agree		Not sure		Disagree		Total	
	N	%	N	%	N	%	N	%
Age (n=34)								
29 or under	10	90,9	1	9,1	-	-	11	32,4
30-39	16	100,0	-	-	-	-	16	47,0
40 or over	7	21,2	-	-	-	-	7	20,6
Sex (n=35)								
Male	7	100,0	-	-	-	-	7	20,0
Female	27	96,4	1	3,6	-	-	28	80,0
Occupation (n=35)								
Nurse-Midwife	20	95,2	1	4,8	-	-	21	60,0
Physician	10	100,0	-	-	-	-	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**34**	**97,1**	**1**	**2,9**	**-**	**-**	**35**	**100,0**

Table. Statement 8 "For the dissemination of information on family planning, the Ministry of Education should be involved as much as the Ministry of Health."

	Agree		Not sure		Disagree		Total	
	N	%	N	%	N	%	N	%
Age (n=34)								
29 or under	8	72,7	2	18,2	1	9,1	11	32,4
30-39	14	87,5	-	-	2	12,5	16	47,0
40 or over	6	85,7	-	-	1	14,3	7	20,6
Sex (n=35)								
Male	7	100,0	-	-	-	-	7	20,0
Female	22	78,6	2	7,1	4	14,3	28	80,0
Occupation (n=35)								
Nurse-Midwife	17	81,0	2	9,5	2	9,5	21	60,0
Physician	10	100,0	-	-	-	-	10	28,6
Health Technician	1	50,0	-	-	1	50,0	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**29**	**82,9**	**2**	**5,7**	**4**	**11,4**	**35**	**100,0**

Table. Statement 9 "For unmarried women, IUDs should not be seen as a family planning method even if there is indication."

	Agree		Not sure		Disagree		Total	
	N	%	N	%	N	%	N	%
Age (n=33)								
29 or under	5	45,5	2	18,2	4	36,4	11	33,3
30-39	3	18,8	7	43,8	6	37,5	16	48,5
40 or over	2	33,3	2	33,3	2	33,3	7	18,2
Sex (n=34)								
Male	3	42,9	1	14,3	3	42,9	7	20,6
Female	7	25,9	11	40,7	9	33,3	27	79,4
Occupation (n=34)								
Nurse-Midwife	7	33,3	6	28,6	8	38,1	21	61,8
Physician	3	30,0	5	50,0	2	20,0	10	29,4
Health Technician	-	-	-	-	2	100,0	2	5,8
NGO	-	-	1	100,0	-	-	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**10**	**29,4**	**12**	**35,3**	**12**	**35,3**	**34**	**100,0**

Table. Statement 10 "When providing family planning methods to women with low education, the health care providers should decide the best method for them to be used."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	10	90,9	-	-	1	9,1	11	32,4
30-39	6	37,5	2	15,5	8	50,0	16	47,0
40 or over	2	28,6	-	-	5	71,4	7	20,6
Sex (n=35)								
Male	4	57,1	-	-	3	42,9	7	20,0
Female	15	53,6	2	7,1	11	39,3	28	80,0
Occupation (n=35)								
Nurse-Midwife	12	57,1	2	9,5	7	33,3	21	60,0
Physician	4	40,0	-	-	6	60,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	-	-	-	-	1	100,0	1	2,9
Worker	1	100,0-	-	-	-	-	1	2,9
Total	**19**	**54,3**	**2**	**5,7**	**14**	**40,0**	**35**	**100,0**

Table. Statement 11 "Low level of education is the most important factor explaining the under-utilization of family planning services."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	10	90,9	1	9,1	-	-	11	32,4
30-39	12	75,0	2	12,5	2	12,5	16	47,0
40 or over	4	57,1	2	28,6	1	14,3	7	20,6
Sex (n=35)								
Male	7	100,0	-	-	-	-	7	20,0
Female	20	71,4	5	17,9	3	10,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	17	81,0	3	14,3	1	4,8	21	60,0
Physician	7	70,0	1	10,0	2	20,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	-	-	1	100,0	-	-	1	2,9
Worker	1	100,0-	-	-	-	-	1	2,9
Total	**27**	**77,1**	**5**	**14,3**	**3**	**8,6**	**35**	**100,0**

Table. Statement 12 "New family planning methods to be developed should be more male-focused."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	5	45,5	3	27,3	3	27,3	11	32,4
30-39	12	75,0	4	25,0	-	-	16	47,0
40 or over	5	71,4	2	28,6	-	-	7	20,6
Sex (n=35)								
Male	4	57,1	3	42,9	-	-	7	20,0
Female	19	67,9	6	21,4	3	10,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	15	71,4	4	19,0	2	9,5	21	60,0
Physician	6	60,0	4	40,0	-	-	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0-	-	-	-	-	1	2,9
Total	**23**	**65,7**	**9**	**25,7**	**3**	**8,6**	**35**	**100,0**

Table. Statement 13 "Service providers have the responsibility if family planning services offered are not sufficiently used by unmarried males and females."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	3	27,3	2	18,2	6	54,5	11	32,4
30-39	4	25,0	4	25,0	8	50,0	16	47,0
40 or over	2	28,6	-	-	5	71,4	7	20,6
Sex (n=35)								
Male	4	57,1	1	14,3	2	28,6	7	20,0
Female	6	21,4	5	17,9	17	60,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	4	19,0	4	19,0	13	62,0	21	60,0
Physician	5	50,0	1	10,0	4	40,0	10	28,6
Health Technician	-	-	1	50,0	1	50	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**10**	**28,6**	**6**	**17,1**	**19**	**54,3**	**35**	**100,0**

Table. Statement 14 "The political will is a determinant factor in making family planning services more effective."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	3	27,3	5	45,5	3	27,3	11	32,4
30-39	7	43,8	2	12,5	7	43,8	16	47,0
40 or over	4	57,1	2	28,6	1	14,3	7	20,6
Sex (n=35)								
Male	6	85,7	1	14,3	-	-	7	20,0
Female	9	32,1	8	28,6	11	39,3	28	80,0
Occupation (n=35)								
Nurse-Midwife	8	38,1	6	28,6	7	33,3	21	60,0
Physician	7	70,0	1	10,0	2	20,0	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
NGO	-	-	-	-	1	100,0	1	2,9
Worker	-	-	1	100,0	-	-	1	2,9
Toplam	**15**	**42,9**	**9**	**25,7**	**11**	**31,4**	**35**	**100,0**

Table. Statement 15 "Curettage should be considered as a method of family planning."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	3	27,3	1	9,1	7	63,6	11	32,4
30-39	1	6,3	1	6,3	14	87,5	16	47,0
40 or over	-	-	1	14,3	6	85,7	7	20,6
Sex (n=35)								
Male	-	-	1	14,3	6	85,7	7	20,0
Female	5	17,9	2	7,1	21	75,0	28	80,0
Occupation (n=35)								
Nurse-Midwife	5	23,8	2	9,5	14	66,7	21	60,0
Physician	-	-	-	-	10	100,0	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
NGO	-	-	-	-	1	100,0	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**5**	**14,3**	**3**	**8,6**	**27**	**77,1**	**35**	**100,0**

Table. Statement 16 "Pregnancies with definite birth defects should be terminated without any consideration of pregnancy duration."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	6	54,5	3	27,3	2	18,2	11	32,4
30-39	11	68,8	2	12,5	3	18,8	16	47,0
40 or over	6	85,7	1	14,3	-	-	7	20,6
Ssex (n=35)								
Male	3	42,9	2	28,6	2	28,6	7	20,0
Female	21	75,0	4	14,3	3	10,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	15	71,4	4	19,0	2	9,5	21	60,0
Physician	6	60,0	2	20,0	2	20,0	10	28,6
Health Technician	1	50,0	-	-	1	50,0	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**24**	**68,6**	**6**	**17,1**	**5**	**14,3**	**35**	**100,0**

Table. Statement 17 "The fact that family planning services are used more by women is an indicator that women have the control over their bodies."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	2	18,2	3	27,3	6	54,5	11	32,4
30-39	2	12,5	3	18,8	11	68,8	16	47,0
40 or over	1	14,3	2	28,6	4	57,1	7	20,6
Sex (n=35)								
Male	1	14,3	2	28,6	4	57,1	7	20,0
Female	5	17,9	6	21,4	17	60,7	28	80,0
Occupation (n=35)								
Nurse-Midwife	5	23,8	4	19,0	12	57,1	21	60,0
Physician	1	10,0	2	20,0	7	70,0	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
NGO	-	-	1	100,0	-	-	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**6**	**17,1**	**8**	**22,9**	**21**	**60,0**	**35**	**100,0**

Table. Statement 18 "The reason why traditional FP methods are still used is the failure of service providers to fulfil their responsibilities."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	3	27,3	4	36,4	4	36,4	11	32,4
30-39	2	12,5	4	25,0	10	62,5	16	47,0
40 or over	2	28,6	2	28,6	3	42,9	7	20,6
Sex (n=35)								
Male	5	71,4	-	-	2	28,6	7	20,0
Female	3	10,7	10	35,7	15	53,6	28	80,0
Occupation (n=35)								
Nurse-Midwife	3	14,3	6	28,6	12	57,1	21	60,0
Physician	5	50,0	2	20,0	3	30,0	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
NGO	-	-	1	100,0	-	-	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**8**	**22,9**	**10**	**28,6**	**17**	**48,6**	**35**	**100,0**

Table. Statement 19 "Delivery of health services including family planning is one of the most important duties of the State."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	11	100,0	-	-	-	-	11	32,4
30-39	14	87,5	1	6,3	1	6,3	16	47,0
40 or over	7	100,0	-	-	-	-	7	20,6
Sex (n=35)								
Male	7	100,0	-	-	-	-	7	20,0
Female	26	92,9	1	3,6	1	3,6	28	80,0
Occupation (n=35)								
Nurse-Midwife	20	95,2	-	-	1	4,8	21	60,0
Physician	9	90,0	1	10,0	-	-	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**33**	**94,3**	**1**	**2,9**	**1**	**2,9**	**35**	**100,0**

Table. Statement 20 "Religious leaders should be actively involved in advocacy for the adoption utilization of the family planning effectively. "

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	4	36,4	4	36,4	3	27,3	11	32,4
30-39	12	75,0	3	18,8	1	6,3	16	47,0
40 or over	7	100,0	-	-	-	-	7	20,6
Sex (n=35)								
Male	6	85,7	1	14,3	-	-	7	20,0
Female	18	64,3	6	21,4	4	14,3	28	80,0
Occupation (n=35)								
Nurse-Midwife	12	57,1	6	28,6	3	14,3	21	60,0
Doctor	10	100,0	-	-	-	-	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
Willows Foundation	1	100,0	-	-	-	-	1	2,9
Servant	1	100,0	-	-	-	-	1	2,9
Total	**24**	**68,6**	**7**	**20,0**	**4**	**11,4**	**35**	**100,0**

Table. Statement 21 "No intervention should be made to a female requesting for tubal ligation unless her spouse's consent is taken**.**"

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	10	90,9	-	-	1	9,1	11	32,4
30-39	13	81,3	2	12,3	1	6,3	16	47,0
40 or over	3	42,9	1	14,3	3	42,9	7	20,6
Sex (n=35)								
Male	6	85,7	-	-	1	14,3	7	20,0
Female	20	71,4	3	10,7	5	17,9	28	80,0
Occupation (n=35)								
Nurse-Midwife	15	71,4	1	4,8	5	23,8	21	60,0
Physician	7	70,0	2	20,0	1	10,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**26**	**74,3**	**3**	**8,6**	**6**	**17,1**	**35**	**100,0**

Table. Statement 22 "Male partner's consent must be obtained for an unmarried woman asking for curettage."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	3	27,3	4	36,4	4	36,4	11	32,4
30-39	1	6,3	2	12,5	13	81,3	16	47,0
40 or over	-	-	-	-	7	100,0	7	20,6
Sex (n=35)								
Male	-	-	2	28,6	5	71,4	7	20,0
Female	5	17,9	4	14,3	19	67,9	28	80,0
Occupation (n=35)								
Nurse-Midwife	5	23,8	3	14,3	13	61,9	21	60,0
Physician	-	-	2	20,0	8	80,0	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
NGO	-	-	-	-	1	100,0	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**5**	**14,3**	**6**	**17,1**	**24**	**68,6**	**35**	**100,0**

Table. Statement 23 "Low service quality is an important factor explaining why family planning services are not used at a satisfactory level in Turkey."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	6	54,5	2	18,2	3	27,3	11	32,4
30-39	8	50,0	4	25,0	4	25,0	16	47,0
40 or over	2	28,6	3	42,9	2	28,6	7	20,6
Sex (n=35)								
Male	4	57,1	1	14,3	2	28,6	7	20,0
Female	13	46,4	8	28,6	7	25,0	28	80,0
Occupation (n=35)								
Nurse-Midwife	10	47,6	6	28,6	5	23,8	21	60,0
Physician	3	30,0	3	30,0	4	40,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**17**	**48,6**	**9**	**25,7**	**9**	**25,7**	**35**	**100,0**

Table. Statement 24 "The fact that family planning services are used more by women is an indicator that responsibility regarding reproductive health is mainly undertaken by women."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	9	81,8	2	18,2	-	-	11	32,4
30-39	15	93,8	-	-	1	6,3	16	47,0
40 or over	5	71,4	-	-	2	28,6	7	20,6
Sex (n=35)								
Male	5	71,4	-	-	2	28,6	7	20,0
Female	25	89,3	2	7,1	1	3,6	28	80,0
Occupation (n=35)								
Nurse-Midwife	18	85,7	2	9,5	1	4,8	21	60,0
Physician	8	80,0	-	-	2	20,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**30**	**85,7**	**2**	**5,7**	**3**	**8,6**	**35**	**100,0**

Table. Statement 25 "Primary level public health facilities fully perform their duties in family planning services."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	8	72,7	1	9,1	2	18,2	11	32,4
30-39	7	43,8	4	25,0	5	31,3	16	47,0
40 or over	3	42,9	2	28,6	2	28,6	7	20,6
Sex (n=35)								
Male	3	42,9	-	-	4	57,1	7	20,0
Female	15	53,6	7	25,0	6	21,4	28	80,0
Occupation (n=35)								
Nurse-Midwife	12	57,1	5	23,8	4	19,0	21	60,0
Physician	3	30,0	2	20,0	5	50,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	-	-	-	-	1	100,0	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Total	**18**	**51,4**	**7**	**20,0**	**10**	**28,6**	**35**	**100,0**

Table. Statement 26 "Family planning services are private issues of the individuals/couples."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	9	81,8	-	-	2	18,2	11	32,4
30-39	14	87,5	-	-	2	12,5	16	47,0
40 or over	6	85,7	1	14,3	-	-	7	20,6
Sex (n=35)								
Male	7	100,0	-	-	-	-	7	20,0
Female	22	78,6	1	3,6	5	17,9	28	80,0
Occupation (n=35)								
Nurse-Midwife	17	81,0	-	-	4	19,0	21	60,0
Physician	8	80,0	1	10,0	1	10,0	10	28,6
Health Technician	2	100,0	-	-	-	-	2	5,8
NGO	1	100,0	-	-	-	-	1	2,9
Worker	1	100,0	-	-	-	-	1	2,9
Toplam	**29**	**82,9**	**1**	**2,9**	**5**	**14,3**	**35**	**100,0**

Table. Statement 27 "Family planning services should mainly be provided by the private sector."

	Agree		Not sure		Disagree		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Age (n=34)								
29 or under	5	45,5	-	-	6	54,5	11	32,4
30-39	1	6,3	3	18,8	12	75,0	16	47,0
40 or over	-	-	-	-	7	100,0	7	20,6
Sex (n=35)								
Male	-	-	1	14,3	6	85,7	7	20,0
Female	7	25,0	2	7,1	19	67,9	28	80,0
Occupation (n=35)								
Nurse-Midwife	7	33,3	2	9,5	12	57,1	21	60,0
Physician	-	-	-	-	10	100,0	10	28,6
Health Technician	-	-	1	50,0	1	50,0	2	5,8
NGO	-	-	-	-	1	100,0	1	2,9
Worker	-	-	-	-	1	100,0	1	2,9
Total	**7**	**20,0**	**3**	**8,6**	**25**	**71,4**	**35**	**100,0**

Annex VII.

An Interview with Women in Diyarbakir Laundry and Tandouri House (In the 2nd Phase of the Study)

Conducted and translated by: Nuriye Nalan Sahin-Hodoglugil

Background: Interviews were conducted with a group of women who were attending a literacy course in their neighborhood in Diyarbakir, in Turkey, in the month of July, 2004. It is a low socio-economic class neighborhood and most men here did not have regular jobs while most women were housewives. The neighborhood was known as a drug-dealing center until recently. Diyarbakir municipality started new initiatives in this neighborhood and opened a laundry house and a tandouri house in 2003, which were the first in the history of Diyarbakir (and probably anywhere else in Turkey). In a one story building owned by the municipality, there were 10 washing machines. Women in the neighborhood could use them on their allocated time of the week for free. Detergent was also provided for free. The building also included a play room for kids. Right next to the laundry room was a tandouri house which had 6 tandouri ovens. The traditional bread in this part of Turkey is cooked in tandouris and women could use them free of charge to bake bread or cook their food. One of the rooms in the laundry room was allocated for literacy course. Personnel of the municipality were teaching women how to read and write. The interview was conducted with 5-6 women plus the three personnel of the municipality present in the beginning. During the course of the interview, more women came to the place, some washed their clothes in the laundry room next door, and some joined the interview, while some left. Some women also had their children with them. The whole interview lasted more than two hours and was conducted in Turkish, in the entrée of the laundry house, around a table. Women gave verbal consent for the taping of the interview. The interview was sometimes interrupted by the information provided by the interviewer (NH) to answer women's questions. It was a casual atmosphere, and more like chatting than interviewing. Below is a transliteration of the interview. Some sections and participation of some other women was cut off to make the transliteration more comprehensible. Translator's notes about the context are provided in parentheses.

N: Tell me about the life of women here…Especially about having children... How did you decide? How many children did you want to have? What is your story?

W1: I wanted to have four-five kids.

N: Tell me about your life, as you remember it. For example you can start from your marriage… Did you choose your husband?

W1: He was my aunt's son.

N: Your aunt's son?

W1: Yes. I was 14 when I got married.

N: Did you want to get married to him?

W1: No, I did not know.

N: You did not know?

W1: No, I was not home. My sister had a baby that night and I was staying with her. The same night they (the groom's family) came (to my parent's home) and asked for my hand in marriage.

N: So, they came to your home when you were at your sister's. What happened next, did they tell you, "Okay, now you are getting married?"

W1: No, they did not tell me anything.

N: When did you know that you were getting married?

W1: I came home. My younger sister told me. They told me my aunt has come…Then, I understood… that they have come for me.

N: Then, did you get married? When you were 14?

W1: (Nods) 14 years old, then I had a daughter when I was 15.

N: Did you want to have a baby when you were 15? Did you know if you could protect yourself (to prevent pregnancy)?

W1: No, I did not know anything. […] I was married too young, and at the time we did not have these things (contraceptives), not as much as now.

N: Then what happened?

W1: I had my daughter. Two months later my husband went for military service. My daughter died when she was five months old.

N: She died when she was five months old? May Allah give his blessings? Why did she die?

W1: Well, I don't know. She had a fever, we took her to hospital, the next day she died.

N: Then what happened? Did you have other kids?

W1: Then my husband came back from military service. I had another daughter, now she is 18 years old, then I had my other daughter and now she is 17 years old.

[…]

N: How old were you when you had your second daughter?

W1: Well, I don't know. My husband went to military service, then he came back and I had her.

N: Then it must have been 2 to 3 years after the death of your first one.

W1: Yes, maybe 3 years.

N: Then, you must have been around 18 when you had your second.

W1: (Nods).

N: So, you had your third daughter. How much age difference is there between your second and third daughters?

W1: One year and two months between the two girls.

N: Then you must have been 19 when you had your third one.

W1: Yes.

N: So, what happened after your third daughter?

W1: I had my fourth daughter.

N: When?

W1: Two years later, when I was 20.

N: So, did you want to have so many so quickly?

W1: No… But we were expecting a boy. We had too many girls. Then I had a son, I fed him for three months then he died, too.

[…]

N: How many years after your daughter?

W1: Two years.

N: So, you had a son two years after your fourth daughter, but you lost him when he was two months old? May Allah give his blessings?

W1: Yes, thank you.

N: Then, did you have other pregnancies?

W1: Then, I had another daughter, Serap. Now she is disabled. After she was four years old, she started complaining, "my eye hurts". We took her to hospital. Then we came home. She was saying "my eyes, my eyes, my eyes…". There was an eye doctor in the hospital. We took her to the doctor several times. Then the doctor said "we have to remove this eye"…He says "this eye is protruding, it is coming out, we have to remove it". He did not understand. Then, afterwards they found that it was eye tension (glaucoma). The other eye got tension, too. Now she can see very little.

N: So she had eye tension, and one of her eyes were removed, and the other eye has tension, too?

W1: Yes. It was eye tension.

N: How old is she now?

W1: She is 14.

N: Do you have other kids?

W1: Yes, I have my son Bayram.

N: Then he is your seventh. How many years are there between Serap and Bayram?

W1: Two years.

N: How old is he?

W1: He is 13…No he is 12…

N: So, do you have another one after him?

W1: Yes, I have Seyhmus. He is disabled, too. When Serap's eye had problems, I went to the hospital, and I went into the machines [had exams in the hospital, could have been anything from an ultrasound to X-ray]. I was pregnant then, I did not know. Then my son became disabled.

N: What happened to him? What is his disability?

W1: He had a seizure.

N: How old is he now?

W1: He is 10 years old.

N: So, how was his seizure? What is his disability? Is he mentally retarded?

W1: No, he is disabled, but his brains are good. He knows everything, but he cannot walk. He can stand up by holding onto something, but he cannot walk.

N: Did he have children's paralysis (polio)?

W1: Maybe, it was like children's paralysis, not exactly paralysis, but they (his legs) were loose.

N: What did they say at the hospital, what disease was it?

W1: They said it was a seizure…Well the doctor was coming and going. He was saying "I don't understand anything from this child". He was doing well. But, then, I don't know how he became disabled.

N: So, then, what happened? Do you have other kids?

W1: Yes, I have this one, Davut (pointing to a young boy next to her).

N: So, this is your son?

W1: Nods.

N: Hi Davut. How old are you?

W1: He will be eight.

N: Then he is your ninth one.

W1: Nods.

N: Allah blesses him. Do you have any other younger ones?

W1: Yes, I have Helin. [She laughs, with an embarrassed looking her face]

[…]

N: So, how old is Selin?

W1: No, Helin. She is three.

N: Helin, okay… Do you have other younger ones?

W1: Azat, he is one.

N: Masallah.

W1: (Apologetically) I was bringing them (giving birth) and they were dying, I was bringing them and they were dying, and besides, they were all girls, weren't they?

N: Hmm, let's see. You have already had three sons up until Helin, Allah bless them.

W1: Ha?

N: With the ninth one, you already had three sons.

W1: Yes. The factory has changed later.

N: And until then you had four girls? … Sorry, what is the thing with the factory?

W1: Our factory has changed. First it was producing all girls, then it started producing all boys (she giggles).

N: Okay, now I get it…(laughs)… So, do you have another one? Well, wait, Azat is only one, so you don't have any younger ones?

W1: No, he is my last one.

N: So, are you protecting yourself now (using contraception)?

W1: Yes.

N: What are you using?

W1: My man is protecting himself.

N: Is he using condoms?

W1: Yes.

N: Did you protect yourself before?

W1: Sure. I was taking pills for six years after this one (pointing to Davut).

N: You used pills for six years up until Helin?

W1: Yes. I was taking pills. Then I did not have periods. I went to a doctor. The doctor said, "give some break from the pills". Then I stopped…Then, I had Helin.

N: So the doctor told you to stop taking pills?

W1: Yes, I almost had no bleeding. The doctor said, "stop for a while, and let your man protect himself". Then my man protected himself, but I still got pregnant, I don't know how.

N: Was your husband using condoms at the time?

W1: No he was protecting himself (using withdrawal)

N: So he did not use condoms?

W1: No, not then. But now he is using condoms.

N: Yeah, Davut is 8 and Helin is 3. So you could protect yourself for five years.

[…]

N: Is your husband fine with using condoms now?

W1: Well he is obliged to use them, if not he is going to have another one.

N: Have you ever tried other methods, like the spiral (intra-uterine device)?

W1: Well, I tried. I went (to the health post) to have a spiral, then, they told me, you have a wound (cervical erosion) in your uterus (cervix), and they did not put in a spiral.

N: But, you know, if you get the wound treated, you could use a spiral. Did they tell you about it, to get treatment?

W1: I am comfortable with the condom now.

N: Maybe did you think they would not insert a spiral at all?

W1: Well, I do not want any more kids; never…do I want to get pregnant. I wish there was something to stop having children. I wish there was a pill or an injection, then they would tell me "now you will never have children again".

N: For that, there is tying of the tubes. Have you ever heard of it?

W1: Yes, but I am scared of it.

N: Why?

W1: My sister in law went and had her tubes tied, but then she became very sick.

N: What happened, what is wrong with her?

W1: Her tension went up, really high. I don't know, but she became very sick. And we have another relative, she had five kids, it is a distant relative; she died.

N: Which one, are you talking about that women [who died during the operation of tubal ligation in Diyarbakir]? She was your relative?

W1: Yes, a distant relative, and she had five kids.

N: You are talking about the woman who died at Maternal and Child Health Center, right?

W1: Yes.

N: Well, I am talking with you for the interview, but I should also inform you. You know, tying the tubes has nothing to do with tension; it does not cause blood tension to go up or down, not at all.

W1: …The woman died of a wrong injection; we heard that she was given a wrong injection.

N: Well, about her, it was not a wrong injection. It is a very rare condition, it is called allergy. [The woman who died recently during a tubal ligation procedure had allergy to local anesthetics] It is an allergy which kills. It is very rare. For example some people may have allergy even to bee sting that kills, too. It is similar.

W1: (…)

N: Now, that injection they made to numb her pain for the procedure, it made the allergy. If you gather two thousand women and give them that injection, only one will have that allergy, but not the others. So, it was not the wrong injection. She had the right injection, but nobody knew that she was allergic to it, and then she died.

W1: I also went for the injection (depo-provera), you know the injection they do every three months…Then they told me "You have goiter, we can not give you the injection".

N: Who said that?

W1: The ones at the health post…The one by the municipality.

N: Well, it isn't exactly true. You can still have the injection with goiter. But anyway…

W1: Which one is better, I don't know. They just did not give me the injection.

N: Well, okay. Did you consider spiral again?

W1: I did. But then they said it is sinful. Then I said "I fast, I pray five times a day, if it is a sin, I should not have a spiral".

N: Who said that it was sinful?

W1: My men, everybody…

N: Women, too?

W1: Yes.

N: Come on, it is not sinful…Everybody has it…I have it…Don't listen to them.

W1: If it is sinful, I don't want it. I am at this age, 37. I am fasting, I am praying, I don't want anything sinful at this age.

[…]

W2: It is not sinful. Even Hatice (religiously devout women) is using it..

W3: Yes, of course…

W4: Professor, I will ask you something… My mom had 22 children, and she had 3 miscarriages.

N: Who? 22 children? Is that true? Really? Did she have 22?

W4: Yes, she had 22.

N: In how many years?

W4: One each year.

W1: Once a year like myself. If I continue, I may have…

N: So, are you 22 siblings?

W4: No, 11 of them died. And plus she had 3 miscarriages.

(…)

N: How old are you?

W4: I am 36

N: You are my age. I am 36, too.

W4: I look older, you, God bless look like a young girl (women laugh)

N: Yeah, I thought you were older, too. But I got married late. I have a daughter. I married when I was 30.

W1: I married when I was 14.

W4: Professor, I married when I was 11.

N: You were 11? Were you having bleeding (menses) when you got married?

W4: No

W3: I had bleeding once (before I got married). The second time I had bleeding I was (married and) at my mother-in-law's home. I saw the blood and I was scared…

W4: When I was pregnant the first time, I did not know. I went to my father's and told them "there is something in my tummy…it goes from here to there" (pointing to the sides of her abdomen). I cried. My mom was not home. My father asked: "how is it?" I said "it goes from here to there". I did not know that I was pregnant, then I went outside to play… Then I told my mom, there is something in my tummy. Like a rat…My father pressed on my tummy, blood came. My feet were all in blood. He told me, "it is as if your belly has dropped"…

N: How old were you?

W4: I was 12…Then my father pressed but bleeding did not stop…My elder daughter is now 16-17 years old.

N: So, how old are you now?

W4: I am now 32…

[….]

N: Now I will ask you women a question. Don't get me wrong. If I were raised here under the same conditions, I would have probably had many children, too. But, we really don't know and understand when we look from outside. We say, "if she did not want to have so many kids, why did not she do anything to prevent it?" It is not easy for us to understand. What do you think, for example? What were the circumstances, what were your thoughts that you had so many children? Did you want to have them all?

W1: No, I swear, I did not want to. I almost got mad when I was pregnant for this one (pointing to Davut)… and same with Azat…I did not have bleeding, then I telephoned. My sister was at my place, too (…) I had bleeding twice when I was pregnant with this one (Davut)…I was pregnant, but I had bleeding twice…Then I went to the municipality (health center)… They did a test. They said "there is a baby". I said "I am bleeding, how can I have a baby?" It (the baby) was 4 months.

N: You were 4 months pregnant?

W1: Yes, four and a half months. The doctor said "Oh, the baby is four and a half months". Then he said, "Go to the

Maternity Hospital". He referred me to Israfilkoy. They told me "There is a doctor, there is the Health Director" (in Israfilkoy). I asked "You are sending me there because my children are disabled?" He said, "The baby is healthy, the baby is 5 months old". At the time, I had 8 weeks left…I had 8 more weeks. I heard the number later…He said "Your son has 8 more weeks"

(…)

N: You had all the previous pregnancies, but you did not understand that it was a pregnancy?

W: She had blood clots.

W1: I thought there were blood clots in my tummy moving from one place to the other, but it was a baby…

(…)

N: So, have you ever wished you had fewer children?

W1: I wanted two boys and two girls. That was enough. God said, "You are talking big. You should have four daughters. I brought 4 girls, 5 girls, then I had a boy, I lost that boy, then I had another girl. After that I had a boy, a son. Then I said, "I don't want to have any more". Then my men wanted, my children's father wanted more…

(…)

N: So, you said you did not want to have any more children?

W1: I had Seyhmus. I had … (problems) after Seyhmus. Then we went to the doctor. The doctor said "You are banned from having any more children; you are not going to get pregnant again…" Then I had Daggul. Then Azat was a newborn. The doctor had said "No more children, or else they will be disabled". Thank Allah, the children (after Seyhmus) were not disabled.

N: You have three more after Seyhmus, right. Did you have them because your husband wanted to?

W1: Yes, he wanted them. But now he does not want any more either. He tells me "Do whatever you do (to prevent pregnancy)". He does not want any more.

N: Allah blesses your children. Of course everybody wants children, it is important to be able to care for them…

W1: We do not have a salary. He (my husband) works in the construction; he does not have work insurance…

N: (To Davut) You look bored, what happened… Do you want to go home?

Davut: Nods.

N: (Turning to W2, who looks in her twenties) Are you sisters (with W1)?

W2: Yes.

N: How old are you?

W2: I am 25.

N: Now, can you tell me your story…

W2: I have two boys and a girl.

N: Allah blesses them. How old were you when you got married?

W2: 15.

N: So you got married early, too?

W3: Well, in our village and in this neighborhood, it is all like that, they all get married at 15… If a girl is 18 and not married, they will say that she is a "dried girl" (a girl who is condemned to stay at home, because she has lost all her chances to get married) (women laugh)

W2: But I won't let my daughter get married until she is 20.

W3: I am not giving my daughter away either. I am waiting until she gets 20. So many people asked for her hand in marriage, I refused, I am not giving her away early.

N: If you are 25 now, it must have been 10 years that you are married, right?

W2: Yes.

N: Did you choose your husband?

W2: I took him with love.

W3: She loved her husband.

N: Are you happy?

W2: Thank Allah, we are fine.

N: So, what are your plans about having other children?

W2: I don't want to have any more.

W1: She wanted to have an operation on herself; I did not let her to…

W2: They told me, 'you are young'. They did not operate me (for tubal ligation). They told me 'we will not operate you until you are 30…'

(…)

W2: They told me "Have a cesarean and then tie your tubes". I told the doctors. They (doctors) said, "No, it can't be done".

(…)

N: Are you using anything else for protection?

W2: My husband protects himself.

N: Is he using contraception?

W2: No, he protects himself.

N: Have you ever used other methods before?

W1: She was using pills…

W2: I was using pills, and then I had this daughter…

N: When you were taking pills?

W2: Yes, I swear, I was taking pills.

N: Were you taking one each day?

W2: Yes, I was taking one every day. Then I went to the doctor…

N: You ever forgot to take any?

W2: No. I went to the doctor. He said "You are pregnant. Do not continue to take pills"

N: This is your daughter? Is she the youngest?

W2: Yes. She is 7 months old.

N: God bless her…

W2: Thank you…

(…)

N: You told me that your husband is protecting himself, but it is not a very safe method.

W2: I went to the doctor. It is safer than the condom…

W3: They say that the condom may have holes…

W2: My husband does not want to have any more children either…

N: No?

W2: If it was up to my husband, he did not want the girl either…He told me "Use pills or do something… Shall we have the operation? ." He said "What am I going to do with too many kids?"

W1: She went to the doctor, the doctor told her to wait. And I say, your children are very young, Allah knows…

(…)

N: There are also other methods that you can use. For example there are the injections, there is spiral…

W2: I told them (the doctors). They did not give injections to me.

N: Why not?

W2: They told me, "You have ….", "Your heart is not good". Then I went to the health post. They did the tests. They told me "You have too much sorrow. They told me it will harm your heart". Then they told me "something may happen"…

N: They told you that you had too much sorrow?

W2: Yes.

N: So how could they test for sorrow?

W2: Well, I don't know. He did some blood tests, and then the doctor examined me. Then he said "Do not give injections to this woman".

N: Do you have other health problems?

W2: Like what?

N: Do you have any complaints, diseases?

W2: Yes, I do. I am always sick. I have typhoid fever. Every year I have to take serums (intravenous lines) and injections, my sister is a witness…I mean, I don't want to have any more children…

N: But even if you have these complaints, you may still use the injection. Having typhoid fever is not against having the injections.

W2: Well, I swear I don't know. I said, "Let me have my bleeding this time, then I will go again". They say "You buy injections from the pharmacy and they inject you four of them…"

N: Yeah, they used to have them for free at the health post, but now the government does not have any more, they did not have the money for it. So you will have to buy them from the pharmacy…

W2: Yes, they told me, you can buy it at the pharmacy… I said, it is good, I can get it from the pharmacy…And my husband is also told me that the nurses are telling him to bring me over there. The nurses said "Bring your wife over here, and we will insert her silver spiral… Because you are working for us here…"

N: Your husband is working at the hospital?

W2: Yes, he is a (cleaning) worker there.

N: What did they tell him that they would insert?

W2: They told spiral…

N: A spiral?

W2: They said, spiral, and a silver one…

N: Now, you know, I am also doing training about spirals, and I know them

all. There are no silver spirals, they are all copper…

W2: I swear I don't know. That's what they told me…

N: But because a spiral is copper does not mean that it is bad. It has to be copper or the body will not accept it. The best is copper. I have a spiral too, and it is copper, too, the best one…

W2: My husband told me, that one day, they brought a woman to the hospital, she gave birth and the spiral was stuck on top of the head of the baby…

N: No, that can't be true…

W3: No, no…

W2: Well, if spiral is suited for me, I want it. If they insert me, I would want to…

(…)

W1: It (spiral) is easy. They were going to insert in me, but then they looked and said "Oh, there is a wound"…

N: But you can always treat the wound and then insert the spiral…

(…)

W3: I went to the Maternity hospital (to have an IUD inserted)…They asked me "Do you have a green card?" (Green card is one form of government provided health insurance for the uninsured) I said, "Yes, I applied, but I did not get it yet". They told me "Go buy a spiral and we will insert it". Then I said, "Why am I buying it? You either insert, or…"

N: When did you go to the hospital?

W3: Three, four months ago…

N: Sometimes they don't have the spiral, the government does not send them any to insert for free. That is probably why they told you to buy it from the pharmacy…

(…)

W3: I told them, I applied for a green card… Now I got my green card…

N: Now you can go again. I know that they have spirals now. But they do not have any more pills right now, I talked with the doctors and nurses there. They are waiting for the government to send them pills…

W1: I swear, I count on the pills. I ate (took) them for six years, and nothing happened…

W2: I ate them too, then I got pregnant…I don't trust them…I ate pills, I did not bleed. Other women said, "It is because of the pills that you are not bleeding". Then I had nausea, my head was turning. I said, "What is this?" I went and had a pregnancy test, they told me it (the baby) is two months old. I took (pills) every night…

N: Well, there was something wrong there, because normally pills are very safe…You know some of them have different colors, there are the white ones and the brown ones… Maybe …

W2: I swear I don't know… Every night, I was telling my self, "do not forget the pill", and I was taking one every night, at the same time…

(…Some informative talk on pills and their side effects, decrease in menstrual flow, that this is not harmful for the body, some questions and information on anemia…some information on where they can get a spiral inserted if they want to…some information on the fact that withdrawal is not a very safe method)

(…)

N: I have another question. How do women here view abortions? For example a woman does not really want to have another child, but she gets pregnant. Is it acceptable for her to have an abortion?

W1: It is sinful.

W3: So what if it is a sin, or if it is not a sin? I can sacrifice myself for Allah... Allah knows our situation…

W1: I swear, I will not have an abortion even if I have 10 more…It is sinful. I am scared of doing something sinful…

W4: This one has 3, what more?

W3: If you bring them (to the world) and then cannot provide for them, that is a sin, too…

(…)

N: Well, okay, did you women go to school?

W1-W4: No (shake their heads)

W1: We came to Fatos. Here we are learning how to read and write.

N: You are here for the (literacy course), too?

W3: Yes.

N: How many brothers and sisters do you have?

W3: Seven, four girls, three boys.

N: How many children do your brothers and sisters have?

W3: One of them has two boys and a girl, my elder brother has two boys and one girl and the eldest has three boys and two girls.

W1: Then we are envious of them…

W3: One sister does not have a child yet. The younger brother does not have a child either…His wife is not pregnant…

W2: Three is normal in 10 years…

W3: My sister-in-law has brought 4 children, I have three… She had one in each year.

N: She has four…

W3: Yes, one for each year…

N: Do they want to have any more?

W3: Yeah. I swear they do. Their have black eye (They take risks without thinking about them too much)…

(…)

N: You said (to Women 1) that you did not want but your husband wanted to have more children. But in this case (to Women 3) your sister-in-law wants to have more children. So, why do you think women may want more than 4 children? It is difficult to raise children, she will get tried, and she will look old…

W3: I guess they like love children…They want to…

W1: Yes, I love children, too, but four is enough. I can love my four children, right?

W5: My younger one has been married for 10 years. She has only one child. Her tubes are tied. She had them tied until her husband got a job. Then, they will open them. They don't want to have kids until the husband finds a job, and until they get a house…

W6: They are right. I have a girl and a boy…

W7: I have two girls and a boy…

N: (Turning to W5) How old is your daughter?

W5: 25.

N: Did they tie her tubes at that age?

W5: Yes, her tubes are tied…

W2: Why did not they tie at the faculty (hospital)?

N: Are you sure she got her tubes tied?

W5: Yeah. They told their TV and had her tubes tied.

W3: Look, this woman (pointing to another woman who just walked in) also wants to have a lot of children. She delivers once a year…

W8: (The one who just walked in) Once in the long one year…

W3: Didn't you have one last year?

W4: She had one last year, the previous year. Now she had her tubes tied.

W8: One year and 8 months.

W1: (to N) Tell us how to prevent getting pregnant…What can we do?

(…)

Annex VIII. Tables and Figures Related to Family Planning in Turkey

Figure 1. Total Fertility Rates in Turkey from 1978 to 2003 Based on Demographic and Health Survey Results

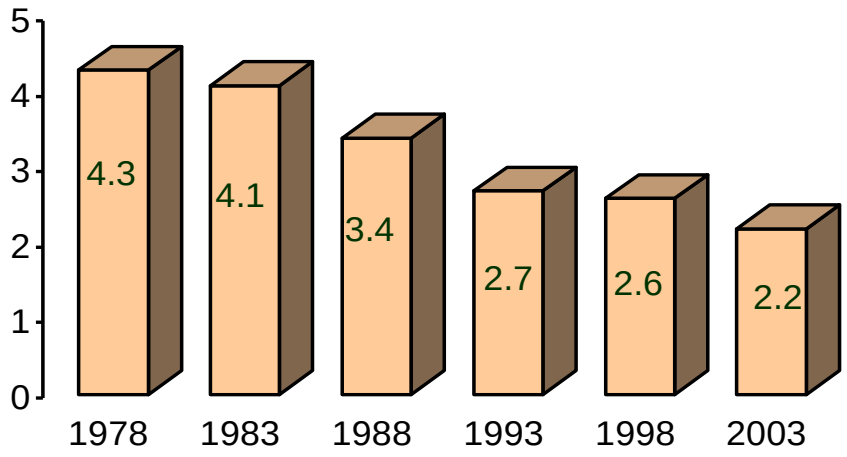

Figure 2. Use of Contraceptive Methods in Turkey from 1978 to 2003 Among Married Women of 15-49

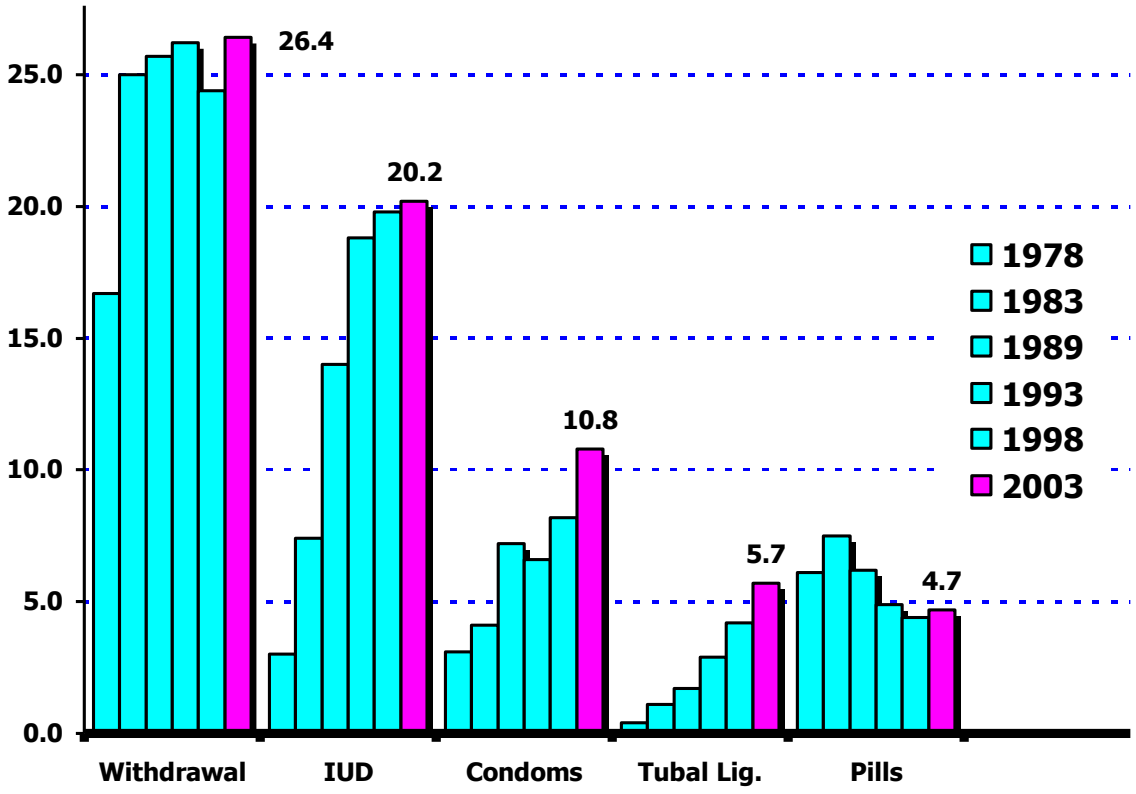

Figure 3. Total Fertility Rates According to Regions in Turkey between 1998 and 2003.

(Total Fertility Rate in Turkey between 1998 and 2003: 2.6 and 2.2 respectively).

First numbers: 1998 second numbers: 2003

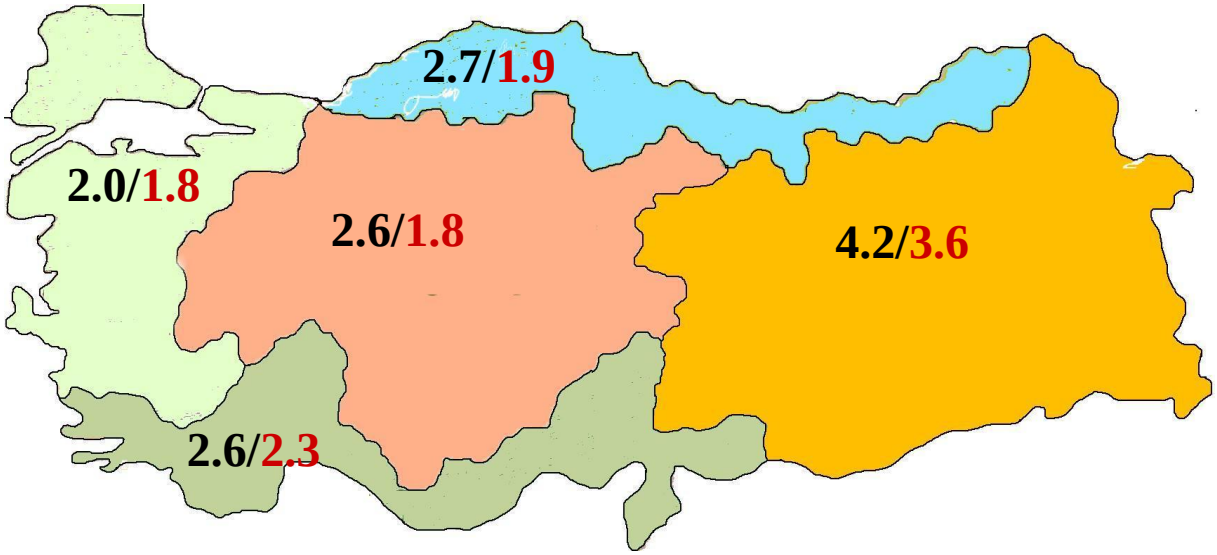

Figure 4. Practice of FP Methods According to the Regions in Turkey between 1998 and 2003 (in percentage).

(Practice of FP Methods in Turkey in 1998 and 2003: 64% and 71% respectively).

First numbers: 1998 second numbers: 2003

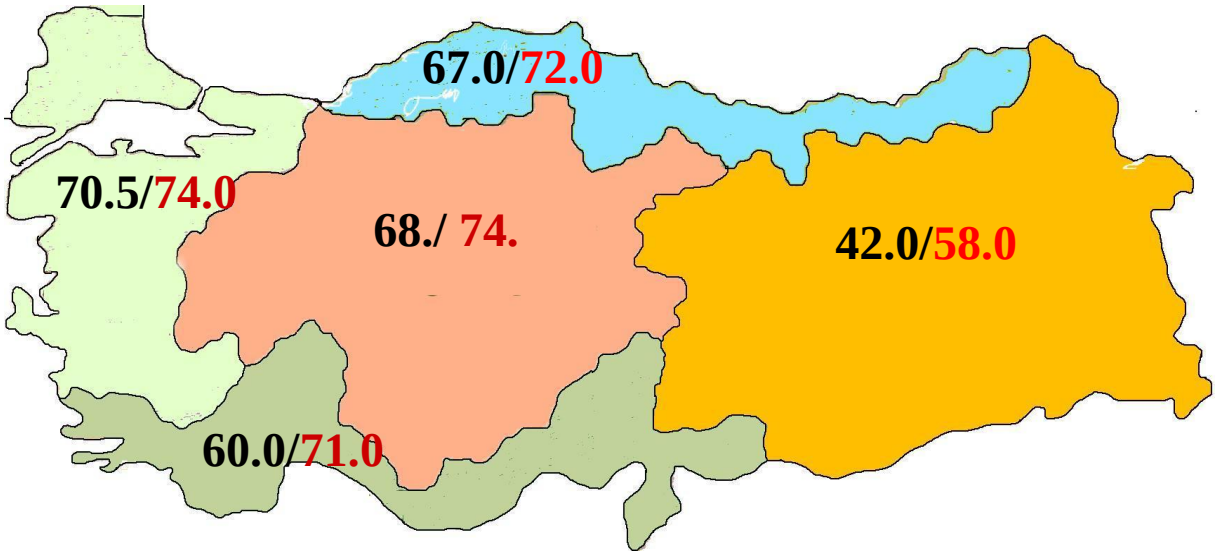

Figure 5. Practice of Modern FP Methods According to the Regions in Turkey between 1998 and 2003 (in percentage)

(Practice of Modern FP Methods in Turkey between 1998 and 2003: 64% and 71% respectively).

First numbers: 1998 second numbers: 2003