



BEST PRACTICES

in SCALING UP CASE STUDY

TURKEY

Scaling up Nationwide Access to Integrated Family Planning through the Turkish Social Insurance Organization (SSK)

INTRODUCTION

In 1990 the population of Turkey was 56.5 million (October 1990 census), and roughly half of the population lived in urban areas. The total fertility rate (TFR) was on the decline—from 4.3 in 1978 to 3.1 in 1993.

Turkey was increasingly becoming an urban, affluent, consumer-oriented, and secular society. In comparison with the previous generation, the younger generation was better educated, married later, and had fewer children.

In 1992, the Soysal Sigortalar Kurumu (SSK), the government social insurance organization in Turkey, had a clearly stated mandate to deliver curative services only. In addition to pension and social benefits, the SSK provided health services to some 22-30 million people—about 40% of the population. Oral contraceptives were available only for “medical reasons” and on a very limited basis, but not for contraceptive purposes.

The John Snow, Inc./Family Planning Services Expansion and Technical Support Project (JSI/SEATS), a USAID centrally-funded project, worked in Turkey from 1992 to 1997, collaborating with the SSK to scale up services to include family planning (FP) and to strengthen the entire SSK health system.

Under the SEATS Project, JSI provided extensive technical support in policy analysis, FP service delivery and quality improvement, logistics and health management information systems (HMIS) development, and information, education and communication (IEC). It also donated equipment and supplies and collaborated with

Why It Mattered

Before the JSI/SEATS Project was implemented (1992-1997), the government social insurance agency, SSK, provided only curative services. Minimal, if any, family planning services were available to its 22-30 million members. By the end of the project, a full range of high quality family planning services were available through trained, proficient providers. Furthermore, SSK was purchasing its own contraceptives, had a functioning logistics and reporting system, and had introduced continuous quality improvement concepts into its management system. As a result, SSK members in Turkey had comprehensive access to integrated family planning services nationwide.

AVSC International (now known as EngenderHealth) to integrate surgical sterilization into the program. By most criteria, the JSI project with SSK exemplifies successful scaling up. Essential to sustainability, the project was considered important and successful by the SSK and the Ministry of Health (MOH) of Turkey.

RESULTS

Measuring Progress and Determining Impact

In 1998, the year after the project ended, the MOH commissioned a Family Planning Quality Survey that included a sample of SSK and MOH hospitals.⁶ In April 2005, an assessment was made to determine what, if any, gains achieved by the JSI/SEATS Project had been sustained nearly a decade after JSI completed its assistance to SSK. Evidence of results from these data sources is presented below.

Process-Level Results

By the end of the project:

- ◆ A national family planning training program had been developed;
- ◆ SSK had a facility-based FP education program, effective IEC materials on hand, and a management information system, including contraceptive logistics and procurement;
- ◆ six regional FP training centers were functioning;
- ◆ SSK staff had been fully trained in the provision of high-quality family planning services, and
- ◆ SSK had a management information system, including contraceptive logistics and procurement; and automated systems for tracking users; contraceptive supplies, and FP data were still in place at the facilities visited during the assessment; and a well-

functioning logistics system.

At the time of the 2005 assessment, five of the six regional training centers set up with JSI/SEATS assistance were still functioning and training both SSK staff and medical and nursing students. SSK Izmir Training Center is the only facility in Turkey currently doing formal vasectomy training.

Impact-Level Results

The following table highlights some of the changes in knowledge and use of FP methods that occurred among SSK populations. Data from 1993 and 1998 include SSK clients who are currently married women drawn from Demographic and Health Survey (DHS). Data from 2003 also came from the DHS, but include all currently married women in Turkey.

Review of service statistics during the 2005 assessment showed that in one of the two SSK hospitals in Izmir (Ege Maternity and Gynecology Training Hospital), the preferred methods of contraception among clients were oral contraception (44.5%), IUD (42%), and sterilization for almost 11% of clients.

Considering that there was a virtual absence of family planning services at SSK facilities in 1991 when the JSI/SEATS Project began, the transformation of the SSK system in six years was dramatic.

Table 1. Knowledge/Practice of FP among Currently Married Women	1993	1998	2003
Percent who reported having heard of the following without any probe:			
Intrauterine devices (IUDs)	77.5%	77.6%	98.3%*
Oral contraception	82.0%	81.7%	97.8%*
Injection	5.7%	31.8%	82.5%*
Condom	48.4%	53.1%	90.0%*
Percent whose method of current use is:			
IUDs	21.0%	22.0%	20.2%*
Oral contraceptives	5.0%	4.8%	4.7%*
Condom	8.0%	10.2%	10.8%*
Female sterilization	3.2%	4.1%	5.7%*
Total modern contraceptive use	38.8%	41.9%	42.5%*
Percent who reported having ever used a modern method of contraception	67.4%	72.3%	73.2%*

Except where indicated with an *, all data are from a sample of currently married women from the SSK population.

* data are from a sample of currently married women in Turkey.

Furthermore, according to Family Planning Quality Survey conducted in 1998 by Management Sciences for Health (MSH), a SEATS Project partner, the quality of the FP services provided at SSK facilities was quite impressive by the end of the project and,

- ◆ 71% of SSK facilities were meeting all 8 standards for contraceptive commodity storage:
 1. accessibility of contraceptives,
 2. cleanliness of the store,
 3. contraceptives stored to prevent water leakage,
 4. room/store adequately ventilated,
 5. room/store properly illuminated,
 6. contraceptives stored away from direct sunlight,
 7. room/store cool enough, and
 8. contraceptives stored without direct contact with walls and floors.
- ◆ The average score for quality of FP services for the two SSK facilities sampled was 2.28 (of 6) compared with 2.63 for MCH/FP Centers that have been providing FP services for a number of years. The index measures the quality of family planning services provided at facilities based on:
 1. modern method availability,
 2. availability of trained providers,
 3. perceived quality of FP counseling,
 4. adequacy of infection prevention measures,
 5. availability of IEC materials, and
 6. physical access to FP services.
- ◆ Two of the three SSK facilities surveyed were providing comprehensive postabortion counseling
- ◆ 33% of postpartum clients reported receiving a modern method of contraception.

Sustainability

From the start, JSI took sustainability into consideration. This was illustrated by the fact that the SSK cost-

share was large from the beginning. The investment by JSI/SEATS amounted to less than \$0.25 per SSK client per year, a fraction of the actual cost of services. As a result, sustainability has been high:

- ◆ Strong evidence of political support included financing by SSK of recurrent costs of the training centers and FP services at clinical and hospital sites.
- ◆ By the end of the project, SSK had become the first



SSK polyclinics, like this one in Istanbul, provide integrated services to young families, including family planning.

USAID-funded FP organization in the region to tender and purchase its own contraceptives.

Findings and observations from the 2005 assessment—from both a programmatic and population/demographic perspective—were heartening in terms of sustainability:

- ◆ Data on SSK hospitals throughout Turkey are still readily available and it was clear that data were still being used. An analysis of FP practices in 40,838 cases in SSK maternities from 2000 to 2004 in Diyarbakir (a southeastern city) and Izmir (a western city) recently won first prize at the 4th International Reproductive Health and Family Planning Congress.¹
- ◆ Many of the SSK maternities still routinely provide sterilization services.

Table 2. Provision of FP services	1992 Baseline	1998 Endline
Number of SSK facilities where family planning services are routinely provided:		
Maternity hospitals	0	100%
Polyclinics	0	85 %
Dispensaries/ambulatory clinics	0	40 %

- Recently, SSK adopted a new system of drug reimbursement through private pharmacies. The SSK still takes responsibility for supplying contraceptives free to its members, but SSK clients, however, can now get prescriptions filled at any participating pharmacy.

SCALE-UP PROCESS

Under the JSI/SEATS Project, scaling up was about the expansion of services within the SSK system.

Taking advantage of the existing infrastructure and facilities of SSK, which were available throughout Turkey, JSI/SEATS supported the scale up of services to include family planning.

Service expansion came about in two stages and proceeded slowly, step-by-step. Activities were guided by a vision of what integrated FP services should look like by the end of the project and how success would be measured. The modes of achieving that vision, however, evolved as opportunities and challenges were encountered.

PHASE I: *Start-Up and Implementation*

The primary components of the first phase of scale up were: policy advocacy, technical assistance, and outreach and community education. They were imple-

The JSI/SEATS vision of what integrated FP services in SSK should look like included widespread access in many facilities, sustainability (financial, management and technical) of services, and client satisfaction.

mented as follows:

- Policy advocacy** was intended to secure stakeholder commitment to preventive services. Early in the project, JSI/SEATS helped SSK organize a number of high-profile advocacy mini-conferences that gave the new SSK family planning program visibility. These conferences received considerable media coverage. Well-publicized statements by leaders of the Ministries of Labor and Health, SSK, and labor unions also served to cement their commitment to making the program work.

Two other policy activities were crucial during this the early period. The first was a study of the comparative costs of FP services and hospital-based maternity care in SSK, conducted in 1993/94.³ The undiscounted cost savings from averting pregnancy were estimated to exceed the program's recurrent costs by 17.6 to 1. This study had a dramatic impact on SSK decision makers, who at the time were increasingly struggling with issues of cost and cost-benefit in the entire SSK system. In addition to purely medical arguments, the study's findings offered sound evidence that FP services make good sense financially and managerially.

The second activity involved the JSI/SEATS team leading a high-level delegation with representatives from the Ministry of Labor and SSK to visit Mexico. Mexico was selected because there are remarkable similarities between the two countries. One key difference between the countries is that Mexico's social security administration has a long history of being an assertive provider of family planning services.

- The SSK Team visited a range of facilities and met with counterparts. A defining moment came when, upon listening to a presentation by the Population Council Representative comparing the two coun-



Private pharmacies, such as this one in Istanbul, are now filing SSK prescriptions at no cost to the client.

tries, the Deputy Minister of Labor quietly commented “*We can do this in Turkey, too.*” They did.

As a result of this policy and advocacy work, the Government of Turkey passed a law which allowed SSK facilities to provide FP services.

- ◆ **Technical assistance** was provided in clinical care, contraceptive logistics systems, and integration of clinical family planning methods into SSK facilities. When the JSI/SEATS project began there were numerous FP activities being implemented in Turkey outside the SSK. JSI linked SSK medical professionals to the overall family planning community and trained them. A team from the JSI Family Planning Logistics Management (FPLM) Project provided technical support for development of a logistics system and JSI/SEATS provided assistance in setting up a record-keeping and reporting system for SSK facilities. In addition, the Project provided minimal funding in order to equip the newly established family planning clinics.

- ◆ **Outreach and community education** was conducted mainly through labor unions. This involved a series of high-visibility activities that marketed family planning as an additional benefit for workers and their families. To do this the project produced the materials, guidelines, and job aids. Over time, the market as well as the communication materials evolved and segmented to target birth limiters, spacers and first-birth delayers with separate messages.

One-day education sessions targeting young workers and new labor union members proved to be especially popular. An important feature of these activities is that sessions were run by labor union staff trained by JSI/SEATS and SSK medical personnel.

As a result, these sessions became institutionalized as a regular part of labor union activities.

PHASE II: *Implementation and Sustainability*

Three key messages were part of JSI/SEATS’ ongoing dialogue with SSK stakeholders:

- The importance of family planning for family health
- Client satisfaction as the centerpiece of service delivery
- The positive cost-benefit of family planning to SSK and labor unions

At the end of Phase I in 1995, the routine family planning services that JSI/SEATS promoted had been integrated widely into SSK clinics. There were, however, a number of technical and quality issues that still needed resolution and the program was not considered sustainable. SSK still relied on outside consultant trainers or

the MOH to train their personnel and on donated USAID contraceptives. This made its program vulnerable, since the USAID medium-term plan was to “graduate” Turkey and discontinue these donations. In keeping with its evolutionary and stepwise approach, therefore, the second phase of the project focused on ways to improve quality and insure sustainability including:

- ◆ **Continuous quality improvement (CQI)** activities, based on the newest hospital and health management principals used in the United States, were promoted to improve quality of care and client satisfaction. For many hospital directors, this was the first time they were exposed to concepts such as listening to their staff, forming quality committees, and setting quality-improvement goals. Despite some initial skepticism about FP providers and hospital decision makers working together to solve problems, this “new” western health management technology was embraced by both providers and administrators. As a result, client satisfaction also improved. One SSK provider wrote: “*Staff reported that clients had favorable responses to the changes. Clients would ask, ‘Why is this department more friendly and comfortable than others?’*”²
- ◆ **Developed and implemented six regional family planning training centers within SSK** to ensure

availability of trained human resources. The centers provided permanent capacity for in-service and on-the-job-training for providers from facilities throughout the system as well as the hundreds of medical and nursing students who cycle through SSK hospitals and clinics every year. Most centers provided general family planning training, but some also provided training in voluntary surgical contraception.

- ◆ **Quality and management improvements** were instituted to enhance sustainability of quality improvement and ensure that SSK-administered programs would purchase and manage their own stocks of contraceptives. Technical assistance continued to be provided in a range of areas related to contraceptive security, notably in logistics, forecasting, storage, recordkeeping, and tendering for supplies. For example, automated systems for tracking users, contraceptive supplies and family planning data were instituted. A number of activities were undertaken with mid- and senior-level managers (hospital directors) to enhance planning. Long-term management commitment was reinforced by linking SSK doctors and administrators to various professional societies and professional groups.
- ◆ **Contraceptive security and system sustainability** was achieved when SSK began purchasing its own contraceptives, versus the previous practice of relying on contraceptives donated by the US government. It took time for SSK to get into the rhythm of forecasting and procuring contraceptives, but the system eventually did work well and procurement has continued.
- ◆ **Targeting special groups**—namely postpartum women for family planning services—was emphasized in the second phase. JSI’s partner, AVSC, trained doctors at maternity hospitals and health personnel in long-term methods. JSI helped equip sev-

eral centers to perform quality sterilization services.

By the time JSI and its partners completed their technical and financial support, the basic infrastructure to provide ongoing and sustainable family planning services was in place at SSK. Moreover, the provision of family planning was now seen as part and parcel of its routine package of services, and recurrent funding line items for contraceptives, supplies and the training centers were in place.

WHAT WORKED

The following summarizes the major factors in successful technical support by JSI/SEATS for scaling up SSK.

- ◆ **The project started with a large structure—SSK—that had its own recurrent funding and engaged in health services on a large scale.** This was critical. Quite simply, scaling up is more achievable when a project starts with a large and already-funded program with an existing structure, facilities, and qualified staff that has the potential for integrating a new service.
- Often, opportunities to do this are missed because public health donors avoid funding those institutions that are seen as private or well-funded. Instead, the more financially fragile or technically weak a health structure, the more likely it is to receive donor support. The SSK experience suggests that the opposite approach—selecting stronger institutions and investing small amounts in technical and financial assistance—may actually enhance sustainability and the ability within a country to provide high-quality services over the long term.
- ◆ **Developing a sustainability plan and vision from the beginning with a clear idea of what would constitute success helped guide project activities** as well as SSK and MOH policies. JSI worked to put the elements of sustainability in place (e.g., pur-

chase of contraceptives, training centers, HMIS, quality improvement procedures). The JSI/ SEATS/ SSK “vision” evolved over time as the growing program presented new challenges and opportunities.

- ◆ **Adopting a gradual and step-by-step approach to constituency building with stakeholders.** IEC directed at labor unions insured both demand and political support. Discussions with SSK managers convinced them that providing family planning services was cost-effective.

As a result of these constituency-building activities, the provision of family planning services enjoyed solid political support from the MOH, from within the SSK health hierarchy, and among key stakeholders in SSK and the major labor unions. Since SSK staff are officially employees of the MOH, the MOH regarded this investment as a “win-win” situation.

- ◆ **Local ownership of and responsibility for new systems.** Key to the success of the technical assistance component and, specifically, the health information and logistics systems, was the fact that SSK managed all information and logistics systems from the start. They provided centrally-located spaces in clinics and maternities and paid recurrent costs.
- ◆ **Consistently high-quality technical assistance and capacity building which evolved as the program evolved** was a key factor of success. SSK demanded the very best international technical support, and JSI/SEATS and other partners provided it.

WHAT WE LEARNED ALONG THE WAY

- ◆ **Leadership, advocacy, and time** At first, not everyone in the senior management of SSK was enthusiastic about the project. It took time for the powerful labor unions to embrace the fact that family planning was in the interest of both the health status

of workers and the economy of the factory. One thing that was consistent and strong, however, was the support from the MOH, the Government of Turkey in general, and a few key stakeholders (namely, several powerful hospital directors and the Deputy Minister of Labor). This was crucial in gradually turning opinion in favor of family planning at SSK.

- ◆ **Financial support to insure sustainability** From the outset, USAID was highly supportive of the project. As the project matured, funding for the SSK program dwindled. JSI/SEATS felt that the SSK program would have benefited from an additional year of technical support. Fortunately, other partners, such as AVSC and MSH, continued providing small amounts of technical support until the USAID Mission in Turkey closed.
- ◆ **There is significant value in linking policy reform** (such as moving from a curative-only to integrated preventive services) **to concrete programmatic activities.** This allows policymakers to see practical results and enables service providers to obtain evidence that new activities or policies have a positive impact.
- ◆ **Challenges happen** Although in retrospect, the path to success might look smooth, in reality there were many challenges faced by the project. The road was bumpy at times with challenges along the way. SSK experienced considerable “growing pains” in the process of establishing a contraceptive procurement system. International tenders took longer than expected, and there were near stockouts of some supplies. SSK borrowed commodities from the private Turkish Family Planning Foundation and the MOH, which was experiencing its own stockouts.

CONCLUSION

The Turkey SSK experience is an excellent example of solid collaboration between local institutions (SSK, Ministry of Health), a major donor (USAID) and technical partners (JSI and others). This case study demonstrates how a step-by-step approach and a clear vision of success can achieve and sustain large scale results.

ENDNOTES

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