THE TURKISH HEALTH SYSTEM IN TRANSITION: FAMILY PLANNING IN THE CASE OF ISTANBUL

by

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"The Turkish Health System in Transition: Family Planning in the Case of Istanbul", a thesis prepared by Belin Benezra in partial fulfillment of the requirements for the Master of Arts degree at the Ataturk Institute for Modern Turkish History.

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Title: The Turkish Health System in Transition: Family Planning in the Case of Istanbul

This thesis focuses on the institutional history of family planning in Turkey and the ways in which it was shaped as part of larger official, international and academic discourses. The thesis provides a historical background on the period starting with the end of the 1960s and coming up to 2012, but it specifically focuses on the changes that took place after the transition in the health system in 2003 until March 2012. Family planning has been used for different purposes under changing socio-economic circumstances from the establishment of the Turkish Republic until the present day. The state policy has utilized family planning for promoting reproduction, thus maintaining a certain population growth in the early decades of the Republic, while the emphasis has changed over time from a pronatalist policy to anti-natalist policy making, especially after the 1960s. In the 1960s mainly the developmentalist perspective and Neo-Malthusian approach were dominant in policy-making. To the developmentalist approach, demographic concerns such as uncontrolled population growth, urbanization, and immigration were added during the 1970s. When the 1980s arrived, the concern with health moved to the center in the family planning. In the 1990s, the rise of human rights discourse on the global scale caused reproductive health to gain further importance. Family planning began to be conceived as a part of reproductive health. In neither of these periods were feminist sensitivities and gender specific considerations not granted their due importance. During the first decade of the 2000s, the emphasis on family planning declined in the state discourse. This was a result of the transformation in the health system initiated by the AKP regime, characterized by a neoliberal attitude to health services, in accordance with the world-wide trends.

Atatürk İlkeleri ve İnkılap Tarihi Enstitüsü'nde Yüksek Lisans derecesi için

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Başlık: Türkiye'de Sağlık Sisteminin Dönüşümü:İstanbul Örneğinde Aile Planlaması

Bu tez Türkiye'deki aile planlamasının kurumsal tarihi üzerine odaklanmaktadır. 1960'ların sonundan 2012'ye kadar olan tarihsel süreç analiz edilmektedir. Fakat, özellikle 2003'te gerçekleşen Sağlık Sisteminin Dönüşümü'nden Mart 2012'ye kadar olan süreçteki değişikliklikler tartışılmaktadır. Aile planlaması Türkiye Cumhuriyeti'nin kurulumundan beri değişik çerçeveler içersinde, değişik amaçlarla kullanılmıştır. Ülkenin kuruluş aşamasındaki devlet politikası nüfus arttırmaya yönelik çalışmalar sürdürmekteydi. 1960'lardan sonra, odak noktası pronatalist nufüs politikasından antinatalist nufüs politikasına geçişi gerektirdi. 60'lı yıllar, kalkınmacı ve Neo-Maltusçu zihniyetin hakim olduğu yıllar iken, 70'li yıllara gelindiğinde demografik endişeler de bu zihniyete eklemlendi. 80'lerde ise, odak noktası sağlığa kaymaya başladı. 90'larda insan hakları söyleminin de küresel düzeyde yaygınlaşması ile birlikte, üreme sağlığı kavramı önem kazanmaya başladı. Aile planlaması, üreme sağlığının bir parçası olarak algılandı. Bu tarihsel süreçlerde, feminist bakış açısına ve toplumsal cinsiyet duyarlılığına gereken önem verilmedi. 2000'lerin ilk on yılında, aile planlaması devlet söyleminde önemini kaybetmeye başladı. Bunun sebebi ise, AKP tarafından uygulamaya koyulan neoliberal politikalarının bir parçası olan Sağlık Sisteminin Dönüşümü Programı'dır.

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CHAPTER I

INTRODUCTION

This thesis examines the development of family planning in Turkey in the time frame remaining between the end of 1960s and March 2012, but it concentrates on the changes after the transition in the health system initiated by the AKP regime in 2003. The aim is to show how the concept of family planning and its institutional framework have changed over the years. It is crucial to look at why family planning is used in a particular context and period, the aim behind the policy, and what purpose it really serves. Analyzing the different names that are given to this concept is a way to reflect on the ideological discourse.

It will be argued that family planning has been shaped by different discursive aims and different state policies in Republican Turkey. Historically, it has been employed as a tool in pronatalist population policy and anti-natalist population planning. Moreover, from time to time, the changes in the formulation of this concept have been attempts to adapt to changes in the international context, particularly in the transformation of population policies. In this sense, the transformation of family planning should be thought of within an international context and the changes in conjecture. The present work examines the transformation of this concept by comparing Turkey with several other leading countries in some periods, especially the establishment of family planning programs. In order to reflect on this change, especially the institutional and historical backgrounds will be considered. State policies will be at the center of this thesis.

The overwhelming influence of state policy actually shows that family planning is not a grassroots matter as in many other issues in the political process in

Turkey, similar to the case of women's suffrage. Focus will be on the General Directorate of Mother and Child Health and Family Planning (*Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü*)[1] to give an institutional background. This organization was established first under the name of the Population Planning Directory (*Nufüs Planlaması Genel Müdürlüğü*) in 1965 under the Ministry of Health. The changes in institution name or the formulation of the concept name also indicate a changing mentality and ideological emphasis in state policies and, in the international context, from population planning to family planning, and to reproductive health.

One of the main arguments is that the birth control and family planning policies have been top-down campaigns, movements applied by the state. The first occurrence of family planning and permission for use of contraceptive methods were planned by the state in the 1960s. However, the periodization of this thesis starts from 1923, because the time period between 1923 and 1960 will provide a background for the establishment of the concept of family planning. The thesis takes up the time frame until March 2012. It is argued here that the legislative process has not been an answer to a demand from below; conversely, it has been a part of the state population policy and integration to the international and historical contexts.

In addition to this, no feminist movement contributed in this initial process of family planning and legalization of contraceptive methods. This process has been determined by the state and the changes in the international context, such as some worldwide agreements. The state as a policy maker is active in this task as a lawmaker. Comparing the materialization of the concept of family planning in England and the U.S. with that in Turkey, it is obvious that there is a lack of feminist

[1] *Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü* is one of the directories employed by the Ministry of Health.

writers and movements and the argument of the liberation of women. While in most western countries the demand for birth control has been framed as a right to personal freedoms without the hindrance of pregnancy, in Turkey, the arguments have been based on the danger of maternal death, the population issue and demography by the leading doctors, demographists, and government bureaucrats.

As a first step, family planning was stated as a population policy in the 1960s. As a second step, in the 1980s, health issues become more visible for constructing family planning program. However, there was no defense/argument that family planning was as a tool for the liberation of women in the early period in the social or socio-economic sense. Actually, it is important also to consider as a motivation in itself the difference between the liberation/emancipation of women and the liberation of sexuality as, under the concept of family planning, the liberation of sexuality has never been discussed.

Foucault discusses the history of sexuality by criticizing the repressive hypothesis, which claims that the history of sexuality over the past three hundred years has been a history of repression. Sex, except for the purposes of reproduction, has been taboo. Foucault disagrees with the claim that sex has been repressed and has not been talked about in society. According to him, since the eighteenth century the discourse about sex has become more widespread in society. As an example, confessions become more visible and important in society by the motivation of priests, and sexual behavior became an important object of study for demographic and statistical analysis. Foucault suggests that the repressive hypothesis gives great importance to the discourse on sexuality. His interest is firstly the "discursive fact" of sexuality; Foucault wants to know how and why sexuality is made an object of discussion. Actually, his interest is not in sexuality, but its power in the knowledge

that society shares. According to Foucault, reproduction is seen as superior/dominant to sexuality. Sexuality that is not employed for reproduction could be ignored and respected as mistake, iniquity, and guilt. When the nineteenth century arrived, Foucault writes, sexuality could be talked about in some discourses, such as in medical discourse as a health issue, or in sexology. Science was a tool to talk about sexuality (Foucault, 2003).

In the Turkish example, Bozbeyoğlu states that in the demography literature, population and family planning are key terms in the demography establishment process. However, sexuality is always ignored in the population and demography literature as Foucault states. The term "reproduction" is growing more dominant compared to sexuality (Bozbeyoğlu, 2011: 26). It is possible to say the same thing for the health discourse. Sexuality is taken as part of a discourse on reproduction and there is limited area to talk about it.

In his study, Bozbeyoğlu presents a critical exploration of the decision-making processes behind contraception and abortion practices in Turkey. Rather than adhering to the mainstream economic reductionist approaches found in the population studies literature, he focuses on the means of fertility control (i.e. contraception and abortion), and their causal relationships with each other. He stresses that the interconnectedness between contraception and abortion within social and cultural structures and the details of the characteristics of fertility control are within the context of social conflict. While he criticizes rational reproductive theory, he uses a holistic approach with regards to the systems of fertility control which have been seen in Turkey in the 2000s. In addition to this, he discusses the relationship between fertility and sexuality, including the remarkable effects of gender norms,

power dynamics, and family ideology on those two important facets of culture (Bozbeyoğlu, 2011).

It is difficult to find written sources analyzing the history of the institutionalization of family planning in Turkey. First of all, looking at what exists in the literature shows the transformation and changes at the discursive level, and it represents changes in international trends in other countries.

In this sense, it is crucial to consider Thomas Robert Malthus and his work *An Essay on the Principle of Population*[2] (Malthus, 1970). He argues that the fundamental problem of populations is overstretching their resource limitations. His focus is more on economic issues. In this context, Malthus states that two types of checks hold population within resource limits. One is positive checks, which is the rising the death rates; and the other is preventive ones, policies which lower the birth rate. Positive checks include hunger, disease, famine, infant mortality and war. Preventive checks include abortion, birth control, prostitution, late marriage, abstinence and celibacy. At the end of the nineteenth century and the beginning of the twentieth century, Malthusians such as Jeremy Bentham, Francis Place, Richard Carlile, Robert Dale Owen and Charles Drysdale, who drew on the French example, and Aletta Jacobs from Britain saw contraception as a way of responding to the problems of poverty posed by over-population (McLaren, 1992: 182-183). In this framework, it should not to be forgotten that eugenicists discussed the concept of family planning, too.

In Turkey, especially after the Second World War, family planning became a matter of discussion once again, as in other countries. Before the 1950s, a pro-natalist policy was accepted and the concept of family planning was not employed.

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[2] Thomas Robert Malthus wrote "An Essay on the Principle of Population" in 1798.

The details will be given in Chapter 3. However, after the Second World War, family planning was not argued as a single concept; it was argued as a subheading under the demography, population theory/planning program and developmentalist ideology. The institutionalization of demography influenced the term "family" planning a great deal because it was believed that Turkey was at stage two in the demographic transition model in the 1950s. This stage led to a fall in death rates and an increase in population. Recovery in food supply, agricultural improvements and technology improved conditions and significant improvements in public health reduced mortality, particularly in childhood. A consequence of the decline in mortality at stage two is an increasingly rapid rise in population growth, or a population explosion, as the gap between births and deaths grows wider.

One of the reasons to discuss family planning is to control the stability of the population and prevent population growth. Another one, which is similar, is related to urbanization and planned development. Therefore, it is possible to read about the concept of family planning in the demography literature, developmentalist ideology and population planning programs especially by focusing on the five-year development plans.

Another area in which family planning has been discussed is in the health discourse. Actually, the best known area for activating the family planning program in Turkey is health. Family planning programs generally have been activated by reference to health issues such as preventing maternal and child deaths. However, the difference between the Law on Population Planning in 1965 (*Nüfus Planlaması Hakkında Kanun,* no.557, 1 April 1965) and the Law on Population Planning in 1983 (*Nüfus Planlaması Hakkında Kanun,* no. 2827, 27 May 1983) must be noted. The founders of the State Planning Organization (SPO) wanted to counteract the effects

of rapid population growth on economic development. In November 1960, the SPO decided to add family planning to the First Five-Year Development Plan. Although the new population policy was stated in the First Five-Year Development Plan, the Law on Population Planning had to wait until 1965. The plan pictured a forceful implementation of this new anti-natalist policy. Although the economic development dimension of the new population policy was emphasized, the beneficial effects of low fertility on the health of mothers and children were not mentioned. At this point, Nusret Fişek, as an exception who supported such a program to improve maternal and child health, was concerned more with the health and human rights dimension of the issue. The Law on Population Planning (*Nüfus Planlaması Hakkında Kanun,* no.557, 1 April 1965), which was accepted in April 1965, stated that families could have as many children as they wished and whenever they wished, through measures preventing pregnancy. However, sterilization and abortion could not be performed except in cases of medical necessity.[3]

After all these changes, in 1965, the Population Planning Directory was established. However, the focus on maternal and infant health had to wait until the 1980s. In the 1980s, health issues became a more important concern in both Turkey and international context. With the 1982 constitution, the General Directorate of Mother and Child Health and Family Planning (Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü) was founded. As seen, mother and child health were made part of the name of that directory. In 1983, the Law on Population Planning (*Nüfus Planlaması Hakkında Kanun,* no. 2827, 27 May 1983) was accepted. Accessibility of contraceptive methods become more widespread and abortion was

[3] Abortion, except in case of medical necessity, was illegal until 1983. The Law on Population Planning (*Nüfus Planlaması Hakkında Kanun*, no. 2827; *Resmî Gazete*, 27 May 1983), which replaced the former law (no. 557), legalized abortion within 10 weeks of pregnancy. Abortion was practiced also when it was illegal, either secretly or with the consent of two doctors who declared medical necessity although there was no such necessity.

legalized to up to 10 weeks of pregnancy. In this sense, all the scholars, non-governmental organizations, and doctors first emphasized mother and child health as a reason for the need for family planning. By avoiding unwanted pregnancies and unsafe abortions, family planning would prevent deaths caused by unsafe childbearing and abortion practices, thus would contribute to women's health.

In the 1990s, HIV/AIDS was the most common subject discussed among governments, NGOs, and in Turkey. One reason for the application of family planning programs by the WHO is to help prevent the spread of HIV/AIDS. Therefore, in the literature, it is not easy to find the institutional history or background of family planning, but it is possible to find data on family planning in particular periods, like in the health literature especially during the 1980s. The focus of most studies is on the use of contraceptive methods by giving quantitative data in order to criticize the usage rate or the accessibility of contraceptives or offer statistics for seeing the whole picture of Turkey. In this data, the gap between West and Eastern regions, rural and urban areas, low income and high income is clear. All of the Turkish Demographic and Health Surveys attest to these wide gaps. Table 1 from the 1983 Turkish Population and Health Survey is given as an example to support this argument.

Table 1. Percentage of Women Currently Using Specified Contraceptive Methods – by Region and Type of Place of Residence

	MODERN METHODS								TRADITIONAL METHODS			
	No Method Used	Pill	IUD	Condom	Female Scient.	Injection	Female Steril.	Male Steril.	Withdrawal	Douche	Rhythm	Folk Methods
ALL TURKEY	39	9	9	5	3	0	1	0	30	2	14	1
REGION												
West	23	11	9	7	3	0	1	0	38	3	2	1
South	42	9	8	5	2	0	2	0	29	1	1	0
Central	39	8	13	4	4	0	1	0	27	2	1	1
North	34	7	9	4	3	0	3	0	38	1	0	0
East	69	6	5	3	1	0	0	0	14	0	1	0
TYPE OF PLACE												
Urban	29	9	11	7	4	0	1	0	33	2	3	1
Rural	49	9	7	3	2	0	1	0	27	1	0	1

(Hacettepe University, Institute of Population Studies, & the Westinghouse Health Systems, 1987: 98).

The other focus point is the accessibility and applicability of contraceptive methods by unmarried women, the disabled, the young, and people with low income. Especially international organizations such as the UNFPA[4] focus on the access to quality family planning services and availability. For instance, according to the UNFPA, there can be no doubt that Turkey has made progress in improving reproductive health since the UNFPA started to support population programs in Turkey in 1971. Especially, in line with the 1994 International Conference on Population and Development (ICPD), the rates for maternal and infant mortality have dropped and the prevalence of contraception has grown. As mentioned above, in the 1980s and the 1990s, the center of attention was to improve the rate of usage or the aim to decrease infant mortality by the UNFPA and state.

[4] The UNFPA, the United Nations Population Fund, works for universal access to reproductive health and the right of all people to be able to decide on the number and timing of their children. Family planning is essential to this work. The UNFPA works with governments, civil society and other UN agencies. The UNFPA helps to forecast needs, provide and coordinate the distribution of reproductive health commodities. The UNFPA works with family planning in 140 countries around the world, providing contraceptives to health posts and hospitals that serve millions of men and women (the UNFPA official web site).

In addition to this, the UNFPA has supported population programs in Turkey since 1971, stating that the lack of reliable data is also an important problem in family planning services. Moreover, the UNFPA has supported the government of Turkey and non-governmental organizations in a wide variety of activities, many of which are directly related to reproductive health. The other central point is from the medical perspective. In this part, which is mostly the focus of medical students research, in which especially the quality and functionality of contraceptive methods are predominantly studied. The comparison between modern contraceptive methods and traditional contraceptive methods (such as withdrawal) still is being argued in order to find the reason why the traditional contraceptive methods rate is still high.

In studies undertaken by NGOs, the emphasis is more on gender issues and equality between the genders. The status of women in society has a big place on the agendas of NGOs. As an example, the Turkish Family Health and Planning Foundation (*Türkiye Aile Sağlığı ve Planlaması Vakfı, TAPV*) has projects on mother and child health. In one of these projects, the aim is to upgrade the status of women. Another problem NGOs deal with is sexually transmitted diseases such as AIDS/HIV. As seen, health issues are still dominant while arguing for family planning.

The departments or research centers of universities are other institutions responsible for both education and research on family planning. However, their concentration is not focused on family planning or reproductive health, but on areas such as gender issues, violence, and gendered work. Therefore, in the family planning context their existence and their valuable works is not seen as a contribution to the literature for this thesis subject. However, there is one exception, Ayşe Akın, head of the Baskent University Women – Child Health and Family

Planning Research and Implementation Center, BUWCRIC (*Başkent Üniversitesi, Kadın – Çocuk Sağlığı Ve Aile Planlaması Araştırma Ve Uygulama Merkezi, BÜKÇAM*), who is interested in the institutional and historical background of the reproductive health issue. Her work has contributed a great deal to our knowledge of the historical perceptions on family planning. In addition to this, Ferhunde Özbay's work also has contributed a great deal to my thesis and my theoretical background. Especially, her work focuses on the demographic transition and the extensions and problems while considering the demographic transition in Turkey from 1923 to today. While she is working on this issue, she gives a broad overview about the institutionalization of the family planning concept, especially about state policies before the 1960s (Özbay, manuscript to be published in 2012).

Another area in which discussion of family planning and birth control can be found is feminist literature. It was in the early twentieth century that the issue of birth control was introduced by feminists in Europe and the U.S.. It started to be discussed that sexuality was not just a part of productivity. In addition to this, it is important to indicate that in this period, in parallel with this discussion, the working class also asked for their rights in the U.S. (Hartmann, 1995). As a result of the interaction of these two movements, feminists started rethinking the issue of the reproductive rights of women. According to Karaca Bozkurt, the demands on reproductive rights changed and the feminist movement, especially the socialist and anarchist feminists, called for accessible birth control and contraceptive methods, and the freedom of women in sexuality (Karaca Bozkurt, 2011: 41-42).

In this process, Margaret Sanger was a notable figure and is accepted as a pioneer in the establishment of the birth control issue in the U.S.. She wanted women to be freed from unwanted pregnancies and to have the right to decide about their

pregnancies. To this end, she set up the first birth control clinic in 1916 (Hartmann, 1995; Sanger, 1922).

However, there was no tangible result on the concept of family planning in the feminist literature in Turkey. Feminists did not assert that no woman should be forced to have children against her wishes. It will be meaningful to look at the feminist movement in different periods to have a better understanding of the lack of a debate on family planning. When the state feminism with the effect of Kemalism is considered, the representation of women was more family-centered and focused on being good/perfect mothers and good educators for the next generation of the nation. The emphasis was on the concept of "modern but modest" women (Najmabadi, 1991). Therefore, it was not possible to find discussion of the liberation of sexuality or sexuality in extramarital relations and (preventing the birth of next generation).

In 1949, the Turkish Women's Association (*Türk Kadınlar Birliği*) reopened. When the values and vision are considered, it is seen that the Association strengthened the woman's role as a self-denying mother, excellent wife, and responsible citizen (Kılıç, 1998: 349). In the 1950s, all of the associations that were established were like the Turkish Women's Association. They stressed the aim to make up for the deficiency of women's rights rather that to take women's rights a step further or to do critical thinking on women's rights. The Association for the Defense of Women's Rights (*Kadın Haklarını Koruma Derneği*), the Turkish Mothers Association (*Türk Anneler Derneği),* the Federation of Turkish Women's Associations (*Türkiye Kadınlar Dernekleri Federasyonu*), the Turkish Women's Culture Association (*Türk Kadınları Kültür Derneği*), and the Home Economics Club (*Ev Ekonomisi Kulübü*), all of which were established in the 1950s, are

examples of organizations founded to strengthen woman's role as self-denying mother, excellent wife, and responsible citizen (Kılıç, 1998: 350).

In 1975, there was a different association on the left wing that believed in gaining liberation is possible to work with man. The Progressivist Women's Association (*İlerici Kadınlar Derneği*) defined itself as a proletarian women's establishment. On its agenda, it put emphasis on the status of women in the family and at home and also on abortion. However, they also feared challenging the values of the society. Because of this, the PWA did not put that part of its agenda to action (Kılıç, 1998: 351-353). Before the 1980s, the character of the left wing did not permit militant women to discuss on the sexuality or the liberation of women as such (Tekeli, as citied in Kadıoğlu, 1998). Moreover, feminist women wearing headscarves emphasized the commodification of women's bodies and sexuality, yet they did not touch the birth control movement either (Sirman, 1989: 25). In the beginning of the 1990s, socialist feminists had a disappointment with the results of the Cold War. They did not create any new arguments (Kadıoğlu, 1998). Also, when the socialist feminists got together after that disappointment, the Law on Population Planning (*Nüfus Planlaması Hakkında Kanun*, no. 2827, 27 May 1983) had already been promulgated.

In the mid-1990s, some socialist feminists started to discuss the liberation of sexuality. However, the focus point was to reject the hegemony of the patriarchy and social pressure of the family (Dikmen, 1994: 31). It is tenable to claim that in this feminist context, neither the concept of family planning nor the issue of birth control was as central as in European or the U.S. feminist literature and there was not so much pressure for the establishment of family planning in Turkey.

The final step in the changes concerning family planning in Turkey was the transition of the health care system that was started in 2003 by the Justice and Development Party (AKP). In current literature, this transition is seen from a wider perspective in the social sciences. The effect of the transition and liberalization of health have become the focus points of debates, so scholars do not emphasize family planning issue, an area which was remained in the background. The closest thing to debate on family planning has been on preventive health services and its situation within the health system. However, the family planning concept has not been studied particularly within the context of the transition in the health system.

Given this background, this study focuses on the institutional history of family planning, hoping to fill the gap in the literature, especially in the social sciences. The institutional background of the subject of family planning has not been studied from as wide and as long-term a perspective as this before. The emphasis generally has been on the usage, quality, and accessibility of the family planning issue or program in medical students' theses or medical theses as referred to above. There is an absence of a holistic historical perspective, particularly on the subject of family planning. This thesis aims to take a step to cover that lack of information and observation in history, specifically regarding the concept of family planning.

This study brings together such diverse areas as medicine and health, the social sciences and social policy in the light of family planning. In this framework, this study's research question is to examine how the Turkish state historically has implemented family planning, birth control, and abortion with the help of the Ministry of Health (particularly the General Directorate of Mother and Child Health and Family Planning) with a particular focus on the recent changes in the 2000s. The changing discourses in Turkey or transformations in the international context have

affected this process in Turkey. This thesis is a descriptive and comparative work in order to understand the process in Turkey.

The study operates on a wide historical spectrum, from the establishment of the Turkish Republic to the present, March 2012. One of these periods is the institutionalizing of family planning in the 1960s, which also occurred and was debated in England and the U.S earlier than Turkey. Moreover, the periods have different motivations within themselves in order to be accepted as periods in this study. Therefore, the comparison between periods is also questioned and investigated in the following chapters. For our purposes, the historical periodization is organized in two chapters. The first chapter of historical context covers the period from 1923 to 1978. The second chapter of historical context covers the period from 1978 to March 2012.

The thesis argument is to show the changes in the discourse on the family planning concept defined in time periods in Turkey. Accordingly, state policies from 1923 to 1960s focused on the basis of pronatalist policies. The concept of family planning was not used in these years. After that period, as Ayşe Akın[5] states, in the 1960s, all over the world but particularly in developing countries, like Turkey, people began to discuss and be concerned with the negative effects of uncontrolled population growth on the economic and social circumstances of their countries. During the 1970s, the demographic discourse was dominant and this demographic perspective also had an effect on the concept of family planning in Turkey. Obviously, among the things that played big roles in turning to the demographic perspective were immigration and its accompanying problems.

[5] Prof. Dr. Ayşe Akın, who is head of Baskent University Research and Implementation Center on Woman-Child Health and Family Planning (BUWCRIC), specializes on public health, obstetrics and gynecology. She has carried out clinical research and program abroad and in Turkey.

When the 1980s arrived, the direction of the discussion changed. The concern on health moved to the center in the family planning debate. It can be seen as a turning point or a rupture at the discursive level in the case of the concept of family planning when compared with the pervious period. For the 1990s, human rights became a focal point of the debate like the other crucial discussion in the world, such as being a woman in society, the conditions of prisons, and difference in human beings and their recognition. In a parallel manner, human rights became a critical issue for family planning in Turkey (Akın, 2010: 1). In addition to this, the definition of reproductive health and its application from a holistic perspective on women's health began to be discussed. Last, in the 2000s, Turkey was characterized by the AKP-initiated forms in the health system and the implication of neoliberal policies both in Turkey and the international arena.

Methodology

This study makes use of historical data on the institutional and discursive changes in family planning concept and on semi-structured interviews. I conducted semi-structured in-depth interviews with Nurcan Müftüoğlu, the general coordinator of the Turkish Family Health and Planning Foundation (TAPV); and Prof. Dr. Ayşe Akın, the head of the Baskent University Research and Implementation Center on Woman-Child Health and Family Planning (BUWCRIC). In addition to them, I conducted semi-structured interviews with six doctors in Düzce, Izmir, and Istanbul. Last, I conducted interviews with the employees in the Istanbul Provincial Directorate of Health (*İstanbul İl Sağlık Müdürlüğü*). Other sources related to legislation which cover instructions, regulations, laws especially from 1965 to 1983 in which all the institutionalized process of the family planning took place.

In addition to this, I worked with the strategic plans of the Ministry of Health (*Türkiye Cumhuriyeti Sağlık Bakanlığı*). I also focused on all of the five-year development plans since 1963. Moreover, the conferences, seminars and their reports gathered in those years served as primary resources. This study also provides a wide secondary literature review on family planning. Last, statistics about the usage of IUDs, condoms, and statistics on applied abortion, applied family planning service, and family medicine in Istanbul since 1998 from the Istanbul Provincial Directorate of Health were utilized.

In this part, it is necessary to mention the process of attaining the data and statistics. It took a great deal of time and required great effort. It was very difficult to obtain permission from the Istanbul Provincial Directorate of Health to access the official data. Before applying to the Istanbul Provincial Directorate of Health, I initially went to Düzce, which is the first pilot area of the transition of health, to conduct my research. I asked for the data from the Düzce Provincial Directorate of Health, because I believed that it would be meaningful to focus on the beginning area of the transition health transformation in order to have a better understanding of the state policy on family planning. However, after the rejection of the Düzce case, I had to change my direction to Istanbul case.

Organization

The thesis is organized as follows. The second chapter examines the family planning concept in general. First, it gives a brief history of the emergence of birth control and then institutionalized family planning in England and the U.S., as pioneer countries in the world. In this context, Margaret Sanger, Emma Goldman, and Marie Stopes are the main characters of the story. It is necessary to give a brief history of

the historical emergence of the concept, since later a comparative perspective will be provided. Second, it provides the definitions of the concept of family planning according to the international context and Turkey. Then, the chapter discusses the benefits of family planning programs, since the discursive changes also transformed the percieved benefits of family planning in Turkey. Third, a brief history of contraceptive use in general and unmet needs of family planning is provided.

The third chapter covers the period from 1923 to 1978. In this chapter, the pronatalist policies put into practice from 1923 to 1960 and the institutionalization of the family planning concept in 1965 with the Law on Population Planning and its implications will be described. The pronatalist policies aimed at interventionist child health and welfare served as one of the main pillars of the war waged against de-population. The policy in Turkey (and in the world) turned to anti-natalist policy in the 1960s, due to the population boom. The establishment of the Population Planning Directory in 1965, and the Turkish Family Planning Association (*Türkiye Aile Planlaması Derneği, TAPD*) in 1963 are presented in this chapter as significant developments. In this process, the Law on the Socialization of Health Services (*Sağlık Hizmetlerinin Sosyalleştirilmesi, no.224, 12 January 1961*) also had a significant impact on improving the living conditions of especially the rural poor, who lacked basic services throughout the country. The debates regarding population and demography during this period addressed by the larger society and the Turkish state are given in this chapter. Although the economic development dimension of the new population policy is emphasized, the beneficial effects of low fertility on the health of mothers and children are not considered. However, the activities of Nusret Fişek[6] who had an important role in process are discussed in this chapter.

[6] Nusret Fişek was the architect of both the socialization of health services and population planning. He worked on the population section of the First Five-Year Development Plan and prepared the

The fourth chapter covers the period from 1978 to March 2012. This chapter provides the recent history of institutionalization in state structures, especially by referring to the transitions in the health system and legal reforms since the 1980s, which includes the Law on Population Planning (no.2827) in 1983. Family planning was regarded in terms of health issue in the 1980s and then of human rights issues in the 1990s. The international context also supports this transition in Turkey. The Declaration of Alma-Ata[7] which expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people of the world in 1978, are given as an example. It was the first international declaration underlining the importance of primary health care which also includes family planning.

In this context, the change in the name of the Population Planning Directory to the General Directorate of Mother and Child Health and Family Planning is examined in this chapter. The enterance of NGOs and international organizations to Turkey is examined as part of a network society particularly in the health system, in the context of globalization. The last example, which supports the claim of focusing on the health issues in this period, like Alma-Ata, is the International Conference on Population and Development in 1994, in Cairo. This was the first time the term "reproductive health" was used and accepted all over the world. The reproductive health approach is relatively new and an "umbrella concept" (Germain, 1987, as citied in Özbay, 1994) to cover problems related to reproductive choice, successful childbearing, maternal mortality, reproductive morbidity, and the emotional and

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Population Planning Law together with the early planners although there was a difference in their priorities. The former emphasized the health and human rights dimension of birth control while the latter was more interested in its economic dimension.

[7] The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC) in Kazakhstan (formerly Kazakh Soviet Socialist Republic), 6-12 September 1978.

social health of women. Last, in this chapter, data from the Istanbul Provincial Directorate of Health are provided, followed by a discussion of its implications for neoliberal policies and preventive health services.

Finally, in the conclusion chapter, an overview of the thesis will be given, bringing together the findings and reflections on the chapters.

CHAPTER II

THE CONCEPT OF FAMILY PLANNING

Birth control is essentially an education for women[8]
Margaret Sanger

Before discussing birth control and family planning, it is important to look at the international context and the emergence of birth control movements abroad. In addition to this, clarifying the concepts of family planning, birth control, population planning, and contraceptive methods will give a better understanding of the Turkish context. This chapter will shed light on the feminist debate on birth control and family planning in America and how birth control emerged there and in England. America and England were selected because they were early in the historical process when compared to other countries such as France (1967), and Turkey (1965). The second reason is the direction of the movement in those countries, which is detailed in this chapter.

The concept of birth control, family planning and reproductive health issues according to some leading institutions in the world, especially in Europe will be discussed. The chapter will then focus on the perceived benefits of family planning and family planning programs according by international organizations and the state policy and NGOs. The discussion will be divided into three categories; health, population, and the socio-economic development of society. Next, information about contraceptive use in general and the unmet needs of family planning and

[8] Sanger, M. (1922).

contraceptive methods in the world will be given, and last, family planning methods or contraceptive methods will be demonstrated and their usage in the world and Turkey.

Brief History of the Emergence of Birth Control Movements in the U.S. and England

The process of the legalization of birth control methods in the U.S. had its own difficulties. It was not an easy process to make contraceptive methods legal and accessible in the country. It took 30 years for birth control to receive an official endorsement from medical professional society after 1916 when Sanger set up the first birth control clinic in Brooklyn, New York (where the New York State Panel Code made the distribution of birth control devices illegal), and was arrested (for "maintaining a public nuisance") serving thirty days in working house (Kennedy; Cho, 1970).

In the early twentieth century, the issue of the birth control was discussed in the U.S and England by intellectuals, social reformists, and especially in feminist circles in the sense of the difference between reproduction and sexuality. It was argued that sexuality was not just a part of productivity. It is important to note that in the same period, the working class also was demanding rights in the U.S.. As a result of the interaction of these two movements, the feminists started rethinking the issue of the reproductive rights of women. In the beginning of the twentieth century, the feminists focused on the argument that sexuality did not necessarily serve reproductive purposes. With the effects of the demand for social and economic rights for workers, women also were able to contribute to this discussion in a sense (Hartmann, 1995). In other words, the working class strengthened the feminist

movement on the issue of reproductive rights because the labor force participation rate had been increasing among the women and this increase had an effect on the feminist movement's concern about the working class women and their demands. There was a change in the feminist movement's demand for attainable contraception methods when it is compared with that of their demands in the nineteenth century. The change was about the belief on the affect of contraception methods on liberating the women. Nineteenth century feminist movement had argued that contraception and abortion would serve the interests of men instead of women.

In this process, Margaret Sanger was a notable figure and was accepted as a pioneer in the establishment of the birth control issue in the U.S.. Sanger was a New York housewife who had been raised in a progressive atmosphere. In 1911, she moved to New York City, and in her capacity as a nurse began to discover the plight of poor women burdened by series of unwanted pregnancies (McLaren, 1992: 216). She wanted women to be freed from unwanted pregnancies and have the right to decide about their pregnancies. She set up the first birth control clinic in 1916 in America (Hartmann, 1995; Sanger, 1922).[9]

In addition to this, in 1921, she established the Birth Control League in America, which would be a component of founder of the Planned Parenthood Federation of America (PPFA). Moreover, in 1927, Sanger sponsored the first world population conference in Geneva, which gave rise to the International Union for the Scientific Investigation of Population Problems (renamed in 1947 the International Union for the Scientific Study of Population). According to Özberk (2006, as citied in Karaca Bozkurt, 2011), in the same period, the writer Marie Stopes and birth control promoter Humprey Verdon Roe set up the first birth control clinic in 1921 in

[9] In 1878, Aletta Jacobs founded the first birth control clinic in the world in Amsterdam.

England (Karaca Bozkurt, 2011: 41-42; Özberk, 2006). Marie Stopes focused on the study of sexuality and her book called *Married Love* was published 1918. Stope's main argument in *Married Love,* which went through seven printings and eventually sold more than a million copies, was that married woman had as much right to sexual pleasure as her husband. Stopes only noted the issue of birth control in passing, but in the huge number of letters she received from her readers learned that the inability to limit fertility was the source of much marital misery (McLaren, 1992: 217). In Great Britain the Malthusian League, aided by Marie Stopes, established a birth control clinic in London in 1921.

Another significant figure was Emma Goldman, who, in part because of her radical politics, did not create a mass movement, but helped to win to Margaret Sanger's. She began to defend the necessity of birth control publicly in the U.S., England, and France. The most important point is that the idea was not based on Malthusian economic grounds such as the Malthusian League, which supported fertility control on economic grounds, but on the liberation of women through the birth control (McLaren, 1992: 216 and 225). Goldman was imprisoned several times in the years that followed for inciting riots and illegally distributing information about birth control. The main point that Goldman argued was not the benefits of family planning for whole society and economic development like Malthusian, but on the improvement the liberation of women and women situation in society by the legalization of birth control.

According to Özberk (2006, as citied in Karaca Bozkurt, 2011), Sanger and Stopes were the leading women involved in the birth control issue. They were defenders of birth control and because of that they were punished and were inhibited especially by conservative groups that were governed by the church. As an example,

in 1917, Sanger went to jail for distributing an early version of the diaphragm from a makeshift clinic in a tenement storefront in Brooklyn. She received a 30-day jail sentence.

The difference between them and the Malthusians was related to the issue of birth control. The Malthusian's were focused on economic growth, but Stopes and Sanger argued this issue through the liberation of women.

With Stopes and Sanger's efforts, 300 birth control centers were set up by the end of 1920 in the U.S. and England (Karaca Bozkurt, 2011: 41-42; Özberk, 2006). The argument of the liberation of women while demanding birth control that was endorsed was Stopes, Sanger and Goldman had to do with their feminist backgrounds and their belief in women's rights. According to Robinson and Ross (2007), in these feminist attempts, the focus point was on women as individuals. The emphasis was on their individual health, their individual well-being, and their welfare. The beginning point was to have the right to be protected from unwanted pregnancies as a woman. It could be argued that these attempts made women more powerful in their social lives and in asserting their rights in their daily lives, in a sense. According to Rothman (1986, as citied in McLaren, 1992: 225),

> birth control for Stopes and Sanger was essentially an instrument that, by sparing the woman unwanted pregnancies, would permit the emergence of the happy, sensual family unit in which she could have the leisure for delighting in motherhood.

In the inter-war period, the women's movement slowly moved in the direction of the notion, advanced by Stopes and Sanger, that women had to be freed from unwanted pregnancies. Although feminists were weak on this issue until the 1960s, it

was in this light that the oral contraceptive pill[10] in 1960 and the IUD[11] were welcomed in the 1950s. Moreover, Simone de Beauvoir, Sherry Ortner and Betty Friedan all stressed the idea that maternity had been used to keep women down (De Beauvoir, 1974; Ortner,1974; Friedan,1963).

In addition to these reasons, related to the liberation of women, it is important to cite others. Stopes and Sanger were concerned with maternal and infant mortality as well. According to McLaren, "Stopes and Sanger both were alarmed by the high maternal and infant mortality rates associated with large families, and exploited the eugenic concerns for the need to improve the 'quality' of the race." In addition, they both emphasized the need for clinics supported by the government. Moreover, they asked the government for trained personnel to educate society in contraceptive use. They made an effort to stress that the limitation of family size was not only an economic necessity, but also morally acceptable among the society (McLaren, 1992: 218).

In 1953, Sanger and McCormick looked for a scientist to develop a birth control pill. They found Dr. Gregory Goodwin Pincus, who was working for the scientific community at a time when most serious scientific research was being conducted at universities. Pincus developed the pill, which was licensed by Federal agency in 1960 (PBS web site). According to Kennedy (1970), in the 1960s, the

[10] "Dr. Pincus developed a relatively safe and simple oral contraceptive that revolutionized family planning. In 1960, the Federal Agency licensed that contraceptive pill and it was first marketed" (http://www.nytimes.com/learning/general/onthisday/bday/0409.html).

[11] "The modern plastic-based IUD began to take shape in the United States in the 1950s. Lazar C. Margulies, an obstetrician in New York, is generally credited for pioneering plastic IUDs to help reduce the danger associated with previous IUDs. In 1958 he introduced his version of the IUD, though it was not greatly successful because of its large size. In 1962, Jack Lippes, a gynecologist also in New York, developed a smaller, plastic IUD that became more popular. In the late 1960s, Howard Tatum, another New York obstetrician, developed a plastic-cased, cooper-based IUD that could be dramatically reduced in size without sacrificing its effectiveness. During the 1970s, in an effort to help cheaply curb reproduction and enforce the "one-child policy," Chinese physicians developed the stainless-steel IUD, but banned them by early the 1990s because of a 10% pregnancy rate due to steel's lowered contraceptive capability" (http://findingeve.wordpress.com/2008/11/28/history-of-the-iud/).

government and many institutions supported birth control, and oral contraceptives were taken by millions of women around the world. In addition to this, the U.S. presidents accepted birth control as family planning. This improvement on the discourse of family planning was not the simple technical result of the creation of the pill, it was also about the result of Sanger's long fought social, legal and political battles. Her efforts led to the creation of the pill.

It is necessary to see that the emergence of birth control in the U.S. and in England was progressing at a grass roots level (i.e. bottom-up). Demands were made from bottom to up, clinics were established and penalties were given by the states. The pioneers of the bottom-up movement included medical profession (doctors) and feminists. According to Chesler (1993), Sanger's goal was to mobilize local groups to provide clinical birth control services throughout the U.S.. Sanger concentrated her personal energies and resources on the Birth Control Research Bureau, which she founded in 1923, in an office next door to the American Birth Control League, which was established in 1921. As Chesler states, "organized birth control, in fact, advanced only tentatively through the 1920s with the formation of state affiliates and local clinics as its major achievement" (Chesler, 1993: 226).

> In 1922, after considerable lobbying of dubious New York State officials, Margaret incorporated the American Birth Control League in accordance with laws governing not-for-profit charitable institutions and set out an ambitious and far-reaching declaration of intentions that included public education, legislative reform, medical research in contraception, and the actual provision of services (Chesler, 1993: 223).

In this context, the difference between England and the U.S. should be noted, according to Hartmann (1995). To him, England had unit established in 1877, which was supported by neo-Malthusian approach in the process of the acceptance of birth control. The first supporters of birth control were the English radical neo-Malthusians. Although, Malthus had rejected the contraceptives in principle, earlier

neo- Malthusians thought that high population rates were a crucial reason of poverty. Because of that, they supported birth control among the needy in order to decrease poverty in the country. However, the situation was different in the U.S., according to Hartmann. Robert Dale Owen brought the neo-Malthusian approach to the U.S.. In contrast to the English neo-Malthusians, Owen thought that the cause of poverty was not poverty but the inequitable distribution of wealth. They supported the role of birth control in giving women control of their bodies. This approach, which relied on the reproductive rights of women, brought on and helped the occurrence of the feminist movement in the U.S around the mid-nineteenth century (Hartmann, 1995).

In Turkey, the movement was more of a top-down movement, as will be elaborated in the following chapters. Similarly with England and the United States, doctors played a significant role in the passing and development of the legal bill in the late 1960s. However, contrary to England and the United States, feminists in Turkey seem to have been absent. While in England and the United States, the issues of the liberation of women could be discussed with ease as early as the 1920s, in Turkey, in the 1960s, issues on birth control were discussed related to matters of health, population control, and maternal and infant mortality.

The Concept of Family Planning

According to Kut (1974, as citied in Bulut, 1979: 17-18), the concept of family planning has many definitions, but the main issue is not to mix the concept of family planning and the concept of population planning. Population planning is a policy decision that is related to the general politics adopted in principle by a government, as China has (which will be discussed below). However, family planning is a service that plays a significant role in family welfare. Family planning

is a concept which includes free choice, the ability to decide about yourself, improving the individual well-being and happiness. According to Kırımlıoğlu (1997), Özvarış (2002: 5-13), Cengiz (2001: 3-25) who have medical backgrounds, the basic principles of family planning seem to make it possible for families to have as many children as they want, when they want. Moreover, having as many children as they want, whenever this want is a natural right at the Turkish state level and in the international context (as an example, the WHO, the UN and UNPFA also accept and employ this definition). Family planning helps couples in deciding to have children, in determining the timing of child bearing and size of the family (Döngel, 2006: 1-2; Cengiz, 2001).

In this context, family planning is defined as "Family planning policies that allow individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility." (WHO web site). At an international conference on population in 1984, in Mexico City, this approach was ensured by an unanimous vote by the countries at this conference (Özvarış, 2005: 5-13). Also at a 1968 UN conference, it was accepted that "parents have a basic human right to determine freely and responsibly the number and the spacing of their children" (Connelly, 2008: 238).

According to a service guidebook by the Ministry of Health of Turkey, in order to have a successful family program, education, service, and a system of management and control are necessary. The guidebook says that it should be taken into consideration the need for contraception of society, the presentation of contraceptions, control of the employees, the stock of contraception, the adequacy of

supplies and places (T.C. Sağlık Bakanlığı Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü & UNFPA, 2005).

According to the ICDP in 1994, family planning is articulated as follows;

> Actions are recommended to help couples and individuals meet their reproductive goals; to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality; to make quality services affordable, acceptable and accessible to all who need and want them; to improve the quality of advice, information, education, communication, counselling and services; to increase the participation and sharing of responsibility of men in the actual practice of family planning; and to promote breast-feeding to enhance birth spacing (ICDP, 1994, chapter VII).

Recently, especially in the last 20 years, family planning has appeared as part of the issue of "reproductive health". The term "reproductive health" was preferred instead of "family planning" in 1994 by the ICPD's Programme of Action, which was organized by the UNFPA.

The idea is to look at the issue of family planning with the help of a holistic approach as a reproductive health issue. The International Conference on Population and Development (ICPD) was convened in Cairo, Egypt, from 5 to 13 September 1994 under the auspices of the United Nations and was organized with the help of the Population Division of the UN Department for Economic and Social Information and Policy Analysis and UNFPA. It was the biggest intergovernmental conference on population and development to date. There were around 11,000 participants from governments, UN specialized agencies and organizations, intergovernmental organizations, non-governmental organizations, and the media. The Programme of Action was finalized with the participation of 180 states in the area of population and development for the next 20 years (UNFPA web site). According to the UNFPA, "it

was the first international conference that did not specifically address women's issues and interests but at which they were nevertheless the main focus of attention" (UNFPA web site). In addition to this, The Programme of Action provides a new strategy that emphasizes the linkages between population and development. In addition, it underlines the importance of meeting the needs of individual women and men, rather than giving priority to demographic targets (ICDP, 1994). According to the UNPFA's Programme of Action, reproductive health and family planning are defined as follows:

> Reproductive health is a state of complete physical, mental and social well being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health-care services that will enable women to go safely through pregnancy and childbirth. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations (ICDP, 1994, chapter VII).

According to this definition, reproductive health-care programs should give priority to the needs of women, including adolescents. Putting women in roles of leadership in the planning, decision-making, management, implementation, organization and evaluation of services is essential. These services should be attainable by adolescents and also adult men. The emphasis on men in this programme is a crucial addition that should not to be ignored.

> Such programmes must both educate and enable men to share more equally in family planning, domestic and child-rearing responsibilities and to accept major responsibility for the prevention of STDs (ICDP, 1994, chapter VII).

Perceived Benefits of and Approaches to Family Planning Programs

The WHO promotes family planning by producing guidelines for contraceptive methods, developing quality standards and providing contraceptive commodities, and helping countries introduce and implement these tools to decrease their unmet need for contraception. The aim is to give a chance to people, especially women, in order to have their desired number of children and determine the spacing of pregnancies (WHO Media Center). Providing qualified family planning programmes is the priority of the WHO.

Qualified family planning programmes bring a wide range of benefits to women, their families, and society. In the opinion of Prata (2007:221), family planning is an effective public health intervention with multiple individual and societal benefits by lowering fertility rates. Couples can achieve their desired family size and can help lower maternal and child mortality by the help of family planning program.

The following section examines these reasons in a coherent context. In order to do this, the reasons related to health, the population issue and the socio economic development of society will be discussed.

Reasons Related to Health: Maternal and Infant Mortality

All scholars, non-governmental organizations, and doctors first emphasize the health of the mother and child as a reason for the need for family planning. According to Prata (2007), there is a strong negative correlation between maternal mortality and the use of contraceptives. As claimed by the WHO, the UNFPA, the UNICEF (1999, as citied in Prata), contraceptive use decreases the risk of maternal

death by decreasing the possibility of becoming pregnant. As stated by Martson and Cleland (2004, as citied in Prata), the use of family planning can potentially play a protective role among women at high risk for maternal mortality, such as during adolescence, older age, and short birth intervals. Lastly, Prata cites the WHO statistics, acoocrding to 2004 which there are an estimated 80 million unwanted pregnancies and more than 19 million unsafe abortions annually, in order to explain how family planning is a mandatory issue in mother and child health (Prata, 2007: 219-220).

Döngel (2006:1-2) also claims that, by avoiding unwanted pregnancies, family planning prevents deaths caused by unsafe childbearing and abortion practices, and thus contributes to women's health. The Maternity Welfare and Family Planning handbook (T.C. Sağlık Bakanlığı Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü, 1992), and Hatcher (1990) agree that family planning is a tool to prevent maternal and child mortality and improve women's health (Hatcher et al., 1990; T.C. Sağlık Bakanlığı Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü, 1992: 135).

Lastly, the WHO also concentrates on reasons related to health issues in order to promote family planning globally. Preventing pregnancy is related to reducing health risks for women. Because,

> A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing. This reduces maternal mortality (WHO Media Center).

Another reason citied by WHO is the prevention of HIV/AIDS:

> Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition,

> male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV (WHO Media Center).

Moreover, the WHO takes into account the reasons related to reducing the need for unsafe abortions. Family planning reduces the need for unsafe abortions by reducing rates of unintended pregnancies. The other issue is about the reducing the number of adolescent pregnancies.

> Pregnant adolescents are more likely to have preterm or low birth-weight babies. Babies born to adolescents have higher rates of neonatal mortality. Many adolescent girls who become pregnant have to leave school. This has long-term implications for them as individuals, their families and communities (WHO Media Center).

In parallel, Abdel and Omrean (citied in Bulut, 1979: 19-20) also claim that family planning works to prevent the adolescent pregnancies.

The graphs below show how family planning is related to women's health. [12]

(See appendix A for further)

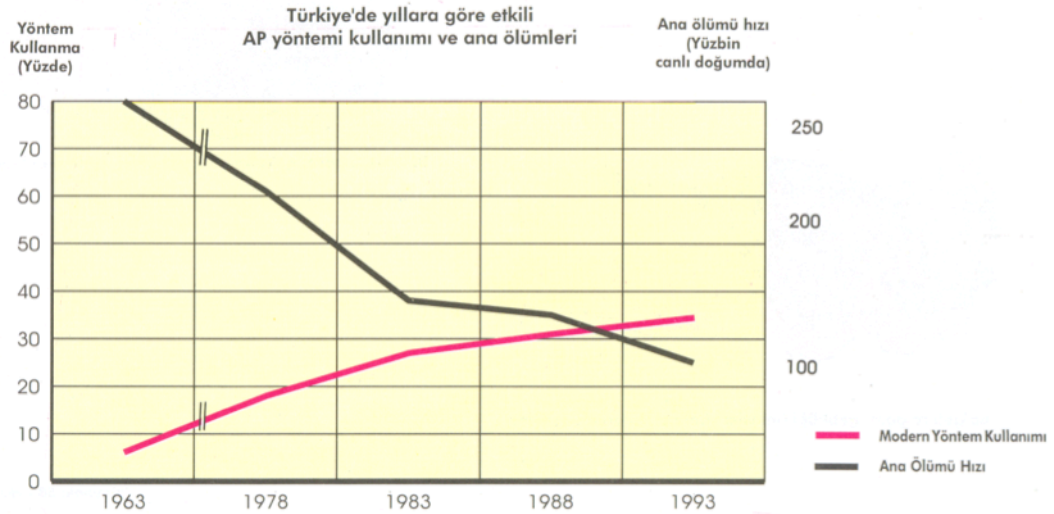

Figure 1. The relationship between usage of family planning and maternal death by year, in Turkey.

When the usage of family planning increases the maternal death declines.

[12] These graphs are taken from a presentation titled "Türkiye'de Değişen Aile Planlaması Politikaları", by Prof Dr. Ayşe Akın, presented in İzmir.

Reasons Related to Population: Fertility Decline and Slower Population Growth

Family planning contributes to fertility decline because it provides spacing in childbearing for the mother, and enables women to limit the number of children that women would have. According to the World Bank (1993) (citied in Prata, 2007), "family planning is an effective way of controlling fertility. Low fertility leads to a slower population growth. It has long been acknowledge as an effective public health intervention, highly cost-effective in decreasing maternal and child health burden of disease" (Prata, 2007: 212). Moreover, the WHO also accepts that family planning serves to slow population growth: "Family planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts" (WHO Media Center).

Consequently, family planning does not limit rights; it gives people choices by providing them the tools to control the timing and number of children they will have.

Reasons Related to Socio Economic Development of Society:
Education, Economy, and Social Life

Family planning also serves the socio-economic development of societies. By slowing population growth, it can create happy, well-educated, economically self-sufficient individuals and families. It provides women an opportunity to attain better positions in society (Hatcher et al., 1990; Omrean, as citied in Bulut, 1979: 19-20; T.C. Sağlık Bakanlığı Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü, 1992: 135).

According to Population Reports (1994, as citied in Döngel, 2006: 1-2) "the control over fertility has important outcomes for the life of women. Secondly by

avoiding unwanted childbearing and childcare, family planning helps women manage their time more effectively and allocate more time for education, employment and other opportunities."

High population growth in developing and undeveloped countries causes slow socio-economic development. The studies show that the problems of unemployment, education, housing needs, immigration, self-abortion, and irregular urbanization could be solved by reducing the overall rate of fertility. As an example, China introduced a policy on family planning in 1979 that put pressure on society in order to reduce the high rate of population growth. The one-child policy is an example of an anti-natalist policy. Families were limited to one child by a rigid system of benefits for only having one child and punishments for having more than one child. In the following decade, fertility in China declined more rapidly than it ever has in a major country. After 1984, the one-child limit was largely abandoned in the countryside, partly to stem a wave of female infanticide (Rennie, 2001: 32). China has started a new program which is based on family promising the state they will not have more than one child; in return the state gives cheaper education and better opportunities of employment.

Therefore, in China, with the help of birth control policy, population growth decreased in the 1970s and 1980s (Hatcher et al., 1990). At this point, it is crucial to emphasis the concept of birth control policy, family planning, and population policy. According to definitions, it is not a pure family planning which is applied in China. In a wider sense, it is a population planning policy. However, it should not be forgotten that population planning policies which are based on reducing high fertility or increasing low fertility should go along with a family planning program.

The following are graph which show the relationship between population and income per capita, education level for children, opportunity for employment, is given to show how population is related to each issue on the socio-economic development of society.[13]

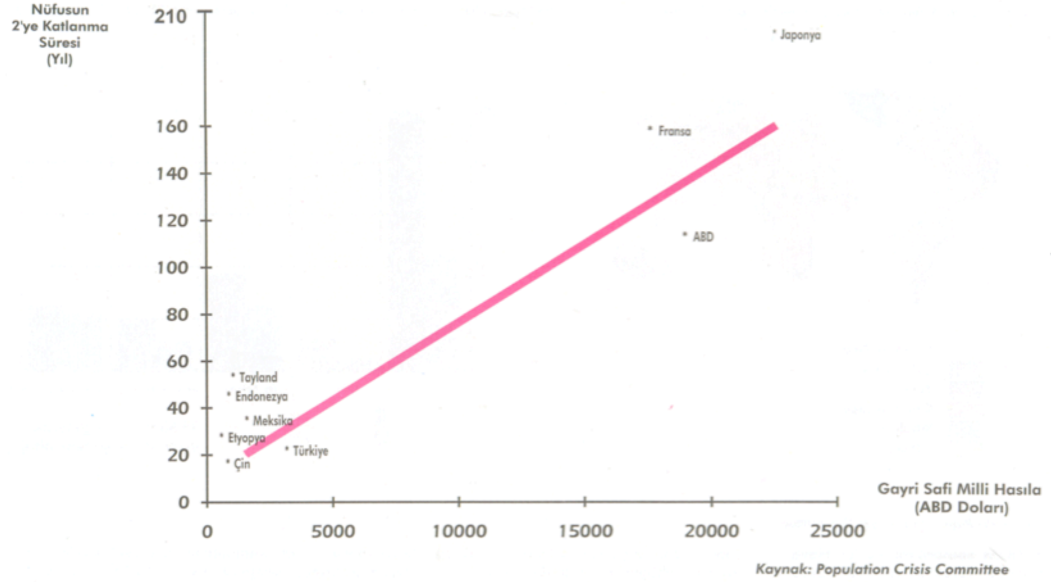

Figure 2. The relationship between population growth and GNP
When population growth is high, GNP becomes low. (See Appendix B for further)

It is obvious that there is a need for family planning. The direct impact of making family planning available includes decreasing both maternal and child mortality, decreasing the number of unsafe abortions, reducing population growth, and meeting the desires of men and women worldwide for smaller families with larger spacing between their children (Prata, 2007: 221). In addition to this, the impact of family planning is inevitable on slowing population growth.

[13] These graphs are taken from a presentation named “Türkiye’de Değişen Aile Planlaması Politikaları” by Prof Dr. Ayşe Akın, presented in İzmir.

Contraceptive Use in General

Looking at some rates of contraceptive use will help to understand and demonstrate how common contraceptive use has become and to show the current situation in the world to have a better and wider understanding on the issue of birth control usage. Prata writes that, "Worldwide, since the 1960s the percent of married women using contraception has steadily increased. Since the early 1990s, more than half of all married women in the world have used some form of contraception" (Prata, 2007: 213-214; See Appendix C).

According to McLaren, by the 1980s, something like 90 per cent of married couples in most western countries were employing contraceptives. An international survey of contraceptive users found that 33 per cent had been sterilized, 20 per cent employed the oral contraceptive, 15 per cent the IUD, and 10 per cent condoms (McLaren, 1992: 252).

According to the WHO,

> contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, contraceptive use has risen, from 54% in 1990 to 63% in 2007. Regionally, the proportion of married women aged 15–49 reporting use of any contraceptive method has risen minimally between 1990 and 2007, from 17% to 28% in Africa, 57% to 67% in Asia, and 62% to 72% in Latin America and the Caribbean, with significant variation among countries in these regions (WHO Media Center).

Also, worldwide, 11.3% of women of reproductive age report that they rely on one of these methods in their marriage or formal union (WHO Media Center).

However, according to Prata (2007), while there has been a great growth in contraceptive use but, there is still a problem with the use of birth control among

countries and people. There are still unmet needs for contraceptive use, especially in Africa.

> Despite overall progress, enormous differences exist between the world regions. Contraceptive use is higher in middle and high-income countries, and is lowest in the least countries. With the countries in Southern Africa (i.e. South Africa, Swaziland, Lesotho, Botswana, and Namibia), sub-Saharan Africa (all African regions except North Africa) presents the lowest levels of contraceptive use globally (Prata, 2007: 213-214).

The Unmet Needs of Family Planning, Contraceptive Methods and Birth Control

There is no doubt that the expansion of family planning is still needed in order to provide tools for couples to reach their desired family size, optimize child spacing, reduce the rate of slow population growth, and prevent maternal and infant mortality. According to Prata (2007: 212), globally, the use of modern contraceptive methods and the desire for smaller families has been increasing. In other words, small numbers of member in one family is desired among people. However, a large gap between rich and poor still exists in access to services, and these results in disproportional high unmet need for the poor.

Information provided by the WHO is significant in order to understand the importance of the unmet need for family planning. The WHO considers the job of family planning to be unfinished. Despite great progress over the last several decades, according to the WHO, more than 120 million women worldwide want to prevent pregnancy, but they and their partners are not using contraception. There are several reasons for this. One of them is that services and supplies are not yet available everywhere or choices are limited. The second one is that fear of social

disapproval or partner's opposition pose formidable barriers. The other reason is that worries about possible side effects and health concerns hold some people back. Finally, the lack knowledge about contraceptive options and their use is another reason. According to the WHO, there is still need to help these people.

In addition to this, the WHO also sheds light on failure at using one of the family planning methods. People may not receive clear instructions on how to use the method properly, are unable to obtain a method better suited to them, are not properly prepared for side effects, or supplies out. According to the WHO, "Moreover, the job of family planning never will be finished. In the next five years about sixty millions girls and boys will reach sexual maturity. Generation after generation, there will always be people needing family planning and other health care"(WHO, 2011). Therefore, these data and reasons which are citied by the WHO show the significance and urgency of the reachable and accessible services in family planning.

Prata (2007) explains the reasons for the unmet needs as being such things as the lack of knowledge, fear of side effects, limited method choice, financial costs, misinformation, as stated by some scholars.

> An essential first step in planning to eliminate unmet need is to understand its underlying causes. Using data from DHS I[14], Bongaarts and Bruce (1995) identified lack of knowledge, fear of side effects, and husband's disapproval of family planning as the primary reasons for non-use of contraception. Using DHS II, Westoff and Bankole (1995) identified lack of information about contraception, opposition to family planning and ambivalence about future childbearing as the main underlying causes for unmet need. A recent review of the literature on the barriers for fertility regulation from a consumer perspective identifies limited method choice, financial costs, women's status, medical and legal restrictions, provider bias and misinformation as reasons for non-use of contraception (Campbell, Sahin-Hodoglugil, Potts, 2006). Affordability of contraceptives is a very important barrier to use. When contraceptive cost amounts to more than 1% of the household income, a decline in use is observed (Harvey, 1999). (Prata, 2007: 217).

[14] Demographic and Health Surveys

The reasons for global unmet need for contraception are stated by the WHO as limited choice of methods, limited access to contraception, particularly among the young, the poor, or unmarried people; fear or experience of side-effects; cultural or religious opposition; poor quality of available services; and gender-based barriers (WHO Media Center).

Last, the WHO presents some global numbers as evidence of the idea of the global unmet need for contraception.

> The unmet need for contraception among married women is declining but is still high. In Africa, 22% of married women are at risk of an unplanned pregnancy but are not using contraception; this is only a small decline from the level a decade earlier (24%). In Asia, and Latin America and the Caribbean – regions with relatively high contraceptive prevalence – the levels of unmet need are 9% and 11%, respectively (WHO Media Center).

The Contraceptive Methods Used in Turkey

In the UK, the Family Planning Association[15] is the organization that makes sexual health a priority public health issue. Their goal is to make talking about sex seem normal. They educate and inform many people about sexual health and work to improve sexual health services. According to the FPA, the contraception methods are as follows:

<u>Long-acting reversible contraception (LARC):</u>

- Contraceptive injections
- Contraceptive implant
- The IUD

[15] "The FPA was first formed in 1930. There were only 20 family planning clinics and knowledge was limited. During the next 50 years, the FPA set up over 1,000 family planning clinics which were handed over to the NHS in the 1970s, marking a landmark event when contraception became free for all. In the last decade the FPA has extended its remit to providing information, help and advice on a wide range of sexual health issues including sexually transmitted infections, reproductive rights including abortion, sex and relationships education and, increasingly, help and support around sexual pleasure and wellbeing" (FPA official web site, http://www.fpa.org.uk/)

- The IUS

Hormonal methods:

- Combined pill
- Progestogen-only pill
- Contraceptive patch
- Contraceptive vaginal ring

Barrier methods:

- Male and female condoms
- Diaphragms and caps

Permanent methods:

- Male and female sterilization

Natural family planning:

- Natural family planning

Emergency contraception:

- The emergency contraceptive pill, Levonelle
- The emergency contraceptive pill, ellaOne
- The emergency intrauterine device (IUD) (FPA official web site).[16]

According to the WHO, emergency contraception refers to back-up methods for contraceptive emergencies which women can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy. Emergency contraceptives are not suitable for regular use (WHO Media Center, 2005).[17]

According to the WHO, the contraceptive methods are articulated as a table (WHO Media Center).[18]

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[16] See Appendix A.
[17] See Appendix B.
[18] See Appendix C.

All of these modern contraceptives methods are used in the world. At this point, it will be meaningful to look at methods available in Turkey that are used by women and men and accepted as family planning methods (Hatcher et al., 1990; T.C. Sağlık Bakanlığı Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü, 1996; Istanbul Provincial Directorate of Health official web site).

Effective methods:

Long-acting reversible contraception (LARC

- The IUD

Surgical methods:

- Tubal ligation as a female sterilization
- Vasectomy as a male sterilization

Hormonal methods:

- Combined pill
- Progestogen-only pill
- Contraceptive injections
- Contraceptive implant

Barrier methods:

- Male and female condoms
- Diaphragms and caps
- Spermicide

Ineffective methods:

- Withdrawal
- Lactation
- Calendar methods
- Vaginal douches

At this point, it is crucial to emphasize that emergency contraceptive pills and abortion are not accepted as family planning methods in Turkey. Especially emergency contraceptive pills are accepted as emergency contraceptives. They are not accepted as a family planning method is that they are not a planning intervention before sexual intercourse and for reproduction.[19] In addition to this, while during family planning consultations, emergency contraception methods are not explained (T.C. Sağlık Bakanlığı Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü & UNFPA, 2005: 592).

[19] The idea is approved by the interviews with the Unit of Mother-Child Health and Family Planning Directory in İstanbul.

CHAPTER III

FROM PRONATALIST POLICY TO ANTINATALIST POLICY IN TURKEY

This chapter offers an historical overview of the developments in family planning between 1923 and 1978. This periodization is presented in three parts in order to shed light on the changes in policy. First of all, it is crucial to start with the separation between the period until 1965 and after 1965. The turning point was the enactment of the Law on Population Planning in 1965 (*Nüfus Planlaması Hakkında Kanun, no.557*, 1 April 1965) and the establishment first under the name of the Population Planning Directory (*Nüfus Planlaması Genel Müdürlüğü*) in 1965 under the Ministry of Health. These two laws mark the beginning of the concept of family planning in Turkey. An examination of the early period between 1923 and 1965 will provide a background for the establishment of the concept of family planning in Turkey. The policy developments will be examined in three parts, as mentioned above. The first part will focus on 1923 to 1958. The second part will cover from 1958 to 1965. The last one will examine the period from 1965 to 1978. I argue that each period had significant policies in itself and thus should be analyzed separately.

First, the separation between the pre-1965 and post-1965 periods presents the official policy change on family planning issue and population policy. Actually, the pre-1965 official policy is characterized by a pronatalist policy, which refers to the practice of encouraging the bearing of children and government support for a higher birth rate in the country. The period witnessed important legal changes together with some government aids for larger family, as will be described below. After 1965, with the help of the Law on Population Planning (*Nüfus Planlaması Hakkında Kanun,* no.557, 1 April 1965), an anti-natalist policy ruled in Turkey due to concerns with

limiting population growth. Overall, it could be argued that the government policy aimed to lower the overall birth rate. Several reasons such as international concerns and the population boom issue helped shape the policy concerns of this period, the details of which will be given below.

The periodization will be finished in 1978, a date which had a key role in history, and the international context as well. In 1978, The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC) in Kazakhstan as mentioned before. This declaration underlined the necessity for providing health of all people of the world and stressed primary health care, which also includes family planning issues. This transition in international context also affected the Turkish context, as the details will be given in Chapter 4.

Another important break is the year of 1958, also could be taken as a turning point for the transition to the anti-natalist policy. The official policy did not change in one night. It had a history to be established a background and the date of 1958 had a crucial role in this process. In 1958, a commission that was part of the Ministry of Health and Social Assistance[20] (MHSA, the old name of the Ministry of Health in Turkey) established with government support published a report on abortions and the attempts to procure abortion and stated the steps to prevent criminal abortion in Turkey. It was the first official document on abortion. It was an indication that "criminal" abortion and maternal death were acknowledged and examined by the government as well. In addition to this, in 1958 there were some published articles on this issue in the journals and newspapers of the day.

Within this framework, this chapter examines these three periods in terms of policies, institutions, laws, research, speeches, reports, five-year development plans,

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[20] Sağlık ve Sosyal Yardım Bakanlığı

government decisions, and some published articles by decision makers on this transition in the issue of family planning in Turkey.

Pronatalist Policy in Turkey

According to Dixion-Mueller (1993, as cited in Özberk, 2006), the aims of population policies are to determine population size, growth, distribution, and demographic variables in general. There are three determinants to set a population policy, which are reproduction policies that influence population size, health policies that influence the rate of death and illness, and migration and urbanization policies. As this study focuses on reproduction policies in Turkey it will also be concerned with health policies since there is a close interaction between these two policy spheres.

According to Metiner, who was the first General Director of Population Planning, appointed as the director of a family planning organization (1965; 135), Turkish policy in the early 1920s was to increase the population at a maximum rate, especially to cover the results of the manpower losses in wars from 1911 to 1922. In the 1920s, the population of Turkey was only 13 million. (Akın, 2010: 448). The aim of the pronatalist policy was to increase the population because of the many losses during the Turco Italian War[21], the Balkan War, the First World War and the War of Independence. In these fifteen years, there were millions of deaths in country. The other reason of high death rates was illnesses such as typhus, malaria, and smallpox (Akın & Sevencan, 2006: 1-14). As told above, Tthere were some justifiable reasons to apply pronatalist policy in Turkey.

[21] Trablusgarp Savaşı 1911- 1912

Pronatalist policy, which would be quitted around the 1960s, begun to be applied in the 1920s, as there was a need to expand population in the shortest time possible. Therefore, the importation of contraceptives was prohibited, abortion was made illegal, and advertising and education concerning contraceptive methods and materials were prohibited, big families were promoted, and lastly financial incentives for large families were provided.

Another point Akın makes is the high level of infant mortality associated with the poor economy and the need of manpower for agricultural activities (Akın, 2010: 448; Akın & Sevencan, 2006: 1-14). For Döngel (2006: 11), the main reasons for this policy were the insufficient labour force, need for a defense force, and the high death rates among infants and children.

During that time, many legal changes were undertaken to stimulate the birth rates, directly and indirectly (Döngel, 2006: 11). The Republican elite believed that the basis of a strong nation state was a healthy, fit, loyal and numerous population. This population was needed to serve as a strong "military power" during wartime and also as "economic power" as a base for industrial development. There was a need for a new generation citizens loyal to the Turkish state, the manpower for the economy, and soldiers for the army. The aim was to develop the country in the shortest time possible to catch up with the industrialized countries that had already started to become industrialized.

Pronatalist Policy from the 1920s

The pronatalist policy was enacted with a series of laws. Before examining the laws, several speeches in the Turkish National Assembly and various

publications on this issue that put the emphasis on increasing population size should be discussed. Mustafa Kemal Atatürk underlined the issue of the population "problem" in his speech in 1 March 1923 (Güriz, 1975: 42). In a speech on 1 November 1924, he mentioned the epidemic diseases and their negative effects on population growth (Güriz, 1975: 43).

After 1930, the Italian policy on increasing population was monitored carefully among policy makers and leaders in Turkey (Güriz, 1975: 51). In 1932, a booklet titled *Policies on the Population Issue* was translated into Turkish from Italian by Yusuf Adil in order to present the Italian pronatalist policy. It focused on the principles of population policy as applied by Mussolini (Güriz, 1975: 51). It was obvious that setting the principles of pronatalist policy in Turkey had been affected by the Italian pronatalist policy. The aim was to increase the population in Italy, as well. Actually, the government of Italy desired territorial expansion in Europe along with increasing its population (Güriz, 1975: 59).

The legal changes made in Turkey were similar to those in Italy. In this process, it is obvious that Turkey took Italy as a role model in order to adapt a pronatalist policy.

Lastly, Yaşar Nabi Nayır wrote an article titled "Turkey in the Face of Population Issue" in *Ülkü Halkevleri Dergisi* in 1939. The article offered three recommendations fot the population issue. These were decreasing the death rate, increasing the birth rates, and the need for migrants in Turkey.

These speeches, articles, and translations show that the Turkish government, policy makers, and opinion leaders were focused on finding a solution to keeping the pronatalist policy in practice. The direction of the movement was top-down to build and practice an appropriate pronatalist policy. The laws that were enacted by the

government and policy makers in Turkey require examination.

In the Turkish Criminal Law passed in 1925, induced abortion was a punishable crime except when the life of the pregnant woman was in danger (Tezcan et al., 1980). The Penal Code of 1926, which was adapted from the Italian code, made abortion illegal. Induced abortion remained a crime. The minimum marriage was accepted as 18 for men and 17 for women (Özbay, manuscript to be published in 2012; Güriz, 1975: 143; Özberk, 2006). According to Akın (2007),

> The laws on Local Administration and on Municipalities, passed in 1929 and 1930, respectively, imposed several obligations on local administrations to implement the population increase policy by improving public health, establishing free maternity hospitals, and distributing medicines to the poor for free or at low cost.

In addition to these, the 1930 Law on General Hygiene[22] was the most obvious legislation in relation to the pronatalist position of the Turkish government. It provided obligations to the Ministry of Health to encourage births and to grant monetary awards or medals to women who had six or more children. Moreover, it also prohibited the importation, production and sale of contraceptives (Özbay, manuscript to be published in 2012; Akın, 2007).

In 1936, the Turkish government increased the penalties for induced abortion and punished any action that attempted to avoid conception. Family planning education was forbidden. The Law of Public Health deneed that birthing services were to be free in state hospitals. In 1938, the minimum age for marriage was reduced to 17 for men and 15 for women (Piyal, 1994: 2). Also, it gave the priority for land distribution to families with many children. In 1944, the government gave public sector employees modest child support payments. In 1949, the government provided income tax reductions based on the number of children (Güriz, 1975).

[22] Umumi Hıfzıssıhha Kanunu

Untill 1953; the penalties for abortion were again increased (Özbay, manuscript to be published in 2012; Akın, 2007; Güriz, 1975). During the pronatalist period, a number of laws attempted and a number of laws granted tax exemptations for children (Güriz, 1975).

As seen above, a number of legal changes were introduced to support the pronatalist policy in that period. Moreover, health policies were also used to support the population policies in Turkey in that period.

In that context, the contents of the law should be analyzed from the feminist perspective as well. According to Karaca Bozkurt (2011: 68), there was no gender perspective in the process of the enactment of these laws. Especially, women and their needs were ignored in that process. The responsibility of the reproductive rights of women did not belong to women; the decision process of having a child was a part of state policy directly, and indirectly with the help of laws and pronatalist policies. The government had domination over women's bodies and women's decision. Women's decisions were manipulated according to the state policies. However, it should not be forgotten that in this period in fact other laws and policy were not gender sensitive either.

In light of the pronatalist policy, it will be meaningful to look at the numbers on population and the annual growth rate of population. In 1927, there were 13,648,270 people. Despite of the pronatalist policy, the population increased to just 16,158,018 in 1935. Between 1935 and 1945, there was no significant growth in population; on the contrary, there was a decline. The reason was the affects of the Second World War. However, after 1945, there was a leap especially between 1945 and 1950, when a significant increase was experienced in Turkey, as well in the world (Piyal, 1994: 2).

Table 2. Population in Turkey (1927 – 1960)

Year	Population
1927	13,648,000
1935	16,158,000
1940	17,821,000
1945	18,790,000
1950	20,947,000
1955	24,065,000
1960	27,755,000

(TUİK, Population, annual growth rate of population and mid-year population estimate, 1927-2000; Piyal, 1994: 4)

Table 3. Annual Growth Rate of Population in Turkey (1927 -1960)

Period	Annual population growth rate (‰)
1927 - 1935	21.1
1935 - 1940	17.0
1940 - 1945	10.6
1945 - 1950	21.7
1950 - 1955	27.8
1955 - 1960	28.5

(TUİK, Estimations of population growth rate, 1927-1985; Piyal, 1994: 4)

The Situation after the Second World War

In the twentieth century, there was an unprecedented increase in world population. In the 1900s, the population had been 1.7 billion, but in 1950, the population was 5.7 billion (Hartmann, 1995). After the Second World War, almost all developing countries had population booms. The single reason was not high fertility rates, but a decline in fatality rates. Improved health conditions, living conditions, good nutrition, developed health services and better housing were developed. The average age of death rose (Sönmez, 1980: 2). Moreover, after 1950, it became also more valuable to have a strong-armed force instead of simply keeping large number of soldiers. With the 1950s the high population growth rates caused an

increase in urbanization (Döngel, 2006). In that rapid urbanization process, agricultural mechanization, which started after 1950 in Turkey, also had a big effect on migration from rural to urban areas. According to Sönmez, a collective solution was needed not an individual one for high population growth rates.

The pronatalist policy was not effective during the Second World War. However, after the Second World War, population growth started to increase rapidly in Turkey. In the period from 1945 to 1960, there was a significant demographic change. Metiner writes that,

> From 1958 to 1962 various studies revealed that the rate of increase of population was about 3% to 3.2%, the age group 15 years and younger was 41.5%, the births per 1,000 were about 45 per year, and the death rate had been reduced to about 13 per 1,000 per year (Metiner, 1965: 135).

The high population growth rate was seen as a barrier to development. Starting with the 1960s, international organizations and the Turkish government started to discuss on this "problem."

The incidence of abortion started to increase in the late 1950s as a result of the increased cost of rearing children, the decreased benefits of having many children, the gradual rise in the status of women in society, and the lack of adequate family planning services. As a result, induced abortion became a very important medical and social problem in Turkey (Tezcan et al., 1980).

In 1952, the Maternal and Child Health Organization[23] within the Ministry of Health and Social Assistance (MHSA) was established. The organization cooperated with the WHO and UNICEF. The Universal Declaration of Human Rights, which is accepted as a basic document in international context, was signed in 1948. In this document, there is no direct reference to reproductive rights, but there are some

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[23] Ana Çocuk Sağlığı Şube Müdürlüğü

articles that indirectly refer to reproductive rights such as the right to life, freedom of conscience, health issues and welfare (they are seen as a reference to reproductive rights by several decision leaders in the 1950s in Turkey) (Türkiye Aile Planlaması, 1997).

However, in 1954, population issues started to be discussed in the international context. The United Nations summoned a population conference, but it had a rather technical perspective on the population “problem”. However, with the effect of the development perspective that started in the 1960s, a conference in the context of population policies in Bucharest in 1974 was convered. In this period, population policies became a part of development policies (Karaca Bozkurt, 2011). It was obvious that there was a need for a dramatic policy revision in the world, as well in Turkey.

In this context, an attempt started to change the pronatalist policy in Turkey. Thus, the need for permission of contraceptives in country was started to be argued by a group of scientists. One of the scientists in this group was Dr. Zekai Tahir Burak, gynecologist from Ankara. He sent a letter to the Ministry of Health to explain the issues of abortion and contraceptives in Turkey. According to him, although abortion was prohibited by law, many women attempted to induce abortion by themselves or with the help of other people in unhealthy conditions. Thus, this led to a high rate of maternal deaths. He recommended a legal change which was the responsibility of the government (Akın, 2007).

On the basis of this letter, the Ministry of Health charged a commission to research the claim (Güriz, 1975: 88). The results showed that although abortion was legally as a crime, many doctors was lining their own pockets, many women applied to hospitals due to complications of unsafe abortions and many women had lost their

lives. The results substantiated Dr. Zekai Tahir Burak's claims. In advice part, the commission recommended a change in law to the effect that abortion should be legal several conditions and permission should be given for contraceptives in order to prevent unwanted pregnancies (Özberk, 2006; Akın, 2007).

In addition to this, the Ministry of Health took one more step on this issue, conducting a panel meeting to discuss these changes with a number of experts in this area. The outcomes of this panel were similar to those above. They recommended a change in regulations to allow abortion under the necessary medical conditions and contraceptives use as well.

At this time, there were also several articles on population policy to shape public opinion. To Fişek (as citied in Güriz, 1975: 92), the first article published on 7 May 1958 by Haluk Cillov, who would be the Minister of Commerce between 1974 and 1975. In an article titled "Our Population Increases in Our Cities" (*Şehirlerimizde Hızla Nüfus Artıyor*), he explained the problems caused by rapid population growth. A second article published in 1959 by Baykurt, was titled "Over Reproduction" (*Aşırı Çoğalma*) stated that increased in population was not an indicator of the development of the country nor security for future. The need was to have a reproductive population in the country (Güriz, 1975: 92).

Moreover, it was obvious and proved that overly, frequent, and inappropriate age childbearing causes maternal and child death.

Population Boom, the Demographic Transition Model and Its Application in Turkey

To understand the Turkish context from a wider perspective the demographic transition model created by Kingsley Davis might be helpful. In the 1950s, most of developed countries had decreases in their fatality rate and fertility rate. In this sense,

the important point is that the fatality rate compensated for the fertility rate. Thus, population growth in the developed countries stabilized. This process was called a transformation in demography.[24] Population started even to decrease in some developed countries (Hartmann, 1995).

In developing countries, however with the end of the Second World War, in the fatality rates decreased, and the average age of death increased, and fertility rate remained high. This process caused a phenomenon called population boom.

Classic population theory explains fertility rate decline as "demographic transition." The demographic transition model has three stages based on the relationship between the degree of development and the level of the fertility rate of the country. The first stage represents a high fertility rate and a high fatality rate. This stage mostly is seen in pre-industrial societies, because of inadequate health servicing and nutrition levels. Due to the high fatality and fertility rates, population is fixed and does not increase or decrease. The second stage represents a low fatality rate and a high fertility rate. Parallel to the development level of the country, the fatality rate starts to decline, but it takes time to do this. Thus, population growth increases rapidly in this stage. The third stage represents a low fertility and a fatality rate. With the help of the industrialization process, due to placing higher value on women and the high cost of child rearing, the fertility rate becomes low (Hartmann 1995; Özberk, 2006).

It can be argued that in the 1920s, Turkey went through the first stage of the demographic transition model. There was a high fertility rate and a high fatality rate and the population was more or less stable. Between 1935 and 1940, the death rate declined to 0.3 percent and fertility rate increased to 6.7 percent. Turkey passed to

[24] Replacement level of fertiliy is accepted as 2,1.

the second stage between 1940 and 1960. Efficient health servicing decreased the fatality rate, but the fertility rate was 6.85 percent. Due to these rates, the population growth was high. In the 1960s, Gürtan (who would be the founder of Istanbul University the School of Business Administration and had a focus on subject of demography) saw the solution in family planning because the population growth rate and employment opportunities were not in balance and also urbanization had become a problem. After the 1960s, Turkey can be conceived as having reached the third stage, but it took lots of time for Turkey (Paker, 2009) and it had to be wait until the 1980s.

The Change in Policy, 1958 – 1965

The Neo-Malthusian Approach and Developmentalist Perspective

The Malthusian approach began to be used to explain the rapid population growth in developing and undeveloped countries after the Second World War. The Neo-Malthusian approach began to consider the relationship between low quality living conditions and high fertility rates.

According to Karaca Bozkurt (2011), the Neo-Malthusian population approach that was formed by reshaping the Malthusian population approach argues that rapid population growth is a barrier to development for countries. This approach was used for controlling the rapid population growth rates of developing countries, especially after the Second World War. In addition, international organizations were influenced by this Neo-Malthusian approach. Population control and family planning programs began to be practiced in many developing around the world in the 1960s.

However, these population policies ignored the individual needs and demands of women and men and their living conditions. The aim was to control women's reproductive capacity in order to control population growth rates. However, these practices violated women's reproductive rights.

In Hartmann's opinion (1995), rapid population growth was not a cause of the development problem; on the contrary, rapid population growth was a consequence of development. He stated that population and family planning should not be imposed people in a top-down manner; first, government should improve primary health care. Thus, if family planning were practiced just with the aim of slowing population growth, women's reproductive right and welfare would be violated.

Without waiting to reach industrialization, high living standards, and a low fertility rate, the population planning programs, which were taken from developed countries as a model, were applied. However, there was a big impact of developed countries that wanted to decrease population growth rates in undeveloped and developing countries in this process. Population and family planning programs were spread rapidly around the world (Hartmann, 1995; Özberk, 2006; Abramitzky and Braggion, 2009, as citied in Karaca Bozkurt, 2011).

Hartmann put emphasis on the role of undeveloped countries in this game. However, he emphasized another issue, one related to the distribution of wealth in countries and the world. He stressed that undeveloped countries faced starvation not because of insufficient resources, but because of their inequitable distribution in the world (Hartmann, 1995).

According to Hartmann, the Malthusian approach was West-centered. Because of that, in developing and undeveloped countries, the policy, which included

population and family planning, ignored women's health and individual reproductive rights. The aim just focused on reaching the targeted numbers in the shortest possible time and this aim could ignore the individual woman's rights in order to reach these targeted numbers and catch up with the welfare level of developed countries. However, the population problem was not just about rapid population growth, it was also about the lack of fundamental and individual rights (Hartmann, 1995).

It is important to stress the consequences of the developmentalist perspective and its impact to explain the change in the population policy in Turkey and in the international context. According to Akın (2007: 1), in the 1960s, mostly developed countries began to discuss the negative effects of uncontrolled population growth on economic and social development. The first reason to change the pronatalist policy in Turkey was the adoption of the developmentalist perspective and the aim of planning Turkey's future.

The second one was the high maternal death rate. As mentioned before, family planning had a positive effect on decreasing the number of maternal deaths as well. These two issues affected the development planners and demographers a great deal in Turkey.

The Players on Changing the Policy in the International and Internal Context

According to Smith, in the 1960s, the concern was to make family planning services available on a large scale to the population of the less developed countries of the Commonwealth. These countries' governments were supported to conduct family planning programs in the 1960s and 1970s (Smith, 1975: 31).

The big financial contributions came from organizations for international development. Developed countries provided large amounts of financial aid to these organizations to prevent rapid population growth in developing and undeveloped countries. Developmentalist economists thought that rapid population growth in undeveloped and developing countries was a barrier to the development of the whole world.

In this period, countries like China and India, which had rapid population growth, were given as examples to support the claim that because of high population growth, there would be not enough resources for all of the world's population. This period also saw an increase in the use of the IUD and birth control pills as contraceptives (Özberk, 2006). At the beginning of the 1960s, the usage rate of contraceptives was 10 percent, but in the mid-1960s, this rate increased to 45 percent in developing and undeveloped countries (Entre Nous, 1989, as citied in Karaca Bozkurt, 2011: 19).

It was understood that applying population and family planning programs was only possible with the help of other developed countries and organizations for international development. Especially after the Second World War, organizations of Bretton Woods agreement such as the World Bank and International Monetary Fund (IMF) had a crucial influence by providing the budgets for population and family planning programs in undeveloped and developing countries (Sen & Snow, 1994, as citied in Karaca Bozkurt, 2011: 20).

In addition to the United Nations Population Fund and the World Bank, the United States, Japan, Germany, the Netherlands, Norway, and Sweden had important roles in transfering the population and family planning programs to undeveloped and developing countries, and conducting the globalized population policy in those

countries in the 1960s. Agencies, like the US Agency for International Development (USAID), the International Planned Parenthood Federation (IPPF), and the Population Council played roles in this process (Hartmann, 1995; Özberk, 2006).

At the end of 1960s, Robert McNamara, who was the president of the World Bank, became the leading advocate for controlling population. World Bank experts directed top management of the administrations in countries to improve their population policies (Hartmann, 1995).

However, the point Hartmann (1995) stresses is that the policies imposed or the help for policies by developed countries not only ignored women's reproductive rights, but violated them. Feminists and supporters of women's health criticized the applied policies to serve only economic aims with the help of international countries and donor countries, ignoring women reproductive rights and demands. It brought mostly negative effects to women. According to feminists, cuts to social state budgets increased women's responsibility on the reproductive issues (Sen & Snow, 1994, as citied in Karaca Bozkurt, 2011: 20). In that period, the important point is that there was a lack of organized feminist action, supporters of women's health, and critical thinking about these policies in Turkey.

In the Turkish case, in response to the results of the commission that was employed in 1958 by the Ministry of Health and Social Assistance; the State Planning Organization and the Ministry of Health and Social Assistance (MHSA) decided to work together (Piyal, 1994: 2). Moreover, during that process, there was collaboration between the media, the scientific community, leaders of thought, the Ministry of Health, Obstetric/Gynecology associations, and public health specialists (Akın, 2010: 449).

Before starting to explain the policy changes, it will be meaningful to look at the population and annual growth rate of population in that period in Turkey.

Table 4. Population in Turkey (1955 – 1965)

Year	Population
1955	24,065,000
1960	27,755,000
1965	31,392,000

(Source: TUİK, Population, annual growth rate of population and mid-year population estimate 1927-2000; Piyal, 1994: 4)

Table 5. Annual Growth Rate of Population in Turkey (1950 – 1965)

Period	Annual population growth rate (‰)
1950 - 1955	27.8
1955 - 1960	28.5
1960 - 1965	24.6

(TUİK, Estimations of population growth rate, 1927-1985; Piyal, 1994: 4)

The Role of the State Planning Organization between 1959 and 1964

In May 1960, a military coup took place, and many reforms, including legislative changes, were actualized. The new government drafted a constitution that stressed planning and set up the State Planning Organization as a branch of the Prime Minister's Office. The 1961 Constitution and the State Planning Organization were the two main products of the coup of 27 May 1960. Population planning started to become a serious objective of the government. In this planning period, it was believed that the high population growth rate was a barrier to development. Thus, the Ministry of Health and the State Planning Organization decided to focus on changing

the population pronatalist policy to an anti-natalist one.

In 1961, according to Akın, when the preparation of the new population planning law began, there was close collaboration between the Ministry of Health and NGO's (Akın, 2010). In the 1960s, the Family Planning Association was established (1963) by the government with its 20 branches, assisted with educational work and operated several clinics after the enactment of the Law on Population Planning in 1965. According to Akın (2010), changing the pronatalist population policy gradually gained support in the country but more support was needed. In addition to this, the research was conducted during this period, helped to support changing policy. The research will be given in detail below.

In November 1960, the State Planning Organization decided to add family planning to the First Five-Year Development Plan. Nusret Fişek, who was a marked and crucial character in the health sector, worked on the population section of the First Five-Year Development Plan and prepared the Population Planning Law together with the early planners, yet there was a difference in their priorities. The former emphasized the health and human rights dimension of birth control, while the latter was more interested in its economic dimension. However, the maternal health dimension of population planning was not mentioned in the First Five-Year Plan. Although the new population policy was stated in the First Five-Year Development Plan, the Population Planning Law had to wait until 1965.

The population planning policy and program were introduced for the first time in the First Five-Year Development Program. In the past, pronatalist policy had supported the goal of increasing the population. However, the conditions were no longer appropriate for this policy. In this regard, the current pronatalist policy, which prohibited abortion and contraceptives, had to be replaced with an anti-natalist policy

promptly. This change would slow the population growth rate and provide a decrease in the child population percentage.

According to the First Five-Year Development Program aimed for 1963-67 (published in July 1962, during the ninth İnönü government) the following were the steps that should be taken:

> a. The law on the prohibited the spread of contraceptive knowledge and materials, and also import and sale of contraceptive will be abolished.
> b. The personnel employed in health service (doctor, nurse, midwife, health officer, nurse assistant) will be provided knowledge on population planning. Courses on population planning will be added to the curriculums.
> c. Health service personnel will be responsible for providing population planning education and materials to who wants them to take free of charge.
> d. Population planning education will be provided in the context of existing opportunities.
> e. Contraceptives and pills will be provided at low prices and distributed to poor for free of charge [25] (Devlet Planlama Teşkilatı, 1963: 73).

It showed that doctors and government would be the motors of the population planning program. However, it was obvious that there was the need to increase the number of health personnel (Devlet Planlama Teşkilatı, 1963).

The First Five-Year Development Program considered the rapid population growth rate as an obstacle to growth of the per capita income. It can be seen that at every chance, population planning was stressed to lay the groundwork for the legitimation of a new anti-natalist policy (Devlet Planlama Teşkilatı, 1963; Özberk, 2006; Akın, 2007).

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[25] *a. Gebelik önleyici bilgilerin yayılmasını ve gebelik önlemekte kulanılan araç ve ilâçların ithal ve satışını yasaklıyan kanun hükümleri kaldırılacaktır.*
b. Sağlık hizmetlerinde çalışan personele (Doktor, hemşire, ebe, hemşire yardımcısı, sağlık memuru) nüfus planlamasıyla ilgili olarak gereken bilgiler verilecektir. Bu, hem İlgili okul ve kurslarda bu konuda yeni dersler konularak, hem de normal okul ve kurs safhasını geçirmiş personeli yeniden kurslara çağırarak yapılacaktır.
c. Bu kimseler gerekli bilgiyi ve parasız dağıtım söz konusu olduğu hallerde malzemeyi istiyenlere vermekle ödevli olacaktır.
d. Mevcut imkânlardan faydalanılarak nüfus plânlaması eğitimi yapılacaktır.
e. Gerekli araç ve ilâçların ucuza ithali, yurt içinde imali ve muhtaç olanlara parasız dağıtılması imkânları araştırılacaktır (Devlet Planlama Teşkilatı, 1963: 73).

According to the State Planning Organization,

> Undeveloped countries were in competition to raise the standard of living. The countries of the OECD targeted a fifty percent increase in their income over the next ten years. Every developing country worked to raise its standard of living. In this context, rapid population growth should be seen as an obstacle to the "economic" development of Turkey (Devlet Planlama Teşkilatı, 1963).

In the opinion of the State Planning Organization, preventing rapid population growth would bring not just economic development and raise the standard of living, it would also bring development as a whole to Turkey (Devlet Planlama Teşkilatı, 1963). It was no longer possible to pursue a pronatalist policy under the new circumstances.

The focus of the law or new policy was on population policy or on the individual and family. In the First Five-Year Development Program, it was expressed that population planning was not a state intervention into child bearing patterns. However, it was stressed that population planning would provide an opportunity of democratic individual right to have the number of children he or she desired and to procreate at the time of his or her choice (Devlet Planlama Teşkilatı, 1963).

However, the First Five-Year Development Program did not address the issue of maternal deaths caused by illegal abortions and it established no links between the fertility of women and their social status in society. Normally, a low fertility rate would provide women to be involved in the work force. However, it should not be forgotten that it was not realistic to hope for women's participation in the labour market because women in the 1960s did not have adequate qualifications to be active in the labour market.

Again, the First Five-Year Development Program and policy change in the 1960s aimed to achieve economic goals with the help of the developmentalist approach in Turkey.

During this policy transition, Turkey received support from international organizations as well. In 1963, the government asked the Population Council to send experts to analyze the demographic circumstances. A team from the Population Council conducted a field survey, called the Knowledge, Attitudes and Practices Survey (KAP), to determine the feasibility of a nationwide program of family planning. A dollar budget was provided from the Population Council and a 4.5 million liras budget provided by the Ministry of Health (Metiner, 1965: 135-136; Akın, 2007; Akın, 2010). The results showed that there was a need for family planning policy to be implemented by the government, especially in the rural areas. Moreover, it showed that most of the families wanted to have more information on contraceptives (Akın, 2007).

In 1964, a Turkish delegation was sent to the United States to receive training on aspects of family planning (Metiner, 1969: 136). The Ministry of Health established a Family Planning Organization. The first director of the new Family Planning Unit in the Ministry of Health was appointed in 1964 (Akın, 2007: 87).

There were some studies related to abortion in Turkey that helped the enactment of no. 557 legislation, mentioned above. Tezcan (et al., 1980) presented them in three parts, hospital- based, community-based, and nationwide studies. Some of them will be given as an example in this part.

One of the earliest studies was hospital-based and conducted in 1959 by Burak. Five thousand women who applied to the Ankara Maternity Hospital for different reasons with abortion histories were interviewed. The results showed that twenty-seven percent of the women who had had abortions had become infertile. Even though the sample was a selective one, according to Tezcan (et al., 1980), the study had great historical value, because its findings were used later to argue for a

change in the pronatalist policy of Turkey to permit the sale and use of contraceptives. The second one was Esendal's hospital-based study (1962). He drew his sample from women who had came to his private practice in Ankara between 1953 and 1957. According to his study, thirty-nine percent (760 women) reported having had at least one induced abortion.

The last type of study conducted in that period was community-based. In this sense, Tezcan gave Fişek's study, which was conducted to research the extent of maternal and infant death and abortion in 137 villages, as an example of these efforts to change the pronatalist policy. The survey was conducted in the west and central Anatolian regions in Turkey. Twenty-nine percent of 7,029 married women younger than 45 reported having had one or more abortions. This was the first community-based study concerning child and maternal health and abortion in Turkey that was not covered in the First-Five Year Development Program.

The Enactment of the Law on Population Planning and Its Financial Sources

After these preparatory steps, the Turkish government developed a new law to provide the legal framework for a nationwide family planning program. This law was passed by the Assembly and was signed by the president on 10 April 1965. The Population Planning Law (*Nüfus Planlama Kanunu*) was a result of close cooperation between the government, scientific communities and NGOs.

The Population Planning Law stated as follow;

> The term "Family Planning" shall mean the right of each individual to have the number of children he desires and to procreate at the time of his choice. This right may be exercised solely by the use of contraceptive methods. Except in cases where medical intervention is essential, the interruption of pregnancy shall be prohibited, sterilization and castration are being likewise prohibited (The Law on Population Planning "Nüfus Planlaması Hakkında

Kanun", no. 557, *Resmî Gazete*, 1 April 1965).

With the application of Law no. 557 in 1965, the right of family planning was allowed. According to this law, having the desired number of children, importing birth control methods, supporting the health education of couples, and supplying free birth control services in public health organizations were permitted (Güngördü, 2003; HUIPS, 2004, as citied in Döngel, 2006: 11).

Lastly, during the First Five-Year Development Program period (1963 - 1967), the government made intrauterine contraception device (IUDs) and oral contraceptives available to the public, established 215 family planning clinics and 3 mobile rural teams, and trained 425 gynecologists and general practitioners for inserting the IUDs (Fişek, 1969: 473).

With the Population Planning Law in 1965, the prohibition on contraceptives and abortion was partially abolished. With the context of the Population Planning Law, implementation responsibility was given to the Maternal and Child Health Organization (established in 1952) under the Ministry of Health (Özberk, 2006; Akın, 2007).

The other official institution established in 1965 was the Population Planning Directory (*Nüfus Planlaması Genel Müdürlüğü*) (after a while, the name of this institution will be changed as the General Directorate of Mother and Child Health and Family Planning (*Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü*)) under the Ministry of Health (AÇSAP, 2009). The name of the institution showed also the intent of the policy change. Actually, the aim was to control the population, not to consider maternal and child health as a priority. As mentioned above, maternal and child deaths were not mentioned in the First-Five Year Development Program either. The preferred aim was to focus on population planning and to solve the

population “problem” in line with the developmentalist approach. According to Berelson (1969), the costs of national planning programs were low compared to the calculated economic value of a slower rate of population growth (Berelson, 1969: 357) due to the fact that, the government gave priority to the issue of population growth and establishing a national planning programs.

Lastly, it should be added that international organizations also played roles in that establishment process. They had a big impact on the establishment and application of policy related to population and reproductive health. In this sense, the establishment and application of policy was in the same direction as those of other countries in the world (Karaca Bozkurt, 2011: 78).

When the financial support for the first family planning program in Turkey is considered, there were three sources that made this process easier. Part of these finances came from national funds from the Ministry of Health’s budget. Another source was grants from the agreement between the Ministry of Finance and the USAID. Lastly, there were grants and technical assistance from sources such as the Swedish International Development Cooperation Agency (SIDA), the Population Council, the Ford Foundation and the WHO, all of which worked on population issues (Akın, 2007).

The Socialization of Health Services in 1961 and Its Relationship with the Population Planning Program

Before considering the effects of the Population Planning Program, it will be meaningful to discuss the Socialization of Health Service and its relationship with the Population Planning Program. Law no. 224 of the Socialization of Health Services passed in 5 January 1961 aimed to socialize health services by employing a horizontal organizational structure (Kurt & Şaşmaz, 2012: 21). It states that the units

were more in equality between each other and the prevalence of the health care system were given emphasis. According to Kurt and Şaşmaz (2012), there were always political objections to the socialization of health services, and a complete socialization was never achieved due to the different political attitudes toward health care services by the parties in power. Thus, there was not stability in the process of the socialization of health services. According to Aksakoğlu, the whole process took 22 years and was completed in 1983 (Aksakoğlu, 2008; Kurt & Şaşmaz, 2012; Günal, 2008; Fişek, 1966).

In 1961, the Turkish government decided to nationalize health services and decided to implement the new services on a province by province basis between 1963 and 1982. Thus, the provinces were socialized one after another. According to Fişek (1974), by 1973, health services were nationalized in 25 out of 67 provinces. The socialization model could be analyzed as an attempt to bring universal health coverage to all citizens based on the principle of equality. The law's objective was to extend health care, including preventive and environmental services and health education to the whole country. The aim was to make health services easily and equally accessible to everyone.

In its earlier stages, the socialization model did not work well. However, it had a great importance in the establishment and application of the population planning program throughout the country. Population planning activities were considered a part of preventive health services. The socialization of health services allowed for the implementation of the population control policy. The socialization of health services, including reaching the farthest villages (especially rural areas) and teaching people modern birth control methods, was considered the most proper and useful model of organization. In addition to this, both the socialization of health

services and the population planning policy aimed to improve the living conditions of the rural poor who lacked basic services.

Fişek underlined the importance of the population planning program in the socialization of the Turkish Health System and proposed using an integrated service, which meant the health care services and population planning program would be implementing together. According to him,

> There are three main reasons in favor of an integrated service. First, population control is a continuous operation and requires confidence and close relations between the public and the workers for satisfactory results. Second, women, especially in conservative countries, are shy and do not like to be seen taking an interest in birth control as such. It is much easier for them to apply to a multipurpose clinic or worker for advice on birth control. Third, since the type of personnel and equipment necessary to run a population control program would duplicate those of a maternal and child health clinic, an independent organization for population control would be an unnecessary and wasteful use of resources (Fişek, 1965: 302).

It is hard to say the socialization process was a total successful or a failure. However, it is obvious that it helped the spread of the population planning program to the whole country, especially to rural areas, thanks to regional health care centers and mobile servicing teams.

Anti-natalist Policy in Turkey

The Population Planning Law and Its Denotation

With the help of the Population Planning Law, women gained the right of protection against unwanted pregnancies. However, women who became pregnant against their will did not have a chance to undergo abortion by their own accord. Because of the lack of this right, women did not have control of their own bodies.

Thus, it was not possible to say that the protection of women's health rights was improved by means of that law. Intentional abortion was still prohibited. For that reason, induced abortion in unhealthy conditions continued to comprise took an important part of the maternal death rate (Akın & Sevencan, 2006: 1-14).

Another point necessary to stress was that the IUD was provided free of charge to women, but condoms were not provided free. Thus, the responsibility of family planning was given to women in a sense (Akın, 2007).

After the Population Planning Law Period

Freedman and Berelson (1976) considered the population planning program in Turkey to be weak. They gave several statistics related to the development of the program as follows;

> Turkish fertility is clearly on a downward trend, from a crude birth rate of about 40 in the mid-1960s to about mid-30s in the early 1970s. Current users of contraception increased from 22 percent in a 1963 national survey to 32 percent in 1968, but about three-fourths of that use represented the folk methods of withdrawal and douche. The national program established in 1965 has never been energetically pursued or widely operative, and indeed only about 2 percent of MWRA use the IUD, the program's central method (Freedman & Berelson, 1976).

In additon, the number of population and annual growth rate of the population show the slowness and partly ineffectiveness of the beginning period of the population planning program.

Table 6. Population in Turkey (1960 -1970)

Year	Population
1960	27,755,000
1965	31,392,000
1970	35,605,000

(TUİK, Population, annual growth rate of population and mid-year population estimate, 1927-2000; Piyal, 1994: 4)

Table 7. Annual Growth Rate of Population in Turkey (1955 – 1970)

Period	**Annual population growth rate (‰)**
1955 - 1960	28.5
1960 - 1965	24.6
1965 - 1970	25.2

(TUİK, Estimations of population growth rate, 1927-1985; Piyal, 1994: 4)

After the enactment of the law, there was a small decrease in the population growth rate, but not at the desired level. According to Akın (2010), after the acceptance of the law, public knowledge about family planning methods, and the prevalence of modern methods were increased, but traditional family planning methods were still commonly used. As stated by Fişek,

> The diffusion of family planning practice, however, has been relatively slow: to date, about two-thirds of the married couples in Turkey still do not practice contraception, and most of the remaining one-third use ineffective, traditional methods, particularly coitus interruptus (Fişek, 1978: 103).

The illegal abortion rate also had increased. Therefore, it could be said that the law and not prevent induced abortion and its consequences.

It will be meaningful to look at the reasons why the population planning program did not work as desired in Turkey. According to Fişek (1969), after the new policy was accepted, the government faced some difficulties in getting the program underway. One major problem was active opposition from some part of the intelligentsia's rejection of the program. The other two were the relatively low level of education and the inadequacy of the rural health services, which was stressed also in the process of the Law on the Socialization of Health Service.

The education problem in Turkey was one of the key reasons for the inadequacy of the national family planning program. According to him, education promoted and facilitated the acceptance of new and progressive ideas and practices. Also, small family size tended to increase the education level of households. In addition to these, the negative attitude of the public should not be forgotten (Fişek, 1969: 467).

Another issues on which Fişek put an importance on was the level of urbanization. It was obvious that the level of urbanization brings higher use of contraceptives and a decline of the number of children couples had.

Fişek wrote an article on the problems in starting a program (Fişek, 1965). His critics of the policy change process are remarkable. According to him, the problem had to do with the name and the definition of the program. He differentiated between the terms “birth control”, “family planning”, and “population control”. He stated that they were not synonymous. To his mind, the preferable term was “population control” because it reflected the aim much better than the others. The term represented the effort to raise the standard of living of the developing countries (Fişek, 1965: 297). It should be remembered, Hartmann (1995) also argued that population and family planning programs should not be imposed from the top down by governments. To him, first primary health care should be improved and the standard of living conditions should be raised.

In 1965, at the Family Planning and Population Programs Conference, Fişek stated that Turkey was at the beginning of its family planning effort and put the blame on the Turkish medical profession for the hesitant reception of the IUD in.

> However, many members were still hesitant to accept the IUD for immediate nationwide use even after reading the studies. ... Another point of significant interest is the use of paramedical personnel for IUD insertations. It is difficult to accept this in my country because the medical profession is very

conservative (Fişek, 1965: 807).

Berelson (1969) from the Population Council gave some of the steps of the establishment of new programs. The second step, in which he stressed the political and intellectual leadership and their role of the acceptance of new policy change, is applicable for explaining the failure or inadequate beginning of the program in Turkey. To him,

> A favorable policy does not automatically lead to an effective program: the political and intellectual leadership is often ambivalent about the new policy, and in any case incorporation of a major new program into a bureaucracy is never easy on organizational, fiscal, and personnel grounds (Berelson, 1969: 347).

Another point stated by Berelson in this article was the emphasis on the considerable progress of national family planning programs in the previous few years in Turkey, but he pointed out that the programs still had a long way to go (Berelson, 1969: 379).

The crucial point is to figure out the reasons why the population growth rate did not decline as quickly and adequately as desired. According to Hartmann (1995), children had a vital importance for the family economy in farm laborer societies such those living in Asia, Africa, and Latin America. The children were responsible for taking care of their siblings, working in the fields, taking care of animals, and carring water. Having more children meant having a bigger family economy according to these farm laborer societies. The children added value to their family economy by working in the fields. Children also were seen as an assurance for when their parents are aged. In undeveloped and developing countries, parents just stop having children when they think they have reached adequate number children for the family's needs (Hartmann, 1995; Özberk, 2006; Hardon, 1997). In this sense, it should be borne in mind that during the years of the beginning of the program, Turkey was in transition

from an agrarian society to an industrialized one. Most people earned their bread from agriculture. This schema of social organization influenced the speed and rate of the population planning program acceptance in a negative way among the people.

The other reason for having many children was the high rate of child mortality, since families wanted to be sure to have an adequate number of children to meet the family's needs (Hartmann, 1995). Obviously, the child death rate was high in those years. According to the World Bank data, around 160 infant deaths per 1,000 live births occurred in the 1960s in Turkey.

Another reason for having many children was the secondary position of women in the country. In patriarchal societies, women are sidelined from the development process and it causes them to have more children (Hartmann, 1995). Women could be especially valuable if they gave birth to boys. Turkey presented an example of this argument for those years.

The above arguments show that applying the Neo-Malthusian approach was not a correct or appropriate idea. It had been taken from developed countries as a model for Turkey. However, it was forgotten that the development level was different between these countries and Turkey; and this difference caused several negative consequences.

The Neo-Malthusian approach believed that rapid population growth was an obstacle to the development of countries. This approach is generally practiced to control the rapid population growth rates of developing countries. As Hartmann states, rapid population growth was not a cause of development problem; in contrast to rapid population growth, which was a consequence of under development. Primary health services needed to be developed at first for the sake of population planning programs. Without having passed through the industrialization process,

Turkey applied the population planning program taken from the developed countries, which engendered several negative effects. First, it took long years to spread the population planning program throughout the country, especially in rural areas and among farm agricultural workers. It should not be forgotten that the direction of the movement was top-down, and it took a longer time to for the public to support the program.

Aside from the inadequate population planning program, there were many valuable works published on the population issue in order to improve the program and collect data for it. As mentioned above, Tezcan presented some studies on abortion in three parts, which were hospital- based, community-based, and nationwide studies. Three studies could be given for the hospital- based studies. The first one is Baysal and User's studies, in which 168 women who had visited the family planning and gynecological clinic of the Zeynep Kamil Maternity Hospital in Istanbul in 1970 were interviewed. The second one is Sayın et al.'s study, which focused on 776 hospital abortion cases admitted between 1963 and 1968 to the Haseki Hospital in Istanbul. The third one is Bölükbaşı's study, which presented the 469 abortion cases admitted to the Maternity Clinic of the Medical Faculty of Hacettepe University, in Ankara, from 1972 to 1974 (Tezcan et al., 1980).

The other part was community-based studies. The earliest study on knowledge, attitude, and practice (KAP) was conducted by Özbay and Shorter in the rural part of the Etimesgut district (Özbay and Shorter, 1969; Tezcan et al., 1980). Güven, in the Yenikent rural sub-district of Etimesgut, conducted another study in 1971. A study similar to Güven's was conducted in 1971 in Sincan, a semi-urban district of Etimesgut. Another one is Bumin's study conducted in 1972 on the reproductive histories and gynecological examination findings of 270 married, fertile

women in Sincan. Ayşe Akın conducted another community-based study in 1975 in the city of Ankara with 400 household representative samples. In this study, thirty-five percent of the 2,272 women reported that they had not planned and had not wanted their last pregnancy (Tezcan et al., 1980).

The last part comprised nationwide studies. Four national socio-demographic surveys were conducted in 1963, 1968, 1973, and 1978 (which were repeated every five years). The staff of the Hacettepe Institute of Population Studies (HIPS) conducted the 1968 and 1973 Demographic Surveys. The 1978 survey was conducted with the HIPS and in conjunction with the World Fertility Survey. The questions asked to married women of reproductive age, which was defined as 15-44 years (Tezcan et al., 1980; Hacettepe University et al., 1978). The abortion-related figures from the 1963 and 1968 Demographic Surveys were first reported by Özbay and Shorter (Özbay & Shorter, 1970).

> It was found that 7.6 percent of the 2,555 women interviewed in 1963 and 10.1 percent of the 3,280 women in 1968 reported never having had an abortion. Based on these findings, the author concluded that the prevalence of "admitted abortion" (self-induced or with medical assistance) showed a statistically significant increase in Turkey (as a whole) within the five-year interval between two surveys (Tezcan et al., 1980; 30).

The second groups of nationwide figures on abortion were reported by Fişek in 1972. The data for this report was taken from the National Socio-demographic Survey of 1968. According to this report,

> The total number of abortions in Turkey was estimated at about 270,000 between the summers of 1967 and 1968. The abortion ratio and rate for the entire country were found to be 26.2 per 100 live births and 6.5 per 100 married women of childbearing ages (Tezcan et al., 1980; 31).

There was a significant difference between the regional and rural-urban categories in the abortion ratios. According to Tezcan (Tezcan et al, 1980), together with urbanization, there were different socio-demographic factors such as age, the

educational status of women, the number of living children, modernity values, profession, and the income level of husband, which influenced the difference between abortion ratio in different regions. The abortion ratio increased when woman became more urbanized, modernized, and educated.

The last example of nationwide studies is Kişnişçi and Akın's work and report on the 1973 Socio-demographic Survey in 1978. "Between the years of 1968 and 1973, the ratio of induced abortion rose significantly from 11.8 per 100 live births in 1968 to 16.0 per 100 live births in 1973" (Tezcan et al., 1980; 32). "In comparison to the results of the 1968 survey, the abortion rates and ratio of the 1973 study had declined in the cities and metropolises and risen in the towns and villages" (Tezcan et al., 1980; 33).

These studies show that there was still a widespread need for contraceptives throughout the country. Abortion was a big issue in health care and it needed to have a modification on the law. Actually, the most important point that I would like to stress is that the number of these studies had increased, showing the emphasis on the family planning issue especially by the medical establisment. Thus, the family planning and abortion issues became subjects which could be discussed and the studies helped to see the need of law modification and the discourse change.

In addition to these studies, in 1967, the Hacettepe Institute of Population Studies was founded in response to the worldwide implications of fertility control and the establishment of the national family planning program. The purposes of this Institute was to:

> 1. Set up an Information-Documentation Center and collect data systematically concerning population and population planning in Turkey and other countries, and to distribute these data to official and private organizations for their use.
> 2. Establish a Public Education unit. Improve public education methods and materials, do research, and convey the results to official and private

organizations.
3. Train technical and administrative personnel in population planning and do research in this field (Fişek, 1969: 474).

Last, in 1968, the Survey on the Structure of Family and Population Problem in Turkey[26] was conducted with the collaboration of the Ford Foundation, as mentioned above.

The Second Five-Year Development Plan and Family Planning

The important point that should be stressed is the change of terms in the Second Five-Year Development Plan, which spanned between 1968 and 1972. In this plan, contrary to the first one, the term "family planning" was used instead the term "population planning." In addition to this, the plan put an emphasis on the extension of the family planning program. It reported that 5 percent of the female population in the fertile age group needed to be reached every year and that two million women should be practicing some measure of birth control by 1972.

According to Fişek (1969), the government added 0.50 Turkish liras (9TL=1 dollar) per capita to the state budget in addition to the usual health expenditure to achieve this goal.

In addition, there were several goals in the Second Five-Year Development Plan directed at the practice of the family planning program in Turkey. It was emphasized that regional mobile teams for villages should be created. Family planning education became a crucial debate. One proposition was to put emphasis on the people's education. In order to achieve this goal, it was decided to use radio and

[26] Türkiye'de Aile Yapısı ve Nüfus Sorunları Araştırması

newspaper. Moreover, family planning education program was to be pursued in schools and in the military (Devlet Planlama Teşkilatı, 1966).

The socialization of health services was another important point emphasized in the Second Five-Year Development Plan. Reaching the women in rural areas was one of the main concerns in those years. According to the plan, the socialization process also could help to educate rural women and help in the application of the family planning program throughout the country (Devlet Planlama Teşkilatı, 1966: 180).

According to the plan, by the end of 1966, 38,000 IUDs had beeen placed in women and 80,000 women had received family planning services. However, reaching rural areas and villager women remained difficult. Thus, the plan suggested first to spread and improve the preventive health care service, which also includes the family planning service, in order to reach those women (Devlet Planlama Teşkilatı, 1966: 248). After a while, in addition to free IUDs, Pills and condoms became free of charge (Akın, 2007).

In 1967, U Thant, who was general secretary of the United Nations, said the following in a speech related to population:

> The Universal Declaration of Human Rights accepts the family as the natural and basic unit of society. Members of the family should decide on the number of children they will have and no intervention is acceptable. However, it will not be possible to apply that right without getting information and education. Thus, reaching the information and provided service should be seen as basic rights of people (United Nations Population Division, 2003, as citied in Karaca Bozkurt, 2011: 22).[27]

[27] *İnsan Hakları Evrensel Bildirgesi, aileyi toplumun doğal ve temel birimi olarak tanımlamaktadır. Ailenin büyüklüğüne ilişkin tercih ve kararlara kuşkusuz aile üyeleri karar vermeli, aile dışından bir müdahale olmamalıdır. Ancak ebeveynlerin özgürce tercih yapmaya ilişkin bu hakları, kendilerine açık olan imkanlar hakkında bilgi sahibi olmamaları halinde bir anlam ifade etmeyecektir. Bu nedenle, her ailenin bu alanda bilgiye ulaşma hakkı ve sunulan hizmetlerin varlığı, giderek temel insan hakları arasında yerini almakta ve insan onurunun ayrılmaz bir parçası olarak kabul edilmeye başlanmaktadır.*

As seen above, international organizations especially the United Nations Population Division, accepted access to family planning services and information as a human right. It was in the same direction as the Second Five-Year Development Plan's purposes in the rural areas.

In 1968, at the Human Rights Conference in Tehran, Iran, the UN member states agreed that, "Parents have a basic human right to determine freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect" (Hardon, 1997: 3). This statement was also in the same direction as the above and the Second Five-Year Development Plan's purposes, as mentioned.

The 1970s

The 1970s were characterized by the rise of the demographic approach in the social policy sector (Akın, 2010: 1). The developmentalist approach, which was dominant in the 1960s, continued to have influence during the 1970s. However, because of the continuation of self-induced abortion (despite its prohibition) and its negative consequences on women's health caused both policy makers and researchers to reconsider the population policy that focused on developmentalist approach.

In order to see the wider picture, it will be meaningful to look at the population and annual growth rates in those years again.

Table 8. Population in Turkey (1965 – 1980)

Year	Population
1965	31,391,000
1970	35,605,000
1975	40,347,000
1980	44,736,000

(TUİK, Population, annual growth rate of population and mid-year population estimate, 1927-2000; Piyal, 1994: 4)

Table 9. Annual Growth Rate of Population in Turkey (1960 – 1980)

Period	Annual population growth rate (‰)
1960 - 1965	24.6
1965 - 1970	25.2
1970 - 1975	25.0
1975 - 1980	20.7

(TUİK, Estimations of population growth rate, 1927-1985; Piyal, 1994: 4)

There was a decline in annual growth rate of the population in the second half of the 1970s. This must have been due to the beginning of the family planning program and the emphasis put on this issue. In addition to this, the UNFPA supported reproductive programs in Turkey by 1971, as well.

According to the Third Five-Year Development Plan, which covered the years between 1973 and 1977, mother and childcare services were not at the desired levels (Devlet Planlama Teşkilatı, 1972). Reaching 250,000 – 300,000 women for family planning services was predicted, but it did not happened. The plan suggested that the integration between health services and family planning program would solve this problem. Importantly, the integration between mother and childcare and family planning issues were suggested. This was the first time that mother and child health in the context of family planning was mentioned (Devlet Planlama Teşkilatı,

1972; Bulut, 1979: 21). This change would provide family planning program a wider prevalence through the health care services in the country.

In 1973, the Demographic Survey of Population Structure and Population Problems in Turkey was conducted with the collaboration of the UNFPA, as mentioned above. One of the questions was "How many children do you want?" 66.6 percent said that they wanted to have three children or less. At that time (1973), according to the survey, the total fertility rate was 5.3 (Fişek, 1998: 204). It shows that there were still unmet needs for family planning in the country.

According to Hardon (1997: 3),

> Reproductive right have been reiterated at UN population conferences, the first of which was held in Bucharest in 1974. This World Population Conference rephrased the 1968 formulation of reproductive rights slightly by assigning couples and individuals, and not just parents, the basic right to decide freely and responsibly on the number and spacing of their children.

It separated the family planning subject from marriage and emphasized the significance of the decision of the number of children as a basic right of the individual.

Two more surveys of importance should be mentioned here. In 1978, the Hacettepe University Institute of Population Studies conducted the third Turkish Fertility Survey, which was a nationwide field survey to provide researches comparative demographic data and statistics for research. It was conducted with the collaboration of the Hacettepe University Institute of Population Studies and the UNFPA. The Institute started the surveys in 1968 and surveys were to be carried out over 40 years.

According to the survey, by 1978, contraceptive use rose to only 50 percent of couples, two-thirds of whom relied on traditional methods with their high failure rates (Akın, 2007). According to the Turkish Fertility Survey (1978), although the

family planning program had been applied, only eighteen percent of women practiced effective contraception (not traditional contraception) (Akın, 2007).

As discussed previously, between 1923 and 1958 the official position was focused on a pronatalist policy. There were several laws that prohibited contraceptives and abortion in the country. The concern was to make the country more powerful among the other countries by increasing the size of the population. After the 1960s, thanks to the Law on Population Planning in 1965 (no.557), an anti-natalist policy dominated Turkey's population policy. When the 1960s came, developmentalist policy, which was effected mostly by the Neo-Malthusian approach, was the key element that dictated the policy on population. It was believed that high fertility rates were a barrier to the development of country.

It should not to be forgotten that these days (1940-1960) were accepted as second stage according to the demographic transition model, which was based on the relationship between the degree of development and the level of fertility rate of a country. Social and economic development was the first concern of the decision and lawmakers and the Turkish government. Until 1966 (the publication date of the Second Five-Year Development Plan) -1968 (the start date for the Second Five-Year Development Plan), the issue was called "population planning," but after these years the term was replaced by "family planning." This change showed the mental change on this issue at the official level. The perspective begun to focus on "family", and the issue become to be considered as related to a narrower frame, as "family."

In the 1970s, in the international context, family planning was accepted as a basic human right, which provides parents to determine freely and responsibly the number and spacing of their children and to access adequate education and information in this respect. In Turkey, the 1970s takes attention with its demographic

approach on population/family planning issue continued; and the developmentalist approach continued to have influence during the 1970s. The different between difference various parts of country (east- west, rural- urban) was one part of the concern about family planning with the effect of the demographic approach. One of the other areas of the concern in light of the demographic approach was the high fertility rate according to years in the country in spite of the legalization of contraceptives.

In these years, surveys began to be conducted with the collaboration of international organizations such as the Demographic Survey (1973) as well. However, at the end of the 1970s, family planning was still a problem for Turkey in terms of expanding it to the whole country as desired and there were still many steps to be taken in order to improve the family planning programs.

CHAPTER IV

THE NEW ERA FOR FAMILY PLANNING AND THE NEO-LIBERAL TRANSFORMATION

This chapter covers the period from 1978 to 2012. Four parts examine the family planning issue in Turkey. The first part looks at the period from 1978 to 1990. In this part, the Alma Ata Declaration will be covered in the international context. In addition to this, the Law on Population Planning *(Nüfus Planlaması Hakkında Kanun,* no. 2827, 27 May 1983), which was modified from the previous one, will be examined in detail. The preparatory process and after effects of the law will be noted. In addition, one of the media campaigns (1988) and several surveys and studies undertaken at regular intervals (such as the Turkish Population and Health Survey) will be given in this part. Lastly, the change in mentality and policy will be examined. In the 1980s, the concern shifted to a concern with health issues, instead of demography or development as was previously claimed.

The second part analyzes the developments of the 1990s. The reproductive health approach is examined in the international Turkish context. The usage of the term “reproductive health” instead of “family planning” was a reflection of the changing approach and the mentality on this issue. The issue began to be considered in a more holistic manner. The concern was not just about family planning, it was also about the whole reproductive health in these years and in recent times. Reproductive health term is an "umbrella concept" (Germain, 1987, as citied in Özbay, 1994), as mentioned previously.

In the third part of the chapter, the 2000s to 2012 and the transition in the Turkish health system brought by the Justice and Development Party (AKP)

government in 2003 will be described. The previous system and the new system will be explained in the context of family planning referring to neoliberal policies and the concept of primary health care. Criticisms and the strengths of the transition also will be covered in this part.

In the last part, the recent family planning situation, which is accepted under the primary health care system, will be presented. Since the transition in the health system, family planning also has been influenced. The changes will be analyzed by referring to my own fieldwork and interviews. In addition, a status analysis of family planning will be given by referring to data from the Istanbul Provincial Directorate of Health. In this part, the discussion will focus on with the help of transition in the health system, how family planning has taken a back seat by referring to the data from the Istanbul Provincial Directorate of Health since 1998.

The Period from 1978 to 1990 and the Modification of the First Population Planning Law

The Alma-Ata Declaration and the CEDAW

In the 1970s, Turkish official attitude concentrated on family planning and its accessibility, and the difference contraceptive use rates between rural and urban areas. However, by the end of the 1970s, the subject had taken a new direction in the international area.

In 1978 (6-12 September), the International Conference of Primary Health Care met in Alma-Ata, Kazakhstan. In this conference, the need for "health for all" was expressed for the first time. The call focused on urgent action for especially primary health care including family planning by all governments, all health and

development workers, and the world communities. The aim was to protect and promote the health of all the people of the world. At the end of the conference, the Declaration of Alma-Ata was published (Declaration of Alma-Ata, 1978).

The conference first strongly stated that health is a state of complete physical, mental and social wellbeing, and not just about the curing of disease or infirmity. It also articulated the existing inequalities in health conditions among people. The message was the need for a reduction in the gap between the health status of the developing and developed countries in order to contribute to a better life quality. The target was to improve primary health care by referring development and social justice by 2000.

In the declaration, the accessibility and affordability of primary health care and individuals' participation in primary health care were declared priorities. It focused on providing promotive, preventive, curative, and rehabilitative services. These include

> promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

As seen above, family planning services was articulated in priorities as well.

All governments were called for urgent and effective national and international action in coordination with other sectors in order to develop primary health care. The International Conference of Primary Health Care pushed the governments in the world to support commitment to primary health care. Cooperation between the WHO, the UNICEF, international and national organizations, non-governmental organizations, funding agencies, and all health workers had also an importance in achieving this goal. In this sense, globalization effects started to be felt in the health

sector as well, also in Turkey. This declaration would be of significant importance for the Turkish Health system, and family planning services in the 1980s. It also would contribute to the official perspective on health and the concern with maternal mortality, which will be detailed below.

The second important international document was the CEDAW. In 1979, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) was adopted by the United Nations. By June 1995, the majority of the UN member states (140 out of 159) ratified it (Hardon, 1997: 3). Turkey signed the convention in 1985 and put into effect in 1986. By 2009, 185 states had ratified it. For the first time, it was declared that "reproductive rights" (this will be given details in the part of the 1990s) should rely on the basis of equality between men and women. Specifically, it recommends that:

> States Parties … shall ensure, on a basis of equality of men and women… the same rights to decide freely and responsibly on the number and the spacing of their children and to have access to the information, education and means to enable them to exercise these rights (Hardon, 1997: 3).

The Law Modification Process before the Enactment of the New Population Planning Law (1978-1983)

At the end of the 1970s and the beginning of the 1980s, in the areas of women's health and population the concern was high maternal mortality rates. Two solutions were suggested, preventing the traditional contraceptive methods usage, and reducing the unsafe self-induced and induced abortion.

For the first one, preventing the traditional contraceptive usage and revaluating the modern contraceptive usage among the couples had a big impact on reducing maternal mortality rate. Research has bund that the prevalence of modern

methods of contraception and the maternal mortality ratio has a negative correlation. When the use of modern contraceptive methods prevails the maternal mortality rate declines. In this sense, it will be meaningful to look at the rates of total and modern contraceptive usage in these years (1978-1983) in Turkey.

Table 10. Contraceptive Use, Selected Years: Percentage of Married or Cohabiting Women Aged 15-49 Using Contraception

Method	1963	1978	1983	1988	1993	1998	2003	2008
Any method	22.0	50.0	61.5	63.4	62.6	63.9	71.0	73.0
IUD	0.0	4.0	8.9	17.1	18.8	19.8	20.2	16.9
Pill	1.0	8.0	9.0	7.6	4.9	4.4	4.7	5.3
Condom	4.3	4.0	4.9	8.9	6.6	8.2	10.8	14.3
Surgical sterilization (female)	0.0	0.0	0.1	2.2	2.9	4.2	5.8	8.3
Coıtus interruptus	10.4	22.0	31.1	31.0	26.2	24.4	26.4	
Other	12.0	12.1	8.6	10.2	3.2	2.8	4.1	
Total effective-method users	5.3	18.0	27.2	32.3	34.5	37.7	42.5	46.0
Total ineffective-method users	22.4	32.0	34.2	31.0	28.1	25.5	28.5	27.0
Unmet need for contraception	-	-	-	-	12.0	10.0	6.0	
Abortions per 100 pregnancies	7.6	16.8	19.0	23.6	18.0	14.5	11.3	10.0

(TDHS data)

According to findings (referencing the Turkey Demographic and Health Surveys, the percentage of married or cohabiting women aged 15-49), in 1978, the total usage of any method was 50 percent, and 32 percent of that were traditional contraceptive methods. In 1983, the total usage of any method was 61.5 percent, and 34.2 percent of them were traditional contraceptive methods. These ratios were still high compared to future date, especially after the enactment of the 1965 law. As mentioned above, these rates also had effect on the high rate of maternal mortality.

The second one, which was the solution to reduce maternal mortality, was to prevent unsafe self-induced and induced abortion. As seen the table above, in 1978, the rate of induced abortion in 100 pregnancies was 16.8. In 1983, induced abortion

in 100 pregnancies' number increased to 19. According to Akın (1992, as citied in Akın, 2007), abortion was used almost as a regular method of birth control by women in the higher socio-economic strata of society. They obtained services from medical specialists at a high cost. However, low-income women often had to apply self-induced abortion, which usually caused injury or death. "Estimates indicate that there were 300,000 induced abortions and 50,000 self-induced abortions in 1981" (Akın, 1992; as citied in Akın, 2007). Here, there were two results. One of the results was the law against induced abortion did not prevent the high rates of induced abortion, especially among high-income women. The second result was the truth on the high maternal mortality rate of low-income women because of unsafe self-induced abortion.

As a result of these two major problems, the modification of the First Population Planning Law (1965) was seen necessary. The aim was to expand the delivery of services and make them more available and equitable (Akın, 2007). In this process, it is necessary to stress several names that made valuable contribution to this process. Professor Nusret Fişek and Professor Ayşe Akın were two major academic figures involved in that law modification process.

According to Akın, this modification process necessitated a well-planned strategy, based on the evidence of scientific studies and the advocacy of lawmakers (Akın, 2007; Akın, 2010).

Several local and national investigations and studies were conducted to show the negative effects of illegally induced abortion (Akın, 2010). One of them was the Nationwide Demographic Health Survey (TDHS) where the analysis was continued at five-year intervals by the Hacettepe University Institute of Population Studies and the Ministry of Health (the Nationwide Demographic Health Survey is still

continuing now). The second one that was articulated by Akın (2010), a multicenter study on the cost of illegal abortion on the health care system conducted with the collaborations of the WHO and the Hacettepe University Public Health Department (1980). The third one was the operation research, which was conducted in conjuction with the WHO in 1979. In this research, it was indicated that trained non-physicians (nurse, midwife) could insert intrauterine devices (IUD) as successfully as physicians. It would be meaningful to increase the prevalence of the modern contraceptive methods among women. The fourth one was the introduction of safe and simple techniques like manual vacuum aspiration (MVA) for pregnancy termination by the WHO in 1981. The last one was the training of general practitioners in pregnancy termination by using MVA in 1981 (Akın, 2007; Akın, 2010). All these researches had a very big effect in the modification of the 1965 Law and its promulgation.

Akın and Fişek believed that research should never be done just for academic purposes. The research results must be used for the benefit of the people and then it needed to be supported to take necessary actions (Akın, 2010: 459). They involved the modification process with their valuable work including the social effects of their research, advocacy efforts, and the persuasion process of the policy change.

The results of the studies were publicized in several meetings, which were organized by the Ministry of Health, NGOs, and universities. The media produced programs and articles on population issues in newspapers, scientific journals, and magazines. At the parliamentary level, workshops were organized by the military government on health care reform.

With the collaboration between the Ministry of Health, NGOs and Universities, all advocacy activities and the scientific evidence from research helped

prepare the enactment of the new law. The new law was completed by the General Directorate of Mother and Child Health – Family Planning in the light of these efforts and findings, and the bill was submitted to the Parliament for their consideration (Akın, 2010).

Within this framework, it is important to stress the point that according to Akın (2010: 455), "for the legalization of abortion, strong opposition arose especially from non-medical decision makers. Fortunately, no serious religious objections were apparent."

On 24 May 1983, the new/ second Population Planning Law (no. 2827) was passed. The law stated that:

> authorizing trained nonphysicians to insert intrauterine devices (IUD), legalizing abortion up to 10 weeks on request, allowing trained general practitioners to terminate pregnancies, legalizing surgical sterilization for men and women on request, and establishing intersectoral collaboration to provide family planning services throughout the country (Akın, 2007: 87).

The necessity of cooperation between the public and private sectors was emphasized. In addition, the law provided permission for educated midwives and nurses to insert intrauterine devices (IUD), the permission for surgical contraception methods such as vasectomies for men and tubal ligations for women, and permission to terminate a pregnancy within the first 10 weeks on request. Özbay (manuscript to be published in 2012) also stressed that the law provided a chance to terminate pregnancy free of charge.

Akın stated in an interview that the bill was accepted as submitted, but that one part of the bill had been changed by the Parliament. It was the time period of the termination of the pregnancy. Twelve weeks as a time period was submitted, but 10 weeks as a time period was accepted.

It took a while to observe the impacts of the New Population Planning Law on

maternal health and family planning practices. Akın (2010: 457) stressed several most significant impacts, the majority of which also were seen in the results of the Turkish Demographic Health Surveys.

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Pill	1.0	8.0	9.0	7.6	4.9	4.4	4.7	5.3
Condom	4.3	4.0	4.9	8.9	6.6	8.2	10.8	14.3
Surgical sterilization (female)	0.0	0.0	0.1	2.2	2.9	4.2	5.8	8.3
Coıtus interruptus	10.4	22.0	31.1	31.0	26.2	24.4	26.4	
Other	12.0	12.1	8.6	10.2	3.2	2.8	4.1	
Total effective-method users	5.3	18.0	27.2	32.3	34.5	37.7	42.5	46.0
Total ineffective-method users	22.4	32.0	34.2	31.0	28.1	25.5	28.5	27.0
Unmet need for contraception	-	-	-	-	12.0	10.0	6.0	
Abortions per 100 pregnancies	7.6	16.8	19.0	23.6	18.0	14.5	11.3	10.0

(TDHS data)

Akın stated that the legalization of abortion made a great impact on the prevention of abortion-related complications and maternal deaths in the country. In addition to this, she emphasized in all but disappearance of maternal mortalities due to unsafe abortions. Hospital beds were not occupied with complications from induced abortions. There also was a decrease in the burden of induced abortions on the health care system and the cost of induced abortion for individuals (Akın, 2010: 457).

In addition to these, as seen in the table, the prevalence of the effective/ modern contraceptives usage went beyond the prevalence of ineffective/ traditional methods usage for the first time. This was the one of the aims of the law. At the beginning, the prevalence of induced abortion increased, but after the 1990s, it started to decrease (and is still in a downward trend). There was a fear of the

probability of increasing the abortion rate and parallel decline in the usage of total contraceptive methods. However, it was understood that this fear was unnecessary. In addition, after the new law, IUD use doubled in next five years. The prevalence of modern contraceptive methods such as IUD had a big importance for this law, as it proved the law successful (Akın, 2010). In addition to the IUD, condom use almost doubled in the next five years as well.

The Fourth Five-Year Development Plan spanning the years 1979 and 1983 was published in 1979 by the State Planning Organization. Mother and child health and the family planning issue were examined under the headings of "Health" and "Tools for Economic Objectives." According to the plan, the efficiency of family planning services was inadequate. The reason why the family planning service was inefficient was partly because the socialization progress of the health system was unsuccessful. In this framework, the advice was to empower the mother and child health and family planning services to improve the socialization program established in 1961 (Devlet Planlama Teşkilatı, 1979: 463). An additional aim was to strengthen the mother and child health and family planning services, as stated in the section titled "Tools for Economic Objectives" (Devlet Planlama Teşkilatı, 1979: 670).

With the 1982 constitution, the institution called the Population Planning Directory was transformed into the General Directorate of Mother and Child Health and Family Planning (*Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü*). Actually, as seen, the conjuncture had slowly started to change. The "population perspective" gradually lost its value, but "mother and child" became important at a slow pace at the policy level. The concerns had started to take a different direction.

In the 1983 law, there was emphasis on establishing intersectoral collaboration to provide family planning services throughout the country. As an

example, the establishment of the Turkish Family Health & Planning Foundation (TFHP*, Türkiye Aile Sağlığı ve Planlaması Vakfı,* TAPV) could be given. TFHP is a voluntary organization (NGO) working for the public interest. The Turkish Family Health & Planning Foundation was established by academics, employers, and businessmen led by Vehbi Koç in 1984. It still carries out of work on reproductive health issues and is a significant actor in connecting with international organizations and the globalization process.

In these years, there was one more nationwide survey on health and fertility. It was the 1983 Turkish Fertility and Family Health Survey with the collaboration the USIAD and the Westinghouse Health Systems. As seen, consistent with the health approach of the 1980s, the word of "Health" was added to title of the survey.

In addition to these, as mentioned before, the globalization process had its effect on the international operations. Turkey signed the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) in 1985 and put it into effect in 1986, as mentioned above.

According to Petchesky (1995), since the 1980s, feminist rhetoric has dealt with the language of "owning" or "controlling" one's body in the domains of reproductive rights.

> Feminist caveats against using the "language of property" or the "language of control" in reference to the female body share a common concern about women's bodily subjection, whether through medical science, population-control agencies, or the patriarchal organization of sexuality and kinship (Akhter 1990, Diamon and Quinby 1988, Pateman 1988, as citied in Petchesky, 1995: 388).

Within this framework, it is really difficult to say that Turkey and "Turkish feminists" discussed these concerns in the 1980s as well. In the 1980s, neither "the language" nor sexuality was a subject of their concerns. This came to Turkey relatively late (as seen in the recent abortion debate of 2012). The status of women

in society began to discuss by several minority groups of feminists in terms of employment and visibility in the public sphere in the 1980s. However, sexuality was a taboo that could not be discussed about in Turkey.

In the 1980s, the approach focused on health, as seen above. The Alma Ata Declaration (1978) had also impact to the application of the health approach in Turkey. Maternal death took a big place in discussions. Efforts to empower women's status were made by referring to the right to live at the beginning. The language, which was used, was ignored. As mentioned in the introduction chapter by referencing to Foucault (2003), sex or sexuality, which is employed for reproduction, could be acceptable in society. He claims that sexuality can be discussed in several areas. One of these areas in which sexuality can be discussed is medical discourse as a health issue. Science became a very powerful tool with which to discuss the sexuality. As seen, Turkey was not ready to examine sexuality or the sexual freedom of the individual, especially women; thus family planning, which is actually about sex/ sexuality, was discussed within the health discourse. The focus point was maternal health and its consequences for the whole of society, which was still a population issue.

In 1984, the family planning issue was examined under the headings of "Population" and "Health" in the Fifth Five-Year Development Plan which spanned the years 1985 and 1989. As mentioned above, the contexts that wer applied for family planning were mostly health and also population. According to the plan, in order to protect mother and child health, family planning should be integrated to other health services (Devlet Planlama Teşkilatı, 1984: 125). The second emphasized point was to provide suitable and efficient family planning services for families to

determine freely and responsibly the number of their children according to their socio-economic level (Devlet Planlama Teşkilatı, 1984: 151).

In 1988, a mass media campaign concerning family planning was conducted in Turkey. In this campaign, the Turkish Family Health and Planning Foundation (TFHP), the Turkish Radio and Television (TRT), the Ministry of Health, the Zet Market Research Services and the USIAD worked together, in an example of intersectoral collaboration. The Mass Media Family Planning Campaign aimed to generate broad support for the national family planning campaign and to promote family planning, the use of modern contraceptive methods, and the use of family planning service facilities. The campaign targeted both men and women in rural and urban areas. After the campaign, to see the results of the campaign, a study was conducted. According to this research, 63% of women felt encouraged to talk with their husbands about family planning issues. In addition, the TDHS 1998 showed that around half of all women and husbands reported that they had heard or seen family planning messages on radio or television (Döngel, 2006: 19-23). This campaign was important to show the intersectoral collaboration and the efforts to promote family planning among the people in 1988.

In 1984, Bulut conducted a study to examine the relationship between providing adequate family planning service in the post-abortus period and the prevalence of modern contraceptive usage. In 1989, Tezcan and his colleagues researched women's socio-economic levels and fertility character in Antalya. In 1981, Turhan studied the relationship between family planning and education in Bursa. Between 1989 and 1991, Bahar examined the education approach on family planning in Etimesgut (Piyal, 1994: 36- 39).

These studies show that the concern for family planning was still alive in these

years in Turkey and that academia tried to contribute with their research. The research subjects were mostly focused on education, method use, and fertility. They showed the inadequacy of the prevalence of modern contraceptives, and the positive correlation between the education level and the family planning methods usage.

In addition to these studies in historical order, there was one more nationwide survey that was the 1988 Turkish Demographic and Health Survey in joint cooperation with the USIAD, the Center for Disease Control, and the Hacettepe University Institute of Population Studies.

Before discussing the 1990s, it will be meaningful to give a brief description of Turkey in terms of family planning by referring to the 1988 Turkish Demographic and Health Survey.

Table 10. Contraceptive Use, Selected Years: Percentage of Married or Cohabiting Women Aged 15-49 Using Contraception

Method	1963	1978	1983	1988	1993	1998	2003	2008
Any method	22.0	50.0	61.5	63.4	62.6	63.9	71.0	73.0
IUD	0.0	4.0	8.9	17.1	18.8	19.8	20.2	16.9
Pill	1.0	8.0	9.0	7.6	4.9	4.4	4.7	5.3
Condom	4.3	4.0	4.9	8.9	6.6	8.2	10.8	14.3
Surgical sterilization (female)	0.0	0.0	0.1	2.2	2.9	4.2	5.8	8.3
Coitus interruptus	10.4	22.0	31.1	31.0	26.2	24.4	26.4	
Other	12.0	12.1	8.6	10.2	3.2	2.8	4.1	
Total effective-method users	5.3	18.0	27.2	32.3	34.5	37.7	42.5	46.0
Total ineffective-method users	22.4	32.0	34.2	31.0	28.1	25.5	28.5	27.0
Unmet need for contraception	-	-	-	-	12.0	10.0	6.0	
Abortions per 100 pregnancies	7.6	16.8	19.0	23.6	18.0	14.5	11.3	10.0

(TDHS data)

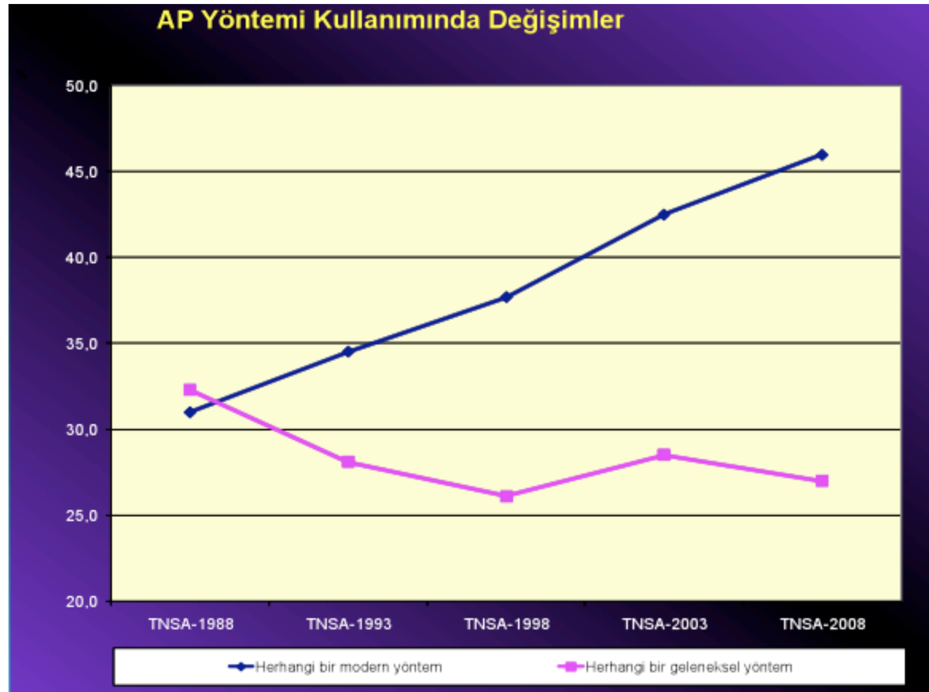

Figure 3. The Changes in Family Planning Methods Use (According to TDHS data)

As seen above, between 1978 and 1988, there was a significant increase in the prevalence of IUD use. It rose from 50 to 63.4. In 1988, for the first time, total effective methods used passed by the total ineffective method users. Abortions per 100 pregnancies had the highest level (23.6) in 1988. The legalization of abortion had a big effect on this increase. However, Turkey still needed to increase the use of modern methods according to these numbers.

Table 11. Annual Growth Rate of Population in Turkey (1965 – 1990)

Period	Annual population growth rate (‰)
1965 - 1970	25.2
1970 – 1975	25.0
1975 – 1980	20.7
1980 – 1985	24.9
1985 – 1990	21.7

(Piyal, 1994: 4)

It is also important to stress the annual population growth rate and total fertility rate. The annual growth rate was 2.52 percent for 1970, 2.5 percent for 1975, 2.07 percent for 1980, 2.49 percent for 1985, and 2.17 percent for 1990. It gradually declined in Turkey. Population policies and the prevalence of family planning services also had a big impact on this decline.

The other issue was total fertility rate (number of children per woman). The total fertility rate was 4.33 for 1978, 3.2 for 1988, and 2.65 for 1993 (TDHS data), gradual decline.

The 1990s and Introducing the Reproductive Health Approach

In the 1990s, the World Bank's focus on the demographic perspective began to change, and it reacted to countries which targeted demographic goals and applied incentive or punishment methods to achieve these demographic goals (Hartmann, 1995).

Actually, it is hard to say that the health approach of the 1980s was totally discarded in the 1990s. However, family planning started to be thought in the context of human rights and health. Besides, the concept of "reproductive health" (which will be discussed in detail below) is observable for these years and it could be interpreted as an under heading of human rights and health as well.

According to Hardon (1997: 4), during the 1980s and early 1990s, the rationale behind population programmes was criticized by the international women's health movement. They challenged the aim that focused on reducing fertility in developing countries. "They took issue with the belief that limiting family size is a societal responsibility that takes precedence over individual well-being and

individual rights" (Hardon, 1997: 4). Their goal was to empower women to control their own fertility and sexuality according to their free choice and with minimum health problems. The movement criticized the aim to deliver contraceptives primarily to married women as a tool to reduce fertility. They articulated that this type of action is a way of manipulation and this manipulation prevents the principle of free choice that is embedded in the reproductive rights declarations. In addition to this, they put an emphasis on the issue of male responsibility and the needs of adolescents (Hardon, 1997: 4). These demands later were effective in the preparatory period of the UN International Conference on Population and Development (ICPD) (1994) and its decisions.

Before discussing the implementations of the 1990s, to explain the International Conference on Population and Development in 1994 is important to understanding the "reproductive health" approach that dominated the decade and is still dominant on family planning issue in recent years as well.

The International Conference on Population and Development (ICPD) was convened under the United Nations in Cairo on 5-13 September 1994. It was the largest intergovernmental conference on population and development ever held. Eleven thousand registered participants, from governments, UN specialized agencies and organizations, intergovernmental organizations, non-governmental organizations and the media. 180 states took part to finalize a Programme of Action in the area of population and development for the next 20 years.

The subjects related to reproductive health traditionally were associated with fertility and focused on women by referring to mother and child health. However, during the 1990s the approach started to change towards "reproductive health." The ICPD was separated from the other conferences in terms of its approach to the

population issue. In this conference, the traditional population approach was left, and the conference put human beings on the heart of development. In addition, this conference gave priority to individual's reproductive rights and reproductive health, and emphasized gender equality in this process. After the conference, the Program of Action, which was applied by 2015, was produced and Turkey also ratified it (Karaca Bozkurt, 2011).

According to the conference, reproductive health was articulated as follows:

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (Hardon, 1997: 5).

As seen, reproductive health includes family planning and contraceptive methods.

Akın (2010) stressed the similarity between the reproductive health definition and the health definition in 1948 by the WHO. As seen above, it included physical, mental and social well being in terms of reproductive health and as well as sexuality. It had a holistic approach to reproductivity. The Programme of Action also emphasized the integral linkages between population and development and focused on responding to the needs of individual women and men, rather than on achieving demographic targets.

The conference's Program of Action set the stage for how family planning could be expanded to cover the whole area of reproductive health and sexuality. One of the primary goals of the Programme of Action was to make family planning

universally available by 2015. According to the conference, access to contraceptive and a free and informed choice of methods were accepted worldwide as a human right. According to the Program of Action, all countries should make the primary health care system and reproductive health accessible to all individuals of appropriate age in the shortest possible time and no later than 2015. For abortion, the conference's Program of Action emphasized that abortion is not a method of family planning and should not be promoted. Governments should deal with the health impact of unsafe abortion and the recourse of abortions.

According to Özbay (1994), reproductive health is related to the social and economic environment and the status of individuals within their environment. The availability of medical services is just one of these aspects of reproductive health. The solution for the problems of reproductive health is to correct more inequalities in societies and improve the basic quality of life. The reproductive health approach should be taken as an approach to enrich knowledge about women's health problems. The focus point would be not just to improve women's health and the medical system, but it should go beyond those. The problem of women's subordination should be solved in the other social institutions, including the state and this solution would help to work out the women's reproductive health problems (Özbay, 1994: 17). The conference' members believed the fertility regulation needed to be founded within the services that aimed at enhancing reproductive health, not at reducing fertility.

The second point that should be emphasized is that the international conference did not specifically address women's issues and women. It had gender sensitivity. First, the key to this new approach was to empower women and provide them with more choices through expanded access to education and health services.

One of the greatest achievements of the Cairo Conference was the recognition of the need to empower women.

Second, the other issue was the male responsibilities and participation in reproductive health. As articulated:

> Men play a key role in bringing about gender equality since, in most societies, they exercise preponderant power in nearly every sphere of life. The objective is to promote gender equality and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. Governments should promote equal participation of women and men in all areas of family and household responsibilities, including, among others, responsible parenthood, sexual and reproductive behaviour, prevention of sexually transmitted diseases, and shared control in and contribution to family income and children's welfare (International Conference on Population and Development (ICPD) (1994).

This approach was a way to prevent women from taking all of responsibility upon themselves. Men also were seen as actors in this process. The perspective was changed and it would affect the government’s policies as well. Before that conference, Turkey mostly had focused on mother and child health and it saw that this needed to be changed.

After arguing on the concept of reproductive health, it will be meaningful to look at the 1990s historically in Turkey and in the international context. The highlights of the 1990s were the effects of globalization in terms of new collaborations, research, and surveys; international and domestic conferences, meetings, and congresses; right-based women’s health; the beginning of discussion about the gender issue; the holistic approach to women in terms of social and economic status, education, and health; the institutional process of women health; and empowering the health and the other systems. However, it was not still discussed in the development plans. In the mid-90s, “reproductive health” began to be discussed and it was used in the discourse and policies.

The problems that were handled in Turkey were the high rates of women and infant mortality; the enhancement of the prevalence of modern contraceptive use, the sustainability and efficiency of family planning services; and providing services in high quality. In addition, the low level of education of women, the existence of pregnancy at earlier ages, inadequate prenatal and postnatal care, unwanted pregnancies, and the collaboration of sectors and organizations were also a part of the concerns of the 1990s. These all are could be considered to be part of the reproductive health approach.

The indirect issues of reproductive health were also considered in these years. They were to empower women in the areas of education, health, and employment and the rectification of laws that did not carry gender sensitivity.

In light of these problems and concerns, women became an independent issue in the development plan and program in the 1990s (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008). In 1990, the General Directorate of the Status of Women (*Kadının Statüsü Genel Müdürlüğü, KSGM*) was established to prevent gender discrimination in Turkey.

The Sixth Five-Year Development Plan which spanned the years between 1990 and 1994, was published in 1989. In other words, it was announced before the International Conference on Population and Development (ICPD, 1994). Thus, the family planning issue was considered in two aspects, population and health (Devlet Planlama Teşkilatı, 1989).

In the population part, the written aim was to improve the availability of mother and child health and family planning services especially, among citizens who could not to be previously reached (Devlet Planlama Teşkilatı, 1989: 285). In the

health segment, the aim was to activate and to improve the mother and child health and family planning services (Devlet Planlama Teşkilatı, 1989: 289).

RamaRoa and Mohanam (2003: 230-231) stress an intervention that took place between 1992 and 1997. The objective of the intervention was to establish and expand the high-quality family planning services within the system of the Social Insurance Organization (*Sosyal Sigortalar Kurumu, SSK*). It included staff training; development of information, education, and communications materials (posters and method-specific brochures for distribution); an upgrading of infrastructure and equipment; initiation of policy dialogues; and strengthening of management systems. By the end of 1995, a number of SSK facilities had started to offer family planning services. Moreover, the number of SSK associates had access to family planning information and methods. In addition to this, between 1995 and 1997, one focus of the project was to establish postpartum and post abortion family planning services, which were, emphasized its absence before. As a result of this effort, a new program for postpartum and post abortion services was developed. Thanks to this, more women (especially those who need the family planning services) could be reached.

In 1993, the Population Planning Advisory Committee (*Nüfus Planlama Danışma Kurulu*) was established as a requirement of the 1983 law. After the ICPD, in 1994, its name was changed to the Women's Health/ Reproductive Health and Family Planning Advisory Committee (*Kadın Sağlığı Üreme/ Üreme Sağlığı ve Aile Planlaması Danışma Kurulu*) (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008).

In 1993, there was a nationwide survey called the 1993 Turkish Demographic and Health Survey in conjunction with the USIAD, the Macro International Inc., the Ministry of Health, and the Hacettepe University Institute of Population Studies. The

1993 TDHS was a part of the worldwide Demographic and Health Surveys (DHS) program, which was administered by Macro International Inc. in various countries. According to the survey, in Turkey there were approximately 5,000 health centers and 12,000 health houses. In addition, 268 MCH/FP centers in provinces and districts delivered services as well as carried out the education of staff. FP services were also offered by the FP units in hospitals and maternity hospitals (Ministry of Health, Hacettepe University, & DHS, 1996: 5).

In 1994, the first The National Guide Book of Family Planning Services (*Ulusal Aile Planlaması Hizmet Rehberi*) was published (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008). The renewed version was published in 2005, and "reproductive health" was added to headline (T.C. Sağlık Bakanlığı Ana Çocuk Sağlığı ve Aile Planlaması Genel Müdürlüğü & UNFPA, 2005).

In 1995, Turkey participated in the Fourth Conference on Women in Beijing and ratified the program of action without reservation, which emphasized the results of the 1994 Conference again.

In 1996, for the first time, the Ministry of Health and the General Directorate of Mother and Child Health – Family Planning prepared the National Strategy of Women's Health and Family Planning *(Kadın Sağlığı ve Aile Planlaması Ulusal Stratejileri*) with the participation of related sectors and was applied by 2000. In 1998, the Program of Action for Women's Health and Family Planning (*Kadın Sağlığı ve Aile Planlaması Faaliyet Planı*) was announced according to the national strategy of women's health and family planning. This plan would be called the National Strategies and Program of Action for Sexual Health and Reproductive Health 2005-2015 *(Cinsel Sağlık ve Üreme Sağlığı, Sağlık Sektörü için, Ulusal Stratejiler ve Eylem Planı 2005-2015*) in 2005.

In addition, in 1996, with the participation of 17 voluntary organizations, the Commission of Women's Health (*Kadın Sağlığı Komisyonu, KASAKOM*) was established by the Family Planning Association of Turkey (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008).

The Seventh Five-Year Development Plan, which spanned the years between 1996 and 2000, was published in 1995. Family planning issue was considered under the heading "Population and Family Planning." According to the plan, between 1985 and 1990, the total fertility rate was 3.4, and in 1994 the rate declined to 2,69. Between 1985 and 1990, the population growth rate was 2.17, and in 1994 the rate declined to 1.78 as assumed.

The points stressed were the low level of education of women, and pregnancy at young ages, the adequate before and post pregnancy services, unwanted pregnancies, and the gap between different regions for contraceptive use. For the family planning services, it targeted accessibility, continuity, high quality, availability and adequacy. An increase in women's participation in education, employment, health and social security was also stressed. Moreover, strengthening the women in society and establishing gendered-base regulations and laws were other points that were taken as a priority. Actually, these aims were parallel with the international approach. However, it is necessary to point out that the heading that was used for the family planning issue in the plan was still "Population and Family Planning." Although the ICDP (1994) focused on reproductive health, the plan still did not refer to the issue as a reproductive health issue.

Parallel to the 1983 law, education in schools, use of media channels to promote family planning with the help of voluntary organizations, and the private sector were also targeted. Lastly, at the end of period of the plan, it was aimed to

reach 70 percent of modern contraceptive use in the contraceptive usage rate, but it would be near 55 percent in 1998 and near 60 percent in 2003 (TDHS data).

In 1998, the nationwide Turkey Demographic and Health Survey was conducted with the help of USIAD, Macro International Inc., the UNFPA, the Ministry of Health, and the Hacettepe University Institute of Population Studies as a part of Demographic and Health Surveys. The survey would be used as a tool to understand the rate and problems in the 1990s.

The first point was education level and its relationship to contraceptive use. According to the TDHS 98, the level of education was an important variable that affects the user's choice of withdrawal. The proportions of couples using withdrawal are lower for couples where both are educated or the husband is educated and the wife not (Ergocmen & et. All, 2004: 229).

Table 12. Percentage of Currently Married Women Using Contraception According to Education Level

	Current contraceptive method			
Characteristics	Modern	Withdrawal	Other Traditional	Number
Educational level of women				
No education/primary incomplete	55.4	41.9	2.7	779
Primary completed/secondary incomplete	57.5	40.6	1.9	2397
Secondary completed +	70.1	24.0	6.0	606
Education level of husband				
No education/primary incomplete	44.5	53.6	1.9	235
Primary completed/secondary incomplete	58.4	39.4	2.2	3069
Secondary completed +	71.2	22.1	6.7	468
Couple's education				
Both educated	60.5	36.7	2.8	2920
Wife educated, husband not	44.6	54.0	1.4	78
Wife not, husband educated	58.1	39.0	2.8	617
Both not educated	44.4	53.4	2.2	157

(TDHS 1998)

Higher education for both a woman and her husband significantly reduces the

probability of withdrawal use. Higher education increases the use of modern contraceptives. Moreover, Kulczycki (2008) also stresses that Turkish culture and socio-economic structures are still male dominated. Thus, many women still need their husband's approval to use family planning. Husband's attitudes effect on their contraceptive practices and their fertility rates.

The other points were the gap between rural and urban and income in terms of contraceptive use. Women living in rural areas rely on withdrawal more than their urban counterparts. There is a negative correlation between the level of household welfare and withdrawal (Ergocmen & et. al, 2004: 231).

Table 13. Percentage of Currently Married Women Using Contraception According to Type of Place Residence and Welfare of Household

	Current contraceptive method			
	Modern	Withdrawal	Other traditional	Number
Type of place of residence				
Urban	61.2	35.8	3.0	2653
Rural	54.0	44.0	2.0	1128
Welfare of household				
Low income	56.9	41.1	2.0	2257
Middle income	62.3	34.8	2.9	1220
High income	67.7	24.5	7.7	214
Total	59.3	38.1	2.6	3690

(TDHS 1998)

According to Yiğit and Roman (2004: 240), the decision to use withdrawal is influenced by societal, cultural, and political factors. These are using withdrawal as a first method, women's age, husband's education, woman's social security status, ethnicity of the couple, couple's approval of family planning, and the number of living children.

Within this framework, after the 1990s efforts on family planning, it will be

meaningful to look at the fertility rates in Turkey. In 1978, the total fertility rate (number of children per woman) was 4,33. In 1988 the rate declined to 3,2. In 1993, the total fertility rate was 2.65. In 1998 the rate declined to 2,61. The rate would be 2,23 in 2003 (TDHS data).

Finally, the table below gives the percentage of married or cohabiting women aged 15-49 using contraception in 1998, and it gives a chance to compare with previous years.

Table 10. Contraceptive Use, Selected Years: Percentage of Married or Cohabiting Women Aged 15-49 Using Contraception

Method	1963	1978	1983	1988	1993	1998	2003	2008
Any method	22.0	50.0	61.5	63.4	62.6	63.9	71.0	73.0
IUD	0.0	4.0	8.9	17.1	18.8	19.8	20.2	16.9
Pill	1.0	8.0	9.0	7.6	4.9	4.4	4.7	5.3
Condom	4.3	4.0	4.9	8.9	6.6	8.2	10.8	14.3
Surgical sterilization (female)	0.0	0.0	0.1	2.2	2.9	4.2	5.8	8.3
Coitus interruptus	10.4	22.0	31.1	31.0	26.2	24.4	26.4	
Other	12.0	12.1	8.6	10.2	3.2	2.8	4.1	
Total effective-method users	5.3	18.0	27.2	32.3	34.5	37.7	42.5	46.0
Total ineffective-method users	22.4	32.0	34.2	31.0	28.1	25.5	28.5	27.0
Unmet need for contraception	-	-	-	-	12.0	10.0	6.0	
Abortions per 100 pregnancies	7.6	16.8	19.0	23.6	18.0	14.5	11.3	10.0

(TDHS data)

Between 1983 and 2000 (after the enactment of the law), contraceptive use among married couples rose to 71 percent. Abortion incidence declined in the country. Maternal deaths from unsafe abortion declined sharply and the total fertility rate fell to 2.2 births per women (Akın, 2007).

The 2000s and the Health System in Transition by the AKP, 2003

In this part, the tranformations that took place in the 2000s will be discussed in terms of family planning issue. It will focus more specifically on the health reform. The critiques of the whole system also will be presented briefly. In addition, the family planning will be considered as a case in this system, and how family planning is positioned in this system will be analyzed in this chapter.

The Health System in Transition, which was applied in 2003 by the AKP (JDP, Justice and Development Party) affected also by the neoliberal policies in the international context. According to AKP, existing health system does not respond the growing needs and it needed a transformation to be more accessible, efficient system and have high quality services for citizens. The details will be given below.

First, in this part, before discussing the health reform, the 2000s historically in Turkey and the international context will be presented. In addition, the old organizational work schema of the Ministry of Health and the primary health care (before the Health system in Transition) will be demonstrated in order to have a better understanding to compare the two systems in terms of family planning. In this framework, Istanbul will be given as a case.

According to TDHS data, the total fertility rate (number of children per woman) was 2.61 for 1998, declined to 2.23 for 2003, and last declined to 2.16 for 2008. In Turkey, there was a substantial decline in fertility rates within the previous three decades as the decline from 4.3 in 1978 (HUIPS, 1980) to 2.2 in 2003 (HUIPS, 2004) in the total fertility rate. The total fertility rate was nearly four children (3.65) for women living in the eastern region, and decreased to around two children (1.86) in the Central Anatolia (HUIPS, 2004). According to Döngel (2006),

> Although the knowledge of family planning methods is widespread with almost 99.5 percent of currently married women being able to name a family planning method, only 42.5 percent are observed to be using modern family planning methods, and an additional 28.5 percent rely on traditional methods, mainly withdrawal (HUIPS, 2004).

The Eighth Five-Year Development Plan, which spanned the years 2001 and 2005, was published in 2000. The family planning issue was considered under the headings of “Population” and “Health.” The headings were still not called reproductive health. On the other hand, under the heading “Population,” the issue was considered as reproductive health and family planning. Under the “Population” heading, there were some points that were stressed in this plan. One of them was the gap between the regions in terms of accessibility and quality of reproductive health and family planning services. The other point was the lack information and education for the personnel and their employment in these areas.

According to the plan, reproductive health and family planning services should be integrated with the primary health care with a lifelong approach and gendered equality base. Here, it needs to be stressed that family planning and reproductive health services were considered as primary health care. They were also seen as preventive health care. The plan recommended increasing the prevalence and the continuity of the reproductive health and family planning services and their demands (Devlet Planlama Teşkilatı, 2000: 79 – 80).

Under the “Health” heading, the emphasis was on the inadequate primary health care services, which also included family planning services (Devlet Planlama Teşkilatı, 2000: 85 – 86).

In 2001, the Hacettepe University Women's Research and Implementation Center (HUWRIC) was established. According to the 2008 data, there were 15 women’s centers under universities in Turkey. Their role is to provide better

understanding on women issue (including reproductive health of women) by doing research and their publications. (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008).

In addition, in order to raise the youth's consciousness on reproductive health, between 2001 and 2005, two projects were applied in pilot cities, the Strategies to Meet Needs of Reproductive Health Knowledge for Adolescent and the Project to Improve Adolescent's Health (*Adolesanların Üreme Sağlığı Bilgi ve Hizmet Gereksinimlerinin Karşılanması İçin Strateji Geliştirilmesi Projesi and Adolesan Sağlığı ve Gelişmesi Projesi*) (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008).

In 2003, the nationwide TDHS 2003 was conducted with collaboration the Ministry of Health and the Hacettepe University Institute of Population Studies.

Table 10. Contraceptive Use, Selected Years: Percentage of Married or Cohabiting Women Aged 15-49 Using Contraception

Method	1963	1978	1983	1988	1993	1998	2003	2008
Any method	22.0	50.0	61.5	63.4	62.6	63.9	71.0	73.0
IUD	0.0	4.0	8.9	17.1	18.8	19.8	20.2	16.9
Pill	1.0	8.0	9.0	7.6	4.9	4.4	4.7	5.3
Condom	4.3	4.0	4.9	8.9	6.6	8.2	10.8	14.3
Surgical sterilization (female)	0.0	0.0	0.1	2.2	2.9	4.2	5.8	8.3
Coitus interruptus	10.4	22.0	31.1	31.0	26.2	24.4	26.4	
Other	12.0	12.1	8.6	10.2	3.2	2.8	4.1	
Total effective-method users	5.3	18.0	27.2	32.3	34.5	37.7	42.5	46.0
Total ineffective-method users	22.4	32.0	34.2	31.0	28.1	25.5	28.5	27.0
Unmet need for contraception	-	-	-	-	12.0	10.0	6.0	
Abortions per 100 pregnancies	7.6	16.8	19.0	23.6	18.0	14.5	11.3	10.0

(TDHS data)

According to the 2003 TDHS, 99.5 percent of married women knew one of the contraceptives. However, contraceptive use rate was 69 percent. Modern

contraceptive use rate was 42.5 percent, which included 20.2 percent for IUD, 4.7 percent for the Pills, 10.8 percent for condoms, 5.7 percent for tubal ligation and 1.1 percent for the others. Traditional contraceptive use rate was 28.5 percent, which included 26.4 percent for withdrawal (See table 10).

According to this survey, termination of the pregnancy within the first 10 weeks on request was applied in several institutions. As follows;

Table 14. Institutions Rate for Terminating Pregnancy Willingly in Turkey

Institution	(%)
Public Hospital	9.2
Maternity Home	5.2
Primary Health Care Center	0.5
Hospital of Social Security Institution	3.9
Private Hospital	20.9
Doctor's Office	56.5
Traning Hospital (University)	1.9
Other	1.8
Unknown	0.2

(TNSA, 2003)

The reason to give that table (Table 14) is to show that the further analysis on abortion does not include private hospitals, since the numbers that are taken from the Istanbul Provincial Directorate of Health mostly includes the public health sectors (However, in one table the private one will be given).

In 1996, the Ministry of Health and the General Directorate of Mother and Child Health – Family Planning prepared the National Strategy of Women's Health and Family Planning (*Kadın Sağlığı ve Aile Planlaması Ulusal Stratejileri*) with the participation of related sectors and had applied by 2000, as mentioned before. This

plan, whose name changed to the National Strategies and Program of Action for Sexual Health and Reproductive Health 2005-2015 (*Cinsel Sağlık ve Üreme Sağlığı, Sağlık Sektörü için, Ulusal Stratejiler ve Eylem Planı 2005-2015*) in 2005, included the years between 2005 and 2015. This new plan aims to reduce the number of maternal deaths, to prevent unwanted pregnancies, to reduce the gap between regions in health, to improve the health of young people, and to prevent sexually transmitted diseases (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008). As seen, the target is defined in terms of reproductive health approach and the term “Sexual Health” and “Reproductive Health” was added in the new heading.

Referencing the National Strategies and Program of Action for Sexual Health and Reproductive Health 2005-2015, the Reproductive Health Programme in Turkey (*Türkiye Üreme Sağlığı Programı, TÜPS*) was applied between the years 2003 and 2007 in collaboration with the Ministry of Health and the European Commission. The budget for this program was 55 million Euros and also 87 NGOs contributed to that program by giving 20 million Euros (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008). Here, the collaboration between state and the other sectors was very extensive. The aim was to improve safe motherhood and emergency obstetric care, to institutionalize pre-service and in-service training, to give priority to the needs of youth, to prevent the sexually transmitted diseases, and to increase the number of family planning services (T.C. Bakanlık Kadının Statüsü Genel Müdürlüğü, 2008).

The Ninth Five-Year Development Plan, which spans the years between 2007 and 2013, was published in 2006 and is currently underway. In this plan, interestingly, the words “family planning” and “reproductive health” did not appear. The plan gives priority to primary health care and just mentions mother and child’s

health (Devlet Planlama Teşkilatı, 2006: 88).

Last, the 2008 TDHS was conducted with collaboration the Ministry of Health, the State Planning Organization, and the Hacettepe University Institute of Population Studies. The results are as follows;

Table 10. Contraceptive Use, Selected Years: Percentage of Married or Cohabiting Women Aged 15-49 Using Contraception

Method	1963	1978	1983	1988	1993	1998	2003	2008
Any method	22.0	50.0	61.5	63.4	62.6	63.9	71.0	73.0
IUD	0.0	4.0	8.9	17.1	18.8	19.8	20.2	16.9
Pill	1.0	8.0	9.0	7.6	4.9	4.4	4.7	5.3
Condom	4.3	4.0	4.9	8.9	6.6	8.2	10.8	14.3
Surgical sterilization (female)	0.0	0.0	0.1	2.2	2.9	4.2	5.8	8.3
Coitus interruptus	10.4	22.0	31.1	31.0	26.2	24.4	26.4	
Other	12.0	12.1	8.6	10.2	3.2	2.8	4.1	
Total effective-method users	5.3	18.0	27.2	32.3	34.5	37.7	42.5	46.0
Total ineffective-method users	22.4	32.0	34.2	31.0	28.1	25.5	28.5	27.0
Unmet need for contraception	-	-	-	-	12.0	10.0	6.0	
Abortions per 100 pregnancies	7.6	16.8	19.0	23.6	18.0	14.5	11.3	10.0

(TDHS data)

Years	Traditional Methods	Modern Methods	Total
1993	28.1	34.5	62.6
1998	25.5	37.7	63.9
2003	28.5	42.5	71
2008	27	46	73

Figure 4. Family Planning Practices in Turkey by Years (1993- 2008)

As mentioned before, in this part, the organizational work schema of the Ministry of Health (see the Figure 5) and the institutions under the primary health care system (see the Figure 6) before the Health Transformation Project are presented below.

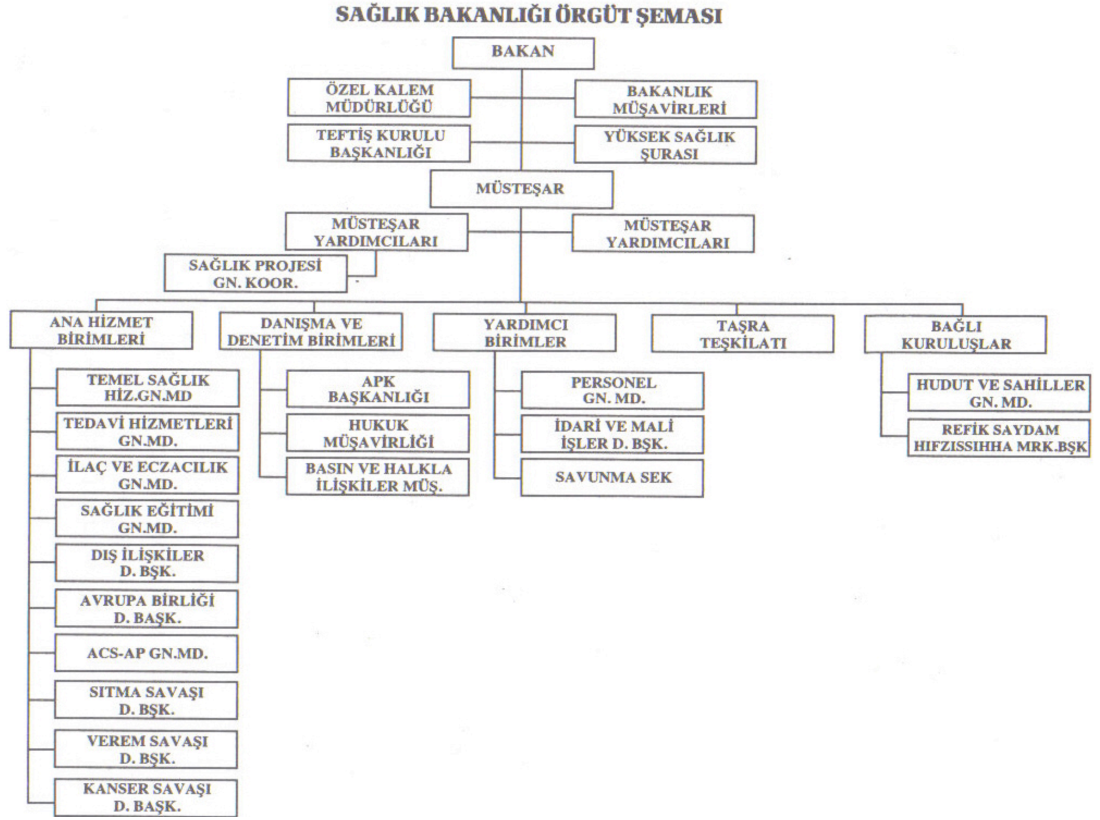

Figure 5. The Organizational Work Schema of the Ministry of Health

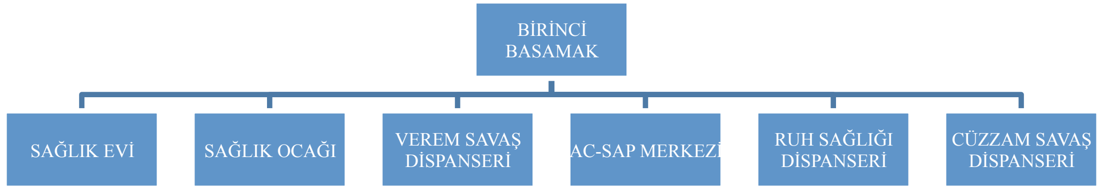

Figure 6. The Organizational Work Schema of the Primary Health Care Services

As seen above, the General Directorate of Mother and Child Health – Family Planning as a unit in itself is located under the Main Service Units. In addition, the point is that the General Directorate of Mother and Child Health – Family Planning is also categorized as a separate from the General Directorate of Primary Health Care. This clearly shows the emphasis on this subject placed by the state. On the

other hand, the fact that it was not called reproductive health needs to be questioned as well.

In addition to this, family planning services were given in primary health care centers (*sağlık ocağı*), private asylums (*sağlık evi*), and mother and child health – family planning centers (*AÇSAP merkezi*) under preventive health care services or could be called primary health care. Their role was to be a gatekeeper for advanced health problems. Family planning service was given in secondary and tertiary care[28] as well (such as post abortion family planning service, etc.). The hospitals of the Social Security Institution, which were under the Ministry of Labor and Social Security, public and private hospitals as secondary care, medical faculty of the universities as tertiary care, local administrations, the Ministry of Education, the Turkish Radio and Television Company (TRT), media, associations, and foundations have responsibility for family planning services, education, and applications (Piyal, 1994: 20).

As seen above, there were several attempts to adopt the term reproductive health, but still they are not sufficient. The reason to give all information and data above about the old system is to compare to the new system. As seen, the old system put an emphasis on the preventive health care (including family planning service) and preventive health care was separated from the curative one. It brings that the preventive health care was perceived as important in the system as curative health care services.

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[28] Briefly, primary care includes preventive health care and it is employed in primary health care centers (*sağlık ocağı),* private asylums (*sağlık evi)* or family health centers (*aile sağlığı merkezi)* and community health centers (*toplum sağlığı merkezi*) in the new system. Secondary and tertiary care includes more curatory care. Secondary care is employed in public and private hospitals. Tertiary care is employed mostly in public university hospitals.

The 2003 Health Reforms

According to Yazıcı (2012);

> After the AKP's rise to power in 2002, neoliberal policies in welfare politics became more resilient. Along with the IMF's close supervision of the economy and the government's commitment to fiscal discipline, the social security and health-care system was subject to a radical restructuring with significant losses in terms of social rights (Yazıcı, 2012: 109).

The AKP promised "Health for All" in its party program and in its Emergency Action Plan. They were announced after the party formed the government in 2002. The AKP argued that the existing health system became inaccessible, inefficient, and unresponsive to the growing needs. In addition to this, the costs of the system had increased according to the AKP (Ağartan, 2007; Ağartan, 2008; Bulut, 2007). Thus, the AKP government announced its reform program, the Health Transformation Project (*Sağlıkta Dönüşüm Programı*, HTP) in December 2003.

The Health Transformation Project claims to be as effective, accessible and high quality health system compared to the old one. To meet the basic health needs of everybody is announced as a priority in this project co-operation with the private sector is recommended when it is necessary.

According to Ağartan (2008), the AKP's interest in health care reform has two dimensions. The first one relies on the party and its ideological position. The AKP locates itself as a pro-Western party in the Turkish political spectrum. In addition to this, the AKP advocates a conservative social agenda and a liberal market economy. The second one was affected by the wider trends in policymaking both in advanced industrial countries and developing countries, in other words, the countries were undergoing the pressures of globalization, liberalization and economic restructuring. As Ağartan stated, the "AKP's approach to health care system and its

problems clearly reflected the characteristics of its social policy approach" (Ağartan, 2008: 276). Ağartan also discussed the parallels between the global social policy agenda and the AKP's social policy approach. These two agendas were similarity to the employment of the reproductive health approach (The World Bank's role was also clear in this process. It was very supportive and approved the Health Sector Transformation Project. The World Bank's health sector review was prepared in close collaboration with the Turkish government in 2003. It was used for shaping the formulation of the health reform proposal in return).

The project offered a social insurance system financed by contributions as opposed to tax-based funding (Keyder, 2007). The idea relied on universal health insurance, but at the same time encouraged the private sector to invest in the health sector. According to Ağartan, the AKP successfully combined elements of universalism and a market-based approach in its reform proposal.

Within this framework, it will be meaningful to mention the Turkish Medical Association (TMA) and its attitude to the Health Transformation Project. The Turkish Medical Association took its place on the opposite side of the reform, as expected. According to Ağartan,

> The disagreement among the two groups cannot simply be explained in terms of conflict of interests. What is also important to consider is the ideological difference among them … The AKP-big bourgeoisie alliance favor the transition to a market system. On the other hand, the TMA and the unions adopt a state-centered ideological stand and view health care as a public service. This ideological difference which lead to the emergence of divergent visions of the health system and competing agendas of reform explains why the debate on health care reform was so fierce (Ağartan, 2008: 293-294).

The Medical Association believed in health care as a public service and did have worries about the privatization process (Türk Tabipler Birliğ, 2012).

The Health Transformation Project introduced several applications and changes

in the health sector. The Social Security Institution[29] (SSI, *Soyal Güvenlik Kurumu, SGK*) (Buğra & Keyder, 2006), the implementation of family medicine in primary care, and the autonomization of public hospitals two of the several new applications in the system. However, this thesis does not focus on details of the new system, instead, its focuses specifically on the changes concerning family planning in the new system. Thus, the critiques of the whole new system will not be given in detail.

One of the critiques to the new system is important to understand how the services could not reach every citizen. This critique was as follows:

> Adopting a rights-based discourse, the TMA emphasized that health services should be considered as holistic and therefore there should be no limitations on their provision. However, the proposed General Health Insurance model, the TMA argued, would bring a system, which provided limited services for those who pay their contributions regularly. First, the system asked for the citizens to pay contributions and co-payments and it refused to provide services to those who fail to do so. This, according to TMA, was against any conception of health care as a social citizenship right (Ağartan, 2008: 299).

Another new practice was the introduction of family medicine. It has changed the organizational work schema especially for the primary health care. Instead of primary health care centers (*sağlık ocağı*), there are two dimensional structured new, Community Health Centers (*Toplum Sağlığı Merkezi*) and Family Health Centers (*Aile Sağlığı Merkezi*).

In the Family Health Centers, one single-handed family physician (*aile hekimi*) and one health worker (*sağlık elemanı*) have a responsibility. In primary care, unlike the current general practitioners working in public health centers, the family physicians are employed on a contractual basis. They are responsible for a population of 1.000 to 4.000 people. Their contracts will be renewed if their service

[29] The Social Security Institution (SSI) was merged with the Social Insurance Institution (SII, Sosyal Sigortalar Kurumu, SSK), the Social Security Organization for Self-Employed (Bağkur), and the Social Security Organization for Civil Servants (Emekli Sandığı) under a single umbrella.

is rate of acceptable quality according to their patients (Aksakoğlu, 2008: 32). In addition to this, when the number of people who are under the responsibility of the family physician becomes less than 1,000, the contract is canceled in two months. According to Ağartan (2008), this new mechanism represents a loss of job security for the general practitioners involved. To her,

> In order not to lose their contracts, the doctors would be forced to prioritize the cost-control and cost-efficiency concerns of the SSI as well as the health facility, which now ran as a business and had to compete. In such a context, the TMA argued, the medical profession could neither practice its profession nor protect the rights of patients (Ağartan, 2008).

It is important to stress that mother and child health and family planning are the responsibility of the family medicine unit (*aile hekimliği birimi*)[30].

Every county has one Community Health Center. In the Community Health Centers, preventive health care services are given such as inoculations and mother and child health – family planning services and public health specialists are responsible of these services. It represents the separation between public health specialists and family physicians. Therefore, family pyhisicians do not feel responsibility in providing family planning service anymore. In addition to this, the family planning / reproductive health education to family physicians is given by the Community Health Centers. Actually, providing family planning service is a part of family physician's job.

In addition, the mother and child health – family planning centers (AÇSAP merkezi) continues with their jobs. Number of the mother and child health – family planning centers and their situation will be given below in the case of Istanbul.

[30] The family medicine unit consists of a family pyhisician and a secretary.

In 2005, Düzce was set up pilot area. Izmir passed to the new system (Community Health Center and Family Health Center) in 2007, and Istanbul started to employ the new system in 2010.

The Recent Situation in Family Planning, 2012

In this part, one of the main arguments of the thesis will be discussed. The argument is that since the Health Transformation Project, family planning has never been granted its due importance. The important point is that while reproductive health perspective still has an influence on the health system, the findings show that family planning takes a back seat in the reproductive health system. Therefore, this part can be seen in two parts.

The first part is focused on the new health system and systematic problems. The Indirect effects on how family planning loses ground in the health system that are related to the system will be given. First, the role of the state on the responsibility of the health system will be discussed. Second, rural and urban relationship in the health system will be argued. Third, the Health Transformation Project plays preventive health care services down and there is an overemphasis on curative services. The indirect effect of this issue on family planning will be argued. Fourth, reducing the numbers of empolyees in Family Health Centers will be associated with the situation of family planning services.

In the second part, Istanbul will be taken as a case in order to show how family planning services have lot ground in the new health system. The argument will be supported by data from the Istanbul Provincial Directorate of Health. The first table shows the declining trend in contraceptive use between 2010 and 2012. Second, the increase in abortion in private hospital and its causes will be discussed.

Third, the small number of Community Health Centers, which are responsible for family planning services, will be discussed by giving the number of the institutions which give family planning services. Fourth, the decline trend of the number of MCHFP which is the backbone of the family planning services will be argued. Fifth, the family planning services which are given by Family Health Centers will be illistruated by the numbers in order to have a better understanding of the lack services regardimng the use of the IUD in Istanbul. Sixth, which is actually related to the fifth one, the issue pf certification for IUD provision will be given in detail. Last, the factors of the new performance managment will be examined to show how family planning does not exist anymore.

Akın stated that the Health Transformation Project is a neoliberal project and it serves the larger privatization process in Turkey. Especially, after the 1980s, the reason why the socialization program was always attacked was to create a justification for the privatization of health as a part of globalization. As part of globalization, the AKP government has applied neoliberal policy in the health sector. As well known neoliberal policies, privatization causes health to be seen as a commodity. As a result, the role of the state starts to be stayed behind and have an active role in health managment. It also brings an increase in the cost per individual in health services. As a result, it brings high consumption of pharmaceuticals, low emphasis on preventive health care, overemphasis of curative health services and diseases, and the disappearance of services in teamwork. To her, these especially affect women, children, infant, the elderly, and disabled people in a negative way.

In her opinion, the world's leading powers tend to manipulate this process exclusively for their own benefit in the so-called name of globalism. However, the attitudes of the countries differ, in this respect, due to their development levels. On

the other hand, it is not possible worldwide to stay out of this issue. The countries are bound to consider the mentioned transitions in the way their characteristic political configurations require, and they should do so in a realistic and scientific manner.

Second, accoding to Akın (also many colleges and the TMA shared the idea) that the new Health Transformation Project puts the urban above the rural. The family physicians have a right to choose their place to work. Thus, it is thought that the privilege will be given to the cities and developed areas in the country by the family physicians. In addition, in cities, people have the right to decide on their family physicians, but in rural areas, people have no such a right of decision. When the family planning is considered, the rural areas already had a low prevalence of contraceptive and family planning; furthermore, putting more emphasis on cities could cause worse conditions in the rural areas. In Akın's opinion, this transformation is against the principle of widespread (/nationwide) equality health service, which was emphasized in the Law of Socialization, and it puts more focus on the urban health services.

Third, Akın wrote that this new model is not applicable to the Turkish health system. There are several difficulties in controlling and coordination. As mentioned before, the system does not rely on population-based services (the system is based on the contributions and co-payments paid by the citizens and it refuses to provide services to those who failed to do so). In addition, she wrote that it is counter to the principle of integrated health services, both preventive and curative. The preventive health services cluster around the Community Health Centers, and the curative health services cluster around the Family Health Centers (in primary health care). Therefore, following a patient's situation up is getting a more complicated issue because of the existing of two institutions/centers. Another related problem is that

the severeal deseases, which are caused by the lack of preventive health services such as inoculations, become more complicated and caused disease to be seen more frequent. The seperation of these two centers affects the recovery process of the patients.

When the family planning that is part of the preventive health care is considered, the most important critique is that the Health Transformation Project plays preventive health care services down. The overemphasis on curative health services causes ignorance about the preventive health services, and thereby the family planning services.

As argued above, the preventive health care services are attributed to the Community Health Centers. When the salaries that are earned by staff are compared, it shows that the Community Health Centers staff have lower salaries than those of the Family Health Centers. In addition to this, the number of Community Health Centers is low. Every county has one Community Health Center. It is a representation of losing ground and putting little emphasis on preventive health services, and thereby family planning services.

Fourth, within this framework, it will be meaningful to discuss the poor numbers of the staff of the Family Health Centers, which are also “responsible” for family planning services. In the old system, at least seven health personnel were employed at the primary health care centers (*sağlık ocağı*), which were doctor, nurse, midwife, health officer, secretary, driver, and servant. However, now, one family physician and one health officer are responsible in one Family Health Unit. This health officer could be a nurse, midwife or health officer or regular civil servant. In other words, the team in the Family Health Unit consists of two persons. Family physicians are expected to give mobile team services as well for their performance

point. It was easier to give mobile team services in the primary health care centers, because seven persons were responsible and they did their job on a rotation basis. However, in the Family Health Units, it has difficulties to leave the unit for mobile team services. This fact affects the services in terms of not being able to reach many women.

In the primary health care centers, the chief officers for the family planning services were general practitioners, nurses and midwifes. However, in the new system, there is a lack of nurses and midwives in the Community Health Centers.[31]

In the second part, Istanbul is taken as a case study to support the argument that family planning is losing ground in the new system. First, after the Health Transformation Project, when Istanbul is taken a case study (Istanbul passed to the new system in November, 2010), the data show that the prevalence of contraceptive use, which represent the extent of family planning services, declined rapidly (see Table 15).

[31] The information is from Akın's interview.

Table 15. The Numbers of Family Planning Methods Use in Public Hospitals Between 1998 and 2011

The Number of Family Planning Application from 1998 to 2011 (Primary Health Care Centers, Mother and Child Health – Family Planning Centers, Hospitals,University and Military Hospitals)

YILLAR	The Number of Family Planning Policlinic Application	The Number of Family Planing Consultancy	Pill	Comdom	Storage	Mesigna	IUD	Implant	Tubal Ligation	Vazectomy	The Other Methods	Abortion (MR)	
1998	197,652		72,897	71,658	8,155	0	44,420	0	511	11	0	3508	MR Sayısı TSİM den alındı
1999	270,995		116,976	102,890	6,949	0	43,609	0	545	26	0	3037	MR Sayısı TSİM den alındı
2000	337,969		137,780	142,535	7,050	3,377	46,589	0	622	16	0	3230	
2001	380,954		155,735	159,291	4,328	11,074	49,709	0	783	34	0	2980	
2002	346,510		154,939	127,820	4,172	9,397	49,523	0	622	37	0	2574	
2003	398,110		180,244	158,811	4,942	6,539	46,942	0	608	24	0	2175	
2004	454,652		165,207	218,937	6,208	9,617	53,844	0	771	68	0	2457	
2005	507,357		198,957	235,860	7,145	7,914	56,434	104	918	25	0	2964	
2006	405,941	300,205	145,264	186,933	7,362	11,482	53,532	75	1,279	14	0	2961	
2007	524,802	406,144	244,076	199,748	8,779	11,372	59,536	21	1,252	18	0	2717	
2008	1,032,176	642,153	324,464	379,498	12,255	26,355	61,517	10	1,538	18	488	2861	
2009	1,147,685	626,777	399,635	391,878	14,466	34,595	63,669	18	1,231	20	169	2926	
2010	1,110,263	565,054	331,536	463,064	12,475	56,049	54,050	19	1,138	6	164	2390	
2011	966,060	601,094	269,429	426,560	9,695	35,982	43,653	14	2,126	4	172	2051	

*1998- 2007 yılları AP Poliklinik Başvuran Kişi Sayısı" Form 102 de olmadığı için "Yöntem Başvuru Sayıları toplamı alınarak işlenmi
2008 yılında Form 102'de AP "Poliklinik Başvuran Kişi Sayısı" , AP Danışmanlığı Alan Kişi Sayısı eklenmiştir. 2006 ve 2007 AP Dar
Tablo Form 102 Aile Planlaması Çalışmalar ve 1. Basamak İzlem Formu kaynak alınarak hazırlanmıştır.

This table shows the usage of each contraceptive method, the applicant numbers for family planning services and the number of abortions in the public institutions which include primary health care centers, mother and child health –

family planning centers, hospitals attached to the Ministry of Health, military hospitals, hospitals attached to public universities in Istanbul according to the years between 1998 and 2011.

According to this table, the number of applicants (note: one person could apply two times, three times or more, but each is counted just one), used the Pill, condoms, the IUD, implant, mesigna, and vasectomy has declined in 2010 and 2011, as seen. In contrast, for example, the Pill use was 244,076 in 2007, 324,464 in 2008, 399,635 in 2009. As seen, it gradually rose in Turkey. At the same time, comdom use was 186,933 in 2006, 199,748 in 2007, 379,498 in 2008, 391,878 in 2009, and 463,064in 2010. In parallel with the IUD use growth, condom use also rose until 2010. Until 2010, it could be said that the numbers were mostly increasing. However, in the years 2010 and 2011, most of the use methods number declined. For example, in 2010, the IUD use was 54,050 but in 2011 it declined to 43,653. Comdom use was 463,064 in 2010 but in 2011 it declined to 426,560. These data support the new system critiques in terms of preventive health services especially family planning services. (Note: it should not to be forgotten that the end of the 2010 and the year 2011 was the beginning of the new system integration to the Turkish Health Service in Istanbul.)

Second, the table below shows the usage of each contraceptive method, the applicant number for family planning services, and the number of abortion in public and private health services which include primary health care centers, mother and child health – family planning centers, hospitals attached to the Ministry of Health, military hospitals, hospitals attached to universities, and private ones in Istanbul according to the years between 2008 and 2011.

Table 16. The Numbers of Family Planning Methods Use Including Private Hospitals Between 2008 and 2011

The Number of Family Planning Application from 2008 to 2011 Public and Private (Primary Health Care Centers, Mother and Child Health – Family Planning Centers, Hospitals, University and Military Hospitals)

Years	The Number of Family Planning Policlinic Application	The Number of Family Planning Consultancy	Pill	Condom	Storage	Mesigna	IUD	Implant	Ttubal Ligation	Vazectomy	The Other Methods	Abortion (MR)
2008	1,135,524	696,467	374,380	415,051	15,418	30,013	76,279	232	5,638	46	2097	19857
2009	1,234,354	685,068	441,490	426,241	17,284	36,508	77,051	141	4,679	83	1138	17223
2010	1,221,821	638,543	391,040	510,049	15,724	59,549	69,210	175	4,740	112	1502	15303
2011	1,090,635	691,104	343,599	482,845	12,416	39,039	64,144	357	6,867	61	993	20478

According to the table above, the number of applicants (note: one person could apply for two times, three times or more, but every application are counted as one), who used the Pill, condoms, the IUD, mesigna, vasectomy and other modern contraceptives have declined as seen in 2011. These data prevent the comment that individuals prefer the private health services instead of public ones to terminate their

abortion or get contraceptives. Both public and private services' numbers have declined. However, in this picture, the abortion numbers are crucial. In public health services, the abortion number declined in 2011, but when the private one are considered the abortion numbers surprisingly increased. It could be said that prefer to have abortion services in private health services, despite the cost (it is unnecessary to say, with fee charging). The reasons should be investigated in detail, but it could be commented that the inadequate public abortion services could be the basis for this preference. In addition to this, hidden or illegal abortions which are not unrecorded should not be forgotten to have a comment on general abortion issue in the health system.

The decline in the number of consumable materials support the above results (the decline in the use of contraceptives) as well (see Table 17).

Table 17. The Number of Consumable Materials in Between 1998 and 2011

Equipment						
Years	Pill	Condom	Storage	Mesigna	IUD	Implant
1998	186,992	1,675,345	8,155	0	44,420	0
1999	153,010	1,265,398	6,949	0	43,609	0
2000	204,929	1,782,150	7,050	3,377	46,589	0
2001	211,141	1,951,863	4,328	11,074	49,709	0
2002	162,159	1,550,551	4,172	9,397	49,523	0
2003	187,118	1,893,823	4,942	6,539	46,942	0
2004	168,142	2,636,726	6,208	9,617	53,844	0
2005	200,711	2,833,278	7,145	7,914	56,434	104
2006	146,244	2,247,170	7,362	11,482	53,532	75
2007	244,825	2,391,004	8,779	11,372	59,536	21
2008	325,234	4,562,137	12,255	26,355	61,517	10
2009	400,597	4,703,176	14,466	34,595	63,669	18
2010	332,428	5,550,728	12,475	56,049	54,050	19
2011	270,008	5,120,547	9,695	35,982	43,653	14

As a third one, now the discussion turns to which institutions are giving family planning services (see Table 18).

Table 18. The Number of the Institutions which Give Family Planning Services

Institution (March 2012)	Gives FP Services	TOTAL
MCHFP Center	32	32
Family Health Center	860	866
Community Health Center	1	39
Public and Maternity Hospital	20	55
District Polyclinics	6	-
Other Public ones (military)	1	3
University Hospital	2	9

As seen above, MCHFP Centers, Family Health Centers, Community Health Centers, public hospitals and maternity hospitals, district polyclinics, other public ones (military), and universities provide family planning services in Istanbul. Actually, as mentioned before, the main responsibility is given to the Community Health Centers, but the rate (1/39) is very low. In fact, the Community Health Centers take responsibility for super visioning, regulatory job and distributing materials for family planning services. Thus, the responsibilities for family planning services fall on the Family Health Centers (the details and the negative circumstance will be given below).

Fourth, it will be meaningful to look at the number of MCHFP Centers in Istanbul in 1998 and 2012 (see Table 19).

Table 19. Numbers of Active MCHFP Centers Between the Years 1998 and 2012

Years	Number of MCHFP Centers
1998	33
1999	35
2000	35
2001	35
2002	35
2003	36
2004	36
2005	35
2006	35
2007	40
2008	40
2009	39
2010	32
2011	32
2012	32

As seen above, after 2008, year by year, the number of MCHFP Centers in Istanbul has been reduced. It was 40 in 2008, but it has declined to 32 in 2012. Thus, the institutions giving family planning services are declining in Istanbul. (These centers were employed under the General Directorate of Mother and Child Health – Family Planning until 2012 (Piyal, 1994: 18))

Fifth, in these centers, a doctor, a nurse, a midwife, a servant, a laboratory technician, a medical secretary (tıbbi sekreter), and and officer were employed before the Health Transition Project. It could be said that personnel were the backbone of the family planning services. However, after the Health Transition Project, the number of employees on the teams was reduced, and the centers have been returned to family medicine units (including a family pyhisician and a secretary) slowly. This is a sign of the recent preference for low of personnel and

limited services.

Sixth, it is crucial to look deeper at the Family Health Centers and their content and their services in terms of family planning. The tables below show the number of Family Health Centers and Family Health Units in Istanbul according to the family planning services they provide.

Table 20. The Situation of the Family Health Centers and the Family Health Units' Family Planning Services

The Family Planning Services of the Family Health Centers (March, 2012)	
Number of Active Family Health Centers	866
Number of Family Health Centers Which Give the Pill, Condom, and Injection Services	702
Number of Family Health Centers Which Give IUD, the Pill, Condom, and Injection Services	158
Number of Family Health Centers Which Do Not Give Any FP Services	6
The Family Planning Services of the Family Health Units (March, 2012)	
Number of Active Family Health Units	3551
Number of Family Health Units Which Give the Pill, Condoms, and Injection Services	3213
Number of Family Health Units Which Give IUD, the Pill, Condoms, and Injection Services	286
Number of Family Health Units Which Do Not Give Any FP Services	52

As seen above, all Family Health Centers or Family Health Units cannot give family planning services. In addition to this, the Pills, condoms and injection services are given by most of the Family Health Centers and Family Health Units. However, when it comes to giving IUD service, the number sharply declines. For the all methods, the reasons could be listed as inadequate materials, and inappropriate office, etc. However, giving IUD service has an important place in these reasons because it has its own reason that will be given in detail below.

One family physician/ nurse/ midwife can give IUD service after passing two steps. The first one attends a course and the IUD certificate given. However, the

obtained certificates are not adequate to place an IUD in women. After getting this certificate, the family physician/ nurse/ midwife should take another certificate which proves that the family physician/ nurse/ midwife could place an IUD in practice. Therefore, it became necessary to take two courses to obtain two certificates. In this context, there are lots of family physicians/ nurses/ midwives who have the first certificate but still have not been to offer IUD services in their Family Health Centers and Family Health Units. The table below (see Table 20) shows the number who can give IUD service and the numbers of personnel holding the first certificate in Istanbul.

Table 21. The Number of the Family Physician Who Have Certificate for IUD Service

The IUD Certificate Situation of Family Physicians (March, 2012)	
Number of Doctor Who Have IUD Certificate	787
Number of Doctor Who Can Insert IUD	246
Number of Family Health Personal (Nurse and Midwife) Who Have IUD Certificate	589
Number of Health Personal (Nurse and Midwife) Who Can Insert IUD	190

Approximately, there are 3551 family physicians in Istanbul (March, 2012). However, only 787 of them have the first certificate, and only 246 of them can give IUD service in their Family Health Centers and Family Health Units.

The Health Transformation Project said that the lack of IUD services of the Family Health Centers should be supported by the Community Health Centers. However, in the case of Istanbul, it is obviously impossible to do that. The rate of giving family planning services of the Community Health Center is 1 to 39. Thus, the lack of giving IUD service is still a problem, and the usage of IUD data support that claim as well.

Last, the other significant transformation is the “performance management”

applied by the Ministry of Health in the healthcare system. According to Akın, with the application of performance management, curative health services increased.

Table 22. The Comparison between the Years 2002 and 2010 According to the Number of Applications to Hospitals and Number of Surgeries

	2002	2010
Number of Application to Hospitals	124 309 469	302 984 218
Number of Surgery	2 056 005	8 614 789

(Source: Sağlık Bakanlığı, Tedavi Hizmetleri Genel Müdürlüğü, 2011)

She argued that, with the application of the performance management, curative health services are getting more widespread among doctors because, the new performance management system provides more money and performance point for doctors than preventive services. The preference of doctors turns into spending time on curative health services instead the preventive health services. In addition, as seen in Table 21, the number of surgeries (as a curative health service) increased in 2010.

On the Measuring Performance in Family Medicine (*Kurumsal Performans Katsayısı Bildirim Formu*), there are five ingredients, which are the factor of accessibility to service (*muayene erişim katsayısı),* the factor of quality of 112 service (*112 hizmet kalite katsayısı*), the factor of efficiency to 112 Service (*112 verimlilik katsayısı*), the factor of performans management (*kurumsal performans katsayısı)* and preventive service factor (*koruyucu hizmet katsayısı*).

In order to have a better understanding on family planning services, it is necessary to look at the content of preventive services. There is the number of pregnancies observed (*gebe izlem sayısı*), the number of baby and inoculation observed (*bebek ve aşı izlem sayısı),* the number of mother death and the number of application for polyclinics[32] (Sağlıkta Performans ve Kalite Yönergesi). As seen,

[32] *"Gebe Başına Ortalama izlem Sayısı", "Bebek Başına Ortalama İzlem Sayısı", "O Yaş Grubunda DaBT-_PA-Hib III Aşılama Oranı", "1 Yaş Grubunda KKK Aşılama Oranı (KKK)", "0 Yaş*

there is no separate measuring factor for family planning services.

However, in the old system, which was based on the Socialization Law, the factors were different for the primary health care centers. According to Akın, there were 10 factors in order to determine performance in the system. These were such indicators as the number of school inoculations (*okul aşıları*), the number of patients (*poliklinik başvuru sayısı*), the number of family planning services, the number of pregnancies observed (*gebe izlem*), the number of infants observed (*bebe izlem*), the number of children observed (*çocuk izlem*), and the performance of the mobile team (*geziler*). As seen, in the previous system, family planning services had a place among the performance criteria. Thus, the performance management and the consideration the medical practitioners give to its assessment have a decisive impact on their choices between preventive and curative health care services. Since the latter enables a physician to be given more credit, thus increasing his/her assessment figures, doctors have a tendency to spend more time on curative services during their work hours.

As previously argued the comparison between the old and the new system clearly indicates that family planning service has been trivialized and thrown out of focus within the healthcare system. Furthermore, its span has been narrowed down with the state negligence related to the issue. Although reproductive health is still officially held as crucial, the lack of initiative about the matter of family planning, which is a significant part of reproductive health, makes the entire reproductive health services remarkably more dysfunctional. This in turn proves to be detrimental especially to women and to rest of the citizens.

Grubunda BCG Aşılama Oranı (BCG)", "Gebe Tespit Oranı", "Anne Ölüm Oranı" ve "Bebek Tespit Oranı".

CHAPTER V

CONCLUSION

In conclusion, family planning as an issue was used by the Republican state and academia in many contexts, and for many intents and purposes during the establishment of the Turkish Republic. Turkey's social policy in the early 1920s was to increase the population. The pronatalist policy was enacted with a series of laws in the period of 1923 to 1960. Thus, the importation of contraceptives was prohibited, abortion was made illegal and advertising and education concerning methods and materials of contraception were prohibited, big families were promoted, and financial incentives were given for large families. The reasons to apply pronatalist policy in Turkey between 1923 and 1960 were to supply a strong military power during wartime and to serve economic purposes by creating manpower during that period. Women did not have reproductive rights; the decision of having children was a part of state policy directly and indirectly with the help of laws and pronatalist policies. Prevent in family planning was seen as a tool for the development of the nation state.

However, after the Second World War, there was an unprecedented increase in world population, and in Turkey as well. The high population growth rate came to be seen as a barrier to developing the country. The social institutions around the world started discussing the negative effects of uncontrolled population growth. In the 1960s in Turkey, efforts were made to change the pronatalist policy to an anti-natalist one, for two major reasons: These was the concern about the high maternal death rate, and the rapid population growth, which was believed to have a negative effect on the development processes. In this context, valuable efforts by some actors

were seen and the institutional process of family planning begun. In addition, the family planning issue begun to take appear in the Five-Year Development Programs.

In 1965, with the application of Law no. 557, the right of family planning was set free. According to this law, having the desired number of children, importing birth control methods, supporting the health education of couples, and providng birth control services in public health organizations free of charge were permitted. In the 1960s, the approach relied on was the developmentalist one.

In the 1970s, the demographic approach was introduced. However, the earlier developmentalist approach maintained its influence. After the enactment of the 1965 Law, research and work on family planning began. Moreover, the international organization began to be active in Turkey as well, such as the UNFPA.

In the 1980s, the official and academic focus shifted to a concern with health instead of demography or development. The biggest concern was maternal deaths, which mostly were cause by self-induced abortions. Nusret Fişek and his team, including Ayşe Akın had a valuable effort in order to modify the 1965 Law. As Akın stated, the modification process necessitated a well-planned strategy, based on scientific studies and guidance of policy making. With the help of these efforts, the new/second Population Planning Law was accepted in 1983.

Cooperation between the public and private sectors was targeted. In addition to this, the law permitted the education of midwives and nurses to insert intrauterine devices (IUD), to allow of surgical contraception methods such as vasectomies for men and tubal ligations for women, and the termination of the pregnancies within the first 10 weeks on request. With the application of this Law, the maternal death rate began to decline and the prevalence of contraceptive use increased.

In the 1990s, the approach shifted to human rights and reproductive rights with the help of the international context including the International Conference on Population and Development in 1994. The reproductive health approach has been dominant in the family planning issue recently as well.

In the 2000s, with the globalization process, the AKP government announced its new reform program, the Health Transformation Project in 2003. Family planning services were investigated in this system by referencing critiques, programs, and Istanbul was taken as a case. It was seen that the reproductive health approach continues in both the international context and in Turkey as well. However, in the Turkish case, it was seen that family planning services, which are a part and necessary components of reproductive health, is discounted in the new system as given below in detail. Due to the negative effect of the neoliberal process was noted in the Turkish health system.

At the time this thesis was written, a new legal amendment was introduced related to the organizational work schema of the Ministry of Health. It is difficult to discuss it in detail, but the ongoing structural change in the General Directorate of Mother and Child Health – Family Planning is important to mention for this thesis subject.

First of all, with the enactment of the Law 663, which was promulgated 2 November 2011, the Ministry of Health took the position controller in the health system rather than provider as part of the requirement of the neoliberal change. All of the institutions attached to the Ministry of Health underwent sharp change in their structures and the General Directorate of Mother and Child Health – Family Planning underwent change as well. The General Directorate of Mother and Child Health – Family Planning was abolished and its responsibility was given to the Turkish

Community Health Institution (*Türkiye Halk Sağılığı Kurumu*), which overseas six other institutions; the General Directorate of Primary Health Care (*Temel Sağlık Hizmetleri Genel Müdürlüğü*), the Department of Malaria (*Sıtma Savaşı Dairesi Başkanlığı*), the Cancer Control Department (*Kanserle Savaş Dairesi Başkanlığı*) the Tuberculosis Control Department (*Verem Savaşı Dairesi Başkanlığı*), the Directorate General of Personnel (*Personel Genel Müdürlüğü*), the Refik Saydam Hygiene Center Presidency (*Refik Saydam Hıfzıssıhha Merkezi Başkanlığı*) (see Appendix H). Therefore, family planning services no longer belong to a single institution. As seen, the family planning services have taken a back seat in the Turkish healthcare system with the added effect of not putting emphasis on preventive health care services. The data and findings given before also strongly support that claim.

In addition, a speech by the director of the Ministry of Health can be given as an example to support that claim. In 2007, he said, "yes to reproductive health but no to family planning" (*Üreme sağlığına evet, aile planlamasına hayır*). According to Akın, if reproductive health was accepted as a policy, it would be necessary to apply also to family planning services. As mentioned before, reproductive health includes such issues as pregnancy, the time before and after pregnancy, and family planning services. In my opinion, the last decision on how many children they would like to have should be given by the families. The state should provide family planning services to all citizens.

The discourse of the Prime Minister Erdoğan was important and also should be mentioned. He stated in 2008 that every family should have at least three children[33]. Then, in 2010, the number was modified and he stated that every family

[33] In 8 March 2008, in Uşak (http://arsiv.ntvmsnbc.com/news/438418.asp).

should have at least five children[34]. These speeches also show that the deemphasization of family planning services is not just in practicing the new transformation in the health system also in the state discourse.

Within this framework, Özbay points out another fact about Turkey. According to her, the decline in the fertility rate has caused a decline in the child population in Turkey. Then, the generation who are now young and adult will be elderly in the future. Therefore, Turkey will have an ageing population, which will bring several problems. The change of the state discourse could be interpreted as linked to this concern as well. However, this approach is similar to the 1970s' demographic approach. It does not put emphasis on women and their right to make their own decisions about their reproduction.

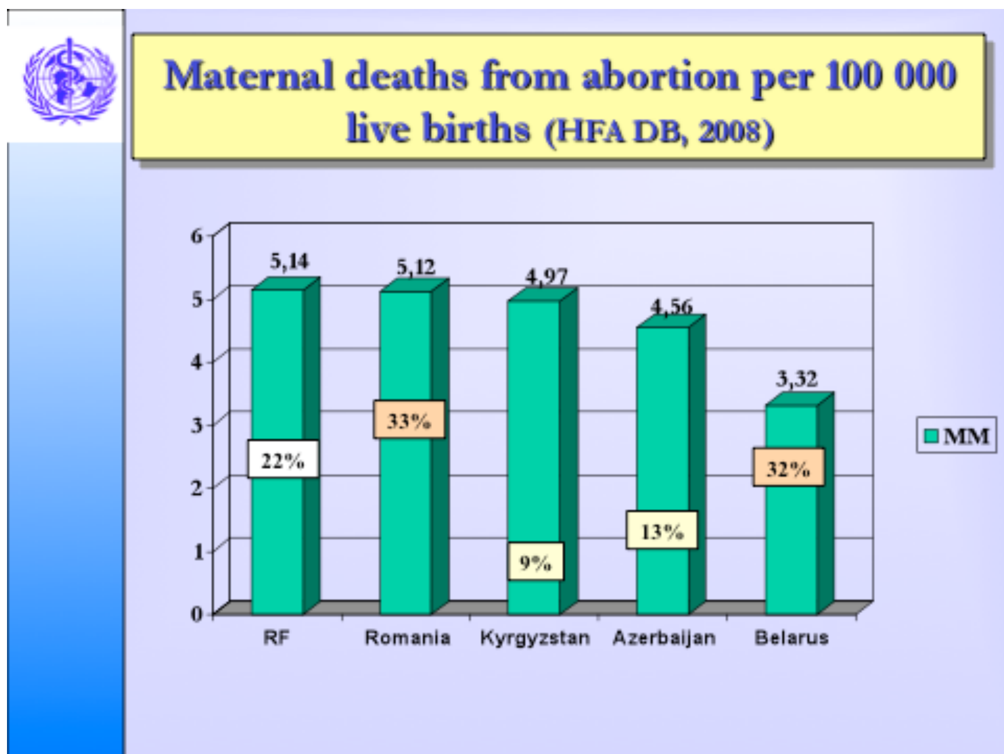
Lastly, this thesis agrees with Akın that, Turkey has made a marked progress in family planning up to day. However, continued efforts are required to prevent unwanted pregnancies and fulfill the need for family planning. In order to do that, the social status of women has to be improved, and public policies need to be designed with gender sensitivity. Policy makers and political leaders in Turkey must give priority to these issues and work to ensure the success of family planning nationwide. Sustainable access to high-quality family planning and reproductive health services should be provided by the state. In addition to this, international cooperation and collaboration should continue. Last but not least, Turkish women should not be seen just as mothers and in a secondary position, they should have the right to their own reproductive decisions.

[34] In 15 September 2012, in Bosnia and Herzegovina (http://www.haberturk.com/dunya/haber/776812-3-az-5-cocuk-yapin).

APPENDICIES

APPENDIX A

GRAPHS ON THE RELATION BETWEEN WOMEN'S HEALTH AND FAMILY PLANNING

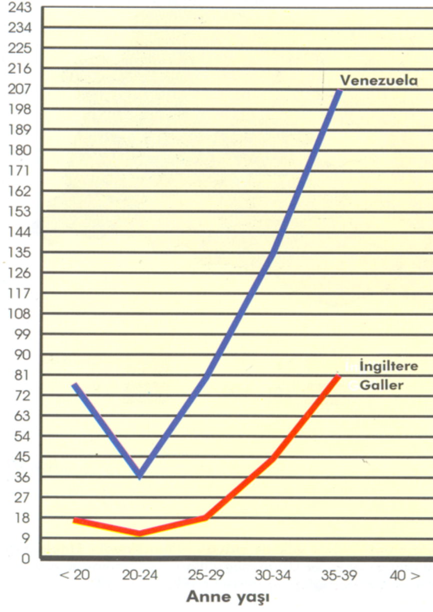


The pregnancy at very young and old age is danger for mother and infant health.

ERKEN VE İLERİ YAŞTAKİ GEBELİKLER ANNE VE BEBEĞİ İÇİN TEHLİKELİDİR

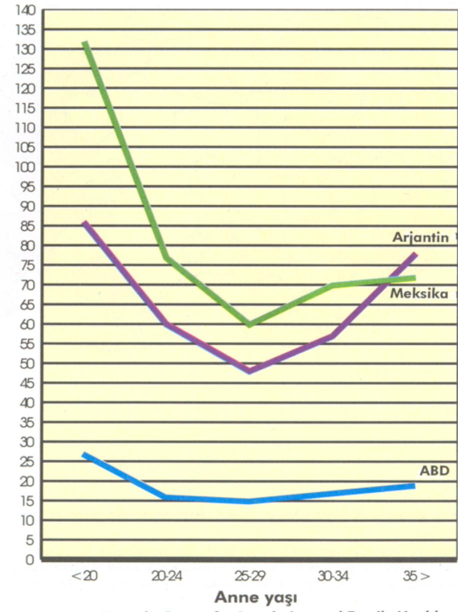
Yüzbin canlı doğumda ana ölümü

İki ülkede, doğumdaki yaşa göre anne ölümleri



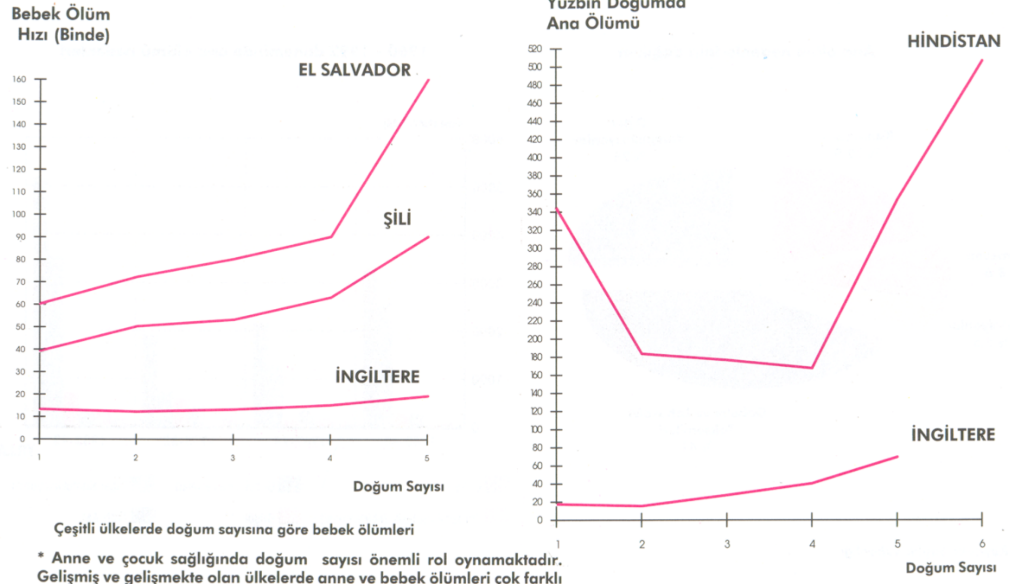
Bin canlı doğumda bebek ölümü

Üç ülkede, doğumdaki yaşa göre anne ölümleri



Kaynak: Center for Population and Family Health

When the number of pregnancy increases, death risk for infant and mother also increase.

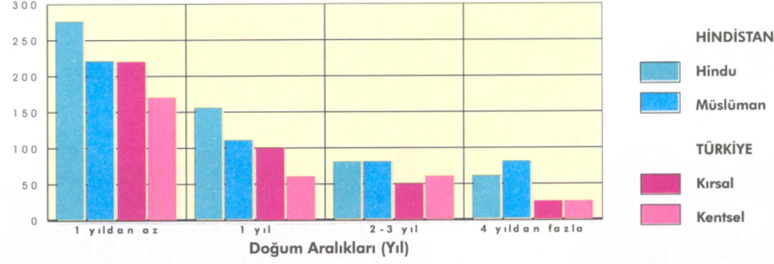


When the gap between two pregnancies is less than two or three years, the infant and mother death rate increases.

GEBELİK ARALIĞININ 2-3 YILDAN KISA OLMASI, ANNE VE BEBEK ÖLÜMLERİNİ ARTIRMAKTADIR.

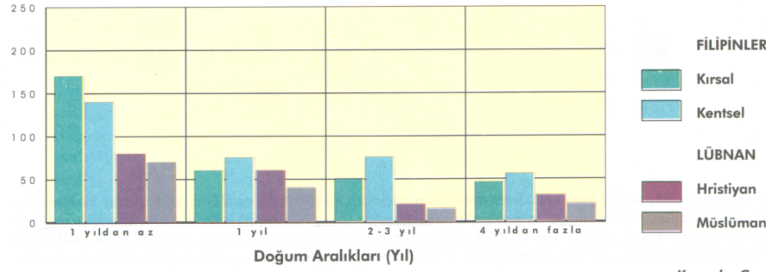
Çeşitli Ülkelerde doğum aralıklarına göre bebek ölümleri

1000 canlı doğumda bebek ölümü



Çeşitli Ülkelerde doğum aralıklarına göre çocuk ölümleri

1000 canlı doğumda çocuk ölümü



* İki gebeliğin arasındaki sürenin 3 yıldan kısa olduğu durumlarda annelerde kansızlık ve diğer beslenme bozuklukları, doğum zorlukları, kanamalar ve enfeksiyon hastalıkları sonucu ölümler daha sık görülmektedir. Doğum aralıklarının kısa olması bebek ve çocuk ölümlerinin de belirgin şekilde artmasına neden olmaktadır.

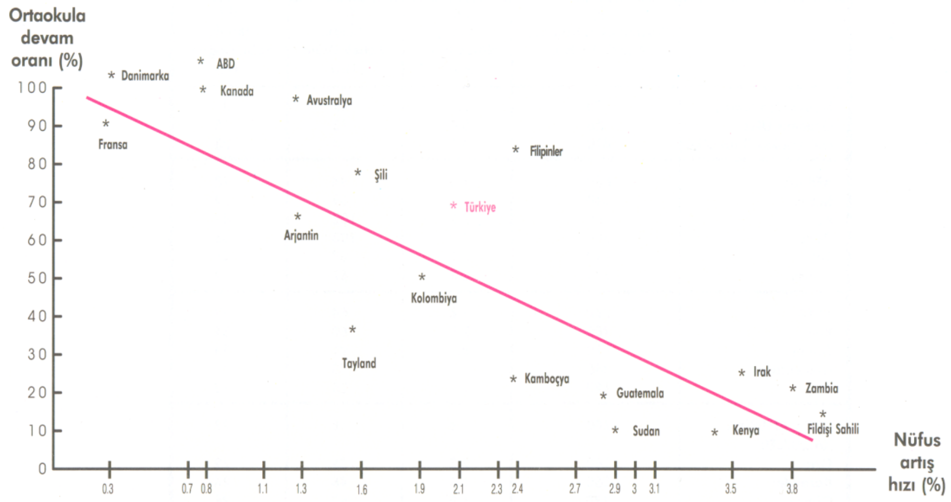
Kaynak: Center for Population and Family Health

APPENDIX B

GRAPHS ON THE RELATION BETWEEN POPULATION AND THE SOCIO-ECONOMIC DEVELOPMENT OF SOCIETY

When the population increases, the opportunity of getting education for children decreases.

NÜFUS ARTIŞ HIZI YÜKSELDİKÇE ÇOCUKLARIN EĞİTİM GÖRME ŞANSI AZALMAKTADIR



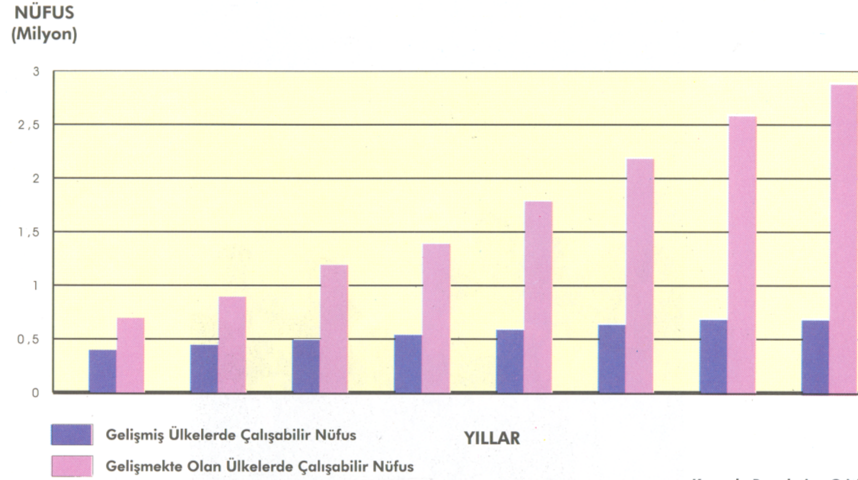
Çeşitli Ülkelerde nüfus artışı hızına göre ortaokul çağında okula kayıt oranları

Kaynak: Population Crisis Committee
M.E.B. İlköğretim Genel Müdürlüğü Raporu (1993)

*** Gelişmekte olan ülkelerde, 300 milyon okul çağı çocuk, ilkokula ve ortaokula devam etmemektedir. Endüstrileşmiş ülkelerde bile, 10 kişiden 4'ü ortaokul üstü eğitim görmemektedir. Orta öğrenime devam yüzdesi bir ülkede insan varlığına yapılan yatırımı gösteren önemli bir ölçüttür. İlkokul eğitiminin kişilerin temel yaşam becerileri kazanmasına yardım ettiği gibi ortaöğrenim de daha fazla sosyal ve ekonomik ilerlemeye fırsat yaratmaktadır. Nüfus artış hızı yüksek olan ülkelerde, kişi başına gelir düzeyi yüksek bile olsa, ortaöğrenime devam yüzdesi düşüktür. Bu durum, özellikle kız çocukların erkeklerden daha az okula gönderildiği ülkelerde, kızların ekonomik ve sosyal gelişme imkanlarını kısıtlamaktadır.**

Even though population increases every year in developing countries, there are not enough job opportunities available.

GELİŞMEKTE OLAN ÜLKELERDE ÇALIŞABİLİR NÜFUSUN HER YIL ARTMASINA KARŞILIK YETERLİ İŞ OLANAĞI MEVCUT DEĞİLDİR



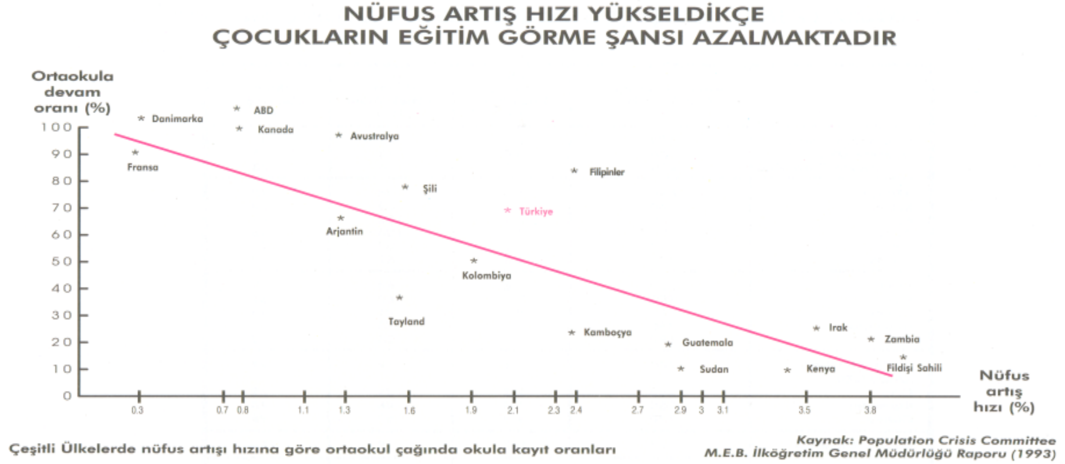
* 1950 - 1990 yılları arasında gelişmiş ülkelerin çalışabilir nüfusu % 50 den biraz fazla artarken, gelişmekte olan ülkelerde bu artış % 120 yi geçmiştir. Gelecek 30 yılda halen 1.8 milyar olan işgücünün % 61 daha artması beklenmektedir. Geçmiş yıllarda giderek büyüyen işgücü fazlası, gelişmekte olan ülkelerden her yıl milyonlarca insanın iş bulma umuduyla gelişmiş ülkelere göç etmesine yol açmaktaydı. Ancak, gelişmiş ülkeler son 10 yılda işgücü kabulünü iyice azaltmış ve kapılarını kapamışlardır.

* Öte yandan aynı nedene bağlı ülke içi göçler, kentlerin aşırı büyümesine, gecekondulaşmaya ve çevre koşullarının tehlikeli biçimde bozulmasına sebep olmaktadır. Kalabalık bir işgücü arzı iş ücretlerinin düşmesine ve fakirliğin artmasına yol açmaktadır.

APPENDIX C

GRAPH ON THE RELATION BETWEEN CHILD EDUCATION AND POPULATION GROWTH

When the population increases, the opportunity of getting education for children decreases.



Çeşitli Ülkelerde nüfus artışı hızına göre ortaokul çağında okula kayıt oranları

Kaynak: Population Crisis Committee
M.E.B. İlköğretim Genel Müdürlüğü Raporu (1993)

* Gelişmekte olan ülkelerde, 300 milyon okul çağı çocuk, ilkokula ve ortaokula devam etmemektedir. Endüstrileşmiş ülkelerde bile, 10 kişiden 4'ü ortaokul üstü eğitim görmemektedir. Orta öğrenime devam yüzdesi bir ülkede insan varlığına yapılan yatırımı gösteren önemli bir ölçüttür. İlkokul eğitiminin kişilerin temel yaşam becerileri kazanmasına yardım ettiği gibi ortaöğrenim de daha fazla sosyal ve ekonomik ilerlemeye fırsat yaratmaktadır. Nüfus artış hızı yüksek olan ülkelerde, kişi başına gelir düzeyi yüksek bile olsa, ortaöğrenime devam yüzdesi düşüktür. Bu durum, özellikle kız çocukların erkeklerden daha az okula gönderildiği ülkelerde, kızların ekonomik ve sosyal gelişme imkanlarını kısıtlamaktadır.

APPENDIX D

CONTRACEPTIVE METHODS EXPLAINED
BY THE FAMILY PLANNING ASSOCIATION

"Long-acting reversible contraception (LARC)

Contraceptive methods that do not depend on you remembering to take or use them.

Contraceptive implant

An implant is a small flexible rod that is placed just under your skin in your upper arm. It releases a progestogen hormone similar to the natural progesterone that women produce in their ovaries and works for up to three years.

The main way it works is to stop your ovaries releasing an egg each month (ovulation). It also:

- Thickens the mucus from your cervix. This makes it difficult for sperm to move through your cervix and reach an egg.
- Makes the lining of your uterus (womb) thinner so it is less likely to accept a fertilised egg.

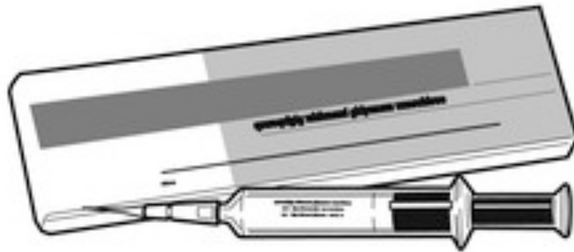
Contraceptive injections

Contraceptive injections contain a progestogen hormone, which is similar to the natural progesterone that women produce in their ovaries.

There are two types of injections. Depo-Provera protects you from pregnancy for 12 weeks and Noristerat protects you for eight weeks. Both of these are very effective hormonal methods of contraception.

The main way they work is to stop your ovaries from releasing an egg each month (ovulation). They also:

- Thicken the mucus from your cervix. This makes it difficult for sperm to move through it and reach an egg.
- Make the lining of your uterus (womb) thinner so it is less likely to accept a fertilised egg.

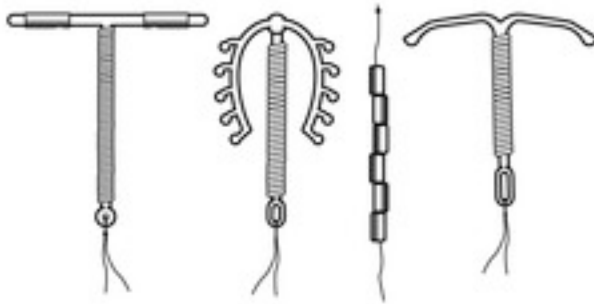


The IUD:

An IUD is a small plastic and copper device that is put into your uterus (womb). It has one or two soft threads at one end. These thin threads hang through the opening at the entrance of your uterus (cervix) into the top of your vagina.

There are different types and sizes of IUD to suit different women. An IUD can stay in for 5–10 years, depending on type. If you are aged 40 or older when the IUD is fitted, it can be left in until the menopause. It should only be fitted by a trained doctor or nurse. An IUD is sometimes called a “coil.”

The main way an IUD works is to stop sperm reaching an egg. It does this by preventing sperm from surviving in the cervix, uterus or fallopian tube. It may also work by stopping a fertilised egg from implanting in the uterus. An IUD does not cause an abortion.



The IUS:

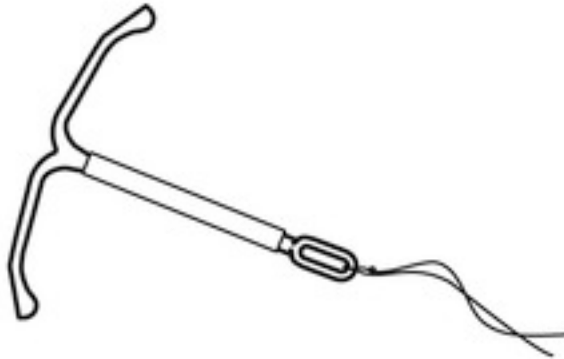
An IUS is a small T-shaped plastic device, which releases a progestogen hormone. This is similar to the natural progesterone that women produce in their ovaries.

A trained doctor or nurse will put the IUS into your uterus (womb). The IUS has two soft threads at one end, which hang through the opening at the entrance of your uterus – cervix – into the top of your vagina.

It works for up to five years.

- It makes the lining of your uterus thinner so it is less likely to accept a fertilised egg.
- It also thickens the mucus in your cervix. This makes it difficult for sperm to move through it and reach an egg.

- In some women it stops the ovaries releasing an egg (ovulation), but most women who use an IUS continue to ovulate.



<u>Hormonal methods:</u>

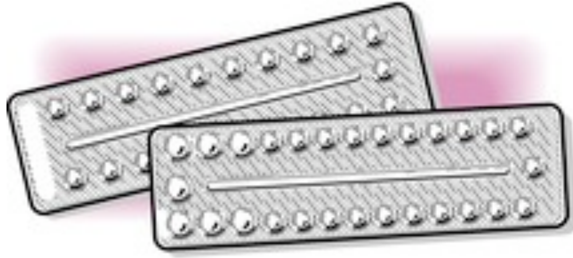
Hormonal methods of contraception contain estrogen and progestogen or progestogen alone.

<u>Combined pill:</u>

The combined pill is usually just called the Pill. It contains two hormones – estrogen and progestogen. These are similar to the natural hormones women produce in their ovaries.

The main way the pill works is to stop the ovaries from releasing an egg each month (ovulation). It also:

- thickens the mucus from your cervix. This makes it difficult for sperm to move through it and reach an egg
- makes the lining of your uterus (womb) thinner so it is less likely to accept a fertilised egg.



<u>Progestogen-only pill (POP):</u>

The progestogen-only pill (POP) contains a progestogen hormone that is similar to the natural progesterone women produce in their ovaries.

Progestogen-only pills are different from combined pills because they do not contain any estrogen. The POP works in a number of ways.

- It mainly works by thickening the mucus of your cervix. This makes it difficult for sperm to move through it and reach an egg.
- It makes the lining of your uterus (womb) thinner so it is less likely to accept a fertilised egg.
- It sometimes stops your ovaries releasing an egg (ovulation). This is the main action of one POP, Cerazette. This may mean that Cerazette is more effective than other POPs, but research has not yet confirmed this.

<u>Contraceptive patch:</u>

The contraceptive patch is a thin, beige patch, nearly 5cm x 5cm in size. You stick it on your skin and it releases two hormones, estrogen and progestogen. These

are similar to the natural hormones that women produce in their ovaries and like those used in the combined pill.

The patch releases a daily dose of hormones through the skin, into the bloodstream.

The main way it works is to stop the ovaries from releasing an egg each month (ovulation). It also:

- thickens the mucus from your cervix. This makes it difficult for sperm to move through it and reach an egg
- makes the lining of the uterus (womb) thinner so it is less likely to accept a fertilised egg.

<u>Contraceptive vaginal ring:</u>

The contraceptive vaginal ring is a flexible, transparent, plastic ring. It is placed in the vagina where it releases two hormones, estrogen and progestogen. These are similar to the natural hormones that women produce in their ovaries and are like those used in the combined pill.

The vaginal ring releases a constant dose of hormones into the bloodstream through the vaginal wall. The main way it works is to stop the ovaries from releasing an egg each month (ovulation). It also:

- Thickens the mucus from your cervix. This makes it difficult for a sperm to move through it and reach an egg.
- Makes the lining of the uterus (womb) thinner so it is less likely to accept a fertilised egg.

<u>Barrier methods:</u>

Barrier methods of contraception prevent sperm from meeting an egg.

<u>Male and female condoms:</u>

Male and female condoms are barrier methods of contraception. They stop sperm meeting an egg. A male condom fits over a man's erect penis and is made of very thin latex (rubber) or polyurethane (plastic). A female condom is made of very thin polyurethane. It is put in the vagina and loosely lines it.

Diaphragms and caps:

Diaphragms and caps are barrier methods of contraception. They fit inside your vagina and cover your cervix (entrance to the uterus – womb).

They come in different shapes and sizes. Vaginal diaphragms are circular domes made of thin, soft latex (rubber) or silicone with a flexible rim. Cervical caps are smaller and are made of latex or silicone.

To be effective, diaphragms and caps need to be used with a spermicide. Spermicides are chemicals that kill sperm.

A diaphragm or cap stops sperm reaching an egg. It covers your cervix while the spermicide kills any sperm. To be effective in preventing a pregnancy, you must use spermicide with a diaphragm or cap.

Permanent methods:

Male and female sterilizations are permanent methods of contraception suitable for people who are sure they never want children or do not want more children. Sterilization works by stopping the egg and the sperm meeting.

In female sterilization (tubal occlusion) this is done by cutting, sealing or blocking the fallopian tubes (which carry an egg from the ovary to the uterus – womb).

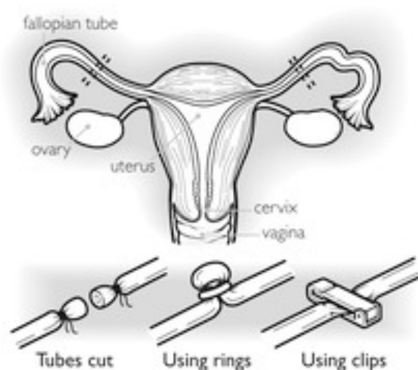
In male sterilization this is done by cutting, sealing or tying the vas deferens (the tube that carries sperm from the testicles to the penis). It is sometimes called a vasectomy.

Sterilization is a permanent method of contraception suitable for people who are sure they never want children or do not want more children. You may want to find out about long-acting reversible contraception (LARC), which is as effective as sterilization but reversible.

How is male sterilization done?

You will be given a local anaesthetic. To reach the tubes, the doctor makes either a small cut or puncture, known as the no-scalpel method, in the skin of your scrotum. The doctor will then cut the tubes and close the ends by tying them or sealing them with heat. Sometimes a small piece of the tubes are removed when they are cut. The opening(s) in your scrotum will be very small and you may not need to have any stitches afterwards. If you do, dissolvable stitches or surgical tape will be used. The operation takes about 10–15 minutes and may be done in a clinic, hospital outpatient department or some general practice settings. Sometimes it is necessary to do the operation using a general anaesthetic, but this is not common.

Female sterilization (tubal occlusion): How is female sterilization done?



There are several ways of blocking the fallopian tubes: tying, cutting and removing a small piece of the tube; sealing; or applying clips or rings. There are two main ways of reaching the fallopian tubes, laparoscopy or mini-laparotomy.

Laparoscopy is the most common method. You should be told which method is being used and why it has been chosen.

You will be given a general or local anaesthetic. A doctor will make two tiny cuts, one just below your navel and the other just above the bikini line. They will then insert a laparoscope, which lets the doctor clearly see your reproductive organs. The doctor will seal or block your fallopian tubes, usually with clips or occasionally with rings.

For a mini-laparotomy you will usually have a general anaesthetic and spend a couple of days in hospital. The doctor will make a small cut in your abdomen, usually just below the bikini line, to reach your fallopian tubes.

The time you stay in hospital after sterilization depends on the anaesthetic and the method used. It can be as little as one day.

Hysteroscopic sterilization is a new method and does not involve making any cuts. A tiny titanium (metal) coil is inserted into the fallopian tubes through the vagina and cervix. Body tissue grows around the coil and blocks the fallopian tube. This can be done under local anaesthetic or heavy sedation. This method is not reversible. Alternative contraception needs to be used after this procedure for at least three months. You will then need a test to check that the fallopian tubes are blocked. This method may not yet be widely available. The doctor will discuss your options with you.

Natural family planning:

Natural family planning allows a woman to closely monitor the fertile and infertile times of her menstrual cycle so that she can have sex when there is no risk of pregnancy. Fertility awareness involves being able to identify the signs and symptoms of fertility during the menstrual cycle so you can plan or avoid pregnancy.

Natural family planning works by observing and recording your body's different natural signs or fertility indicators on each day of your menstrual cycle. The main fertility indicators are:

- your body temperature
- cervical secretions (cervical mucus)
- the length of the menstrual cycle.

Changes in these fertility indicators can help you to identify your fertile time.

Emergency contraception:

If you have had unprotected sex, that is, sex without using contraception, or think your contraception might have failed, you can use emergency contraception. There are different types of emergency contraception:

- the emergency contraceptive pill, Levonelle
- the emergency contraceptive pill, ellaOne
- the emergency intrauterine device (IUD).

Emergency contraception can be very effective especially if you have an IUD fitted or if the emergency contraceptive pill is taken soon after sex. You don't need to use emergency contraception for the first 21 days after giving birth.

(FPA official web site)

APPENDIX E

EMERGENCY CONTRACEPTIVES BY THE WHO

The WHO's recommended regimen for emergency contraception is 1.5 mg of levonorgestrel as a single dose.

Who needs emergency contraception?

Any woman of reproductive age may need emergency contraception at some point to avoid an unwanted pregnancy. It is meant to be used in situations such as:

- when no contraceptive has been used;
- when there is a contraceptive failure or incorrect use, including:
  - condom breakage, slippage, or incorrect use
  - three or more consecutive missed combined oral contraceptive pills
  - progestogen-only pill (minipill) taken more than three hours late
  - more than two weeks late for a progestogen-only contraceptive injection (depot-medroxyprogesterone acetate or norethisterone enanthate)
  - more than seven days late for a combined estrogen-plus-progestogen monthly injection
  - dislodgment, breakage, tearing, or early removal of a diaphragm or cervical cap–dislodgment, delay in placing, or early removal of a contraceptive hormonal skin patch or ring
  - failed coitus interruptus (e.g., ejaculation in vagina or on external genitalia)
  - failure of a spermicide tablet or film to melt before intercourse
  - miscalculation of the periodic abstinence method or failure to abstain on fertile day of cycle

- IUD expulsion;

- in cases of sexual assault when the woman was not protected by an effective contraceptive method” (WHO Media Center, 2005).

APPENDIX F

TABLE OF CONTRACEPTIVE METHODS BY THE WHO

Method	Description	How it works	Effectiveness to prevent pregnancy	Comments
Combined oral contraceptives (COCs) or "the pill"	Contains two hormones (estrogen and progestogen)	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use 92% as commonly used	Reduces risk of endometrial and ovarian cancer; should not be taken while breastfeeding
Progestogen-only pills (POPs) or "the minipill"	Contains only progestogen hormone, not estrogen	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	99% with correct and consistent use 90–97% as commonly used	Can be used while breastfeeding; must be taken at the same time each day
Implants	Small, flexible rods or capsules placed under the skin of the upper arm; contains progestogen hormone only	Same mechanism as POPs	>99%	Health-care provider must insert and remove; can be used for 3–5 years depending on implant; irregular vaginal bleeding common but not harmful
Progestogen only injectables	Injected into the muscle every 2 or 3 months, depending on product	Same mechanism as POPs	>99% with correct and consistent use 97% as commonly used	Delayed return to fertility (1–4 months) after use; irregular vaginal bleeding common, but not harmful
Monthly injectables or combined injectable contraceptives (CIC)	Injected monthly into the muscle, contains estrogen and progestogen	Same mechanism as COCs	>99% with correct and consistent use 97% as commonly used	Irregular vaginal bleeding common, but not harmful
Intrauterine device (IUD): copper containing	Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus	Copper component damages sperm and prevents it from meeting the egg	>99%	Longer and heavier periods during first months of use are common but not harmful; can also be used as emergency contraception

device (IUD) levonorgestrel	inserted into the uterus that steadily releases small amounts of levonorgestrel each day	of the lining of uterus (endometrium)		menstrual cramps and symptoms of endometriosis; amenorrhea (no vaginal bleeding) in 20% of users
Male condoms	Sheaths or coverings that fit over a man's erect penis	Forms a barrier to keep sperm out of the vagina	98% with correct and consistent use 85% as commonly used	Also protects against sexually transmitted infections, including HIV
Female condoms	Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film	Forms a barrier to prevent sperm and egg from meeting	90% with correct and consistent use 79% as commonly used	Also protects against sexually transmitted infections, including HIV
Male sterilization (vasectomy)	Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles	Keeps sperm out of ejaculated semen	>99% after 3 months semen evaluation 97–98% with no semen evaluation	3 months delay in taking effect while stored sperm is still present; does not affect male sexual performance; voluntary and informed choice is essential
Female sterilization (tubal ligation)	Permanent contraception to block or cut the fallopian tubes	Eggs are blocked from meeting sperm	>99%	Voluntary and informed choice is essential
Withdrawal (coitus interruptus)	Man withdraws his penis from his partner's vagina, and ejaculates outside the vagina, keeping semen away from her external genitalia	Keeps sperm out of the woman's body, preventing fertilization	96% with correct and consistent use 73% as commonly used	One of the least effective methods, because proper timing of withdrawal is often difficult to determine
Fertility awareness methods (natural family planning or periodic abstinence)	Calendar-based methods: monitoring fertile days in menstrual cycle; symptom-based methods: monitoring cervical mucous and body temperature	The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days, usually by abstaining or by using condoms	75%	Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy
Lactational amenorrhea method (LAM)	Temporary contraception for new mothers whose monthly bleeding has not returned; requires exclusive breastfeeding day and night of an infant less than 6 months old	Prevents the release of eggs from the ovaries (ovulation)	99% with correct and consistent use 98% as commonly used	A temporary family planning method based on the natural effect of breastfeeding on fertility
Emergency contraception (levonorgestrel 1.5 mg)	Progestogen-only pills taken to prevent pregnancy up to 5 days after unprotected sex	Prevents ovulation	Reduces risk of pregnancy by 60–90%	Does not disrupt an already existing pregnancy

WHO response

WHO is working to promote family planning by producing evidence-based guidelines on safety and service delivery of contraceptive methods, developing quality standards and providing pre-qualification of contraceptive commodities, and helping countries introduce, adapt and implement these tools to meet their needs. WHO is also developing new contraceptive methods, including male methods, to reduce the unmet need for contraception.

APPENDIX G

THE OFFICIAL RECORD OF THE ISTANBUL PROVINCIAL DIRECTORATE OF HEALTH

TUTANAKTIR

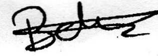
TC. Boğaziçi Üniv. Atatürk İlkeleri ve İnkılap Tarihi Enstitüsü'nün 16.01.2012 tarih ve 33 sayılı yazısı ile enstitüde Yüksek Lisans yapan Belin Benezra tez konusu olarak "Türkiyede Aile planlaması ve Üreme sağlığının Kurumsal Tarihi ve Bugünkü Uygulaması" konulu araştırması için istenilen bilgiler;

- 1 sayfa yüzyüse görüşme soru formu cevabı,
- İstanbul ili kamu kuruluşları 1998-2011 yılları Malzeme Sarf Durumu 1 sayfa,
- İstanbul ili kamu kuruluşları Sayıları 1998-2011 yılları Aile Planlaması Yöntemi Başvuru Sayısı 1 sayfa,
- İstanbul ili 2008-2011 yılları Aile Planlaması Yöntemi Başvuru Sayıları Kamu-Özel dahil (Sağ.oc., AÇSAP Merk., Sağlık Bak. Hast., Askeri Hast., Üniversite Hast.) 1 sayfa,
- AÇSAP Merkezlerinin Yıllara Göre sayıları (1998-2012) , 2011 tılı Kamu ve Özel sağlık Kuruluşları Dahil aile planlaması Yöntemi Başvuru Sayısı 1 sayfa
- 2012 Yılı Mart Ayı Aile Sağlığı Merkezi Ap Hizmeti Verme Durumu, 2012 Yılı Mart Ayı Aile Sağlığı Birimi Ap Hizmeti Verme Durumu, Ap Hizmeti Veren Kurum Sayısı (Mart 2012), Aile Hekimleri Ria Sertifika Durumu 1 Sayfa
- Form 102 Boş Örnek, Form 102/A boş örnek 2 Sayfa

Şeklinde 8 sayfa olarak Belin Benezra' ya elden teslim edilmiştir. 08.03.2012

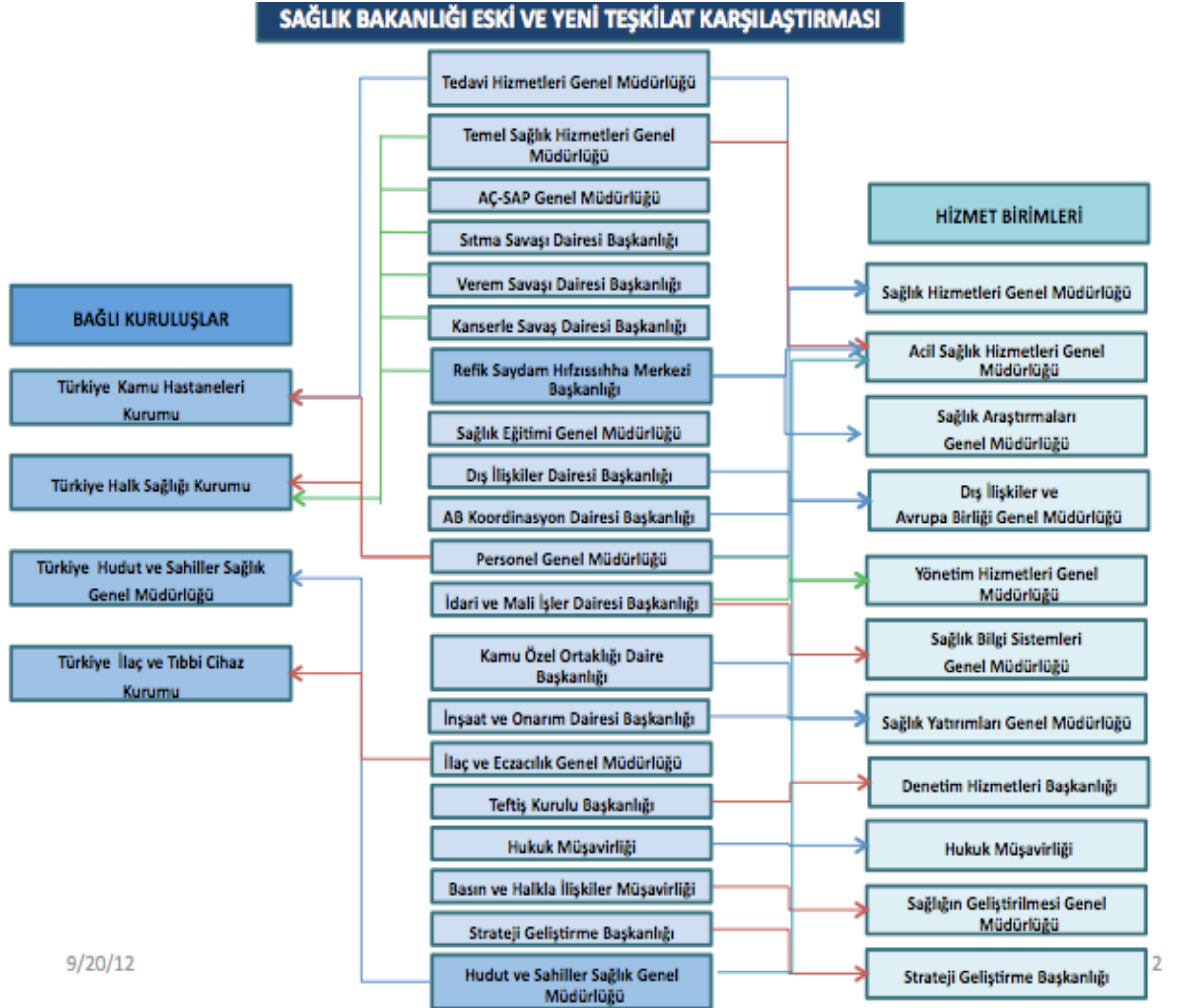
TESLİM EDEN
İl Sağ. Müd. AÇSAP Şb. Md.
Tıb. Tek. Serpil SÜMER

TESLİM ALAN
Belin Benezra



APPENDIX H

THE COMPARISON BETWEEN THE OLD SYSTEM AND NEW ORGANIZATIONAL SCHEMA OF THE MINISTRY OF HEALTH WITH THE HELP OF LAW 663



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