

# **ADAPTING, SCALING UP, AND SUSTAINING A FAMILY PLANNING & REPRODUCTIVE HEALTH MODEL: THE WILLOWS FOUNDATION OUTREACH PROGRAM IN TURKEY**

## **Introduction and Background**

The Willows Foundation (WF) has been implementing the “Community-Based Reproductive Rights and Health Information, Education and Referral Services Project (RRH Project)” in Turkey since 1999. Building on the success of Matlab and other community-based projects, the RRH Project’s intensive community-based approach aims to increase women’s knowledge about family planning and reproductive health (FP/RH), improve access to services, change reproductive health (RH) behavior, and to encourage other preventive behaviors, e.g., antenatal care, breast self-examinations and cervical cancer screenings. To date, almost 1 million poor urban women of reproductive age from 32 project districts in 16 provinces of Turkey have been reached by nearly 1000 secondary school-educated Field Educators (FEs). In each district, education and referral services are provided over a period of 18 months. Once positive changes brought about by the project are deemed sustainable in particular areas, the project ends its activities and moves on to other areas. As of December 2005, the WF program was being implemented in 13 project sites in nine provinces of Turkey and about 300,000 women were receiving health information from over 200 WF Field Educators.

In 2004-2006, an evaluation conducted by the Istanbul University Institute of Child Health assessed ongoing and completed RRH project activities in the urbanized areas of six provinces of Turkey –Istanbul, Ankara, Gaziantep, Diyarbakir, Van and Adana – where approximately 300,000 women of reproductive age had received WF services. The purpose of the evaluation was to measure the effects of the program on both the intended beneficiaries and the project staff. The 12-month evaluation began in July 2004 with the actual fieldwork taking place over the four months between September 2004 and January 2005. The main outcome indicators were changes in use of effective contraception (modern methods and emergency contraception) and related preventive behaviors, e.g., Pap smears, breast self- examination, and antenatal care. The data management and analysis were completed in late 2005 and by fall 2006 a detailed report was written and then translated into English. This extended abstract summarizes the main outcome indicators and accomplishments of the project.

## **Community-based Approaches to Reproductive Health**

Community-based distribution (CBD) projects identify and train members of a community to offer information and contraceptives to poor women in the community through home visits. This type of intervention was first initiated on a large scale in Bangladesh in 1978. In both rural and poor urban areas, the Matlab and Extension CBD projects lowered the cost of contraception to users and significantly increased contraceptive use. A 1988 qualitative study found that home visits by project workers yielded other positive effects on the women visited. In rural areas of Pakistan, the two-fold increase in the use of reversible contraceptives (from 1990-1991 to 2000-2001) was linked to a “lady visitor” program. In rural Punjab, a study revealed that 70% of women were unable to visit a health center “unaccompanied,” due to traditional restrictions on women’s mobility. In this case, the study demonstrated the usefulness of home visits to deliver health services to women.

CBD has been fine-tuned over the years and many projects have also successfully been implemented in Africa and Latin America. In Turkey, several CBD approaches have been implemented by NGOs since the 1980s. In these projects, local distributors typically visit married women to offer information on temporary contraceptive methods and refer them to clinics for long-term methods. Recently, however, a

number of organizations, including Willows Foundation, have added other RH elements, e.g., Pap smears, breast self-examinations and referrals for specific RH problems.

### **The Willows Foundation's Community-Based Project**

The RRH project builds on lessons learned from other CBD projects but represents a systematic effort to scale-up and adapt CBD approaches to specific Turkish settings and make reproductive behavior changes more sustainable. The Willows Foundation approach emphasizes identification of intended beneficiaries and the obstacles they face regarding RH; targeted messages based on survey research performed in the community; frequent systematic management and documentation of repeat visits to each woman of reproductive age in the community and follow-up customized for each woman based on her priority for service and RH background.

The first three months of fieldwork in a new project area are spent on household assessment studies to collect data on the female population in the district, including age, education, pregnancy history, contraceptive practice, knowledge of sexually transmitted infections (STI), use of antenatal care, breast self-examination practices, and knowledge of emergency contraception. The RH needs of the population are then analyzed and prioritized; household-by-household and woman-by woman. A follow-up visitation card is created for each woman 15-49 years old. At the same time, the FEs receive refresher training specific to the needs of the community, after which they initiate the home visits. Depending on the characteristics of the area, each FE visits an average of 1,000 women four times each during the 18-month life of a project in a given area. Information on modern contraceptive methods, including emergency contraception; breast self-examination; and how to access health services for reproductive health, is shared with all women progressively after the initial visit. After each home visit, the completed follow-up visitation cards are entered into the project database and kept in a separate folder for each woman beneficiary until the next visit. The supervisor determines which women should be visited next after a weekly review of the cards and puts the cards of women to be visited in the coming week into the FE's box. Each FE has on average of 150 cards assigned to her for a week, and makes 15 to 20 home visits per day. First priority visit cards, selected by supervisors, identify women who are not using contraception, are pregnant or lactating, or have recently had a delivery or abortion. Second priority is given to newlyweds, engaged couples, and users of traditional methods.

Willows conducted operational research in 2001 to explore obstacles to the use of services, including distance to the health facility and perceived quality of services; the woman's status in the household and restrictions posed by husbands, detailed information on why RH services are indicated, and the cost of services. Women reported having been negatively affected by bad treatment at health facilities. They suggested that health facilities be visibly rewarded for providing quality services, so that they could distinguish between good facilities and those that are not carrying out their responsibilities. Because Willows works cooperatively with government health services, collaborating institutions were informed about the women's views; recommendations were made for actions to improve the communication skills of the midwives and nurses; and training programs were offered. In addition, the health facilities were advised of the need to improve their management capacity and the need to improve their physical infrastructure so that counseling could be provided in private spaces. Those facilities significantly improving their services were rewarded with a financial grant from Willows to be used to further improve their facilities and services.

### **Structure of the evaluation**

Quantitative and qualitative data collection techniques were used for evaluation of the RRH Project. Trained interviewers from the local communities, used questionnaires to gather information from women

of reproductive age. (Field educators' data were collected by self-administered questionnaire). Detailed qualitative information also was obtained from a small subset of women served by the project and from field educators using focus group discussions (FGDs) and in-depth interviews (IDI) to explore issues in more depth. Also, data were collected through IDIs with health professionals working in referral health institutions in project areas.

### ***Quantitative survey***

Provinces served by the project were grouped into two strata: (1) more developed provinces/areas with higher social and economic indicators (Istanbul, and Ankara), and 2) less developed provinces/areas with lower social and economic indicators (Adana, Diyarbakir, Gaziantep, and Van). Six provinces were selected by purposive sampling to be included in the evaluation. Within the six provinces selected, all project areas in which services were provided were included in the evaluation.

The design called for a sample of 2000 women in the intervention group and 1000 women in the control group. The target sample size for each project area within a province (classified as either more or less developed) was based on the number of women served by the RRH project in that project area, relative to the total number of women served by the WF RRH project in all project areas classified as either more developed or less developed. The actual final sample was 2965 women, 1965 in the intervention groups and 1000 in the control group. However, in selected sites, other than Istanbul, during the analysis stage, it was discovered that some women in control group had previously lived in WF Project areas, therefore findings for the control group other than Istanbul were excluded from the analysis.

Researchers used questionnaires, which included both closed-ended and some open-ended questions, to interview women in the intervention and control groups at each site. The survey included socio-demographic information; sources of information about fertility and contraception; STIs; emergency contraception; and preventive RH behaviors (antenatal care, breast self-examination, Pap smears), changes in attitudes and practices regarding RH, including method of contraception used; use of preventive RH services; access to RH Services; empowerment; fertility intentions; sexual discrimination; and impact of the project on their lives.

Questionnaires for FEs were self-administered and were sent by registered mail to all 377 women FEs who had worked in the six selected provinces. The questionnaire forms were used to gather information on background characteristics, current occupation, income-generating activities, RH service use, history of contraceptive use, changes in RH attitude and practice, fertility intentions, personal experience with issues addressed by the WF, empowerment, sexual discrimination, impact of the project on their own lives and on that of women reached, and expectations for the future. The response rate for this survey was 62%.

### ***Qualitative research***

Following preliminary analysis of the quantitative data, eight FGDs, of 6-8 women each, were held with women served by Willows in selected provinces. Participants were selected from both intervention areas and control sites to explore differences in use of RH services. Eight focus groups were also conducted with the Willows FEs, who had completed or were continuing their work with the Willows Project.

In order to clarify and explore further the findings of the FE Survey, in-depth interviews were also conducted with one newly appointed FE, one experienced FE, one supervisor, and one coordinator in the selected provinces of Adana and Van. Following the survey data collection, IDIs were also conducted with four health workers in Adana and Van, where the FGDs with women beneficiaries were held.

## Results

### *Impact on women reached*

Regarding the impact of the WF project on the women served, there was a pronounced, significant difference between the first and last visits by WF staff, in the overall use of modern methods increasing from 45.5% ( $\pm$  8.7%) to 69.8% ( $\pm$  6.5%) by the end of project service- more than a 50% increase. Permanent, long-term method usage increased 38% in the more developed areas and 65% in the less developed project areas.

Temporary modern method usage among the women served by the WF Project more than doubled from 16.% to 33.1%. More than 50% of women using traditional methods of contraception shifted to a modern method. At the end of the intervention period, average continuation rates for women who reported initially using modern methods were extremely high, 94%. Those who continued to use modern methods averaged around 77% at the time of the evaluation with 16% and 32% of attrition rate, in the more developed and less developed areas, respectively. This attrition rate is significantly lower than the national average attrition rate of 40% (Turkey DHS, 2003).

Around 20% of women who had received WF services but persisted in using traditional methods or using no methods adopted modern methods of contraception in the two years following the end of services in their area. Additionally women in more developed areas not directly receiving WF services reported modern methods of contraception prevalence rates almost twice that reported by women at first contact who had received WF services. This is a significant effect, possibly a “spin-off” effect of the project and suggests that the women who did not receive WF services (either due to omission in original selection or migration into the project area after initial selection) were affected through word of mouth by the community members.

The project has had an especially significant effect on younger women and women who were married for less than 4 years. At the time of the evaluation, it was found that in all project areas this group of women had much higher modern method use than women married for the same length of time in the Turkish general population (46% vs 28%)

The survey also demonstrated that there was roughly a 40% increase in modern method adoption for women married 1 and 2 years ( 6-48% in year 1 and 23-63% in year 2). The increase was 35% for women married for 3-4 years and 20% for women married for 5 and more years.

The evaluation found that exposure to the Willows program dramatically increased women’s knowledge and use of preventive behaviors including obtaining Pap smears, mammography, and obtaining or conducting breast exams. From beginning to end of project service, the proportion of women going to a doctor or hospital for a mammography increased from 8% to 25% in more developed project areas and from 1-2% to 10-15% in less developed areas. In more developed areas, knowledge about emergency contraception increased from 7% to 39% from the beginning until the end of project service.

In general, women in both Willows and non-Willows neighborhoods were aware of the available government, private, and university health services in their areas and said that they use these services. For example the evaluation found that, the average number of antenatal visits to health services in the last pregnancies of women surveyed was 6.0 in developed areas and 2.8 in less developed areas. The qualitative research revealed that impolite treatment by some health workers, difficulty in accessing

services, and the poor overall quality of care in public health services appeared to be the reasons which led some women to prefer private physicians.

The evaluation survey revealed that the most frequent sources of information on RH were the women's spouses, neighbors, also female relatives and friends. Most women indicated that the husband was very important in deciding on what contraceptive method to use.

### ***Impact on field educators***

The field educators had in general applied the skills or attitudes that they had acquired during the WF training to their own lifestyles: they controlled their fertility, used reproductive health services, and practiced positive reproductive health behaviors. They increased their reproductive health knowledge and reported gaining self-reliance, and improved communication skills through their work with the project.

The field educators stated that major challenges of their work were difficulty in communicating with women with low levels of education, adverse weather conditions making it difficult to travel and poor relations with health facilities' staff . They also indicated harsh economic conditions that women in the community experience and thus the difficulty the women have in accessing RH services. The field educators felt that referring women to health facilities was an important service and it was a service that they enjoyed providing. Although the health facilities were conveniently located, relationships with the staff of the facilities were often difficult in the beginning. Field educators were often not initially accepted by health service providers, the women referred by Willows staff were treated poorly, and there were insufficient supplies – all of these factors made their work more difficult.

### **Discussion and Conclusions**

In her qualitative study of CBD in Bangladesh, Simmons *et al*<sup>1</sup> maintained that the women of Matlab who served as community-based distributors were not only viewed as providers of contraceptives but also were considered as trustworthy friends with whom women could talk about their concerns regarding the use of contraceptives. Apart from Simmons' pioneering study, little research analyzes the nature and quality of such services provided by home visits, and the impact on the home visitors as well as the women served. The research presented herein demonstrates that trained home-visitors who did not have medical backgrounds were successful in providing information and counseling, and in stimulating the use of government services even when those services were viewed as flawed and thus made a significant impact on the reproductive behaviors of women at project sites. The evaluation also demonstrated that WF approach is highly effective in maintaining the use of modern method use once adopted.

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<sup>1</sup> Simmons R., Baqee L., Koenig MA., Phillips JF (1988), Beyond Supply, The Importance of Female Family Planning Workers in Rural Bangladesh, *Studies in Family Planning*, 19 (1): 29-38