Monitoring Report on Sexual and Reproductive Health Services in Turkey Before and During the Pandemic

Uluslararası İnsan Hakları Çerçevesine Uyumun İzlenmesi İçin
ETKİNİZ
AB PROGRAMI

CİSÜ
CinselSağlık&Üreme SağlığıHaklarıPlatformu

TAPV
Türkiye Aile Sağlığı ve Planlaması Vakfı

Monitoring Report on Sexual and Reproductive Health Services in Turkey Before and During the Pandemic

Turkish Family Health and Planning Foundation

Assoc. Prof. Volkan Yılmaz, Boğaziçi University

November 2020

"This publication has been produced with the financial support of the European Union within the scope of Your Impact EU Program. Only the Sexual and Reproductive Health Rights Platform is responsible for the content of this publication and in no way reflects the views of the European Union."

Turkish Family Health and Planning Foundation

Monitoring Report of Sexual and Reproductive Health Services in Turkey Before and During Pandemic

ISBN: 978-605-70326-2-1

Report (Translated by a professional company into English from the original report written in Turkish)

İstanbul, November 2020

Monitoring Coordinator: Assoc. Prof. Volkan Yılmaz

Monitoring Assistant: Oğulcan Yediveren

Contents

Abbreviations 5

Introduction: Sexual and Reproductive Health Services During Pandemic 7

The Need for Sexual and Reproductive Health Services in Turkey 15

Monitoring Method 19

Overview of Sexual and Reproductive Health Services in Turkey Before the Pandemic 23

- Maternity Care 24
- Contraception and Family Planning 28
- Sexual Health and Well-Being 41

The State of Sexual and Reproductive Health Services During the Pandemic 45

- Maternity Care 47
- Contraception and Family Planning 52
- Sexual Health and Well-Being 59

Results and Recommendations 65

- General Results and Recommendations 65
- Results and Recommendations Related to the Pandemic Period 67

References 71

Abbreviations

AÇSAP-Maternal and Child Health & Family Planning Center

ARV-Antiretroviral

ASM-Family Health Center

CDC-American Centers for Disease Control and Prevention

ÇEKÜS-Child, Adolescent, Woman and Reproductive Health Unit

CİMER-the Communication Center of the Presidency

CSO-Civil Society Organization

EPF-European Parliamentary Forum for Sexual and Reproductive Rights

EU-European Union

FP-Family Planning

GDTM-Voluntary Test and Counselling Center

HÜNEE-Hacettepe University Institute of Population Studies

ILO-International Labor Organization

IPPF EN-International Planned Parenthood Federation – European Network

IUD-Intrauterine Device

OECD-Organization for Economic Cooperation and Development

SDG-Sustainable Development Goals

SGK-Social Security Institution

SHM-Healthy Life Center

SRH-Sexual and Reproductive Health

STI-Sexually Transmitted Infections

TAPV-Turkish Family Planning Foundation

TDSH-Turkish Demographic and Health Survey

TTB-Turkish Medical Association

UNFPA-United Nations Population Fund

UNHCR-United Nations Refugee Agency

UN-United Nations

USA-United States of America

ÜSBEM-Reproductive Health Regional Training Center

WHO-World Health Organization

Introduction: Sexual and Reproductive Health Services during Pandemic

Sexual and reproductive health (SRH) services are one of the most important tools that enable people to exercise their fundamental human rights and freedoms. SRH started to be considered within the scope of human rights upon the United Nations (UN) International Conference on Population and Development held in Cairo in 1994 (for the Turkish translation of Statement on Reproduction Rights and Sexual Rights published by IPPF in 1995, see. (TAPV, 1997)). World Health Organization (WHO) defines SRH rights as the right of all people to have access to the highest standard sexual and reproductive health, free of coercion, discrimination, or violence. According to WHO (2002), these rights include the following:

- Having access to sexual and reproductive health services,
- Requesting and collecting information on sexuality and reproduction,
- Getting training on sexuality and reproductive health as well as physical integrity,
- Choosing your spouse/partner,
- Deciding on whether to be sexually active,
- Consensual sexual relationships,
- Consensual marriage,
- Deciding on whether to have children,
- Deciding on the number of children to have,
- Leading a pleasurable and safe sexual life.

As seen in many countries around the world during recent years, a new wave of political opposition to SRH rights is trying to present these rights as the imposition of a certain lifestyle to society. However, SRH rights offer an approach that aims for everybody to decide on their sexuality and reproduction in an adequately informed and free manner, and at their discretion. In this respect, SRH rights encourage individuals to take their decisions without being coerced, subjected to discrimination and violence.

Based on this approach, access to SRH services, as one of the sub-goals of Gender Equality, the 5th of Sustainable Development Goals (SDG), is defined as follows:

> "Ensuring global access to sexual and reproductive health in line with the conference outputs determined as a result of the International Conference on Population and Development Program of Action, Beijing Action Platform and review conferences thereof." (Global Goals, 2020).

Two SDG indicators aim at assessing the extent to which this goal is achieved are developed as follows:

> "1) Use of contraceptive methods, the rate of women that are aged between 15 and 49 and make their own conscious decisions on sexual relationships and reproductive health, and 2) Number of countries that guarantee providing information and education on sexual and reproductive health to women aged between 15 and 49 through laws and regulations" (Global Goals, 2020).

Even though these indicators set up by UN and UN institutions offer useful reference points to compare progress in different countries, data for these indicators are collected using two methods that are restricted in validity for assessing the desired components: survey research and legislation review. These methods may remain inadequate in capturing on which basis individuals state that "they have made their own conscious decisions" in opinion surveys and the extent to which the legal framework is practiced in real life. Therefore, monitoring reports, including this one, reviewing the implementation especially from the perspective of service providers may present a more comprehensive assessment of the state of SRH services compared to survey research and legislation review.

United Nations Population Fund (UNFPA, 2020a) details the above-mentioned second indicator, which aims to assess the extent to which countries manage to provide universal access to SRH services, under 4 titles and 13 elements. These elements provide us with a useful guide in terms of listing key domains that must be taken into account in assessing SRH services:

"Maternity Care:

1) Maternity care,

2) Life-saving commodities,[1]

3) Legal status of abortion,

4) Post-abortion care,

Contraception and Family Planning:

5) Contraception,

6) Consent for contraceptive services,

7) Emergency contraception,

Comprehensive Sexuality Education and Information:

8) Legal framework of comprehensive sexuality education and information,

9) Curriculum of comprehensive sexuality education and information,

1. UN suggests that 13 life-saving products must be made accessible worldwide. These products are as follows: 1) Maternal health commodities: Oxytocin, misoprostol, magnesium sulfate; 2) Neonatal health commodities: Injectable antibiotics, antenatal corticosteroids, chlorhexidine, resuscitation tools; 3) Child health commodities: Amoxicillin, oral rehydration salts, zinc; 4) Reproductive health commodities: Female condoms, contraceptive implants, emergency contraception (UN, 2012).

Sexual Health and Well-Being:

10) HIV testing and counseling,

11) HIV treatment and care,

12) Confidentiality of health status for men and women living with HIV,

13) HPV vaccine" (UNFPA, 2020a).

When we started this monitoring study during the early stage of the pandemic, there was limited research offering a comprehensive and up-to-date assessment of SRH services in Turkey before the pandemic. As the first component of this monitoring study indicates, SRH services had a limited capacity and were provided in a disorganized manner in Turkey before the pandemic. For instance, the Turkish HIV/AIDS Control Program (2019-2024) prepared with valuable contributions of shareholders was published (Ministry of Health, 2019), but limited steps were taken in the protection and prevention components of SRH services. Like many other countries around the world, the field of SRH has become a politically contentious topic in Turkey to the extent that the polarization over the SRH has become hard to comprehend from a scientific point of view.

In such a context, the COVID-19 pandemic broke out and affected the whole world including Turkey. According to WHO, the first COVID-19 case was diagnosed in Wuhan, China, on December 31, 2019, and WHO announced Global Emergency on January 30, 2020 (2020, April 9). Starting especially from the March of 2020, many countries have put social distancing measures into force such as lockdown, the closing of businesses and schools, travel restrictions, etc. to control the spread rate of the virus (ILO, 2020). As of June 15, 2020, there were about 8 million confirmed cases and around 500,000 pandemic-related deaths that were reported to WHO globally (WHO, 2020, June 15).

Direct damages of the pandemic on public health and its socioeconomically destructive effects were not limited to these fatalities. The unpreparedness of countries to guarantee access to other important healthcare services during the pandemic inevitably added another layer to the effects of the pandemic itself. This report provides a review of these kinds of effects of the pandemic period that fall within the scope of SRH services.

Before the pandemic took hold of the world, United Nations High Commissioner for Refugees (UNHCR, 2011) defined a minimum initial service package aimed at reproductive health during a crisis and underlined that SRH services should be included in the strategies of tackling different forms of crisis. Similarly, WHO (2012) recommended that SRH services should be incorporated into the strategies of national disaster recovery. WHO suggested that the following measures should be taken in a disaster situation:

1. "Incorporate SRH into multisectoral and health emergency risk management policies and plans at national and local levels.
2. Integrate SRH into health risk assessment and provide early warning for communities and vulnerable groups.
3. Create an environment of learning and awareness.
4. Identify and reduce risks for vulnerable communities and SRH services by reducing underlying risk factors.
5. Prepare existing SRH services to absorb impact, adapt, respond to, and recover from emergencies" (WHO, 2012).

According to the information provided by UNFPA, the COVID-19 pandemic "has already severely disrupted access to life-saving sexual and reproductive health services" (UNFPA, 2020b). It is reported that the service capacity of SRH decreased significantly due to the increased pressure on health systems in different countries during the pandemic, and the allocation of a large part of healthcare budgets and human resources to the fight against the pandemic (UNFPA, 2020b). UNFPA stated that countries with weak health systems and low income were the most severely affected ones (UNFPA, 2020b).

In addition, it is reported that implementation of pandemic-related measures such as travel restrictions and lockdown without considering its impact on access to SRH services, led to serious problems in family planning (FP) services, healthcare services provided before, during, and after birth, diagnosis of sexually transmitted infections (STI), and treatment services (UNFPA, 2020b). UNFPA also pointed out that some factories that manufactured important medical products used in the field of SRH were closed down due to the same reasons, and access of persons living with HIV and pregnant women to some vital medications and contraceptives became quite difficult due to disruptions in the global and local supply chains (UNFPA, 2020b). The institution highlighted that such disruptions have aggravated the existing inequalities within and between societies in the field of SRH, and affected vulnerable groups (women, girls, HIV patients, etc.) the most (UNFPA, 2020b).

FP services include services such as the supply of contraceptives, safe abortion, and counseling. FP counseling is known to be one of the most effective tools to prevent unwanted pregnancies (WHO, 2020, April 6). Because it is possible to eliminate potential negative effects such pregnancies may create on women's health, prevent unsafe abortions performed under unhealthy conditions, and avoid maternal deaths (WHO, 2020, April 6). Additionally, the prevention of unwanted pregnancies also contributes to saving the healthcare facilities from an additional burden of service especially in the context of the pandemic (WHO, 2020, April 6). It is reported that increased inadequacy of healthcare staff, insufficient time of healthcare staff, lack of adequate amount of personal protective equipment, the closure of health institutions, or the restriction of their service capacities in several places led to a decline in the capacity of FP counseling services and thus an increase in unmet FP needs (UNFPA, 2020c). Besides, it is pointed out that there is a reduction in the application of women to healthcare institutions due to their anxiety of getting infected by the virus (UNFPA, 2020c). Disruptions in the supply chain have also been creating problems in access to contraceptive tools (UNFPA, 2020c).

A report covering all European countries showed that 307 clinics and healthcare centers had to close down due to the pandemic (EPF and IPPF EN, 2020). This figure represents about 78 percent of the healthcare institutions participating in this research (EPF and IPPF EN, 2020). The same report also demonstrated that there was a reduction by 80 percent in outpatient visits to healthcare centers in Brussels and Valon regions in Belgium even though all FP centers were kept open (EPF and IPPF EN, 2020). The inadequacy of the number of healthcare staff required for the continuity of SRH services is another problem stated in the report (EPF and IPPF EN, 2020). For instance, it is observed that the staff of 11 institutions were either ill or in quarantine, and the staff of six institutions was assigned temporarily for the fight against pandemic (EPF and IPPF EN, 2020).

No similar study has been conducted on the situation in low and medium-income countries yet. However, some studies estimated the effects of the pandemic in the field of SRH in these countries. For instance, according to a report of UNFPA, if the pandemic lasts for more than six months, it is estimated that 47 million women would not be able to have access to contraceptive methods in 144 low and medium-income countries (UNFPA, 2020c). The same report set forth that there would be an increase of about seven million in unwanted pregnancies if service breakdowns and lockdown continue for another six months (UNFPA, 2020c). Another study including 132 low and medium-income countries anticipated a ten percent decrease in the use of contraceptive pills (Riley et al., 2020). Such a decrease in the use of contraceptive pills is expected to increase the number of women needing pills by about 48 million, and accordingly cause more than 15 million women to be subject to unwanted pregnancy (Riley et al., 2020).

In addition to FP services, healthcare services provided before, during, and after birth also constitute an important part of SRH services. Factors leading to a disruption in FP services also lead to similar levels of service breakdowns in this field (UNFPA, 2020g). UNFPA underlined continuing to provide these services during the pandemic is of key importance to prevent an increase in the rates of maternal and neonatal deaths (UNFPA, 2020d). A study, examining 132 low and medium-income countries, estimated that pandemic would lead to a ten percent decrease in the capacity of birth-related healthcare services in these countries (Riley et al., 2020). It is anticipated that such a decrease would increase the number of women experiencing birth-related complications by 1 billion 745 thousand, and accordingly lead to the death of 28 thousand mothers and 168 thousand infants (Riley et al., 2020).

Effects of the 2014 Ebola virus pandemic on maternal and neonatal healthcare services in countries with weak healthcare systems may shed a light on the negative implications that the current pandemic may cause. For instance, a study estimated that a 22 percent decrease was observed in the capacity of SRH services in Sierra Leone during the Ebola pandemic, leading to an additional 3,600 maternal deaths, neonatal deaths, or stillbirths (Sochas, Channon and Nam, 2017). Researchers stated that these figures are estimated based on the most moderate scenario, and underlined that these deaths, as indirect results of the pandemic, may have been as destructive as the deaths directly caused by the pandemic (Sochas, Channon and Nam, 2017).

Moreover, we do not have enough information yet on the potential negative health implications for pregnant women infected with COVID-19 and neonates (CDC, 2020). Research conducted on nine pregnant women infected with COVID-19 in China suggested that the progress of infection in these women is not different from non-pregnant women, and there is no case of intrauterine transmission of the infection from mother to the child (Chen et al., 2020). Even though this research reported that the virus does not have a severe effect on pregnant women, another study highlighted that such research was conducted with women who were in the last three months of pregnancy and the critical period when pregnant women must be very cautious about their health is the first three months (Qiao, 2020). WHO stated that even though there is no evidence of pregnant women being affected worse by the virus yet, additional precautions must be taken to protect pregnant women from the virus (WHO, 2020, March 18). WHO also underlined that pregnant women should be treated as humanely as possible, have a companion of their own choice during birth, communicate with birth staff clearly and openly, receive a pain-relieving treatment suitable for pregnancy, and give birth at a position of their choice which is easy for them to move, for the pregnant women to have a safe and positive birth experience (WHO, 2020, March 18).

WHO suggested that mothers infected with COVID-19 may breastfeed and have close contact with their babies (WHO, 2020, May 7). However, mothers are recommended to wash their hands before and after breastfeeding, and wear a mask while breastfeeding (WHO, 2020, May 7). In research conducted on 33 children infected with COVID-19 in China, symptoms of the virus were observed mildly only in three children (Zeng et al., 2020).

Another important problem in healthcare for women during the pandemic is estimated to be access restrictions to voluntary pregnancy termination services. The United States of America (USA), as part of its Life Protection policy in Global Health Aid, stopped providing aid to civil society organizations (CSO) offering abortion services or referring individuals to these services, providing counseling about these services or advocating for them (Hall et al., 2020). This change in the American development aid policy is believed to cause negative results in the future such as decreased coordination between stakeholders, the exclusion of abortion from the global policy agenda, increase in unwanted pregnancies due to the decrease in access to FP services (Hall et al., 2020). Additionally, it is pointed out restrictive migration policies of the USA and European Union (EU) member states cause disruptions in the access of undocumented migrant women living in those countries to maternity services, hygiene materials, and safe abortion (Hall et al., 2020).

Abortion bans or restrictions of access to abortion services that existed before the pandemic continue to limit access to safe abortion during the pandemic as well (EPF and IPPF, 2020). For instance, it is pointed out that pandemic in conjunction with restrictive abortion policies in Poland makes access to safe abortion almost impossible (EPF and IPPF EN, 2020). It is underlined that the decision of the Romanian government to suspend non-urgent healthcare services resulted in restricted access to these services (EPF and IPPF EN, 2020). Furthermore, it is stated that some countries consider pandemic as an opportunity to ban abortion. For instance, the Minister of Health of EU member state Lithuania stated that the time spent by

women in quarantine is a good opportunity for them to review their abortion decisions, while another EU member state Poland restarted the discussion about the bill that de-facto bans abortion (EPF and IPPF EN, 2020). Another study on access to abortion services in low and medium-income countries during pandemic estimated that unsafe abortions performed under unhealthy conditions would increase by ten percent, which would lead to a significant rise in maternal mortality (Riley et al., 2020).

Pandemic is also expected to create problems in the diagnosis of STI and access to medication and treatment services especially concerning HIV. It is indicated that social distancing measures reduce access to HIV tests, which will lead to delays in the diagnosis of individuals infected with HIV and the start of treatment on time (Jiang, Zhou and Tang, 2020). Furthermore, delays may occur in starting antiretroviral (ARV) treatment of individuals diagnosed with HIV due to reasons such as overburdened health services or reduction in resources allocated to fight with HIV due to pandemic (Jiang, Zhou and Tang, 2020). For instance, a published report found a remarkable decline in STI and HIV services such as counseling, tests, and routine screenings provided in Switzerland, Albania, and Poland such (EPF and IPPF EN, 2020).

Besides, it is thought that the supply chain affected by the pandemic may lead to problems such as inventory stock-outs of ARV medication in certain locations, or failure to deliver such medication to locations in need (UNFPA, 2020e). In this context, the pandemic is predicted to cause several problems for people living with HIV to continue ARV treatment (Jiang, Zhou, and Tang, 2020). According to a study in China, 32.6 percent of participants report that they do not have a sufficient amount of ARV medication to meet their needs in case of a potential lockdown or travel restriction and will face the risk of running out of all medication the following month (Guo et al., 2020). The same study suggested that 64.15 of participants have difficulty accessing ARV medication due to lockdown restrictions (Guo et al., 2020).

Similar to the rest of society, about 37.9 million people living with HIV worldwide carry the risk of getting infected with COVID-19 (Jiang, Zhou, and Tang, 2020). Studies started to examine the consequences of COVID-19 infection for individuals living with HIV. Research conducted on 1174 individuals infected with HIV in China found that individuals living with HIV who are on regular medication are protected from severe symptoms of COVID-19 (Guo et al., 2020). However, researchers underlined that this finding must be supported by larger-scale studies (Guo et al., 2020). WHO stated that it would be sufficient for individuals with HIV to take the same precautions against COVID-19 as the rest of the population (2020, March 24).

One of the key groups that will be most adversely affected is adolescents and the youth (UNFPA, 2020f). Disruptions are anticipated to occur in SRH counseling and education for adolescents and the youth (UNFPA, 2020f). For instance, the comprehensive sexuality education stopped along with the suspension of formal education in 23 of 28 countries that are members of the International Family Planning Federation European Network, and in 24 of those countries, pieces of training for persons providing peer education was interrupted (EPF and IPPF EN, 2020). Participants of the same report indicated that youth- and adolescent-friendly SRH clinics were closed down during the pandemic in the United Kingdom and Finland (EPF and IPPF EN, 2020).

For the access to SRH services to be interrupted to the minimum extent during the pandemic, the importance of delivering healthcare services through a community-based approach, providing universal health coverage to reduce the negative effects experienced by vulnerable groups due to inequalities, employing methods such as telemedicine, self-care, and personal health practices, and changing policies and laws that restrict access to SRH services is recommended (Hall et al., 2020; WHO, 2020). Community-based health services include all the services provided by human resources that are defined on a quite broad scale in terms of education and capacity (WHO, 2020). Such broadly defined human resources may involve all the professional or non-professional; formal or informal; paid or unpaid staff as well as employees that support or supervise such staff and provide support services for them (WHO, 2020). Opinion leaders, municipality employees, CSO staff, and volunteers are listed among the local actors (WHO, 2020). Implementation of the community-based healthcare approach includes important steps such as providing basic healthcare services through a community-based approach, enabling smooth communication between health authorities and society, assigning suitable roles to healthcare professionals, and strengthening the supply chains (WHO, 2020). WHO underlined that provision of healthcare services through a community-based approach is a useful means of preventing an increase in illness and death rates (WHO, 2020). It is estimated that enabling healthy communication between health authorities and society, and strengthening inter-community bonds around positive health behaviors will build trust among society and lead to a decrease in fear and an increase in cooperation (WHO, 2020). In this way, it is believed that subscribing to health behaviors that comply with recommendations of healthcare staff will increase (WHO, 2020). WHO underlined that providing the healthcare professionals with required personal protective equipment and making regular tests are of vital importance for the healthcare staff to fulfill their roles in the best way within this approach (WHO, 2020).

As a result, important interruptions are expected to occur in the access to SRH services due to reasons such as failure to implement measures for the COVID-19 pandemic in coordination with plans to meet other health needs, reduction in SRH service provision capacity of healthcare systems due to increasing work overload, allocation of a significant part of public health budgets to fight against the pandemic, and decrease in the request for health services due to risk of infection. Interruptions in SRH are expected to be most intense in access to FP services, access to health services related to birth, and access to diagnosis of STI and medication and treatment services. As discussed above, groups such as women, adolescents, people with disabilities, people living with HIV, and international migrants are among the key social groups that will be affected by such interruptions in the first place. Studies suggest that to prevent potential negative health consequences, the continuity of access to SRH services without interruption is of as much vital importance as the fight against COVID-19.

The Need for Sexual and Reproductive Health Services in Turkey

Turkish Demographic and Health Survey (TDSH) conducted by Hacettepe University Institute of Population Studies (HÜNEE) once every five years, based on a nationally representative sample, provides us with information on the content and size of the need for SRH services in Turkey. Published at the end of 2019, TDSH 2018 results indicate a remarkable increase in the rate of unmet needs related to SRH services in Turkey as compared to 2013 (HÜNEE, 2019).

The extent to which gender equality is realized and the effectiveness in child protection systems are among the most important determinants of SRH outcomes. One of the significant results of TDSH is that four percent of girls aged between 15 and 19 and 1.3 percent of girls aged between 15 and 17 started giving birth (HÜNEE, 2019). Although a one percent decline in the first rate as compared to 2013 suggests an improvement, there is still a need for public interventions aimed at decreasing these rates due to the negative health results of pregnancy in adolescence, and other consequences that damage gender equality.

Another important finding of TDSH is that there is a considerable demand for FP counseling and services. The fact that more than half of married women aged between 15 and 49 (53 percent) do not want to have any more children in the future and 14 percent of women in the same age group want to wait for at least two years for having another child are the most remarkable findings showing the size of demand for FP counseling and services. More than one-third of married women not using any contraceptive methods (38 percent) state that they intend to use a method in the future. The most common method that is intended to be used by women is the intrauterine device (IUD) (28 percent) followed by male condoms (21 percent), pills (11 percent), and tubal ligation (8 percent) (HÜNEE, 2019).

A decline in the rate of unintended births among women between 15 and 49 by five points as compared to 1993 is a promising development. Despite this development, the finding of TDSH 2018 that 15 percent of births that occurred during the last five years were unwanted births (HÜNEE, 2019) shows that available FP counseling and services are not adequate for meeting the needs yet. Especially old-aged women with more than one child stand out as a key group with unmet needs. As the age of women and the number of children increases, the rate of unwanted births rises as well (HÜNEE, 2019). Women living in rural areas is another key group. The difference between the total desired fertility rate and the total actual fertility rate is 0.3 across Turkey, while it increases up to 0.5 for women living in rural areas (HÜNEE, 2019).

The rate of knowing at least one FP method among women is 97 percent (HÜNEE, 2019) according to the findings of TDSH 2018, which is another positive finding. However, it is important to note that women's knowledge of a single FP method should not be accepted as adequate, and FP counseling and services should be offered in a way to create awareness among women of different contraceptive options. This will give women the right to decide which contraceptive method they would like to use. According to the research, 81 percent of women state that they could not get information about family planning from the media (HÜNEE, 2019), which implies that public providers have a very major role and unique function in the field of AP counseling.

The findings of the research indicate that 70 percent of married women report using at least one FP method. The most commonly used methods by married women are the withdrawal method (58 percent), the male condom (49 percent), IUD (35 percent), and pills (30 percent) (HÜNEE, 2019). According to the results of TDSH 2018, more than half of the women (52 percent) access modern FP methods through public providers. However, it stands out that the share of public providers in accessing modern methods decreased by four percentage points between 2013 and 2018 (HÜNEE, 2019). Such a decrease in the share of public providers in the provision of contraceptive materials may have caused some women to quit the methods involuntarily. This interpretation is supported by the finding of one-tenth of the women that quit IUD, injection, and pill methods due to facing difficulty in accessing them (HÜNEE, 2019). Based on these results, public providers play a key role in the implementation of women's SRH rights. On the other hand, the negative effects of the shrinkage in the capacity of SRH service provision by public providers within the last five years in the SRH field are noteworthy. The authors of the TDSH 2018 report analyzed this situation as follows:

> "The decrease in the use of conventional methods in Turkey could not be compensated by the limited rise in the use of modern methods, therefore the rate of women who do not utilize contraceptives has increased from 27 percent to 30 percent from 2013 to 2018" (HÜNEE, 2019: 85).

The rate of unmet FP need in Turkey has declined between 1993 and 2013 (from 15 percent to 6 percent), but this rate increased back to 12 percent in 2018 (HÜNEE, 2019). Two-thirds of the unmet FP need of women constitutes birth termination, while one-third is birth spacing (HÜNEE, 2019).

One of the striking findings is that the rate of women who have unmet FP needs in Northeast Anatolia, İstanbul, West Marmara, and Southeast Anatolia is above the country average (HÜNEE, 2019). The abovementioned regions with unmet FP need exceeding the average of Turkey include regions both with the highest or lowest economic development rates. This leads us to conclude that there is a countrywide need for comprehensive and free of charge FP services that are offered by public providers. In addition, it is observed that the unmet FP need of the women who live in the places with the lowest level of welfare is also above the average of Turkey by six percentage points (HÜNEE, 2019). Such finding also points out the key role of public providers in FP services.

The situation in maternity services seems more positive compared to other SRH fields. It is found out that 96 percent of the women aged between 15 and 49 who had a live birth during the last five years received prenatal care from expert health personnel and that 99 percent of the live births occurred at a healthcare facility (HÜNEE, 2019). It is mentioned that 96 percent of the women who gave live birth within the last two years got postnatal care within 41 days following birth. Despite this picture seemed positive in general terms, it should also be noted that the rate of the women who did not receive any prenatal or postnatal care is 3.5 percent (HÜNEE, 2019). Considering the limitations of TDSH to access specific vulnerable groups such as seasonal agricultural workers who are sometimes not recorded in the address-based population registration system, it is suggested that special interventions about maternal health and birth services may be required for such groups.

Lastly, according to the results of the research, 5.9 percent of every 100 pregnancies end with voluntary pregnancy termination (HÜNEE, 2019). It is seen that slightly more than half of the voluntary pregnancy termination services are provided by public providers whereas slightly less than half of them are offered by private providers (HÜNEE, 2019). As underlined before, in parallel with the finding that the rate of unwanted births among old-aged women with multiple children is higher than that of the overall women, the ratio of voluntary pregnancy termination rises as the number of children and age of women increase (HÜNEE, 2019). Another remarkable finding of the research is that 64.3 percent of the women who had induced miscarriage reported that they did not use any FP method before the termination of pregnancy (HÜNEE, 2019). Along with the unmet FP need that was discussed before, this finding leads us to conclude that meeting the unmet FP need may also lead to a decline in the rate of voluntary pregnancy termination.

Monitoring Method

We conducted this monitoring study to examine the state of SRH services in Turkey during the COVID-19 pandemic. To examine the changes that occurred in these services during the pandemic, we needed comprehensive information on the state of SRH services before the pandemic. Due to the lack of comprehensive and up-to-date studies, we decided to gather information on the SRH services provided before and during the pandemic, as part of this monitoring study. This monitoring report examines the state of SRH services in Turkey during the pandemic as compared to that before the pandemic. Furthermore, the report also reviews the state of SRH services in Turkey before the pandemic in the light of Turkey's obligations about SRH services arising from international conventions and commitments.

This study was prepared with the support of the Sexual and Reproductive Health Rights Platform (based in Turkey) in which national or local civil society organizations, academic institutions, professional associations, and academics working to support access to sexual and reproductive health rights and services of all without any discrimination gather together to collaborate for SRHR advocacy. The outbreak of the COVID-19 pandemic led the Platform to take steps for primarily understanding the effects of the pandemic in the field of SRH.

Before starting this monitoring study, the Platform's executive board carried out a survey including open-ended questions, to identify the difficulties experienced by CSOs while providing SRH services, collect information on the changes in the provision of SRH services as well as the violation of rights in the field, and understand the good practices during the pandemic. Dr. Doğan Güneş Tomruk prepared the questionnaire for that study, and 20 CSOs participated in the study. The results of the study pointed out that CSOs working in the field of SRH moved their programs to online platforms largely during the pandemic. Representatives of these CSOs had the impression and concern that access of especially women and disadvantaged groups to SRH services was restricted during the pandemic. Even though this study is quite valuable in terms of collecting CSOs' insights, we decided that it would be important to get the opinions of healthcare providers to better examine the changes in the provision of SRH services during the pandemic.

This monitoring study is based on a qualitative method approach in social sciences. We conducted in-depth, online interviews with individuals from 18 institutions operating in the SRH field. The purposive sampling method was used in the identification of interviewees. We considered the following criteria while choosing our interviewees: Diversity of specialty among the professionals working in the field of SRH (phy-

sician, midwife, and nurse; infectious diseases specialist, gynecologist, etc.), cities, and institutions where the individuals work, and their expertise in SRH sub-fields. We identified our interviewees from among the experienced professionals or institutions that are actively working in the field of SRH based on convenience, by sticking to the purposive sampling method at the same time. The majority of our interviewees consisted of professionals who are experts in their field, work in the field of SRH and have experience in working together with CSOs operating in the field of SRH. Since the fight against the COVID-19 pandemic continued in Turkey during June and July 2020 when the interviews took place, we could reach most of the interviewees with the support of TAPV and Sexual and Reproductive Health Rights Platform members and thanks to trust relations between these organizations and our interviewees. All the healthcare professionals we interviewed worked in the public sector. The distribution of our interviewees is as follows:

- Family practitioner (2 people)
- Family planning specialist and a midwife working under district health directorate
- The staff of a specialist institution in the field of SRH
- Infectious diseases specialist (2 people)
- Former AÇSAP staff and a physician working under district health directorate (2 people)
- Former family planning clinic staff and a Healthy Life Center physician
- Public health services manager
- The staff of CSO offering services to people living with HIV
- GDTM staff working under district municipality
- GDTM staff working under district municipality, nurse
- Gynecologist
- Gynecologist, working in an FP clinic of a public hospital
- The staff of CSO offering SRH services for refugees (2 people)
- The staff of CSO offering services to women subjected to violence

We asked our interviewees to describe the state of SRH in Turkey before and during the pandemic, share their observations and assessments, and express their opinions on which solutions can be developed for the shortcomings they have identified. The duration of interviews varied between 20 minutes and 70 minutes. Interviewees shared their thoughts not on behalf of their institutions, but according to their professional experiences.

We applied a content analysis on the qualitative data we have collected, using NVIVO software. We followed a deductive coding strategy in the content analysis. As mentioned at the beginning of this report, the classification of UNFPA related to SRH services constituted the general themes we used. Following the coding process, we identified the general patterns in the collected data associated with each sub-theme we used in the analysis (each component of SRH services). We drew up the findings using direct citations exemplifying these general tendencies.

To complement the interview data, we searched for information on how many FP counseling centers re-started operation in the period when mobility restricting measures were loosened in İstanbul (in the middle of July 2020). We could not get this information from the official website of the İstanbul Provincial Health Authority. Therefore, we called each of the 26 centers in various districts of İstanbul, which we could find by searching on the Internet and all of which were named AÇSAP. We could reach only three of 26 centers during working hours. Among the three centers that replied to us on the phone, staff of two stated that they only performed IUD applications in their centers while the staff of the other center stated that they did not accept any applications due to the pandemic and could refer us to the maternity unit of a public hospital. We would like to thank Cemre Canbazer, the researcher of Social Policy Forum, for her support in this stage of the study.

Lastly, we asked a condom company with a large market share in Turkey to provide us with their sales statistics to check if the interruption of condom distribution by public providers is compensated by condom sales. The company informed us that sales declined by over one-forth in April when measures restricting human mobility were taken on a large scale, as compared to the previous month. If the decline curve in the sales of this company applies to the overall sector, then we believe that an increase might have occurred in the unmet FP needs during the pandemic.

This report provides an overview of SRH services in Turkey before and during the pandemic by focusing on the following three titles of four suggested by the UNFPA: Maternity care; contraception and family planning; and sexual health and well-being. We excluded the comprehensive sexuality education and information component from the scope of this study. We also excluded components requiring the collection of information directly from service receivers. We would like to note that the prevention of gender-based violence and intervention on such violence cases are often evaluated within the scope of SRH (See WHO, 2017). However, we did not collect any data on this issue. People who want to follow the developments on this issue can get information from the monthly reports published during the pandemic by Purple Roof Women's Shelter Foundation (2020).

There are important limitations of this exploratory monitoring study. The main limitation is that it did not collect data on the experiences of SRH service users. As expressed before, this monitoring study is largely based on the professional observations of health service providers. Another limitation is its limited sample, which does not sufficiently reflect the diversity of providers. On one hand, the centralized structure of the healthcare service system in Turkey brings together nationwide standardization in terms of service provision, service organization, and scope of social health insurance. In this respect, even the observations of two infectious diseases specialists, for example, may provide us with important information on the state of diagnosis and treatment of STIs. On the other hand, we believe that an evaluation based on observations of two physicians only is not likely to reflect the detailed state of diagnosis and treatment of STIs in Turkey. For instance, types of healthcare institutions where physicians work (state university hospital, training and research hospital, etc.) and diversity in the needs of people for SRH services who live in different areas of

the country make it impossible to generalize based on a few interviews. Therefore, further studies may interview a larger number and diversity of professionals and focus on different sub-components of SRH services. Nonetheless, given the lack of research on SRH services in Turkey, we believe that this study offers a quite comprehensive assessment of the state of SRH services in Turkey despite all these limitations.

We would like to thank Nurcan Müftüoğlu, TAPV general coordinator, and Hilal Döner, TAPV project manager, who offered their generous support at many stages of this study. We would like to extend my thanks to Oğulcan Yediveren, who successfully served as my monitoring assistant, compiled international discussions in the field of SRH during the pandemic, and conducted interviews with the GDTM staff. We are indebted to all our interviewees that spared their time for this study despite working overtime during the pandemic.

Overview of Sexual and Reproductive Health Services in Turkey before the Pandemic

Reviewing the overall picture of SRH services in Turkey before the pandemic was important for providing us with a reference point to assess what kind of changes occurred in SRH services during the pandemic. SRH services had a limited capacity and were provided in a disorganized manner in Turkey before the pandemic. One of our interviewees, who is an employee of an institution specialized in the field of SRH, summarized the picture of SRH in Turkey before the pandemic as follows:

> "Right before the pandemic, the priority of SRH services and public services in Turkey was about nothing but preventing maternal and neonatal deaths. What did that mean? Performing at least four follow-ups during pregnancy, referring risky pregnancies, and encouraging birth services in particular in primary healthcare services... There was no investment in family planning. What we call family planning is actually the prevention of unwanted or risky pregnancies. These services continued during this period to an extent but since these are the services that would disappear on their own unless actively supported, they disappeared."
>
> (Staff of a specialist institution in the field of SRH)

Described similarly also in other interviews, this overall picture indicated a strong political commitment to reducing maternal and neonatal deaths, while it also underlined that such commitment did not apply to all of SRH services. An infectious diseases specialist we have interviewed stated HIV as follows that similar problems were present also in the field of fight against:

> "There was almost no effort on protection or prevention. The focus was on treatment services. Therefore, we had difficulty in preventing the increase in the number of patients, which disturbed us quite a lot. We used to rank Turkey among one of the countries worldwide with a rapid increase in infection rates. We do not know what is going to happen now."
>
> (Infectious diseases specialist, 1)

As cited above, the interviewee highlighted that the failure to implement protective and preventive measures in the fight against STIs overshadowed the success achieved in the treatment services. In general, interviewees emphasized that treatment services in maternal health, sexual health, and well-being in the field of SRH had a relatively strong structure in Turkey before the pandemic whereas contraception and family planning and protective and preventive components in sexual health remained weak.

In this part of the report, we will thoroughly review the state of SRH services in Turkey before the pandemic under the titles of maternity care, contraception and family planning, and sexual health and well-being.

> "Interviewees emphasized that treatment services in maternal health, sexual health, and well-being in the field of SRH had a relatively strong structure in Turkey before the pandemic whereas contraception and family planning and protective and preventive components in sexual health remained weak."

Maternity care

The practice of pregnancy follow-up applied in Turkey includes the registration of a woman as pregnant and four follow-ups performed by the family health centers (ASM). Family practitioners we have interviewed considered pregnancy follow-ups as one of the main components of ASM services and reported that pregnancy follow-ups are mostly performed successfully and on time. Family practitioners stated that they also make postpartum home visits for once to monitor the health of mother and baby.

Interviewed family practitioners attributed such regular service provision especially in pregnancy follow-ups to the inclusion of these services into the performance-based remuneration system for family physicians. While the inclusion of pregnancy follow-ups with the performance system appears to have improved the overall access to this service, one family practitioner claimed that this resulted in some family practitioners tend not to register women that are hard to follow-up (for instance, seasonal agricultural workers). The findings of TDSH 2018 also showed that such a possibility claimed by the interviewee must be taken into consideration, given that the rate of women reporting to have received no healthcare before or after birth was about 3.5 percent.

> "While the inclusion of pregnancy follow-ups with the performance system appears to have improved the overall access to this service, one family practitioner claimed that this resulted in some family practitioners tend not to register women that are hard to follow-up (for instance, seasonal agricultural workers)."

Another family practitioner we interviewed remarked that problems of individuals with ASM registrations could have negative effects on pregnancy follow-up. The interviewee stated that the bond between the individual and family practitioner could be quite weak in cases when the individuals are not registered to

an ASM that is the closest to their permanent address or do not update their ASM registration when their permanent address changes, which would make pregnancy follow-up harder.

> "The application of performance-based physician remuneration in gynecology services turned out to be a factor undermining service quality."

While the inclusion of especially the pregnancy follow-ups into the performance-based physician remuneration in ASMs is generally presented as an enabling factor for the continuity of these services, the application of performance-based physician remuneration in gynecology services turned out to be a factor undermining service quality. For instance, a gynecologist working in a public hospital stated:

> "A patient came and I asked about her complaint. I took her to the gynecology table. She undressed, stood up, and got dressed again. Then I prescribed her laboratory tests or the medication and sent her away. All these procedures cannot be completed in just five minutes. Therefore, we try to do some things based on estimations. Maybe some of my colleagues will disagree with me but a gynecologist claiming to examine 400 patients a day in a public hospital cannot argue that they are examining the patient thoroughly. That they are taking everyone to the table. That they are prescribing medication. Plus they are answering the questions of patients. These are not possible."
>
> (Gynecologist)

As seen in the citation above, the interviewee does not believe that gynecology services could be provided as required within the time allocated to the patient as part of the performance system. The interviewee underlines that the minimum time allocated to the patient must be extended, which he sees as the only way to offer quality gynecology services.

> "The interviewee underlines that the minimum time allocated to the patient must be extended, which he sees as the only way to offer quality gynecology services."

During the interviews, we got the impression that there is no significant obstruction related to social security or access to services other than the language barriers for the Syrians under temporary protection to have access to primary maternal healthcare services through Migrant Health Centers or ASMs. Even though there is no obstruction for access of Syrian women under temporary protection to gynecology services in secondary and tertiary healthcare, we received responses suggesting that especially the language barrier still gives rise to some problems. For instance, a CSO employee offering SRH counseling for refugees indicated the following problem:

> "One of the greatest complaints of women is that translators at hospitals request extra payment for their services. Unfortunately, this is a very typical situation in X Maternity Hospital, as an example. We are trying to explain the solutions to these women in our workshops. We are trying to provide information about how to use the complaint mechanisms. What is the patient rights center, what does it do, where to make a complaint, how to write to CİMER, how to contact the Provincial Directorate of Health, etc."
>
> (Staff of a CSO that offers SRH counseling for refugees, 1)

As seen in the above citation, some of the translators employed to eliminate the language barrier of Syrians under temporary protection in their access to healthcare services may ask for illegal charges from them. If such practices continue in an uncontrolled manner and remain unpunished, Syrian women most of which are on very low incomes may continue to have difficulties in accessing services.

A common problem mentioned in interviews about maternity care was the presence of serious restrictions in the provision of voluntary pregnancy termination services despite the enabling legal framework. Even though voluntary pregnancy termination is possible in Turkey within the 10-week legal period, this service is covered by the Social Security Institution (SSI) and public healthcare providers are liable to provide the relevant service, it seems that access to such service has become significantly difficult. Important studies were conducted during the last years that thoroughly examined the scope of the problem (O'neil et al., 2016; Topgül et al., 2017). This monitoring study corroborates with the results of those studies. On the other hand, findings of TDSH 2018 showed that about half of the voluntary pregnancy termination services are received from public providers. This, again, confirms that there is a disorganized service structure in the field of SRH.

Almost all the healthcare staff we have interviewed stated that they did not know where to refer a patient requesting a voluntary pregnancy termination service. A family practitioner indicated that such a restriction in voluntary pregnancy termination services would give rise to negative results also for maternal health:

> "If the Ministry of Health states that they want to increase the birth rate and country's population, and decrease the maternal and neonatal death rates, then they have to provide a very good pregnancy termination service and a very good family planning service. What kind of dilemma is that? The problem is that when you do not allow pregnancy termination and push the patients to illegal abortion, maternal and neonatal death rates rise. Your main target is pregnancy and increasing birth rates, but the woman who will give that birth dies under those conditions. If you want to increase birth rates, then you should know that people's relation to pregnancy changes when they intentionally get pregnant. It is also possible to establish a structure that allows individuals to get intentionally pregnant and have a healthy birth process rather than unwanted pregnancies or risky pregnancies with unpredictable consequences."
>
> (Family practitioner 1)

> “Almost all the healthcare staff we have interviewed stated that they did not know where to refer a patient requesting a voluntary pregnancy termination service.”

As mentioned above by the interviewee, restricting access to abortion services poses the risk of increasing maternal deaths as a result. In this respect, the interviewee underlines that there is a dilemma between decreasing the maternal and neonatal death rates as the main policy target in the field of SRH services before the pandemic and limiting access to voluntary pregnancy termination. In addition, it must be noted that the reduction of demand for voluntary pregnancy termination service through effective FP counseling and services and turning abortion into the last resort would be much more appropriate.

> “In this respect, the interviewee underlines that there is a dilemma between decreasing the maternal and neonatal death rates as the main policy target in the field of SRH services before the pandemic and limiting access to voluntary pregnancy termination.”

A CSO staff offering SRH services for women suggested as follows that different alternatives can be offered to women for voluntary pregnancy termination in addition to medical abortion:

> “Medical pills. I do not know if you have heard about them but medical pills are very common around the world. We went to a meeting in 2011. Physicians recommended these pills there. They said those pills are being used all over the world including Europe.
>
> Researcher: Are they used for terminating unwanted pregnancies?
>
> Yes, yes. They are used under the supervision of physicians. But they were not allowed in Turkey. This method could be applied in family health centers under a physician’s supervision. If people think abortion, anesthesia, operating room, or other stuff are expensive, they can apply this method. But they cannot.”
>
> (Staff of a CSO that offers SRH counseling for women)

As mentioned by the CSO staff cited above, including available alternatives for voluntary pregnancy termination in the coverage of SSI provided that they are scientifically effective, and allowing the women to have access to different options may be seen as a step to improve the system.

Contraception and family planning

Along with the reform in healthcare services, the decision was to offer contraception and family planning services in primary care, i.e. ASMs. Majority of our interviewees approved in principle that FP services should be offered to citizens at the closest location by the ASMs. However, they emphasized important issues concerning the ASMs' failure to offer FP services and counseling effectively in practice. For instance, an employee that had worked in a closed Maternal and Child Health & Family Planning Center and was working at a district health directorate at the date of the interview stated as follows:

> "The first target was that when we shift to family physicians model, family practitioners should have this role (referring to FP services and counseling). And actually, I also think that is reasonable and correct. They know about their population, the people visiting the center. People have a lot more chance to reach them. Because otherwise they have to search for us and come here, but ASM is right in their neighborhood. The chance of receiving that service is naturally higher because they already go there to have their children examined or get prescriptions. But in practice, did it work like that? No, it did not."
>
> (Former AÇSAP staff, a physician working under district health directorate, 2)

Follow-up of women aged between 15 and 49, which is under the responsibility of ASMs, has provided an important channel for FP counseling. But the family practitioners we have interviewed stated that such follow-up is perceived in some ASMs as collecting data from women, rather than an opportunity for offering FP counseling. Besides, interviewees emphasized that one of the important factors causing follow-up of women in the 15-49 age group turn into a practice aimed at data collection only was the large size of the population registered to each ASM. Lastly, family practitioners we have interviewed indicated that follow-up questions are often not asked unmarried women, which may lead to skipping important health information. The aversion of ASM staff from asking follow-up questions to unmarried women may be partly attributed to restrictions imposed by available cultural codes and deficiency of the skills and materials required to inform young people about FP in ASMs.

"Follow-up of women aged between 15 and 49, which is under the responsibility of ASMs, has provided an important channel for FP counseling. But the family practitioners we have interviewed stated that such follow-up is perceived in some ASMs as collecting data from women, rather than an opportunity for offering FP counseling."

According to the interviews, one of the obstructions against offering FP services and counseling effectively in ASMs was the large size of the population per ASM and the limitations arising from the standard infrastructure and human resources of ASMs. For instance, a healthcare administrator explained the issue as below:

> "We could not adapt the operation logic of community healthcare centers (the primary care model that preceded the family physician model) to that of ASMs. We used to have a responsible team at the community healthcare centers before. For instance, we had a manager. And we also had staff that could support other working teams. We could increase the number of staff at any time we wanted. We could request extra personnel. Or an extra midwife. But now it is all limited. Limited with a number. Limited with a unit. Furthermore, you cannot allocate more space for these units. Because the rental contract belongs to family practitioners, it is private in a sense."
>
> (Public health services manager)

In parallel with the above citation, family practitioners indicated that the demographical structure and income level of the neighborhood where the ASM is located create serious differences in the demand of the community for FP services of the ASM. Therefore, family practitioners underlined that ASMs that are located in neighborhoods with high fertility and low-income rates may remain inadequate in meeting the demand for FP services of ASMs especially in terms of human resources. These opinions lead us to conclude that the standardization of staff allocation for ASMs fails to meet the needs for FP services equally where the scope of such need varies across neighborhoods.

"Family practitioners underlined that ASMs that are located in neighborhoods with high fertility and low-income rates may remain inadequate in meeting the demand for FP services of ASMs especially in terms of human resources."

Some of the interviewees suggested that the qualifications of staff are another obstruction against ASMs' ability to offer an effective FP service. As a confirmation of the findings in the report of Topgül et al. (2017), family practitioners generally consider the other healthcare staff they work with as responsible for FP services. Therefore, the quality of the FP service provided in ASMs was mostly described as a function of the qualifications of other healthcare staff. For instance, a family practitioner commented on the issue as follows:

> "This is not (just) a quantity issue; there is also a qualitative issue. Because the Ministry of Health says that the person working with the family practitioner can either be a family health worker, health officer, nurse, or emergency medical technician. However, a job title is given based on completing a particular curriculum. Midwives, for instance, are trained in this specific field (referring to FP services and counseling)."
>
> (Family practitioner 1)

As mentioned by the family practitioner cited above, the majority of the interviewees working in primary healthcare stated that the presence of especially a midwife or a nurse in an ASM is an enabling factor

for the more competent and comprehensive provision of FP services in that ASM. For instance, a family practitioner's opinion on the issue was as follows:

> "If the midwife is a person that really embraces the work [family planning counseling in ASM], then yes. But today you do not get anything extra for this. I mean, your population is fixed in family practice. So is your wage. You get the same money whether those four thousand people visit you every day or not. Therefore, midwives here could have the same opinion but that is just a chance you know. I mean here they talk to people for hours to explain the issues but it was not like that in the previous place (referring to another ASM that she worked previously)."
>
> (Family practitioner 2)

> "The majority of the interviewees working in primary healthcare stated that the presence of especially a midwife or a nurse in an ASM is an enabling factor for the more competent and comprehensive provision of FP services in that ASM."

As expressed by the family practitioner, the provision of FP counseling in the ASMs is not a standard service. If trained healthcare staff is present in an ASM who also commits oneself to offer FP counseling and continue to perform her job even if there is no financial incentive, then ASMs offer FP counseling. Even according to the experience of a single family practitioner who worked for two ASMs, one ASM provides FP counseling while the other does not.

Emergency medical technicians whose education does not include SRH subjects can work as a family healthcare worker in the ASMs, which may have contributed to the weakening of the FP service capacity of ASMs. An interviewee who works as a midwife in a reproductive health unit under the district health directorate expressed the problems that may arise due to this situation as follows:

"Assume that a woman is coming here for SRH counseling. Problems may occur when receiving service from her (referring to the healthcare staff that has not received education in the field of SRH). What do we tell about reproductive health services? Family planning, communication, sexual health for young people, STI, and safe motherhood. If she has received good training on these subjects, that's OK. But since this information is constantly updated and renewed, the service she provides may remain limited."

(A family planning specialist midwife working under district health directorate)

In this regard, in-service pieces of training offered by the Ministry of Health to support the healthcare staff who do not have sufficient knowledge of FP services appear to have great importance. One interviewee working as a family practitioner stated that the district health directorate occasionally makes in-service

training announcements related to family planning and reproductive health, and they encourage the ASM staff to participate in these training programs. A physician working in the Reproductive Health Regional Training Center (ÜSBEM) that offers training on FP and reproductive health said that participation in such training programs is voluntary:

> "In-service pieces of training offered by the Ministry of Health to support the healthcare staff who do not have sufficient knowledge of FP services appear to have great importance."

> "We cannot say they are mandatory training programs but of course you need that certification to conduct specific programs. I mean, if the worker will insert an IUD, then family planning training is a must. If he or she will provide counseling, then either a family planning services training certificate or a reproductive health certificate is required. So what does this mean? Things are becoming mandatory. Or if they plan to open a pregnancy school or provide training to pregnant women in the district for informing them, then such colleagues come and get reproductive health training."
>
> (Former AÇSAP staff, a physician working under district health directorate, 1)

As seen in the above citation, participation in the in-service training that is necessary to offer FP services is voluntary. However, if specific ASM or healthcare staff intend to provide FP services and counseling, they must participate in these training programs. Even this structure suggests that FP service and counseling are perceived as an optional service in practice in ASMs. A physician working in Healthy Life Center (SHM) mentioned that one incentive that encouraged participation in the FP skills training was canceled before the pandemic:

> "Family planning units had a classification in the past as A, B, and C, and now there is no classification. A and B were the units that received the highest amount financially in terms of remuneration. These pieces of training were mandatory until June 2019; getting an IUD certificate, completing that family planning skills training. Therefore, family practitioners or accompanying nurse or midwife used to take this course to be entitled to class A or B and receive a higher rate of remuneration."
>
> (Former family planning clinic staff, a Healthy Life Center physician)

Lifting the requirement that encourages participation in family planning training might lead to a decrease in the participation of ASM staff in these kinds of training programs. Furthermore, it does not appear quite likely for Turkey to offer a standard FP service in ASMs through voluntary participation in these pieces of training. Yet one interviewee expressed the insufficiency of the previous requirement in securing the standard provision of these services in ASMs as below:

> “It does not appear quite likely for Turkey to offer a standard FP service in ASMs through voluntary participation in these pieces of training.”

“But were they applying the skills that they got in such training in practice? No, they were not. Why not? Because the family practice model… only prioritizes services that are included in the performance system (for remuneration). Family planning services are not part of that.”
(Former family planning clinic staff, a Healthy Life Center physician)

As remarked in the citation above, even though the ASM staff gets training on FP and reproductive health, the lack of any central mechanism to monitor regular FP service provision, and the exclusion of FP services from the performance-based remuneration remains insufficient to secure the provision of FP services in ASMs. As a confirmation of this impression, family practitioner interviewees stated that the gynecological examination table was not used in ASMs even if there was one, and procedures such as IUD were not generally performed. One interviewee indicated that failure to use the gynecologic table made it difficult to perform new procedures such as cervical cancer screening in ASMs as follows:

> “Even though the ASM staff gets training on FP and reproductive health, the lack of any central mechanism to monitor regular FP service provision, and the exclusion of FP services from the performance-based remuneration remains insufficient to secure the provision of FP services in ASMs.”

“Gynecology table became so important that processes that are ignored in family planning now became a requirement in chronic health services, cancer screening for instance. It has now been noticed that if you want to increase HPV cervical cancer screening rates, there must be family planning experience or family planning capacity in that healthcare institution. Because there is already a gynecology table for vaginal examination in the centers where family planning services are provided frequently and the intrauterine device is inserted. Then all you have to do is to add an HPV screening kit to that setup. But if there is no such capacity, you have to provide a gynecologic table, hygienic environment, and a room for privacy from scratch. (If that capacity had been utilized) those patients would have experienced being on the gynecology table as part of the family planning services. However, since they do not have that experience they are saying ‘I will not have the cancer screening in the family health center’. This indicates that failure to perform primary healthcare services in the past leads to quite big problems... Then you have to start from scratch.”
(Family practitioner 1)

As expressed by the family practitioner above, even when a gynecology table is present in the ASM, the failure to turn this capacity into service appears to be common. The interviewee points out that failure to put this capacity into practice in the past poses a significant challenge against performing procedures such as cervical cancer screening effectively in primary healthcare today. The same family practitioner attributes the lack of an effective, quality, and sustainable FP service provision in ASMs to the failure of central monitoring mechanisms:

> "Health authorities normally ask a healthcare institution that does not prescribe medications 'why don't you prescribe medication during all those polyclinic procedures?'. But I have never seen any health authority asking any family health center why they do not provide family planning services or meet the need for intrauterine device insertion procedure."
>
> (Family practitioner 1)

As mentioned by the interviewee above, the lack of centralized monitoring of the execution of FP services in ASMs reinforces the perception among the ASM workers that such services are optional. Another interviewee explained why the FP services and counseling did not put into practice in ASMs as envisioned in the 2003 reform based on the following factors:

"The lack of centralized monitoring of the execution of FP services in ASMs reinforces the perception among the ASM workers that such services are optional."

> I believe mainly because they are not included in the performance (-based remuneration) and there is an increase in the workload (of ASMs). It could not be applied (Refers to family planning services in ASMs).
>
> (Former family planning clinic staff, a Healthy Life Center physician)

One of the most important problems in the field of contraception and FP services in primary healthcare before the pandemic was the lack of contraceptives especially after 2019. Most interviewees indicated this problem as follows:

"One of the most important problems in the field of contraception and FP services in primary healthcare before the pandemic was the lack of contraceptives especially after 2019."

> "There are sometimes problems in the supply of 3-month injections, monthly injections, or condoms. And a positive response can be received about this issue if the citizens make a complaint by calling 184, health information system."
>
> (Family practitioner, 1)

> "Back then we never had a time when we had none (contraceptives) or few. We were never concerned that we were short in stock or about what we were going to do (refers to the time when AÇSAPs were still in operation). But then we started to be out of stock for long periods. There were no pills or condoms for two or three months, for instance. What are people supposed to do in that case?"
>
> (Former AÇSAP staff, a physician working under district health directorate, 1)

> "It is obvious that there is a problem in the distribution of contraceptives. Let us say for the last six months. Starting from the end of last year. We are having trouble meeting the demand for contraceptives. It is a nation-wide problem. Only a higher executive can address this problem. The general directorate can answer why we are facing such a problem. Unfortunately, there is no answer. But the shortage of contraceptives is apparent."
>
> (Public health services manager)

The above-cited healthcare professionals that work in different cities stated that problem related to the supply of contraceptive materials resulted from the failure of the central administration to procure these materials. It does not seem reasonable for Turkey, a country in the upper-middle-income group (World Bank, 2020), not to be able to supply contraceptive materials sustainably due to financial reasons. Nevertheless, the findings of TDSH 2018 show that a significant part of women has a demand for contraceptive materials, and prefers to obtain such materials from public providers. The failure of the central administration to supply contraceptive materials denotes inaccessibility to such materials by a substantial segment of the society. Considering also the fact that the distribution of income in Turkey is quite unequal as compared to other member states of the Organization for Economic Cooperation and Development (OECD) (OECD, 2020), it is not difficult to foresee that interruption in the supply of contraceptive materials will turn into unmet FP needs especially for individuals on low incomes. Two interviewees expressed this problem as below:

"The failure of the central administration to supply contraceptive materials denotes inaccessibility to such materials by a substantial segment of the society. Considering also the fact that the distribution of income in Turkey is quite unequal as compared to other member states of the Organization for Economic Cooperation and Development (OECD) (OECD, 2020), it is not difficult to foresee that interruption in the supply of contraceptive materials will turn into unmet FP needs especially for individuals on low incomes."

> "The monthly injection that we provide for free costs 59 Liras (in the market). 59 Liras is very important for a family that makes a living with minimum wage. Because they have to get on the bus and come here to get the injection, which costs 10 Liras. The injection is 59 Liras. If there is no injection, they buy it from the pharmacy and come here. It is a real burden. So people are in demand but cannot reach it. So it is a problem."
>
> (Former family planning clinic staff, a Healthy Life Center physician)

> "Contraceptive pills are very expensive, too, you know. About 60-70 TL and women have to buy them every month. It is quite an expensive method."
>
> (Representative of a CSO that offers SRH counseling for women)

As is seen in the above citations, interruption in the supply of contraceptive materials will likely increase the need for unmet FP identified in TDSH 2018 further especially among those with low income. During the interviews, we learned that some healthcare professionals talked to their managers about the elimination of the supply problem regarding contraceptive materials and their managers responded that those materials could be supplied at the city level. For instance, a physician working in a Healthy Life Center talked about his experience as follows:

> "There was no material procurement for the last two years since 2019. When we went to Ankara for training, I wanted to talk to officers in the ministry. They told me that provincial directorates can procure the materials, but they do not. That they should buy from their budgets. Provinces have their revolving funds, you know. But that also varies based on the province. Ours did not procure. For about one year, we had no condoms, monthly injections, or contraceptive pills, which are normally provided as part of the standard family planning service. I am talking about the standard in our center by the way. For instance, we had a project called SIHHAT and had procured so many oral contraceptives for that project. So we took some from that project. With no charge. We distributed them ourselves. Because not only the migrants (referring to Syrians under temporary protection) but also the rest of the local community are coming to us. But we only have IUD since the beginning of 2020. There is no other family planning method available at this point."
>
> (Former family planning clinic staff, a Healthy Life Center physician)

As is seen in the above citation, the physician we interviewed tried to compensate for the interruption in the supply of contraceptive materials on his initiative, however, they had finished all those extra materials before the pandemic. Similarly, one GDTM employee stated that there was a high demand especially for condoms, so they cooperated with various CSOs to meet that demand. However, he added that it was not possible to ensure the sustainability of condom supply through the cooperation made with CSOs. In-

terviewee underlined that they could not get any support for condom supply from either the Ministry of Health or their district municipality. Another interviewee suggested that it was impossible to compensate for the inability of central administration to supply contraceptive materials by procurement at the provincial level:

> "(Procurement at the provincial level) Impossible because let's say our budget is about hundreds of thousand liras, but the annual need (for contraceptives) in our province is around millions of liras. So we need thirty to forty times our budget. You cannot procure anything with the money that the province does not have. You cannot procure without a budget... What would we buy? Things that could be purchased with a lower budget. Let us assume that we perform nine thousand IUD procedures a year in our province. Say ten thousand as an even account. Ten liras per procedure makes up to a hundred thousand. We can afford such a budget. But the budget reaches millions of liras for materials that we distribute in hundreds of thousands such as condoms or pills. The province has no such budget."
>
> (Public health services manager)

The above citation exemplifies the fact that interruption in the supply of contraceptives from the central administration cannot be compensated by the procurements at the provincial level. We believe that even if there was a sufficient budget that could be used for the supply of contraceptives at the provincial level, leaving the decision on the supply of contraceptives to provinces will not be desirable due to the imbalance that will emerge among the provinces.

In brief, the overall state of contraception and FP services in ASMs before the pandemic was as follows: Effectively conducted pregnancy follow-ups despite the substantial rate of unreached women which is around 3.5%, follow-up of women in 15-49 age group mainly for data collection purposes, FP counseling offered only if there is a trained and highly-motivated healthcare professional in the ASM, and lack of contraceptive materials.

Service units that offered contraception and FP services other than ASMs consisted of another component of this overall picture. These service units include FP centers of hospitals, AÇSAPs most of which have been closed but some of which are still in operation, ÇEKÜSs operating under health directorates, and newly opened SHMs some of which also include reproductive health counseling services. As mentioned before, even though contraception and FP services were defined in the remit of ASMs with the health reform, the overall picture of interviewed healthcare professionals pointed out that these services were not conducted effectively in the ASMs. Under such circumstances, the role of the abovementioned service units other than ASMs in the field of contraception and FP services seemed quite significant before the pandemic. First, family practitioners considered the cancellation of AÇSAP services in their provinces as a crucial problem:

> "All procedures performed in AÇSAP centers of the Ministry of Health are free of charge. It is a service you apply for with your identity card only. The problem gets bigger here since there is no substitute for it. The collapse of this system means the dissolution of an irreplaceable service."
>
> (Family practitioner 1)

> “Even though contraception and FP services were defined in the remit of ASMs with the health reform, the overall picture of interviewed healthcare professionals pointed out that these services were not conducted effectively in the ASMs. Under such circumstances, the role of the abovementioned service units other than ASMs in the field of contraception and FP services seemed quite significant before the pandemic.”

“Everyone is talking about the previous system like those were really good times, because all these services really existed. More quality service was provided with more staff. Now we are kind of by ourselves and AÇSAPs are needed a lot more as the workload (in ASMs) gets higher.”
(Family practitioner 2)

“Of course, family planning is the best as it includes premarital health counseling or pre-pregnancy health counseling, pre-adolescence, etc. When AÇSAPs were effective, there were age-sensitive services. It’s a bit awkward to get training when you are in your 40s and holding a baby.”
(Family practitioner 2)

As cited above, family practitioners remarked on the importance of contraception and FP services provided by AÇSAPs and their role complementary to ASMs in several aspects. The first aspect is that services provided by AÇSAPs could not be substituted by ASMs. Description of family practitioner 2 suggests that the period of AÇSAPs is recalled like a kind of golden age. It was emphasized that the service gap that emerged with the closure of some of AÇSAPs could not be filled. The second important aspect of the services provided by AÇSAPs was the high quality and diversity of services provided thanks to the employment of specialist staff in these centers and their direct focus on the population with demand for FP services. For instance, as noted by family practitioner 2, FP counseling was offered in an age-sensitive manner by the AÇSAPs, but it was not possible to provide such counseling in ASMs.

> “Family practitioners remarked on the importance of contraception and FP services provided by AÇSAPs and their role complementary to ASMs in several aspects.”

While the need for complementary and specialist FP service units is obvious, two physicians that are former AÇSAP workers described that these service units were not operating well before the pandemic:

> "Many units are closed because there is no staff and you cannot provide service. They (referring to central administration) do not really care about it anyway. They say that people will find service somehow when they search for it. They may go either to family practitioners or hospitals with FP clinics. That is the way it is. A service that is stuck in-between."
> (Former AÇSAP staff, a physician working under district health directorate, 1)

> "We offer services to patients; family planning services are still ongoing. Training also continues on the side. Family planning units that do not provide training are already closed down. There are very few which are active now. We are one of them."
> (Former AÇSAP staff, a physician working under district health directorate, 2)

> "There is a demand, which is obvious... Huge institutions turned into single rooms over time. The number of staff decreased but reproductive health is a very broad field... We could do many things when we were a large team. Now we have come to a point where we can only perform IUD procedure."
> (Former AÇSAP staff, a physician working under district health directorate, 2)

As reported by the interviewees, centers that keep operating are rather expected to continue their in-service training activities. Because of the reduction in employment of specialist staff in these centers, even though some continue to offer FP services, a serious shrinkage is remarkable in their scope of services. Although administrators mostly think that there is no need for AÇSAPs in FP services and FP services can be obtained from other centers, as mentioned by the above-cited second interviewee, we believe that such an opinion is inaccurate in light of the information we have gathered in this study. A healthcare administrator we have interviewed stated that AÇSAPs had an important complementary function in the field of contraception and FP services in his province before the pandemic:

> "When (family planning services are) insufficient in our public hospitals, there are two AÇSAP centers that are still in operation in our province, for instance."
> (Public health services manager)

We learned that the above-cited healthcare administrator initiated a plan for FP service delivery on a provincial scale and decided to keep two AÇSAPs open. However, other interviews we made with healthcare professionals working in different provinces showed that this administrator's practice of service planning at a provincial scale was an exception. For instance, a physician working in an SHM described the situation as below:

> "We are the only unit in this province. I do not know if you are aware but this city has a metropolitan status. It has one central district. Also, another 11 or 12 districts. It has large districts that are like big cities. However, there is no other place offering these services in those dis-

tricts either. They have their Healthy Life Centers but these services are not provided there. So they come to us as well."

(Former family planning clinic staff, a Healthy Life Center physician)

Women and reproductive health counseling services are among the services to be provided by SHMs, which are established to promote healthy lifestyles (Ministry of Health, 2020). However, as suggested by the interviewee, there is no standardization in these centers concerning contraception and FP counseling. Even though it is still possible for the SHMs to assume an important function related to unmet FP counseling services, such services are still seen as an optional field of service in the existing organization.

"Even though it is still possible for the SHMs to assume an important function related to unmet FP counseling services, such services are still seen as an optional field of service in the existing organization."

There was a consensus among our interviewees that people's needs for FP counseling services, and SRH counseling services in a more general sense, was not met adequately. For instance, an interviewee described the state of SRH services in Turkey before the pandemic as below by underlining the fact that Youth Counselling and Health Service Centers were closed despite a large investment made on capacity-building for many years:

"People, including the youth, could get counseling and information. Now young people cannot get access to SRH information and counseling."

(Staff of a specialist institution in the field of SRH)

CSOs specialized in the field of humanitarian aid compensated to an extent for the service gap that emerged in FP and SRH counseling before the pandemic. Carrying out activities to help Syrians under temporary protection to get access to their basic needs, these CSOs offered their counseling services in the fields of FP and SRH to the refugee population as well as Turkish citizens. In the interview with a CSO staff working in this field, the interviewee described her observations as follows:

"Majority of the problems are similar for the Turkish people, too. I can summarize the big issues we have encountered during the training programs as follows: The biggest problem is misinformation. Common misconceptions. In the training programs, we got much feedback like 'Oh, is it like that? I thought it was the other way'."

(Staff of a CSO that offers SRH counseling for refugees, 2)

As the citation above suggests, the interviewee stated that Turkish citizens and refugees have common needs for FP and SRH counseling. Another worker from a CSO operating in this field told us about the importance of offering SRH counseling not only for refugees but also for all women:

"This is a bit sensitive issue because the majority of the local community thinks that they (Syrians under temporary protection) give birth a lot and those women are under serious pressure in this regard. They also encounter some things (implying discriminative behaviors) in hospitals. Therefore, talking about this issue requires some sensitivity... I broach the subject by saying these issues are not only about Syrian women and actually concern all women. So I envisage the problem in a more integrated manner, including women in Turkey, then I talk about it."
(Staff of a CSO that offers SRH counseling for refugees, 1)

CSOs in the humanitarian field, as the quote above exemplifies, adopt an inclusive approach in both delivering counseling and designing the content. We find it thought-provoking that, in a country like Turkey where there is such an advanced healthcare services system, citizens' need for SRHR counseling can only be put into agenda within the framework of humanitarian aid programs targeting refugees. Even though these programs respond to a significant need even of the Turkish citizens, it seems very unlikely that these needs can be met sustainably unless public providers meet the needs in this field.

"Even though these programs respond to a significant need even of the Turkish citizens, it seems very unlikely that these needs can be met sustainably unless public providers meet the needs in this field."

A gynecologist working in the hospital of a state university pointed out that maternal health, and contraception and FP services must be considered as closely interlinked fields of service, as follows:

"There is no organized post-birth or post-miscarriage contraception counseling service in Turkey."
(Gynecologist, family planning clinic)

"We find it thought-provoking that, in a country like Turkey where there is such an advanced healthcare services system, citizens' need for SRHR counseling can only be put into agenda within the framework of humanitarian aid programs targeting refugees."

As expressed by the interviewee, post-birth and post-miscarriage contraception counseling services were not generally offered in Turkey before the pandemic. In a part of other interviews, healthcare professionals stated that such services were only offered in few hospitals of state universities, public hospitals that include a maternity hospital, and some maternity and children's training and research hospitals. But, as seen in the findings of TDSH 2018, such counseling programs would serve a significant social function especially for women with multiple kids voicing the need for FP services.

"Post-birth and post-miscarriage contraception counseling services were not generally offered in Turkey before the pandemic."

Lastly, it was indicated that Turkey manifests an overall positive picture in treatment services related to infertility, which is described as a reproductive system disorder. For instance, a gynecologist working in an FP clinic described the overall picture related to infertility treatment in Turkey as follows:

> "Infertility (refers to treatment) is common all around Turkey, and services are equivalent to the rest of the world."
>
> (Gynecologist, family planning clinic of a public hospital)

Indeed, in the case of both male and female infertility, treatment expenses, and in vitro fertilization expenses for women younger than 40 and up to 3 trials are covered by the SSI. We believe that the only obstacle against access to this service is the relatively high rate of co-payment that is expected to be paid by patients for in vitro fertilization.

Sexual health and well-being

The state of sexual health and well-being services in Turkey before the pandemic was uneven. The main reason for this unevenness resulted from the disregard for protective and preventive practices, while services related to diagnosis and treatment of STIs were strong in general terms along with some aspects open to improvement. An infectious diseases specialist talked about the overall picture as below:

> "We have lots of strengths. Access to medication as well as the ability to perform tests during diagnosis and follow-up. However, problems are present when it comes to sexual training and other preventive methods."
>
> (Infectious diseases specialist, 2)

Indeed, even though Turkey is historically a country with a low prevalence of HIV, it has experienced a remarkable increase in the number of people infected with HIV before the pandemic. Our interviewees stated that they were hopeful about the positive progress that the Ministry of Health's Turkish HIV/AIDS Control Program (2019-2024) can bring. Nevertheless, although an infectious diseases specialist thought that the Ministry of Health also took seriously the increase in the number of people living with HIV, he observed that there was still resistance from the Ministry against the introduction of some preventive and protective interventions:

"Our interviewees stated that they were hopeful about the positive progress that the Ministry of Health's Turkish HIV/AIDS Control Program (2019-2024) can bring."

> "Despite all our recommendations about the pre-exposure medication which is known to be the most effective method today, there is still no word on this in the strategic plan. This has been really disappointing for us."
>
> (Infectious diseases specialist, 1)

Disregard related to protective and preventive interventions about the fight against STIs appears to be consistent with the failure to provide contraception and FP services as mentioned in the previous section of this report.

While the common impression of our interviewees was that the overall picture of Turkey about diagnosis and treatment of STIs was positive before the pandemic, they also mentioned that some improvements were required in this field. As is known, social prejudices related to STIs and hesitancy of individuals about applying to healthcare institutions due to such prejudices may create obstacles against the access of individuals to treatment. Therefore, the provision of anonymous STI test services significantly facilitates the diagnosis process, and access to the treatment process of individuals, if they are infected. As a product of the partnership of the Ministry of Health and municipalities before the pandemic, the GDTM model is remarkable with its potential to offer an effective solution for this problem.

Another shortcoming related to the STI diagnosis and treatment seemed to be the problems resulting from SSI reimbursement in some hospitals. An infectious diseases specialist working in a state university hospital described the problem as follows:

> "One of the most problematic areas for us is the reimbursement for state university hospitals. The reimbursement policy (of the SSI) has not changed for a long time. But the costs of tests, expenses of hospitals, and many other things have changed. Therefore, we are experiencing financial difficulty. And due to that difficulty, we either do not procure anything or companies do not want to supply when we want to procure, because our payment terms are long. So we have trouble with access to some tests. Sometimes we cannot test CD4 and CD8 rates. And sometimes we cannot test HIV RNA, Hepatitis B DNA, Hepatitis C RNA. We cannot perform genotype tests for Hepatitis C, either. Why? The infrastructure is ready but these are all items that must be procured. The hospital says that they want to procure them but there are no offers. For instance, we cannot test HIV RNA in our hospital at the moment. Or, Hepatitis B DNA. And it seems like we will not be able to for a long time."
>
> (Infectious diseases specialist, 2)

As cited above, the services are interrupted due to low rates of reimbursement of some tests in a state university hospital where STI diagnosis and treatment services. Even though the interviewee stated that they refer the patients to the nearest hospital where they can have the tests in such cases and thus prevent interruption of the services, it is not difficult to predict that this is a challenging situation for the patients to get access to services.

“We would like to note that UNFPA defines the HPV vaccine as one of the SRH indicators in the scope of Sustainable Development Goals, and the inaccessibility of the vaccine denotes Turkey’s failure to fulfill its responsibility towards its citizens.”

Besides, the HPV vaccine was not still included in the reimbursement list of the SSI in Turkey before the pandemic. Nonetheless, as part of the cancer screenings performed since 2012, a smear and HPV-DNA test is applied to women in the 30-65 age group in ASMs once every 5 years. A gynecologist described the situation as below:

> “Screening tests, HPV screening. You know that the Ministry already has a cancer-screening program. This works well. We support it as much as we can. But HPV vaccine is not supported by the Ministry. It is a very expensive vaccine. They tried to procure it here as well but it is too expensive. We have to understand them, too. They are right because it is very expensive. And they could not get the discount they wanted.”
>
> (Gynecologist, family planning clinic)

Even though the interviewee attributed the exclusion of the HPV vaccine from the reimbursement list in Turkey to its high cost, we would like to note that UNFPA defines the HPV vaccine as one of the SRH indicators in the scope of Sustainable Development Goals, and the inaccessibility of the vaccine denotes Turkey’s failure to fulfill its responsibility towards its citizens. Lastly, TTB issued a statement underlining a lack of coordination among health institutions in the application of cervical cancer screening programs in Turkey (TTB, 2019, April 19), which should be taken into consideration in improving the screening program.

The State of Sexual and Reproductive Health Services during the Pandemic

After the pandemic affected Turkey, the priority of healthcare professionals and the healthcare system have changed radically, and almost all healthcare resources have been allocated to fight against the pandemic. The pandemic has revealed an important deficiency related to health policies in nearly all countries including Turkey: the disruption in the complementarity relationship between preventive and curative health services in favor of the latter. As a result, countries faced pandemic unprepared in terms of their public healthcare systems and human resources in public health. Under such circumstances, shifting the available healthcare system and human resources to the fight against the pandemic turned into an obligation for many countries.

Turkey faced the pandemic with a limited and uneven SRH service structure, as reviewed in the previous part of the report. Concerning the SRH services before the pandemic, Turkey had a strong service infrastructure in fields such as pregnancy follow-ups, STI, and infertility treatment, while there were serious restrictions in practice in the fields such as FP services and counseling, the supply of free and accessible contraceptive materials, and voluntary pregnancy termination. In this respect, one of our interviewees described the overall effects of the pandemic on the SRH services in Turkey briefly as follows:

> "The change in service providers are as follows: Shift of priorities and workforce, numerical decrease. ... We may see the results of... unmet needs in the field of SRH later."
>
> (Staff of a specialist institution in the field of SRH)

During the interviews, we got the impression that no comprehensive central planning was made for the continuity of SRH services after the onset of the pandemic. This might be partially attributed to the primacy of the fight against the pandemic within the restrictions of the above-mentioned institutional structure. However, as underlined in the introduction of the report with references to statements of WHO and UNFPA, continuity of SRH services during a health crisis or disaster plays a key role in the prevention of negative health outcomes in the medium term. Accordingly, we believe that failure to prepare a central plan that will enable continuity of SRH services during the pandemic indicates a significant deficiency in terms of Turkey's strategy to fight against the pandemic.

> "We believe that failure to prepare a central plan that will enable continuity of SRH services during the pandemic indicates a significant deficiency in terms of Turkey's strategy to fight against the pandemic."

An interviewee attributed the lack of a comprehensive plan concerning SRH in the strategy to fight against the pandemic to the fact that SRH services are considered as an optional field of service at the administrative level:

> "Is this an optional healthcare service? Is this a service similar to plastic surgery? Or is this really a period when we need this service more due to the birth rates that will increase after this crisis? This has to be discussed at some point."
>
> (Family practitioner 1)

Nonetheless, SRH services were not the only field that was interrupted during the pandemic. Although it is not yet possible to know the exact effects of these interruptions, interruptions in the healthcare services likely to include many other fields including but not limited to SRH. The citation below summarizes the kind of institutional framework in which healthcare professionals work that are not directly assigned to the fight against the pandemic:

> "The Ministry has not given an order on what to do or not to do but they ordered us not to perform anything except for those that are really urgent and not optional."
>
> (Gynecologist, family planning clinic)

As stated above by the interviewee, it seems that healthcare professionals who were not directly assigned to fighting against the pandemic continued to provide service within a framework that leaves many questions untouched. In a period when healthcare professionals are expected to act to minimize the risk of infection, a central guideline that would clarify the distinction between urgent and non-urgent (or services that can be postponed and the services that must be sustained, to put it more accurately) would help in establishing a standard in the continuity of healthcare service nation-wide.

> "In a period when healthcare professionals are expected to act to minimize the risk of infection, a central guideline that would clarify the distinction between urgent and non-urgent (or services that can be postponed and the services that must be sustained, to put it more accurately) would help in establishing a standard in the continuity of healthcare service nation-wide."

Maternity care

In line with the overall picture of SRH services in Turkey before the pandemic, we observed that central guidance is issued and a monitoring mechanism is executed only to continue services in the field of maternity care during the pandemic. ASMs continued to offer service throughout the pandemic even though they did not admit the number of patients as they did in their former capacity. Healthcare professionals pointed out that there was a strong commitment from the central administration for the maintenance of pregnancy follow-ups in ASMs during the pandemic:

"We observed that central guidance is issued and a monitoring mechanism is executed only to continue services in the field of maternity care during the pandemic."

> "We have received statements on neonatal and maternal follow-up from the Ministry during that time (pandemic)."
>
> (Public health services manager)

One of the family practitioners stated that some pregnant women might have not applied to a healthcare institution during the pandemic to protect themselves from the infection risk:

> "We think that, after the pandemic, there might be women that have not visited any healthcare institution for a long time and might start visiting when they are pregnant for five months. That's another problem. So I try to motivate my colleagues to call women in the 15-49 age group for follow-up as much as possible. Even one phone call a day will decrease the risk quite a lot. Because otherwise, you will notice it (pregnancy) very late."
>
> (Family practitioner 1)

Another family practitioner stated that they continued to follow-up women aged between 15 and 49 during the pandemic and there were inspections in place for these follow-ups.

> "We carried out a follow-up of women aged between 15 and 49 because there were inspections about it. They say like, you have not done your 15-49 follow-up this month. You have X number of people to follow-up. You have 1000 people for screening and you have only completed thirty percent. You have to complete it. So we did it over the phone."
>
> (Family practitioner 2)

As the quote above suggests, similar to the other family practitioner, this family practitioner indicated that they carried out the follow-up of women aged between 15 and 49 by phone, rather than inviting them to ASM due to the pandemic conditions. In addition, he also expressed that there were disruptions in services such as home visits for maternity care during this period, and making such visits would contradict the measures for the fight against the pandemic after all.

Another interviewee noted that information provided to healthcare professionals regarding the continuity of pregnancy follow-ups during the pandemic was inadequate in eliminating the ambiguity in this period. An interviewee told about the confusion about how to continue the services at the beginning of the pandemic:

> "Should they come to the center for pregnancy follow-ups or not? Pregnant women came here sooner or later. We were in such a situation that all polyclinics ended up examining pregnant women by the second month of COVID. But they did not come for normal diseases unless it was an emergency. This turned into an advantage for us because patient examination intervals were extended."
>
> (Gynecologist, family planning clinic)

"Another gynecologist indicated that the ambiguity they experienced concerning service provision would be overcome by a central guideline on pregnancy follow-ups. While guidance was issued on COVID-19 treatment, such guideline did not include adequate information about pregnant women."

Another gynecologist indicated that the ambiguity they experienced concerning service provision would be overcome by a central guideline on pregnancy follow-ups. While guidance was issued on COVID-19 treatment, such guideline did not include adequate information about pregnant women:

> "I think it was a bit problematic that there was no individual section about pregnant women in the national guideline (for COVID-19 treatment). For instance, we told pregnant women not to come here but normally they should come here for four follow-ups. Ministry even suggested increasing the number of follow-ups to eight, so that we could provide higher quality care. This was discussed a lot among all gynecologists. I mean, how to tell patients to visit us less often? Ministry should have announced like; these specific screenings are mandatory. Consult first for other screenings. Contact a call center. There should be an information line because the guideline did not clarify whether the mother should breastfeed or come here with the child or not. This is not a problem specific to Turkey only. All guidelines including CDC in America, World Health Organization, authorities in England informed the pregnant women about what to do in the first place. We actually do not know what the pregnant women should do but we update everything with the information we get from China or other countries over time."
>
> (Gynecologist, family planning clinic)

As seen in the quote above, the pandemic brought along many questions in the maternal health services as well as other fields of healthcare services. Lack of adequate information in national guidelines on the fight

against the pandemic about the key groups in the field of SRH may have resulted from the lack of available data at the beginning of the pandemic. However, it seems significant in the upcoming period to prepare guidelines on both COVID-19 risks of these groups, and how to meet other healthcare needs of such groups during the pandemic.

Birth services seem to be one of the most affected fields of SRH services during the pandemic. In the interviews with gynecologists, we got the impression that birth services were suspended in a significant number of hospitals due to reasons such as the conversion of almost all public hospitals to pandemic hospitals, and the assignment of healthcare professionals to new roles as part of the fight against the pandemic. Interviewees stated that the central administration allocated a few hospitals to offer birth services in some cities to compensate for restrictions that were experienced in the birth services during the pandemic. One interviewee described the transformation as follows:

> "Our hospital was completely converted to a pandemic hospital with all its departments including maternity care. Only one maternity polyclinic continued its services. Apart from that one, the maternity and neonatal care departments as well as all the others were converted to the pandemic polyclinic. Specialists including myself were assigned to another hospital. A maternity clinic was required since people were still giving birth. But there was nothing else left related to birth services in our district. Neither birth services nor reproductive health. Including polyclinic services. We started to offer polyclinic services again starting from the beginning of June. But we cannot offer birth services at the moment because we do not have neonatal care, some physicians quitted or they do not do night shifts. Birth is one of the main fields, a fundamental part of the gynecology department. We cannot provide delivery services now. We have not started the C-section procedures yet due to the pandemic. That's because there is no neonatal care or pediatrician as I said before."
> (Gynecologist)

"Interviewees stated that the central administration allocated a few hospitals to offer birth services in some cities to compensate for restrictions that were experienced in the birth services during the pandemic."

Even in June and July of 2020 when we conducted the interviews, birth services were not provided in the usual way in some public hospitals. It is likely that disruptions occurred in the access to birth services especially in public hospitals during the first months of the pandemic and people had to apply to private hospitals more often as compared to the past. Difficulties might have been experienced in access to birth services in public hospitals especially due to long distances in metropolitan cities, the tendency not to use public transportation during the pandemic, and the costliness of transportation especially for those on low incomes. For instance, a CSO employee offering SRH services for refugees described her experience of referring a refugee woman to birth services during the period we conducted the interviews, as below:

> “Difficulties might have been experienced in access to birth services in public hospitals especially due to long distances in metropolitan cities, the tendency not to use public transportation during the pandemic, and the costliness of transportation especially for those on low incomes.”

> “We faced significant problems related to birth. I called the training and research hospitals (public hospitals) yesterday. Is the gynecology polyclinic active? Do you offer birth services? These were my questions. In several public hospitals, they told me that these services were suspended, there was a gynecologist in the ER but we should advise patients not to go to the hospital unless it was an emergency during this period. Yes, a restriction was present in the hospitals but there should have been another hospital, polyclinic, etc. to refer these patients. There was just the X Maternity Hospital that was active then, but I think it was not adequate because it was very far to reach from many places and these were pregnant women at risk. Therefore, they would not generally take the risk by using public transportation from far locations and that is why I think and know that many of them had problems. It is like OK, I have completed my duty: You can go there. But I know that the person will not be able to go there, and she does not. So the problem continues. In very difficult cases, they reached the hospital by taxi, etc. but there was such a problem in the hospitals. This really caused trouble for us. We do not just tell people what to do and hang up the phone. We follow the case and provide translation services. We all have a bond and responsibility related to these people. This period which is still ongoing has really knocked us out.”
>
> (Staff of a CSO that offers SRH counseling for refugees, 1)

The above-cited experience of the CSO worker refers to many elements that were not taken into account when planning the birth services during the pandemic. These elements include informing the public about which public hospitals continue to offer birth services, and estimating how the access of people with low-income to birth services will be affected during the pandemic, and how those people will reach the hospital which offers birth services. Even though such elements were not taken into account in the provision of birth services during the pandemic, a gynecologist thought that people could somehow access birth services based on the considerable increase in the number of births in hospitals with active birth services:

> “Only a part of the pregnant women could come to the hospital I was assigned to, not all of them, unfortunately. ... So I was able to see, perhaps, one-tenth of patients I was following-up. ... Therefore there was a real decline in the number of patients. I would say it decreased to one-third. But women that were already in labor came to the hospital somehow. In the hospital I worked, the birth rate increased. Yes, about two to three times.”
>
> (Gynecologist)

As expressed in the report of TAPV published in 2017, the practice of voluntary pregnancy termination services "based on discretion rather than the system" seems to have continued during the pandemic as well. A CSO employee offering SRH counseling for women described the story of a client facing immense difficulties in accessing abortion service during the pandemic as follows:

> "During the COVID period when travel restrictions started, a woman called from city A. ... She was married and her husband supported her decision of abortion. She went to the state hospital in city A. They performed a gynecology examination. It turned out that she was seven-week pregnant. The physician said 'I cannot do it'. And the woman replied 'This is my right. It has not been ten weeks yet, why can't you?' 'Yes', said the physician. 'I know, but I do not want to do it'. Then the woman and her husband went to the chief physician. They told the chief physician that this is their legal right and they have not completed ten weeks. The chief physician told them: 'It is up to the physician, I cannot do anything'. Anyway, the woman could not have an abortion there. Then they heard about a hospital in city B where the procedure is performed. ... The woman called us crying each time. Then she started to say things like 'I have two grown-up children so I do not want any more, what should I do, kill myself?'. She would go to city B but she could not because of the travel restrictions. And she went to the governorate to get the travel permit and wrote a petition. She explained her reasons, the remaining time for abortion, and added that it should be done that week or else it cannot be done after two weeks. She could not get the travel permit either. We did not know what to do, and by the way, there was no private hospital there. Yes, right, it was the reason... There was no private hospital. ... That's why we referred her to the chief physician again. The chief physician said, 'She can come but I cannot promise anything'. Insisting on not making a promise, he invited her anyway. The woman went there. The chief physician met with her. And he said that she should come on day X. He gave an appointment for two to three days later probably. Anyway, the woman went to the hospital three days later and had the operation. In the end, we all together put up such a big fight. So think about it..."
>
> (Staff of a CSO that offers SRH counseling for women)

"This citation shows that abortion services continued to be provided at the discretion of healthcare staff during the pandemic, as well. However, according to the experience cited above, we may conclude that such an arrangement can have worse effects on women during the pandemic especially when there are travel restrictions in place."

This citation shows that abortion services continued to be provided at the discretion of healthcare staff during the pandemic, as well. However, according to the experience cited above, we may conclude that such an arrangement can have worse effects on women during the pandemic especially when there are travel

restrictions in place. In contrary to this negative experience, another gynecologist who works in a different city stated that they have been providing abortion services without interruption during the pandemic:

> "Since the beginning of the pandemic, we have applied no restrictions on legal abortion because it is not a procedure that can be postponed. The period for termination of maternity is ten weeks, after which patients are not allowed to have an abortion. But we also provided a significant amount of post-abortive contraception counseling and methods in that period."
>
> (Gynecologist, family planning clinic)

Contraception and family planning

As examined thoroughly in the previous section of the report, there were significant problems in the field of contraception and FP services before the pandemic. The main problem was the failure to implement the original target of the provision of contraception and FP services by the ASMs. Furthermore, the number of specialist service units such as AÇSAP centers was reduced, which had a significant complementary role in this field during the past years. Those that continued operation, on the other hand, generally faced the problems of decreased human resources and reduced service capacity. SHMs and FP clinics in hospitals could have filled that service gap, however, there was no such service planning. Additionally, public healthcare providers were out of contraceptive material stocks especially since last year and new materials could not be supplied. Despite all these restrictions, contraception and FP services were provided with a limited capacity and in a disorganized manner in ASMs with trained and motivated healthcare professionals, some AÇSAPs that were still active, ÇEKÜSs operating under health directorates, relatively new SHMs some of which offered maternal and reproductive health counseling services, and public hospitals that had family planning units.

"During the interviews, we had the impression that contraception and FP services have come to a standstill during the pandemic. The most significant reason for such a standstill seems to be the assignment of almost all the healthcare professionals in AÇSAPs, ÇEKÜSs, and SHMs in the fight against the pandemic."

During the interviews, we had the impression that contraception and FP services have come to a standstill during the pandemic. The most significant reason for such a standstill seems to be the assignment of almost all the healthcare professionals in AÇSAPs, ÇEKÜSs, and SHMs in the fight against the pandemic. Some of the healthcare professionals that were assigned to the pandemic teams thought that these temporary assignments resulted from the lack of adequate healthcare professionals in their district especially during the first months of the pandemic. The remaining part believed that they were assigned to fight against the pandemic because SRH services were considered as an optional field of service. Two physicians working in FP services before the pandemic described the transformation as follows:

> "They told us that we were going to stop these services on around the fifteenth of March and start working in contact tracing services. And we kind of shut down the institution starting from that date."
> (Former AÇSAP staff, a physician working under district health directorate, 1)

> "We, as the workers in Healthy Life Centers, all joined the contact tracing teams. I am heading one of those teams. So family planning was shut down completely."
> (Former family planning clinic staff, a Healthy Life Center physician)

As two citations suggest, the assignment of healthcare professionals offering contraception and FP services in the pandemic teams seems to have resulted in the almost complete suspension of these services. As discussed at the beginning of this part of the report, such transformation was one of the steps that must be taken by a country with an unprepared public health system when faced with a pandemic. However, before the pandemic, UN institutions recommended that key SRH services should be included in responses to disasters and health crises, and pointed out that this field of service had important components that cannot be postponed, as mentioned in the first section of the report. The perspective recommended by the UN was generally adopted by the interviewees that worked in the fields of contraception and FP services before the pandemic. An interviewee described one of her observations as follows:

> "(Upon the pandemic) We started to work under the district health directorate. We could ask the district administrators about what to do during this period or where people would go for family planning services. Their responses were like 'We are not going to do anything because that's not our priority. They must find a way somehow, there are many ways of accessing contraception. You are not the only means to help them with that.'"
> (Former AÇSAP staff, a physician working under district health directorate, 1)

> "Considering that reproductive behaviors may change in times of crisis, the loss of income experienced during the pandemic may have restricted access to contraceptives, and measures restricting human mobility increases the likelihood of some people being subject to sexual violence, we believe that the need for SRH services has some aspects that cannot be postponed or substituted."

Some administrators may believe that the emergency of the fight against the pandemic takes precedence over the need for SRH services, as the citation above suggests. However, the assumption that the contraception and FP services of public providers can be substituted easily with other means is inaccurate. The findings of TDSH 2018 showed the key position of the public sector in meeting the need for contraception and FP services. Considering that reproductive behaviors may change in times of crisis, the loss of income

experienced during the pandemic may have restricted access to contraceptives, and measures restricting human mobility increases the likelihood of some people being subject to sexual violence, we believe that the need for SRH services has some aspects that cannot be postponed or substituted.

A family practitioner stated that ASMs did not offer contraception and FP services during the pandemic, and they were not informed about where to refer the demand received by the ASMs. When the specialist units offering contraception and FP services other than ASMs suspended their operations temporarily, some interviewees indicated that there were other centers they could refer patients to in their cities while the remaining said that there was no other center to refer the patients. Two citations below indicate that the continuity of the provision of contraception and FP services during the pandemic was uneven across the provinces:

“When the specialist units offering contraception and FP services other than ASMs suspended their operations temporarily, some interviewees indicated that there were other centers they could refer patients to in their cities while the remaining said that there was no other center to refer the patients.”

> “They stopped IUD insertion procedures because it was not safe. Either for the physician or the patient. So they stopped the service. They do not insert IUDs any more. But my colleagues told me that other methods are still applied.”
>
> (Former AÇSAP staff, a physician working under district health directorate, 1)

“I think this is a natural process but if you stop IUD insertion then you should offer another method. Do you understand? Alternatives should be offered along with adequate counseling. Not like an imposition. We cannot perform the insertion procedure in this period, so here is your condom. Not like this. It should be provided together with proper counseling. But of course, it is not possible to offer face-to-face counseling either.

Researcher: So who responds to these needs for counseling services at the moment? I’m talking about reproductive health and family planning.

> The colleagues in the districts, if there are any left. If not, they stop the services. They stopped in our district for instance. There is no staff. If there is no staff, they tell that reproductive services cannot be offered at the moment. It is over. We cannot meet the demands. Here (in contact tracing teams) there are 2-3 shifts and we still cannot meet the demand, so it is impossible to allocate staff for reproductive services. There is no trained staff left anyway.”
>
> (Former AÇSAP staff, a physician working under district health directorate, 1)

As the second citation above suggests, the assignment of all the healthcare staff in contraception and FP services to the fight against the pandemic in some districts seems to have caused the total suspension of such services, since this is a field that has already suffered from a lack of qualified personnel. The temporary shutdown of centers and units offering FP services during the pandemic might have given rise to some unmet needs. An interviewee made the following assessment based on information received from a healthcare professional who was on shift in the center offering FP services:

> "Many people are coming for IUD insertion or contraceptive material request and going back with nothing."
>
> (A family planning specialist midwife working under district health directorate)

Unmet FP needs may have increased during the pandemic due to the lack of central guidance on maintenance of contraception and FP services, the focus of ASMs on neonatal and maternal follow-up, assignment of a considerable part of the staff working in specialist units other than ASMs to fight against the pandemic, and failure to provide alternative service channels.

"Unmet FP needs may have increased during the pandemic due to the lack of central guidance on maintenance of contraception and FP services, the focus of ASMs on neonatal and maternal follow-up, assignment of a considerable part of the staff working in specialist units other than ASMs to fight against the pandemic, and failure to provide alternative service channels."

In some of the interviews, we learned that services were suspended temporarily and just one healthcare staff was left in some clinics and centers (For instance, A family planning specialist midwife working under district health directorate). We believe that such a practice must have provided a contact channel for the patients to at least get information and reach the healthcare professionals in emergency cases. Another interviewee told that she started providing counseling over the phone on their initiative, to substitute the emergent service gap:

> "I wanted to provide more counseling over the phone. For instance, a woman that has IUD with complaints. All patients on whom we performed the IUD procedure already have our phone number. They can also call the institution. But there was another problem. A woman calls us but we were on the field. So she could not reach us. There was no one. We were at different locations. We continued to offer to provide counseling over the phone to those that could not reach us. And since the normalization started as of June 1... even though few, we started to serve patients by appointment. It was busier in the past, a hustle and bustle. Now we want to ensure that the room is ventilated and cleaned at least. We give appointments at intervals of half an hour. The duration is longer for insertions but half an hour is given for follow-ups, counseling, etc."
>
> (Former family planning clinic staff, a Healthy Life Center physician)

As seen in this citation, some needs might have been met thanks to the personal sacrifices of healthcare professionals working in the field of contraception and FP services during the pandemic. Nevertheless, we believe that such individual sacrifices are not likely to meet the entire need for services that arise in the absence of a systematic response. Besides, during June and July when we conducted interviews, many healthcare professionals and centers did not still restart their usual operations. All such interviewees stated that they wanted to go back to their main fields of service rapidly, and were concerned that unmet needs would increase much more if the suspension were extended.

“Besides, during June and July when we conducted interviews, many healthcare professionals and centers did not still restart their usual operations. All such interviewees stated that they wanted to go back to their main fields of service rapidly, and were concerned that unmet needs would increase much more if the suspension were extended.”

The pandemic also caused the suspension of in-service training provided to healthcare professionals, as well as public health training programs, by ÜSBEMs and AÇSAPs in the fields of reproductive health, FP, and safe maternity. The two interviewees below indicated that some of those training programs were about to be moved to the online platforms:

> “I know that the Ministry started preparations for online training because I got such signals from my colleagues working in the Ministry in the fields of family planning and health training. Breastfeeding had already got online. We started online training programs about that topic. We even started establishing online maternal counseling centers. And I was quite engaged with that job since I was working with pregnant women. It became successful instantly. We were able to offer it online.”
>
> (Former AÇSAP staff, a physician working under district health directorate, 1)

> “You know that there are pregnancy courses in hospitals. Their curriculum includes topics such as pregnancy care, pregnancy diet, tackling labor pain, delivery method, and post-delivery contraception. Since the women could not come to the pregnancy course, we completed two online training programs. Now we are completing the third one. People connect from their homes online. Contraception was also included in such training programs.”
>
> (Gynecologist, family planning clinic)

Online provision of public training programs such as pregnancy courses, covering especially the post-delivery contraception information, is a positive development since the content of such training programs will be more accessible to pregnant women during the pandemic. However, a CSO worker offering

SRH services for refugees pointed out a significant obstacle against the online provision of training in the fields of contraception and FP services, as follows:

> "Online provision of public training programs such as pregnancy courses, covering especially the post-delivery contraception information, is a positive development since the content of such training programs will be more accessible to pregnant women during the pandemic."

> "This was a big problem for people in need including the refugees as they had to minimize their expenses. They were the people that mostly canceled their Internet contracts, could not pay their bills and thus did not have access to basic technological devices. Remote access to information is unfortunately a matter of social class. Phones are effective and relatively cheap devices to access, but we have to think of new means. New communication and information channels."
>
> (Staff of a CSO that offers SRH counseling for refugees, 2)

As underlined in the above citation, when information is provided for the public on online platforms about contraception and FP, there might be some restrictions in access to such information both in financial terms and due to the lack of technological infrastructure. Due to interruption in Internet access of people with low-income during the pandemic, such training content may not always be accessible for all.

> "When information is provided for the public on online platforms about contraception and FP, there might be some restrictions in access to such information both in financial terms and due to the lack of technological infrastructure. Due to interruption in Internet access of people with low-income during the pandemic, such training content may not always be accessible for all."

Regarding the provision of in-service training programs for healthcare professionals on online platforms, interviewees appreciated the efforts of the Ministry of Health to continue these training programs under pandemic conditions. However, they emphasized the need for diversification of the contents of training programs that would be provided online. The interviewee cited below stated that there should be a reproductive health module among the training modules that would be provided online:

> "But I do not see such efforts in the reproductive health module yet. I know about the intentions, but I do not see them. A course on skills is out of the question. Do not get me wrong

but it is impossible neither theoretically nor practically. But what about reproductive health? I would say it is acceptable. You know like an acceptable option. It would be much better than nothing."

(Former AÇSAP staff, a physician working under district health directorate, 1)

The above-cited interviewee stated that in-service training on reproductive health was not yet provided online, but such a method would have much more positive consequences as compared to the total suspension of these training programs under the available conditions.

"The above-cited interviewee stated that in-service training on reproductive health was not yet provided online, but such a method would have much more positive consequences as compared to the total suspension of these training programs under the available conditions."

Lastly, infertility treatment was interrupted as many other services due to the pandemic. Because patients must meet the age criteria for the infertility treatment to be covered by the SSI, extended duration of access of people with ages closer to the upper limit might have made their treatment impossible to be covered by the SSI. An interviewee working in the family planning clinic of a state university hospital described this issue as follows:

"Because patients must meet the age criteria for the infertility treatment to be covered by the SSI, extended duration of access of people with ages closer to the upper limit might have made their treatment impossible to be covered by the SSI."

"We received a notification in our in vitro fertilization center and shut it down. Now we started to receive patients that are aged 39 or 40 and have an emergency in terms of decreased ovarian capacity. Because we don't know how long this waiting period will take. They may lose their physiological capacity to get pregnant, and the age limit is 40 for the state's coverage of in vitro fertilization. The SSI does not pay anymore after that age. We started with those patients so that they do not lose their chances even if their conditions are suitable."

(Gynecologist, family planning clinic)

As seen in the above citation, based on a decision taken at the FP clinic level, they prioritized the women that were at the risk of losing their right to get infertility treatment covered by SSI or those whose possibility of getting pregnant decreased due to their age and were able to offer services for them.

Sexual health and well-being

The interruption in HPV screenings performed by ASMs is the main disruption that emerged in the field of sexual health and well-being during the pandemic. Since such an interruption in screening services will make an early diagnosis of cervical cancer difficult, it is required to take action for the continuity of these services during the pandemic.

The interviews showed that the most important need that emerged during the pandemic in terms of STI diagnosis and treatment services was access to adequate and reliable information. A CSO worker providing counseling services for people living with HIV described such need as below:

> "COVID brought along many questions for those living with HIV at the beginning. Are we under a greater risk? What should we do? Or should I go to the hospital? I have routine follow-ups once every three months. What should I do?"
>
> (Staff of a CSO that offers services to people living with HIV)

As mentioned by the interviewee above, almost all the healthcare professionals working in the field of STI diagnosis and treatment stated that a considerable part of those living with HIV was concerned if they were under a specific risk during the pandemic. Fortunately, starting from the early stages of the pandemic, scientific data was revealed that people living with HIV were not under a specific risk related to COVID-19, and those receiving ARV treatment were under a lower risk (Del Amo et al., 2020). However, such information needed to be communicated to the people living with HIV. Healthcare professionals working in this field stated that CSOs provided such information successfully through online channels.

"Such information needed to be communicated to the people living with HIV. Healthcare professionals working in this field stated that CSOs provided such information successfully through online channels."

In the previous part of the report, before the pandemic, we mentioned that SRH services in Turkey were weak in providing information, counseling, and implementing protective and preventive measures aimed at reducing the risk of STI. An employee working at an institution specializing in the field of SRH responded to our question regarding the change to be expected in the risk of STI during the pandemic as follows:

> "About HIV, I believe that restrictions of social isolation will have a short-term but pseudo positive effect which should not result in misleading implications. The restricted socialization will have a partial and pseudo positive effect on HIV, and thus STIs. The concerns will push people to keep safe."
>
> (Staff of a specialist institution in the field of SRH)

> "Anonymous STI test services provided in Voluntary Test and Counselling Centers that operate under the municipalities were suspended for a long time during the pandemic."

As specified above, some decrease might be expected in the risky behaviors during the early stage of the pandemic due to the restricted human mobility. Furthermore, an artificial decrease might be observed in STI diagnoses during the pandemic due to the interruption of STI diagnosis services as well as the reduced demand for people related to these services. Indeed, anonymous STI test services provided in Voluntary Test and Counselling Centers that operate under the municipalities were suspended for a long time during the pandemic. Even though counseling services did not continue in a systematic and planned manner, GDTM workers stated that the clients could receive such services partially over the phone. One GDTM worker stated that they could restart testing from June when the municipalities began the practice of working in rotations. He added that, upon commencement of the test service, there was a high demand for these services. Another interviewee stated that they restarted offering test services starting from July. One other interviewee described the considerable demand they received from the community for restarting their services in June as below:

> "There is a very close family practice that we work with. They are tired of questions about us. They are like, 'enough already, you should restart services so we can get rid of these questions'. ... Of course, we realize in the calls we receive that people do not want to go to the hospital. Especially because they do not want anybody to hear about it, they want to remain anonymous. Being anonymous is very important here. We do not get any identity information, record, or report them anywhere. That's what makes us special. Therefore, we got many thanks and were really appreciated when we restarted."
>
> (GDTM staff 2 working under district municipality, nurse)

The interruption of GDTM diagnosis services at the beginning of the pandemic does not mean that STI diagnosis services were all suspended in Turkey. The capacity of ASMs and hospitals to conduct relevant tests, and continuity of services in CSOs providing such services, as specifically underlined by a GDTM worker, suggested that there was no obstacle against the access of clients with urgent needs to these services, at least theoretically. Nevertheless, due to a significant increase in the workload of infectious disease departments of hospitals, hesitation of people regarding submitting to hospitals, and lack of information provided to GDTM workers about the extent to which the STI diagnosis and treatment services were continued.

The infectious diseases department was one of the busiest specialties during the pandemic. The interviewed infectious diseases specialists also stated that routine services were suspended in their clinics, and they started to work completely about the pandemic. Temporary suspension of the provision of routine

services by the infectious diseases departments does not appear to have posed a significant problem for people living with HIV that were on treatment. Thanks to the decision of the Ministry on the automatic extension of prescriptions of patients with chronic diseases, it seems like people living with HIV had access to their medication during the pandemic. An infectious diseases specialist also had a positive comment on this practice:

“Thanks to the decision of the Ministry on the automatic extension of prescriptions of patients with chronic diseases, it seems like people living with HIV had access to their medication during the pandemic.”

“This was, of course, a good decision for patients that did not have a problem in continuing their regular treatment.”

(Infectious diseases specialist, 1)

People living with HIV on regular treatment had access to medication during the pandemic and CSOs specialized in the field provided information on HIV and the pandemic. However, these did not decrease people’s need to reach their regular physicians and receive information from them. One of the interviewed infectious diseases specialists described his experience as below:

“Apart from that, the most relaxing thing for me regarding my patients was... I always gave my phone number to them. They texted me ‘Am I going to be sick? What will happen to me? ‘Will I become more ill?’, and secondly questions like, ‘How will I use my medication? How to take them?’. So the patient must be able to reach you all the time. There must be a system to respond to their hesitations and fears. I tried to do all three at once; do something, on one hand, do something else on the other hand, and try to respond to the patients on the phone as well.”

(Infectious diseases specialist, 2)

“The need for obtaining accurate information in the field of sexual health and well-being turns out to be one of the most significant needs during the pandemic.”

As the quote above suggests, the need for obtaining accurate information in the field of sexual health and well-being turns out to be one of the most significant needs during the pandemic. Even though telemedicine practices are not still used in public providers in Turkey, it is clear that such practices have been used during the pandemic. We believe that it is a good practice for an infectious disease specialist fighting against the pandemic during the time we made the interview to provide information to patients just due to his responsibility against them. However, as underlined by the interviewee, it should be noted that leaving

such information and counseling services to the mercy of healthcare professionals is not sustainable, as the needs of patients may not be met systematically through these voluntary sacrifices.

"It should be noted that leaving such information and counseling services to the mercy of healthcare professionals is not sustainable, as the needs of patients may not be met systematically through these voluntary sacrifices."

The interviews suggested that the interruption of sexual health counseling and STI diagnosis and treatment services during the pandemic might have left some people vulnerable. The people living with HIV who had difficulty in adhering to treatment were deemed among those in the interviews. The patients with difficulty in treatment compliance might have missed the regular follow-up of specialists during this period, which may affect their health adversely in the medium-term. Secondly, the interviews pointed out that especially people who were newly diagnosed with HIV have been in a vulnerable position:

"The patients with difficulty in treatment compliance might have missed the regular follow-up of specialists during this period, which may affect their health adversely in the medium-term."

"Individuals who were recently diagnosed were not able to find a specialist in hospitals, especially in the initial period. Because most of the hospitals were turned into pandemic hospitals and it was very hard to get an appointment. However, there were alternative centers here (refers to his city). In smaller cities with a single center, the people whose treatment just started wanted to go to the hospital to have tests during the initial periods. Because that's the period when tests should be made more frequently. Or the patients who took medicine were unable to ask the physician about the side effects of the medicine. Physicians started to change location and unit. And then, patients started to see different physicians each time. Since they could not establish a trust relationship with the new physician, they usually ignored and delayed their problems. Some even quitted treatment."

(Staff of a CSO that offers services to people living with HIV)

"It was really a challenging period for them (refers to the individuals recently diagnosed with HIV) since we had to warn them about not going to the hospital. On the other hand, they wanted to know and speak about their situations, and wanted to start treatment right away. In some emergency cases, we even had to prescribe without seeing the patient. Some of them were at risk because of their advanced stage diseases. .... We had to follow-up certain patients who were recently diagnosed, but we could not. Because we perform tests for these patients

every month, every two months, or every three months after starting the treatment. This is the case for the individuals who just started treatment. It is also important... It is important for following up on how the treatment is going, if it has side effects, if the patient can get medication regularly, and if there is a problem. Unfortunately, we could not perform our follow-ups. We had to neglect our patients who were diagnosed and started receiving treatment in the last few months. In this respect, I feel a little uncomfortable."

(Infectious diseases specialist, 1)

As specified in the above citations, treatment and follow-up processes of the people newly diagnosed with HIV might have failed since the infectious diseases departments began not to accept outpatients during the pandemic after their workload increased, and the human resources in these clinics were assigned to fight against the pandemic.

"Treatment and follow-up processes of the people newly diagnosed with HIV might have failed since the infectious diseases departments began not to accept outpatients during the pandemic after their workload increased, and the human resources in these clinics were assigned to fight against the pandemic."

Some interviewees reported the failure to prepare a sound plan about the provision of inpatient healthcare services for the patients in infectious diseases departments other than those diagnosed with COVID-19 as another problem in the field of sexual health and well-being during the pandemic:

"All patients should be regarded as potentially infected (with COVID-19) or positive, and appropriate measures should be taken. So it is hard to define a hospital as virus-free from now on with the information we got upon these developments. But there is the problem of overcrowding. For example, I am too busy that I admit only the patients who are COVID positive to the entire infectious diseases department. They are the only inpatients. I cannot accept any other patient. Then, there must be other hospitals for such patients to apply."

(Infectious diseases specialist, 2)

"Fortunately, we did not have any inpatients (other than COVID positive). I do not know what we would do in that case... And that was actually an administrative problem. All hospitals in our city were looking after patients with coronavirus. Therefore, I've no idea about what we would do if we had emergency patients."

(Infectious diseases specialist, 1)

As stated by the interviewees, although both infectious diseases specialists did not encounter a situation that required admission of inpatients other than those infected with COVID-19, they highlighted that this possibility had to be taken into account in service planning during the pandemic. Both interviewees

underlined that the failure to prepare a plan for the fight against the pandemic in a way that other healthcare services will not be interrupted poses the risk of not meeting the emergency health needs other than those related to the pandemic.

Results and Recommendations

This monitoring report describes the overall state of SRH services in Turkey before the pandemic and evaluates the situation of these services during the pandemic in comparison to their state before the pandemic as well as the national obligations of Turkey in this field. The framework of this evaluation relies on the sub-goals and indicators defined for SRH as part of the Sustainable Development Goals, relevant national obligations of Turkey in SRH, and directives of the UN institutions on how SRH services should be handled in case of disasters and health crises. The assessments in the report are mainly based on the qualitative analysis of interviews conducted with the individuals who were employed in 18 key organizations in SRH services between June and July 2020, mostly as healthcare professionals. Besides, analysis of the interview data in this report is supported by the review of policies and practices in Turkey, the needs of the population in the field of SRH as identified in the TDSH, and other information we have gathered during the monitoring process. This part of the report presents the general results and recommendations as well as results and recommendations related to the pandemic period.

General results and recommendations

As a whole, SRH services in Turkey had a limited capacity and were provided in a disorganized manner before the pandemic. Turkey had a strong profile in the provision of services in the fields such as pregnancy follow-ups, STI treatment, infertility treatment, and access to such services whereas it remained inadequate in the fields such as contraception, FP services and counseling, protective and preventive services for STIs, and voluntary pregnancy termination. Unless SRH services are addressed in a holistic manner, the unmet needs in one field may lead to negative health outcomes in another field. Therefore, such limited and disorganized service structure of SRH before the pandemic indicated the absence of a comprehensive SRH service planning in Turkey, which also overshadowed the success of Turkey in some SRH services. Lastly, we would like to note that only a strong public sector presence could ensure fairness in accessing SRH services in Turkey due to the high level of income inequality. Turkey has the fiscal capacity to deliver such services to its citizens. In this respect, we believe that considering the following recommendations will be useful in ensuring the provision of free and quality SRH services by the public sector, based on a scientific, rights-based, and holistic approach:

- The inclusion of postnatal contraception counseling to standard delivery services is recommended.
- Necessary measures should be taken to include all pregnancies in the follow-up process.
- Examination duration per patient in gynecology services provided by the public providers must be extended to allow for a quality service.
- Provision of voluntary pregnancy termination services must be guaranteed without leaving them to the personal discretion of service providers. Furthermore, the inclusion of the medical options other than legal abortion in the scope of SSI reimbursement can be considered.
- An institutional structure must be established to offer country-wide available, easily-accessible, free, and quality contraception and FP services and counseling for all women including those with unmet FP needs (e.g. women living in rural areas).
- Central administration should make all contraceptive options accessible and free in the ASMs, specialist centers offering FP services and counseling, and the family planning centers of hospitals.
- The following recommendations can serve the effective provision of contraception and family planning services by the ASMs:
  - To reduce the size of the population for which ASMs are responsible to meet the average ideal population size (about 2,500 per ASM),
  - To employ healthcare staff who are competent in FP services and counseling in ASMs,
  - To make the participation in in-service training programs such as Family Planning Training and Reproductive Health Training mandatory for all ASM employees,
  - To ensure that ASMs maintain follow-up services for the women aged between 15 and 49, including FP counseling,
  - To include the FP services in the performance-based reimbursement system applied in ASMs,
  - To have the health administration regularly inspect the FP services and counseling provided by ASMs.
- Considering the workloads and personnel competencies of ASMs before the pandemic, and based on the low potential of ASMs to offer extensive FP services and counseling as planned in the reform, ASMs should be supported by complementary and specialist FP service units. Accordingly, the AÇSAPs which are still active, the ÇEKÜSs working under the health directorates, and the SHMs some of which include maternal and reproductive health counseling service units can be structured as such complementary and specialist FP service units. To make such centers function effectively in the provision of FP services and counseling, we suggest that:
  - They have an adequate number of competent health professionals (gynecologists, midwives, nurses, clinical psychologists, etc.),
  - They own sufficient equipment (ultrasound, gynecological examination table, etc.),
  - They employ health professionals who are competent in providing SRH and FP counseling to patients of different ages, and have age-sensitive materials,

  - Healthcare professionals are provided with better earning and promotion opportunities depending on their performance,
  - Service capacity and human resources are identified and planned in accordance with the average family planning needs of the local population.
- Actions should be taken to enable young people to access SRH counseling and services.
- GTDMs, which facilitate the diagnosis processes of STIs and access of the individuals to treatment, should be established across Turkey.
- Problems arising from SSI reimbursement levels should be eliminated to ensure the smooth functioning of diagnosis and follow-up tests in all state and state university hospitals having the necessary infrastructure.
- Monitoring and inspection mechanisms must be established to ensure effective follow-up and guidance of cases in HPV screening processes carried out by ASMs.
- The SSI should include the HPV vaccine in the reimbursement list.
- All the necessary specific measures should be taken to ensure that individuals who are disadvantaged at accessing SRH services due to various reasons (language barrier for the people under temporary protection, not being registered in ASM, or being away from the registered ASM during a long period of the year for seasonal agricultural workers) have access to such services.

Results and recommendations related to the pandemic period

The COVID-19 pandemic led to a large-scale public health crisis. The pandemic broke out almost in all countries following a period in which public health services and related human resources were overshadowed by curative healthcare services, so most countries including Turkey faced such a health crisis unprepared. Even though the UN institutions highlighted the need for designing SRH services as the basic components of disaster response and recovery for many years, such unpreparedness of the countries caused the whole focus in healthcare services to be directed to the fight against the pandemic. After the effects of the pandemic were seen, the fight against the pandemic became the almost only focus of the healthcare system in Turkey, which had a limited and disorganized service structure in the field of SRH services before the pandemic. Although considering the size of the threat, it is understandable that the fight against the pandemic is likely to rank at the top of the agenda, this should not lead us to disregard the SRH needs and how key groups in SRH have been affected by the pandemic. Otherwise, the interruptions in SRH services may have negative effects on the health outcomes in the short and medium-term. Therefore, success in the fight against the pandemic alone may not be sufficient for preventing the potential deterioration expected in health outcomes during the pandemic period. For this reason, it is of key importance to carry out the fight against the pandemic in Turkey and all other countries without compromising, as far as possible, the provision of health service needs that cannot be delayed and by considering the external effects of the pandemic on the other needs for health services.

The positive examples of maintaining the SRH services in Turkey during the pandemic can be listed as continuity of pregnancy follow-ups, and facilitation of the access of people living with HIV to their medication. Nevertheless, this monitoring study points out that services in many other fields of SRH services were interrupted significantly, restricted considerably, or suspended wholly. We believe that actions should be taken immediately to address the unmet needs for SRH services. In this respect, we believe that taking the following considerations into account will be useful in ensuring the continuous provision of free and quality SRH services by the public sector within a scientific, rights-based, and holistic approach in case of pandemic and similar disasters in Turkey:

- In the case of pandemic and similar disasters, the following actions are recommended:
  - Including the uninterrupted continuity of SRH services in the central planning, considering the special conditions caused by disaster period, and offering such services broadly as part of the pandemic response by taking all the occupational health and safety measures for the healthcare professionals,
  - Preparing guidelines covering issues such as the health risks and needs of the key groups in SRH (for instance, pregnant women and the persons living with HIV) during the pandemic, additional measures that must be taken by these key groups to protect themselves, and detailed descriptions of how to take such measures, and the steps that must be followed in access to healthcare services when they need it, as well as sharing such guidelines with the general public and healthcare professionals,
  - Providing information service through phone and online platforms for the people to access basic information such as when people should apply to health institutions, which measures they should take if they need to apply to these institutions, and which health institution that is closest to them provides the service they need,
  - Establishing a science committee composed of individuals specialized in the SRH field in case of pandemic and similar disasters to develop the above-mentioned planning, preparation, and practices, and monitor the implementations,
  - Collecting data on the health effects of the pandemic or other disasters on the key groups in the SRH field regularly, analyzing the data, and developing protective and preventive measures in light of these analyses.
- Physical infrastructures (e.g. buildings, ventilation systems, etc.) of the health institutions such as ASMs and SHMs should be improved to assure the sustainability of their services in all disasters, including earthquakes and pandemics. As part of this, the Ministry of Health may get involved in the construction or purchase of buildings and lease contracts, and invest in the infrastructure as necessary.
- Having observed that SRH services, especially contraception and FP services, were suspended during the pandemic, we recommend taking urgent steps that will eliminate the risk of further increasing the unmet FP needs in the medium-term. Therefore, all service units offering services in ma-

ternal health, contraception, family planning, reproductive health, and sexual well-being in Turkey should re-start their operations, and the specialist staff in SRH field who were assigned to the fight against the pandemic should be re-assigned back to their main duties without interrupting the fight against the pandemic.

- Public providers offering birth services should be planned and such information should be shared with the public in an easily accessible way, to avoid the interruption of access to these services during the pandemic. The planning should take into account which people would be disadvantaged in accessing select providers, and effective solutions should be developed for the elimination of such disadvantages.
- The loss of income experienced by a considerable part of the public during the pandemic and its impact on access to contraceptive materials in the market should be taken into account as well while ensuring continuous access of the public to contraceptive materials through public providers.
- SRH and FP counseling and pregnant courses for the general public, as well as in-service trainings for the healthcare professionals about reproductive health and FP, should be moved to online platforms as much as possible during the pandemic.
- Given that the workload of the infectious diseases specialists increases during the pandemic, practices such as telemedicine should be developed to track the compliance of HIV patients to HIV treatment as well as following up on their treatment process. The regulations required to enable the individuals newly diagnosed with HIV to access treatment and ensure their compliance during the pandemic should be introduced. Furthermore, inpatient service planning for the infection disease departments should take into account the individuals that must receive inpatient treatment due to reasons other than COVID-19.
- Concerning infertility treatment, those with decreasing potential for getting pregnant and/or those whose age is closer to the upper age limit for SSI reimbursement must be prioritized for treatment across Turkey.
- In the context of restrictions on human mobility as part of the fight against the pandemic, the risk of an increase in domestic gender-based and/or sexual violence should be considered. Therefore, the healthcare system should have a functioning infrastructure ensuring the provision of services, including emergency contraception, psychological support, and termination of unintended pregnancies, to the women that are subject to violence.

References

- CDC. (2020, Haziran 9). *If You Are Pregnant, Breastfeeding, or Caring for Young Children*. www.cdc.gov: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fpregnant-women-faq.html.
- Chen, H., Guo, J., Wang, C., Luo, F., Yu, X., Zhang, W., Li J., Zhao D., Xu D., Gong Q., Liao J., Yang, H., Hou W., Zhang Y. (2020). Clinical characteristics and intrauterine vertical transmission potential of COVID-19 infection in nine pregnant women: a retrospective review of medical records. *Lancet*(395), s. 809-815.
- Del Amo, J., Polo, R., Moreno, S., Díaz, A., Martínez, E., Arribas, J. R., Jarrín, I., Hernán, M. A. (2020). Incidence and severity of COVID-19 in HIV-positive persons receiving antiretroviral therapy: a cohort study. *Annals of Internal Medicine*.
- EPF & IPPF EN. (2020). *Sexual and Reproductive Health and Rights during the COVID-19 pandemic*.
- Guo, W., Ming, F., Dong, Y., Zhang, Q., Zhang, X., Mo, P., Feng Y., Liang, K. (2020). A Survey for COVID-19 among HIV/AIDS Patients in Two Districts of Wuhan, China. *Lancet*.
- Guo, W., Weng, H. L., Bai, H., Liu J., Wei X. N., Zhou K., Sande A. (2020). Quick Community Survey on Impact of COVID-19 outbreak for the healthcare of people living with HIV. *Chin J Epidemiol*, 663-667.
- Hall, K. S., Samari, G., Garbers, S., Casey, S. E., Diallo, D. D., Orcutt, M., Moresky R. T., Martinez N. E., McGovern, T. (2020). Centering Sexual and Reproductive Health and Justice in the Global COVID19 Response. *Lancet*(395), 1175-1177.
- HÜNEE. (2019). *2018 TDSH-Turkish Demographic and Health Survey*.
- ILO. (2020). *ILO Monitor 2nd edition: COVID-19 and the world of work*.
- Jiang, H., Zhou, Y., & Tang, W. (2020). Maintaining HIV care during the COVID-19 pandemic. *Lancet*, e308-e309.
- Ministry of Health. (2019). Türkiye HIV/AIDS Kontrol Programı (2019-2024). Sağlık Bakanlığı Yayın No: 1131, Ankara.

- Ministry of Health. (2020). Sağlıklı Hayat Merkezleri, https://shm.saglik.gov.tr/index.php adresinden alındı.
- O'neil, M. L., Aldanmaz, B., Quiles, R. M. Q., & Kılınç, F. R. (2016). *Yasal Ancak Ulaşılabilir Değil: Türkiye'deki Devlet Hastanelerinde Kürtaj Hizmetleri*. Kadir Has Üniversitesi Toplumsal Cinsiyet ve Kadın Çalışmaları Merkezi.
- OECD. (2020). Income inequality. https://data.oecd.org/inequality/income-inequality.htm.
- Purple Roof Women's Shelter Foundation. (2020). *June 2020 Report*.
- Qiao, J. (2020). What are the risks of COVID-19 infection in pregnant women? *Lancet*, s. 760-762.
- Riley, T., Sully, E., Ahmed, Z., & Biddlecom, A. (2020). Estimates of the Potential Impact of COVID-19 Pandemic on Sexual and Reproductive Health in Low and Middle Income Countries. *International Perspectives on Sexual and Reproductive Health*(46).
- Sochas, L., Channon, A. A., & Nam, S. (2017). Counting indirect crises-related deaths in the context of a low-resilience health system: the case of maternal and neonatal health during the Ebola epidemic in Sierra Leone. *Health Policy and Planning*, iii32-iii39.
- TAPV. (1997). *IPPF Üreme Hakları ve Cinsel Haklar Bildirgesi.*
- The Global Goals. (2020). *The Global Goals for Sustainable Development*.
- Topgül, C., Adalı, T., Çavlin, A., & Dayan, C. (2017). *Sağlık Çalışanları Gözünden İstanbul'da Kürtaj ve Aile Planlaması Hizmetlerinin Durumu*. TAPV.
- TTB. (2019, Nisan 19). Kanser taramalarında sorunlar giderilemiyor, https://www.ttb.org.tr/kollar/_ahek/haber_goster.php?Guid=6b8c6cb8-6295-11e9-994d-fcf6dd719ec4.
- UN. (2012). *UN Commission on Life-Saving Commodities for Women and Children*.
- UNFPA. (2020a). *Ensure Universal Access to Sexual and Reproductive Health and Reproductive Rights.*
- UNFPA. (2020b). *Koronavirüs (COVID-19) Salgını: UNFPA Küresel Müdahale Planı.*
- UNFPA. (2020c). *COVID-19 Salgının Toplumsal Cinsiyete Dayalı Şiddeti, Kadın Sünnetini ve Çocuk Yaşta Evliliği Sona Erdirme Çabaları ile Aile Planlaması Üzerindeki Etkileri.*
- UNFPA. (2020d). *Toplumsal Cinsiyet Perspektifinden COVID-19: Cinsel Sağlık, Üreme Sağlığının ve Haklarının Korunması ve Toplumsal Cinsiyet Eşitliğinin Teşvik Edilmesi.*
- UNFPA. (2020e). *Cinsel Sağlık ve Üreme Sağlığı ve Hakları: COVID-19'a Yönelik Önleme, Koruma ve Müdahale Amaçlı Ürün Tedariki de Dâhil Olmak Üzere, Modern Gebeliği Önleyici Yöntemlerin ve Diğer Tıbbi Ürün Temini.*
- UNFPA. (2020f). *Ergenler ve Gençler & Koronavirüs Hastalığı (COVID-19).*

- UNFPA. (2020g). *Sexual and Reproductive Health and Rights, Maternal and Newborn Health & COVID-19.*
- UNHCR. (2011). *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations.*
- WHO. (2002). *Defining Sexual Health: Report of a Technical Consultation on Sexual Health.*
- WHO. (2012). *Integrating Sexual and Reproductive Health into Health Emergency and Disaster Risk Management.* https://www.who.int/hac/techguidance/preparedness/SRH_HERM_Policy_brief_A4.pdf?ua=1.
- WHO. (2017). *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence.* https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/.
- WHO. (2020). *Community-based Health Care, including Outreach and Campaigns, in the Context of COVID-19 Pandemic.*
- WHO. (2020, Haziran 15). *WHO Coronavirus Disease (COVID-19) Dashboard*. https://covid19.who.int/: https://covid19.who.int/.
- WHO. (2020, Mart 18). *Q&A: Pregnancy, childbirth and COVID19*. www.who.int: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth.
- WHO. (2020, Mart 24). *Q&A: HIV, antiretrovirals and COVID-19*. www.who.int: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-hiv-and-antiretrovirals.
- WHO. (2020, Mayıs 7). *Q&A: Breastfeeding and COVID-19*. www.who.int: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-and-breastfeeding.
- WHO. (2020, Nisan 6). *Q&A: Conception/Family Planning and COVID-19*. https://www.who.int: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/contraception-family-planning-and-covid-19.
- WHO. (2020, Nisan 9). *Rolling updates on coronavirus disease (COVID-19)*. who.int: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen.
- World Bank. (2020). Turkey. https://data.worldbank.org/country/turkey.
- Zeng, L., Xia, S., Yuan, W., Yan, K., Xiao, F., Shao, J., & Zhou, W. (2020). Neonatal Early-Onset Infection with SARS-CoV-2 in 33 Neonates Born to Mothers with COVID-19 in Wuhan, China. *JAMA Pediatrics*, s. E1-E3.