REPRODUCTIVE HEALTH PROGRAMME OF TURKEY

HEALTH SEEKING BEHAVIOUR STUDY

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Conseil Sante, EDUSER, SOFRECO (2007) *Health Seeking Behaviour Study.* Ministry of Health General Directorate of Mother-Child Health and Family Planning and the Delegation of the European Commission to Turkey, Ankara.

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ABBREVIATIONS

ANC	Antenatal Care
ECD	European Commission Delegation
FC	Field Coordinator
FGD	Focus Group Discussion
FS	Field Supervisor
FW	Fieldworker
HSBS	Health Seeking Behaviour Study
MCH/FP	Mother-Child Health/Family Planning
MoH	Ministry of Health
NGO	Non-Governmental Organization
RC	Research Coordinator
RHPT	Reproductive Health Programme of Turkey
SC	Steering Committee
SPO	State Planning Organization
SRH	Sexual Reproductive Health
STE	Short-Term Expert
TAG	Technical Advisory Group
TAT	Technical Assistance Team
TBA	Traditional Birth Attendant
TDHS	Turkey Demographic Health survey

PREFACE

Although Turkey has every legal framework and infrastructure regarding the provision of reproductive and primary health care services, the primary health indicators are not at desired levels. Especially the fact that maternal mortality is high when compared to developed countries and the existence of urban and rural disparities is a matter of concern. In addition, the fact that more than a third of maternal mortality is during the antenatal period and that the level of antenatal care utilization is not at desired levels is another point to be considered. At this point, the questions "Is the health care services provided not sufficient or Is the provided service not sufficiently utilised" come to mind.

The main factors that affect health care utilization are listed as the geographic, bureaucratic, and economic accessibility of the services, health perceptions of individuals, and their attitudes and behaviours when faced with health problems. It is not possible to say that any health service provided without examining and taking into consideration the health perceptions, and health seeking behaviour of individuals, will be appropriately utilised. The health seeking behaviour of pregnant women has been investigated in this study. Being a natural process pregnancy is not an illness. However, the fact that the risks faced by pregnant women are different than healthy women and men, makes it essential that this group should utilize certain health care services during the antenatal period.

This study, which has been carried out under the EC funded Reproductive Health Programme of Turkey being implemented by the Ministry of Health, aimed to explore and describe the perceptions of, and health-seeking behaviour related to, pregnancy and childbirth, and the responsiveness of Primary Health Care (PHC) and Mother-Child Health/Family Planning (MCH/FP) services to these in selected urban and rural sites in Turkey, in order to inform the design of interventions contributing to increased utilisation of antenatal care (ANC) and skilled birth attendance. The study which utilised qualitative methods also had the objective of strengthening the capacity in the utilization of qualitative methods in health sciences.

The Health Seeking Behaviour Study has been carried out by a consortium comprising Conseil Sante (France), EDUSER (Turkey) and SOFRECO (France). The contributions of many academicians and experts in the field of qualitative research have been taken during the study which was initiated in April 2006 and completed in April 2007. In this regard, Prof.Dr.Belkıs Kümbetoğlu and Assoc.Prof.Dr.Filiz Kardam who were both members of the Advisory Group have played an important role guiding the research. The full list of all who have contributed to this study is given in Annex 13. We would like to express our gratitude to them.

The European Commission Delegation to Turkey and the Ministry of Health as the stakeholders have provided all the required support and contribution during the study and have helped us overcome difficulties. In this regard, we would like to thank Figen Tunçkanat from the European Commission Delegation to Turkey and Dr.Rıfat Köse, the Director General of Mother-Child Health/Family Planning of the Ministry of Health and their colleagues.

We would especially like to thank the Deputy Director General of Mother-Child Health/Family Planning, Dr. İbrahim Açıkalın for displaying a very good example of how bureaucracy could be used to correctly and effectively carry out work by finding practical and sensible solutions and to Dr. Levent Eker from the same General Directorate who apart from being a good bureaucrat has provided support and contribution through his scientific knowledge, and also to Dr. Sibel Bilgin for her support and attention.

We also extend our thanks to Governors, Deputy Governors responsible for health issues, authorities of the health directorates, health centre personnel and community leaders in Adana, Afyon and Van for the support they have provided to our research team during field work.

We would like to extend our gratitude to all women and their families who have accepted to participate in our study and thus contributed to shedding light on this important public issue through their invaluable views. Without them, the efforts of all the academicians, experts, and bureaucrats would have been meaningless. We believe that with the implementation of the recommendations formulated based on the findings; we in part will have paid our duty to them.

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SUMMARY

The overall objective of the study is to explore and describe the perceptions of, and health-seeking behaviour related to, pregnancy and childbirth, and the responsiveness of Primary Health Care (PHC) and Mother-Child Health/Family Planning (MCH/FP) services to these in selected urban and rural sites in Turkey, in order to inform the design of interventions contributing to increased utilisation of antenatal care (ANC) and skilled birth attendance.

The study was conducted in Adana, Afyon, and Van provinces (in parts of these provinces where problems regarding ANC and birth services are observed) with pregnant women who have never attended ANC or have discontinued ANC services, their husbands, family elders, peers as well as with health service personnel and community leaders/key informants using qualitative methods. The sample size was not calculated as the study was of qualitative nature, and purposive sampling and the snowball method was used as the sampling method. In line with the objectives of the study, data collection was done until *saturation* was reached.

Data was collected through *in-depth interviews, focus group discussions and interviews with key informants*. The in-depth interviews and key informant interviews were conducted by *fieldworkers* who were selected from the region and given training. The focus group discussions (FGD) were conducted by *short-term experts* who were experienced in this field. Audio recordings of the interviews were made along with observational notes and these were transcribed and stored digitally.

Data analysis was undertaken by experts. The concepts and categories which were coded in detail were grouped under themes and theoretical constructs and interpretations were made. Various utilities of *Microsoft Office Word* and *Microsoft Office Excel* programmes were employed during data analysis. Data was collected through in-depth interviews and FGD from a total of 239 participants, of whom 111 were pregnant women, the remainder (128) being comprised of peers, relatives, health care personnel, and community leaders in the selected regions. In this regard, 60.4% of the pregnant women were in the 20-29 age group, 59.1% resided in urban areas and 98.2% was either illiterate or elementary/primary school 'graduates'. Furthermore, 57.4% were from extended families.

In short, **the pregnant women covered under this study were in the young-middle age group, mostly living in extended families, with low education attainment levels.**

The women participating in the present study perceive pregnancy as a natural process even as a process giving a sense of happiness and fulfilment in general and that it is unnecessary to go to a health care institution for a check-up in the absence of any severe complaint. Concern and anxiety observed in some pregnant women is more related to childbirth and the health of the unborn offspring than to the pregnancy

process. Childbirth, and how the baby will be after birth, are important for women and their relatives and all concern is focused on these aspects.

The feeling of 'shame/embarrassment' is present in almost all women interviewed and this is expressed universally with a smile. It is understood that this feeling negatively affects obtaining information and accessing services.

Such symptoms as vaginal haemorrhages, immobility of the unborn offspring, severe aches and pains, nausea during pregnancy, increase risk perceptions as does the occurrence of miscarriages, stillbirths, babies with deformities, and babies with serious diseases, in their proximity.

Although pregnant women and their relatives state that attending ANC is a good thing, they cannot give satisfying explanations as to why it is a good thing. The explanations given for the benefit of services remain limited to learning the status of the unborn offspring.

According to pregnant women and their relatives who were interviewed, there are many and serious obstacles impeding access to health care services. The most common and highly-rated obstacle is 'lack of interest and negative behaviour of the health personnel'. Inattentiveness, bad practice, and miscommunication at health care institutions come out as being the most responsible features for underutilization of the provided services.

Other common obstacles in this group are the lack of health insurance and economic problems. These emerge along with lack of education, and gender problems. Low education levels, lack of education, and living in an extended family structure where permission of the mother-in-law and husband is required, seriously impede women accessing information and services regarding ANC and childbirth.

In some peri-urban areas of Adana and Van provinces and to some extent in the rural areas, prejudice and concern stemming from distrust of health services provided are important obstacles in the utilisation of services. Not providing ANC at primary health care institutions, or inadequate ANC provision, insufficient personnel, and the occurrence of organizational and administrative problems, are important obstacles in the utilization of services.

It is possible to group the pregnant women in the study in 4 categories with regards their health seeking behaviour:

1. **Women who are uneducated, live in extended families and have never attended ANC although their fertility is encouraged and they are under risk.**

2. **Women who mostly live in the peri-urban areas and seasonal workers areas in Adana and Van and who have problems in communicating with the health care institutions**

3. **Women who have previously applied to a health care institution for ANC or childbirth, however due to such negative experiences as inattentiveness and ill treatment at the health care institution have decided against utilising services.**

4.**Women who mostly reside in urban areas and who do not feel the necessity of attending ANC unless there are serious health problems but who definitely think of giving birth at a hospital and who have previously received services.**

The information and data gathered from health personnel, community leaders and key informants indicate that the present primary health care services being provided are inadequate and problematic with regards ANC and childbirth services. In light of the findings, recommendations have been formulated to inform policies, strategies and interventions.

1. INTRODUCTION

This project is a study that has been carried out in the context of "Reproductive Health Programme – Turkey" (RHP), which is financed by the European Commission. The overall objective of the RHP which is implemented under the support provided to the Ministry of Health (MoH), is to increase the demand for sexual and reproductive health services and the provision of high quality sexual and reproductive health services. In Health Seeking Behaviour Study which is carried out in line with the "Research and Policy Development" activities implemented under this project, it is aimed to explore and describe perceptions and health seeking behaviour related to pregnancy and childbirth and the responsiveness of PHC and MCH/FP services to these in selected urban and rural sites in Turkey, to inform the design of interventions contributing to increased utilization of ante-natal care (ANC) and skilled birth attendance. The study where qualitative methods have been used approaches the issue from the point of view of the people who utilise these services as well as the service providers.

Turkey has legal framework with regards reproductive health and family planning. Reproductive health services are provided widely as a part of primary health care services through the health centres, health houses and mother-child health/family planning centres (MCH/FP) which make up the first step of public health organizations and also through secondary health care institutions. However, the indicators related to the utilization of reproductive health care services are not at desired levels. According to the results of the "Turkey Demographic Health Survey" (TDHS) carried out in 2003, the percentage of women who have never attended antenatal care during their last pregnancy in the period 1998-2003 is 18.6. This percentage is three times higher in the rural areas (34.2%) when compared with that in urban areas (11.6%). According to the same survey, 17% of all the childbirth was done without the attendance of health personnel. There is a serious disparity when the east of the country (40.3%) is compared with the west of the country (4.7%) in this regard.

When the TDHS-2003 results are examined, the fact that there are problems in the utilization of ANC and childbirth services especially in central and eastern Anatolia is noticeable. It can also be seen from the statistics of the Directorate General of Primary Health Care Services of the Ministry of Health that the percentage of childbirths realised without the attendance of health care personnel is noticeably higher in Muş, Bitlis, Bingöl, Şırnak, Hakkari, Van, Kars, Ardahan when compared with other provinces (Annex 1). On the other hand, it is a known fact that with the intense migration to big metropolises in the recent years and the quickly expanding peri-urban areas, there are problems in the utilisation and provision of all types of health care services and especially preventive health care services. However, in the statistics of big cities and primarily in the statistics for İstanbul, due to the imbalance in the urban

structure, the acute condition of the peri-urban areas is masked and the real situation is not properly reflected.

The factors affecting utilization of health care services can generally be examined under three headings:

- Economic reasons,
- Geographical reasons,
- Psycho-social and cultural reasons.

It is a well known fact that individuals with no health insurance and bad economic conditions cannot utilise any type of health care service. There are no reliable and conclusive data with regards the population covered by pension fund, social security fund (SSK), Bağ-Kur (social security for tradesmen) and private insurance. Activities to establish infrastructure for this purpose is on going. The Green Card practice which has been established to support people with no economic power and who have no health insurance has been on-going for many years now.

Geographical factors that affect the utilization of health care services can be summarised as how wide spread these services are, their proximity to places of residence and the availability of transportation facilities. There are regional differences with regards the distribution of health centres, health houses and MCH/FP centres present as of 2005, their personnel and equipment. When the statistics of the Ministry of Health are examined, although it seems as if there are no differences between regions with regards the population covered per health centre, the fact that there are differences in urban and rural population ratios among regions makes one think that people living in rural areas are more disadvantaged in utilising services. Furthermore, the institutions in different regions show differences with regards the number of personnel and equipment they possess and the low numbers of personnel and insufficient number of equipment is noteworthy especially in the central and eastern regions. In this context, in the State Planning Organisation Health Comission's Report prepared for the Ninth Planning Period, in 38% of the health centres in the eastern regions there are no physicians and 85% of them do not have any midwives. These percentages are 12% and 65% respectively for the Marmara region and 14% and 53% respectively for the Mediterranean region. The Ministry of Health authorities have stated that arrangements have been made as of the end of 2006 to overcome the lack of personnel and to balance the distribution and in this context "contract personnel" and "acting personnel" practices have been initiated. Furthermore, over 14 million Euro has been allocated for the procurement of supplies and equipment under the Reproductive Health Programme of Turkey. It is thought that these measures will be effective.

Among the psycho-social and cultural reasons that affect health care service utilization there are many factors like the habits of people regarding health and illness, knowledge-attitude and behaviours, beliefs, traditions and customs. For example; it is not common for a person who has been brought up in a culture that does not place importance on the protection of health to regularly visit a physician for check-ups without being ill and utilise existing services. On the other hand in all cultures people with serious bodily complaints, seek ways to relieve these complaints. This could sometimes be a visit to the physician, sometimes self administration of a drug, sometimes taking the advice of someone they trust, or even hope for the help of

supernatural powers. What people do for their health and sicknesses, in other words their health behaviour; carry importance for reasons of their cultural and individual characteristics. ***Health behaviour, health seeking behaviour and health service seeking behaviour*** issues, are issues which are always present in the evaluation of factors affecting health care service utilization and studies done for the development of interventions to ensure service utilization.

Why people behave differently about their health and when they apply to health care institutions has been examined in numerous studies. When these studies are reviewed it is observed that they fall roughly into two groups:

- Some studies are oriented to the "*end-point*" of the behaviour. In other words, they are related to where people apply in the existing health system and this is called "*health care seeking behaviour*",
- Another group is related to the behaviour "*process*". That is it is related to what people do when they do not feel well and this is called "*health seeking behaviour*".

Many theoretical models have been developed with regards health behaviours. In a review carried out in international scientific journals in the field of health education, public health and behavioural sciences, 66 different theories developed for this purpose were found and 21 of these were used in 8 or more articles. The most commonly used among these theories and models are "Health Belief Model", "Social Cognitive Model", Transtheoretical Model", "Grounded Theory", "Planned Behaviour Theory", Social Support and Social Ties", "Ecological Models" and "Diffusion Theory".

This project has been developed taking into account that although reproductive health services have been widely provided in Turkey under the responsibility and support of the Ministry of Health for many years, there are still individuals who do not or cannot utilise these services. This group, is a special group whose behaviour with regards health care services has to be carefully studied.

Pregnancy is a healthy process as long as it has a healthy progress and thus cannot medically be regarded as an illness. On the other hand, it is necessary for the pregnant woman to be more sensitive about her body and the health of the unborn offspring as the health risks she may encounter are higher than a woman who is not pregnant. In short, it is a normal condition that definitely must be closely monitored. The health related perceptions and behaviours of this group must be studied differently than the ***"health behaviours"*** of those who do not have any complaints or those who have complaints or illnesses.

Qualitative research methods have been used in this study where pregnancy and childbirth related perceptions and health seeking behaviours of women who have never attended ANC or who have discontinued ANC as well as the view points of their husbands, relatives and service providers are examined. Although qualitative research methods which are actually methods of social sciences have a very recent past in the health field in Turkey, it has been long employed in the health field in the world.

The classical method applied in the health field is quantitative research. Although, with quantitative methods it is easy to determine the quantity or in other

words the “how much” and the “how many” of the matter under investigation, it is not always possible to gather reliable information related to “what”, “why” and “how”. Apart from knowing how much the services are utilised, in order to correctly organise and manage health care services, it is important to know why they are utilised and if they are not utilised why they are not.

It is not sufficient to analyse these type of qualitative conditions which change from society to society, individual to individual and time to time, using questionnaires commonly used in quantitative studies and by analysing the existing statistics. Instead, using qualitative methods, it is necessary to analyse the thinking processes that affect people’s behaviours, define the individual, environmental, social and cultural variables that cause these behaviours, and examine their interaction. Underlying factors of behaviour, can only be thus reliably defined and interventions to cause behavioural changes be recommended.

There are many qualitative research methods that could be used in the health field. The key methods used in this study were in-depth interviews, focus group discussions, key informant interviews and literature review.

The main target group of this study were pregnant women who never received or discontinued ANC services. In addition, their husbands, family elders, peers, community leaders and primary health care service providers were interviewed in order to collect data.

The general and specific objectives of the study can be summarised as follows:

1.1 Overall Objective:

To explore and describe perceptions and health seeking behaviours related to pregnancy and childbirth and the responsiveness of PHC and MCH/FP services to these in selected urban and rural sites in Turkey, and to inform the design of interventions contributing to increased utilization of ante-natal care (ANC) and skilled birth attendance.

1.2 Specific Objectives:

- To identify factors influencing perceptions and health seeking behaviours related to pregnancy and birth among pregnant women who never attended ANC,
- To identify factors influencing perceptions and health seeking behaviours related to pregnancy and birth among pregnant women who discontinued ANC attendance,
- To identify the understanding, attitudes and behaviour of health care providers related to factors which influence perceptions and health seeking behaviours of pregnant women who never attended or discontinued ANC attendance,
- To identify health care providers perspectives on appropriateness of ANC and birth services offered,

- To explore and describe husbands and other family members, especially older women and men's perspectives on and involvement in the health seeking behaviour of pregnant women,
- To recommend interventions which aim at increasing the utilisation of ANC and birth services at PHC and MCH/FP institutions.

2. METHODS

2.1 SELECTION OF PROJECT PROVINCES

In line with the ToR of the Project, the study provinces were determined by using TDHS-2003 data, MoH statistics, literature review of the studies carried out in field previously and expert opinions (Annex 1 and 2). Furthermore the Development Index prepared by the SPO was analysed to support and give further information regarding the sites to be selected.

Although it was foreseen in the ToR of the Project that further analysis of TDHS-2003 data would be carried out in order to determine the provinces with worst conditions with regards ANC service utilization, despite various attempts and correspondence, permission for the further analysis of the data could not be obtained and the data concerned could not be reached. Instead, published data and findings were used. In actual fact, even if the data could have been obtained, due to the fact that the data was collected at regional level, it would not have been possible to make ascertainment at provincial level, thus this was not evaluated as a missed opportunity.

According to the TDHS-2003 data, the regions with highest number of women who do not attend ANC are Central-Eastern Anatolia and North-Eastern Anatolia regions (Annex 1). According to the Development Index for the Health Sector the most underdeveloped ten provinces are as follows in descending order: ***Bingöl, Van, Bitlis, Iğdır, Şırnak, Batman, Muş, Ağrı, Hakkari and Ardahan.***

Among these provinces Ardahan has the highest infant mortality rate and population per physician. It has to be noted that although Van seems to be among the better of 10 provinces, infant mortality and population per physician is the second worst. The analysis of TDHS 2003 data, literature review and Health Sector Development Index as well as MoH statistics indicate that ***Ardahan and Van*** should be among the provinces to be selected under this study.

On the other hand, when the fact that cultural factors have an important influence on health seeking behaviour and specifically on reproductive health seeking behaviour is taken into account, choosing provinces with different cultural and demographic characteristics comes out as a necessity. In this context, in line with the recommendations of the authorities of Directorate General of MCH/FP of the Ministry of Health, it was decided that choosing from among **Yozgat, Tokat, Çorum and Afyon** provinces, which are all typical central Anatolian provinces with their homogeneous and relatively stable population, mid level development, would be beneficial and that in this way the comparisons would be better positioned and the policies formulated and recommendations would be more realistic.

In addition, it is a known fact that demographic mobility and migration also have an effect on the health seeking behaviours and health care service utilization of individuals. Keeping this fact in mind, **İstanbul** with its large and heterogeneous population structure, its high in-migration from all over Turkey and peri-urban areas with under developed infrastructure and health conditions; and **Adana** with a constantly mobile population due to seasonal workers, problematic peri-urban and rural areas come to the forefront.

In light of the information given above and detailed explanation in Annexes 1 and 2, the research sites could be selected as one from every group of provinces listed below:

Groups	Characteristics	Provinces
Group 1	Low ANC and delivery service utilization, low Development Index, highest infant mortality and high population per physician	Ardahan, Van
Group 2	Moderate ANC and delivery service utilization with different socio-demographic and cultural characteristics	Yozgat, Tokat, Çorum, Afyon
Group 3	Crowded heterogeneous population structure, high levels of in-migration, poor health conditions in large peri-urban areas	Istanbul, Adana

As a result of detailed analysis of the existing statistics and literature and the recommendations of the Ministry of Health authorities, it was decided to choose **Van, Afyon and Adana** from these groups as the project sites.

2.1.1 Determination of problematic areas of the selected provinces

After the selection of research sites, a research coordinator was assigned to each province. The research coordinators visited these provinces to determine the problematic areas of each province and to select the local fieldworkers who would work in the project.

In the research provinces, after informing the local authorities such as the Governor and the Health Director, the necessary permissions were taken and their support was ensured. Then, the Health Directorate Statistics, research reports and publications related to the region were examined and the views and recommendations of local NGOs were taken. In light of all the information collected, the most problematic regions of the province were determined. The problematic regions were visited and the health care institutions providing services to that region and if present NGOs were visited and detailed information was gathered.

As a result, the most problematic regions with regards ANC and childbirth services in the urban and rural areas of each province was determined (Annex 3) and the process of locating people to be interviewed was initiated.

2.2 SAMPLING

Women who have never received ANC services during their pregnancy or who have discontinued ANC services make up the universe of the research. In addition to these women, it was decided to collect data from the husbands, relatives, peers of these women, health care personnel and community leaders. Since the study was planned as a qualitative research the calculation of sample size to represent the universe was not made and non-probability sampling methods were used in the selection of people to be interviewed.

The method used in the first step of sample selection was "**purposive sampling**". In the regions determined as problematic with regards ANC and childbirth services, with the assistance of the health personnel and/or NGOs, pregnant women who have never attended ANC or who have discontinued ANC were determined and these women were interviewed.

In the second step, using **"snowball method"** through the women who were interviewed other pregnant women with similar characteristics were determined and reached. The interviews were continued until no new concept or different expression was identified and once the data reached **saturation** point (**theoretical sampling**) data collection was ended.

2.3 DATA COLLECTION

Data collection was done by *focus group discussions, in-depth interviews and key informant interviews.* The *interview guides* to be used during interviewing each group were prepared in line with the objectives of the study and in light of literature on the topic (Annex 4, 5, 6, 7).

If the number of pregnant women to be interviewed in one region was enough for focus group discussion, then focus group discussion was conducted, otherwise in-depth interviews with individuals were held. The peers of pregnant women were included in the focus group discussions held with pregnant women. Attention was given to have an average of 6-8 individuals in pregnant women-peer focus group discussions with at least half of them being pregnant women. In these discussions, the general health perceptions as well as their pregnancy and childbirth perceptions, their previous pregnancy and childbirth experiences, their views, attitudes, behaviours, practices regarding attending ANC and views concerning health care services were asked and areas of consensus and differentiation were investigated.

The pregnant women-peers focus group discussions were usually held in the house of one of the pregnant women, at a convenient time and date for all participants in a comfortable environment. The discussions were conducted by one interviewer and one observer, two short-term experts. Audio recordings of the interviews were made after getting permission and observation notes were kept by the observer. Each focus group discussion lasted 1.5 hours on average.

If the number of pregnant women were not sufficient for a focus group discussion, in-depth interviews were held. The in-depth interviews were conducted by

fieldworkers who had previously been selected from the province and trained in the objectives of the study and the methods to be used. Each in-depth interview was conducted by one interviewer and one observer. During the in-depth interviews the general health perceptions as well as their pregnancy and childbirth perceptions, their previous pregnancy and childbirth experiences, their views, attitudes, behaviours, practices regarding attending ANC and views concerning the existing health care services were asked using semi-structured interview forms. Audio recordings of the interviews were made after getting permission and observation notes were kept by the observer.. Each in-depth interview lasted 45 minutes on average. The interview forms used for focus group discussions and in-depth interviews with pregnant women are given in Annex 4.

During the in-depth interviews held with the husbands and family elders of pregnant women, the evaluations of the participants regarding the attitudes and behaviours of pregnant women on ANC was examined. In-depth interviews were also conducted with key informants (community leaders, health managers) whose evaluations and views regarding health care services in that region could be important. The interview forms used in this respect are given in Annex 5 and 6.

Focus group discussions with health care personnel excluding managers of the institutions and in-depth interviews with managers were conducted in order to collect information regarding the quality and quantity of services provided and the problems faced and questions were asked to deduce how compatible the ANC services provide were with the expectation of pregnant women. The interview forms used in this respect are given in Annex 7.

2.3.1 Pre-field test

Pre-field tests were conducted in Ankara and İstanbul to test the data collection methods and interview forms. Two focus group discussions – one pregnant women-peer and one health personnel – as well as two in-depth interviews were conducted in Istanbul. Similarly one pregnant women-peer focus group discussion and three in-depth interviews – pregnant woman, mother-in-law and village head – were conducted in Ankara. In light of the results the forms were reviewed and finalised.

Initially it was foreseen to collect data using observers' notes, audio recordings, and video recordings, however, during the pre-field tests it was seen that video recordings would cause discomfort among the participants and thus affect the quality of the data collected. Therefore it was decided not to do video recordings of the interviews. Ethical aspects were adhered to during all interviews, and the participants were given detailed information regarding the study before their informed consent was obtained.

In short, data was collected from four main groups and three methods were used during data collection. Data was collected from the following groups:

- Pregnant women and their peers
- Husbands and relatives of pregnant women
- Health care personnel
- Key informants, community leaders

The methods of data collection were as follows:

- Focus group discussions
- In-depth interviews
- Key informant interviews

The distribution of completed focus group discussions and in-depth interviews according to provinces is as follows:

Table 1: Sample distribution of the study

Target Groups	Number of Focus Group Discussions			Number of In-depth Interviews		
	Adana	Afyon	Van	Adana	Afyon	Van
Pregnant women and peers	4	2	2	35	15	15
Husbands and relatives	-	-	-	11	5	5
Health personnel	4	2	2	8	5	5
Key informants	-	-	-	11	5	5
Total	**8**	**4**	**4**	**65**	**30**	**30**

As a result 16 focus group discussions and 125 in-depth interviews were held.

2.3.2 Selection and training of fieldworkers

In order to determine the individuals to be employed for in-depth interviews, the terms of reference of fieldworkers were drawn up and announced in the research provinces and on the project web-site.

Taking into consideration the project ToR, the qualifications required for fieldworkers were determined as follows:

- 25-30 year old male or female
- Residing in the project province with knowledge of the people of the area
- Having good communication skills
- Able to communicate in local languages and dialects
- Having computer skills
- Having the time and conditions to participate in the study
- Graduate or student of public relations/anthropology/ psychology/sociology/ women's studies/social work/ other social and health fields.

Candidates who applied with their CVs were interviewed by the research coordinators and the "candidate fieldworkers" were identified and invited to the training programme in Ankara.

An eight day training programme was organised in Ankara for the training of candidate fieldworkers (Annex 8). The objective of the training programme was to assist the candidate fieldworkers in gaining knowledge and skills regarding the research subject and methods and thus minimize the biases to increase the quality of the data to be collected.

The first 5 days of the training was theoretical and information was given to the candidate fieldworkers on the specific objectives of the study, health seeking behaviour models, the Turkish health care system, antenatal care services, qualitative research methods, interview methods, research ethics and communication skills.

During the second part of the training programme, a two day field reality test in the peri-urban areas of Ankara was conducted and each candidate fieldworker was asked to conduct at least one interview as the interviewer and one interview as the observer. These were supervised by research coordinators. The mistakes made were noted and were dealt with during the one day refreshment training given after the field reality test. A *"Training Module"* to be used in the training of fieldworkers was developed.

The successful candidates were selected as *"fieldworkers"* and for each province one of the fieldworkers was selected as the *"field supervisor"*. A *"Fieldworker Manual"* containing all rules to be abided by and the interview forms was prepared and given to each fieldworker (Annex 9).

2.3.3 Qualifications and duties of short-term experts

At almost every stage of this study short-term experts were used. During the Preparation Phase in literature review and pre-filed tests, and then in the training of fieldworkers, in conducting focus group discussions, data analysis and reporting many short-term experts were employed.

Although short-term experts had different qualification according to the activities they participated in, they had the following common qualifications:

- Knowledgeable and experienced in reproductive health,
- Familiar with the Turkish health system,
- Knowledgeable and experienced in qualitative studies,
- Computer literate,
- Knowledgeable and experienced in conducting focus group discussions,
- Able to do qualitative data analysis and reporting,
- With a background of social or health sciences education.

In order to ensure the quality of the results, special care was given to work with the same short-term experts in the data collection stage, data analysis stage and reporting, however, some new experts were employed in place of those whose conditions were not suitable to continue.

2.4 DATA ANALYSIS

2.4.1 Preparation to data analysis

The analysis, in other words the coding and indexing of the collected data was done by short-term experts from health and social sciences with experience in

reproductive health and qualitative research as well as the research coordinators. Most of the experts were ones who had worked in the pre-field and field stages and who had contributed to the preparation of interview forms and actually conducted the focus group discussions.

Before starting the data analysis, two workshops, one in Ankara and one in İstanbul were conducted to determine how the analysis would be done and the methods to be used. Some of the technical advisory group and Steering Committee members participated in these workshops and made invaluable contributions. The purpose of these workshops was to attain concept, terminology, and vocabulary unity among the experts during data analysis..

In the first workshop held in Ankara, after giving information regarding the objectives, methods and data collection tools of the study, as well as health seeking behaviour models and theories, the method to be used during the analysis was discussed.

It was decided to first, examine the concepts and statements existing in the transcripts and observer notes and code them and then form the categories and themes and lastly to arrive at suitable theoretical constructs.

During the discussions on reporting the results of the analysis, mainly three approaches were highlighted:

1-Using the analysis of the interviews conducted at provinces as the starting point, writing the provincial reports first and then prepare the final report by putting these together,

2- Using the analysis of the interviews conducted with different target groups as the starting point, preparing reports for each group first and then prepare the final report by putting these together,

3-Using the analyses of all the data collected as the starting point, first preparing the general report and then prepare individual provincial reports.

As a result of the discussions made it was decided to code and interpret all the collected data and preparing the general report would be more in line with the essence of qualitative research and that in this way all concepts, categories and relationships would be more detailly underlined.

Another issue discussed during the first workshop was whether software programmes for data analysis would be used or not. Since this study also aims to develop the infrastructure and capacity for qualitative studies to be conducted in the health field this was discussed in detail. During the inquiry made by the technical assistance team members before the workshop, it was understood that most experts conducting qualitative research manually analyse their data or sometimes use some features of the Microsoft Word programme to do so. Although NVivo and Etnograph are widely known programmes for qualitative data analysis, no expert who regularly uses these programmes was found. A meeting was conducted with an expert who was doing his postgraduate thesis on the use of NVivo for the analysis of Turkish data.

However, a qualified person or organization that offers training on neither NVivo nor Etnograph could be located. The possibility of bringing an international expert for training was also discussed but it was then decided that it was not a very good idea. Although there were a few experts in the group who used these programmes before, the group decided to conduct the analysis manually. As a result it was decided to analyse the data using some features of *Microsoft Word* and *Microsoft Excel* programmes.

At the beginning of data analysis, in order to find the most frequent concepts and to familiarize the experts with the data, three groups of four experts were each given randomly chosen transcripts of 5 in-depth interviews and 2 focus group discussions and were asked to read and form a draft concept, category and coding list for the next workshop to be held a week later.

In the second workshop held a week later in İstanbul, the draft lists of concepts and categories prepared by the experts were discussed and a general list was developed using all the lists. This list was updated as the new concepts and codes appeared during the data analysis phase.

2.4.2 Data analysis process

Data analysis was carried by a total of 10 experts – three research coordinators, seven short-term experts. The technical advisory group members contributed to this process by sometimes commenting on the process and sometimes analysing the data themselves. The five groups of two were given transcripts of randomly selected in-depth interviews and focus group discussions from different target groups and provinces. The experts in each group were asked to read and code the interviews in accordance with the draft coding list developed during the workshop, to note possible new concepts, categories and the codes to be used and inform the Team Leader of these new codes by a certain deadline.

The second list formed by the addition of new concepts, categories and codes was compiled the Team Leader and sent to the experts. The experts were asked to read and code the interviews in light of the new list, to insert warnings and comments where necessary, and add any new codes found to the list and submit them to the Team Leader. In the groups of two the experts were asked to exchange their documents once they were finished thus having the same documents being read by two different experts. Some interviews were read over and over again in keeping with the nature of the analysis.

Using this method, it was aimed to capture every concept, category and theme and analyse them thoroughly. By allowing the documents to be read by different experts, it was aimed to capture every possible variation and to minimise the mistakes stemming from differences among interviewers and observers.

After the initiation of the readings a third workshop was held, to discuss the analysis process, experts' evaluations, and problems encountered. During this workshop the final version of the codes and categories was reviewed (Annex 11). The short-term experts and the technical assistance team members participated in this workshop.

All the in-depth interview and focus group discussion transcripts which were read by at least two experts were coded according to the final coding list and the

statements under each code and category were listed. By allowing the same statement to be listed under more than one category due to its content, it was aimed to catch all probable relations.

2.5 REPORTING

Five experts were identifies to assist the research coordinators during the reporting process. A meeting was held with these experts to review the coding and categories list that had come out during the analysis process, and to determine the themes. During this meeting, grouping of concepts under certain categories and themes and existence of probable relations were discussed. In line with the overall and specific objectives of the study, the thematic framework and the outline of the report to be prepared were determined.

Since the three research provinces were selected due to their specific characteristics and that the special findings of these provinces are important for the project results, it was decided to prepare one general and 3 provincial reports. The three research coordinators worked with four experts to prepare the provincial reports while the Team Leader with one expert took the responsibility of preparing the general report. It was asked to abide by the thematic framework decided on during the reporting but freedom was given on any new concept, relationship and explanation that could come up during the interpretation of the data. The short-term experts employed during the reporting process were one sociologist and three public health specialists with experience in all these subjects.

After the preparation of the draft reports each research coordinator went to their respective provinces together with short-term experts to present the findings to local authorities and those who had participated in the study for feedback. The feedback thus gathered is very important for the validation and reliability of the findings. In light of the feedback received the data was once again reviewed and the reporting of the findings were finalised.

2.6 MONITORING AND EVALUATION

Organization and management as well as monitoring/evaluation at every stage of the study are important for the suitability of activities to the objectives and for the quality of the data collected. Therefore, special attention was given to quality assurance starting with the planning period, and mechanisms to supervise and prevent biases were developed.

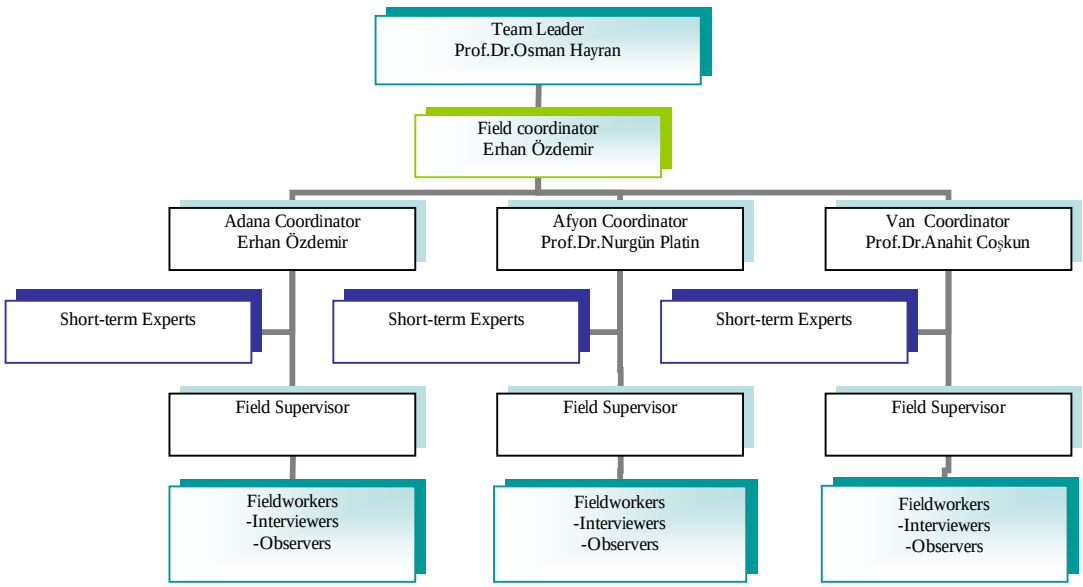
The meetings held with European Commission Delegation and Ministry of Health authorities during the preparatory stage were very conducive and it was concluded that their support on every issue could be obtained. The ownership observed in both side representatives encouraged the technical assistance team. The Reproductive Health Programme team also were very helpful and opened all their documents and information to the team's use.

- The ***"Technical Assistance Team"*** which took the technical responsibility of the project, took every precaution to carry out an impeccable and high quality work through regular weekly meetings, monthly progress reports, close relations with the stakeholders,

well prepared terms of reference and distribution of duties and a well working information and feedback mechanism.

- In order to have the planned and implemented activities to be evaluated from technical and scientific points of view, a ***"Technical Advisory Group"*** comprising three experts was formed. This group which was composed of one *sociologist*, one *anthropologist* and one *public health specialist* were all professors known for their publications and work in qualitative research and reproductive health. With the reports this group prepared for each activity, their recommendations and comments they contributed to the study acting as it were the "objective eyes" of the study.
- The ***"Project Monitoring-Evaluation Group"*** headed by the representative of the Ministry of Health and comprising the representative of the European Commission Delegation, the contractor and the technical assistance team reviewed the work carried out through monthly meetings and discussed the problems encountered and the work plan. In this manner, while attaining a healthy information flow, with a proactive approach measures against possible risks were taken.
- For the training of fieldworkers, data collection and storage, data analysis and reporting which require special expertise, experienced ***"short-term experts"*** were employed. The short-term experts were identified after the candidates proposed by the technical assistance team were reviewed by the representatives of the Ministry of Health and the European Commission Delegation in accordance with the terms of reference prepared. The short-term experts were asked to report every activity they undertook.
- In addition, a **"Steering Committee"** headed by the Director General of Mother-Child Health/Family Planning comprising Ministry of Health representatives, European Commission Delegation Representative, State Planning Organization Representative and academicians from various universities was established by MoH. The Steering Committee has reviewed the activities carried out and gave comments during the meetings held.
- In order to establish an effective monitoring-evaluation mechanism during field work the following ***organization*** was developed.

Figure 1 Field Organization of Health Seeking Behaviour Study



- ***"Fieldworkers Field Manual"*** and ***"Research Coordinators Field Manual"*** were prepared and given to all researchers to explain the work to be carried out in the field, terms of reference and distribution of duties, relationships and feed back mechanisms (Annex 9 and 10).
- In accordance with the organization made each ***research coordinator*** was given the responsibility of one province. Sufficient numbers of interviewers and observers to carry out the in-depth interviews and short-term experts to carry out the focus group discussions in each province were employed. One of the fieldworkers in each province was assigned as the ***field supervisor*** of that province. Similarly one of the research coordinators was given the responsibility of ***field coordinator*** and given the duty of coordinating the work between provinces.
- In order to standardise the field work and to minimise any differences among interviewers and observers they were given training and supervised by the research coordinators throughout their work. Special attention was given to selecting local people familiar with the characteristics and culture of the provinces where the study was carried out. Especially in Van, fieldworkers were chosen from people who could speak the local languages and dialects to minimise biases stemming from language.
- Data analysis in qualitative research requires more subjective approaches and could be affected from the personal interests, world views and view points of persons doing the analysis. Thus, in order to minimise individual effects, to carry out the analysis in an objective manner using a similar approach three workshops were conducted with experts and the technical advisory group members participated in these workshops to comment on the work carried out. The workshops also had the purpose of forming a common terminology and language. A similar approach was also employed during reporting.

2.7 QUALITY ASSURANCE SYSTEM

In order to ensure quality, the quality assurance system of Conseil Sante/Eduser /Sofreco was used and mechanisms that the technical assistance team deemed necessary were established. The following make up the components of the quality assurance system:

- **Operations Manual:** This manual contained all the details regarding the management of daily activities of the project office and methods of every activity to be implemented, reports to be prepared and rules were given in detail. The manual was prepared by the Quality Assurance Unit of the contractor in cooperation with the technical assistance team.
- At every stage of the project the stakeholders were duly informed and all activities were implemented with the **approval of the stakeholders and in accordance with the rules of the European Commission**.
- **The views and comments of the Technical Advisory Group** was taken and they were asked to review the planned activities at every stage of the project. The technical advisory group in a way were given the role of ***Quality Assurance Group*****.**
- A well working, effective reporting system in line with the rules of the European Commission was developed and in this context, the technical assistance group has prepared an *Inception Report, Progress Report, Final Report and Monthly Activity Reports.*
- All reports submitted to the European Commission and the Ministry of Health were reviewed by the Contractor.

- During technical activities such as literature review, training of fieldworkers, focus group discussions, data analysis, reporting and strategy formulation **short-term experts** were used.
- In order to minimise the **biases stemming from interviewers** and observers, the fieldworkers were given training and field manuals were used during data collection.
- The collected data were continually checked by research coordinators and in the instances where there were low quality or missing data, the interviews were replaced by new ones.
- In order to form method and language unity during data analysis and reporting, 4 workshops were conducted with the participation of short-term experts, technical assistance team and sometimes members of the technical advisory group.
- In order to test the **validity and reliability** of the findings **feedback meetings** at provinces were organised by research coordinators.

2.8 ETHICAL PRINCIPLES

- At every stage of the study ethical principles were adhered to, and this topic was examined in detail during the training of fieldworkers.
- Special attention was given to the principle of **confidentiality** during data collection and storage. During the transcription of the interviews codes were used instead of real names.
- Prior to each interview, the participants were given **information** regarding the objectives of the study and their permission was taken for the interviews. In this context, **informed consent forms** were prepared which are annexed to the field manuals.
- During interviews, audio recordings were made in line with the consent of the participants.
- The fieldworkers were chosen from local people who were familiar with the culture, local languages and dialects and it was ensured that they were not prejudiced or judgemental about the views of the participants.
- Preliminary findings of the study were shared with the research sites and those who had participated in the study, so that they would not feel just a subject but a beneficiary of the conducted study.

3. FINDINGS

In the data collection process, 125 in-depth, and 16 focus-group interviews were carried out; the data was collected from a total of 239 subjects. The distribution of the interviews (in accordance with the various characteristics of the participants) is shown in the Table 2. As for the distribution of the provinces with respect to all interviews held, the data is given in detail in the maps (Annex 13).

Since the research was qualitative and based on a non-probabilistic sampling method, the numbers and the percentages given in the Table 2 cannot be used for generalization purposes in a statistical sense. The numbers and the percentages given in the Table can however be used to understand our research sample. As is seen in the Table, most pregnant women interviewed are between 20-29 year of age (60%), 96.9% of whom were illiterate or graduated from elementary school.

Table 2: Distribution of the study group according to various characteristics

Characteristic	*Pregnant women (in-depth interview)* *Number (%)*	*Relatives of pregnant women (in-depth interview)* *Number (%)*	*Health personnel (in-depth interview)* *Number (%)*	*Key informants (in-depth interview)* *Number (%)*	*Pregnant women-peer (focus group discussion)* *Number (%)*	*Health personnel (focus group discussion)* *Number (%)*	*Total* *Number (%)*
Settlement place							
Urban	36 (55.4)	14 (68.2)	10 (55.5)	14 (66.7)	33 (53.2)	39 (75.0)	146 (61.3)
Rural	26 (40.0)	7 (31.8)	7 (38.9)	6 (28.6)	29 (46.8)	13 (25.0)	88 (36.7)
Area of seasonal workers	3 (4.6)	0	1 (5.6)	1 (4.7)	0	0	5 (2.0)
Age							
15-19	5 (7.8)	3 (13.6)	0	0	5 (8.1)	0	13 (5.4)
20-29	39 (60.0)	5 (22.7)	3 (16.7)	1 (4.7)	39 (62.9)	24 (46.1)	111 (46.3)
30-39	17 (26.2)	5 (22.7)	13 (72.2)	3 (14.3)	15 (24.2)	21 (40.4)	74 (30.8)
40-49	4 (6.1)	2 (9.1)	2 (11.1)	12 (57.1)	2 (3.2)	7 (13.5)	29 (12.1)
50+	0	6 (31.8)	0	5 (23.8)	1 (1.6)	0	12 (5.4)
Sex							
Female	65 (100)	16 (77.3)	13 (72.2)	3 (14.3)	62 (100)	40 ((76.9)	199 (83.3)
Male	0	5 (22.7)	5 (27.8)	18 (85.7)	0	12 (25.1)	40 (16.7)
Educational Status							
Illiterate	35 (53.8)	10 (50.0)	0	0	39 (62.9)	0	84 (35.4)

Elementary	28 (43.1)	8 (36.4)	0	11 (52.4)	22 (35.5)	0	69 (28.7)
Middle school	2 (3.1)	1 (4.5)	0	1 (4.7)	0	0	4 (1.7)
High school	0	2 (9.1)	5 (27.8)	3 (14.3)	1 (1.6)	18 (34.6)	29 (12.1)
University and higher	0	0	13 (72.2)	6 (28.6)	0	34 (65.4)	53 (22.1)
Total	**65 (100)**	**21 (100)**	**18 (100)**	**21 (100)**	**62 (100)**	**52 (100)**	**239 (100)**

As it is seen in Table 2, number of in-depth interviewed pregnant women was 65. Forty-six pregnant women were interviewed during focus groups and 111 pregnant women in total were included in the study.

Demographic characteristics and ANC attendence of these women are presented in Table 3. Majority (60.4%) of the interviewed pregnant women were in 20-29 years old, 59.1% were living in rural areas and 98.2% were illiterate or graduates of primary school. More than half of them (57.4%) were living in extended families.

In other words, **our study group consisted of young-adult pregnant women living in mostly extended traditional families and with a very low level of education.**

Table 3: Distribution of the interviewed pregnant women according to demographic characteristics and ANC attendance

	No ANC *Number (%)*	*Discontinued ANC* *Number (%)*	*Total* *Number (%)*
Age			
<20	4 (6.3)	5 (10.4)	9 (8.1)
20-29	37 (58.7)	30 (62.5)	67 (60.4)
30-39	20 (31.7)	10 (20.8)	30 (27.0)
40-49	2 (3.2)	3 (6.3)	5 (4.5)
Settlement place			
Urban	33 (52.4)	32 (68.1)	65 (59.1)
Rural	28 (44.4)	14 (29.8)	42 (38.2)
Seasonal workers area	2 (3.2)	1 (2.1)	3 (2.7)
Educational status			
Illiterate	36 (57.1)	28 (58.3)	64 (57.7)
Elementary	26 (41.3)	19 (39.6)	45 (40.5)
Middle school	1 (1.6)	1 (2.1)	2 (1.8)
Family type			
Nuclear	27 (42.9)	20 (41.7)	47 (42.3)
Extended	36 (57.1)	28 (58.3)	64 (57.4)
Total	63 (100.0)	48 (100.0)	111 (100.0)

3.1 PERCEPTIONS OF PREGNANCY AND CHILDBIRTH

The women participating in the present study perceive **pregnancy as a natural process even as a process giving a sense of happiness** and fulfilment in general. On the other hand, those who had many pregnancies or had problematic pregnancies do not share this '**happiness'**; those who experienced a negative pregnancy process or those with relatives who experienced difficult pregnancies are afraid of having similar problems in their own pregnancies. While part of their fear is related to worries about their babies' lives as well as their own, another cause for concern is the possibility of unpleasant and/or unkind conduct by health personnel during the childbirth process, and the fear of neglect and carelessness. **The number of those who state that they want to give birth to their children at home because they are worried that they will encounter poor conduct from caregivers at the hospital, and that bad things may happen to them as a result of the lack of care cannot be underestimated.**

Even though the pregnancy is perceived as a process giving a sense of happiness in general, older **women especially those who have had many children, and economic problems, perceive pregnancy negatively** as being a burden. This of course depends on how much say a woman has regarding her own fertility: in some cases a woman, who does not want to have a baby, becomes pregnant selflessly because the male partner wants a child; and, in other cases, a woman may want to terminate an unwanted pregnancy, but cannot for the same reason.

The relatives of pregnant women perceive the pregnancy positively and provide them with support. However, there are pregnant women who cannot get any support and are in effect ignored or neglected during their pregnancy.

Throughout pregnancy such complaints as nausea and aches and pains are considered normal if they are not too severe and are not taken as a reason for receiving antenatal care. If these complaints become severe or are accompanied with bleeding, it causes women to have recourse to a health care institution.

The movement of the unborn offspring in pregnancy is perceived as a sign of health. **Lack of movement in the unborn offspring is considered sufficient reason to have recourse to a health care institution.** However, sometimes economic hardship, or the disinclination of senior family members, or the processes of obtaining permission from the spouse, make it difficult to receive these services.

If senior family members, especially mothers-in-law, had had healthy deliveries and given birth to their children at home, they consider receiving antenatal care unnecessary for pregnant women and state that the members of the young(er) generation crave comfort and resort to doctors at their every slightest whim. As for the husbands, they generally consider antenatal care necessary, but there are times in which care cannot be received because of its simply not being **economically feasible**.

In relation to pregnancy, **a prevalent perception especially evident amongst people from the countryside is shame/embarrassment** [Turkish *utanma* covers both

'shame' and 'embarrassment']**.** Women show a tendency to go out less as their pregnancy proceeds and their enlarged abdomen becomes noticeable. In addition, they feel shame/embarrassment talking about the pregnancy with others, both relatives and peers. As a result of not talking about and discussing their feelings, the knowledge gained, and experience acquired by women cannot be shared. This diffidence extends to health personnel and affects the quality of health care they receive. As can be seen, **the consequences of feelings of shame/embarrassment negatively affect the women's utilisation of antenatal care services.** It is understood that pregnant women feel most at ease talking about their pregnancy and its attendant discomforts with their husbands.

3.1.1 Positive perceptions of pregnancy

It is observed that almost all the women interviewed perceive pregnancy as a normal and natural process and even as a pleasant one giving a sense of happiness, regardless of their demographic and socio-economic characteristics. Parallel with this perception is the sentiment that it is unnecessary to go to a health care institution for a check-up in the absence of any severe complaint.

> *"I swear it's true, pregnancy is a natural condition – I mean to say – if you don't become ill, if you don't feel uncomfortable, it's a very normal thing. It's nice…" (Pregnant woman, 20-year old, first pregnancy, received no antenatal care, urban, Van)*

> *"Of course it's a normal thing, a thing everyone should experience, everyone experiences, and we want ourselves to experience as well." (Pregnant woman, 30-year old, received no antenatal care, rural, Afyon)*

> *"I have never been ill, so why go [to receive antenatal care]." (Pregnant woman, 38-year old, discontinued antenatal care, semi-urban, Adana)*

Women consider it normal to have such complaints as nausea during the first months of pregnancy, and heartburn and fatigue during the final months and even in these cases they do not consider it a necessity to go to a health care institution.

> *"For instance, you're pregnant; nausea may happen, this is normal, in other words, such things might happen, [therefore there is] no need to go." (Relative of a pregnant woman, 26-year old, housewife, urban, Adana)*

The desire to learn about the development of the unborn offspring is a primary reason to go to a health care institution in the absence of any specific or severe complaint. It is understood that women go to a health care institution to receive antenatal care services once in the fourth and fifth months of pregnancy, during which the movements of the baby are evident. When learning of the fact that the baby is normal, they find it unnecessary to go again. It has been said that **for those who state they may resort to a health care institution in the event that they have a serious health problem, the priority level is the degree to which they are laid up because of illness.**

Although a number of the participants state that pregnancy is a condition requiring regular examinations, they do not say anything about how useful such

examinations are in relation to the health of the mother and child, except for learning the health status of the child. According to these informants, going to a health care institution for an examination without having a specific or serious problem is a 'good' thing.

> *"[You] should go. Yes, it would be fine. You know, if the child develops, it becomes large. They go to learn if it [the baby] takes vitamins or not. Now they go into an x-ray as well; they all go." (Pregnant woman, 22-year old, received no antenatal care, urban, Afyon)*

> *"Of course, one should go. It's better if you go – I mean to say – if you learn whether you have a something wrong, if your baby is healthy or not. It's good, if one goes." (Pregnant woman, 35-year old, received no antenatal care, urban, Adana)*

3.1.2 Pregnancy and shame/embarrassment

Another commonly shared perception observed in relation to pregnancy is that **it is "a shameful/embarrassing condition"**. This perception is stated by pregnant women living in rural areas especially; indeed, this perception is emphasised by relatives and health personnel as well. Pregnant women feel ashamed/embarrassed in front of senior members of the family and male doctors. They describe their pregnancy as **"shameful/embarrassing"**, and they behave diffidently at the prospect of going out of their house and meeting others. **This phenomenon is considered an obstacle for women wanting or needing to access reliable sources of information on pregnancy and/or access to health services as well as a more general hindrance to their social lives.**

Living with her mother- and father-in-law, a 20-year old woman, experiencing her first pregnancy, received no antenatal care, but said that pregnancy is good if it is comfortable. The same 20-year old woman also stated that she was reluctant to receive antenatal care simply because she is ashamed/embarrassed.

> *"I swear it is true that pregnancy is a normal condition – I mean to say – if you aren't ill, if you do not feel discomfort, it is very normal. It's beautiful – I mean to say – mine has been going well up to now, that's why it was not necessary to go for any examination; a whole lot of my friends have gone for vaccination, injection. I swear, I feel ashamed/embarrassed, I'm reluctant, and that's why I do not want to go* [laughing]*." (Pregnant woman, 20-year old, received no antenatal care, no school education, first pregnancy, Van)*

Many women stated the belief that pregnancy is something to be ashamed of/embarrassed about. It is evident from the words of an illiterate pregnant woman, who has had no antenatal care during her fifth pregnancy, how feelings of shame/embarrassment limit the social lives of pregnant women.

> *"Yes, I swear it's true that* [smiling] *my brother was ill, too, he went to Ankara regularly, he's been ill for two months and I still cannot visit him… because I*

feel ashamed/embarrassed to go… I mean to say—it is a shame/embarrassment in our culture, we feel ashamed/embarrassed. I don't talk about pregnancy with anyone in my life – I mean to say – not with my family, not my husband's family, I don't talk with my family about pregnancy." (Pregnant woman, 33-year-old, fifth pregnancy, received no antenatal care, urban, Van)

"It's shameful/embarrassing here, so we do not ask [laughing]. *(Are you ashamed/embarrassed?) "Yes." (Well, don't you even share your pregnancy with your sister?) "No, no." (Pregnant woman, 22-year old, discontinued antenatal care, rural, Adana)*

"[Laughing] *People are ashamed/embarrassed, it's true; I'm ashamed/embarrassed; I do not know why." (Pregnant woman, 24-year old, received no antenatal care, rural, Afyon)*

A physician stated the difficulty he experienced with a woman who came for antenatal care, because of her shame/embarrassment.

"Of course, they feel ashamed/embarrassed of talking about their pregnancy with any male other than their husbands. [Despite being a doctor] I'm no exception. As you know, they find the midwife first. When the midwife brings her to me, I have to question the midwife. When I ask a pregnant woman [a question] directly, I don't receive an answer. I ask the midwife, and she asks the pregnant woman. She answers the midwife's questions, not mine. There are times she feels ashamed/embarrassed of her pregnancy, not because she sees pregnancy as an illness, you know… How can I explain…? The event of pregnancy… I can't explain the phenomenon… Look, anyway, shame/embarrassment accompanies the pregnancy. They also feel shame/embarrassment in describing their pregnancy-related problems" (General practitioner, male, health personnel, focus group discussion, Afyon)

A midwife in Adana shares similar views about how pregnant women feel.

"…they aren't open enough, [they are] *reluctant when they are with senior family members, for example; they hide their pregnancy …even their neighbours do not know if they are pregnant until a certain month…" (Midwife, 34-year old, rural, Adana)*

"We are villagers, you know, we are ashamed/embarrassed [laughing]. *(Pregnant woman, 35-year old, fifth pregnancy, received no antenatal care, Adana)*

A remarkably common feature related to the feelings of shame/embarrassment in pregnancy is that **women always smile abashedly while they are talking about it**. These feelings of shame/embarrassment in pregnant women appear not to be because pregnancy is somehow regarded as intrinsically shameful/embarrassing but because pregnancy is a sign, a flagrant physical exclamation if you will, of having engaged in sexual intercourse.

3.1.3 Pregnancy perceived as a kind of 'burden'

Considered as a happy condition in general, pregnancy might be perceived **as a difficult experience and a burden by older women who have already have a number of children and for whom the pregnancy is undesired**.

> *"I see it as a burden, you come and go with a burden; you carry a burden. (Do you carry a burden for 9 months?) Yeah, I carry a burden yeah, and indeed it is very difficult for me." (Pregnant woman, 40-year old, discontinued antenatal care, rural, Adana)*

3.1.4 Perceptions of childbirth

Although pregnancy is perceived as a normal and natural process, this perception does not extend to childbirth. A number of pregnant women perceive parturition as 'dangerous', so they opt for to give birth (especially to their first child) at a hospital. According to the focus group interviews conducted with pregnant women and peers, it was clear that **the anxieties and worries emerging over the course of the pregnancy resulted not from the unique features of the process by itself, but rather originated from the perceived uncertainty about what would happen in the end, in other words, during labour (childbirth).**

> *"…Yeah, it's true; it is difficult. Either I'll die or I'll give birth. I mean to say— we live with this anxiety until the birth… There is always a fear inside about what might happen. Will we die or will we be saved? Yeah, I say I feel bad, I'll die; I pray to God, he comforts me, nothing will happen; my husband worries with me until the birth… Mine [my husband] neither stays at home nor worries." (Pregnant women and peers, focus group, urban, Van)*

There is a general perception that if childbirth happens at the hospital, it will be altogether healthier. As indicated by pregnant women interviewed, 'traditional birth attendants' (TBAs)[Turkish *ara ebesi*, (singular), *ara ebeleri*, (plural): 'women who act as midwives but who do not have formal qualifications'] rarely deliver the child at home. As for the health personnel, they state that they encounter a number of cases with complications after the childbirth carried out by traditional birth attendants. However, even though childbirth at a hospital is considered healthy, in rural areas especially it is not favoured by women because of the widespread belief that surgical interventions are likely, and are likely to be oriented toward a caesarean section. As a result, if there is considered no risk, deliveries are carried out at home. Again, **there might be a number of cases where people do not have recourse to a hospital because of the fear of encountering poor conduct among health care providers during childbirth**. It happens, though rarely, that people intending to have their child at a hospital, give birth on the way to the hospital because of the distance from the hospital or the difficulties encountered in organizing transportation.

It is observed that there is a relationship between the perception of childbirth as being dangerous, and the desire to give birth at a hospital. Senior family members, especially mothers-in-law, sometimes do not consider it important for

pregnant women to give birth at a hospital or do not perceive it as risky and approve of childbirth at home, particularly if the mothers-in-law had never themselves experienced a problematic delivery.

Although making use of health care institutions for childbirth seems a general tendency, mothers-in-law and economic problems emerge as factors increasing the probability of childbirth occurring at home.

Another important finding concerns caesarean section. **There is a prevalent negative perception about caesarean section. Such perceptions of caesarean section may affect the degree to which a number of pregnant women have recourse to a hospital for childbirth.** In a focus group interview held in the rural parts of Adana, a pregnant peer (wife of the village *imam* [a Moslem cleric]) stated that the likelihood of having a caesarean section, instead of a vaginal delivery, at a hospital makes a number of women opt for childbirth at home. These women think that pregnant women are given a caesarean section merely because it is undemanding for the health personnel. However, caesarean section is not a favoured practice for women living in the area and is perceived negatively.

This perception is founded on two reasons. First is the idea that **after a caesarean section the number of possible deliveries becomes limited.** Naturally, it is those families with a desire to have a plenty of children especially, who do not want to have a caesarean section. Another reason behind the reluctance to have a caesarean is that it is related to **the emergence of a number of health problems afterwards**.

> *"I had my second child through normal childbirth, the third with caesarean. I had the caesarean and returned [home]; they [the people around me at home] even said that you had an operation; [but] if you had it at home, it would be normal because you've got two children. You had two normal childbirths, the third one was caesarean. (What matter if it is caesarean?) [It is] as if you are half a person, they think you have ailments when you have caesarean, actually some may have, [but] thank God, I didn't have any ailments. I'm in my fourth year and I don't have any ailments…That's the way people think. Why did you go? Look, it would be normal if you had it at home? When you go there [to the hospital], they make you lie down anyway as an easy procedure [for them] and cut you up with a knife. Why do you have yourself cut up and made a half person? You know, they have a desire to have lots of children, so when you have caesarean, it prevents you having more [children], they think it is harmful for childbirth, that's why [they think that it is not good]." (Pregnant-peer focus group, rural, Adana)*

3.1.5 Perception of the unborn offspring

Women evaluate the course of pregnancy with the movements of the unborn offspring. These movements are considered important and worthy of vigilance. For this reason, the use of ultrasound is quite common and **is a notable factor in ensuring that pregnant women have recourse to health care institutions during pregnancy.** Mothers want to learn the condition of the unborn offspring. The women who go to receive antenatal care services want to have the unborn offspring scanned with

ultrasound and be informed about it. A number of women complain about physicians not giving enough information about their pregnancy and the condition of their unborn offspring.

Ultrasound is considered important because it provides information about the position of the unborn offspring as well as indicating the course of its development. Therefore, expectant mothers opt for ultrasound examinations because they can be informed beforehand of any likely problems that may befall during childbirth. This leads expectant mothers to solicit antenatal care services from state hospitals and even from private hospitals—the latter because of the perception that they provide better treatment and more satisfying explanations than health centres.

Even though pregnant women care about the inactivity of the unborn offspring, **the distance of the institutions providing antenatal care services and transportation difficulties hinder their access to these services.**

> *"For example, my pregnancy is in its sixth month, the fifth is over. It's been four to five days since it's entered the sixth month. Sometimes my baby doesn't move frequently. A six-month old baby should move often, but it doesn't. If there were a health care institution here, I would go there and I'd say I have a problem. But even if I go now, who shall take an interest in me. I mean to say—I have to go to Van. It's another problem. If there were such an institution here giving help, I would go. You usually feel sick. Recently, my abdomen has hardened. The baby didn't move for one or two days, but I couldn't go… I had nowhere to go." (Pregnant woman, 21-year old, second pregnancy, received no antenatal care, rural, Van)*

3.1.6 General health perception and behaviour

Women state that they do not have recourse to a health care institution upon having a health problem. The problem is expected to get better spontaneously or with medicines taken at home. The women who were interviewed generally stated that if they were 'very ill' or had a serious condition requiring an urgent intervention, then they would go to a health care institution. A number of participants describe those who have recourse to the health care institutions without any severe condition as being **'fond of comfort'**.

> *"I swear it's true, if it doesn't get to be too intolerable, I don't go. I don't even remember, as I said, the last time I went there… I mean to say—I'm not that kind – I mean to say – like fond of comfort. If they take me to the Emergency by ambulance, then I'll go. I'm not that kind – I mean to say – a woman fond of comfort* [laughing]." *(Pregnant woman, 31-year old, discontinued antenatal care, semi-urban, Adana)*

While most of the participants reveal that they would go and receive health services only if they had serious health problems, a number of **the participants are proud of not receiving preventive health services**.

The condition of not receiving any health services unless they are sick is a condition observed by community leaders as well.

> *"There is no such thing. What I mean to say is that our people definitely do not go to the doctor until they become sick. They do not go, whenever there is illness and they are in a difficult position they run to the health centre." (Muhktar [Head of Village], 38-year old, elementary school graduate, rural, Van)*

The tendency commonly observed as general health-seeking behaviour is toward not going to a health care institution without being ill, or rather seriously ill. Even during the course of illness, people show such a behaviour as waiting for a while, then when the symptoms of the illness get intense, and then, and only then, having recourse to a health care institution.

> *"First of all, I try to get better by myself.—Er—this is our style; somehow – I mean to say – I try some hot drink made with mint and lemon.... That is to say if I were very sick and bedridden, then I'd go to a doctor. Otherwise, I try to recover by myself." (Husband of pregnant woman, 22-year old, urban, Afyon)*

A number of women adopt **a fatalistic point of view** towards their health, and both illness and good health are considered an 'act of God'. **Those who adopt this point of view do not believe that they have any determinant role over their health and do not receive any antenatal care services.**

> *"No, I swear to God, there is not. Whatever is written in one's destiny, it will happen." Pregnant woman, 30-year old, received no antenatal care, semi-urban, Adana)*

> *"… we do not go. We say it's an act of God, whatever the consequences." (Pregnant-peer focus group, semi-urban, Adana)*

> *"If God wishes, one doesn't feel sick; I mean to say—whatever the one and the only God wishes, it will be. Until this age, I never got sick; [I have] always relied on God, now…I'm very well." (Pregnant woman, 20-year old, received no antenatal care, urban, Van)*

In such cases like 'the pain of death', seeking outside help and assistance may take the place of fatalism.

> *"I'm going to give birth to my child at home. If God and all Muslims do not withhold their compassion…God is great. If I had the pain of death, then I would go to Van for labour." (Pregnant woman, 43-year old, illiterate, eleventh pregnancy, received no antenatal care, rural, Van)*

As for a number of other pregnant women, they consider health a priority. However, this priority is not related to the idea of protecting or improving one's health, but rather with the condition of getting over illness.

3.2 ATTITUDES AND BEHAVIOURS TOWARD PREGNANCY AND CHILDBIRTH

3.2.1 Self-care in pregnancy

In pregnancy, the most carefully attended thesis is not doing any heavy work and not carrying heavy weights. This thesis has been cited as significant by both pregnant women and their relatives. Besides this, pregnant women and their relatives pay attention to their nutrition and hygiene.

Many pregnant women and their peers agree with the idea that a pregnant woman should not carry weights during pregnancy. There is an opinion that carrying heavy weights results in miscarriage and defects in the baby.

> *"But as you know—er—my husband tells me all the time as a health precaution, you know, do not carry heavy things, do not tire yourself much, as a precaution for such kind of things—er—we do not do many things. We do not – I mean to say – I do not do myself, my husband tells me that something might happen in the end, and I swear it's true that I try to take care of myself better. For example, I try not to carry heavy things while I'm cleaning my house. For example, sometimes I take reactions, too you know, the neighbourhood, saying that you do not do much work—er—you do not…" (Pregnant woman, 26-year old, first pregnancy, discontinued antenatal care, rural, Van)*

> *"We take care of our nutrition, I do not carry heavy weights, if I did, either I would have a miscarriage or my baby would be disabled – I mean to say – I pay attention to my food, regularly." (Pregnant-peer focus group, rural, Adana)*

Pregnant women are **in need of obtaining information from health personnel especially about nutrition**. In the focus group interviews held with health personnel it was stated that training is given to pregnant women on nutrition and hygiene. However, expectant mothers and their peers complain about not getting any information from health personnel. Pregnant women state that they can ask the questions on their minds freely and get satisfying answers about nutrition only if they go to a private practitioner.

> *"A private practitioner tells everything; you can ask whatever you want; she pays attention to you. You can call and ask her whenever you want; when you have a question, you can call, she informs you, tells you to eat fish, [to] nourish yourself well." (Pregnant woman-peer focus group, semi-urban, Adana)*

Pregnant women take care of their nutrition and food and try to consume such nutriments as milk and egg which they believe to be beneficial. A number of them keep themselves away from the places where people smoke, try not to eat much and not to be gorged during pregnancy.

One of the participants stated that wearing tight dresses results in miscarriages. Wearing comfortable clothes and being in places where they are at ease are favoured. The insalutary effects of smoking are also accepted.

"Cigarettes, I used to smoke; I haven't smoked since I got pregnant." (Pregnant woman, 34-year old, fifth pregnancy, received no antenatal care, urban, Adana)

Those who try to expand their knowledge about pregnancy and childbirth do this by watching TV more. Again, a few participants stated that they read things about pregnancy and birth. Pregnant women find it normal to move around and do some light housework during pregnancy. Also, there are some who go for walks during pregnancy.

"What do I do? I do my regular housework. I cook. After dinner, I go for a walk in the coolness of the night." (Pregnant woman, 34-year old, fifth pregnancy, received no antenatal care, urban, Adana)

3.2.2 Ailments experienced during pregnancy

The most commonly cited **types of discomfort in pregnancy are lack of appetite, nausea, pyrosis (a burning sensation in the stomach and oesophagus, with belching of watery fluid), stomach-ache, weakness, and complaints about teeth.** These complaints are regarded as normal and do not require a visit to a doctor. Health personnel state that people have recourse to a health care institution when the ailments of women get intense or when any problem is detected in the baby. Such conditions as kidney pain, bleeding or fainting are considered sufficient reason to go to a health care institution. Pregnant women have recourse to the health care institution when pain becomes intolerable or any life threatening condition emerges.

"Yea, I swear to God it's true, the same things are happening again but this time I've got a lot of discomfort… When I get pregnant, I can't eat anything, have no appetite… I do not eat food and so… I'm so unwell; I have backache, stomach-ache, you know, one cannot lie down, with these." (Pregnant woman, 23-year old, fifth pregnancy, no antenatal care, urban, Van)

Sometimes in pregnancy women have such a problem a swollen feet, a potentially serious problem, but they do not receive any antenatal care for this problem.

"Yeah, my feet get swollen, swollen very much." (Pregnant woman, 26-year old, eighth pregnancy, received no antenatal care, rural, living in an extended family, Adana)

In the event of having severe aches, pains and **threats of miscarriage in pregnancy, antenatal care is more frequently received** and the suggestions of physicians are more readily welcomed and accepted.

"My pains increased at home, you know; I went [and] the doctor told me not to carry any [heavy] weight. We went to the maternity hospital, we were examined, and there was a threat of miscarriage. The doctor said your baby was on the way down, so you had to be careful. I went there once for this reason. Later on he asked me to go again, and I went there once more." (Pregnant woman, 27-year old, seventh pregnancy, discontinued antenatal care, living in an extended family, urban, Adana)

Complaints related to teeth become evident in the pregnancy. Most pregnant women stated that they had rotten teeth during pregnancy, so they had to have them extracted.

> *"I swear it's true, I have tooth ache whenever I got pregnant. That is to say, I have to have two to three teeth pulled out throughout my whole pregnancy." (Pregnant woman, 38-year old, received no antenatal care, urban, Van)*

> *"No, I swear, I do not use any [medication], unless the doctor gives [it to] me. He gave me a blood building medicine and an analgesic and I used them. I didn't use any other medicine up to now. Well, as you know, I also had a toothache, so I had to have my tooth pulled out." (Pregnant woman, 27-year old, seventh pregnancy, discontinued antenatal care, urban, living in an extended family, Adana)*

In addition to such complaints as nausea, groin pain, rashes, and limited movement, other complaints like weakness, fatigue, headache, back pain and pains in other areas of the body increase during pregnancy. Expectant mothers' ailments are evaluated according to the customs, traditions, and practices of her milieu. A pregnant woman who received antenatal care states that since she does not tell anything to her mother- and father-in-law, because she cannot go to a doctor, even if she has complaints.

> *"If I you say let's go to the 'dogdur'* [doctor], [they say] *it's just the state of pregnancy, that amount is normal. Okay, I'll take care. We cannot say anything to the mother-in-law, father-in-law. It's a normal thing. They say it happens in pregnancy." (Pregnant woman, 20-year old, discontinued antenatal care, rural, Afyon)*

Relatives and pregnant women worry that some health problems may affect the baby. Therefore, **relatives and pregnant women want to have recourse to a health care institution not because of the discomfort of the pregnant woman but purely to discover if there has been any damage done to the unborn child.**

> *"That's why my kidneys are inflamed as well, excuse me, my kidneys are inflamed, inflamed [distracted, unhappy], that's why I want to go. Let me just have look, if it has any [done any] harm?" (Pregnant woman, 31-year old, discontinued antenatal care, semi-urban, Adana)*

A pregnant woman who is living in a rural area, undergoing her third pregnancy without any antenatal care clearly describes an iron deficiency symptom called pica (defined as a tendency or craving to eat substances other than normal foodstuffs). When the symptom shown by this woman who has had no antenatal care is taken into consideration, **it is understood that there is an intense need for a type of care which cannot be met solely through antenatal care services.**

> *"I mean to say—you want to lick the soil up off the ground. I feel like eating my own body like this, but I cannot, it smells to me – I mean to say – I wanted to tell*

you yesterday, but I forgot, I remember today, I wanted to ask." (Pregnant woman, 30-year old, received no antenatal care, rural, Afyon)

3.2.3 Traditional practices

Among the traditional practices related to pregnancy and childbirth **the most well-known is the assistance provided by a 'traditional birth attendant'** [*ara ebesi*] **or senior family members.** Health personnel, pregnant women, and peers participating in the present study indicated that the number of traditional birth attendants [*ara ebeleri*] has decreased to a great extent, in some areas they have totally disappeared. But even if it is rare, they may still assist during childbirth. Although a number of pregnant women, peers and relatives had positive views towards traditional birth attendant [*ara ebesi*], health personnel stated that uterine atony bleedings and uterus rupture caused by these women endanger the health of the mother and child. Most of the participants also expressed the view that traditional birth attendants [*ara ebeleri*] were a relic of a bygone era and that today childbirth at a hospital is preferred.

In the present study, no folkloric behaviour related to antenatal care or a healthy pregnancy process was encountered. However, there do persist traditional beliefs and practices regarding the inability to get pregnant and to the treatment of the baby after birth. A number of these practices are carried out by traditional birth attendants [*ara ebeleri*]. For example, regarding the former point concerning the inability to get pregnant: it is believed that **traditional birth attendant [*ara ebesi*] change the position of the uterus through massage and enable these women to get pregnant**. It is stated that some traditional birth attendants [*ara ebeleri*] may ease pain, or stimulate the movement of a hitherto inactive unborn offspring by inspecting it with their hands and changing its position.

"Women had changed the position of the uterus by groping well then. You know, it is hard for a reverted uterus to get pregnant, but according to what they say, the woman had loosened, relaxed, crumbled with massage, such things have been said; there are even some who tell that without any gynaecologic intervention from below, something had been done only with outward massage, and finally they got pregnant; there are still ones who engage in this stuff." (Health personnel focus group, semi urban, Adana)

"Now, she applied soap to her hand, she was pulling upwards under my abdomen, she was turning my belly like this. When she turned, I sensed – I mean to say – the turning of the baby. When she turned, she revolved my abdomen and the baby started to move. She said look how I turned your abdomen and your baby, and it has started to move. It was really so. It had not been moving for a week. It was…in my womb, [but] there was no activity. I mean to say – to say – however she touched, the baby got well." (Pregnant woman, 27-year old, discontinued antenatal care, second pregnancy, semi-urban, Van)

"There are licenseions and such and such as you see, when they occur, they go to traditional birth attendants. They have their abdomen pulled; I mean to say—they say it has fallen down [laughing]*" (Pregnant woman, 40-year old, discontinued antenatal care, rural, Adana)*

In Afyon area there are holy places where the women who are unable to get pregnant go to and those who vowed to make an offering go there again when they get pregnant to celebrate their wish come true by killing an animal as a sacrifice. In the rural parts of Afyon, the rope tied to the waist is described as a method to get pregnant and it is not removed until the birth.

> *"We've got a holy place* [Turkish *yatır*, 'place where a holy man is buried']. *We go there. People go there frequently. Those who are unable to get pregnant go there. They say please God, give me a baby. They visit there again when they are pregnant. They sacrifice an animal. Young women go to this holy place if they do not have a child for three or four year." (Pregnant-peer focus group, Afyon)*

> *"I went there twice. We go there. H— B— tied it. This rope (they tie it to their waist until birth), we believe in [this] deeply. Oh, here we have. I have, too. Here, when you believe, look I am tied, too. You won't remove it until birth. He said it will stay there until it breaks off." (Pregnant-peer focus group, Afyon)*

With regard to the second point concerning the treatment of the baby in the period after birth: there are **various practices such as salting the baby; pressing a piece of burnt linen on the navel; and rub ant eggs under the armpits.** In the focus group interviews, participants stated that they had learnt these practices from senior family members and they asked the researchers if they are harmful to the baby or not. Younger women especially tend to question the accuracy of these traditional practices. Health personnel also agree that these traditional practices exist.

> *"Friend, oh, if you washed the baby with honey, it would be honeyed. They especially apply this to girls, thinking that they would be pleasant. Later on they salt the baby so that it wouldn't smell, then they apply ant eggs under the armpits if they find [any] so that the baby girls do not have hair. If you found ant eggs, no hair would grow. I do not know." (Nurse, 31-year old, urban, Adana)*

In addition to the beliefs regarding remedying the inability to get pregnant and the treatment of the baby after birth, there is a **belief that the position adopted whilst lying on the bed determines the gender of the baby.** It is notable that even health care personnel take this belief seriously.

> *"According to what they say if you get pregnant and if the baby rests on your right, it will be a boy. If it rests on the left, it will be a girl." (Pregnant-peer focus group, Afyon)*

> *"… I mean to say—if you lie on your right, it is girl; if you lie on your left, it is boy. You see, I know a doctor who recommends lying on the left. Yes, the doctor that our daughter-in-law went to in Yeşilevler recommended it. I said to myself oh, goodness gracious* [Turkish, *allah, allah*]*; there are whole lots of things I don't know. Oh, if I lie on my left, it will be a boy, I said well, lie on your left anyway. Look at the coincidence, she had a boy. Now believe me, I think whether I might be pregnant* [laughs]*." (Nurse, 31-year old, urban, Adana)*

A small number of women put the suggestions arising from the customs and traditions of their milieu into practice and find explanations of the changes in pregnancy. For example, suggestions come from the senior family members about the spots appearing on the skin during pregnancy.

> *"My mother told me… As you see, there were a lot of spots around here (showing her nose and cheeks) in my first pregnancy. —Er—she said to me—er—when you give birth —er—for example, wet your hair like this [showing the way she does so, by moistening the tips of her hair with her tongue] and strike your face with it… I've only got around here [showing the place between her nose and lips]." (Pregnant woman, 22-year old, third pregnancy, discontinued antenatal care, urban, Van)*

> *"My mother-in-law told me to apply stingy nettles (the milk of stingy nettles), so that it might get well. They didn't tell me to drink anything, just made me apply it. I only applied it, but it didn't help. I made a poultice twice but it didn't work. Later on, the traditional birth attendant* [TBA] *told me to go to a gynaecologist at all costs." (Pregnant woman, 22-year old, no antenatal care, urban, Afyon)*

Even though the people who are invited to help the childbirth at home are called 'old woman' or 'neighbourhood midwife' [*ara ebesi*], most of the time it is the female relatives who provide support during childbirth.

> *"We had to bring the old woman to the house because there was no doctor. But if we have a doctor, we won't bring the old woman. If there were health personnel, why should we bring an old woman? But since there is no doctor, we have to have an old woman. I swear to God, that's it. But do you know that she doesn't attend every childbirth? If the old woman thinks that the mother is in a bad condition, if the childbirth is difficult, she never interferes. She says take the mother to Van. She looks, makes an examination and if the mother's condition is good, she does it well, [and the] woman feels pleased as well." (Relative of pregnant woman, 37-year old, illiterate, semi urban, Van)*

There are **also some practices to make the childbirth easy**. One of them is **rubbing the arms and waist of pregnant woman with sherbet** [Turkish *şerbet*, 'a mixture of sugar and water'] **and examining the uterus manually**. Another is a religious one, like putting the Koran or bread at the bedside to make the childbirth easy.

> *"For example, they were helping me, making me walk, giving a massage to my waist, sherbet, and so on… No, my mother-in-law was sitting next to us, rubbing our arms. She was holding our waist. She was examining our uterus with her hands. Until the birth…" (Pregnant woman, 43-year old, eleventh pregnancy, received no antenatal care, rural, Van)*

It is understood that the most prevalent traditional practice related to health in all regions is bone setting. The reasons for this are on the one hand, ignorance, and economic hardship, and on the other, the waiting and perceived complexity of the procedures of the hospitals. It can be extremely difficult for illiterate women especially to solve their problems at the hospital. However, it is stated that bonesetters may solve the problems of the patient straightforwardly and in a short

period of time. Furthermore, it is known that the cost of such traditional practices is much lower compared to those of a health care institution. For these reasons, it is understood that people opt for the bonesetters that are well-known and have been trusted for years in their area. Even a member of the health personnel recommended that his own patient go to such a bonesetter to treat a broken arm. The health personnel member states that since the bonesetters do not intervene in the cases they find difficult to cope with and they refer the patient to a health care institution, they do not do any harm to the patient.

> *"There is, hadji* [hajji], *we've got such a bonesetter; as a matter of fact his name is Hadji anyway. I've broken my arm recently; patients have recommended me to go to him. They listen to Hadji when he says you should see the doctor, they then say I should go, and they go." (Health personnel focus group, semi-urban, Adana)*

> *"You see, he applies soap and pulls the finger. Yes, it helps the broken [mend the broken bone]. I take her there. If she [this] is sick [showing her daughter], I take her to the physician. (Relative of pregnant woman, 32-year old, housewife, urban, Adana)*

> *"I swear to God it is true that I do not believe in such things as hadji-hodja [faith-healing]. I just believe in God. But there is bone setting stuff. They do [it] when there is dislocation. When the x-ray is taken, when there is something broken, it is shown anyway, when it is put in the plaster cast, but most recommend the stuff here. I mean to say—they do [it] and it also gets well." (Relative of pregnant woman, 37-year old, illiterate, semi-urban, Van)*

3.2.4 Privacy and shame/embarrassment

Most pregnant women, their relatives, and peers, participating in the present study **revealed that they do not go to a male physician because they are ashamed/embarrassed unless they are constrained to do so**. The feeling of shame/embarrassment is especially **evident on the subject of gynaecological examinations**. Besides, **there are those who are ashamed of/embarrassed about talking to a physician and asking about her own condition**. The feelings of shame/embarrassment also influence the selection of health personnel. Even though there is a physician available, pregnant women may sometimes opt to have their child delivered by a midwife. But still, many of the participants indicated that they are growing accustomed to the idea of male physicians dealing with pregnancy, and expectant mothers should they feel obliged to will be examined, or have their baby delivered, by a male physician.

Expectant mothers may increasingly have recourse to private hospitals because these hospitals cognizant of the traditions, customs and practices of their clients, choose their gynaecology specialists among women. It is also stated that sometimes women may have their baby delivered at home instead of the hospital just because of the feelings of shame/embarrassment.

A number of women will not be examined by a male physician at all; others are examined by a male physician only if there is no female physician available.

"When I first went to a physician when I was pregnant with this one, we went to the maternity hospital, later on to MarSA [a health institution constructed by a Turkish company, part of the Sabancı group]. *There were male physicians there; my husband didn't let me be examined; I didn't think it was appropriate, either. So, if there is a female physician, why go to a male physician?" (Relative of pregnant woman, 26-year old, housewife, urban, Adana)*

"Women opt for the stuff; they opt for the female physicians. They do not opt for male physicians as long as they don't have to." (Pregnant woman, 26-year old, the first pregnancy, discontinued antenatal care, semi-urban, Van)

It was stated by health personnel that **the lack of careful attention to expectant mothers' privacy decreases the likelihood that they will make use of health care institutions**. It was stated that expectant mothers' privacy was not taken into consideration in the design of these institutions; for example, the placement of the rooms is such that there is likelihood that women during their examination can be seen by casual observers from outside.

"The atmosphere is not suitable here to ask an expectant mother to uncover her abdomen; there is no suitable place to examine her. What has been done? This is a two year old building, prefabricated; it was planned as a health centre but with only two rooms for physicians and a policlinic; no secretariat was built, no special unit for family planning was considered. I myself had a PVC folding screen made for family planning after informing the head of personnel—it's like this. I had it made so that the visitors outside couldn't see the gynaecology table directly in front of them; I mean to say—they do not plan anything, it has been made haphazardly, a whole lot of money has been spent in establishing this place, lots of things have been done, [but] it's not suitable for a health centre." (Health personnel focus group, Adana)

The feelings of shame/embarrassment do not only affect the capacity to ask questions, but also the relationship between the physician and the patient.

"I mean to say—sometimes my mother-in-law, and others with her, speak in this way, my mother and others as well. They say how will we go? For example, this girl, she says we sit like this. She says ah girl, I used to be like this before. I say when I used to go to the doctor, s/he used to look at me, I used to close myself, and I used to feel shame/embarrassment. But now I do not feel shame/embarrassment anymore. A person that saw, and looked that much doesn't feel shame/embarrassment anymore. I swear to God it is true, everything is obvious." (Pregnant woman, 26-year old, fourth pregnancy, discontinued antenatal care, rural, Adana)

3.2.5 The factors that facilitate the process of pregnancy

Among the factors that facilitate the process of pregnancy, the foremost is the help provided to the woman in doing household chores. **It is generally accepted that pregnant woman ought not to lift any heavy weights, nor work in the field during pregnancy—and she receives adequate support in these matters**. Expectant mothers

living in extended families stated the fact that they generally support each other in doing household chores. This mutual support is considered significant and facilitates the pregnancy process. Pregnant women indicate that such chores, as washing the clothes and rugs or kneading dough which they describe as 'heavy' work, are performed by the other women in the house.

> *"For example, she was feeling sick in her stomach because of the food, its smell; we didn't let her do it; I or my mother-in-law was doing it [instead]." (Relative of pregnant woman, urban, Adana)*

> *"For example, you hang out the laundry, they say do not hang them out I'll do it, you are pregnant; you knead dough, [they say] do not knead it, I'll do it." (Pregnant-peer focus group, rural, Adana)*

> *My mother-in-law is doing [the work], my sisters-in-law are doing [the work]… For instance, for all I know, a heavy weight, they do not let me cook the bread. Our water has been cut off since yesterday; they do not let me go and fetch water. That is to say, they help me a lot with [respect to] my pregnancy. They do this much—I mean to say." (Pregnant woman, 18-year old, first pregnancy, discontinued antenatal care, semi-urban, Van)*

> *"For example when my womb gets bigger, they try not to send you to work. They get a job. . Later on, they look after your kids. You only deal with cooking—um—. I mean to say—when the childbirth is close. That is to say that they protect you." (Relative of pregnant woman, woman, 19-year old, rural, Afyon)*

Some pregnant women stated that their husbands behave more conscientiously during their pregnancy. They state that the husbands help them if they need it.

> *"Mine does, when I have cravings, when I feel nauseous, he helps me. I mean to say—not in normal times, only when I'm pregnant." (Pregnant-peer focus group, rural, Adana)*

> *"I mean to say—for example that when my family learns that I'm pregnant, they treat me better. Especially my husband. I mean to say—even if he doesn't have a job, he tells me everyday not to go to work, eat well—er—such things – I mean to say – he treats me well, but in spite of this, I still think, I mean—er—no job, such and such." (Pregnant woman, 22-year old, third pregnancy, discontinued antenatal care, urban, Van)*

However, the condition mentioned above is not always the case. The situation is **different for most pregnant women who migrated from Eastern and Southern Anatolia to Adana. These women state that a man cannot do a 'woman's job' and they do not find it natural for a man to be busy with household chores**. In this environment, men are expected to work in jobs that enable them to earn money. When they arrive home, men want to be waited upon. Even if their husbands do not help them, women state that their husbands take the pregnancy process into consideration and do

not ‘force’ them. Many women do not have any expectations regarding support from their spouses—in household chores at least.

> *“Husbands don’t do women’s job.” (Pregnant-peer focus group, semi-urban, Adana)*

> *“Husbands do not want to; they do not do [household chores] for us, but neither do they force us. They do not do such things…; I mean to say—they do not disturb us.” (Pregnant-peer focus group, semi-urban, Adana)*

3.2.6 Working during pregnancy

Since all expectant mothers interviewed in the province of Van were housewives, the subject of daily household chores was topical. A small number of expectant mothers said they had worked in a job to earn money previously. Women who live in a nuclear family stated that they carry out their daily chores by themselves. As for women who live in an extended family, they stated that they share the household chores with other family members and they do not do such work as cooking bread, going to fetch water, and caring for animals throughout their pregnancy. Pregnant women who live in families engaging in agriculture in Afyon continue to perform household chores, as well as take care of animals. Even though doing such heavy work is not desired for pregnant women, they may nonetheless have to.

The case is a bit different in Adana. The women living in extremely poor families have to work in paid jobs at home or outside of the home because of economic reasons, even if they are pregnant. These people who migrated from Eastern and Southern Anatolia generally work in unqualified jobs for a daily wage. In addition, **pregnant women who come to the region as seasonal workers are perceived as workers and they work in the fields during their pregnancy**.

> *“Yes, they go, I know those who go harvesting; there are ones who are about to give birth to their child en route, aren’t there friends? Yes, there are.” (Pregnant-peer focus group, rural, Adana)*

Health personnel state that pregnant women who are poor, without any health insurance, and with a lot of children have to work in the fields for economic reasons.

> *“I mean to say—they—er—are not in a position to attend on a routine basis as would be desirable in ideal circumstances. I mean to say—they work in the fields as they are, taking their children on their backs* [in a papoose-like pouch] *they work. They work even if they experience every kind of problem. Think of how often—er—they go to the doctor—er—I mean to say—at most—it’s impossible for them to go to a doctor even twice or three times during a pregnancy. —Er—this is, of course, not ideal.” (General practitioner, 36-year old, woman, area of seasonal workers, Adana)*

As we can see from this example, being an expectant mother is not perceived as a sufficient reason to quit work in the fields, or to work full stop. The main reason for this is the fact that being continuously pregnant and giving birth to children is understood as a not unnatural course by the society, or in the local milieu in which it

features, or at least one that does not merit censure. In addition to this, as one health personnel stated, it is a political choice for these families to produce children.

> *"No. She doesn't get a different service when she gets pregnant. Here there is a thing as why doesn't she get pregnant when she can't. It is a problem. I mean to say—a woman should always give birth. I don't know why. I think it is probably their own policy. I mean to say—a policy of proliferation, [but] I do not know." (General practitioner, 32-year old, woman, urban, Adana)*

The working life of expectant mothers either at home or in the fields may make it difficult for her to access the services or may hinder the process. Health personnel state that women with an intense workload may have recourse to a health care institution when they finish their work, or may not avail themselves of it.

3.2.7 The place where the childbirth will take place

It seems difficult for a woman to decide on where to give birth to her child. Even if it seems safe to deliver the baby at the hospital, there are cases in which childbirth at home is found more comfortable and problem free.

> *"… as you see, I prefer to deliver it at home unless the life of the baby is at risk, let me say so… But sometimes I say to myself if my child's life is endangered, it's better to give birth at the hospital … As you see I'm caught in-between." (Pregnant woman, 26-year old, first pregnancy, discontinued antenatal care, extended family, semi-urban, Van)*

Such factors as economic condition, having health insurance or not, determine if childbirth will occur in a state hospital, in a private hospital, or at home.

As is seen in previous findings, **it is especially the past experiences of expectant mothers, and the past experiences of those around her, related to pregnancy, and their perceptions of risk in pregnancy and/or childbirth that encourage childbirth at the hospital.** It is noteworthy that women living in an urban area who received no antenatal care services consider giving birth to their children at the hospital for these reasons.

> *"Not at home, but at the hospital… If you ask me why, let's say you couldn't give birth to the child at home; let's say we know plenty of women [who] gave birth here. Like two or so: one of them was my uncle's daughter-in-law; the other was our neighbour's daughter-in-law. Their placentas didn't separate* [abnormally adherent placenta]. *Their bleeding didn't stop. When such a thing happens, midwives act roughly, they apply stitches. It is as I said, they act roughly." (Pregnant woman, 22-year old, received no antenatal care, urban, Afyon)*

> *'I swear to God it is true, I want to give birth at the maternity hospital. As I said so, under the control of the doctors, as usual – I mean to say – I want both my husband and doctors to come with me." (Pregnant woman, 38-year old, received no antenatal care, urban, Van)*

"I swear to God it is true that it is better I give birth at the maternity hospital. I think of maternity hospital like that. At home – I mean to say – if I do so, I do not bring a woman to my home; I always give birth at the maternity hospital. It is nice, clean. Sometimes they do not know and bring a woman. They kill the baby. They do not take care of the woman well either; I do not take any woman into my home at all, I always go to the maternity hospital." (Pregnant woman, 23-year old, fifth pregnancy, received no antenatal care, urban, Van)

The main deterrents related to childbirth at the hospital are the negative perceptions remembered or anecdotally passed on of previous experiences such as the lack of interest, being exposed to impolite treatment, lack of adequate help provided by health personnel during the childbirth, and sometimes the delay in the intervention.

A number of women from rural areas who had received no antenatal care before and had their previous deliveries at home stated that they what to give birth to their child at home again. Around these women who gave birth to their child at home or have been considering childbirth at home again are their same sex relatives who support them.

"Well, it is near, good, I say, at home…" (Pregnant woman, 29-year old, third pregnancy, received no antenatal care, rural, Van)

"Yes, I'll give birth to this one at home, too. No, I swear to God, thank God, I've never gone there. If God helps, I won't go this time, either." (Pregnant woman, 43-year old, eleventh pregnancy, received no antenatal care, rural, Van)

The case of a 29-year old woman who wanted to have her fifth baby at the hospital because she planned to have a tubal ligation (ligation of the fallopian tubes as a method of sterilization) but later on decided to have her childbirth at home since she was informed that she was too young an age for such an operation as a contraceptive method, is a typical indicator of the perception that home environment is free of risks for childbirth.

"I was thinking of going for this one. As a matter of fact, I was considering an operation. I would have my cords tied, I didn't want to have anymore, but I asked, they said I wasn't old enough. That's why, I do not know now. I will have this one at home again in all probability. I mean to say—if I had an operation, I would go." (Pregnant woman, 29-year old, fifth pregnancy, received no antenatal care, rural, Van)

From the statements of a nurse who has been working as the lone health provider in a health centre without a physician for five years in Afyon, it appears that the economic conditions of pregnant women are significant in the selection of the place of childbirth.

Poor pregnant women living in rural areas have to opt for childbirth at home. If they are not followed up by a gynaecologist in his/her private office, they do not have the opportunity to have childbirth attended by a specialist at the hospital as a

known patient. **They also hesitate from going to a hospital for childbirth because they fear that the gynaecologist will decide on a caesarean section**. What plays a significant role in this is the fact that caesarean section is not a favoured mode of childbirth, and it is more frequently applied than actual conditions necessitate. **The fact that caesarean section is not a favoured mode of childbirth (and the fact that it is more frequently applied than actual conditions necessitate) plays a significant role in this reluctance.**

An indicator showing how the frequency of caesarean has increased over a certain period of time is the rumour regarding the relationship between caesarean section and tetanus vaccination. Pregnant women who were followed by physicians had received tetanus vaccination more than other pregnants and consequently had more deliveries at hospitals sometimes with caesarean section. This was concluded as, "tetatus vaccination during pregnancy causes caesarean" by the people.

Since money is needed for childbirth in the hospital, recourse to hospital is deferred if there is no problem with respect to the childbirth. If there are no health personnel available in the health centre area, then the 'traditional birth attendants' maintain their presence as the only solution.

> *"… first you should go to the doctor's office, he'll see you, know [who] you [are]. You'll give money, and then get the answer. Later on when you go to the hospital, they take care of you. They do not want to go to the hospital for this reason. Also, they think that if there is a problem, the doctor may do an operation, we may have a caesarean; it's better if we can have childbirth at home; if we cannot, we have to both pay money and have childbirth. They didn't want to have a tetanus vaccine for a while; they fear that they might have a caesarean. About two years ago there were a lot of caesarean cases. They said that they thought it was because of the vaccination. We have recently overcome this. Midwives have to be available, when there is no health personnel; they have to. (Health personnel focus group, Afyon)*

3.3 PREVIOUS EXPERIENCES

3.3.1 Experiences related to previous pregnancy and childbirth

Those who had problems with the health personnel in their previous pregnancy feel reluctant to go to a health care institution in their present pregnancy. Such problems as **the threat of miscarriage, anaemia, severe pains, and lack of appetite** are problems which caused ANC attendance during previous pregnancies. There are also those whose pregnancies and deliveries are free of problems. While a number of pregnant women were having difficulties in their first pregnancies, the others had problems in their subsequent pregnancies.

A number of pregnant women who experienced problems received health care services; on the other hand, some did not and amongst these a number had miscarriages. **Those who experienced miscarriages or similar problems in their previous pregnancies and those who observed such problems in their relatives may go for check-ups more frequently in their present pregnancy**. But there is still a group that even if something bad had happened to them in their previous pregnancies, persist in not receiving any care in their subsequent pregnancies.

It is observed that previous childbirth experience is very important in the identification of the place where the subsequent childbirth will take place. **If a pregnant woman describes her previous childbirth as 'hard', she prefers the hospital for her later deliveries; if a pregnant woman describes her previous childbirth as 'easy', home is considered sufficient**. Prolonged or complicated deliveries are described as 'hard'. Those who had problems in their previous pregnancies, or had a malformed child, try to avoid having such an experience again. This causes a number of them to have recourse to a health care institution.

> *"…The child was handicapped, didn't live, and died. But, look, that's why we were frightened; this time we went to doctors. Thank God." (Husband of pregnant woman, 33-year old, urban, Adana)*

Having caesarean in the previous childbirth makes it necessary for pregnant women to opt for a health centre for subsequent deliveries.

> *"I have to go to the maternity hospital because I had caesarean." (Pregnant-peer focus group, semi-urban, Adana)*

In the interviews held with pregnant women, **the density of miscarriages, stillbirths, and infant deaths is notable**.

> *"I had two, two deliveries; they died at birth, and also a six-month old [child], in my womb." (Pregnant woman, 38-year old, seventh pregnancy, discontinued antenatal care, semi-urban, Adana)*

A relative of a pregnant woman stated that she had lost her baby because she did not receive a diagnosis and medical treatment on time while waiting for a long time in the queue.

> *"If they had taken care of me, if the others hadn't waited in front, if they hadn't put me in the queue, they might have saved it. I went to work. I stayed at Balcalı for eight days in intensive care. They took my baby dead." (Relative of pregnant woman, 41-year old, housewife, urban, Adana)*

Those who want to deliver their baby at the hospital think that it is necessary to visit the doctor's private office for antenatal care for having childbirth at the hospital easily.

> *"By hospital – I mean to say – Van maternity hospital. I went there with my sisters-in-law once or twice. If you have a private physician, if you have gone to a private practitioner, they take care of you. But if your physician is not a private practitioner, you've got Bağ-Kur (the social security agency for tradesmen, craftsmen, etc.). You'll give birth; you go to the hospital; for all I know, childbirth is not carried out under the same conditions. Generally it is more, you know, in order to make the childbirth quicker; there are more deliveries." (Pregnant woman, 21-year old, second pregnancy, received no antenatal care, rural, Van)*

> *"… they took care of me, they said you had your name written, you went into television [you had ultrasound], so they showed interest, but they hadn't taken care of my sister-in-law. They had made the stuff, put her baby on the thing, and said if it weighed two and a half kilograms, we would deliver the baby. Otherwise we wouldn't deliver [it] here; we would refer you to Afyon." (Pregnant woman, 19-year old, discontinued antenatal care, rural, Afyon)*

A number of participants state that they have healthy deliveries even without receiving antenatal care, but as for other participants, they do not think of receiving antenatal care anymore because of their previous bad experiences.

> *"It was okay. That's why I didn't care about anything. Others said eat that, otherwise your baby suffers from avitaminosis, but I didn't do anything. But the cravings were ad this time. I couldn't eat anything for a month. It coincided with the harvest." (Pregnant woman, 22-year old, third pregnancy, received no antenatal care, urban, Afyon)*

> *''I have my deliveries with the village midwife. I'm very sorry I went to the examination in my first pregnancy, but I was about to die." (Relative of pregnant woman, 37-year old, housewife, middle school graduate, semi-urban, Van)*

A number of the participants stated that they do not have recourse to **a health care institution even if they experience bleeding**. On the other hand, a relative of another pregnant woman who had had a miscarriage previously may frequently go for check-ups.

"No, I swear to God, there was not. Before that, my bleeding started two days ago. I didn't go. I said nothing would happen. Next day, I had a miscarriage." (Pregnant woman, 29-year old, fifth pregnancy, received no antenatal care, urban, Van)

It is revealed that even if a number of them do not receive any antenatal care services, they learn the things that are done in the follow-up process from their relatives who are being or have been followed up during a high-risk pregnancy.

"I swear it's true, my sister-in-law's sister went to [antenatal care services], she is saying that they were examining her, measuring the blood pressure, and telling [her about] the time left, how many months, and days left until the childbirth; examining the baby if it was healthy. You see, my sister-in-law says her sister is very anxious, that's why she goes. She had had a miscarriage in her first pregnancy, she was frightened, and she is going to the doctor every week so that something bad will not happen to her baby." (Pregnant woman, 20-year old, first pregnancy, received no antenatal care, urban, Van)

Some bad experiences the relatives had, such as intrauterine death, misdiagnosis by the health personnel or unqualified service provision **are considered important by pregnant women and play a significant role in directing them to the services.**

"I swear to God, I've got one, my husband's sister…She said oh, it' had been a week my baby hasn't moved at all, I went to the maternity hospital with her, I said to the doctor that her baby wasn't moving, he said oh, everyone's coming here says mine is moving a lot, some say mine is not moving, mine is healthy. He said no, yours is fine. He gave a painkiller and let her go. Next day, her husband took her to the stuff, emergency service, to a private hospital. The doctor said the baby has been dead a week, he recommended an immediate operation; he said if required, have it surgically removed, otherwise she will die; she's my husband's sister... I mean to say—if she didn't go to the private hospital, she would have been poisoned; the baby had been dead in her womb a week. She says I feel it, my baby is dead, and it is not moving at all [with an accusing expression]" (Pregnant woman, 38-year old, received no antenatal care, urban, Van)

In pregnant-peer focus group interviews it is stated that **a great deal of women had negative experiences with the health personnel during childbirth**. **There are a great many statements indicating that health personnel have been indifferent, and have been treating pregnant women harshly, saying judgmental and denigrating words to expectant mothers.** A number of pregnant women state that the health personnel pushed down on their womb during childbirth. The negative experiences of pregnant women at the hands of health personnel are presented in detail under the section related to the reasons that prevent pregnant women from having recourse to a health institution.

"My waist doesn't ache, but my womb is very big; when they apply pressure, I have worse labour pains, but at home no one interferes, we wander about – I mean to say – it's normal. It's easier for me, that's why I stayed at home, Thank

God, nothing bad happened; my kids are healthy as well. How do I know? They get angry there, they beat you; you can wander about at home. Nurses are strict there." (Pregnant-peer focus group, semi-urban, Adana)

"In childbirth at the hospital the midwife took care of me, but generally was like such. They shouted, made a lot of noise, I had a sudden childbirth anyway. They shouted, rise, push the baby – I mean to say – such and such. Some of them are good, some treat you badly, and that's it. They do the stuff, when we go to the hospital, we wait a lot; it is too crowded. There are these difficulties." (Relative of pregnant woman, woman, 19-year old, rural, Afyon)

3.3.2 General experiences related to receiving health services

It appears that there are problems in making use of health care services generally, and not just in the cases of pregnancy. **The fact is patients find hospitals neither user-friendly nor effective places from which to receive health services; hospitals do not have flowcharts enabling users to find the relevant departments without difficulty; they are crowded and they have negative features such as long queues; and they do not have service standards. Private hospitals, especially because they require excessive tests and examinations in order to form diagnoses, which push up costs, are also viewed negatively.**

"As an individual when you go somewhere, you want to be responded to; when you go to the hospital, you do not receive a response even from a security guard. The thing that makes people the most uncomfortable is being unable to find what they are searching for. I mean to say—if I, as a member of the health personnel, feel uncomfortable, other people definitely will. I couldn't find the Ear-Nose-Throat Policlinic in the hospital or found it last, even though I am a nurse at the hospital." (Health personnel focus group, semi-urban, Adana)

Long queues at the hospitals bring about complaints from people. Patients complain that they are not examined properly in some health care institutions.

"They make you wait a lot. I mean to say—there are lots of people there… When you go, you have to get up at 5 o'clock in the morning and wait, you have to be the first in the line, and otherwise you will have to wait throughout the morning till noon." (Pregnant woman, 27-year old, received no antenatal care, urban, Adana)

Health personnel believe that the lack of public investment in public services and the ongoing disruption of such services is a strategy designed to induce patients to avail themselves of the services provided by private health care institutions. However, the quality of the services provided by private hospitals is also considered low. It is stated that private hospitals amplify costs by doing unnecessary tests and examinations and are incapable in solving patients' problems.

"But you go to the private hospital as well; I went to a private one, for the same problem as my friend; I am a hypertension patient. I stayed in coronary intensive care for two days; I've got lots of problems. I use Kardura, Meloc. I use such a whole lot of drugs that I get confused about which one to take. The

doctors gave all of these drugs in the end – I mean to say – the doctors of internal medicine. I can't risk going to the SSK [Sosyal Sigortalar Kurumu, Social Security Organisation] *hospital. After those agreements were made, I went to a private hospital, but you cannot reach any resolution there either: studies and x-rays one after another. They explore again and again; they say go now, but come tomorrow. You cannot come to an end; you cannot receive your treatment. You are sick again. Will you continue taking your former drugs? What will be the result of all these studies?" (Health personnel focus group, semi-urban, Adana)*

Based on their own experiences, health personnel stated that **the problems encountered by the patients at the hospitals are a significant obstacle to receiving health care**.

"If a member of the health personnel suffers from such problems, consider what happens to a fellow citizen." (Health personnel focus group, semi-urban, Adana)

Health personnel describe their own experiences in private doctors' offices positively, and contrary to their experiences in private hospitals, being considered negative. General patients as well as pregnant women are in the main taken care of at the private doctor's offices; they can receive answers to their questions; obtain a clear idea of the issues; and they can resolve their health problems. Pregnant women and their relatives agree with this estimation.

"Private, you know, not a private hospital. By saying private I thought of a hospital, if they would pay me attention, but it was not so. Now I'll come to this point. At the end, I couldn't have any result from there [the private hospital], my results are still in their hands, and they still aren't close to forming a diagnosis, they said neither possible nor impossible; they said nothing. I collected all my documents there, I went to a gynaecologist's private office, and we sat together, and got acquainted. She examined my analyses, looked at my husband's analyses, the x-ray results, and said Mrs. Midwife, the case is this, because of this problem in your husband, because of that problem in you, and we cannot expect a natural course of pregnancy. Let's try Intra Uterine Insemination first, if we do not have any results, then try having a test-tube baby. We said well, okay. We got out of the office; we learnt what we needed to learn; we received attention; we sat and drank our tea or coffee, we had chat, and our work was completed properly." (Health personnel focus group, semi-urban, Adana)

It is understood that pregnant women are also pleased with the services they receive in some health centres and find the personnel working there interested and friendly. Even if they find these clinics small, they seem to be happy with both their treatment and communication.

"Yes, I went there twice, three times. The first time I went there to see if it was there. I also went there with my sister-in-law and my mother-in-law. It was good. The third time, I went by myself. They treat you well, they vaccinate you, treat you well; they speak well. They chat, we also chat – I mean to say – they

are very good people." (Pregnant woman, 18-year old, discontinued antenatal care, living in an extended family, Van)

On the other hand, it is found that physicians in some health centres tend not to stay there long and this creates problems.

3.4 SOURCES OF INFORMATION ON PREGNANCY

3.4.1 Obtaining information from peers and relatives

A number of pregnant women state that they share the information or problems related to pregnancy with their close friends or neighbours. Consequently, peers can be important sources of information and useful interlocutors for the sharing of experiences.

> *"Whenever I have a problem, I ask a person who I see as like-minded, close to me—if I have any problems. If I do not, it's not like that… they tell me about the things they know, and I tell them... We talk, share things, both about the development of the child and the vaccination, the illness after birth; whenever we come together … we talk." (Pregnant woman, 21-year old, second pregnancy, received no antenatal care, rural, Van)*

For the women who can talk with their friends or neighbours about pregnancy, **experienced individuals are considered significant**. Women describe experienced and older individuals as "those with plentiful knowledge" and they defer to their knowledge and trust what they say. Pregnant women also consult these experienced women when they experience any problems.

> *"[A] neighbour told me, one of them told me to go that woman, and they said she knows well; that's why, I went her." (Pregnant woman, 29-year old,no antenatal care, semi-urban, Adana)*

> *"I mean to say—my sister-in-law is older and generally more experienced than me. I mean to say—sometimes she tells me some things." (Pregnant woman, 20-year old, discontinued antenatal care, semi-urban, Adana)*

However, this type of behaviour is not common in most pregnant women, especially in those who have migrated from Eastern and Southern Anatolia to Adana. These women live in a very restricted social environment. Within this environment, social relations are not extensive. In point of fact, **a number of women state that their husbands do not even let them visit their neighbours**.

They cannot talk about topics related to pregnancy and childbirth with their peers. A 22-year old pregnant woman who was married in a religious wedding ceremony, having her second pregnancy, and living in the area of temporary workers in Adana stated that she cannot exchange information with her peers about pregnancy. She added that within the environment where she lives such topics as pregnancy and childbirth are considered shameful/embarrassing, so she cannot talk about these issues even with her sisters.

> *"(H'm, well, do you have conversations about pregnancy with… your sister-in-law or your neighbours around?) No, we never do. (So why not? Are you ashamed/embarrassed?) It's shameful/embarrassing; we do not ask about it*

here [laughing]. *(Well, don't you share your pregnancy with your sister?) No, no. (Pregnant woman, 22-year old, discontinued antenatal care, rural, Adana)*

3.4.2 Obtaining information from written and visual media

One of the most common features of the women interviewed **is their lack of exposure to any books or magazines on pregnancy and childbirth**. A number of them are illiterate; the others read with difficulty. No newspapers or magazines enter most of the houses. Some do not find any time to read because of the workload.

"No, no, there's no opportunity to read them—housework, also two kids, vineyards, and orchards, then comes the evening." (Pregnant woman, 23-year old, discontinued antenatal care, rural, Afyon)

"We do not read the newspaper much. (Why not?) We do not know reading well. (Well, does your child or your sister-in-law's daughter read health news and inform you, and make it possible for you to discuss that?) We never talk." (Pregnant woman, 26-year old, discontinued antenatal care, urban, Adana)

Women living in extended families express that they generally do not watch TV either. A small number of women stated that they can watch programs related to pregnancy or health on TV only if they can find enough time after household chores are completed. It was stated that, at most, women watch TV series and morning programs specifically designed for women.

A number of women report that when something happens to them in relation to their health, they pay particular attention to written and visual material about their problem and their interest inclines towards these materials. In this respect, the first pregnancy can be significant. In the first pregnancy the need and motivation for obtaining information can be greater. A pregnant woman stated that she read magazines about pregnancy in her first pregnancy.

"Yes, I do. I mean to say—my husband's sister has got magazines about pregnancy. I take them and read. It is very important in the first pregnancy." (Pregnant woman, discontinued antenatal care, semi-urban, Adana)

3.4.3 Obtaining information from the health personnel

Women generally indicate that **health personnel serving in public health care institutions do not inform them well enough** about pregnancy and other matters. It appears that they are generally informed by the health personnel when they ask, but they sometimes feel hesitant to ask questions. The predominant opinion among a great number of pregnant women is that the communication channels between the health personnel and pregnant women are not open enough.

"No, she doesn't inform us much, for example she writes the prescription and lets us go, that's all… Not much, if we ask she informs us, but if we don't ask, she doesn't. They do not take pains over us that much, for example, thinking that

we do not know they do not try to inform us." (Relative of pregnant woman, 18-year old, housewife, urban, Adana)

Health personnel state that they provide sound health training to pregnant women, but **a number of them complain about the fact that the information they provide is not taken into account and pregnant women focus more on the information they obtain from those of their milieu instead of that provided by health personnel**. Part of the information on pregnancy and childbirth obtained from relatives or peers is based on hearsay. Health personnel maintain that a rumour, for example, implying that such and such a drug or vaccination results in 'infertility' may be taken extremely seriously, and that it takes time, a year or so, to lessen its effects.

"*For example, they come to me and say that for example, a patient with episiotomy* [incision of the vulval orifice to facilitate childbirth]*, she gave birth. She developed episiotomy. We say that you should use antibiotics; you need to have the wound dressed regularly. But they, you know, the older ones say that if you use anti-inflammatory drugs, your baby will be infertile. Later on we say that, you know, at the beginning, for example, if you do not use anti-inflammatory drugs, your stitches will be inflamed, if you do not dress the wound regularly, your stitches will be infected. But when their neighbour or a senior family member say that it will poison your milk, your baby will be infertile, and that it won't help you, then they do not take the drugs and this was more prevalent in the past." (Midwife, 42-year old, urban, Adana)*

Conversely, some health personnel state that people do take the information and suggestions provided by health personnel into consideration. **One physician thinks that "every word from health personnel" is valued**. The roots of this difference of opinion may lie in the views people form about the success of communication in this context.

Health personnel report that there is a decrease in the demands for information after the first pregnancy. The idea that "nothing happens even if I do not comply with their [health personnel] suggestions" becomes prevalent as the women become more experienced in giving birth and encounter no problems during the process. **Pregnant women state that they obtain information from health personnel on nutrition and receive such advice as not carrying heavy weights in the course of the pregnancy**. Another finding that appears here is the fact that pregnancy tests are taken from the pharmacy rather than health centres. The instructions related to the application of the test are explained by the pharmacist.

3.5 VIEWPOINTS HELD BY THE RELATIVES AND FAMILY MEMBERS ON PREGNANT WOMEN'S HEALTH BEHAVIOURS

The views of the relatives of pregnant women about pregnant women's health behaviours are generally positive and supporting. **It is common that relatives warning expectant mothers on those issues they perceive as risky and a potential cause of miscarriage: doing work outside the home, carrying heavy weights, and excessive fatigue**. It is considered a characteristic unique to the regions where the present study was held, that pregnant women who had been married off at a young age and gone to live in extended families need the attention and suggestions of their husbands and mothers-in-law.

Suggestions concerning the health of pregnant women have turned into a cliché. **Some relatives point out that although they think it is necessary to take pregnant women for regular check-ups, economic conditions prevent them doing this**. While going for check-ups, the mother-in-law is generally with the expectant mother, but as quoted in the example, she is sometimes asked out of the policlinic by the doctor and this is a vexation for the mother-in-law.

> *"You take her once, if it is suitable; you take [her] very rarely (once a month, once a year), if not, you cannot. If our conditions allow, we take her there regularly. I say come on, you know. Sometimes when we got there, they are good like you, thank you, God bless you for what you have done* [Turkish, 'Allah (senden) razı olsun'], *but not the stuff—er—sometimes they say out, out, out, aunt, you out." (Mother-in-law, 55-year old, rural, Afyon)*

It is notable that some husbands are more protective and compassionate towards their pregnant wives.

> *"Yes – I mean to say – if I feel ill, my husband warns me not to do any work. He says do not do [it], it's sinful… Yes, I swear to God he carries out all my wishes. I mean to say—if I feel unwell, he doesn't let me cook bread. He says if something happened to you, who would care about the bread?" (Pregnant woman, 43-year old, eleventh pregnancy, received no antenatal care, rural, Van)*

> *"My husband always tells me… measure your blood pressure, go, but I cannot go. I cannot go and leave my kids. He always tells me, regularly, but I cannot go. My sister-in-law's daughter also tells me to go. You've got blood pressure. For example, I've got a sister-in law. She cannot give birth; they have forbidden her because of high blood pressure. I mean to say—they said if you get pregnant this time, there is an absolute risk of death. They took her baby. It was 8 months old, because of high blood pressure." (Pregnant woman, 29-year old, fifth pregnancy, received no antenatal care, rural, Van)*

Relatives state that if the pregnant woman has a health problem, she needs to have permission to resort to a health care institution from senior family members first.

When a pregnant woman says she is sick, those who make the final decision on having recourse to the health care institution are in most cases her mother-in-law or husband. Even though relatives state that a pregnant woman is taken to a hospital when she is sick, it has appeared in pregnant-peer interviews that the case is not always so. Here it is important to understand what the concept of 'sickness' connotes. Having recourse to a health care institution is possible only if the family members perceive the sickness to be 'serious'; if it is not serious, it is arguably not 'sickness'.

> *"The one who is sick decides. Then, a senior family member is informed. I mean to say—there's no such thing as going [by oneself], in this neighbourhood. They may, for example, go to a traditional birth attendant* [ara ebesi]*, a bone setter. But in our family, there is no such thing as not giving permission when there is sickness – I mean to say – we go." (Relative of a pregnant woman, female, 26-year old, elementary school graduate, Adana)*

It is stated by participants that having to take permission should not be regarded purely as a problem of women's restricted autonomy, but that, in some cases, it is useful for women, when their condition is taken into account they are not capable of doing certain things on their own anyway. **A husband reveals that his wife is ignorant; because she had an inadequate education and was furthermore unable to learn life by exploring their environment, so she is left behind the men.**

> *"My wife is an elementary school graduate, too. They don't know certain things. Because they do not walk around and see, they remain as a stranger to the outside. I don't know. If she wants to go to the health centre on [or] to the town for example, she cannot. I mean to say—she cannot figure out where to go, which way to turn. They remain a stranger to those kinds of things. Since we [the men] go to the town regularly for example, we know much better about these things." (Husband of a pregnant woman, 22-year old, urban, Afyon)*

Just like pregnant women and their peers, a great many of relatives think that when there is a serious health problem during pregnancy, recourse to a health care institution is necessary. Both mothers-in-law and husbands do not consider it necessary to have any recourse, or frequent recourse, to a health care institution if it is (ostensibly) a naturally progressing pregnancy. When it is adjudged to be a 'normal' pregnancy or when no problem is detected in the check-ups, they (pregnant women, their peers, and relatives) do not think it is necessary for pregnant women to go to a health care institution.

> *"No, if it is normal, there's no need for her to go every month. For example, I went for a few months, it was normal, so there was no need for me to go. I used the medicines the doctor gave me. If it is a problematic one, she should go every month." (Relative of a pregnant woman, 26-year old female, elementary school graduate, Adana)*

Relatives of pregnant women are aware of the fact that expectant mothers ought to have a healthy diet. A healthy diet is equated with the consumption of milk, yoghurt, and fruit. Even if the relatives can state the basic nutrition groups, they cannot give clear information regarding balanced diets. A husband stated that he gets whatever his wife wants, but he cannot know what she wants if she does not express her wishes. This

shows a behaviour related to craving rather than one motivated by a desire for a healthy diet.

Based on their experiences, some mothers-in-law think that it is helpful to work during pregnancy for the health of both the expectant mother and baby. The idea is that working during pregnancy facilitates childbirth. Even if mothers-in-law believe the benefits of working during pregnancy; they know that it would force pregnant women at the final phase of pregnancy.

> *"Household chores are good daughter… If you work and move, the child moves as well, but if you lay down, gain weight, the child gains weight also, then your childbirth gets hard, but movement is a very good thing. I mean to say—I'm opposed to that [not being active]. I mean to say—let her move, walk around; pregnant woman can walk around, talk, sit, and she can do her chores comfortably as well, but if she feels very uncomfortable in the final phases, I cannot tell anything about that [I would not insist on her being active]." (Relative of a pregnant woman, 56-year old, mother-in-law, illiterate, Adana)*

3.6 PLACES TO GO TO RECEIVE HEALTH SERVICES DURING PREGNANCY AND THE EXPERIENCES PREGNANT WOMEN GO THROUGH

3.6.1 Going to a health care institution in pregnancy

Expectant mothers' not having recourse to a health care institution unless experiencing serious discomfort is a generally observed tendency during pregnancy. As for those who have recourse without having any discomfort, it is understood that they go to a health care institution **to have a pregnancy test, to get information about the health and sex of the baby, and to have a tetanus vaccination**.

In most of the cases health centres are only used for tetanus vaccination in pregnancy. While the health centres are not generally favoured due to the lack of gynaecologists or sufficient equipment, those with laboratory facilities are preferred especially by green card owners [health insurance recipients: such health insurance is provided – without having to pay premiums – by the state to people who have no social security cover and are very needy] and others with SSK [Sosyal Sigortalar Kurumu, Social Security Organisation] or similar health insurance.

Private hospitals, on the other hand, are favoured for having female gynaecologists, laboratories, and ultrasound facilities. Although state hospitals are considered very reliable, they are not favoured by those with sufficient economic power, but are rather the preferred choice of holders of health insurance and green card owners. The reason being that state hospitals when compared to private hospitals **are more crowded, and have impolite health personnel who are unwilling to inform the patients**.

3.6.2 Going to the private doctor or hospital

Private doctors' offices and private hospitals are women's most preferred institutions in all regions where the present study was carried out. The main reason for this preference is the interest shown by the health personnel and the technical, especially ultrasound-based, facilities they possess.

Those who go to a private hospital seem happy with **the quality of the services provided and the attention given to them**. It is understood that private physicians form positive relations with their patients and provide satisfactory services especially in the personal atmosphere of their offices. The health personnel interviewed within the scope of this study agree that those physicians and health personnel working in the public sector show insufficient interest in their patients, nor establish a suitable connection with their patients, and hence communication suffers; for this reason pregnant women do not want to go for check-ups in the public sector; rather they opt for private hospitals as far as their economic conditions allow. The health personnel interviewed acknowledge the wisdom of this preference.

Private practitioners are perceived as more open to communication. The participants who went to a private practitioner to receive antenatal care stated that they communicated with the physician well being able to ask questions and obtaining helpful information about their pregnancy.

> *"A private doctor tells you everything; you ask whatever you want. She shows you interest, you can call her when you have any question; you can call, she informs you, tells you to eat meat, fish, tells you to eat well." (Pregnant-peer focus group, Adana)*

> *"[Talking about private practitioners] Very good, instead of wandering around at the hospitals, instead of struggling, you go and give money. Also, they pay you attention. They do all analyses. They say what your disease is. They give you the time of day, time. Otherwise, when you go to the hospital, they make you struggle with the works." (Relative of pregnant woman, 37-year old, illiterate, sister-in-law, rural, Van)*

A pregnant woman who has had recourse to a private doctor's office is at the same time subject to a follow-up by the physician who will deliver the baby at a state hospital. However, to be examined by a specialist at a doctor's office is a privilege. It requires economic clout.

> *"Private practitioners take care. They give the money, Seventy-five. Then they take care. When your childbirth is near, she watches carefully. A lot of women are going. But not here. Most cannot go anywhere. If you have a green card, you go to the hospital. If not, no. What happens if your economic condition is not suitable?" (Pregnant-peer focus group interview, rural, Afyon)*

When going to a health care institution in pregnancy the most desired thing is to be examined by a 'private physician' specialised in gynaecology and to make use of ultrasound-based services. Such features of a private doctor's office as hygiene, and the capacity to do careful examination as well as the doctor's solicitude, influence the service users. However, in families with economic problems the use of these services might be deferred to the later stages of the pregnancy, or used only when serious problems are encountered, due to the cost of the service provision of a private practitioner.

> *"We say so as well. My husband told me to go. I said no, you know, because I do not have any discomfort. Besides that, when he told me to go to the private doctor, we were not already going to the hospital; people say they do not t pay attention there. When he said let's go to the correct place, I said let's save [money] this month first. And he said okay." (Pregnant woman, 30-year old, third pregnancy, received no antenatal care, rural, Afyon)*

3.6.4 Going to the state hospital and maternity hospital in pregnancy

The idea of a 'hospital' is very important in association with childbirth. All the parties participating in the present study (pregnant women; relatives of pregnant women; community leaders; and health personnel) do not have any doubt about the fact

that **hospitals are the most important health care institutions with regard to childbirth**.

> *"They used to go to the midwives* [Turkish *ebe*, 'formally-qualified midwife'] *in the past. Now they [midwives] have disappeared. Now everyone certainly goes to the hospital whether they have a vehicle or not. They give birth at the hospital." (Imam, 40-year old, semi-urban, Afyon)*

As distinct from the health centres, since **the state hospitals or maternity hospitals have ultrasound-based facilities, they increase the desire of pregnant women to receive antenatal care services**.

> *"I went there twice: once [when] it was four and a half months old, I went into ultrasound… No, in the state hospital, I went once more when it is seven months old as well. H'm, they said it was normal again. I went into ultrasound again, they said it was well." (Pregnant woman, 28-year old, discontinued antenatal care, urban, Adana)*

However, **the crowdedness and the necessity to wait in the line** in state hospitals **have been cited as negative attributes by many of the participants**. On the other hand, there were those who stated that state hospitals provided a good health care service. It is notable that the hospitals are perceived as reliable institutions because of the equipment and facilities they have. A number of pregnant women and their relatives state that they were shown more solicitude at such hospitals than at the health centres.

> *"When you get to the hospital, [and] give money, they take good care. To tell the truth, I want my baby to be born in good conditions. I mean to say—if it is sick, it can be learned [immediately] – I mean to say – they measure its blood. The Physician knows. If the mother needs blood, they give it. Drugs, medicines are bought. Under these conditions – I mean to say – it is good – I mean to say – it is, how you call it." (Relative of pregnant woman, 19-year old, elementary school graduate, rural, Afyon)*

> *"… There is a crowd. Since the newborn service is there, it is crowded. But – I mean to say – they take good care of you." (Pregnant woman, 27-year old, second pregnancy, discontinued antenatal care, Van)*

One of the most significant factors found in influencing the utilisation of services at a state hospital is health insurance. In favouring the state hospitals, the fact of being covered by green card system plays an important role. **Having a green card becomes especially important for risk groups (namely the families with low socio-economic level) in terms of receiving antenatal care and having childbirth at the hospital**. It is understood that **the utilisation of services is negatively affected by the fact that the men neglect the procedures enabling them to have health insurance and that women are not capable of carrying out these procedures for themselves**.

> *"Now pregnant women go to the maternity hospital, but the others – I mean to say – there aren't many with social security.—Er—when there is none, they go to the public – I mean to say – the state hospital, generally with a green card. They don't accept those with the coverage of insurance, oh, two or three people.*

They hardly go – I mean to say – to the hospital for the insured. You know, the citizens consider their stuff as being weak—er—their care. They go to the state hospital, but this time everybody is crowded together, your turn barely comes in the state hospital." (Mayor, 41-year old, male, elementary school graduate, Afyon)

"I mean to say—say at the hospital, say resolve the green card issue immediately. At least we'd take her to the maternity hospital. We'd look if we can have her [fallopian] tubes tied, five is enough. What will she do? I want her to have many, I swear it is true, I don't have [an insurance card] either, and there is nothing to do about it." (Relative, housewife, 41-year old, illiterate, Adana)

A relative of a pregnant woman with too many children stated that the hospital is preferable because she – pregnant woman – can have a tubal ligation after childbirth.

3.6.5 Going to a health centre

A number of pregnant woman stated that they have recourse to health centres to receive antenatal care services. When they have recourse, **the services they receive generally include a pregnancy test and tetanus vaccination**. Even though a number of health centre personnel stated that they carry out complete examination of pregnant women on a regular basis, the interviews held with pregnant women who had recourse to health centres suggested that it is not the case. **Pregnant-peer focus group interviews and a great many in-depth interviews indicate that pregnant women's examination and health training are exceptional practices in health centres of all regions.**

Since pregnant women know that health centres do not provide any services except vaccination, they **have recourse to these clinics in the later months only to receive this service**. Even though rumours circulated in Adana and Van intimating that vaccination actually results in infertility among women, tetanus vaccination is generally accepted by women and perceived as an important practice. Therefore, **even if a great many pregnant women do not receive antenatal care services on a regular basis and do not have an examination, they know that they have to have recourse to a health institution for vaccination**. Pregnant women who receive antenatal care services from a private practitioner also have recourse to the health centres for vaccination.

"Huh, I had my vaccines the other day. I went to the health centre, I completed my vaccine… I went there last week. On Thursday." (Pregnant woman, 34-year old, discontinued antenatal care, urban, Adana)

"No. Not much, for example, she went there for the stuff, once for the pregnancy test to see if she was pregnant or not, and she went for the vaccination once or twice. I mean to say—she didn't go to the health centre for sickness much; she went to a private one." (Relative, 18-year old, housewife, urban, Adana)

"Everybody receive, everyone receives, because while pregnant they have vaccinations, everybody has them completed, and goes for the check-ups. I

mean to say—if they have a problem, they first have recourse to here, then to a doctor. When you go there, they ask – I mean to say – if you went for check-ups or not, if you didn't they say you should and things like that." (Pregnant woman, 24-year old, second pregnancy, discontinued antenatal care, rural, Afyon)

A number of pregnant women stated that when they had recourse to the health centre, **midwives did not do any examination of pregnant women especially in the initial phases of pregnancy**. A pregnant woman pointed out that the midwife working in the health centre did not carry out an examination because it was 'risky' during the first months of pregnancy. A number state that health personnel direct them to the centres with ultrasound-based facilities. It is understood that this state of affairs arises from the idea of a number of pregnant women and health personnel that it is useless to do an examination without ultrasound.

"The midwife doesn't take care of a small baby, doesn't touch it. I didn't go to the doctors and private ones. She doesn't do anything, just vaccinates, doesn't take care, and lets you go. She doesn't interfere, in case it would be risky." (Pregnant-peer focus group, semi-urban, Adana)

In the health centres in rural parts, health personnel sometimes do not carry out the follow-up on pregnant women and may not be interested in those who opted for it.

"Here, they go to the hospitals; they don't go to the health centres much because they don't take care there. I went there for the delivery. At that time they told us that they didn't deal with this. We asked them to tell us about its heart beat at least. They said no. But A— had gone to a midwife she knew who had had a small device; she had listened to it [its heart beat]." (Pregnant-peer focus group, Afyon)

As for a number of other cases, the health centres do not have any other meaning than being a place referring educated people with health insurance to the hospitals.

"We just make a referral; we don't go there together with my husband either. Since they know we are teachers at school, we take the patient's form and make a referral to Afyon maternity hospital. That's all. We haven't been there many times except that." (Teacher, 41-year old, rural, Afyon)

Even if examination of pregnant women is not carried out in a systematic way in health centres, upon the request of a pregnant woman they may measure blood pressure; perform blood analyses; and they may prescribe medicine based on the ailments of the expectant mother or the results of the analyses. In other cases, it is even impossible to receive the simple services requested.

"I have had headaches recently; I went to the health centre. I was pregnant for three or four months. I gave the name of the drug to the midwife and asked which drug to take, she told me. She didn't examine me, just gave me a name." (Pregnant-peer focus group, semi-urban, Adana)

"I went to the health centre for measuring my blood pressure. She said their sphygmomanometer was broken at the present time. That's why I never want to go there." (Pregnant woman, 34-year old, discontinued antenatal care, urban, Adana)

Private physicians and gynaecologists in state hospital are more trusted than the health personnel in the health centres. The quality of antenatal care services provided by health centres is felt to be inferior. The institutions considered providing these services more thoroughly and more reliably are state hospitals and private doctor's offices.

"They chat – I mean to say – I don't trust the physicians [in the health centre]. But when you go to a different place, for example a private physician, she takes an interest in the patient in every way; it was the same when I go to the state hospital. For example, they see the patient as she enters, asks who she is, what problem you have, if it is this or that." (Pregnant woman, 24-year old, discontinued antenatal care, rural, Afyon)

In sum, even though the health centres are well-known by the pregnant women in our research group, they seem to be places where no regular examinations of pregnant woman are conducted nor follow-ups carried out (no services beyond the measuring of blood pressure and the giving of advice with regard to certain complaints) and which pregnant women only resort to for a pregnancy test or tetanus vaccination at the appropriate phases of pregnancy.

3.6.6 Going to the pharmacy in pregnancy

There are those who, in addition to health institutions, have recourse to a pharmacy to have a pregnancy test.

"Now, my mother and others with her went to the pharmacy presumably. My mother, she had gone. She had bought the stuff. You know, there is a buzz. People talk to one another everywhere; I mean to say—there is something like that. She had bought such a thing, like a test. They had heard of it. They had gone to the pharmacy. They presumably had the test done there. I mean to say—that's the way [it is]." (Husband, 22-year old, middle school graduate, living in an extended family, Afyon)

3.6.7 Receiving home-care services

Even though a number of women stated that health personnel visiting their homes with mobile teams invited them to the health centres for vaccination and examination, **home-care service during pregnancy is an unfamiliar concept for our research group**. There is not any home-care service, but it is observed that **a great many deliveries have been carried out at home**. Especially **those who had no health problems, or had an easy delivery before, were in poor economic circumstances or no health insurance to give birth at the hospital prefer to deliver their baby at home**. Another reason for preferring a delivery at home is the conviction that health personnel will behave badly at a health institution. With respect to the delivery at home, even if it is stated that midwives working in the health centres are invited, as mentioned

in other parts of this report, it may also be possible to make use of traditional birth attendants (TBAs).

In a focus group interview held with health personnel in Adana, participants stated that a number of women (a small proportion) give birth at home, and they prefer to do so because they believe it is comfortable. As for another interviewee in the same focus group, she outlined that these deliveries were carried out by people other than health personnel generally in sections of population unable to make use of health services. Other interviewees also emphasised that their proportion is very small.

> *"I remember, while I was working in* On Dokuz Mayis [a hospital]*, they invited a midwife friend; they wanted to deliver at home—their home. They claimed that it was agreeable at home. We are more comfortable at our house, but they invite a midwife trained in health* [care]*; they deliver their child at home." (Health personnel focus group, Adana)*

3.6.8 Frequency of and reasons for going to a health institution during pregnancy

It appears that women who receive antenatal care generally do so **in order to learn if they are pregnant and how the baby is developing during the first months of pregnancy**. For this check-up, they have an ultrasound and obtain information about the development of their baby. The women **who go for check-ups more than once are generally those who have had problematic pregnancies or had negative experiences in their previous pregnancies**. In addition, there are those who go to a health institution to learn through the check-up about the health of the unborn offspring or if the unborn offspring is developing well. Pregnant women and peers generally state that they cease going for examinations when they think that no problems will arise in the development of the unborn offspring. **The women who discontinued their antenatal care cited economic hardship, long queues, and unsatisfactory service as reasons.**

Health personnel explained that pregnant women do not come and receive antenatal care services when they believe that their course of pregnancy is normal. According to health personnel, **among the most important events that cause pregnant women to have recourse to a health institution and receive antenatal care are vaginal bleeding and pains**. The threat of miscarriage is asignificant reason for using antenatal services.

> *"She doesn't come when it* [the pregnancy] *starts. She comes when she has bleedings; otherwise she doesn't if she has a normal course of pregnancy." (Health officer, 24-year old, Van)*

In the event of having no medical problems, **one of the most cited reasons to go and have a check-up in pregnancy (besides a pregnancy test and tetanus vaccination) is the need to learn the health of the baby**. Pregnant women defer resorting to health institutions until the latter months of a pregnancy; this behaviour is based on the commonly-held belief that it is only in the latter phases of pregnancy that the health of the unborn offspring can be deduced. The concept of 'learning of the baby's health' appears rather in relation to mother's curiosity, but, the benefits of this cannot be revealed. Therefore, some pregnant women express that it is of no use to

learn if the unborn offspring is healthy or not. A number of pregnant women on the other hand, aim at learning if the unborn offspring has a disability.

> *"I say let's finish the fourth month – I mean to say – it becomes evident if it has bodily defects. I'll go to the doctor [then] if nothing unforeseen happens." (Pregnant woman, 32-year old, received no antenatal care, semi-urban, Adana)*

> *"You know, for example in learning the child's condition, if it develops well or not, how its condition is." (Relative, 32-year old, housewife, urban, Adana)*

Apart from those cited above, experiencing a serious health problem leads pregnant woman to have recourse to a health institution.

> *"I swear to God, if she has bleeding, she goes, she should. I think if she falls too sick, she should go." (Pregnant woman, 22-year old, discontinued antenatal care, urban, Adana)*

> *"Because I was sick: I had a hernia. That's why, I went there. (You went there because you were sick. Well, did you go when you were not sick?) No, I didn't go like that." (Pregnant-peer focus group, semi-urban, Adana)*

People sometimes have recourse to the health institution to learn about the sex of the baby.

> *"Not in normal times, I* [only] *go there when I'm sick. I mean to say—I went there in this one to learn about its sex, and for a check-up, I mean to say—I'm afraid of undertaking it again because of, you know, the first one, that's why I went there, but they didn't tell me." (Pregnant woman, 16-year old, discontinued antenatal care, semi-urban, Adana)*

Pregnant women do not choose to go to health institutions alone. For many pregnant woman, being unable to go to an institution alone sometimes results from: being ill; not having permission from her husband or his family to go unaccompanied; being illiterate; or not knowing Turkish.

> *"I don't go alone… No, not because of this. I mean to say—er—I don't have confidence in myself. Why don't I have confidence? For example, my blood pressure is low; what happens if I fall, or something bad happens? I'm pregnant, how can I go alone? God forbid something bad happens. He [God] helps me. I either take my mother or sister-in-law or my sister with me." (Pregnant woman, 34-year old, discontinued antenatal care, urban, Adana)*

Pregnant women have both positive and negative experiences at health institutions. **In the experiences mentioned, the communication skills of the health personnel are a main concern**. It is much preferred when health services are dispensed by the health personnel in a 'pleasant' or 'concerned' manner. Pregnant women feel pleased about the services they receive when they have appropriate (that is, congenial) communication with health personnel. They consider it important in order to effectively talk about their ailments as well as to receive feedback from health personnel. After the

examination, they desire to obtain information from health personnel about themselves, the unborn offspring, and childbirth. Those who only write a prescription without giving any feedback or those who only affirm that the baby is 'well' without giving further detail are not favoured.

One of the most important factors that characterises, as positive or negative, the experiences of pregnant women vis-à-vis health personnel is the degree to which they form a communication channel with them or not. Even if pregnant woman has had an examination, **if she does not form a communication channel with health personnel and does not receive feedback, she may describe the whole process as one where 'nothing was done'**.

> *"Yea. You know, for example, I've been there recently. Doctor didn't speak as if we were offended. I felt ashamed to ask questions. Sometimes, you know, when you say any word on what the doctor said, you feel, yeah. I didn't feel comfortable. He didn't tell me your condition is such and such. I mean to say—you are in danger or not, I went there again the doctor was not curious if your condition is good or not. That's it, so and so." (Pregnant woman, 35-year old, discontinued antenatal care, semi-urban, Adana)*

A number of women put their **experiences of being subject to emotional and physical abuse during the delivery** into words. Even if some of them had not had such experiences, they refrain from going to a health institution since they have heard such stories from their peers. Those having their first pregnancy, especially, feel agitated and do not want to go to a health institution for childbirth when they hear such stories. No such occurrences (in which pregnant women were exposed to abuse) were reported in the province of Afyon. This experience of abuse pertains to pregnant women in the families of casual labourers who migrated from Eastern and Southern Anatolia to Adana, and pregnant women from rural parts of Van.

> *"Nurses shout, most of them hit, I experienced this in [the birth of] my older son." (Pregnant-peer Focus Group Interview, semi-urban, Adana)*

> *"I experienced it too, that's why I never go to the hospital, I stayed there for two days, I saw it, and it was like my skirt. (*She shows her skirt, which is purple, to describe the leg of another woman who was beaten at the hospital*)" Pregnant-peer, focus group, semi-urban, Adana)*

> *"I delivered two of my children at home and two at the hospital (Which two of them at the hospital?) The first. (Which one is more comfortable?) At home. (Why is it more comfortable?) I don't know. They get angry to you there, they hit—and you can wander around at home. (Don't you wander around there when you are having labour pains?) Nurses are strict there." (Pregnant-peer focus group, semi-urban, Adana).*

> *"Nurses hit sister F——'s legs as well." (Pregnant-peer focus group, rural, Adana)*

> *"I swear it is true—they sometimes shout at you* (she laughs while recounting)*; sometimes they are good, no two people are the same; they are good sometimes;*

and shout at you sometimes. They say, 'Enough!' You give birth to one every year. But this is an act of God, we don't want them either, but God gives them to us. They say you are always pregnant; they shout and say, 'Enough!' This makes you feel disturbed. And sometimes they are good; sometimes there are nurses, they are very nice; [but] there are ones, behaving to you badly." (Pregnant woman, 23-year old, fifth pregnancy, received no antenatal care, urban, Van)

Positive experiences especially related to childbirth are closely related to coming across health personnel who have empathy and good communication skills. A pregnant woman attributes the positive experience she had to the fact that she came across a 'just person'. In some cases, women state that a 'tip' or 'bribe' should be given to the health personnel in state hospitals in order to receive good service. **There are participants who express that they receive sufficient service if they give 'bribe' or 'tip'**.

"Yea, if she doesn't get a tip, she doesn't take care of that patient. (Who do you give the tip to?) The nurses take it. I gave birth to my first child at home; we took a midwife from the neighbourhood, I was about to die. I preferred the hospital for the second, I went there, but – I mean to say – I came across a good one. Yes, I came across a very good one not better than you; she took good care of me. But there are some who treat you bad, shout at you; you know they don't care about you. Now, I haven't suggested any bribes at the beginning, but after the delivery I just gave it because she took good care of me. Some say when they give bribes, nurses take good care, but if they don't, nurses don't either. They want tips as well: after the delivery several people, nurses – I mean to say – came and wanted tips. This wanted and that wanted; I said there is only one nurse working here, I don't have to give tips to everyone, so I said I couldn't." (Pregnant-peer, focus group, semi-urban, Adana)

There are also pregnant women who state that they are satisfied with the services provided in the health centres, state hospitals, and private institutions. **Among the reasons why they were satisfied with the services they received are: being accepted well in the institution; the interest shown by the health personnel; the professional knowledge the health personnel were perceived as possessing; the accurate and appropriate diagnoses and treatment methods health personnel were perceived as applying; and the perception that the treatment benefited the patient**.

In addition to these factors the following were mentioned as influential in the feelings of satisfaction: **the proximity of the health institution; its hygiene; the availability of ultrasound-based facilities; and the positive attitude of health personnel towards sharing the outcomes of examinations, and such information, with pregnant women and their relatives.**

3.7 OBSTACLES TO RECEIVING ANTENATAL CARE SERVICES

According to the findings obtained from all the interviews, the main factors that affect the utilisation of antenatal care services in the research group are listed as follows, though the priority given to them change in accordance with the region:

- Lack of health insurance and economic reasons
- Remoteness of the health institution and difficulties related to transportation
- Lack of antenatal care services in the health centres
- Negative behaviour of health personnel
- Lack of interest and negligence of health personnel
- Inability to obtain permission from the mother-in-law and/or husband;
- Inability of the spouse to stay with the wife for long
- Having no time left after completing household chores and child care
- Women's illiteracy
- Language problems, inability of self expression
- Feelings of shame/embarrassment and having a male physician.
- Perceptions related to the effects of certain medications suggested during antenatal care service provision
- Lack of an official marriage license

3.7.1 Lack of health insurance and economic reasons

Especially in Van, in the rural areas, and in the area of seasonal workers in Adana, among the difficulties pregnant women encounter in receiving health services, the first and foremost is the lack of health insurance and economic problems. Having no money that could cover the cost of health services or their spouse's being unemployed, greatly hinder access to health services provided by public or private institutions. In a number of cases, although they have a green card, **even having higher fares** for transportation may hinder their utilisation of services.

> *"No money to go, huh; I don't have money for fare; how to buy medicine, no money on him. No money to give to the doctor. I wouldn't know." (Pregnant woman, 25-year old, received no antenatal care, seasonal worker, Adana)*

> *"That woman cannot go. How would she go now? She'll go to the hospital from here. I don't know how much it is. I mean to say—she will first give money, then take her medicines and so… This one cannot buy medicine. She goes or doesn't go. Now there are women who don't go from the beginning till the birth. (Imam, 40-year old, rural, Afyon)*

> *"…since they don't have money, I'm telling on my own, she's my sister-in-law, she has three children, and her economic situation is bad. Her husband is the stuff—er—shepherd. Because of economic conditions she's at home; their*

economic situation is very bad, so they can't." (Pregnant-peer focus group, Van)

In one of the focus group interviews held with health personnel, it was pointed out that even though it had been clarified beforehand in a circular from the Ministry of Health that no payment would be requested from pregnant women, **after the implementation of revolving funds in the health institutions especially, requesting such fees for preventive services create a series of problems in practice**. It was stated that in the process of inspection of revolving fund documents the inspector 'questioned' the tax assessor upon recognising the records of patients who had not paid a fee.

"Or have no social security, cannot find a place to go not having social security. They brought out something called a revolving fund, they give us money as they see it, we haven't understood exactly what it is yet, and we haven't seen it either, we don't know relative to what they proportioned it. We don't want them to implement revolving funds; I want them to just tell me, 'Do what the condition requires without requesting any fee from those with no social security.' Tell the same thing to state hospitals as well as maternity hospitals…" (Health personnel focus group, semi-urban, Adana)

In the same focus group it was also stated that those with no social security were not used as 'pawns' anymore, but they had to sign a voucher in return for their debts. The health personnel explained that this state of affairs also creates an obstacle to the utilisation of services.

It was observed that the citizens who had migrated from Eastern and Southern Anatolia to Adana are predominantly green card owners. It is stated by both health personnel and community members that the percentage of green cards in this area were increasing recently. However, a number of pregnant women complain that they cannot get a green card.

In a focus group interview held with health personnel in the same area, in a semi-urban neighbourhood, where the immigrants from Eastern and Southern Anatolia live, it was indicated that there are those with no green card, even if they meet the criteria required for receiving it. As a matter of fact, one member of the health personnel complained that her/his sister could not obtain a green card even though she met the criteria.

"I exerted myself on this issue especially for my sister. She was pregnant, had no health insurance. They rejected it three times, because she had been shown as broker, I went to the board and said, 'She's pregnant, she needs to have a green card.' And they replied, 'Being pregnant isn't a sufficient reason for her to have a green card'. Her husband doesn't have a job. She had caesarean. We hardly managed to collect the money." (Health personnel focus group, semi-urban, Adana)

3.7.2 Remoteness of the health institution and difficulties related to transportation

Such factors as the remoteness of the health institution from the place of residence, lack, or limited means, of transportation or need to have more than one means of transportation and sometimes closed roads have attracted attention as important obstacles and difficulties with respect to the utilisation of antenatal care and childbirth services. Being obliged to use more than one means of transportation may also be unattractive for some people economically, in addition to its being time consuming.

It is understood **that the remoteness of the health institution and difficulties encountered in transportation are factors that prevent the utilisation of antenatal care services, especially in rural areas.** The inaccessibility of health centres, lack, or limited means, of mass transportation between the place of residence and the health institution are cited as a major problem. In such cases, since transportation to health institutions is effected by personal car or taxi, costs increase accordingly. **Remoteness also constrains the access of pregnant women to the services by themselves.** In cases where the transportation via a personal car is inevitable, the accompaniment of the husband or a male emerges as an obligation.

> *"(Well, if your transportation was easy, would you go to the health centre whenever you feel sick or throughout your pregnancy? Would you try to go?) If it were near, we would try, of course, if we were sick, but since it isn't near, we can't. We would if we took a taxi out of necessity, otherwise we wouldn't have any opportunity; it's too far." (Pregnant woman, 27-year old, received no antenatal care, rural, Adana)*

> *"Well – I mean to say – how can we go as women on our own? No car, and no vehicle here, nothing: I mean to say—it's a small village." (Pregnant woman, 28-year old, discontinued antenatal care, rural, Adana)*

The remoteness of the place where services are provided and hardships related to transportation become prominent especially in cases where obstetric care is necessary. The difficulties encountered regarding this issue have been stated in nearly all regions included in the present study. **The problem of being unable to receive obstetric services because of transportation difficulties is a common problem emerging in the rural areas and city centre of Van, in the seasonal workers' area in Adana, and in the rural areas of Afyon**.

> *"No, we change two minibuses to [get to] the maternity hospital. This is our village minibus, for example. They call here a village, they call Bey Üzümü neighbourhood Bey Üzümü village. You go downtown, to the bus stop, and then get on the minibuses for the maternity hospital. I mean to say—you change two minibuses…For example, you see, in my last miscarriage – I mean to say – if there had been a minibus or a taxi, if I had managed to reach there on time, then I might not have had a miscarriage. My bleeding increased especially while walking. Before I got there, there was some bleeding here though; there were two or three spots, but when I reached there, it got completely worse. If I had reached there, they might have intervened; they might have put me in the hospital. I mean to say—this is a matter of remoteness, that's it. I wish it were closer; I wish, how could I know, that their services could have been reached*

more quickly, or their facilities for example." (Pregnant woman 27-year old, discontinued antenatal care, Van)

"I mean to say—how would [health] service be? Of course if there were any [health] services near here for illness, for urgent conditions. For example, until delivery, you see there is no vehicle; we don't have a personal car either. I mean to say—it is difficult to go. If there were a near place, if they took care – I mean to say – there's no help for it." (Pregnant woman, 35-year old, discontinued antenatal care, semi-urban, Adana)

"There is only one vehicle here. It leaves at eight or half past seven in the morning and returns in the evening. That's all. It comes here at around half past three or four. No more returns. If you have an emergency, you will need to hire a vehicle. If you had a chance, well, here's rural area, you don't have a chance. A rather small portion you give to the men hardly suffices to your throat." (Pregnant-peer focus group, Afyon)

In some areas, when no physician is available at a health centre, pregnant women are directed towards other health institutions in the area. In such cases, transportation difficulties appear again as an obstacle for pregnant women.

"We don't have a physician in our health centre right now. They go to the centre of Saimbeyli.—Er—since there is no physician [here], there are some who have difficulty in going to Saimbeyli. I mean to say—they are having difficulties in working—er—in accessing there. They have to go to Saimbeyli health centre as the nearest settlement, but most of them cannot go actually." (Midwife, 34-year old, rural, Adana)

In Eastern regions in winter, the closed roads result in additional transportation problems.

*"No, one problem is experienced in winter. Since it is cold, there is snow and no road for example. You go through the zevi [*Kurdish*, field]. These problems exist, but no other problems. If you have a car, tick, you stop at your door." (Pregnant woman, 27-year old, discontinued antenatal care, Van)*

3.7.3 Lack of antenatal care services in the health centres

As mentioned in various parts of this report, it is a fact stated by many individuals that there are no systematic antenatal care services in health centres. This situation results from the fact that since there is a huge workload in some health centres, preventive services are not provided with additional personnel. Therefore, **no ANC services are provided in many health centres, except those for pregnancy testing and tetanus vaccination**. Such health centres direct pregnant women to the hospital, stating that they do not carry out examinations of pregnant women. Another reason for directing them to the hospitals is based on the idea generally held by the health personnel that without ultrasound apparatus antenatal care services cannot be adequately provided. This idea is supported by a number of pregnant women as well, and it is stated that without ultrasound apparatus, it will be useless to carry out an examination of the pregnant women 'manually'.

"You see. I went there once or twice for examination. She said, 'There isn't any here'… I don't know. She said, 'We don't carry out examinations, go to the hospital.'" (Pregnant woman, 28-year old, discontinued antenatal care, urban, Adana)

"They tell me to go to the maternity hospital, that's why they don't examine here. They say, 'You have to go to the maternity hospital.'" (Pregnant woman, 23-year old, 5th pregnancy, received no antenatal care, urban, Van)

It is observed in some health centres that **either no antenatal care services are provided** or they are **considered inadequate** by pregnant women since they do not conform to their expectations.

"Anyhow, the nurse, the midwife can't do anything. They just tell pregnant women what to do, and the stuff." (Pregnant woman, 24-year old, discontinued antenatal care, rural, Afyon)

"The health centre doesn't do anything anyway. It does nothing. They just vaccinate once or twice in pregnancy, that's all." (Pregnant woman, 24-year old, received no antenatal care, rural, Adana)

In a number of other health centres **the lack of health personnel providing antenatal care services – and/or the unavailability or inaccessibility of those providing these services in their offices; and/or because of a heavy workload – may hinder the utilisation of antenatal care services** and result in a loss of opportunities. Pregnant women who are unable to find health personnel or have to wait too long to see someone, sometimes return home without receiving any kind of service. In some cases, since they know that they will wait in queues for many hours, they may not bother to try at all.

"Here, it's ruinous, there is health centre, but no midwife, you see. If it had a midwife now, what would I do with a male, I'd go to her and get examined, and she would do the stuff accordingly." (Pregnant woman, 30-year old, received no antenatal care, rural, Afyon)

"Most of the time you go and see it's closed. No one; they've gone to other villages. Also it isn't that near. You cannot go and return whenever you need." (Pregnant woman, 21-year old, second pregnancy, received no antenatal care, rural, Van)

"I mean to say—you go to the health centre but there is no one, no nurse. Some days we go there in the mornings, wait till noon, and just return home again..." (Pregnant woman, 24-year old, received no antenatal care, rural, Adana)

"I mean to say—I don't go there frequently. For example, they told me to come for vaccination, but when I get there it's very crowded, so I cannot go often." (Pregnant woman, 27-year old, received no antenatal care, semi-urban, Adana)

Conditions such as **the temporary nature of the occupancy of health personnel** working in health centres also impede the utilisation of these clinics.

> *"When a physician comes, he or she stays one or two months at most and leaves. We remain without a physician for seven to eight months. It's been a month in any case since the new one came here. A new physician has come but I haven't seen her or him yet. I don't know if he or she is good or not. When you go there, you find it closed. They say they went to the villages to vaccinate; they aren't here, and they've gone to Van, Gürpınar. Because of this, we have to go to Van directly." (Relative, 37-year old, illiterate, sister-in-law, rural, Van)*

It is stated by the health personnel that inaccessibility of the personnel results in the loss of opportunities. They complain about it, but they cannot solve this problem because the number of personnel is inadequate. **Midwives** working in the health centres state that **their job description was not taken into account and they had to deal with such work as registration or accounting instead of dealing with the health of pregnant women and children**. Such circumstances make the health personnel feel dissatisfied.

> *"When our physician is in the policlinic, I deal with the registration. I tell pregnant women or those coming for family planning at that moment to come later in the afternoon but either they have work to do or kids to care for." (Health personnel Focus Group Interview, rural, Adana)*

3.7.4 Negative behaviour of health personnel

Both in pregnant focus group and in-depth interviews, **it was stated by the participants that health personnel sometimes have a judgmental and denigrating attitude toward pregnant women**. Especially widespread in Adana, such attitudes may be toward **the hometown** pregnant women hail from or **the number of children** pregnant women have. Pregnant women from the South or Eastern Anatolia or with a lot of children stated that they are sometimes exposed to such treatment. Pregnant women often stated that they are extremely disturbed of this situation which they define as **'disrespect'**. Among the transcriptions, there are stories that can be described as emotional and physical violence.

> *"There is some disrespectful talk; they say 'Kurd', 'dirty', 'you smell' like that, you go to some of Kurd's houses, and they are very well. We are Kurds as well, but not all Kurds are dirty; they say 'You give birth and throw them into the streets.'" (Pregnant-peer focus group, semi-urban, Adana)*

> *"If you say I've got four children, they make you feel a disgrace. (*Another speaker: *Are four children few?) Who cares? Human, to God, we bring forth humans and they get angry. (Are they angry with you because you give birth to a lot of children?) I went there with someone, they got quite angry, and I was surprised. They say, 'You have already had three, why bring forth the fourth, that's enough!' I don't like such things." (Pregnant-peer focus group, semi-urban, Adana)*

It was found significant to see that the type of behaviour (stated in the pregnant-peer focus group interviews held in Adana) was reflected by a physician in Van.

> *"… We can't refer the patients to the maternity hospital because the midwives there—er—I mean to say—they can be a bit tougher to the patients, so we can't send them. For example, there is a problematic delivery, we don't want to carry out the first delivery here because, —er—anyway—er—she had not come to receive antenatal care, for check-ups, had no follow-up, we don't know how the first delivery is going to be. —Er—that's why, I don't want to use medical terminology but, maybe her delivery will be difficult, that's why in the first delivery we usually refer the patient to Van but they don't want to go there, they want the delivery to be carried out here, at all costs." (General practitioner, 27-year old, rural, Van)*

A number of pregnant women said that they were scolded when they asked any questions.

> *"I went there for my pregnancy. I couldn't find the midwife. There has to be an additional one, she goes for deliveries, one person isn't enough. We went there two or three times but we couldn't find her. We asked the personnel in the health centre, they didn't give us information. Sometimes they look at us like we're idiots. You ask two or three times; they shout at you. They say come up, go down, and shout." (Pregnant-peer focus group, semi-urban, Adana)*

> *"Well, when the stuff happens, the stuff – I mean to say – they* [the health personnel] *scold you. Instead of scolding us, you [*the health personnel] *receive money here; you earn a salary, why the scolding, you have to assist me during childbirth, don't you?" (Pregnant woman, 29-year old, received no antenatal care, Afyon)*

> *"Don't know how many times I went; they scolded me there." (Pregnant woman, received no antenatal care, semi-urban, Adana)*

The inappropriate attitudes and behaviour of health personnel in health institutions are frequently discussed by women. A number of pregnant women were exposed to such negative behaviour in their previous experiences. On the other hand, it was observed that even though some pregnant women did not have any negative experiences with the health personnel, they do not want to resort to a health institution because of the negative stories they hear from others. In this sense, the **negative experiences reported between women discourage those who have not used a health institution from using them**.

> *"She wants to deliver at home, but I think she should give birth at the hospital. She's got a green card, too, for example. It doesn't cost anything; for example, there is a green card, it meets her needs. No need for her to deliver at home—I mean to say. But she says she's afraid. She says those at the hospital, for example nurses shout, midwives shout, she says she wants to have it at home at all costs. (Well, has she seen it – I mean to say – does she hear from others who delivered their children at home that they treat people badly?) She generally hears from others." (Relative, 18-year old, housewife, urban, Adana)*

"They don't care. A woman had delivered her baby in the bed. They said, 'If you gave birth to your baby in the bed, we would cut you in the delivery table, don't tire us'. That's it; can I manage to explain it?" (Pregnant-peer focus group, semi-urban, Adana)

There are those who think that even if they are not scolded, **they are not approved of if they have to resort to a health centre without having a specific ailment**.

"If I go to the doctor at the health centre, the doctor will say, for example, 'Where is your wound? What's your complaint?' But let's say I don't have a pain, for example, here, or any complaint, and then what will I say in front of the doctor? As long as you don't have an ailment doctor will say, 'Now you don't have any ailments, so why are you here?' Of course. That's why I prefer not to go when I don't have any ailments – I mean to say – if I have ailments, I do." (Pregnant woman, 30-year old, rural, received no antenatal care, Afyon)

3.7.5 "Lack of interest" and "Negligence of health personnel"

'Lack of interest' is a frequently used phrase to express negative experiences at the hands of health personnel. Pregnant women define this lack of interest as the inability to form a communication channel with patients, inattentiveness to the ailments, and/or failure to give detailed feedback. A number of other women elucidate this lack of interest as when health personnel prescribe medicine without carrying out a systematic examination.

"I went there once, he just asked me which part was aching, here or there, he gave me medicine accordingly. You know, I had heart-burn like this; he gave me a medicine for it.—H'm—They don't care much; they aren't interested in you much." (Pregnant woman, 16-year old, discontinued antenatal care, semi-urban, Adana)

"Yes, as I said, they don't examine you, you see. They just look at you for a moment; they say, 'Okay'. I mean to say—just write the prescription." (Pregnant woman, 25-year old, received no antenatal care, semi-urban, Adana)

Participants complain that those who only have recourse to public institutions are not shown adequate attention. As negative experiences accumulate, recourse to a health institution becomes increasingly unlikely. Services provided at the health centres are also considered inadequate.

"Here, they don't pay attention to us in the health centre, to tell the truth; they don't pay attention you see; for example when you go there, they don't examine you; they don't do the stuff; they don't care." (Pregnant woman, 19-year old, living in the country, discontinued antenatal care, Afyon)

"You see, that's why, if you go to the doctor, what shall you do, unless they take care of you, then uselessly come and go, what shall I do unless it is a remedy for my trouble, here, I went to but I am still suffering – I mean to say – the same

thing again." (Pregnant woman, 30-year old, received no antenatal care,rural, Afyon)

In a focus group discussion it was stated that **'the lack of interest' might be related to the patient's attire or the district where she lives**.

"If they were inspected, Ministry of Health would do the stuff a little bit, if it were better, we are the common people as well. If a woman with immodest clothing, with pants comes, they show interest, they don't care for those like us." (Pregnant-peer focus group, semi-urban, Adana)

"I don't know, maybe because it is a poor neighbourhood on the outskirts, possibly because you are not well to do, I don't know. If you had money, you would go to a better place, maybe they would care." (Pregnant woman, 29-year old, received no antenatal care, semi-urban, Adana)

In a number of cases, the issue is **beyond a lack of interest, it is nothing less than negligence**. A pregnant woman stated that she was not followed-up sufficiently during delivery, that's why she had to give birth to her baby even without reaching the delivery table.

"I gave birth to my baby in the bed. I went to hospital for delivery; they didn't show any interest, just left me in the bed. They told me to have my labour pains. The baby was about to come but they didn't come and take care of me. My sister-in-law called them, 'Excuse me, the baby's head is out!' And they still didn't come. At the end they told me to step up the legs – I mean to say – I couldn't." (Pregnant-peer focus group, rural, Adana)

Even though health personnel's lack of interest and negative behaviour are cited as important factors hindering the utilisation of services in all regions, it is understood that, **especially in Adana,** it is the most cited issue and that the lack of communication and the prejudices between the citizens who migrated from Eastern and Southern Anatolia and the health personnel are a source of serious problems.

3.7.6 Inability to obtain permission from the mother-in-law and/or husband

It is stated that **childbirth at home is a tradition and considered 'normal' and those who go to the hospital are condemned especially in the families who migrated from Eastern and Southern Anatolia to Adana and living in a patriarchal system**. Under such conditions, sometimes the mother-in-law – or sometimes the husband, or indeed both – does not let the pregnant woman receive antenatal care services or go to the hospital for delivery. In a pregnant-peer focus group interview held in Adana, it is noted that pregnant women who want to go to a health institution sometimes cannot do so because of the pressure applied by other family members.

"Let me say that their [those who migrated from Eastern and Southern Anatolia] traditions are somewhat in this manner; they had learned to live in this manner. It's rural there, you know; there weren't hospitals where they could go […]. They had such a tradition somehow; they always gave birth at

home, you know. It seems to them as if they can do the same here, too. In any case… Didn't they murmur to Hamidiye just because she went there? They murmured to her saying, 'We could make it out here, why did you go there?' They're afraid of their husbands, sometimes of their mothers-in-law; they feel timid in front of them; they feel obliged to do it [have the delivery] at home; their husbands don't let them go [to the maternity hospital] for it is shameful… They don't want the brides [Turkish, 'gelinler', sing., 'gelin'] *to go either; I know the brides insist by saying, 'I'll go'." (Pregnant-peer focus group, rural, Adana)*

"My husband is not here, but my mother-in-law is. I can't go anywhere without getting her permission." (Pregnant woman, 27-year old, second pregnancy, discontinued antenatal care, Van)

A 20-year old pregnant woman who lives with her husband's family said that they did not give her permission to go to the hospital even she had health problems. This woman added that only after her condition got serious –**after she became 'just skin and bone' – could she manage to get the permission from her husband's family** and resort to a health institution by going to *her* own family in her hometown and receiving their support.

"No, not a lot. You know, at first they didn't let me go [Laughs]. *(How didn't they stop you?) Look, they simply didn't let me go – I mean to say – my husband's family. (Why didn't they let you go? Did they tell you anything?) Ah, I don't know. I don't know, but they didn't let me. (Well, why did they let you go later on?) Later on – I mean to say – I turned into just skin and bone. (To skin and bone?) I was almost just skin and bone. They let me – I mean to say – I was almost dead. (You were very sick.) I got very sick. (M'm, but they only allowed you [to go] like that; they let you go.) Yes. (Well, besides that you had nausea early in your pregnancy. Besides that, have you had any other sickness?) No. Thank God. (Has anything happened?) No. (Well, you said you went to the doctor for nausea.) Before I got pregnant, I was inflamed. It was cold, I came here in winter. (M'm) I caught cold. They said I was inflamed and so. I wanted to go to the doctor – I mean to say – my mother-in-law spoke harshly [laughs] – I mean to say – how would I know? Oh, little problems appear. (Well, didn't you go then?) I went. (Where did you go?) Generally, my mother-in-law didn't allow me. But later on she understood that it didn't work – I mean to say – my sickness was serious, I was getting worse. Ah, you know for example they didn't let me go to the doctor. I told my family [in Mardin]. They said, 'Go to the doctor, I'll give money for the examination; go to a private practitioner; I'll send you the money. I mean to say—if you have such little things, they'll handle it. I went to Mardin to my father and the others with him. I've come back recently. I've come from Mardin recently; they took me to the doctor again. They [my husband's family] didn't take me to the doctor here; but they [my family in Mardin] always take me there [to the doctor's]." (Pregnant woman, 20-year old, discontinued antenatal care, semi-urban, Adana)*

Although this condition is explained in the province of Adana as something unique to those who came from Eastern and Southern Anatolia, **the decisions of senior family members such as the mothers- or fathers-in-law play a significant role in**

whether expectant mothers have recourse to a health institution especially in traditional extended families in rural areas, actually independent of whether one has migrant or non-migrant/settled status. A pregnant woman in rural parts of Afyon emphasised that if they go to a health institution without consulting their senior family members, they will be reproached and resented by the senior family members for doing things without permission.

> *"How would you go? You have an old mother- and father-in-law watching over you. Here in our village the words of the mother- and father-in-law are law. They haven't taken me yet; if they take you, you go. If they don't, no problem. I sometimes say to my mother-in-law, I say, 'Mum, it's been eight months, but my tummy is still barely visible. Everybody tells me so. Let's go to a doctor. Does it become the stuff, or is it big, doesn't it develop? I say if it isn't growing. I say vitamins. She says, "Your tummy is fine, as if we have never carried a baby'. What would she say? She says, 'It will be over [soon]'." (Pregnant woman, 20-year old, discontinued antenatal care, rural, Afyon)*

> *"My father-in-law has the last word." (Pregnant woman, 24-year old, discontinued antenatal care, rural, Afyon)*

> *"It's clear-cut: either my husband or my mother-in-law gives permission." (Pregnant woman, 19-year old, discontinued antenatal care, rural, Afyon)*

It is also stated by health personnel that it is difficult especially for pregnant women who live with their husbands' families to have recourse to a health institution without the consent of their mothers-in-law or husbands. Those who have recourse to a health institution without consent tend to conceal it from their families.

> *"My neighbour is like that. The authority is the mother-in-law. They live in two rooms with one bride is on the bottom part, and the other is on the lower part. When the woman got pregnant, she came here secretly, had her vaccines. She says, 'My mother-in-law doesn't give permission.' This prevents [some pregnant women] receiving services." (Health personnel focus group, semi-urban, Adana)*

3.7.7 Inability of the spouse to stay with the wife for long

Women are dependent on their husbands both socially and economically. **Besides having to get permission before they go out, they need to obtain money from their husbands in order to meet a health institution's expenses**. In some regions, it is a common practice for husbands to go to another part of Turkey, or abroad, to work. Women under such a condition cannot access the health institution on their own or assure the money needed.

> *"… there was no chance; my husband is working. He can't take me; there is no one to take me. Now I will, but I can't." (Pregnant woman, 28 years old, discontinued antenatal care,rural, Adana)*

"Of course, from my husband, [but] he isn't here. I've got my mother-in-law. I can't go anywhere without the consent of my mother-in-law." (Pregnant woman, 27-year old, second pregnancy, discontinued antenatal care, Van)

"(Haven't you ever been there?) I haven't. My husband goes [there] to work. He comes here once or twice a month. He's on duty. Within nine months and ten days, if the boss gives them permission, men come here. If he doesn't, they can't. We don't see each other. Most of us are like this here. We can't see our husbands. If you have a telephone, you can receive a call. If we manage to buy a phone card, we can talk. Each month a [telephone] bill comes: if you don't pay, your phone is closed. We've got a lot of impracticalities. Rural area, what would we do." (Pregnant-peer focus group, Afyon)

"Who shall I go with? My father-in-law [and] mother-in-law go to work. We go to my mother-in-law's field. Who shall you go with anyway? If my husband stays, he takes me, if he is on vacation. If he stays, he takes me. This week we would have gone, but as you see, we couldn't." (Pregnant woman, 22-year old, urban, received no antenatal care, Afyon)

"I can't go because I don't have anyone close to me here… I can't go on my own. I don't have anything in my hand, I can't, and my husband is not here." (Pregnant woman, 33-year old, fifth pregnancy, received no antenatal care, urban, Van)

Health personnel also confirm such circumstances. They report that women, in the absence of their husbands, try to solve their problems in the health centres as they are more readily accessible places than hospitals. Women under such conditions cannot risk going to the hospital even if they or their children are referred to.

"(Is the problem going there?) There's no father; there are people working here and there abroad, no men at home. When there are no men, other people are at home, no reading-writing either, no money either, no car either, no stuff to take a taxi. They have nothing. They wait to receive services from the nearest health centre they know. They wait for the morning to come. They come here in the way I've described. Even if you say, 'Go to the hospital!'—even if you refer them to the Emergency, they do their best not to go." (Health personnel focus group, semi-urban, Afyon)

3.7.8 Having no time left after completing household chores and child care

A number of pregnant women have to carry out household chores as well as work in the fields, while being responsible for the care of their children and sick relatives at home. If they do not have any support, it may be impossible to set aside time for antenatal care services. The amount of time spent in the health institution to access any service or finalise the procedures makes this condition worse for pregnant women.

"I've got a house and children as well. My mother is old; I arrived at her house with the kids. She was miserable. Could I go in such circumstances?[…]— Er— I have to get into the queue, [and] take my file. The earliest time I can return is half-past three, you don't say… The earliest time it finishes is at three: half-past

three. Who can I leave them with... Look here, what I'm telling you; I tell you about the time that I went there: I left house at six in the morning and returned in the evening. Who should I leave my children with all that time? My older daughter is nine, she will be ten this month, but she's still nine. Who shall I leave them with? I leave them with my mother-in-law and go." (Pregnant woman, 31-year old, discontinued antenatal care, semi-urban, Adana)

"Now my dear, there's something like that, some have got four, some have got three kids. For example, she doesn't have opportunity; for example, if she goes, she can't leave her kids so that she can take care of herself… Look here, no, as I said, I can't find much time left from these two kids, I want to take an interest in me." (Pregnant woman, 25-year old, received no antenatal care, semi-urban, Adana)

"We have work to do, so we can't go." (Pregnant woman, 23-year old, discontinued antenatal care, rural Afyon)

"As you see, we can't go anywhere because of work and so, we go to the field, we do the housework, we can't go anywhere." (Pregnant woman, 19-year old, received no antenatal care, rural, Afyon)

"We have hard work. Where shall you go? Of course, I wanted to go but, you see, I couldn't. We can't because we have work to do." (Pregnant woman, 20-year old, discontinued antenatal care, rural, Afyon)

A pregnant woman does not want to go to the hospital even at the time of delivery in order not to leave her child(ren).

"I swear it is true, now I think about giving birth at home for my daughter's sake—she feels upset. My father-in-law takes her for a walk but he is old. She never goes to my mother-in-law either. That's why I want to give birth at home very much. I say I would lie for two days, and then stand up – I mean to say – sit down. I would take care of my daughter. I would take care of the baby, too. On the other hand, I think – I say I'm afraid – if I had the baby at home, what if I or the baby would die? What would I do then? It is like that – I mean to say – I'm caught in the middle. I cannot decide what to do, how to cope." (Pregnant woman, 26-year old, discontinued antenatal care, rural, Adana)

Resorting to a health institution cannot take priority over domestic obligations, and always comes a distant second unless the expectant mother has a health problem.

"You look and see a woman who has tidied herself up had come. It's almost the end of working hours. You ask, 'Why come at this time of the day?' She says, 'I have just cooked the bread, I have had guests…', and so on. I mean to say—first of all she doesn't have time for herself." (Health personnel, 40-year old, university graduate, midwife, urban, Van)

3.7.9 Women's illiteracy

Women's illiteracy is a serious obstacle to their having recourse to a health institution on their own. Illiterate women can only receive health services with the help of their relatives.

> *"I don't have literacy so that I can't go on my own." (Pregnant woman, 38-year old, discontinued antenatal care, semi-urban, Adana)*

> *'No, since I don't know reading [or] writing much – I mean to say, for example – I can't go to a doctor on my own. There must be someone literate so that she or he can take me, because on the signs it is written which clinic to go – I mean to say – which stuff I don't know." (Pregnant woman, 28-year old, discontinued antenatal care, semi-urban, Adana)*

Health personnel report that illiterate women can access the health centres more easily, whereas they have difficulty in reaching the hospitals. **Health personnel mentioned that the operation of the hospital is extremely complex even for those who are literate.** Health personnel observed that they have difficulty when they turn to the hospital for their own problems.

> *"In any case, they are illiterate. They say, 'Go and take a filing card'. Even as [a member of the] health personnel, I experience difficulty. Which window to go to? Which window to receive the filing card from? Where shall they take me? Plus when I get to the hospital, I can't find anywhere. I'm a [member of the] health personnel but I need to ask. They don't even give me an answer. I couldn't find the Ear-Nose-Throat clinic in the state hospital because they don't show you. The places change every day: one day it is in this building; one day it is in that one; the next day it was damaged, [and] a new one is being built. You can't find the place you're looking for." (Health personnel focus group, semi-urban, Adana)*

3.7.10 Language problems, inability of self-expression

The language problem appears as a factor that affects the utilisation of services especially in Van and Adana. Pregnant women interviewed in these provinces stated that in making use of the services in health institutions they cannot speak Turkish properly, or cannot explain their problems by themselves since they cannot speak Turkish. Their relatives undertake the job of translation. They observed that some health personnel know Kurdish, and they can make use of services better when one of their relatives is allowed to be present as translator. They stated that in cases where a male relative takes on this role, some pregnant women cannot explain their problems well because they feel ashamed/embarrassed.

Women who are unable to speak Turkish are also inadequate in reading the prescriptions given to them, or in using the medicines prescribed since they are illiterate. It is also impossible for them to watch the health programs on TV and **make use of various sources of information**.

> *"Yea, of course we can't go alone. When one goes alone, she feels afraid. Also I don't have enough Turkish. I speak like this. My sister knows everything. For*

example, she always goes to the hospital." (Pregnant woman, 26-year old, discontinued antenatal care, rural, Adana)

"Our Turkish – our knowledge – isn't enough. We didn't go to school. We don't understand when they prescribe medicine, and it creates anxiety. That's why it's better not to go." (Pregnant woman, 33-year old, fifth pregnancy, received no antenatal care, urban, Van)

Pregnant women in these regions stated that they got used to the translations through the help provided by others, and remarked that the attitudes of the health personnel differ if they have an accompanying person with them. **The lack of Turkish on the part of the women also makes it impossible for them to access the services without having someone – a spouse, or a senior family member – with them.** As observed by the community leaders and health personnel, language problem leaves them in a difficult condition and makes them dependent on others.

Health personnel working in these regions state that the lack of a command of Turkish results in unease amongst the service users and service providers. Providing services through a translator is not always successful, especially with respect to consultancy services. What health personnel observe indicates that information mediated by a translator may not always be correct.

"They generally don't know Turkish. They bring someone with a little command of Turkish. How he or she translates the things we say to her is important as well." (Midwife, 30-year old, rural, Adana)

Health personnel complain that service users cannot understand them even though they explain the things over and over again, and this makes them exhausted. In other words, **there is the problem related to understanding each other—a lack of communication even while speaking the same language—not to mention when there is a difference in languages spoken**.

"There is a communication problem, you tell the same thing five, six, ten times." (Health personnel, focus group, semi-urban, Adana)

"She says, 'I understand' as if she really understood. After a month the women stays the same; she didn't understand anything." (Health personnel focus group, semi-urban, Adana)

On the other hand, some pregnant women state that the use of foreign words on the part of the health personnel while speaking with them creates communication problems.

"H'm, sometimes their words seem different so you can't understand." (Pregnant woman, 29-year old, received no antenatal care, semi-urban, Adana)

3.7.11 Feelings of shame/embarrassment and having a male physician

As indicated in previous parts of the present report, a number of pregnant women in the research group hide the fact that they are pregnant even from family

members because of their feelings of shame/embarrassment. They are ashamed/embarrassed to go to the physician, but more so to the gynaecological examination. Lying on the gynaecologic table and having an examination creates uneasiness in a number of pregnant women and constrain their making use of these services.

> *"(Well, are there times in which you prefer not to go to the doctor because it is sinful, shameful?) It's common here, that's why I don't go* [Laughing]. *(You don't go for pregnancy only because of this?) Yea – I mean to say – they examine you from below, and I feel shy. When I go, I shake like a leaf. That's why I was reluctant." (Pregnant woman, 35-year old, received no antenatal care, urban, Adana)*

> *"I've never been to the doctor in no way. Even now, I'm ashamed of going to the doctor." (Pregnant woman, 35-year old, discontinued antenatal care, semi-urban, Adana)*

> *"I didn't go myself, I was ashamed, and so I didn't. They said let's give you an injection, let's do this, let's do that, I didn't take them." (Pregnant woman, 39-year old, received no antenatal care, rural, Afyon)*

> *"They said, 'Yes, we can't take care of you, go to the hospital immediately'. I went to the stuff—the state hospital. She told me to place my feet on the legs. How could I? She said you will place them. I said I couldn't, I was afraid. I returned home right away." (Pregnant woman, 26-year old, discontinued antenatal care, rural, Adana)*

A pregnant woman stated that she did not even have an injection given by a male doctor. For gynaecological examination, female doctors are preferred. While a number of pregnant women state that they will never have an examination by a male doctor, others claim that they may be examined by a male doctor if they are obliged to do so, or no female doctor is available.

> *"I feel more relaxed at home. A male doctor is not possible. One feels reluctant in front of a male doctor. How could I know that a male doctor was supposed to give me an injection; I slipped out of there." (Pregnant-peer focus group, semi-urban, Adana)*

> *"There is a male doctor, he took care of my sister-in-law; if you're obliged to, you may go, but it's very bad for women to be naked on the legs." (Pregnant-peer focus group, semi-urban, Adana)*

3.7.12 Perceptions related to the effects of certain medications and vaccinations suggested during antenatal care service provision

In a pregnant-peer focus group interview held with people who had migrated from Eastern and Southern Anatolia to Adana, the idea that **some vitamins and iron preparations lead to excessive development in the baby which will make childbirth difficult** has been noted. Therefore, a number of pregnant women stated that they do not use these medicines suggested by the health personnel. The advocates of this idea

are pregnant women who have not had any antenatal care; those who argue that receiving these services is useless; and those who had their deliveries at home. Other participants do not share this idea and state that the medicines suggested by the health personnel are useful for the health of baby and mother; and believe that the baby will 'gain structure' in this way. Pregnant women who argue that medicines are useful also emphasize the importance of receiving antenatal care. Even though no agreement was reached in the focus group on this issue, **it is understood that this is the dominant perception of the medicines suggested during antenatal care services in the area**.

> *"I was telling the stuff; I mean to say—when the babies grow with the medicines, they appear to be hormone babies… Doctor gave me a blood building medicine, and said you have anaemia. I swear to God I bought [them] but I don't use them. (Why not?) My husband went and bought them but I didn't take any, because I don't think it is necessary. (Because you think it may be harmful to the baby?) During the period when you use medicines in pregnancy, the baby gets fat." (Pregnant-peer focus group, semi-urban, Adana)*

> *"They think like that around here. If you take it [Medicine], the baby grows much worse, you can't give birth. Delivery becomes difficult." (Pregnant-peer focus group, semi-urban, Adana)*

In one of the in-depth interviews with pregnant women, **a similar idea emerged in relation to tetanus vaccination**. Pregnant women think that the tetanus vaccination makes childbirth difficult because it causes excessive growth in the baby.

> *"According to what they say, the baby had been developing; I mean to say—because of the vaccination—er—er—I mean to say—the delivery was difficult… The baby is developing, you know… Baby is developing, you see…" (Pregnant woman, 40-year old, discontinued antenatal care, urban, Adana)*

Another rumour about the vaccination is that it leads to 'infertility'. These rumours were observed in the province of Van.

> *"…Oh I swear I don't know from whom and how they heard of it, but I heard that there was a broadcast on TV, in one of the training programs, they said so. A channel—er—I don't know which one, but they had heard people saying that they vaccinate you to make you infertile* [tetanus vaccination for pregnant women]. *It was the same in the polio campaign anyway… You go with the doctor, you can't convince her* [the pregnant woman] *with the doctor either." (Health personnel, 33-year old, university graduate, nurse, rural, Van)*

> *"There are women who communicate with us; the thing they say is that—er—the vaccination that you do (they don't know what it is, anyway, it's tetanus)… they say, 'This vaccine is for infertility, all imams tell us so. Don't you believe in God, don't you have a religion, don't you have any faith?' That's the way." (Health personnel focus group, Van)*

> *"Their husbands don't want us to do it, by no means, say, 'These will make you infertile.' You tell her, and even give training to her husband when possible. Their husbands are generally at home; you talk with them, too. I just met one*

yesterday, he was working in the field; he shouted at me, 'Nurse, be careful! Don't make my wife infertile'. I asked, 'Who would visit a lot of people to make them infertile?' He says 'No, I don't know." (Nurse, 33-year old, urban, Van)

The sentence, 'I don't like medicines' emerges both in focus group and in-depth interviews. Pregnancy is perceived as a natural process, whereas medicines signify disease. This perception may cause pregnant women to see medicines negatively. A number of pregnant women state that they did not take medicines as recommended. **One of them told of not going for check-ups so as not to have to take recommended medicines**.

3.7.13 Lack of an official marriage license

The lack of an official marriage license emerges as a factor that hinders the utilisation of services in costly interventions such as a delivery because of its potential to affect health insurance indirectly. The fact that the lack of official marriage license hinders service utilisation is not a condition observed in pregnant in-depth or pregnant focus group interviews. However, health personnel put this issue on the agenda with respect to social security. **It is stated that a number of women cannot make use of their spouses' health insurance because they do not have an official marriage license**.

Health personnel think that since they appear as single women in the records, they have to make use of their fathers' health insurance, and they carry out official procedures accordingly. On the other hand, it is reported that since there is a legal ambiguity relevant to this issue, a disagreement emerges among health personnel. Health personnel state that they need a statement from the Ministry of Health on this issue. The fact that women do not have an official marriage license may require them to tolerate the consequences of a condition such as **"being pregnant as an unmarried woman"** which is not readily approved of by society in some regions.

"For example, there are those who don't have an official marriage license, and use their father's social security. They receive social security from their fathers. They don't appear to be married, but they are pregnant, for example. What shall we do? Do we not take care of them? (Another speaker) *She appears to receive social security from her father but she doesn't have an official marriage license?") Yes, she appears to be single but she is pregnant. I think for example, the doctor didn't want to prescribe medicine to her, she was pregnant, she had anaemia, and we argued with our doctor: it's her own choice. She was pregnant without an official marriage license. Her delivery is legitimate. It is established by the law – I mean to say – if she wants to give birth to this baby, she will. It's of no importance if she is married officially or not. If she manages to have the baby recorded in the register with her own details, and if her father's social insurance still covers her, which is possible if she is younger than 18 years old (15 years old, 16 or 17 years old). Her private life doesn't interest me. If she needed it, we would note that she needs to take it.* (Another speaker) *The Ministry [of Health]'s opinion is needed on that. As a physician, can I note 'pregnant' under the 'diagnosis' part of the health record of a woman who is pregnant with no official marriage license? We hear from the pharmacists, from here and there, as a traditional practice that it cannot be written 'pregnant'*

there. However, there is an sense that she cannot be recorded as the one without an official marriage license, if she is pregnant. We don't add the word 'pregnant' there, even if we record the anaemia and other stuff. Is there a problem like that? Is there a drawback to put 'pregnant' on the record? I'd like to find out about this. There is such a distinction there: if you record her as pregnant, the pharmacy cannot charge 20% [for her medication]. The government provides all kinds of medicine free of charge to pregnant women." (Health personnel focus group, semi-urban, Adana)

"… when I get there they ask me, 'Why don't you have an official marriage license, why haven't you received it?' … green card, and my health record given when I was a girl, they say you don't have a marriage, you see, I will go to the maternity hospital but I can't because I don't have a health record, anyway, they say she is a girl, how could she get pregnant?" (Pregnant woman, 20-year old, first pregnancy, received no antenatal care, urban, Van)

3.8 THE PRIORITY OF HEALTH-SEEKING AMONG THE OTHER NEEDS OF LIFE

Even though everybody believes in the significance of health, it is observed that health issues do not have priority over the other daily needs, and, indeed, come after the need for food, shelter, and warmth. Money earned is primarily set aside for food and other household expenses. Participants state that the issue of health is important as well, and has a priority among other expenses. However, **such health issues that involve an urgent intervention are perceived as prior** compared to any 'ordinary' condition of illness. Other health problems, on the other hand, are perceived as those that can be deferred. **As for pregnancy, as was explained in the previous section of the present document, it is described as a natural condition, rather than an illness, and does not necessitate recourse to a health institution.**

> *"We primarily spend money on food. Food is the foremost, and then comes clothing. We don't attach importance to parading. (Well, what about the expenses for health?) Health – you now – when it is needed." (Pregnant woman, 38-year old, middle school graduate, received no antenatal care, urban, Van)*

> *"First of all—er—our food needs, then clothing needs, and then the invoices come. Oh, if there isn't an important health problem, it can be delayed, but – I mean to say – if it is important, health will be considered as the first and foremast." (Relative, 26-year old, housewife, urban, Adana)*

A pregnant woman revealed that she thinks differently from her husband over economic priorities. While for this particular woman the issue of health has more priority, for her husband food does.

> *"If it were up to me, I'd go to the doctor, but if it were up to a man, he'd spend it on food." (Pregnant woman, 30-year old, received no antenatal care, semi-urban, Adana)*

In families with poor economic strength and limited resources, the health needs of children are considered more important than those of the woman.

> *"For example—she says, 'Nothing would happen to me if I waited for an additional month,' and gives priority to her children. We don't care about ourselves; we sacrifice our lives for our children." (Pregnant-peer focus group, rural, Adana)*

> *"For example, we spend as we like, but – I mean to say – even if my husband doesn't have a job, when the kids are sick even just for a day, he takes them to the hospital, even if he doesn't have a job. Some people say, 'You don't have a job, you live in a rented house, you don't have a house, so why do you go to the doctor so frequently?' And so on. But – for example – if a person isn't healthy, what shall he do with money and house?" (Pregnant woman, 22-year old, illiterate, third pregnancy, discontinued antenatal care, urban, Van)*

Most participants state that their income hardly suffices for daily needs. Therefore, they cannot save money. Should a health problem emerge, most have recourse to a health institution only by borrowing money.

> *"No, no: we don't save (money). Nothing exists like that. If we have money, we go." (Pregnant woman, 29-year old, third pregnancy, received no antenatal care, rural, Van)*

> *"We go to the doctor by borrowing from here and there." (Pregnant woman, 22-year old, discontinued antenatal care, urban, Adana)*

Recourse to a health institution is most common after an illness becomes acute; in this way does health-seeking behaviour emerge.

> *"No, if your condition was severe, you would go then* [Laughing]. *(Pregnant woman, 20-year old, discontinued antenatal care, rural, Afyon)*

Overall, **among participants it is observed that health is not a priority over and above other daily needs with respect to resources or time allocation**. Health becomes an issue of first priority only if it is seriously threatened, especially a child becomes ill.

3.9 EXPECTATIONS FROM THE HEALTH SERVICE PROVIDERS

3.9.1 Friendliness

Among the expectations from the health service providers **the first and foremost is friendliness and concern**. **Expectations** were stated **especially in relation to birth services**. Pregnant women consider health services necessary even if they do not receive any services during their pregnancies.

Pregnant women and their relatives expect friendliness from the service provider. The 'harsh' and sometimes judgmental attitudes of health personnel create discomfort in pregnant women. They are expected to be friendly and answer questions without rebuking their interlocutor/patient.

> *"Oh, nurses here have become sullen. For example—I don't know something. I ask a question about the thing I don't know, and she answers my question derisively." (Pregnant woman, 24-year old, discontinued antenatal care, rural, Afyon)*

> *"…they are human – I mean to say – they are having labour pains, for example; they're aching… I don't know but they treat you like an animal. They assist in the delivery by force. I mean to say—I wish they were better. For example, it's not like that in the west; they give injection and serum there, for example. They [the pregnant women] suffer less." (Pregnant woman, 30-year old, elementary school graduate, fourth pregnancy, urban, Van)*

> *"Let them be friendly. I want such a thing. Let the maternity hospital be nearer as well* [Laughs]*." (Pregnant woman, 28-year old, elementary school graduate, second pregnancy, received no antenatal care, urban, Van)*

Participants strongly emphasised 'attentiveness' from health personnel as an expectation. By 'attentiveness' is meant **a careful examination and feedback provided to the pregnant women by health personnel**. Pregnant women want to obtain information about the baby's health and the process of delivery. The health of the baby, the estimated delivery date, and the form of delivery are the topics of most concern, since they create apprehension in pregnant women.

> *"But I mean to say—for example, just as I said, you know, I'd like them to pay sincere attention… For example, I' wish pregnant women had privileges. For example they may say, 'Come on, let me help you listen to your baby's heartbeat, or let's see the condition of your baby's heart, or let's see if you have any discomfort'—for example. I'd like a nurse to be interested in me." (Pregnant woman, 25-year old, received no antenatal care, semi-urban, Adana)*

> *"If only she would assist you in delivery, take care of you, treat you well—your suffering is enough for you anyway – labour pain is the stuff – but she could*

treat you well with nice words and warmth to help you. But most don't take care of you, you know." (Pregnant woman, 30-year old, received no antenatal care, rural, Afyon)

Health personnel are aware that pregnant women have expectations of 'attentiveness' and they admit that these expectations are reasonable. Actually, **health personnel have identical expectations when they have recourse to a health institution for themselves or their families**. However, they cannot meet these expectations because of the heavy workload, and burnout.

"They want to be shown interest in at least. When the madam comes in she wants to be introduced – I mean to say – I'm this doctor, you are that, how are you, she wants to be addressed by her name. She wants to be paid special attention to, for who she is, and be taken to a seat. When she comes she wants people to be contented, pleased; she wants to be cherished dearly and wants people to be concerned about why she is there. The psychological state of people is very important—to make pregnant woman feel privileged is a job in itself. If she is paid attention to in the place where she goes, if people are pleased, if she has ultrasound screening, or if she has a response to a few questions she asks, this makes her feel honoured, she feels pleased." (Health personnel, focus group, semi-urban, Adana)

3.9.2 Ultrasound screening

A number of pregnant women want the examination to be done with ultrasound. The reason for this is the belief that information about the baby cannot be obtained solely by abdominal palpation (Leopold's manoeuvres), that is, 'manually'. There are also experiences that indicate that in examinations without ultrasound one might obtain misleading results.

"I went to the health centre twice. They just examine you there, and there is no ultrasound. They told me that my baby had died, I was frightened so I went to MarSA, I was afraid. I went for ultrasound. How could they say it had died? I was continuously holding my breath. The doctor gave me an examination and ultrasound. There was nothing like that; I've learnt this today." (Pregnant-peer focus group, rural, Adana)

"My second child was three and a half months old, I went to the doctor, to the hospital, and s/he [Turkish, *o* for 'he', 'she', and 'it'] *prescribed me medicine and let me go. After fifteen days my baby was dead in my womb; it was almost poisoning me, I went to a private hospital this time; they took me to the ultrasound and said it was dead. If they had taken me to ultrasound there [initially], my baby might have lived." (Pregnant-peer focus group, rural, Adana)*

"But when you go – you know – neither a nurse nor a doctor. What you do is wait, wait, and wait." (Pregnant woman, 25-year old, received no antenatal care, semi-urban, Adana)

"Because there is not a doctor here, I go to Van. If we had one here, I wouldn't go there [to Van]. But being so ill, I go here. Why would I go to Van? But since there is none, it is obligatory. The village midwife comes. If there were here, I'd go. I don't go because there is none." (Relative, 37-year old, illiterate. rural, Van)

Having health services brought to homes through 'home visits' is a preferred practice for a number of participants. They state that they were happy with these home visits in bygone times. A member of the health personnel stated that pregnant women's preference for home visits is closely related to cost. It may also be related to the difficulty in accessing the health centres, and women's inability to leave home alone.

"I'd like the officials and midwives in the hospital to be more understanding. Or – for example – we want health officials to come to our homes and follow up at home. We want them to come and follow up the deliveries, pregnancies – for example – to see if they have any problems with their pregnancy – for example. We expect the hospital, officials to be more understanding." (Relative, 18-year old, urban, Adana)

3.9.3 Receiving services free of charge

Receiving services free of charge is considered important and stated as an expectation. It is observed, however, that a number of people do not know that antenatal care services are free of charge anyway.

"I mean to say—the health centre should provide services free of charge." (Pregnant woman, 24-year old, received no antenatal care services, rural, Adana)

3.10 EVALUATIONS OF SERVICE PROVIDERS OVER THE PERCEPTIONS AND BEHAVIOURS OF PREGNANT WOMEN

In the areas where the research was conducted, **the role of socio-cultural characteristics** is a matter of primary importance in the evaluations made by health personnel over the perceptions and behaviours of pregnant women about their health. This was followed by the evaluations made on **the economic status** and **the quality and adequacy of existing health services**.

Service providers indicate that, especially **lack of education and problems related to gender in rural areas have negative effects on the perceptions and health behaviours of the pregnant women.**

> *"… until she becomes sick, they don't bring her to the health centre. Because she starts being unable to manage her household chores and other work—that's why they bring her—er—the man brings her here for this reason. But again, as I said, it may be wrong to generalize. What I say may cover the majority but—er—there are men who are conscious (aware) of course, there are those who take their wives to a health institution immediately she feels sick." (General practitioner, 27-year old, male, rural, Van)*

In the evaluations made on pregnant women from the rural parts of Afyon, from the seasonal workers' area in Adana, and from those who migrated from Eastern and Southern Anatolia to Adana, **it is observed that women within traditional extended families – who were married early, have had little or no opportunities for education, and whose fertility is provoked – do not have the right to comment on their own bodies and make use of existing services**.

While lack of education and problems related to gender are common in all regions, it is especially those problems resulting from migration from Eastern and Southern Anatolia to Adana, and transportation in Van, that attract the attention.

In the interviews held in Adana, health personnel state that people who migrated from Eastern and Southern Anatolia differ from native people with respect to social and cultural norms—that the former have a much more feudal social structure and lead a socially-withdrawn life. Women with families who migrated from Eastern and Southern Anatolia are illiterate, and again in this group, consanguineous marriages are very common. **In one of the focus group interviews held with health personnel, families coming from Eastern and Southern Anatolia have been described as "problematic";** it was stated that they migrated to Adana because they could not "fit to their place". The same health personnel describe the families from Adana as those who migrated to the 'big city' because of the need of 'work' and a 'livelihood'.

> *"… there is a gap between that side and this side of the canal. On that side, the literacy level is zero; their social lives are very bad; they completely live in a patriarchal way, in a house with two rooms. For example—I remember from my visits in the vaccination campaign, they live in houses with two rooms; there are*

two or three brides living with their mothers-in-law. You cannot see such a lifestyle here; here everyone has his own house, and within this house is his own nuclear family… And also their culture is completely different. The places where they come from, those parts—Diyarbakır, Muş, Bitlis, Tunceli, Siirt. These are the palces of problematic people – I mean to say – those who couldn't take refuge in their own region, disputed, have blood revenge, and whatever. There are people who came here to work, to make a living, completed a certain level of education, came to make a living for their family; here and there the stuff is totally different. (Another speaker) *There are some who came to make it possible for their children to be educated.* (Another speaker) *They are quiet and harmless people." (Health personnel focus group interview, semi-urban, Adana)*

"The problem of this side is solely cost of living, but that side is hometown problem. They couldn't fit the place where they live, problems arose and they had to move." (Health personnel focus group interview, semi-urban, Adana)

"They feel as if being under Turkish Government is not a good thing; they feel oppressed…" (Health personnel focus group,,semi-urban, Adana)

"The other day a woman had come with Bağkur social security and taken the receipt from the cashier's office. An amount of fifty liras remained. Our friend had said, 'I don't have any small change, let it remain here; it doesn't remain in my pocket, it goes to treasury.' The woman replied, 'If it will remain in treasury, not in your pocket, give it back to me, I won't leave it here.'" (Health personnel focus group, semi-urban, Adana)

"That's true, but people should come with the same interest, concern, and compassion. They don't come to us like this. They come sort of agitated, with an antipathy to the system. (Another speaker) *They come here agitated." (Health personnel focus group, semi-urban, Adana)*

It is observed that citizens who migrated from Eastern and Southern Anatolia to Adana mistrust the services provided by the government, and that this situation seriously affects their health behaviour. It is notable that this mistrust is reinforced, and becomes foreboding, as a result of the inadequate services provided—inadequate services that had resulted from the excessive workload of the health institutions in the region, and the problems such a situation generated for health personnel.

As for the rural parts of Afyon where there are no, or a very limited number of, migrants and seasonal workers, and **socio-cultural differences are not significantly pronounced, the determinant role of senior family members, especially the mothers-in-law, within extended families comes into prominence**.

"First of all, the mother-in-law has to say, 'Okay, let the bride go'. If she doesn't [say so], the son never takes his wife, he never takes her there… I mean to say—there is such a problem here: first the mother-in-law should say yes, this bride is sick. There has to be permission from the mother-in-law. Later on, whoever is in a senior position in the house, she should take her. No problem, if

the bride lives or dies; if there is no one at home, then she'll go tomorrow; it's the way they think." (Health personnel focus group, rural, Afyon)

An attribute shared in all regions is that the women's health is of minor importance if the family is poor. **Pregnant women who live in poor, traditional families in the rural areas have to work until the time of delivery is close; their work seems to be more important than their health.**

"Work will be completed, and then she'll come to the health centre towards evening. She says I have hardly completed works, take a look at me, and we examine her without hurting her. They wait for their bride to complete the work at home, then give permission—such a condition exists." (Health personnel focus group, Afyon)

"Our health centre is in the centre, but—I mean to say—er—they are in worse condition than that of a village. They are equivalent to the villages in the centre or other villages. I mean to say—they are in a very bad condition. A pregnant woman comes; I think she's pregnant with another one anyway. Pregnant—I mean to say—er—her tenth pregnancy, no healthy nutrition, no doctor; she has a miscarriage at home or gives birth at home. I mean to say—if we manage to reach them, we can explain things. Her husband doesn't take her to the hospital, they don't even have her vaccinated." (Nurse, 33-year old, urban, Van)

"They made her work during pregnancy, rushed her from one place to the other. As a result they disregarded their health, and she came out of necessity… [Talking about a woman taken to a health centre when her labour started.] *(Health personnel focus group, rural, Adana)*

According to the comments of the health personnel, **health centres are used mainly for curative services and for prescription of medicines by the people**. **It is observed that the importance of preventive services is not understood well, and it is stated that home visits planned for pregnant women are helpful especially for those in poor economic conditions, and pregnant women who are identified by home visits can attend the check-ups more readily later on**. In this sense, although mobile services are beneficial, **invitations for services made by announcing people as applied during mobile services in some regions is considered insulting** and inappropriate.

3.11 THE OPINIONS OF SERVICE PROVIDERS ON THE APPROPRIATENESS OF EXISTING ANTENATAL CARE AND CHILDBIRTH SERVICES

3.11.1 Health services provided in the region

All health personnel interviewed are aware of the fact that preventive services and antenatal care services under them should be adequate and convenient. However, they state that in recent years **while the workload has been increasing in primary health care institutions, the number of personnel has been continuously decreasing**. It is emphasised that as a natural consequence of this, physicians and midwives especially cannot spend an adequate amount of time on preventive health care services and antenatal care, and delivery services are **'get lost in the shuffle'** and cannot be provided for adequately in an appropriate way.

> *"Let me put it in this way—let me explain our way of working. You come to the health centre in the morning: [there are] a whole lot of patients. I come in and say good morning, I swear later on it ends with 'Enjoy your Meal'* [Turkish, afiyet olsun] *in the afternoon. I'm serious; I don't even smoke. I mean to say—I don't have any chance to go out. They bring tea once in a while. [There are] lots of patients; [the] population is big. We have only one assistant… Only our midwife stayed. We had a nurse before. She had time to take care of pregnant women and the babies when we had a nurse.now it is caught in between, if we said that we provide this service, we would be lying." (Health personnel focus group, rural, Adana)*

It is stated that **home visits – which are especially important in rural areas – cannot be undertaken because of the lack of personnel, and equipment**. Many members of the health personnel stress that home visits are important, **but others think that rather than going to people's homes, it is more effective and beneficial to have patients visit a health institution**. There are physicians and health personnel who have never been on a home visit and are unaware of the fact that home visits are an option, let alone a desirable one. Nonetheless, a home visit is an extremely suitable method for reaching individuals who are in an unfavourable position with respect to health-seeking behaviour. On the other hand, it is observed that health personnel try to provide tetanus immunisation though mobile health services, and **health personnel place considerable importance on this service**.

> *"Recently, we started using a school. It speeds up communication. Having an announcement made in the mosque is easy. We establish ourselves at a school. We invite all the children and pregnant women, you know. If she doesn't come at a specified time, [no matter as] we definitely pay another visit within a month. We go there with our tetanus vaccine, invite them, and vaccinate." (General practitioner, 36-year old, rural, Afyon)*

It is noteworthy that in nearly all regions no systematic antenatal care service was provided; services focused predominantly on identification of pregnant

women—inviting them to health centres for check-ups and then administering tetanus vaccinations.

However, there are challenges even in the provision of these limited services. In some regions health personnel indicate that a number of private gynaecologists have instructed pregnant women not to bother with a tetanus vaccination, calling it 'unnecessary'. In addition, even if it is not prevalent, **rumours about a link between 'infertility' and the tetanus vaccination may also be an obstacle for vaccination**. Health personnel also stated that when they see, in the health centre, pregnant women who have not been vaccinated, they can persuade them to agree to vaccination.

> *"I ask whether she has had a tetanus vaccination or not. I ask, 'Have you had your pregnancy vaccination?' 'No?' 'So, come now', I say. How would I know, I haven't. I mean to say—there are those who are careless. There is a little negligence." (General practitioner, 32-year old, female, urban, Adana)*

> *"People in that area had been saying this, 'My doctor doesn't want me to have the vaccination—there is no need." She had been saying 'I will be assist in your delivery; everything is sterile.'" (Health personnel focus group, semi-urban, Adana)*

> *"There is a kind of mentality stuff [going on] here. They think there has been a tetanus vaccination campaign here, why did they do it in this area, is that for infertility?' …" (Health personnel focus group, semi-urban, Adana)*

In the interviews, **it was emphasised that health centres are important health institutions for people – especially for those who are illiterate or with lower levels of educational attainment; have no relatives to accompany them to secondary health institutions; or who suffer economic hardship for their general convenience makes them the cheapest in terms of transportation – in that they provide accessibility to services and solutions health to health problems, even if there are a numbers of obstacles and hindrances to their utilisation (**as mentioned above). These people want their problems to be solved in the health centres, even if they are referred, they do not have recourse to secondary health institutions. On this point, **health centres are important being easily accessible (by bus or on foot—mostly)**. In addition, it is an advantage for health centres to have fewer and simpler procedures in comparison to secondary health institutions.

Health personnel stress that it is necessary to organise and normalise antenatal care and related services both in public and private health institutions in a way that enables standard operationalisation. They also want measures to be taken to change the attitudes of private practitioners with respect to tetanus vaccination.

3.11.2 Places where health services are provided in the region

The places where people receive health services are health centres, state hospitals, maternity hospitals and private physician offices. In urban areas there are also health cabins belong to midwives and health officers and it is seen that a number of pregnant women tend to perceive private working midwives as gynaecologist. It is observed that **a significant number of has closed their private offices recently**

because of the increase in revolving fund revenues, with cutbacks for physicians with private office, but majority of the gynaecologists still continue to run their offices. According to the health personnel, **people prefer private health institutions to make use of more qualified services**.

3.11.3 Appropriateness of local health institutions for ANC

In interviews held with health personnel it was observed that **the physical conditions of health centres are not favourable.** Some buildings were not planned as health centres, and were in fact only turned into health institutions later. Recent **revolving fund practices and performance evaluations affected the provision of preventive and antenatal care services negatively**. The physical space, implements, and equipment required for these services are not sufficient. There are difficulties in reaching these implements and equipment to provide adequate services. A very limited technology is used for diagnosis and treatment.

3.11.4 Problems of health personnel

According to the collected data, the problems of health personnel have a place of considerable importance. Affiliated to the Ministry of Health and obliged to provide antenatal care services, **primary health institutions experience problems related to the physical inadequacies, and to insufficient implements and equipment; in addition, health personnel also have personal problems to a considerable extent**.

These problems extend to working conditions, administrative problems; lack of pre-service and in-service training; job dissatisfaction; burnout; and communication problems with the local people.

Even though they differ according to the regions and the job titles of the personnel, it is possible to summarize the problems stated by health personnel in the interviews, as follows:

- The fact that the positions in the District Health Directorates are not filled with permanent personnel results in a perception that they are powerless and inadequate and these administrative positions with considerable responsibilities to be ineffective.
- Serious communication problems are sometimes experienced between health personnel and the society they serve in terms of regional and cultural differences. In some regions, the citizens and the health personnel virtually constitute two opposing groups.
- Communication problems are experienced between health personnel (responsible for the service provision in health institutions) and the administrative personnel, and that such problems may lead to conflict.
- The lack of implements and equipment needed for service provision is a widespread problem that negatively affects the services provided and communication with citizens.
- Health personnel in health centres want to serve pregnant women utilising better technologies. They are dissatisfied at not having such facilities. While physicians want to use x-ray facilities, midwives need Doppler heartbeat

devices. Shortages in such technologies make it obligatory to refer patients to other institutions. This situation diminishes the prestige of health centres. Service provision is reduced to prescribing medicines, vaccine practices, and health training.

- Health centres in some regions do not have any vehicles for mobile services or emergency cases. Citizens use their own or others' personal vehicles for urgent cases such as childbirth.
- Because of the lack of personnel, such services as secretariat and trust are carried out by the health personnel in some health institutions.
- In addition to the lack of personnel, their mobility is also an important problem in some regions. A number of physicians in the health centres complain that the personnel they train change their places often, and often precisely at *that* time when they can be fully productive.
- It is stated that the workload has increased because of revolving fund practices.
- There are problems among health personnel who worked in rural areas for a long time (such as, social isolation), and in those who has worked in those institutions with heavy a workload (such as, dissatisfaction and burnout).
- It is understood that pre-service training of the health personnel – primarily for the physicians, midwives, and nurses – is not sufficient for field practices. In order to compensate for this, well planned and implemented in-service training is needed.
- Health personnel generally perceive in-service training as that training provided by the Ministry of Health. It is not considered as training carried out among the health centre personnel. It is pointed out that the ministry only organises in-service training in family planning and immunisation—no training is given in pregnancy or childbirth after graduation. The same personnel and young ones generally participate in these trainings.
- Some health personnel emphasise the importance of (but lack of) effective inspection in health institutions. This situation results in the inability to distinguish between efficient and inefficient employees—thereby decreasing the motivation of personnel.
- Professional prestige and identity problems are experienced due to society's views of general practitioners and nurses. Together with the lack of implements and equipment, and infrastructure problems, the image of general practitioners and midwives-nurses in the citizens has been eroded. These problems affect the motivation and productivity of the personnel.

3.12 GENDER ISSUES

3.12.1 Woman's status

A common feature observed **in all women interviewed in the present study is the fact that they are virtually second-class citizens without much of a right to speak; are continuously oppressed in the face of men; are exposed to violence; and under the constraints of a mother- or father-in law**. This is especially evident in women living in rural areas. This condition exists in Van (a typical Eastern Anatolian province), in Adana (a province with many migrants and casual workers), and in Afyon (a typical Central-Western Anatolian province): women seem to be deprived of their fundamental rights in every region.

Health personnel often emphasize that women are perceived as second-class citizens in the family: besides their reproductive rights, they are deprived of the most basic human rights. **Woman does not have a right over her own body. As for her family, they attach importance to her fertility and its continuity.** According to the opinions of health personnel, a woman is excluded if she does not give birth every year, or if she is infertile. The culture of the societies under consideration here regards it as normal and natural that the husband of such a woman would get married again. Therefore, it is observed by health personnel that a lot of women continue to get pregnant even if they do not want to, and feel exhausted as result.

> *"They are extremely oppressed. They see their lives passing by. They can't reach it from one side. They are very submissive. I mean to say—they yield to the mother-in-law and the husband." (General practitioner, 30-year old, rural, Afyon).*

> *"They don't have any reproductive rights; they don't take the initiative in reproduction. Maybe such a woman is seen in one fifth [of the population]. Such a thing cannot happen, 'I don't want any more children'" (Health personnel focus group, semi-urban, Adana)*

> *"A 25-year old woman, she's got five children; there are thousands of people here who bring another wife just because their wives haven't given birth for a year." (Health personnel focus group, semi-urban, Adana)*

> *"… all men want children here…As if the only mission of a woman is to give birth, to deliver." (Health officer, 24-year old, rural, Van)*

> *"Ninety-nine percent of women don't know that their body belongs to them. How many children would they like? They think they don't deserve such a thing. Maybe they think it, but they cannot decide for themselves." (Health personnel focus group, semi-urban, Adana)*

3.12.2 Women and domestic violence

It is notable that women are widely exposed to emotional violence—some to physical violence. Violence can continue throughout pregnancy. Sometimes community members may witness this violence. However, no measures are taken to prevent and stop the violence. Women exposed to violence cannot resolve this problem and feel helpless.

> *"The whole neighbourhood sometimes gets angry with my husband. They say, 'Don't! She is pregnant; it's sinful. Don't fight with her'. I mean to say—that's the way, and they support me. My neighbours are good. I won't hide it from you, they are very good, but when my husband arrives, I hide outside. If he sees me, he beats me. He says, 'Outside is forbidden to you'. If he came here and saw you here – I mean to say – if he didn't find me at home, if he saw you in front of the door, he would cut me up… The other day I got a beating from my husband—what a pity. How fiery he was when he did it. I swear he doesn't think whether something bad might happen to the baby, I swear." (Pregnant woman, 30-year old, received no antenatal care, semi-urban, Adana)*

> *"Emotional violence is more common. I mean to say—no one comes to the health centre saying she was beaten. Up till now? If there were one or two cases, I don't remember. They experience emotional violence more – I mean to say – they are oppressed. They tell you this and that: you have this in your home, you have that on your foot, and you aren't beautiful. I hear such things." (General practitioner, 30-year old, rural, Afyon)*

> *"He tells me not to [lift anything heavy] but how can he see my mother-in-law, father-in-law shouting." (Pregnant woman, 22-year old, received no antenatal care, urban, Afyon)*

3.12.3 Women and social life

Women who marry at an early age, and whose educational level is low, are totally dependent on their husbands in every way. They cannot take decisions by themselves; they have to get permission from senior family members or from their husbands in order to go somewhere, or for the sake of propriety, they have to be chaperoned by them.

> *"My husband takes me; I haven't gone for a walk either." (Pregnant woman, 38-year old, discontinued antenatal care, semi-urban, Adana)*

> *"If I go somewhere, I ask my husband, you know, if I'm going to go there. I'm going to go to the health centre, may I? He says if you are going with someone, you may. But if I'm alone, I can't. If I go by car, I can go alone again. But if I don't go by car, I can't." (Pregnant woman, 21-year old, second pregnancy, received no antenatal care, rural, Van)*

> *"…I cannot act as I want. Now when I'm bored I can't say I'll go there at all. Either my husband or my mother-in-law must give the permission; my father-in-law is the same. When there is a wedding or some joyful occasion, I can go there. We go all together – not on my own, of course – with my mother-in-law*

and others with her. They give us permission, and then we go." (Pregnant woman, 19-year old, discontinued antenatal care, rural, Afyon)

Since the woman cannot go out on her own, her relations with her neighbours are undeveloped. **Women cannot have a satisfactory social life—go to visit their neighbours and meet their peers. This condition negatively affects their interactions with their environment, and hence their ability to obtain information and become aware**.

"Neighbourhood relations here, Oh, there are weddings, funerals and sickness, that's the way we go. Here you cannot go for a walk and such things." (Relative, 26-year old, housewife, urban, Adana)

3.12.4 Women and work

In urban areas, women generally deal with the household chores and child care. In rural areas it is the same, except that, in addition, women also have to work in the fields. Men are expected to work outside the home. However, regarding household tasks done outside the home (shopping and the payment of invoices, for example) men are involved.

"Yes, …when there is a need or an expense, I give to it my husband. I mean to say—I tell him to buy these, for example. When there is no shop nearby, or we don't have a shopping area, my husband shops and brings them." (Pregnant woman, 27-year old, received no antenatal care, rural, Adana)

The position of women in Adana (in families coming to work as seasonal workers) is more subordinate. Health personnel state that for these women being pregnant does not affect the way she is regarded because **women are perceived by their relatives as workers who have to earn money**.

"Now let me put it like this: they are workers there. There is no difference if they are women or men. No difference if they are pregnant or not. Every individual is seen as a daily wage by both themselves and the person who hires them. Therefore, think of their status in the society, woman, man—er—pregnant woman, child, adult: there is no difference. They are seen as a daily wage each—or a worker." (General practitioner, 36-year old, female, seasonal workers' area, Adana)

3.12.5 Women and fertility

Women are expected to get pregnant immediately after they get married. Because of this social expectation most of them get pregnant unwillingly in the subsequent phases of their marriage. A great many of the interviews with pregnant women and their peers stated that their husbands want to have children very much.

"People bear a lot; they give birth a lot. I swore that I wouldn't bear after this one, because I haven't lived a life. I came, got pregnant, and had a miscarriage. One more miscarriage, then I got pregnant and it's gone too. The last one is

this. This one stayed because I protected myself. This one stayed because I saved myself and it. This one was an accident; otherwise I wouldn't have it now." (Pregnant woman, 25-year old, discontinued antenatal care, seasonal worker, Adana)

Having a lot of children on the part of the women is not only a desire of their spouses, in some cases it may be seen as a requirement because of the beliefs. A participant in Adana emphasises that a Muslim family should have five children. This pregnant woman thinks that it is important for siblings to support each other in a large family. In addition, she believes that having a lot of children is beneficial for the country; she thinks, 'young soldiers' will grow up and the country will consequently be stronger. **Children are seen as a guarantee 'protecting' both the family and country.**

"Five. A Muslim family will have five children. (Why?) We know this way. I think it is so. (Who said so?) In my family it is so, a Muslim will have four, five children. (Does the number five have any meaning? Where does it come from?) We like it so. (Why?) For example, if there are two girls and two boys, they will all be aunts and uncles. If there is one, it will be alone, we want the all be. I've got three girls, one boy; it's enough if God gives us another boy. (Is there something like 'a Muslim shall give birth to four or five?') We think it is better. The British Prince was acclaimed for having five – I mean to say – they want to. The European part doesn't give birth. All are old, and also they cannot find proper young boys so that they can send them for military service; he can fight in the war. We've got [proper young boys], may God preserve them. Thank God. Having children is good. They protect us, they look after us. A younger generation develops. (Pregnant-peer focus group, semi-urban, Adana)

3.12.6 Women and ability to make decisions about receiving services

In pregnant-peer focus group interviews many pregnant women state that they decide on having recourse to a health institution with their husbands, and they could go there whenever they wanted. However, **in all regions where the present research was conducted there is always the issue of 'getting permission' from the husband or his family**. Women generally do not go to a health institution or any other place without first getting her husband's permission.

"My sister-in-law goes as well if her husband lets her go; I mean to say—our mother-in-law doesn't get involved." (Relative, 32-year old, housewife, urban, Adana)

"… now when she gets sick, for example she's got her mother-in-law. Her mother-in-law, now there are elders here, juniors have no right to voice an opinion. The elder decides, then her husband takes her." (Relative, housewife, 37-year old, rural,Van)

"I tell my husband and my mother-in-law; they know me. If I go without asking, she [my mother-in-law] says, 'The bride didn't get permission from us'. And such things. She says, 'Look, we didn't let her, and she didn't agree with us'. She says, 'She didn't ask us if she could go'. 'You see,' she says, 'She went

without informing us'. She gives me a sharp rebuke. They say such things." (Pregnant woman, 25-year old, received no antenatal care, rural, Afyon)

The husband's family still maintains its importance in making use of antenatal care services. The pregnant women's relatives state that if she tells them she has a problem, they will take her to the hospital. However, senior family members perceive pregnancy and the ailments experienced during pregnancy as natural, and they do not describe them as problems. Therefore, they do not think that a healthy pregnant woman should go for check-ups.

"I swear, she knows, but we don't. It's her problem. She says 'I've got pains here'. We send her to the hospital. If she says, we will [send her]; if she doesn't tell us, how can I send her?" (Mother-in-law, 56-year old, housewife, urban, Adana)

It can be considered normal for pregnant women who go to a health institution to receive antenatal care services to inform their husbands or senior family members, and this cannot be adjudged as something against their freedom. However, it is observed that there are cases where this behaviour is beyond the boundaries of merely informing: it is done for the purpose of obtaining permission and in same families pregnant women are not given permission to go to a health institution even in times of illness.

A pregnant woman explained that even if she were sick, she could not get permission from her husband's family during her pregnancy. After she turned into 'skin and bone' they gave her permission to go to a health institution.

A number of women state that they have the right to comment at home and they make decisions on the use of the budget, and reproductive health, together with their husbands. However, researchers' experiences, and the statements of health personnel reveal that the state of affairs is actually quite different in the real world. **Women's actions are monitored and a kind of social pressure is exerted on them.**

On this issue, the following episode might be cited. In one of the focus group interviews held in Adana, an extraordinary event took place. The time of the meeting and a place (a house where three brides were living together without their mother-in-law) were arranged. Researchers had established good communication with the brides and completed a considerable amount of the interview. However, in the midst of the interview, a teenager of the house (a late teen, around 18 or 19 years of age and single) and cast the researchers out of the house in an extremely aggressive manner, causing the participants to scatter. None of the older women or the brides could utter a word to this teenager. His behaviour affected many of the participants, and the pregnant-peer group who participated in the first part of the interview, quickly broke up. The interview had to be completed with only five participants in another house.

"Come on, elder sisters, break it up! Break it up! Break it up! [A young man of the house barges in clapping his hands] *Look here, what kind of a doctor are you? Show me your ID!* [Looking at the ID, though he is illiterate] *Haven't we seen any doctors? These women are dim-witted, why do they do such a thing?" (Adana, pregnant-peer focus group)*

3.13 REGIONAL CHARACTERISTICS

3.13.1 Adana

Socio-economic structure

The areas where the interviews were conducted in Adana show demographic and cultural differences. Adana has very high rates of in-migration. People who have come from different regions and settled in urban and rural areas of Adana live in separate neighbourhoods.

> *"Yes, the Arabs have settled in certain areas, Kurds in certain areas, Canos* [a name given to Romany people] *in a certain area. Like this have they settled in the same region." (Midwife, 31-year old, urban, Adana)*

> *"… There are all peoples: there are Macir* [people from former-Yugoslavia]*; there are Laz* [people from the Eastern Black Sea Region]*; there are Çerkes—and there are all peoples. There are Turks; there are Kurds—and there are a lot." (Community Leader, 50-year old, Mukhtar, urban, Adana).*

In almost every part of Adana where interviews were held, economic difficulties, unemployment, and poverty were frequently mentioned. In the rural areas, as expected, families make their livelihood through agriculture and animal husbandry. The income generated is just enough to cover the expenses of the family. In some places, it is observed that some family members (especially men) go to other cities or even abroad to seek short-term work.

> *"Families—I mean to say—our village is poor. It is a poor family. So, they go harvesting: peanut harvests, corn harvests. To live, you see. They keep one or two cattle and make a living... No, almost all the village is poor... I mean to say—there is no one of considerable means." (Community Leader, 46-year old, Mukhtar, rural, Adana)*

In urban areas, low paid work (relative to the cost of living) is listed as a significant issue, as is temporary and seasonal work.

> *"Yes, with my father-in-law, they are temporary workers. They work. They work at temporary jobs and bring in [an income]. We don't have any other security. I mean to say—they are temporary workers they are labourers." (Pregnant woman, 32-year old, sixth pregnancy, no ANC, rural, Adana).*

> *"Around here no one has income or that type of thing. Everyone's a manual labourer. If the husband works, that is by the hour on the construction sites. One day there is [work]; ten days there isn't. Our Kurdish people are like that. They lead a miserable existence on the construction sites." (Pregnant woman, 35-year old, fifth pregnancy, no ANC, urban, Adana)*

"My daughter's milk is 150 million lira every month. We give 160 million for milk. How can we put anything aside for our health? We can barely look after ourselves." (Pregnant woman, 23-year old, second pregnancy, no ANC, seasonal workers area, Adana)

It is stated by the participants that families living in urban areas, and who have economic problems make use of social assistance, borrow from people around them, or cut down on their expenses from time to time in order to balance the family budget.

In the interviews conducted in seasonal workers' areas it was noted that the conditions of life are harsher, and that there is more poverty in these areas.

"Their financial conditions are what we could call totally awful. I mean to say—a person who is not in absolute need would never work there. Hey, if you could only see the conditions, I mean… As I was saying, you would try to give everything you got: if you have clean water, you would give it so they can drink it; if you have food, you would share it; if you have medicine, you would give it. There are really places that are in a horrible state." (General practitioner, male, 36-year old, seasonal workers area, Adana)

It is observed that the uncongenial life conditions that seasonal workers endure negatively affects the health of both women and children. On the other hand, it is also observed that some of the people interviewed have a positive opinion about their financial conditions, and the facilities available at their place of residence; for example, a midwife stated:

"There isn't—there isn't anyone living in bad conditions. Everyone is fine; I mean to say everyone looks after their family." (Pregnant woman, 27-year old, no ANC, 7th pregnancy, urban, Adana)

A relative of a pregnant woman said:

"They have a car. If everyone goes to work in their house, how should I know? Not everyone is renting their houses; all have houses" (Relative, woman, 57-year old, Adana)

Another finding is that **there are families and pregnant women that receive conditional cash transfer** in the areas where interviews were conducted. In the region, a programme called Conditional Cash Transfer is being implemented under the Social Risk Mitigation Project in cooperation with the Social Assistance and Solidarity Fund and the Ministry of Health. Mothers with children and expectant mothers without any social security can get assistance from this project. Payments are made every two months to mothers or expectant mothers.

"Now in this case we have cash assistance. There are six or seven hundred people. Students, pregnant women – before the third month they have to apply. Women who have just given birth, [women] before the third month they have to apply. Let me say, these get help every two months. They get it." (Community leader, male, 55-year old, Mukhtar, urban, Adana)

However, health personnel interviewed in the area stated that while Conditional Cash Transfer had positive effects, it also had negative results in that it increased the reproductive health related problems. They stated that the project has elevated the pregnancy rates.

> *"They encourage them. They give money. They give extra money so that a woman has kids. Why? They look after animals. Austria, Germany, Paris, here, there—if it weren't for the immigrants, there was no population to start with. My friend, are you German? Are you [from] Austria? You are constantly helping women who give birth? Good, do it. Nice. But don't encourage them this much. You are a country with population explosion. You don't know where you are going. A huge hulking car that has lost its brakes is going [out of control]... I mean to say—first do population planning. Reproductive health is very important definitely. Immediately and logically plan the population, and educate urgently." (Nurse, 31-year old, urban, Adana)*

Health insurance

It is stated that with the affect of the green card practice, the percentage of families without any health insurance has dropped, and that green card holders have increased. The percentage of the population with social security such as SSK and Bağ-Kur is lower than that of green card holders.

> *"Ninety percent green card. Maybe more than ninety percent green card. There are very few Bağ-Kur, very, very few. Those who have no social security are a lot less. But mostly green card. More than ninety percent." (General practitioner, male, 32-year old, urban, Adana)*

However, it is noted by some participants that there are some injustices in the distribution of green cards. It is said that some families who were not in need bought green cards, whereas those in real need could not get them. Both mukhtars and health personnel have made statements to this effect.

> *"Hey, me I am going to go beg and get it. A man doesn't have any money—can't get it. They turn him down, because he's got a television and a fridge. They don't give him a green card. On the other hand, a man's got a factory, a workplace, a car. Never goes, pays for it—and the green card comes to his feet." (Community leader, male, 42-year old, Mukhtar, urban, Adana)*

Infrastructure services

Utilisation of infrastructure services differs according to the place where the interviews were held. In some of the urban areas that were visited, while some regularly used such services as electricity and water, at other urban and rural areas infrastructure related problems were voiced more frequently.

> *"I mean to say—now sixty percent of our houses are* gecekondular [Turkish, meagre houses built of poor materials, without permits, literally 'overnight';

singular ‘gecekondu’]. *We have a new settlement. Of those, about five percent have plans. Until now, all were built as* gecekondular. *I wish the state would do something about this—turn it into government housing. It would be cleaner, healthier.” (Community leader, male, 46-year old, Mukhtar, urban, Adana)*

Among issues related to infrastructure, a voiced concern, direct or indirectly, was related to sewerage. The sewerage issue is expressed by all target groups interviewed.

“I swear I had the sewerage built one time. The villagers couldn’t look after it—all the filth collected, and the system clogged-up.” (Community leader, male, 59-year old, Mukhtar, seasonal workers’ area, Adana)

“There is no septic tank; there is sewerage, but, sufficient manholes were not made in the system. If there is a tiny bit of rain the manhole covers are thrown up.” (Health personnel focus group, urban, Adana)

“The manholes throw it all back out. God forbid, I mean to say heavy... rain or whatnot. If it is like a disaster, all the houses will be left under water. Forgive me, but from the WCs all the sewage is thrown back out, from the first thing.” (Community leader, male, 46-year old, Mukhtar, urban,)

In some residential areas apart from sewerage, infrastructure concerns were revealed in complaints about electricity- and water cuts.

“We can’t always drink; I mean to say—these days that type of water can’t be found. I mean to say—clean drinkable water. Now there is a garden there. I got it [water] from there, but all the neighbours bring mud from the bottom of the well.” (Pregnant woman, 40-year old, discontinued ANC, rural, Adana)

A pregnant woman visited in a rural area in Adana talks in detail about the hardships they have to go through to store the water needed by the household:

“*There isn’t a spring anywhere [near] here...Water from that mountain becomes water to those lakes. Those houses you must have passed by... Here we have a tank; we fill the tank and make do with it. In the winter it snows, there is more water sometimes from gas comes from the ground we do things with it... The amount you fill is enough for about two months.” (Pregnant woman, 27-year old, no ANC, rural, Adana)*

Some of the community leaders and health personnel interviewed stated that due to certain sewerage and other infrastructure problems, health issues arise in their regions.

“There are frequent water cuts; I think there is a serious problem related to amoeba in the region. The minute it is hot, this place is full of acute gastroenteritis. I mean to say—we can’t diagnose amoeba but we have a lot of enteritis. When they go to the hospital and come back they say they’ve got amoeba.” (Health personnel, focus group, Adana)

"There are puddles around the village, for example, that even causes filth, causes flies. Down there we have meadows. There for example, it is overgrown with rushes, and a little for example flies from." (Community Leader, 37-year old, Mukhtar, rural, Adana)

Different opinions were voiced with regards the transportation infrastructure of the region where interviews were conducted. While transportation was not mentioned as an important problem in Adana city centre, and areas near the centre, in districts and villages not connected to the city centre, transportation difficulties were mentioned by participants on various occasions.

"...very scattered you see. As you can see, this place has gone beyond Istanbul. On top of every mountain there is a house. If there is no telephone, there is no transportation." (Community Leader, 37-year old, Mukhtar, rural, Adana)

In addition, many of the people interviewed state that problems in transportation make access to health care services difficult. Health care personnel state that problems in transportation present difficulties for people effectively accessing the services they provide—or, likewise, that the services they provide are utilised less than they ought to be.

"Now it is like this: the most important problems I face here are due to transportation, you see. The fact is that I have very little contact with other villages; I can't reach them..." (Midwife, 34-year old, rural, Adana)

Socio-cultural characteristics

Lack of education institutions in the region comes to the forefront as a factor affecting the education levels of women in the region. On the other hand, it is also stated that the region is more developed when compared to the past, and that there is a change in the cultural composition caused by immigration—that the new generations utilise education opportunities more.

"People of our region, the Kurds, didn't look fondly on girls, but now those who have migrated here – I mean to say – have broken this thing. That chain—I mean to say. She is also our child, our kid, they say, and send their kids to school as much as possible now—I mean to say." (Community Leader, 50-year old, Mukhtar, urban, Adana)

Another point raised in focus groups and in-depth interviews is the fact that (in the region where interviews were held) people prefer traditional extended families, and thus are inclined to have a lot of children.

"*Childbirth? Childbirth? God preserve us from evil* [Turkish, 'Maşallah']. *I mean to say—there are at least 10 to 15 children in one family. They bring one child into the world every year without thinking of its future: how I am going to feed this; how I am going to provide an education. They don't think about these things." (Community Leader, 46-year old, Mukhtar, urban, Adana)*

It is also stated by participants that having many children is preferred due to societal and religious considerations.

On the other hand, in the same interviews it is also stated that far from being an advantage having many children creates financial and moral pressures.

> *"No, I say let it be few but let it be clean. It is going to end up in bad places. It should be clean. Let there be few, and you are going to take good care of him or her. Their clothes should be clean. When they go to school, they shouldn't have anything lacking among their friends. When you have many, you can't buy everything. When you buy one shoes, then you have to buy the others shoes—and by the time it is the first one's turn his or her shoes will be worn out. If you don't have the means, you will be miserable with too many kids. " (Pregnant women-peer, FGD, urban, Adana)*

During the interviews it was stated that the health of children has priority over women's health. According to the statements of community leaders, health care personnel and households visited, traditional extended families predominate in the area. While some interviewed say that this is a continuance of traditions, some say that socio-economic conditions are the reason for the existence of such families.

> *"Yes, my daughter-in-law isn't bad. There is God above. My daughter-in-law is nice; we are nice too. We have been living together here for twelve thirteen years. We buy everything. We make our kebab. We eat. Once it is born we chase after it. We live thank God." (Relative, mother-in-law, 53-year old, urban, Adana)*

> *"Relations—really they give and get girls from relatives that are very closely bonded usually. Kurdish people are like that. People with Arabic origins are like that. Therefore relations with relatives are good—I mean to say. Nah, they are not like ...They are not distant from each other. The daughter-in-law lives with the mother-in-law usually. Very rarely are there ones with their own houses." (Nurse, 31-year old, urban, Adana)*

> *"Generally with family elders I mean to say. Now those who have migrated from the east usually live with their family elders. Some – I mean to say, the local people – they live on their own." (Community Leader, 41-year old, Mukhtar, urban, Adana)*

Woman's status

The main result of traditional extended families and its patriarchal structure is the restriction of women's decision rights and thus, directly or indirectly, the related difficulties in utilising health care services. This is due to the fact that the final decision rests on the mother-in-law, father-in-law, or husband.

> *"A woman came the other day. She has nine or ten children. She is finished; she can't stand up. 'Lady, lady, why don't you get her fitted with an intrauterine device?' The second woman by you is younger 'is nothing going to be done for*

her' I said 'nothing is going to be done to her, she is yet young, she is going to give 9-10 births' she said." (Health personnel focus group, urban, Adana)

"(Question: 'Who makes the decision regarding health care institution use?) *My father-in-law does... He says okay, we'll go. We first tell him and then go. We don't just decide ourselves and go." (Pregnant woman, 26-year old, discontinued ANC, fourth pregnancy, rural, Adana)*

The concept of honour within this feudal order is another important finding. The privacy of the woman (and the concept of honour associated with it) is stated to be a determinant in the place of the woman in the public sphere, and her personal relations outside the family.

"*Where could women go? In their own streets, everyone can go anywhere they want—[but] they are kept under control. Very few can go to the hospital on their own, but they go to the health centre on their own. That's the type of place the health centre is. They come to our health centre. Their husbands don't say anything. There are problems stemming from the mother-in-law. If their husbands are doing their military service or are out of town for work, the mother-in-law establishes a weird dominance over the daughter-in-law. The issue of honour has become very significant. For honour, in such circumstances, is on the edge—because honour is very significant. But today there is the Wednesday market; women can walk around there freely." (Health personnel, focus group, urban, Adana)*

In a focus group held in Adana city centre, where the women of the neighbourhood had gathered at a house, a young man (17 years old) of the family, seeing what they were doing, said that he could not take the responsibility for all those women, and caused the interview to end.

"*These women are dim-witted, why do they do such a thing? A man came outside* [the husband of one of the participants of the focus group], *he says [to me], 'If something happens, it will be your fault'. You* [to the women] *are not going to stay here. Go now..." (Pregnant woman-peer, focus group, 17-year old, male child, urban, Adana)* [This is the teenager who broke up the meeting Section]

Even though women have little say in the decision-making mechanisms in the traditional extended family structure, it is observed that some women in these regions are economically active and contribute to the family budget by working. In some of the interviews held in both urban and rural areas, it was determined that besides agricultural activities, women are also involved in such economic activities as doing handiwork at home and marketing it.

"*Before I got pregnant, for example, I used to do tailoring... Yes, you bring money home—I mean to say... Of course; I also contribute." (Pregnant woman, 34-year old, no ANC, fifth pregnancy, urban, Adana)*

"*These are the work women do now, they go digging, in the summer they go hoeing, in the winter they go to citrus* [women work in the fields digging,

hoeing and picking fruit] ... *Some go to work in houses [as maids], some go to work in gardens." (Community leader, 41-year old, male, Mukhtar, urban, Adana)*

Some participants, on the other hand, state that women in their areas did not work or were not allowed to work.

"*It is not in our customs; we don't let our girls, brides work." (Relative, mother-in-law, 56-year old, urban, Adana)*

Religion

Religious belief is common in the areas where the research was conducted. When women express their opinions regarding abortion, unwanted pregnancies, and child health they frequently use such expressions as 'God's work', 'God gave'. However, it is observed that the effect of religion on reproductive health services appears less than in the past.

"*Then, no harm to the child—I mean to say no harm to the woman. After repeatedly saying this; after the imam's wife got fitted with an IUD, it became a thing. In the past, there were things like this, like* Şıhs [Turkish 'Şıh', a religious person of higher status than an imam]. *First from a negative point of view, like such, for example, a patient fitted with an IUD becomes* cenabet [Turkish 'cenabet', 'dirty'; but it has a wide range of connotations including 'sinful', 'polluted']. *I mean to say—during sexual intercourse she becomes cenabet; her ritual ablutions* [the washing done before prayers] *are not accepted, and so they didn't want to be fitted with an IUD. Then you see we spoke to imams and so on. At least there is a need for a sermon [explaining] that this is not a sin." (Midwife, 42-year old, urban, Adana)*

Relations between the public and the health care personnel in the region

According to the interviews held in Adana, it was noted that at the core of health care personnel's view of the region is the belief that the local people are uneducated and, as a corollary, display a lack of awareness of health related issues and societal events, and were in need of knowledge.

"[On mothers-in-law] *Mentality, ignorance, cost: they trust them and also old habits die hard, you see." (Health personnel, focus group, urban, Adana)*

"*I don't know what they expect as regards services. I haven't yet understood—because they don't know what they should expect. They don't know what you are saying. I mean to say—I tell the woman to keep track of the weight and height of the baby. And then the woman comes, and she doesn't know the baby's weight or height. Why should she care? The woman is interested in whether the baby looks chubby or not. I am with the wrong patients. I mean to say—she is going to expect services; she doesn't know services. Only if someone warns her.*

They know very well what they should complain about." (Nurse, 31-year old, urban, Adana)

Interviewed health care personnel state that from time to time they have communication problems with people they provide services to.

"(Discussing problems stemming from the physical conditions and the personnel at health care institutions.) *This is true, but the people should also come with the same compassion, concern, and interest. I mean to say—they don't come to us like that. Now, people come like—they come agitated. They come with a dislike for the system." (Health personnel, focus group, urban, Adana)*

There were personnel who said that communication problems sometimes results in harsh behaviour.

"*But I make everyone I catch breast feed. I really have a go at them, even frighten them, and make them go back to breast feeding." (Nurse, 31-year old, urban, Adana)*

While health care personnel have negative thoughts, and communication problems, as well as other problems related to the people they provide services to, they also have positive thoughts, and make the effort to solve the problems.

"It is a little bit harder a duty, but it's fulfilling. When people come it's really nice—eh—such a demand for you is very nice. Plus, you reach people that really need you. These are the satisfactions you get... To love people, that is the first condition of doing this job. You have to love people." (General practitioner, 36-year old, male, seasonal workers area, Adana)

The local people interviewed in the region have different thoughts regarding the health care personnel. A number seem very happy with the personnel that work and provide services in the area, but this is very rare.

"*I swear when I went and came back there has never been a doctor I had an argument with—can be understood, I mean to say..." (Pregnant woman, 32-year old, no ANC, 6th pregnancy, rural, Adana)*

"For example, there is a doctor in this health centre. I came to this age and have never seen such a good doctor. A very nice doctor. I mean to say—he is so warm, treats people so nicely, very charming, I mean to say. With the medicine he gives you get back on your feet in two days—I mean to say, a very good doctor." (Pregnant woman, 40-year old, discontinued ANC, ninth pregnancy, rural, Adana. Her daughter says the same thing.)

On the other hand, others are not happy with the health care services provided; they state that inattentiveness is common.

"Sometimes we are not satisfied surely; for example, doctors change; some doctors are no good for example; and they don't try to understand people much.

For example, they have their problems and it is taken out on us." (Relative (niece), 18-year old, rural, Adana)

3.13.2 AFYON

Socio-economic structure

Since the areas with problems in the utilisation of health care services in Afyon are mostly in rural areas, the data was mainly collected from rural areas. The means of livelihood in these areas is agriculture, animal husbandry, and quarrying. It is also stated that men leave their homes temporarily to work in construction. There are people who go to other provinces as seasonal irrigation workers. Women outside the home often work as cleaners and maids, or work in the fields and gardens. It is observed that although the people interviewed are not very well off, they are not very poor either.

> *"Here for example [our] income level—if people can, they will do animal husbandry. That is enough for one's family. There is no large scale stock farming really, only animal husbandry with three, five, ten animal types. Women don't work in this* [animal husbandry]. *Yes, we—as the topic is women, pregnant women regularly work outside until the third, fifth month as I said, maybe the sixth or seventh month. She helps her husband;* [their] *income levels are low. I mean to say—low in such a way that there is no time or money for social life." (Community leader, 40-year old, male, imam, semi-urban, Afyon)*

Poverty comes to the forefront as a factor impeding ANC attendance in the region. The unemployed, unskilled workers, farmers of small farms, and those without regular income—all have economic and service utilisation problems.

> "*The peasants don't always have money in their hands. If you don't have a green card or insurance in your hand, then you pay. God don't make anyone needy. I mean to say—therefore, you shouldn't fall or let anyone fell you." (Pregnant woman, 30-year old, no ANC, rural, Afyon)*

> *"My man doesn't have a job; I mean to say—if they* [other women] *have a slight pain they go get treatment there. My man doesn't have a job so I can't go." (Pregnant woman, 40-year old, no ANC, rural, Afyon)*

Health insurance

It is observed that the main health insurance in the region is the green card, and it is stated that the percentage of people with no insurance can show regional disparities.

> "*I speak to other physician friends. For example, if you consider that 40 patients or 50 patients come to me everyday, at least 10 don't have health insurance. But I ask physicians working at other health centres, they tell me at most one – sometimes none – come with no health insurance I mean to say. The concentration of people with no health insurance is highest in Ağılönü* [a village]*." (General practitioner, 30-year old, rural Afyon)*

The only option for people in rural areas, who are not government employees or have no social security, is the green card. However, farmers of small farms who have an

irregular and low income cannot make use of this system as they are land owners. Farmers cannot fulfil such conditions as income status and ownership of assets of the general health insurance and unemployment insurance, and thus are excluded. The same is true for those who do not have a regular job and income. A relative of a pregnant woman stated that while her husband was doing military service they had health insurance.

> *"We got that card. Until he came back from military service we comfortably went to the hospital with it I mean to say—to the doctor." (Relative (woman), 19-year old, rural, Afyon)*

A farmer living in the area, who does not have any health insurance, might need a green card in cases of emergency, but, for example, if he owns a tractor, he may not be eligible for one. However, the hospital expenses might be too high for him to able to afford health care and this causes problems.

> *"A person has someone who is ill. Now they come, 'My mayor, help come quick!' Eh—what happened? 'Give us green card!' Hey, you have a motor* [a tractor] *how can I give you a green card? 'Hey, the person is really seriously ill. Shall I leave him and go sell my motor?' What can you do—I mean to say? Eh—in desperation you go to the sub governor, show the persons condition, have it evaluated; then it is left to his conscience. I mean to say—the man is devastated. It is like this—I mean to say—in our public institutions. If you have a surgery the expenses go through the roof." (Mayor, 40-year old, urban, Afyon)*

In the region, decision-making is difficult for those who are responsible for issuing green cards to people without health insurance. The doctors condemn the fact that there is no health insurance that covers all citizens equally.

> *"You have to provide justice for everyone equally. I gave it to you, not to you—this, that. You are neither going to put the people who do it in difficulty nor the people who will benefit from this. I mean to say—there should be balance, like the scales of justice. Then neither the sub governor, nor the health group director, nor district mayor, nor Ahmet, nor Mehmet would have to think about it. I mean to say—taking care of the citizens, providing for their needs. It is a thing of a social state I mean to say. Therefore, this should be covered. Could I explain what I mean to say?—I agree with the doctor. There can be no bigger shame than not having social security in this country." (Health personne focus group, Afyon)*

In recent years, as a result of the inspections, the fact that the green cards of those who do not fulfil the criteria have been cancelled has put the agricultural labourer who works without social security with low pay in a difficult situation.

> *"We've no assets. He is written in a group for sugar beet—I mean to say plant beet and such. My husband doesn't plant; he gets when there is sugar* [beet]. *He is a group head there. They said this and that and cancelled the card. Another thing you should stay apart from your father, your family—be on your own.*

That's why they cancelled the cards." (Pregnant, 30-year old, no ANC, rural, Afyon)

Infrastructure

It is stated in the areas where interviews were held (including the rural areas, apart from some mountain villages) that there were no infrastructure problems, that in recent years important infrastructure investments had been made, that problems related to electricity and water have decreased.

"We have no infrastructure deficiencies. Our roads are asphalted, the bus situation is very good, and there are six, seven buses a day. From there to here is the same. We have a football pitch. We have a team, a football team: Taşolukspor [name of the football team]. *In addition we have sewerage. There is no water problem. I mean to say—all sorts of infrastructure, electricity, there isn't. Ah, I mean to say—there is everything." (Teacher, 41-year old, rural, Afyon)*

Socio-cultural characteristics

It is observed that in Afyon religious belief has a great impact on social life, that sending children on Koran courses outside school is common and that the people could be defined as being conservative. However, special importance is placed on sending children to school. It is observed that people in Afyon are not prejudiced against sending girls to school.

"*However poor they are, if the child is smart, there is a future. They try to send the child to school. Otherwise, for example, if the child barely passes the classes, they don't try that hard. If they have means they would send the child to* dershane [Turkish, a 'dershane' is a private school that prepares students for various exams; the English equivalent, a 'crammer' where pupils are 'crammed' for examinations] *Let me tell you like this, there is no such thing as not sending girls to school due to conservatism." (Imam, 40-year old, semi-urban, Afyon)*

Despite this, the education level in general is low and there are cases where girls are not sent to school after basic education. The words of a mayor who has sent his daughter to school to set an example are resonant in this context.

"On this topic I am very distressed. I sent my own daughter to school to set an example. Yes, but we fight with my wife, which is a separate issue. She is angry with me saying, 'You are sending her to school!' But you have to send her; at one point, you have to be an example for others. But as you know this place is a very negative place." (Mayor, 41-year old, urban, Afyon)

Although traditional extended families predominate in the rural areas, feudal relations are not as marked as in other provinces. On the contrary, the wish to be more modern is noticeable in the rural people. In this regard, the wish of a husband is noteworthy.

"…now I wish [my wife] could go out without restrictions. I would really want that. I mean to say—to go somewhere with my wife and walk around, hold hands. What can I say? To go somewhere and drink tea or something—but our environment is not suitable for that. Like I said before, there is a lot of gossiping. Old women do a lot of things to them you see. They put pressure on us. This is why we live a little introverted for this reason." (Husband, 22-year old, high school graduate, rural, Afyon)

Neighbourly relations are quite developed.

"People, neighbourly ties are good I mean to say. People visit, visit each other." (Health care officer, 27-year old, rural, Afyon)

The new generation especially, when compared with those before them, are more informed and determined about ANC and childbirth services.

"It's wrong to give birth at home. It's wrong to deliver at home. At the hospital they stop your bleeding. It happened before. My mother did it. Me—I had all four at the hospital. But my mother-in-law criticised me, because I went to the hospital. My husband worked in a foreign land, abroad, so he saw—he took me but my mother-in-law didn't want it." (Pregnant-peer, focus group, Afyon)

Although health care services are widely provided in the area, it is understood that there are still bonesetters, healers and traditional birth attendants even if they are decreasing in number.

"In the past they had it. If you ask why there was, it's not my fault. It was the fault of those running the country. If there is no orthopaedist here, what are people going to do? It's not ignorance going to the thing. There were no doctors in the past; there were midwives. There were traditional birth attendants. They are finished, thank God. They are gone. If there were any now, nobody would go. Also we would report them. They should know this. Second, there wasn't an orthopaedist. We went to bonesetters. H'm. Our orthopaedic doctor came. Would anyone go to the bone setter now? The specialist has come here. This would happen in a place that doesn't have a specialist. The state should know this. I mean to say—why should it know? When there is no specialist in a place what are they going to do? Go to bonesetters. When there is no imam, they will go to an ignoramus. This is how it is I mean to say. There are no bonesetters now. Even if there are, they are null and void." (Imam, 40-year old, semi-urban, Afyon)

Women's status

In the regions where the interviews were conducted in Afyon, it is stated that the participation of women to social life is limited. They cannot act on their own; they have problems going outside the house alone; and they are generally under the supervision of their husbands and mothers-in-law. Moreover, in some cases new brides are not allowed to go outside at all for a while.

"*My mother goes to the market. In our Çobanlar* [district], *new brides are a bit more, a bit thing. They stay home I mean to say—for at least one or two years. For example, a new bride—eh—a new bride to show she is new wears this sequinned stuff." (Husband, 22-year old, urban, Afyon)*

Not sending girls to school after eighth grade results in girls being married off in a short period of time.

"I mean to say like I said; I mean to say—early marriage... the biggest mistake I see here is young marriage. We spoke [about this] *with friends yesterday. We said, "Can't we do anything about this? If we explained..." Then we thought this isn't something you can explain. Because they—what can I say?—I mean to say—when 16, 17 [year olds] get married, have kids, let's live together. There, the bride will help the mother-in-law. It happens for that reason a lot too. Get help, have fun, have a full house." (Nurse, 26-year old, rural, Afyon)*

Living together in extended families is common. In some cases, when there is enough capital to builds a new house, homes are separated.

"*I mean to say—if the father is living on the bottom floor, if he has two sons, they live on the floor above. That is rare. I mean to say—as you can see the houses are usually one storey here. You live separate from them. What would happen? You stay with your mother-in-law, father-in-law for three, five years. Other times you can move out. They build their own house, and go there." (Imam, 40-year old, urban, Afyon)*

Relations between the public and the health care personnel in the region

The relations between the public and the health care personnel in Afyon are more positive when compared to other provinces. It is observed that the health centres are quite widespread in the region, and although certain problems related to the turnover of personnel are experienced, the services provided are in general sufficient. It is also noted that while there are complaints from both sides occasionally, there are no serious communication problems or conflicts between them.

The public is happy with the health centre services, the attitude of the health care personnel, and especially with the services provided for children.

"I have trust. I have trust. I have trust in the health centre. They are very helpful. Also they have useful for children—I don't lie." (Pregnant woman, 39-year old, rural, Afyon)

According to the observations of one health centre physician, people think that physicians would not have understanding of pregnancy, and as a result, when there is a problem with a pregnant woman, they may get in contact with a midwife.

"…when we say pregnant woman there is such a belief: the doctor doesn't understand pregnancy (Goes silent). *Therefore, if she has a problem with her*

pregnancy, she comes and asks the midwife. She sees the midwife as better informed, with respect to childbirth. The midwife then comes and asks us; that is another issue. If she is not satisfied with us, she goes to the hospital. On the weekends, she definitely doesn't bother with us, but goes directly to the hospital. Now, she can't find an OBGYN [a doctor who specializes in obstetrics and gynaecology]. *Again a general practitioner looks at her, but [for her] it is a 'hospital'* (laughs for a long time)*!" (General practitioner, 36-year old, rural, Afyon)*

There is a problem with regard to the use of medicine in the region. The public is, in the words of a physician, 'adamant' that they get the number allowed for them, namely, four medicines, prescribed on their cards. The fact that every type of medicine can be bought over the counter without a prescription was compared to other countries and criticised by a nurse.

"Definitely, in the times when I was abroad, it was a big problem even to get a pain killer. I mean to say—you can't get a pain killer shot when you go to a pharmacy. But here, both really the organizations and by going to a pharmacy, it's easy both to get hold of drugs, and also our people are adamant. It doesn't stem from our personnel. When our people come to the health centre if our doctor gives one drug that he thinks appropriate, the patient then doesn't get the prescription, and looks for that person who will fill the four items. He is using his right I mean to say. There are many." (General practitioner, 36-year old, rural, Afyon)

A community leader has lost faith in the OBGYN's decisions on caesarean section. He thinks that these decisions are made to earn more money. It is understood that the existence of money in the patient-doctor exchange has damaged the relationship.

"Even if it can be a normal birth they say caesarean and pass. To get knife money! Doesn't admit [to the hospital]. *Doesn't show any attention I mean to say. Now like this, admits* [to the hospital]. *The man admits. Comes to ask how you are. Now our old man used to say like this. I mean to say—he is not asking how I am but asking how my money is. The Ministry of Health also knows this; they also know. When a rich person comes, they get different treatment. When a poor man comes, they get different treatment. Also it is like this. Our doctors first listen to your wallets sound, not your heart. If sound comes from the wallet, the doctor treats the patient nicely. Well let me tell you this also, at university hospitals this is a bit different from other private hospitals." (Imam, 40-year old, semi-urban, Afyon)*

3.13.3 Van

Socio-economic structure

The regions where the study was conducted, namely the regions where there are problems in ANC utilisation, were the peri-urban neighbourhoods of Van city centre, and villages in the rural areas. It is observed that in the 1990s due to security considerations, many villages were vacated. As a result of people migrating to Van city centre, there has been a fast formation of peri-urban neighbourhoods. Nearly half of the urban population live in these areas, which lack infrastructure and basic health conditions. The economic conditions of those who left their villages to live in these peri-urban neighbourhoods have naturally been adversely affected. Those who were involved in animal husbandry and agricultural activities have lost their jobs. It is stated that 70% to 80% of the men in the families who live in these neighbourhoods work as labourers, a small proportion work as civil servants or as workers with social security.

The existence of a group of people involved in the petrol trade (that is, with petrol smuggled across the borders of south-eastern Turkey) is noteworthy. It is observed that the economic conditions of these families in petrol transport and trade is quite good. These families are growing in number. However, it is also said that – similar to the 'powder' (heroin) trade spoken about in private conversations – this trade is illegal.

> *"Ah, there is this—people deliberately make use of their authority and bring things illegally, and sell it here to make a living. There is nothing legal; there is no legal trade. Illegal trade. Eh—when people are hungry they will revert to illegal ways. I mean to say—they will go towards illegal ways. Why is there thievery? Because they are hungry. If they are not hungry, would they steal? This is it." (Mukhtar, 44-year old, male, urban, Van)*

The structure of the society, the fact that relations are determined according to patriarchal arrangements and traditions, affect the status of women and children in the area and determine their utilisation of education and health-seeking behaviour. The geographical characteristics of the area make the provision of infrastructure services (such basic things like roads, electricity, water, sewerage) difficult.

> *"…unemployment is a very clear problem. Economic difficulties, health problems, accessing health are at very serious levels. Education is problematic. These types of families, in general, stop the education of one or two of their kids once they finish primary school. Sewerage problems, environment problems, heating problems. In the winter if they get gas, they can get warm. If they can't, they pass the winter in the cold." (General practitioner, 36-year old, urban, Van)*

Due to poverty other basic needs come to the forefront, and health only becomes a priority if there is a problem.

A significant proportion of pregnant women, even if they possess green cards, state that they cannot access health care services to attend ANC and for childbirth services, as they did not have the money to go to a health care institution or to buy medicine.

> *"I swear, our financial situation—if we had health insurance—I mean to say—for any kind of doctors, it would be super. But as we don't have it, I swear, I mean to say—if we are sick, very sick, we go to a doctor. Because, both medicine, as you know, medicine is very expensive. Also there are controls, tests: everything is with money." (Pregnant woman, 38-year old, 5th pregnancy, no ANC, urban, Van)*

The statement below very clearly summarises the economic structure of the region.

> *"Surely on this topic, I – it is really beyond me – but because I am interested I have my observations on the economic situation of the province. I mean to say, I don't have official information though. There are small scale production areas, but really never at a level to meet the needs of the province—because if it did meet the needs, our cafes wouldn't be so full, or labourers wouldn't be waiting in the labourer market from morning till night... People's hope is for a job. The construction sector is here. God willing, it continues with all its speed so we can benefit too, because, when I observe the family structure, they are families living on very small amounts of money. Families who buy their dietary staples with the money they earn in the summer, consume them through the year. Apart from this, they don't have any extra money to spend. I mean to say—in this extra, there are the child's shoes to his coat. I mean to say—these are also among the extras. I mean to say—a child can wear a pair of shoes for two or three years. Sometimes they are without a coat. They usually spend the winter without a coat. I mean to say—the basic thing is they don't go hungry in the winter; they can feed themselves. If they have flour, rice, bulgur wheat* [cracked wheat; parboiled whole wheat, dried and crushed]*, butter, tea-sugar, that family can easily get by." (General practitioner, 36-year old, male, urban, Van)*

Health insurance

With the procedure for getting a green card and ratification of visas becoming easier, most people without any health insurance could get a green card. While health care personnel report that (although there are some rich people among them), most deserving people obtained green cards—and the percentage of those with health insurance in their area is 90% to 95%, an important proportion of which hold green cards. Few people have health insurance under Bağ-Kur, SSK, and the Pension Fund.

Those without any health insurance are very few. Those who could not get a green card are those who could not fulfil the conditions, those who could not follow the procedure, and those who have assets or cars. On the other hand, those who have no insurance use the health book of others.

"Yes I can go with the health book of the neighbours, I mean to say—everyone does that, and I will do it like that. When my husband comes we will. They care for those. We will also do a civil marriage, I will go with that." (Pregnant woman, 20-year old, first pregnancy, discontinued ANC, urban, Van)

"Green card—mine [my husband] hasn't got it yet. We just did our marriage. Ours will come in one or two weeks." (Pregnant woman, 18-year old, first pregnancy, discontinued ANC, urban, extended family, Van)

Health personnel and community leaders state that people who do not have the right for a green card obtain one, whereas due to bureaucratic obstacles there are some people who could not get the card they deserve.

"The green card ratio: I hope my calculation isn't wrong, but I know it as above 70 percent. High, very high, quite high. Eh—surely, sometimes but problems here too. Those deserving can't get it. In general, you see the propaganda made, 'He who has a Mercedes, gets a green card'. Eh—could be. But the number of these is lower than the ones who deserve it but can't get it. But, for some reason there is a lot of propaganda like, 'Have a Mercedes, here take the green card from his hand'. But according to me there is a lot of people who should get a green card, but couldn't." (General practitioner, 36-year old, male, urban, Van)

"Now, in the green card system whoever applies can get it. This is the truth; I mean to say—every citizen can get it, every citizen who applies if there are no cars registered to the name. There are some who get mistreated in these procedures as well. Either he doesn't know how to do it, or the system requires it? I don't know... Or I can say this, give an example, here we have a two house system, as you know. Two marriages. In the first marriage, women have the children on her name. Everyone uses their own surname. That woman looks single. If she looks single, her father has Bağ-Kur, or is retired or has various salaries—that woman, although married – the wife of someone – can get one because of her family. She looks single and as a result is registered under her father—looks like she has Bağ-Kur. She can't get it. There are these." (Mukhtar, 44-year old, male, urban, Van)

"What are the types of social security people have? Green Card (Others?) There are. There are—with Bağ-Kur, with insurance [In Turkey those who are covered under Social Security Organisation (SSK) call this 'insurance' in short] *but 90% have a green Card. " (Mukhtar, 38-year old, male, rural, primary school graduate, Van)*

Infrastructure services

In the peri-urban areas of Van city centre, where an important part of the population resides, there are serious infrastructure-related problems. In the words of a community leader, Van looks like a 'big village'. In the *gecekondular*, which have no infrastructure, there are many households where fifteen to twenty people reside.

"Almost half of the population live in these houses [gecekondular]. *Very big neighbourhoods were set up. As you know, infrastructure problems are present in the most central places; certainly, in these marginal neighbourhoods there are more problems. Because, I know one thing—I know they have to run the sewer through the streets. I know that sometimes swamps form in the neighbourhoods." (General practitioner, 38-year old, male, urban, Van)*

In the urban areas, the sewerage problem especially is commonly mentioned. Another problem frequently expressed in peri-urban areas is transportation. It is said that transportation facilities linking the city centre to the peri-urban areas is non existent and that people have to walk great distances for their basic needs. Transportation comes as a great problem in the rural areas especially in the winter time. This is evaluated as a circumstance that could negatively affect utilisation of education and health care services.

Socio-cultural characteristics

The very low level of literacy among women has been somewhat alleviated in response to the campaigns initiated in 1995 with the schooling rate among the new generation of women starting to increase. The patriarchal traditional extended family with many children predominates. In the rural and peri-urban areas families with eight to10 children are regarded as normal—with the inclusion of the family elders the households can have up to between 15 and 20 members.

How crowded the traditional extended family can be is seen clearly from an in-depth interview carried out with a pregnant woman.

"-We were four sisters-in-law in that house.
-Did all four of you live in the same house?
-Yes, but I have left now. The other two are in the house.
-Were you the oldest?
-Yes. I was the oldest. One just gave birth. Two are newly pregnant. I had seven, six brothers-in-law, and four sisters-in-law.
-All in the house.
-All in the house. I had mother-in-law but I didn't have father-in-law. He had passed away. When I came he had already passed away. I mean to say—I didn't see my father-in-law. I mean to say—we were all in the house but the old way has changed. Now, first of all how can there be peace inside. See, I left in the end. They remained now." (Pregnant woman, 29-year old, fifth pregnancy, no ANC, urban, Van)

As a natural extension of the feudal structure that is predominant in the area, relations with relatives based on clanship are very common and very strong. However, it is observed that relations with neighbours are limited and that people do not trust each other very much.

Women's status

As a result of the feudal relations and the patriarchal traditional extended family structure, women are second class citizens in the society. It is observed and directly stated that the women interviewed were in general of low educational levels, with limited education rights. Moreover, they have little place in work-life apart from working in the fields in the rural areas, and being a housewife. Economically dependent, with limited social relations, they have little role in decision-making.

During focus group discussions, it is stated by health care personnel that women or girls having heart problems are seen as an important problem by families. One of the nurses stated that convulsions among women are common, and women faint or have tachycardia. However, in tests no abnormal clinical evidence was found. According to the health care personnel this is a result of the pressure that women are subject to. It is not very usual for women to leave the house alone even for health services.

> *"Yes, yes, we don't go without permission* (shakes head). *I mean to say—people would ask, why are you going where are you going why didn't you sit in the house, they will say. Therefore we get permission then go. ... Eh—for my own good he says don't set out on your own. There are bad people. People we don't know. Round here is not very good* (laughs). *Gossips." (Pregnant woman, 20-year old, first pregnancy, no ANC, urban, Van)*

Health care personnel and community leaders believe that there is inequality in woman-man relations; the illiterate woman who cannot properly speak Turkish has no freedom of speech and that all these factors impede women's health care service utilisation.

> *"Eh—maybe they are in the second plan. I mean to say—as I said, if a woman got sick, they wouldn't immediately bring her. They will only bring her when she becomes too sick to do her daily work. Then will they bring her. The woman doesn't know Turkish; the man is a little better. Literacy is also low among men. Knowledge of Turkish is not that good either. This is more common in women. Eh—at home, what a man says goes; whatever he says happens." (General practitioner, 27-year old, male, urban, Van)*

Religion

According to statements made by pregnant women, it is understood that religion affects family planning and abortion.

There were also participants that said that if the ANC service provider were a man, they will have sinned—and thus they prefer to give birth at home. Men who come to the health centre also warn nurses not to touch them when taking their blood pressure or giving injections.

Health care personnel state that religion influenced the method of family planning, and why a certain methods was preferred over others, while some were not used at all.

"…we are scared of such things, I swear. We can't do it. If we use those methods we would get sick, get cancer, and get sick. Those drugs make you feel bad. All methods give discomfort." (Mother-in-law, 50-year old, extended family, Süphan, Van)

"Really I never had the intention, but God's work you see. I got pregnant" (Pregnant woman, 22-year old, third pregnancy, discontinued ANC, urban. Van)

"I swear I didn't want it. If you want the truth we were using protection. It happened without our wanting. We couldn't do anything then. I mean to say—they said drugs and such. Neighbours said it. Enough eat they said. Take drugs, you will miscarry. I said no. I can't take that sin upon myself. I didn't take [drugs]. You can take it. No, I won't take it, I said. Where am I going to give birth? It happened. God's will, you see? I will give birth to this as well then. We'll see." (Pregnant woman, 29-year old, 5th pregnancy, no ANC, urban, Van)

Relations between the public and the health care personnel in the region

As can be understood from the statements of the people interviewed in the region, there are serious communication problems between the health care personnel and the public. Health care personnel believe that not having sufficient working materials, equipment, and tools not only hinders their providing quality services, but also negatively affects the communication they have with people. Since many situations evaluated as risky by health care personnel are not perceived as such by the people, there can be problems in directing people for further tests and treatments. It is understood that these types of problems, stemming as they do from differences in perception, can only be resolved through good communication.

While striving to perform their duty, deficient physical conditions and negative work conditions, coupled with the distrust of the people, damage the service provider-service utiliser relationship.

"Now, there is already a psychological factor. I actually come here and have dialogues with a patient when I really shouldn't. I try to be gentle still. I never argue with a patient. If I ever had an argument, it was with very few; but if it happened, I was right, right to the end. If I am unjust to my personnel, having an unsuitable dialogue with my personnel must have taken place. In this way, when these types of problems occur, you get psychologically worn out. I mean to say—I haven't entered my second year but I feel as if I have been a doctor for 20 years... I have stayed on duty for 24 hours here every other day for three months." (General practitioner, 27-year old, male, urban, Van)

"...if there are a sufficient number of personnel, sufficient materials, the people who come there would leave happy. And also when we go on call we would have more time for people. There would be better relations dialogues with people. Once the dialogue with the public is won, that's it then. The important thing is trust." (Midwife, 29-year old, urban, Van)

"...There is such a thing—eh—for example, when patients come continuously—eh—we can have problems. I mean to say—they can have complaints. On this issue, I would like to have the Health Director a bit more on our side... Let me give an example. We can't send the patients to maternity hospital, because at the maternity hospital—eh—midwives, I mean to say—they are a bit harsh on the patients there. They can be a lot harsher; therefore we can't send the patients. For example, a problematic birth—we don't want to have the first delivery here, because—eh—she hasn't come for ANC, for check-ups, doesn't have a follow-up. We don't know how that first birth is going to be. Eh—that's why perhaps—I don't want to use medical terms—but childbirth would be very problematic. Therefore, for the first delivery, we usually send [patients] to Van, but they don't want to give birth in Van. They insist on here." (General practitioner, 27-year old, male, rural, Van)

Health care personnel and community leaders state that when there is a proper approach and sufficient services, when time is made, the behaviour and attitude of service utilisers change in a positive sense, and that they want to utilise services.

"...to the people in the villages if you like... be more constructive. What I have observed is that there seems to be positive developments. But then what happens? I don't know. Because I don't trust the people here, they smile at your face; you never know what they will do behind your back." (Health personnel, focus group, Van)

Pregnant women who had positive experiences with regards service utilisation from health institutions state their faith in the knowledge and skills of health personnel. On the other hand, those who were mistreated at health care institutions, or had trouble accessing health care services, and think that they did not receive sufficient health care services from public institutions have underlined the measures necessary for them to receive better services.

"Where we are there is a health centre. I mean to say—they are very good; I mean to say—good. If you went day or night, they would never say a bad word." (Pregnant woman, 18-year old, first pregnancy, discontinued ANC, semi-urban, Van)

"For example—according to me, here, for this village, establish a nice hospital for us, establish a birth section. For example—when we have an emergency patient, maybe I can't find a car, isn't it? It should be such that, I don't need Van. I could go here; they give me attention, not belittle people—looking from afar as if there is a savage in front of them, or a man-eater. I mean to say—mostly, when I go to the hospital, some ladies from the village—okay so they are dirty, whatever—who is she, isn't it? You look at the woman as she is dirty, as she is dishevelled, she can't speak, and they don't look at her face really. I think this shouldn't be. At the end of the day, she is a human being too, isn't it?" (Relative, 37-year old, housewife, semi-urban, Van)

The fact that health personnel are not allowed in the houses during immunization campaigns, women and children are hidden from them, complained about when there is

an adverse affect or an unwanted situation, or when they cannot deliver the services required—and people openly admitting that they do not trust health care personnel negatively affects the personnel. The news and gossip circulated make people sensitive about becoming infertile (for example, as a result of the tetanus vaccination); in such a manner does the most groundless gossip shape health care service utilisation behaviour. Health care personnel think that people see the government as being against them and that their relations with potential service-utilisers are broken.

> *"…I think this, since I came. Therefore, the people and government live apart from each other... definitely apart. This government—how can I say—this kind of nationalism can't be. What can I say? There is a gap I mean to say—I feel it. (Other participants: yes us too) they are apart from each other." (Health personnel, focus group, Van)*

It is understood that if trust is established on both sides better communication can be established and more effective services can be provided.

> *"…I mean to say—when you guide them these people here hang on to life; they are attached, these people. When they realise the information will be beneficial for them. One or two years ago, a health care personnel member came—a doctor. I mean to say—we made announcements to the students. When we were expecting 50 people, 200 to 300 women came, to be informed. Well I don't know the content, what he did. I mean to say—when you offer support there is no [negative] reaction." (Teacher, 41-year old, male, Süphan, Van)*

The existence of public institutions, having sufficient personnel, health institutions, and infrastructure shapes the relationship between the state and the people, since it is an indicator of the importance given to the area. The lack of these institutions and services causes mistrust of the state.

Community leaders and heath personnel believe that in order to assuage conflicting attitudes and faulty communication everyone should make an effort in joint work towards education and economic development.

> *"…at the provincial level do something together—for example education, economic development. If this type of joint work is carried out there will be no problems, now there are problems in every area – there are social problems." (Health personnel, focus group, Van)*

CASE 1

A CASE WHERE MULTIPLE FINDINGS CONVERGE

The story of this 40-year old pregnant woman (a primary school graduate, who had given birth seven times, had had one miscarriage, and was and living in a mountain village of Adana) is stereotypical since most of the research findings converge within it. This woman, whose husband does not have a regular job, who has given birth in all her pregnancies (she does not regard her miscarriage as a pregnancy), has never had any ANC apart from a tetanus vaccination, upon the insistence of the midwife, during her last pregnancy. She provides an index of mistaken beliefs regarding risky pregnancy, giving birth alone at home, tetanus vaccinations—as well as being embarrassed/ashamed to talk about pregnancy.

HAD NINE PREGNANCIES; NEVER ATTENDED ANTENATAL CARE

The woman, who is in her ninhth pregnancy, does not regard her miscarriage as a pregnancy. She has seven living children. Only in her last pregnancy, she went once to a health centre, upon the insistence of a midwife she met at a wedding, and had a tetanus vaccination.

"*- Your eighth pregnancy. Well did you go to a doctor during your previous pregnancies?*

-I didn't.

- Didn't you go in any one of them?

- I never ever went. They were all born at home. All happened at home.

- Well did you go during this pregnancy?

-I didn't.

-You didn't?

-I went to the health centre and had a shot.

-What shot do you know?

-Tetanus."

HAS MISTAKEN BELIEF REGARDING TETANUS VACCINATION

"-…did you know about this tetanus vaccination during your previous pregnancies?

-Yes, yes, but I didn't have it done.

-… you didn't get it. You didn't know why it was done, did you though?

-I didn't know. Hereabouts they say the child develops because of it... I was frightened of it—I mean to say.

-How I mean to say? I don't understand.

-The child develops—I mean to say—from the shot.

-How I mean to say does the child get sick, what happens in the development?

-Nah, nah...birth becomes difficult—I mean to say."

PERCEIVES PREGNANCY AS A "BURDEN"

The ninth pregnancy has become a burden for the woman.

"-Yes, is pregnancy a normal thing according to you?

-Not normal but here.

-What is it then? How do you see pregnancy? How is pregnancy according to

you—how do you see it?

-A burden, you see. I see it as a burden. You go and come with a burden. You carry a burden."

In actual fact her last pregnancy was not wanted either. She thought that, as she was getting older, she would not get pregnant. The two before the present one were also unwanted pregnancies.

EMBARRASSED/ASHAMED TO TALK ABOUT PREGNANCY

Her eldest daughter is seventeen-year old. She is also married and has given birth to one child. In other words, her last child will be younger then her grand child.

"-Well then, did you speak to her (your daughter) ever? Did she tell you things about her pregnancy?

-No, we never spoke here. They are embarrassed like that. They don't speak—I mean to say.

-Women living here—are they always ashamed of their pregnancy?

-They are ashamed. With their daughters whatnot, they don't talk about such things. There are those who speak, but not everyone speaks I mean to say."

The woman herself is ashamed to talk about her pregnancy to her sisters as well, but she can talk to her neighbours and peers.

"-Well, do you talk to them [neighbours] about your pregnancy?

-I talk to them.

-You speak with them but are you ashamed with your siblings?

-We are ashamed (laughing)*."*

GAVE BIRTH TO ALL HER CHILDREN AT HOME ALONE

She has given birth to all her children by herself.

"-Did you give birth by yourself?

-I do it by myself.

-God preserve us! Okay...

-The umbilical cord, whatever, I do it. I cut it, I wash it...

-What do you cut the umbilical cord with?

-I cut it with a razor blade.

-You cut it with a razor blade okay; when you are cutting with a razor blade do you do anything to the razor blade.

-We smear cologne on it whatnot. Spirit, cologne: we smear like this and cut."

She wants to give birth at home this time as well. She is frightened of doctors. She is embarrassed to have anyone with her during childbirth.

"- Okay, where do you want to give birth?

-I want to do it at home.

-Why?

-Well I am scared of doctors (laughing).

-But you say 'well my pregnancy' you say. Well you say you are getting on a bit, why don't you go?

-They say for those who go, it is difficult as well; I am scared of that, I want to be at home.

-Do you feel ill at ease? I mean to say—what are you anxious about that you don't want to do it at a hospital or health centre?

-Me, well, when I do it alone—I am embarrassed I mean to say—if someone brought a woman to me I can't give birth with her. I can't do anything (laughing)*."*

CASE 2

WOMEN'S STATUS

Living in Adana city centre, this 30-year old pregnant housewife, who left education in the last year of primary school, who is in her second marriage and fifth pregnancy, and who has never attended antenatal care is an important example with regards the status of women. She has given birth to all her children at home, and has never utilised health care services.

AGE: 30 NUMBER OF MARRIAGES: 2 NUMBER OF PREGNANCIES: 5

"-How many pregnancies have you had?
-This is the fifth, this is the fifth.
-Okay, are your children alive?
-They are alive, but we got divorced. This is my second marriage.
-Okay, with your previous children did you receive antenatal care? I mean to say—did you go to a hospital? Did you show them?
-No! No! They were born at home, they were normal births."

CRUEL HUSBAND: BEATS HER UP EVEN DURING PREGNANCY

She describes her husband as 'cruel' and states that he even beats her up during pregnancy. Since they are poor, although she did not want it, she has gotten pregnant on the insistence of her husband.

"-…okay, does your husband help you when he comes from work?
-He doesn't, he is cruel; no he doesn't. Only the other day I got beaten up by my husband. Ah, how in to it he is, he beats me up. I swear he never thinks something might happen to the child. I swear...
-Okay, does you husband want this child?
-Yeah… I insisted, I said no, let's not have it now. I am—I am not sure of myself. With this poverty why bring a child into the world? …Our conditions are not suitable. Let's wait for a while, until we get ourselves together, then we can. He said, 'No, if there is no child, you are going to go to your father's house.' That's what he said. Then it happened."

The woman wants a daughter in the hope that she might help her.

"- Okay, why do you want a girl?
-Girls stand by their mother; boys stand by their father. I want a girl. Did I get up and lie? God is above me. I like girls better. Boys—what can I say? Boys annoy me. Shall I lie? God is above me. He is an offspring. He is also an offspring, but how shall I say?"

HER HUSBAND DOES NOT ALLOW HER TO GO ANYWHERE

The woman complains that her husband is very jealous and ill-tempered and thus does not allow her to go anywhere alone.

"-Okay, when you are pregnant you don't go to a doctor; you don't visit your

neighbours.

-He doesn't let me; my husband never lets me... 'I am going to get some air' I say. He says, 'If you want to get air, open the door, and get air' he says. Don't look [Do not be fooled], *I went to my friend, because he was less irritable today, or else my husband is cruel, he doesn't let me, he doesn't let me. To the toilet, I am sorry, I am going to go to the toilet sometimes; he comes, looks everywhere says, 'Where is this going?' I ran away so I swear his ways are bad."*

She states that she could only go once to a health care organisation to have a pregnancy test and even at that time with her sister-in-law—and her husband was upset about this.

"-Okay, is the health centre near do you know?

-I don't know that either, I swear; if I said I did I would be lying. I don't know. My sister-in-law at that time (I had just got pregnant)—I don't know—I am pregnant. My sister-in-law took me to the hospital, but I don't know which hospital, the health centre—I mean to say. I don't know. I came home. My sister-in-law said to my husband, 'She is pregnant. We had it tested. She is two months pregnant.' My husband got angry, 'Why are you going to the hospital? Why are you going without my permission?' It's like this. Look, he said a thousand things to his sister. 'I will destroy,' he said. 'You haven't got a taste of my punch yet.' She is his eldest sister. Then he looked and said things to her—I mean to say. I said, 'Sister if it wasn't for you, he would have destroyed me."

SHE HAD HER FIRST MARRIAGE AT ELEVEN

The woman, who got married at the age of eleven for the first time due to pressure from her family, said that she immediately got pregnant and that her husband changed after the birth of their first child and that their problems increased.

"-… first, they came and asked [for my hand in marriage]. I said, 'Mother, I don't want to, I am young yet (11 years old). *I am a child, I...I haven't had my period yet. I don't want it' I said. Then they called my mother out, and persuaded her, talked to her. When I came home, they had given me. At that time, I was working at a hair dresser; I mean to say—manicure, pedicure that type of thing. I was working, then when I came home my mother said, 'We gave you'. I said, 'For goodness' sake! Who did you give me to? I am not a person to be given yet, I am, like, a child. Why did you give me?' I had an argument then. I have a brother. You haven't seen him, he is abroad now. He hit me, saying, "You are going to take* [him], *they gave and you are going to take!' Apparently my family is doing this for money, I didn't know. We got married and went. We had to. He is your husband they said. You are going to take him. Nothing to do. I took. We went home. At home. I can't lie—God is above me. There is everything. He didn't drink then—not bad, devoted to his home. This man suddenly changed. A child came home, one child. Suddenly he changed. He went, someone else came."*

-Did he change after you had the baby? How long after you got married did you have the child?

-My child—eh—immediately, one month, one month went—by the second month I was pregnant."

OBSERVER'S NOTES

To get to the city centre from the house you have to use one bus. To go home you have to get off on the main street, and walk a very short distance. It is a house that is behind the houses on the main street, and you have to walk on a mud 'street' to get to the house, which is not painted and is one storey. The size could be only one room, but there is one bedroom, a kitchen, a bathroom and the entrance is made up like a lounge. The interview was conducted. In the lounge, there is an old light brown console across from the entrance door in the lounge. Their television is on this console. Right by the console, there is an armchair with white covers. By the entrance door, there is a horse saddle on the floor. The room is painted light pink; the paint is worn. Imagine a very poor house. The ceiling of the bedroom is covered with zinc sheets and wood. The woman has a head scarf, yellow t-shirt, and long skirt with large pink roses on it.

I felt that because the woman had many problems, she wasn't paying much attention to the audio recorder. During the interview she said that all the furniture in the house was given by the neighbours. There are two people living in the house. Since there is a mosque nearby, the *ezan* [the call to prayer] echoed through the house, and we had to stop the interview for five minutes. During this period the woman lit a cigarette. She offered us one too. At the same time she asked us whether we would like something to drink. As they were a poor family, we politely declined without offending her. She did not insist, and said that they did not have anything to offer. Until this point the interview was going very well, the interviewer kept everything under control. But since the woman had many problems she continually brought the topic to her problems. The interviewer had to bring the interview back on track all the time. Although we had told her the objective of the interview, she kept on asking for assistance. When the interviewer asked the question about green cards the woman suddenly got up and brought her health card from her bedroom and asked us about the visa so we had to check it. When the interview was over she wanted to hug us and we did not refuse her, and we hugged.

4. LESSONS LEARNED AND RECOMMENDATIONS

4.1 PERCEPTIONS RELATED TO PREGNANCY AND CHILDBIRTH

Following are the most significant results derived from our study findings which can be concluded as the determinants of helath seeking behaviour models of our study group:

- Both the pregnant women and their relatives who have participated in the study perceive pregnancy as a natural, normal process that brings happiness in general. Nausea, pain and stomach complaints are accepted as normal during pregnancy and thus not taken seriously unless they are severe. Thus such complaints do not facilitate the utilization of health care institutions.

-It has been observed that concern and anxiety that is observed in some pregnant women stems more from uncertainty about what will happen during birth than to the characteristics of the pregnancy process. Childbirth, and how the baby will be after birth, is important for women and their relatives and all concern is focused on these aspects.

- The feeling of 'shame/embarrassment' is present in almost all women interviewed and this is expressed universally with a smile. It is understood that this feeling negatively affects obtaining of information and accessing services.

-Pregnant women who have experienced several pregnancies and have become pregnant again against their wishes tend to perceive pregnancy as a "burden".

-The fact that no traditional practices related to ANC (for example it has been observed that when there is haemorrhage or threat of miscarriage the first thing that comes to mind is health care institutions rather than traditional practices) were seen could be interpreted as that the people are not seriously looking for an alternative service in this regard and actually the interviews support this view. The existing traditional practices were more related to infertility and the health of the newborn.

4.1.1 Risk perceptions related to pregnancy

-The main conditions that are perceived as risk during pregnancy are the immobility of the unborn offspring, haemorrhages and miscarriage threats. Women, do not revert to health care services for such complaints as nausea and pain unless they are

severe, however, lack of movement in the unborn offspring or haemorrhage are considered sufficient reason to have recourse to a health care institution.

-Miscarriages, still birth, babies born with deformities, or important illnesses experienced by people around pregnant women, increase the risk perceptions of pregnant women which motivates them to attend ANC.

4.1.2 Benefit perception related to antenatal care

-Although majority of pregnant women and their relatives state that ANC attendance is a "good thing", they cannot give a satisfactory explanation of why it is good. The benefits of services stated are limited to "finding out about the health of the unborn offspring".

-There is a wide conception among all interviewed that ultrasound would be beneficial as ANC services. Some of the health personnel also support this view, and direct pregnant women who apply to primary health care institutions to secondary health care institutions for this purpose. It is found that the service understanding of primary health care personnel with regards ANC services is limited to tetanus vaccinations.

4.2 HEALTH SEEKING BEHAVIOUR OF PREGNANT WOMEN WHO HAVE BEEN INTERVIEWED:

It is possible to group the women interviewed in 4 categories with regards their Health Seeking Behaviour:

1. **Women who have never attended ANC although their fertility is encouraged and they are under risk:**

These are women who live in the rural areas of the three provinces and the peri-urban areas of Adana and Van, have not graduated from school, uneducated, generally living in extended families and totally dependent on their mothers-in-law and husbands. Because of their limited social interactions they do not have the opportunity of getting information from their peers. Sometimes they are unaware of the existence of a health centre nearby or even if they are they do not go there. The way to reach them might be through the provision of services at home, mobile services, messages directed at husbands and mothers-in-law and education.

2. **Women who mostly live in the peri-urban areas and temporary workers areas in Adana and Van and who have problems in communicating with the health care institutions:**

Apart from women not being able to access services due to their education levels, poverty and language they speak as well as their accent, they

also have concerns that if they apply for services they will be ill treated, belittled and even harmed (infertility by vaccination etc). It has been observed that in these regions there are prejudices based on region and communication problems between women who are from families that have come with migration and service providers.

3. **Women who have previously applied to a health care institution for ANC or childbirth, however due to such negative experiences as inattentiveness and ill treatment at the health care institution have decided not to utilise services.**

These are women residing in all three provinces in both rural and urban areas, have knowledge about procedures, have positive health seeking behaviour but have had negative experiences in the past. They are prejudiced against health personnel and health care institutions due to their negative experiences. It is understood that they are partly right in having these prejudices. Although they have to get permission from their husbands and family elders, it is not right to say that they are under pressure. The way to reach these women is through the rehabilitation of services provided by primary health care institutions and better communication.

4. **Women who mostly reside in urban areas and who do not feel the necessity of attending ANC unless there are serious health problems but who definitely think of giving birth at a hospital and who have previously received services.**

These are women who mostly reside in the urban areas of the three provinces. They are better educated and have better social and economic conditions. They mostly relate ANC attendance to finding out about the health and gender of the unborn offspring and definitely want the delivery to take place at a hospital. Their preference for place of service utilization is hospitals and if their economic conditions allow private practitioners. However, unless they have serious health problems they do not feel the necessity to attend ANC, and due to their negative experiences unless they are compelled to do so they do not go to public health care institutions.

4.3 BARRIERS IN ANC AND CHILDBIRTH SERVICE UTILIZATION IN PREGNANCY:

-According to the pregnant women and their relatives that have been interviewed, there are numerous and serious obstacles in accessing health care services. Most commonly expressed obstacle is “lack of interest and negative behaviour of health personnel”. Lack of interest, negligence, bad practices and communication mistakes at health care institutions come across as one of the major reasons for the underutilization of services provided. While inattentiveness and negative behaviours of health personnel are more visible in public health care institutions, bad practices (abortion in the sixth month of pregnancy, frequent CS, etc.) are frequently observed at private institutions.

-Another wide spread obstacle observed in the study is the lack of health insurance and economic problems. These usually come out together with the low education level of the women and problems related with gender and results in the

women not attending ANC and usually giving birth at home by themselves. Absence of civil marriage, indirectly affects the health insurance of the women. This condition which is expressed by the health personnel in some regions has not been encountered in the group interviewed under this study.

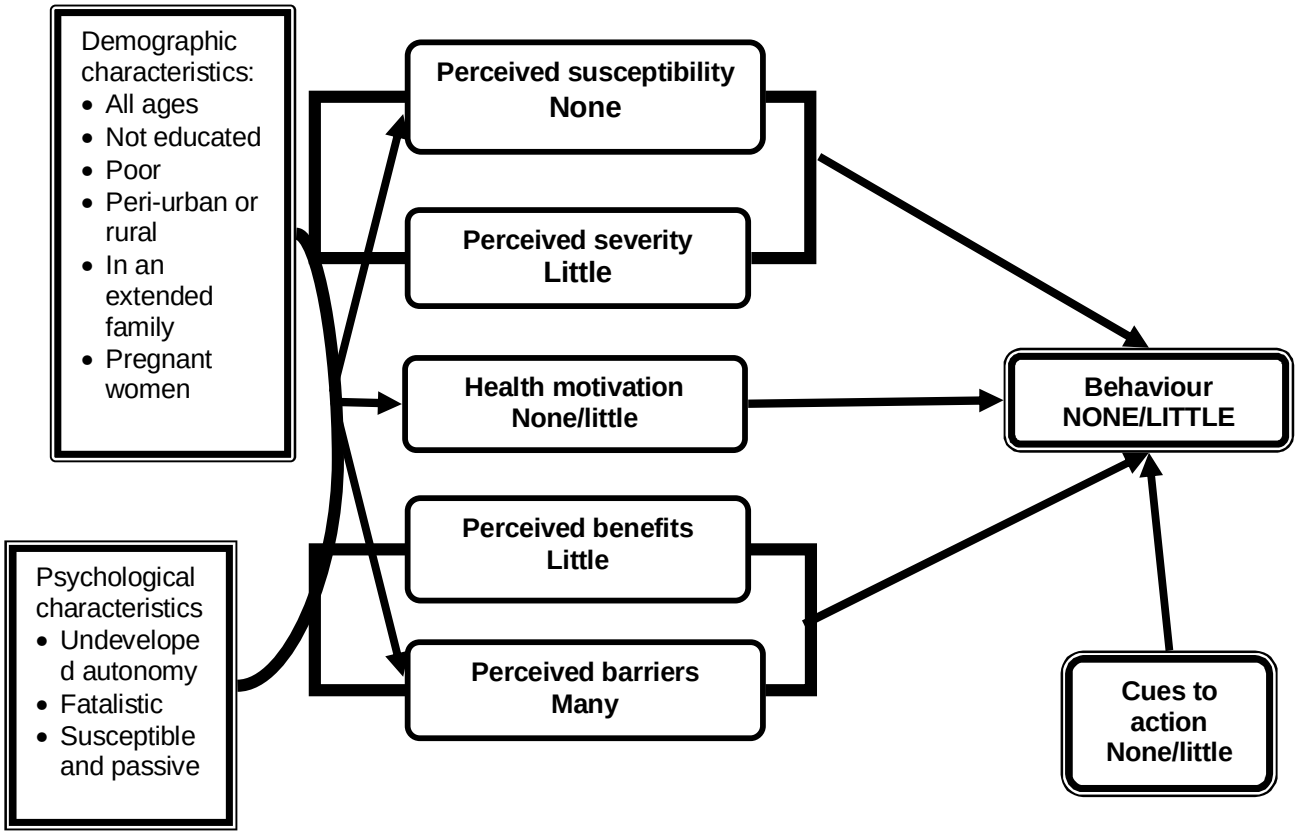
-For women who live in extended families, dependent on the permission of their husbands and mothers-in-law and who cannot easily enter social life, and who also are embarrassed/ashamed to talk about their pregnancy, it is not easy to get information regarding the benefits of ANC attendance from their peers or other information sources and the information remains limited to what they can learn from their mothers-in-law and close relatives. It is not possible for them to access any written information as their education levels are low and thus cannot read.

-Especially in the peri-urban areas of Adana and Van, prejudices and concern stemming partly from mistrust in the services provided, forms an important barrier in front of services. Some women in these areas believe that proper services will not be provided for them and some even think that tetanus vaccinations carry the purpose of castration. Service providers on the other hand, express that in these regions the fertility of women is encouraged for ideological purposes and that the women view the public health personnel as a kind of enemy during service provision. It is noted that this prejudice and misunderstanding that has developed reciprocally has in time turned into a meaningless vicious circle.

- It is understood that religious belief apart from “fatalism” and “preference in the gender of the health personnel” does not have a prohibitory or obstructive effect on service utilization.

- ANC is never or inadequately provided in some primary health care institutions due to the factors, such as, insufficient staff, high turnover in the trained personnel and organizational and administrative problems These factors are also concluded as barriers to ANC services.

Figure 2: Health behaviour model of pregnant women covered under the study[1]



[1] Adapted from "Sheeran P, Abraham C. (1995) The Health Belief Model, in Predicting Health Behaviour (Conner, M. & Norman, P. eds.). Buckingham: Open University Press."

4.4 SUFFICIENCY AND SUITABILITY OF ANC SERVICES

Another topic under investigation during this study was the sufficiency and suitability of the ANC services provided by the local primary health care facilities. The findings from the interviews with local health personnel, community leaders, family members of the pregnant women and pregnant women themselves can be summarized as following:

-It can be ascertained from the statements made by pregnant women, their relatives, community leaders and health personnel that ANC and childbirth services offered by primary health care institutions are inadequate and problematic. It is observed that, most of the problems were associated with poor working conditions in primary health care institutions.

-In some areas the health centres have shortages with regards transportation facilities, physical infrastructure, supplies and equipment. Some do not have trained and sufficient number of personnel or the existing ones mostly work in curative services. The lack of in-service training and problems stemming from management are other negative factors. In short, ANC and birth services are either not provided at all or are limited to keeping records and administration of tetanus vaccinations.

-It is understood that public primary health care institutions are in need of serious reorganization and a different management approach with regards ANC and childbirth services.

4.5 RESULTS OF STRATEGY-POLICY DEVELOPMENT FORUM AND RECOMMENDATIONS

The results of the Health Seeking Behaviour Study were presented to a forum of experts and academic institution representatives for discussion in Ankara. This forum served as a platform to determine the strategies, policies and interventions needed to increase the utilization of ANC and birth services. After giving information regarding the objectives, management and results of the study, the participants were divided into three groups according to their fields of specialization and experiences. The groups were as follows:

-Health Policy Group
-Social Policy and Communication Group
-Health Care Organization and Management Group

All groups were asked perform a Strengths/Weakness and Opportunities/Threats (SWOT) analysis of women who have never attended ANC or who have discontinued ANC attendance and the primary health care institutions responsible for providing these services to these women in light of the results of the study and formulate recommendations. The recommendations formulated by each group were presented by the speaker of each group, discussed and the points agreed on were determined. When the recommendations are evaluated together, it can be concluded that three main strategies are required.

4.5.1 Increasing the awareness of women and families regarding service needs

For women:

- The existing positive perceptions that "pregnancy is a normal and natural process" should be supported as it is the strength of the group in the study.

- Communication programmes should be developed to extend the existing risk perceptions related to childbirth to include the lacking risk perception related to pregnancy.

- The health problems which were perceived as "important" and "requiring attendance to health care institutions" by pregnant women and their peers are found to be quite limited. In general, pregnant women seek health care services when they have severe vaginal bleeding and/or when they cannot feel the movements of the unborn offspring.. Keeping this in mind, the conditions that require health care services could be redefined for pregnant women. Awareness could be created on other conditions that pregnant women do not place importance on but that require medical care such as swelling of the feet, gaining too much weight and double vision. Campaigns could be used for this purpose.

- Pregnancy is perceived as a natural process however, childbirth is defined as "dangerous" and thus is a cause for concern. In this context, it is necessary to focus on the point that with good quality care and consultation, pregnancy

which is a “natural” process could end in a safe manner. It should be highlighted that with good quality care, childbirth could take place naturally and that with sufficient ANC attendance childbirth would be safe.

- Every health facility that provides pregnancy tests should be considered as an opportunity centre for awareness creation on the importance of ANC and for individual consultation services.

- The existing expectation regarding ultrasound examination could be seen as an entry point to ANC and be evaluated as an opportunity.

- Social mobilization campaigns highlighting the importance of ANC should be carried out.

For families:

- Mothers-in-law are the key people in the decision on attending ANC; it is possible for them to facilitate the ANC attendance of pregnant women as well as be an obstacle in this regard. Similar to the situation experienced with the role of religious leaders in family planning activities, mothers-in-law could be taken as a target group and attitudes supporting service utilization could be developed.

- Husbands are another important decision group in ANC attendance. Their role and responsibility in the health of the unborn offspring should be highlighted, and they should be assisted in developing attitudes that support ANC attendance.

- Service providers should aim at getting the husbands to accompany the women who attend ANC.

- Education and awareness creation geared to the target groups is necessary. However, it is important to get the support of experts from the fields of education, social sciences and behavioural sciences in reaching the target groups.

- Social mobilization and advertising campaigns highlighting the importance of ANC should be carried out.

4.5.2 Increasing access to health care services

- The existing health care system is sufficient to meet the needs however it is not run properly. The approach of strengthening primary health care services should be continued.

- Antenatal care and childbirth services should be provided free of charge.

- Keeping in mind that in addition to the “green card” practice which has been established for people without health insurance and with bad economic

conditions, these people could also make use of the Social Solidarity Fund, it should be ensured that the health care personnel plays a guiding role in these respects.

- Especially in the poor peri-urban areas and rural areas, pregnant women and their relatives prefer the childbirth to take place at home. In this context, regulations should be made to allow for childbirths to take place at home but under the supervision of midwives/nurses.

- Keeping in mind the fact that especially illiterate and poor pregnant women cannot use ANC services even if they are located close to their home, home care services should be organised in high risk regions.

- The facilities of NGOs and support of local media should be used to increase utilization of existing health care services.

- Ways of making use of traditional birth attendants [Turkish: ebe-nine] in areas where services are insufficient should be considered.

4.5.3 Elevating the quality of health care services

- The main complaint expressed regarding health care institutions is "inattentiveness" and the most frequent expectation expressed is "attention" and "geniality". The fact that health care personnel cannot establish effective communication with the members of the society has a negative effect on the demand for ANC. Therefore, the communication skills of the health care personnel should be strengthened through in-service training.

- It is necessary to inform the health care personnel and the members of the society with regards reproductive and sexual rights. The units that have been foreseen and are present in many health care institutions for "patients' rights" should be made operational and utilization by the public should be ensured. In addition, health personnel should be provided training on ethical principles and in order to overcome the obstacle of "embarrassment/shame" in women and privacy during services should be respected.

- Management skills of health care managers at every level should be increased through training, total quality management should be wide spread to all health care institutions, and the service network should be strengthened by establishing an effective communication network between primary and secondary level health care institutions.

- Trained personnel should be assigned to work in accordance with their training and should be supported. Unless mandatory personnel change should not be made and the turnover rate for the personnel performing these services should be kept to a minimum.

- An effective health information system should be established to allow the information flow between the institutions which give ANC and childbirth.services.

- In order to increase the quality of clinical services the use of the manuals prepared in the previous years should be ensured and work flow charts should be prepared to ease the understandibility of these manuals.

- The supplies and equipment needed by primary health care institutions should be provided, their technical facilities should be supported and the proper use of the existing technology should be ensured.

- It is observed that performance applications negatively affect both immunization and antenatal care services. The performance criteria should be revised to support these types of services.

- The legislation and regulations regarding the “Socialisation of Health Services” should be taken into account and its holistic execution should be ensured.

- Advantage should be taken of the fact that antenatal care and childbirth services have been a priority service of all past and present governments and the necessary steps should be taken.

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ANNEXES

Annex 1

Findings from TDHS-2003 and Statistics of MoH

FINDINGS FROM TDHS-2003 AND STATISTICS OF MINISTRY OF HEALTH

Findings from TDHS-2003 data

In this section, use of antenatal care services is examined by using 2003 Turkish Demographic and Health Survey (TDHS-2003) findings. It should be noted that the information about the antenatal care (ANC) is based on the last live birth of each woman in last 5 years preceding the survey. The reason is that, as being the most recent birth, the ANC information derived from the last birth is expected to provide the most accurate and recent knowledge about the use of the ANC services, which enables better description for the current situation of the issue. Using the information of the last birth also allows producing frequencies, in which women are the units of analysis. Otherwise, women, who had multiple births in last five years preceding the survey date, would be over-represented and the statistical distributions would be misleading.

Table 1 displays the preferences of women for ANC services or their last birth in the last 5 years prior to the survey date. In total, 18.6 % of women did not receive any ANC during their last pregnancies. Among the ones that had at least one ANC, 75.4 % received the service from the doctor, 5.5 % from the nurse, and 0.2 % from traditional midwife or other persons that were not health personnel.

Urban-rural and regional differences are obvious both in having ANC and ANC from doctor. In rural residences of Turkey, 34.2 % of women did not receive any ANC during the pregnancies of their last births. This proportion decreases to 11.6 % in the urban. 83.5 % of urban women had at least one doctor visit, which is 57.7 % among rural women. The West region has the lowest proportion of no ANC (8.5 %) and the highest proportion of doctor visits for ANC (85.8 %). The South, Central and North regions of the country have similar values for no ANC and doctor visits.

The East region has the highest value of having no ANC in last births in the last 5 years preceding the survey with the proportion of 38.8 % and the lowest doctor visits with 57 % in the total last births. Besides these regional differences, there are also significant gaps within the same regions. In West Turkey, Aegean region has the highest no ANC level with 12.2 %, which is 4 % higher than other western regions in average. Moreover, in Central region, there is a 6 % difference of having no ANC for last births in the last 5 years between West Anatolia (13.7 %) and Central Anatolia (19.6 %).

The most remarkable intra-regional difference for having no ANC are observed in the East: although the proportion of women that had no ANC for their last births in Southeast Anatolia is 35 %, this value is still about 8 % lower than Northeast Anatolia (43.0 %) and Central East Anatolia (43.7 %). Furthermore, doctor visits for the ANC in Southeast Anatolia (62.4 %) is more than 10 % higher when compared with the other two eastern regions of Turkey.

Table 2 presents the distribution of ANC visits for the last birth of woman in the last 5 years preceding the survey according to the type of residence, 5 regions and NUTS1 regions. The sufficiency of ANC is determined by the timing of first ANC

visit, total number of ANC visits throughout the pregnancy and the person that gives the ANC service. In order to be classified to have a sufficient ANC, pregnant woman should have her first ANC visit in the first 3 months of her pregnancy, she should get the service from a health personnel (i.e. doctor and/or nurse/midwife) and she should have at least 4 ANC visits during her pregnancy. If any one of them is not achieved, it is categorized as insufficient ANC.

Table 1: Place of ANC for last births of women in last 5 years preceding the survey by place and region of residence, TDHS 2003

Place of Residence	Doctor	Nurse/ midwife	Traditional midwife/ other	No ANC	No answer	Total	n
Type of Residence							
Urban	83.5	4.6	0.2	11.6	0.2	100.0	2,172
Rural	57.7	7.6	0.3	34.2	0.3	100.0	992
5 Regions							
West	85.8	5.4	0.1	8.5	0.2	100.0	1,119
South	79.6	5.3	0.1	14.6	0.4	100.0	426
Central	75.4	7.3	0.3	16.6	0.5	100.0	673
North	78.4	6.2	0.6	14.8	0.0	100.0	192
East	57.0	4.0	0.2	38.8	0.0	100.0	754
NUTS1 Regions							
Istanbul	89.5	1.6	0.2	8.7	0.0	100.0	537
West Marmara	86.2	5.8	0.0	8.0	0.0	100.0	108
Aegean	75.2	12.6	0.0	12.2	0.0	100.0	330
East Marmara	87.1	3.7	0.0	8.1	1.1	100.0	260
West Anatolia	78.4	6.8	0.6	13.7	0.6	100.0	296
Mediterranean	79.6	5.3	0.1	14.6	0.4	100.0	426
Central Anatolia	71.6	8.3	0.0	19.6	0.4	100.0	185
West Black Sea	74.0	9.4	0.0	16.6	0.0	100.0	166
East Black Sea	80.3	4.6	1.1	13.9	0.0	100.0	102
Northeast Anatolia	49.9	7.1	0.0	43.0	0.0	100.0	131
Central East Anatolia	51.0	5.0	0.4	43.7	0.0	100.0	212
Southeast Anatolia	62.4	2.4	0.1	35.0	0.0	100.0	410
Total	**75.4**	**5.5**	**0.2**	**18.6**	**0.2**	**100.0**	**3,164**

** Source: Akadlı Ergöçmen, B. and Coşkun Y. (2004) "Antenatal Care and Delivery Assistance" in 2003 Turkey Demographic and Health Survey, Hacettepe University Institute of Population Studies, Ankara (2004).*

According to TDHS-2003, in general, 46.4 % of respondent women had sufficient ANC for their most recent births in the last five years preceding the survey, 34.7 % of women did not have either any of the features of sufficient ANC and 18.9 % of women got no ANC for their last births.

This distribution highly varies by place of residence and region of residence. In the urban areas, 56% of women had sufficient ANC and 11.8 % of them had no ANC visits, but in overall rural residences, share of women that had no ANC increases to 34.4 %, where the women that had sufficient ANC for their last births is only 25.6 %. According to 5 regions, the West region has the highest sufficient ANC proportion for overall last births (63.1 percent), insufficient ANC visits for the same region is 28.1 % and merely 8.8 % of women having their last births in the last five years preceding the survey had no ANC. The South, Central and North regions of the country have similar values for sufficient ANC (45.6 %) and no ANC (17.1 %).

The most disadvantageous region for sufficient ANC is the East region of Turkey, where 38.8 % of women had no ANC services, which is about twice of overall Turkey average. Only 23.7 % of women in this region had sufficient ANC during their pregnancies. ANC distribution according to NUTS1 regions indicates that western parts of the country are more advantageous when compared to other parts of the country. Even in Central Anatolia, West Anatolia (including Ankara, Konya and Karaman), share women having sufficient ANC (49.3 %) is 9 % higher than the rest of Central Anatolia (40.3 %).

Another inter-regional divergence is observed in East Anatolia: Central East Anatolia has the lowest sufficient ANC percentage (20.7 %) and proportion of women had no ANC visits for their last births in Southeast Anatolia is 8 % lower than other two Eastern regions (35 %).

Table 2: ANC visits for last birth of woman in last 5 year preceding the survey date by place of residence , TDHS 2003

Place of Residence	No ANC	Suffisant ANC	Insuffisant ANC	Total	Number of Births
Type of Residence					
Urban	11,8	56,0	32,2	100.0	2.172
Rural	34,4	25,4	40,1	100.0	992
5 Regions					
West	8,8	63,1	28,1	100.0	1.119
South	14,9	44,4	40,7	100.0	426
Central	17,1	45,6	37,3	100.0	673
North	14,8	45,6	39,6	100.0	192
East	38,8	23,7	37,4	100.0	754
NUTS1 Regions					
Istanbul	9,0	64,0	27,0	100.0	537
West Marmara	8,0	62,2	29,8	100.0	108
Aegean	12,2	60,4	27,4	100.0	330
East Marmara	9,2	57,7	33,1	100.0	260
West Anatolia	14,2	49,3	36,4	100.0	296
Mediterranean	14,9	44,4	40,7	100.0	426
Central Anatolia	20,1	40,3	39,6	100.0	185
West Black Sea	16,6	43,5	39,9	100.0	166
East Black Sea	13,9	46,6	39,5	100.0	102
Northeast Anatolia	43,0	26,8	30,2	100.0	131
Central East Anatolia	43,7	20,7	35,7	100.0	212
Southeast Anatolia	35,0	24,3	40,7	100.0	410
Total	18,9	46,4	34,7	100.0	3.164

**Source: Akadlı Ergöçmen, B., Coşkun Y. and Eker, L. (2005) "Türkiye'de Doğum Öncesi Bakım ve Doğum Hizmetlerinden Yararlanma" in 2003 Türkiye Nüfus ve Sağlık Araştırması İleri Analiz Raporu, Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, Ankara*

Table 3, presents the reason of not having ANC during the pregnancy of last birth preceding the TDHS 2003. According to the findings, 36.4 % of women that had no ANC reported that they did not need to have ANC during pregnancy. Besides, 42.5 % of women that had no ANC, declared monetary reasons for nor having ANC for their last births. Other highlighted reasons for not having ANC are traditions (5.9 %), accessibility problems for ANC (2.4 %) and other reasons (8.8 %). According to these descriptive findings from TDHS-2003, it may be argued that Turkish women recognize ANC as a private service rather than a public facility that could be provided from governmental health institutions by putting monetary reasons forward among others.

Table 3: Reason for not having ANC during pregnancy for last birth in last 5 years preceding the survey, TDHS 2003*

Reason	%
No need	36,4
Accessibility problems	2,4
Problems using health institution/Distrust institutions/ Poor service	2,4
Traditions	5,9
Monetary reasons	42,5
Don't no where to go	0,3
Other reasons	8,8
Don't Know	1,2
Total	**100**

**Source: Akadlı Ergöçmen, B., Coşkun Y., Eker, L. (2005) "Türkiye'de Doğum Öncesi Bakım ve Doğum Hizmetlerinden Yararlanma" in 2003 Türkiye Nüfus ve Sağlık Araştırması İleri Analiz Raporu, Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, Ankara*

Table 4 presents the place of delivery for all births of 15-49 women in the 5 years preceding the survey. In overall, 78.2 % of all births were delivered at a health facility, in which 65.3 % were in a public sector and 12.9 % were in private sector. 21.2 % of births took place at home. As observed in ANC, regional and urban-rural differences are present according to the TDHS-2003 findings.

The proportion of births at home in the urban is 14.1 %, which increases to 35 % in the rural settlements of the country. In the West region, only 8.1 % of all births in the 5 years preceding the survey were at home, but this proportion raises to 20.6 % in the South and reaches at 45.5 % in the East. At NUTS1 level, there are major differences in all sub-regions of the West, Central, North and East regions of Turkey. For instance, the proportion of home births in the Central Anatolia is as twice as the proportion in West Anatolia; the difference between West Black Sea and East Black Sea for the same proportion is 14 %.

In the eastern part of the country, the intra-regional gaps in terms of place of delivery are more important. The share of births at home in Northeast Anatolia is 34.8 %, which increases to 45.9% in Southeast Anatolia. More than the half of births in the last five years preceding the survey in Central East Anatolia occurred at home (50.9 %).

There are significant divergences in the use of public and private health facilities at regional and residential levels. In the urban areas of Turkey, 20.3 % of health facility births were at private sector, which is only 6.8 % for births of women living in the rural. In the West, proportion of private sector births is 31.7 %, which is less than 2 % in the North (1.9 %).

An interesting figure is that the East region has the highest second proportion for private sector deliveries with 11.8 %. In Istanbul, more than the half of deliveries

were at a private health facility (52.4 %), and the second highest proportion for use of private health facilities is in Southeast Anatolia (14.7 %).

Table 4: Place of Delivery for all births in the last five years preceding the survey, TDHS 2003

Place of residence	Health Facility		Home	Other	No Answer	Total	N
	Public Sector	Private Sector					
Type of Residence							
Urban	68.2	17.4	14.1	0.2	0.2	100.0	2,722
Rural	59.9	4.4	35.0	0.5	0.4	100.0	1,410
5 Regions							
West	62.5	29.0	8.1	0.2	0.1	100.0	1,342
South	70.4	8.1	20.6	0.4	0.5	100.0	557
Central	85.7	2.5	10.9	0.6	0.3	100.0	813
North	83.7	1.6	13.3	0.6	0.9	100.0	252
East	48.0	6.4	45.5	0.1	0.0	100.0	1,168
NUTS1 Regions							
Istanbul	43.7	48.2	8.0	0.0	0.0	100.0	643
West Marmara	90.7	5.8	3.5	0.0	0.0	100.0	124
Aegean	80.7	8.7	10.6	0.0	0.0	100.0	392
East Marmara	80.0	12.0	5.8	1.3	0.9	100.0	328
West Anatolia	87.2	2.8	9.2	0.8	0.0	100.0	349
Mediterranean	70.4	8.1	20.6	0.4	0.5	100.0	557
Central Anatolia	77.7	3.3	18.3	0.0	0.7	100.0	232
West Black Sea	91.0	1.6	5.9	0.9	0.5	100.0	202
East Black Sea	77.2	1.7	19.9	0.3	0.9	100.0	137
Northeast Anatolia	58.0	7.2	34.8	0.0	0.0	100.0	185
Central East Anatolia	46.4	2.7	50.9	0.0	0.0	100.0	314
Southeast Anatolia	46.0	7.9	45.9	0.2	0.0	100.0	670
Total	**65.3**	**12.9**	**21.2**	**0.3**	**0.2**	**100.0**	**4,132**

** Source: Akadlı Ergöçmen, B. and Coşkun Y. (2004) "Antenatal Care and Delivery Assistance" in 2003 Turkey Demographic and Health Survey, Hacettepe University Institute of Population Studies, Ankara (2004).*

Table 5 presents the place of delivery and personnel assisted the delivery for all the births in the last five years preceding the survey by place of residence. According to TDHS-2003 data, unlike the sufficient ANC during pregnancies, a vast majority of the births in the relevant time period occurred either in a health facility (77.4 %) or with the assistance of a health personnel (i.e. doctor and/or nurse/midwife) at home (4.8 %). However, 16.4 % of overall births took place at home without assistance of trained health personnel.

Urban-rural gap and regional differences are very significant for place of delivery and health personnel assistance. Although 84.5 % of births were health facilities in the

urban, 9.3 % of total births in the urban occurred at home without assistance. There is no differentiation between urban and rural in terms of births at home with the assistance of a health personnel (4.8 % and 4.9 %). Despite this, 30.1 % of deliveries in rural Turkey were at home without health personnel assistance. In relation with the high proportion of births at home, number of births occurred at a health facility is lower in the rural (63.7 %). The West and Central regions of Turkey have the highest proportions for births at health facility (91.1 % and 88.3 %).

Table 5: Place of delivery and delivery assistance for all live births of women in last 5 years preceding the survey by type of residence and regions, TDHS-2003*

Place of Residence	At home with health personnel	At home without health personnel	Health facility	Other	Total	N
Place of Residence						
Urban	4,8	9,3	84,5	1,4	100,0	2718
Rural	4,9	30,1	63,7	1,3	100,0	1405
5 Regions						
West	3,8	4,3	91,0	1,0	100,0	1340
South	10,4	10,3	77,4	1,9	100,0	554
Central	2,8	8,1	88,3	0,7	100,0	810
North	1,2	12,2	85,6	1,0	100,0	250
East	5,5	40,0	52,4	2,1	100,0	1168
12 Regions						
Istanbul	3,3	4,7	91,0	1,0	100,0	643
West Marmara	1,3	2,2	96,5	0,0	100,0	124
Aegean	5,2	5,4	89,4	0,0	100,0	392
East Marmara	2,4	3,4	91,5	2,6	100,0	325
West Anatolia	3,0	6,2	90,0	0,8	100,0	349
Mediterranean	10,4	10,3	77,4	1,9	100,0	554
Central Anatolia	5,1	13,4	81,6	0,0	100,0	230
West Black Sea	0,7	5,3	93,1	0,9	100,0	201
East Black Sea	1,7	18,3	78,8	1,2	100,0	136
Northeast Anatolia	5,7	29,1	62,1	3,1	100,0	185
Central East Anatolia	4,0	46,9	47,3	1,9	100,0	314
Southeast Anatolia	6,2	39,7	52,2	1,9	100,0	670
Total	**4,8**	**16,4**	**77,4**	**1,4**	**100,0**	**4123**

**Source: Akadlı Ergöçmen, B., Coşkun Y., Eker, L. (2005) "Türkiye'de Doğum Öncesi Bakım ve Doğum Hizmetlerinden Yararlanma" in 2003 Türkiye Nüfus ve Sağlık Araştırması İleri Analiz Raporu, Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, Ankara*

The highest proportion of births at home without health personnel is in the East (40.0 %), where only about the half of births took place in a health facility (52.4

%). Despite the high proportion of births occurred at the health facility in the South and North regions, about 1 of each 10 deliveries in these regions were at home without health personnel in the last 5 years prior to the survey.

When NUTS1 regions are examined, 90 % or more of total births in the Western regions (i.e. Istanbul, West Marmara, Aegean, East Marmara, West Anatolia and West Black Sea) took place in a health facility and the level of births at home without health personnel is between 2.2 %(West Marmara) and 6.2 % (West Anatolia). There are obvious differences in births at home without health personnel among sub-regions of the North and Central regions of the country: Central Anatolia has the twice the proportion of births at home without health personnel assistance (13.4%) when compared to West Anatolia region, and such births were 4 times higher in East Black Sea (18.3 %) than the West Black Sea region (5.3 %).

Among the Eastern regions, the highest proportion of health facility births were in Northeast Anatolia (62.1 %), this value decreases to 52.2 % in the Southeast Anatolia and reaches at 47.3 % in the Central East Anatolia, which is also the lowest level in overall Turkey. Moreover 46.9 % of total births in this region were at home without health personnel. According to the TDHS-2003 data, proportion of births at home without health personnel is 39.7 % in Southeast Anatolia and 29.1 % in Northeast Anatolia. In addition to these, in all regions as well as both urban and rural, proportion of births at home with the assistance of health personnel is lower than the births at home without professional assistance.

FINDINGS FROM MINISTRY OF HEALTH STATISTICS

In this section, the figures for ANC and delivery services from Ministry of Health (MoH) 2004 Study Yearbook have been examined in order to obtain in regional and provincial levels. The latter level is significant for the selection of project sites. Although the TDHS-2003 data sets are the primary data source in determining the regions in NUTS1 level, the nature of the sampling design of the survey does not allow the analyses for the provincial level. Therefore, the recent MoH statistics at the provincial level are the prior supplementary quantitative data in selecting the project sites as being the only available nationwide data.

Table 6 displays the average number of follow-ups for pregnant women in first level of governmental health institutions (e.g. health centres, MCHFP centres, etc.) and proportion of births delivered without health personnel assistance. The lowest number of follow-ups per pregnant women according to 2004 MoH statistics is Southeast Anatolia with 0.84 follow-ups per pregnant woman in first level governmental health institutions. The rest of East Anatolia has the average of 1.68 follow-ups. The highest number of follow-ups was in Aegean region (4.37). The low number of antenatal follow-up in Marmara region can be explained by the share of use of secondary and tertiary health care level of public sector health facilities. Besides, use of private sector health facilities may be another factor, which is observed in findings related to delivery services from TDHS-2003.

The proportion of births without health personnel assistance is 4.77 % in Turkey: this figure is less than 1 % in Marmara region (0.87 %) and births without health personnel in East Anatolia (19.2 %) and in Southeast Anatolia (15.14 %) are four times the average in Turkey.

Table 6: Average number of follow-ups for pregnant women in first step governmental health institutions and proportion of deliveries without health personnel by regions, MoH-SY 2004

Regions	Average number of follow-ups per pregnant woman	Deliveries without health personnel (%)
Marmara	1.38	0,87
Aegean	4.37	1.82
Mediterranean	2.86	3.13
Central Anatolia	2.51	2.52
Black Sea	2.38	2.66
East Anatolia	1.68	19.02
Southeast Anatolia	0.84	15.14
Turkey	**2.15**	**4.77**

In Table 7, the 10 provinces having the lowest number of follow-ups per pregnant women in first level of health care of governmental health facilities as well as the 10 provinces having the highest percentage of births delivered without health personnel in the year 2004 are given.

Table 7: The 10 provinces having the lowest number of ante-natal follow-ups per pregnants and highest percentage of deliveries without health personnel Provinces, MoH-SY 2004

Average Observation per pregnant woman (%)		Deliveries without Health Personnel (%)	
Province		**Province**	
İstanbul	**0.24**	Ağrı	21.03
Ağrı	0.54	Bitlis	**47.14**
Bingöl	0.77	Hakkari	31.53
Ardahan	1.06	Muş	46.14
Diyarbakır	1.07	Van	29.29
Gaziantep	0.78	Diyarbakır	28.50
Mardin	0.76	Mardin	19.76
Ş.Urfa	0.37	Siirt	29.93
Batman	0.62	Batman	24.18
Şırnak	0.40	Şırnak	31.59

The lowest number of antenatal follow-ups per pregnant woman in Turkey was in Istanbul with only 0.24 follow-ups. Therefore, the low number of antenatal follow-ups in Marmara region given in Table 6 above may be explained with the share of Istanbul population in overall Marmara. Besides Istanbul, all of other the 9 provinces having the lowest pregnancy observation averages are in East Anatolia (Ağrı (0.54), Bingöl (0.77), and Ardahan (1.06)) and Southeast Anatolia (Şanlıurfa (0.37), Şırnak (0.40), Batman (0.62), Mardin (0.76), Gaziantep (0.78) and Diyarbakır (1.07)). Similarly, all of the 10 provinces having the highest proportions for births without health personnel assistance are in East and Southeast Anatolia.

The highest percentage of deliveries without health personnel in the year 2004 was in Bitlis (47.14 %), which is 10 times higher than the average of overall Turkey. Muş also had a very high percentage of births without health personnel attendance with 46.14 %. About 3 of 10 births in Van, Hakkari, Şırnak, Diyarbakır and Şırnak in the year 2004 were delivered without health personnel. This proportion is between 19.76 % and 24.18 % in Mardin, Ağrı and Batman.

Table 8 presents the ranking of all provinces according to their Health Development Index prepared by State Planning Organization. According to the Development Index for the Health Sector the most underdeveloped ten provinces are as follows in descending order: ***Bingöl, Van, Bitlis, Iğdır, Şırnak, Batman, Muş, Ağrı, Hakkari and Ardahan.***

Among these provinces Ardahan has the highest infant mortality rate and population per physician. It has to be noted that although Van seems to be one of the better 10 provinces, infant mortality and population per physician is the second worst.

Table 8: Provinces according to Health Development Index rankings*

	HEALTH Development Index	HEALTH Ranking	GENERAL Development Index	VARIABLES				
				Infant Mortality rate	Physicians per 10000	Dentists per 10000	Pharmacists per 10000	Hospital Beds per 10000
ANKARA	3.73885	1	2	36	31.57	6.04	4.47	37.71
İZMİR	2.57727	2	3	40	22.71	4.57	4.73	29.01
İSTANBUL	2.56186	3	1	39	20.58	4.77	4.38	34.14
ISPARTA	1.83762	4	28	32	14.44	2.49	2.80	53.15
ESKİŞEHİR	1.76978	5	6	40	15.86	2.85	3.70	41.20
BOLU	1.71992	6	14	38	10.53	1.88	5.47	43.97
EDİRNE	1.54585	7	16	38	19.50	2.38	3.20	30.95
ANTALYA	1.19478	8	10	32	12.83	2.97	3.84	16.42
DENİZLİ	1.06159	9	12	39	12.25	3.04	3.95	16.52
MUĞLA	1.02883	10	13	35	11.34	2.54	4.01	18.72
AYDIN	0.98567	11	22	39	12.44	2.71	3.84	17.38
ELAZIĞ	0.80175	12	36	39	14.03	1.05	2.02	40.50
BALIKESİR	0.76233	13	15	41	9.14	2.42	3.56	24.01
BURDUR	0.74961	14	31	33	9.97	1.75	2.92	27.84
KIRKLARELİ	0.70599	15	11	34	9.07	1.89	3.53	21.92
BURSA	0.70374	16	5	39	12.28	2.11	3.08	19.93
ÇANAKKALE	0.69737	17	24	34	8.93	2.15	3.40	20.50
ADANA	0.68863	18	8	44	14.14	1.30	3.40	24.04
ZONGULDAK	0.54247	19	21	45	9.63	1.97	2.89	28.18
TRABZON	0.53537	20	38	31	11.29	1.39	2.08	25.97
SAMSUN	0.51554	21	32	48	13.87	1.22	2.84	27.14
MANİSA	0.50740	22	25	41	9.88	1.90	3.06	21.89
UŞAK	0.46729	23	30	42	8.87	2.23	3.16	19.24
KASTAMONU	0.44689	24	51	44	8.76	1.15	2.29	39.90
KOCAELİ	0.41123	25	4	42	11.03	2.11	2.70	17.23
KIRŞEHİR	0.31511	26	42	35	9.12	1.42	2.69	19.74
NEVŞEHİR	0.26219	27	34	43	9.07	1.65	3.13	17.71
RİZE	0.19942	28	37	32	7.11	1.28	2.49	20.99
ARTVİN	0.13761	29	43	43	10.16	0.94	1.77	30.22
KONYA	0.13386	30	26	35	8.20	1.51	2.57	14.99
SAKARYA	0.11170	31	23	42	7.10	1.97	2.53	18.14
YALOVA	0.11005	32	9	43	11.15	2.91	1.19	11.86
KAYSERİ	0.10705	33	19	42	11.72	0.28	2.58	23.30
KIRIKKALE	0.03905	34	33	34	11.60	1.10	1.54	15.91
TEKİRDAĞ	0.00775	35	7	39	9.53	0.37	3.08	16.74
MALATYA	-0.00397	36	41	35	10.54	1.22	1.58	15.95
GAZİANTEP	-0.00510	37	20	44	7.52	1.14	2.84	19.65
TUNCELİ	-0.07081	38	52	36	9.40	0.53	2.14	18.70
BİLECİK	-0.10706	39	18	42	8.75	1.24	2.32	14.82
GİRESUN	-0.12725	40	50	38	5.82	1.03	2.14	21.86
KARAMAN	-0.13581	41	35	48	9.17	1.52	2.59	11.92
ÇORUM	-0.15435	42	46	51	7.45	0.97	2.38	25.61
BARTIN	-0.16002	43	55	42	9.28	1.57	1.30	17.48
ÇANKIRI	-0.18099	44	59	37	6.99	0.85	2.15	17.75

KARABÜK	-0.19979	45	27	38	9.28	0.71	0.80	26.34
NİĞDE	-0.20562	46	49	47	7.70	1.12	2.44	17.52
SİNOP	0.20627	47	57	57	8.42	1.15	2.35	24.38
SİVAS	-0.22259	48	53	53	11.11	0.34	1.51	30.10
AFYON	-0.25151	49	44	45	7.69	0.30	2.34	23.57
AMASYA	-0.26845	50	39	47	7.12	1.23	2.71	12.73
MERSİN	-0.29239	51	17	45	7.87	0.44	2.62	17.26
AKSARAY	-0.31125	52	56	48	8.76	0.93	2.37	14.01
GÜMÜŞHANE	-0.35139	53	71	32	7.11	0.64	1.23	17.38
KÜTAHYA	-0.35744	54	40	40	5.98	0.70	2.02	18.31
HATAY	-0.39035	55	29	38	5.84	0.36	2.79	11.94
ERZİNCAN	-0.40295	56	58	37	6.60	0.60	1.39	19.60
ORDU	-0.41806	57	62	37	5.67	0.48	2.01	16.64
ERZURUM	-0.42699	58	60	65	12.31	0.52	1.00	31.63
K.MARAŞ	-0.48975	59	48	37	6.29	1.01	1.62	10.48
KİLİS	-0.65089	60	54	48	9.94	0.78	0.52	16.56
DİYARBAKIR	-0.68696	61	63	57	7.02	0.35	1.89	21.13
OSMANİYE	-0.70300	62	47	36	6.02	1.46	0.57	7.08
ŞANLIURFA	-0.76661	63	68	37	4.28	0.35	1.86	8.76
TOKAT	-0.76908	64	61	45	5.37	0.34	1.50	16.09
YOZGAT	-0.79297	65	64	45	5.24	0.64	1.44	12.89
ADIYAMAN	-0.86615	66	65	42	4.95	0.35	1.41	11.46
BAYBURT	-0.87113	67	66	44	7.19	0.51	0.92	10.27
DÜZCE	-0.95200	68	45	50	6.36	0.92	0.16	17.02
SİİRT	-0.99157	69	73	63	4.48	0.34	2.88	10.81
KARS	-1.06279	70	67	65	5.08	0.68	2.15	11.54
MARDİN	-1.11637	71	72	43	3.47	0.20	1.49	6.74
BİNGÖL	-1.13607	72	76	60	5.12	0.39	1.14	16.95
VAN	-1.23070	73	75	61	6.03	0.44	0.83	14.13
BİTLİS	-1.24564	74	79	52	3.58	0.51	0.87	11.19
IĞDIR	-1.31338	75	69	52	5.81	0.53	0.53	5.93
ŞIRNAK	-1.34016	76	78	51	3.48	0.42	1.05	6.09
BATMAN	-1.42375	77	70	50	3.83	0.61	0.46	4.69
MUŞ	-1.54313	78	81	55	2.76	0.22	0.75	7.94
AĞRI	-1.56682	79	80	58	2.38	0.30	1.19	5.30
HAKKARİ	-1.59302	80	77	55	3.55	0.21	0.51	6.34
ARDAHAN	-1.61906	81	74	77	5.98	0.52	0.67	12.34

**Source: Dinçer B, Özaslan M, Kavasoğlu T. (2003) İllerin ve Bölgelerin Sosyo-ekonomik Gelişmişlik Sıralaması Araştırması. DPT Yayın No 2671.*

FINDINGS FROM THE MIGRATION STATISTICS OF STATE STATISTICAL INSTITUTE

Table 9 presents the population sizes of immigration, emigration and net migration as well as the net migration rate of the NUTS 1 regions according to 2000 census in Turkey. It should be mentioned that the migration information was collected for population aged 5 and over, therefore, population given in the second column presents population aged 5 or older in order to calculate net migration rates. As followed in the table, Western parts of Turkey have the highest net migration rates and Black Sea and eastern regions lose population by migration.

The highest net migration rate in 1995-2000 period is observed in Istanbul with a net migration of 46.1 per 1000 population. This region is followed by West Marmara (26.1 per thousand) and Aegean (22.9 per thousand) regions. However, when the number of population for net migration is considered, Istanbul is again the first migration receiver with 407,448 people in 1995-2000 period and Aegean region is in the second place with 184,003 net migrant population for the same period. On the contrary, West Black Sea region is the most migrant sending region with -50.3 per thousand net migration rate and 231,791 people decrease in population by migration. North East Anatolia is the second sending region when net migration rates are compared among regions (-49.8 per thousand) and Southeast Anatolia is the second migrant sending region when number of net migration populations are taken with -209,890 people migrated out of the region during the relevant period.

Table 9: Immigration, emigration and net migration rates of NUTS 1 regions in the 1995-2000 period according to the 2000 General Population Census, Turkey*

Region (NUTS 1)	Population by place of residence in 2000	Immigration (1)	Emigration (1)	Net migration	Net migration rate (‰)
Total	**60 752 995**	**4 098 356**	**4 098 356**	**0**	**0.0**
İstanbul	9 044 859	920 955	513 507	407 448	46.1
West Marmara	2 629 917	240 535	172 741	67 794	26.1
Aegean	8 121 705	518 674	334 671	184 003	22.9
Eastern Marmara	5 201 135	432 921	351 093	81 828	15.9
Western Anatolia	5 775 357	469 610	378 710	90 900	15.9
Mediterranean	7 726 685	413 044	410 316	2 728	0.4
Central Anatolia	3 770 845	205 108	300 113	- 95 005	-24.9
West Black Sea	4 496 766	219 008	450 799	- 231 791	-50.3
East Black Sea	2 866 236	151 193	227 013	- 75 820	-26.1
North East Anatolia	2 202 957	144 315	256 922	- 112 607	-49.8
Central East Anatolia	3 228 793	170 568	280 156	- 109 588	-33.4
Southeast Anatolia	5 687 740	212 425	422 315	- 209 890	-36.2

(1) Migration across the provinces within the region is not covered.

**Source TUIK, http://www.tuik.gov.tr/PreIstatistikTablo.do?istab_id=185*

In Table 10, net migration by population size and net migration rates are given for 1975-1980, 1980-1985, 1985-1990 and 1995-2000 periods for each province. The first 10 migrant receiving provinces by net migration rates according to the 2000 census in 1995-2000 period are Tekirdağ (96.8), Muğla (70.2), Antalya (64.3), Bilecik (57.9), İstanbul (46.1), Bursa (45.1), İzmir (39.9), Isparta (30.7), Çanakkale (27.4) and Ankara (25.6). However, when the number of population for net migration is taken as the unit of analysis the first five migrant receiving provinces are Istanbul (407,448), Izmir (120,375), Ankara (90,884), Antalya (90, 457) and Bursa (85,325). Interestingly, Adana, which includes one of metropolitan cities of Turkey, has a negative net migration rate (-24 per thousand) and it lost 40,497 people with migration within he given period. The ten most migrant sending provinces in the period are Ardahan (-106.7), Bartın (-86.8), Sinop (-75.7), Siirt (-75.1), Zonguldak (-73.8), Adıyaman (-70.2), Mardin (-67.6), Artvin (-63.6), Kars (-61.1) and Muş (-59.8).

Table 10: Order of provinces according to the net migration rate from 1975 to 2000, Turkey

Order Number by size	Province	Census Intervals							
		1975-1980		1980-1985		1985-1990		1995-2000	
		Net migration	Net migration rate (‰)	Net migration	Net migration rate (‰)	Net migration	Net migration rate (‰)	Net migration	Net migration rate (‰)
1	Tekirdağ	4 849	16.5	3 438	10.3	17 907	46.7	51 335	96.8
2	Muğla	1 659	4.3	3 058	7.0	15 998	32.9	42 921	70.2
3	Antalya	17 142	26.5	25 339	32.8	82 737	89.7	90 457	64.3
4	Bilecik	- 394	-3.0	1 095	7.9	3 009	19.6	10 105	57.9
5	İstanbul	288 653	73.4	297 598	60.5	656 677	107.6	407 448	46.1
6	Bursa	58 720	61.0	47 434	41.1	83 641	61.6	85 325	45.1
7	İzmir	119 896	73.7	82 173	41.9	146 208	63.8	120 375	39.9
8	Isparta	- 2 792	-9.3	- 5 148	-15.4	- 6 495	-17.0	13 869	30.7
9	Çanakkale	- 1 408	-4.0	- 1 834	-4.9	- 2 042	-5.2	11 491	27.4
10	Ankara	49 499	20.6	36 631	13.0	69 511	24.9	90 884	25.6
11	Aydın	9 382	16.7	9 365	14.7	19 077	27.1	21 553	25.5
12	Şırnak (1)	-	-	-	-	- 5 165	-24.7	5 950	21.8
13	Denizli	- 3 040	-5.7	2 095	3.5	10 570	15.4	15 205	19.9
14	Kırklareli	- 3 170	-13.4	- 2 252	-8.9	- 5 510	-20.7	5 270	18.0
15	Eskişehir	7 759	16.4	8 506	16.0	6 510	11.3	9 582	14.8
16	İçel	40 273	57.5	49 593	56.5	74 717	68.3	18 429	12.4
17	Düzce (1)	-	-	-	-	-	-	2 243	8.0
18	Balıkesir	- 6 020	-7.8	3 260	3.9	4 848	5.4	4 804	4.9
19	Yalova (1)	-	-	-	-	-	-	514	3.5
20	Manisa	8 980	11.1	6 499	7.1	20 946	20.6	3 687	3.2
21	Gaziantep	- 1 256	-1.8	- 4 256	-5.2	- 481	-0.5	3 499	3.1
22	Konya	- 10 152	-7.5	- 10 623	-6.8	- 27 184	-17.2	2 787	1.4
23	Kocaeli	53 640	112.9	41 287	67.0	83 262	108.2	211	0.2
24	Kütahya	383	0.9	37	0.1	- 4 609	-8.7	- 1 064	-1.8
25	Niğde	- 7 311	-16.6	- 11 167	-22.6	- 15 857	-55.7	- 699	-2.2
26	Kayseri	10 698	16.3	- 5 145	-6.9	- 16 005	-18.9	- 3 307	-3.5
27	Erzincan	- 9 369	-38.4	- 11 583	-45.4	- 25 574	-93.3	- 1 325	-4.7
28	Uşak	- 1 108	-5.0	- 2 909	-11.8	570	2.1	- 2 058	-6.9
29	Nevşehir	- 3 412	-15.5	- 1 399	-5.8	- 10 708	-41.0	- 1 954	-7.1
30	Iğdır (1)	-	-	-	-	-	-	- 1 361	-9.3
31	Trabzon	- 17 143	-26.2	- 25 496	-35.6	- 51 495	-67.9	- 9 977	-11.1

32	Giresun	- 17 523	-40.6	- 19 955	-43.4	- 34 828	-73.9	- 5 849	-12.1
33	Hakkari	- 2 064	-16.5	- 1 052	-7.6	- 4 472	-32.9	- 2 346	-12.5
34	Karaman (1)	-	-	-	-	934	4.7	- 2 771	-12.6
35	Aksaray (1)	-	-	-	-	- 2 391	-8.2	- 4 769	-13.4
36	Edirne	- 2 783	-9.0	- 5 515	-16.5	- 7 493	-21.2	- 5 106	-14.0
37	Çankırı	- 13 828	-59.2	- 9 135	-38.1	- 15 503	-61.0	- 4 471	-18.3
38	Bitlis	- 17 653	-81.9	- 9 240	-37.0	- 20 509	-71.9	- 7 104	-21.2
39	Malatya	- 23 183	-43.2	- 12 944	-22.0	- 35 207	-54.2	- 16 823	-21.5
40	Rize	- 8 624	-26.1	- 11 257	-32.6	- 28 726	-84.0	- 7 473	-21.9
41	Afyon	- 13 379	-25.4	- 15 855	-26.5	- 25 779	-37.7	- 16 616	-22.5
42	Burdur	- 1 580	-7.5	- 4 045	-17.8	- 8 825	-36.8	- 5 374	-22.7
43	Sakarya	4 315	9.1	7 082	13.2	6 353	10.5	- 15 898	-23.1
44	Gümüşhane	- 21 762	-86.2	- 14 075	-54.1	- 22 305	-135.3	- 4 003	-23.5
45	Elazığ	- 17 366	-44.2	- 13 683	-31.6	- 21 164	-46.1	- 12 363	-23.8
46	Adana	819	0.7	23 829	16.4	26 934	15.8	- 40 497	-24.0
47	Osmaniye (1)	-	-	-	-	-	-	- 10 385	-24.7
48	Amasya	- 7 368	-24.5	- 10 463	-32.5	- 19 916	-59.7	- 9 099	-26.8
49	Kahramanmaraş	- 8 206	-13.0	- 10 500	-14.2	- 33 949	-41.6	- 25 530	-28.3
50	Kırıkkale (1)	-	-	-	-	- 8 813	-27.7	- 11 626	-32.7
51	Kastamonu	- 10 717	-26.5	- 11 094	-26.9	- 26 777	-66.1	- 11 689	-32.8
52	Hatay	14 046	20.0	4 869	5.7	- 4 002	-4.1	- 38 241	-33.9
53	Tunceli	- 13 318	-93.7	- 17 797	-123.9	- 20 332	-153.8	- 3 123	-36.7
54	Kilis (1)	-	-	-	-	-	-	- 4 042	-38.9
55	Şanlıurfa	- 35 253	-60.1	- 14 509	-20.9	- 26 800	-30.0	- 49 312	-38.9
56	Diyarbakır	- 15 795	-24.2	- 12 550	-16.1	- 32 212	-34.8	- 48 064	-40.0
57	Karabük (1)	-	-	-	-	-	-	- 8 640	-40.7
58	Bolu	- 505	-1.2	- 4 902	-10.9	- 4 149	-8.6	- 10 254	-40.8
59	Yozgat	- 21 905	-49.2	- 14 279	-29.3	- 34 502	-64.3	- 26 275	-41.9
60	Van	- 7 627	-19.7	- 11 994	-26.3	- 20 780	-37.9	- 32 353	-43.6
61	Ordu	- 20 668	-32.3	- 24 230	-34.5	- 42 910	-54.6	- 36 958	-44.7
62	Kırşehir	- 8 330	-39.3	- 6 080	-26.4	- 19 647	-80.4	- 10 748	-45.1
63	Batman (1)	-	-	-	-	3 925	13.9	- 18 032	-45.2
64	Samsun	- 11 144	-12.6	- 13 709	-13.8	- 31 222	-29.1	- 51 644	-45.5
65	Tokat	- 16 772	-30.0	- 16 782	-27.3	- 45 746	-67.5	- 37 172	-48.4
66	Bingöl	- 10 678	-54.6	- 9 286	-44.1	- 19 888	-87.7	- 11 407	-50.1
67	Sivas	- 50 302	-75.4	- 37 687	-54.6	- 76 451	-105.8	- 35 627	-51.0
68	Erzurum	- 46 093	-66.3	- 48 745	-64.8	- 88 298	-113.2	- 46 491	-54.8
69	Ağrı	- 24 986	-80.5	- 19 005	-53.5	- 37 312	-95.4	- 26 213	-56.4
70	Çorum	- 23 753	-46.3	- 17 712	-32.6	- 33 897	-58.5	- 33 022	-58.4
71	Bayburt (1)	-	-	-	-	- 13 808	-133.2	- 5 360	-59.5
72	Muş	- 16 937	-66.4	- 14 346	-49.4	- 33 829	-100.5	- 24 069	-59.8
73	Kars	- 70 872	-113.1	- 50 426	-77.9	- 105 025	-163.5	- 18 331	-61.1
74	Artvin	- 12 687	-61.2	- 10 855	-51.1	- 20 372	-98.6	- 11 560	-63.6
75	Mardin	- 28 919	-59.8	- 17 495	-31.2	- 34 750	-70.2	- 42 082	-67.6
76	Adıyaman	- 11 371	-34.7	- 13 614	-35.4	- 17 372	-37.5	- 40 745	-70.2
77	Zonguldak	8 679	10.8	- 18 551	-20.0	- 29 368	-29.4	- 44 009	-73.8
78	Siirt	- 10 922	-29.5	- 18 232	-41.7	- 31 311	-140.7	- 17 062	-75.1
79	Sinop	- 7 944	-32.6	- 9 777	-38.4	- 22 569	-88.7	- 16 387	-75.7
80	Bartın (1)	-	-	-	-	-	-	- 15 658	-86.8
81	Ardahan (1)	-	-	-	-	-	-	- 13 526	-106.7

(1) The information related with the previous periods

**Source: TUIK, http://www.tuik.gov.tr/PreIstatistikTablo.do?istab_id=184*

Annex 2 Literature Review Report

LITERATURE REVIEW REPORT

Literature Review Process:

Literature review covers the topics listed below:

- Publications on factors affecting general and reproductive health seeking behaviour of women and families;
- Publications on factors affecting knowledge, opinions, feelings, attitudes and practices related to non-utilization, irregular/inadequate utilization of ANC and child birth without the assistance of health personnel;
- Publication on affect of family members (husband, mother-in-law, mother, sister/brother) and immediate surroundings (peers, neighbours) on health seeking behaviour of pregnant women;
- Research carried out in Turkey regarding the utilization of health care services in general and primary health care services specifically
- Studies on the situation and utilization (service provision, utilization by public, accessibility, equipment related to ANC, qualifications of health personnel regarding ANC, satisfaction, quality of services provided) of primary health care facilities (Health Clinics and Maternal/Child Health and Family Planning) in Turkey;
- "Qualitative Studies" on health in general and reproductive health and safe motherhood specifically;
- Studies on gender discrimination and factors that affect general health and reproductive health seeking behaviour of women;
- Studies reflecting societal culture, health related behaviour in certain locales and traditional practices;
- ***Statistical data*** supplied by the **Ministry of Health** on provincial basis regarding utilization of ANC, the place of delivery, number of births, access conditions to service, and those supplied by the ***Prime Ministry Turkish Statistical Institute*** regarding the immigration ***to regions and provinces***.

The following were carried out during the literature review process:

- "Key words" related to the topic were chosen, a wide range of data base was searched and effort was made to reach the full texts of documents,
- "National Public Health Congress" books from İstanbul and Ankara Public Health Departments as well as post-graduate thesis related to the topic were reviewed;
- The reports of MoH DG Maternal/Child Health and Family Planning as well as Reproductive Health Programme on Reproductive and Sexual Health services and practices were examined;
- The reports of CSOs working in the field of Reproductive and Sexual Health were reviewed.

Results of the Literature Review:

In the context of the topics mentioned above apart from the books, a total of 92 studies and reports (71 national and 21 international) were accessed (Annex 2). **An important portion** of these is regional/local small scale not indexed **studies of quantitative** nature. Difficulties were experienced in reaching the full text of these studies which were accessed mostly through scanning of National Public Health, Reproductive Health/Family Planning and Nursing Congress books. Furthermore, due to the fact that the objectives, sampling and methodology of these studies were very different from each other, it was not possible to do a comparative analysis of regions and provinces and to reach a result. Another problem encountered during the literature review was the limited number studies factors affecting utilization of ANC and that most studies were on utilization of primary health care services and reproductive health behaviour (use of birth control, age of marriage and child birth, obstetric data) of local women.

Only seven studies, which indirectly examine the factors affecting ANC, could be reached. Two of these studies are studies conducted by CSOs and they evaluate community based-activities (69,89). Three of them are on the utilization of delivery services and the quality of service provision (40,83,84). Another study examines the effectiveness of ANC training programmes and another one is on the differences in expectations between the service provider and those utilizing the services (32,71).

There were more international studies that were conducted on women's health seeking behaviour and utilization of ANC using qualitative methods. These are studies that were conducted in Nigeria, South Africa, Indonesia, U.S.A (on Afro-American and Hispanic women) Jamaica and Thailand (1,22,26,37,55,57,63,65,70,78,79).

No regular data can be collected regarding **"maternal mortality"** in Turkey, in spite of the fact that it is a very important indicator defining the level of health and development. In a study on causes of maternal mortality conducted in the years 1997-1998 through examination of records of 615 hospitals in 53 provinces representing the country as a whole, the death rate of mothers was calculated as **49,2 per hundred thousand live birth**. According to this result maternal deaths are among the first 5 most frequent causes of death in women. It is noteworthy that apart from malignancies, most deaths including maternal deaths can be prevented. Among the first three causes of maternal mortality are haemorrhages in the first place, toxaemia in the second and other preventable causes in the third. In the study concerned, not utilising ANC and assisted birth services are shown as an important cause of maternal mortality. In all the maternal deaths, 16.3% are due to the fact that delivery took place under undesirable conditions (at home, outside without the assistance of a health personnel). It was also observed that out of 5 maternal deaths, 1 had not received any ANC (2).

ANC should start as soon as pregnancy is determined and should continue at regular intervals according to the needs of the mother until delivery. ANC should start in the first trimester, as the early diagnosis of illnesses prior to pregnancy is important and in line with the recommendations of the World Health Organization and the MoH should be utilised on average 6 times in normal pregnancies and more in pregnancies that carry a risk.

The TDHS results related to ANC and assisted birth are based on information collected from mothers on all live births in the 5-year period before the survey. In this context, the percentage of women that never use ANC has dropped from 32% to 23% in the 1998-2003 period. These figures are still not sufficient. The assistance women receive during birth is largely related to the place of delivery. Possibility of receiving assistance during delivery is low for births that take place outside health institutions. The proportion of all assisted births in the last five years preceding TDHS 2003 is 83%. It is observed that these figures are largely affected by the woman's age, educational attainment level, work status, marital status and whether the pregnancy is wanted, number of pregnancies and living children, place of residence (urban-rural) and region. There are significant disparities between regions and places of residence in Turkey when we look at the utilization of ANC. While 39% of the women in the eastern regions never use ANC, this figure is 9% in the western regions of Turkey. Similarly, while in the eastern regions 40% of the births are without assistance of health personnel and 46% take place outside health institutions, these figures are 4% and 8% respectively for western regions (28,85).

In the literature review, a study that comparatively analysis utilization of ANC according to regions and provinces and defines service insufficiencies could not be found. However, apart from the TDHS 2003 conducted by Hacettepe University Institute of Population Studies and MoH statistical data, the results of **regional studies conducted and the MoH/EC Reproductive Health Programme Reports** indicate that the most disadvantaged regions are northeast, Anatolia and southeast regions with regards to sociocultural and economic conditions (education and training, employment and unemployment, income levels, position of the women in the society and the family), geographical conditions, reproductive health and safe motherhood indicators (fertility rate, frequency and efficiency of birth control utilization, utilization of ANC, assisted birth, immunization, etc.) (9,10,23,39,44,58,76,91).

In the Reproductive Health Programme Report, Van, Erzurum, Ağrı, Kars, Ardahan, Iğdır: Tunceli, Bitlis, Muş, Diyarbakır, Adıyaman provinces are indicated as the provinces with lowest ANC utilization and the highest numbers of unassisted child birth (76). Apart from this data, there are some regional studies on the subject. The situation in some of the problematic provinces are summarised below.

Van: In a study carried out by Taşpınar et.al. in 2005 which evaluates ante and post natal service utilization in rural areas and areas that are being urbanised, it was observed that: half of the women were illiterate, the age of first pregnancy was low, the number of births was high (5±3.5), most of them did not utilize ANC services, and only 45% gave birth in a hospital (58). In a study that examined the fertility behaviour of the Kirghiz community that had migrated to Van, it was observed that 48.9% of the women did not use birth control methods, the total number of births and pregnancy was above what they expressed as ideal numbers in this respect, 30% of the women did not receive any type of health service during their last pregnancy and 37% did not give birth in a health institution (39). A more detailed study was carried out by "Earth Sea and Atmosphere Sciences Research Group" supported by TUBITAK in 2003. The study which examined the sociodemographic characteristics, quality of life and health levels of the urban population determined that women got married at a young age (15-19), 43% of them were illiterate, number of live births was 5.3±3.5 and on the other hand that number of living children was 4.5±2.8, 25% of the child births took place outside a

health institution and a high percentage of women did not consult a health institution despite health problems (23).

Erzurum: The number of studies related to the province that could be accessed was high due to the presence of Atatürk University. There are three studies on women of the region that have been carried out by Erci in 2003 and 2004. These three studies, which were published in international journals, examine the relation between the demographic characteristics of the pregnant women and their level of satisfaction regarding prenatal services, satisfaction regarding family planning services and utilization of prenatal care services (41,42,43). According to the results of these three studies on women of Erzurum, the utilization of prenatal care services are low, the use of a contraceptive method is inadequate, the utilization of "Health institutions" is low and the fertility rates are high. In other studies conducted in the province, it was determined that the local community did not use effective birth control methods, the utilization of services provided by health institutions was low, the utilization of ANC during last pregnancy was 64%, the group that utilised ANC services started attendance late and was irregular and that there were unsatisfactory health behaviour patterns during illness (53,72,88).

The fertility rates of 15-49 age group women in the villages are higher than those in the same age group living in the city centre and districts. The mean number of live births per woman is 2.67 in the city centre, 3.28 in the districts and 4.62 in the villages. The total fertility rate of the province is 3.51. The rate of use of an effective birth control method is 44%, use of ineffective birth control method is 24% and no use of birth control 32%. It is reported that access to health and especially reproductive health services is very inadequate in Tekman, Karaçoban, Karayazı, Hınız and Çat districts which are situated at the south of the province and are where different ethic groups reside. The public mostly uses the health clinics in the province for vaccination purposes in general. The proportion of women not utilizing health clinics for ANC services is 35%. Among the reasons for not utilizing the services, financial difficulties, not being satisfied by the services provided and distrust could be counted (44).

Kars: No reliable data or publication related to the province could be reached apart from the Kars province "Reproductive Health Situation Analysis Report". According to the report Kars is the coldest province in the North-eastern Region. Long and harsh winters directly and indirectly affect the quality and quantity of the reproductive health service provision and thus service utilization levels are low. The population of women in the 15-49 age group is 78.733. The average size of households in the province is 6.12. This figure is the highest in Digor (7.68). The residences are of inferior quality (according to whether it has a toilet, running water etc.) in the rural areas. The general fertility rate is 3.2%, the crude birth rate is 0.8% and crude death rate is 0.085%. The Maternal/Child Health and Family Planning Centres do not provide ANC, delivery assistance, post natal care and emergency obstetric applications. These centres provide birth control services. The distribution of birth control methods provided is 53.7% IUD, 5.5% birth control pills, 30.3% condoms and 10.2% injections. Although not very regular and extensive, ANC services are provided in Health Centres. The reason behind the high number of applications by pregnant women who are in their first trimester is the fact that these centres provide pregnancy tests. Post-natal care is

very seldom given during house visits. Emergency obstetric cases are referred to Central Maternity Hospital (10).

Ardahan: No reliable data or publication related to the province could be reached apart from the Ardahan province "Reproductive Health Situation Analysis Report". Ardohan is an old settlement in the northeastern region. It is a mountainous location. It is possible to reach Ardahan via highway from Erzurum and Kars. There is no air transportation. More than half of the province population resides in the city centre. The districts with highest population density are Hanak, Çıldır and Damal. Crude birth rate is 1% and the fertility rate is 4.1%. The proportion of birth given in hospitals is 80.8%, and that with midwife assistance is 8.4%. The proportion of unassisted birth is 10.8%. The Maternal/Child Health and Family Planning Centres do not provide ANC, delivery assistance, post natal care and emergency obstetric applications. The total use of effective birth control methods in 2004 is 42.5%. The distribution of birth control methods provided are 20.18% IUD, 4.76% birth control pills, 9.12% condoms and 4.14% other effective methods. Use of ineffective birth control methods is 22.19%. Although not very regular and extensive, ANC services are provided in Health Centres. Postnatal care services are very inadequate (92).

Ağrı: No reliable data or publication related to the province could be reached apart from the Ağrı province "Reproductive Health Situation Analysis Report". Ağri is a mountainous province. Of the whole population 35.21% lives in the rural areas. The population of women in the 15-49 age group is 116.787. The number of live births in the year 2003 was 619. The general fertility rate is 5.3%. The distributions of birth control methods used in general are 7.89% IUD, 15.67% birth control pills and 18.93% condoms. Use of ineffective birth control methods is 41.01%. The Maternal/Child Health and Family Planning Centres and Health Clinics provide partial and inadequate ANC services. Hospital referral chain is used for deliveries and emergency obstetric cases (9).

Diyarbakır: There are some local studies conducted for Diyarbakır. According to Erdem et.al marriage at young age is a very important and wide spread problem for the province. In the study frequency of marriage at young age was found to be 42.4%. It was determined that the educational attainment of those getting married at a young age was low and that they mostly resided in rural areas. The illiteracy rate of this group was found to be 67.8% (46). Another study was conducted on the family planning utilization frequency of women living in the Diyarbakır Şehitlik Health Center catchments area. In this study, it was found that 25.7% of the women were illiterate, 20% of them lived in gecekondus and 51.6% did not use an effective birth control method. Among the reason for not using an effective birth control method educational status, having social security, proximity of their house to the health centre, being concerned that the method could be harmful; believing that birth control is a sin was listed (59). The study conducted by Arcak and Çelik in Diyarbakır is on the role of nurses working in the Central Hospital and Health Center related to health services and their level of job satisfaction (5). It was determined that nurses, who have an important role in health services, have many complaints. Out of 320 nurses although 63% expressed that they liked their jobs they primarily complained about patients and their relatives. They also complained about insufficient numbers of staff, long working hours and too many night duties.

Literature points out that **"migration"** is one of the important factors that affect access to health services. It is a known fact that migration brings along such risks as poverty, misery, unsuitable/unhealthy living conditions, cultural conflicts, not utilizing health services etc. In light of this challenge and according to the data of the Turkish Statistical Institute, it was decided that inclusion of **Istanbul,** which has the highest rate of migration and a very high population increase, would be correct and essential for the study (86), 63.9% of the migration to İstanbul is from the cities in Mid, North and Southeast Anatolia and those migrating to İstanbul settle in peri-urban areas of the city.

From the provinces listed above, taking into consideration the presence of migration and peri-urban areas, the ease of access from air and land, the presence of a university and the ease of identifying local field workers, it is recommended that the study will be carried out in ***İSTANBUL, VAN, KARS, ERZURUM****.*

Another output of the literature review has been identified as the determination of "*research variables*" and "*interview content*".

In this context, in light of the literature review carried out, the factors affecting utilization of ANC services during pregnancy are given below.

Factors affecting ANC service utilization:

In a hospital and community-based study on 303 Afro-American women conducted by Johnson et.al in 1977 in Washington DC, factors for non-utilization of ANC services were determined as unwanted pregnancies, getting information related to pregnancy from friends/family, late determination of pregnancy, thinking of having an abortion, not having any social security, not realising one is pregnant, being under stress, being unhappy about pregnancy, not knowing the main aims of ANC and not being able to meet the expenses of ANC (57).

Abraham also got similar results in a study conducted in 2001 in South Africa (1). In a study conducted by Erci in 2003 in Erzurum, it was determined that illiteracy, high number of pregnancies and children, unwanted pregnancies, not having the social support of the family had a significant affect on utilization of ANC services (43). Aslan et.al pointed out similar factors and that not having a civil ceremony during marriage is an important factor (6). In another study conducted by Erci pregnant women were asked about their satisfaction with ANC services and it was found out that they were satisfied with the "courtesy", "communication", "suitability", "cost", "consultancy" and "quality" of the health personnel (41). Woman's education level, the fact that they are working and the economic status of the family were determined as factors increasing satisfaction from services. Pasinli, in a study carried out in Erzurum determined that the reasons for utilization/non-utilization of ANC services were living far from the health centre, mother being old, and father having low educational attainment levels and not having social security. In addition, it was stated that the duration of residence in Erzurum played an important role and as this duration got shorter service utilization rate decreased (72). Miligan et.al observed in a qualitative study that the negative attitude of the health personnel played an important role in the non-utilization of ANC services (65). In a study conducted in Malatya through the administration of questionnaires to 102 mothers to determine factors affecting utilization of ANC services, number of

previous births given (4 or more) and living in rural areas (receives two times less) were found to be significant factors (30).

Gender discrimination and violence towards pregnant women are also among negative factors (81). Yılmaz and Özşahin in their study for Denizli province showed that adolescent pregnant women were more likely to be on the receiving end of physical violence (1).

Health workers could do another type of discrimination to women of ethnic groups and also to poor and neglected women. Therefore the victimised women may be reluctant to utilise health care. In this regard a study was carried out in Edirne on Roman and other pregnant women and it was observed that Roman women utilised health services less than the others (19).

In a traditional culture study carried out in Trabzon and Çorum by Balıkçı on "Customs and belief on child birth and childhood", it was determined that women did not seek ANC services until the child moved as they were ashamed and hid their pregnancy from the elders of the family. However such sayings as "iki canlı (with two lives)", "ağır ayak (heavy footed)", "karnı yüklü (loaded womb)" used in these regions indicate that they do not want to tire pregnant women. On the other hand pregnant women being ashamed in front of their mothers-in-law is seen as an important obstacle in their receiving ANC in the first trimester (11,13).

Factors that motivate/ease utilization of ANC:

In their study, Johnson et.al identified factors facilitating ANC utilization (57). According to this and other similar studies among factors that facilitate ANC utilization, the following could be counted: having a healthy baby, acquiring better health habits, knowing how to protect ones health, knowing that there could be problems if care is not received, easy access to ANC services, not waiting too long in queues, desired pregnancies (78). Erci and Dönmez determined that working women are more willing and determined to utilise ANC services than women who are not working (36,43). In a study conducted in Nigeria, it was stated that husbands could play a supportive role in ANC and emergency obstetric care utilization by pregnant women (70). Husbands' views on pregnancy, and whether they want the pregnancy as well as their education level gives support to pregnant women and increases ANC service utilization (21,22,55, 60,62,79).

ANC service satisfaction:

The quality and diversity of services offered as well as the attitude of the health personnel are important factors that affect the service satisfaction and regular ANC attendance of pregnant women. In this regard there are many albeit regional studies that have been carried out in the recent years. Erbaydar in a study conducted in İstanbul, Maltepe has determined that the perceptions of the pregnant women and secondly the quality and accessibility of health services are most important factors affecting ANC (40). The quality of the services provided and the attitude of health personnel are counted as some of the important factors affecting ANC utilization (32,36,69,83,89) Another factor is the job satisfaction levels of the health personnel working at Maternal/Child Health and Family Planning Centers and Health Centers (16). In a study

conducted in Trabzon, “Maslach Burnout Inventory” and “job satisfaction scale” were used and it was found that the personnel had high burnout levels and low job satisfaction (90).

As can be seen from the information given above, risk factors related to not utilizing or not being able to utilise ANC services are numerous. In light of these insights, it is recommended that the ***“interview form”*** *to be used in in-depth interviews and focus group discussions should contain the following headings and sub-headings.*

Factors affecting non-utilization of ANC services

Factors stemming from socio-cultural status:

The following could be important determinants in the utilization and non-utilization of ANC services:

- Low education levels of both the pregnant woman and the husband;
- Traditional practices and negative health behaviours existing in the region;
- General health seeking behaviour of families and pregnant women;
- Consanguineous marriages (as a result of being in the same household from very young ages, not being able to make decisions on their own, more violence towards women in the household/according to some other sources paying more attention to those from the same blood line);
- Extended families (negative attitude of the elders towards utilization of health services, hiding pregnancy form elders as a result of being ashamed and due to respect and thus delaying the utilization of health services);
- Not having a civil ceremony marriage;
- Religious beliefs,
- Being in a region that gives or receives migration (in these regions there could be problems like language and not being aware of the services provided. Especially reproductive health services are negatively affected from migration. As the period of residence in the area increases, service utilization rates could also increase),
- Residing in rural and peri-urban areas.

Factors stemming from socio-economic status:

- Low income status of the family, economic problems, having to pay for services provided, proximity of the residence to the health centre and transportation expenses;
- Not having health insurance, not being able to get a green card;
- Employment status of the woman;
- Employment status of the spouse;
- Geographical and climate conditions of the area;
- Being a member of an ethnic group.

Factors related to pregnancy and child birth:

- Health perceptions related to pregnancy;
- Source and content of information related to pregnancy and child birth;

- Unwanted pregnancies;
- High fertility rates;
- Number of previous births;
- Positive/negative impressions, experiences and information from previous births and pregnancies;
- Late pregnancies;
- Experiences of the immediate environment related to pregnancy, child birth and utilization of health services.

Factors related to gender:

- Position within the family;
- Utilization of ANC services, not getting any social support from family with regards child care;
- Large and extended family structure, household size;
- Physical and emotional violence to woman in general and specifically to pregnant women within the household;
- Not being able to decide on "emergency obstetric care" in the absence of spouse;
- Decision on health care expenses;
- Socialization of the women;
- Division of labour within the house.

Factors stemming from Health Institutions and Health Personnel:

- Difficulty in accessing services, proximity of the health centre to place of residence;
- Not trusting health institutions and health personnel, not enough attention;
- Attitude and communication problems of health personnel;
- Having to wait in queue;
- Not having anyone to look after the other children at home;
- Health service providers not being sufficiently sensitive to the "reproductive and sexual rights" of the people who apply to the centres and not being able to sufficiently advocate for the cause;
- Insufficient job satisfaction and exhaustion of personnel working at Health Centers and also not having the desired life standards;
- Inequalities of the payments in the current revolving fund system of health centres;
- Not enough promotion of primary health services in the region/area;
- The customers find the quality and content of the ANC services provided by primary health care institutions insufficient;
- The cost of ANC services;
- Not preferring child birth at hospitals due to the attitude of the health personnel;
- Emotional and physical violence administered by health personnel to the pregnant woman during child birth;
- The negative attitude of the health personnel towards women with many children and low socio-cultural and economic status;
- Pregnant women not being able to go to health institutions alone.

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Pre-Field Study

Annex-3

Reports

HEALTH SEEKING BEHAVIOR STUDY
PRE-FIELD STUDIES

Province **:** Adana
Research Coordinator **:** Erhan Özdemir
Dates of Visit **:** 12 July-14 July 2006

Summary

As proposed in research proposal and planned in Inception Report, the selected provinces for field study (according to the literature reviews, statistical re-evaluations and advices of the MoH during the Inception Stage) were visited for pre-field activities. These activities include introduction of Health Seeking Behavior Study project to relevant local administrators in the province, determination and mapping of problematic residences/regions for ANC services use in the first step public health institutions and selection of field worker candidates.

1. Activities

Although the RC arrived to Adana in 12 July 2006, he could not meet with Province Health Director, Deputy Health Director responsible for MCH/FP and Director of Department of MCH/FP in the first visit date. The reason is that, Province Health Director and Director of MCH/FP were not in the province on that date. However, the RC had previously wrote an e-mail to the Director of MCH/FP that briefly explains overall objectives of the project, the activities planned to be conducted in Adana as well as the purpose and tasks of the first visit to the province. Moreover, according to the telephone call with the Director of the MCH/FP, the list of statistical information of health centers in the province like populations, number of pregnant women and average number of pregnancy follow ups and distribution of births with and without health personnel assistance of each health center regions was requested in the same e-mail.

In the absence of high-rank health administrators in the province, the scope of tasks in the first visit day was determined as mapping of problematic regions/residences and job announcement for field workers. A physician from Department of MCH/FP assisted the mapping study.

1.1 Mapping

During the mapping of problematic regions/residences of Adana for ANC services use, three main categories were organized to reflect the socio-economic and cultural diversity of the province. The first category is composed of health center units established in metropolitan territory of Adana, in which there are high density of migrated population (especially from East and Southeast Anatolia) and gecekondu settlements. The second category is based on problematic public health center units in the periphery residences (i.e. districts, sub-districts and villages) of the province. Finally, the third category includes the regions in the province, where temporary

seasonal agriculture workers were settled. It should be noted that in organizing the categories and listing the problematic health center units, Director of Department of Health Center, responsible MCH/FP doctor for mobile health units in temporary agriculture workers' settlements and a doctor from one of these mobile health units made significant contributions to RC's mapping studies. The list of health center units by categorization described above is presented in the table below.

Table 4. Problematic Health Center Units for ANC Services in Adana

Health Center Unit	***District***	***Administrative Level***	***Characteristics of the Unit***	***Estimated Population***
Category 1 Problematic Metropolitan Residences				
19 Mayıs Health Center	Yüreğir	Province Center	Totally formed by migration, a relatively old residence	73,748
Levent Health Center	Yüreğir	Province Center	Totally formed by migration, a relatively old residence	15,858
Şehit Erkut Akbay Health Center	Yüreğir	Province Center	Formed by migration, relatively a newer residence	21,140
Akkapı Health Center	Seyhan	Province Center	A mixed population of migrants and native Adana population	9,700
Barbaros Health Center	Seyhan	Province Center	Totally formed by migration, a relatively old residence	15,713
Dağlıoğlu Health Center	Seyhan	Province Center	Totally formed by migration, a relatively old residence	32,366
Category 2 Problematic Periphery Residences				
Solaklı Village	Seyhan	Village	Formed by migration	6,500
Yolgeçen Village	Seyhan	Village	-	2,200
Ali Ekinci	Ceyhan	District Center	The most migrant receiving residence in Ceyhan	13,717
Mercimek Village	Ceyhan	Village	A settled and old village	2,400
YumurtalıkMerkez Health Center	Yumurtalık	District Center	Problems in the primary health services because of insufficient number of health personnel, there is also a temporary population in summer	7,800
Sevinçli Health Center	İmamoğlu	Village	A settled and old village	2,939
Karakuyu Health Center	Saimbeyli	Village	A health center unit facing with problems because of insufficient number of health personnel and distance from the province center	4,800
Category 3 Temporary Agriculture Workers' Settlements				
Tuzla Village	Karataş	Village	Temporary agriculture workers' settlement mobile health units	N/A
Karagöçer	Tuzla Karataş	The outskirts of village	A semi-settled temporary agriculture workers' community	N/A
Kapı	Tuzla Karataş	The outskirts of village	A semi-settled temporary agriculture workers' community	N/A

The three of listed problematic health center units (19 Mayıs, Dağlıoğlu and Solaklı) were planned to be visited in the second day of the pre-field visit to the province. However, Director of MCH/FP did not approve the visits to these health

centers because of two reasons. The first of them was that they were not approved by the Province Health Director, so he argued that it would have been wrong to visit the health center units in this provisional list. The second reason was that after the approval of the list given above (with revisions of Province Health Directorate if necessary), it would be better to organize a meeting in forthcoming weeks (but before the beginning of field study) with the participation of responsible personnel from all of these from these health units rather than visiting them one by one, which will prevent time cost and other disadvantages that may arise because of misunderstandings. Therefore, visits to these centers were postponed. The statistical information requested before the visit will be sent by e-mail in the week beginning with 17th of June, 2006.

1.2 Introduction of the Project to Local Administrators

As mentioned above, the planned meetings with Province Health Director was postponed because of the absence of the director. The presentation of the project to the Director of MCH/FP was done on 13 June 2006 (the second day of the visit). He said that they were glad to be a province in Health Seeking Behavior Study. He expressed that Adana would provide significant findings for the research with respect to cultural diversity and population structure of the province. However, he mentioned that the official letter sent from the General Directorate of MCH/FP before the visit is inadequate to describe the project. Therefore, he requested a more detailed information note that explains overall and specific objectives of the project as well as the activities planned in the province before, during and after the field study. Besides this, he pointed out the necessity and importance of a local kick off meeting with the participation of Province Health Director and other related persons/institutions. Moreover, as expressed in Mapping section above, he said that the TAT should submit the provisional list of problematic health units to Province Health Director. In the last day of the visit, the RC visited the Province Deputy Health Director with the Director of MCH/FP.

1.3 Selection of Candidate Field Workers

Several ways were used in announcing the project for field workers. The first channel was the health personnel in Province Health Directorate. They were asked to find appropriate candidates to apply for the job during the RC's visit in Adana. The second way was the calls with the Çukurova University faculty staff to inform their students about the project. Another method of job announcement was relations with the NGOs in the province; in this regards Willows Foundation and Adana City Council assisted the RC to find out candidates in the province. The candidates were applied by these channels and they were individually interviewed by the RC and they were informed about the details of the jobs that they are expected to conduct. Their CVs were received to be evaluated in central project office. There are 2X applications in total. The results of selection will be announced in 19 and 20 July 2006 by phone and/or e-mail.

2. Other Activities

During the preliminary visit to Adana, some NGOs and university members were connected. The first NGO connected in the province is Willows Foundation,

which is an experienced NGO in Adana in reproductive health issues. This foundation works in cooperation with Province Health Directorate, so they know the problems in the province in details. The second NGO is City Council of Adana, which is a cooperative that conducts development projects supported by EU and UN; they have previously conducted a peer group education in reproductive health issues for adolescences. Another NGO communicated was Association for Protection of Women's Health (Kadın Sağlığını Koruma Derneği). The representatives of former two organizations were met in Adana office of Willows Foundation, exchange of ideas and share of experiences in the region were the issues during the meeting. The RC talked with head of board of directors of Association for Protection of Women's Health in a telephone call.

3. Conclusion and Overall Evaluation of the Visit

The preliminary visit to Adana has provided important outcomes including an insight for the possible facilities as well as obstacles that may arise as a result of co-operation with the Province Health Directorate. These outcomes are listed in below:

- Preliminary introduction of Health Seeking Behaviour Study to local administrators was conducted.
- The problematic regions/residences in ANC services in Adana were categorized and provisional list of these health center units was prepared to be submitted to the Province Health Directorate for approval.
- NGOs active in reproductive health studies were connected and met for exchange of ideas and experiences in the province.
- Job announcement was done by several channels, applications were received and applicants for field work were interviewed.

The most significant problem in the activities in the province is seen as the load of procedures bureaucratic that may be requested from the research team. The detailed official letter to be sent to Province Health Directorate, the submission of problematic health units' list for approval, a possible demand for the list of field workers for security investigation and official order of province health directorate to proposed health units for cooperation and assistance to the TAT are pronounced bureaucratic procedures, which will create loss of time and burden of administrative contacts for the TAT. These requests and procedures should be evaluated, revised and discussed with the MoH to facilitate these processes.

HEALTH SEEKING BEHAVIOUR STUDY
PRE-FIELD STUDIES

Province **:** Afyon
Research Coordinator **:** Nurgün Platin
Dates of Visits **:** 12-14, 19 July 2006

Summary

Two visits were organized in Afyon Province, which is one of the provinces where Health Seeking Behaviour Study will be conducted, with a view to announce that the data collection stage of the study has started, and to determine data collection fields and interviewees.

1. **Activities relating to the determination of data collection fields (12 - 14 July 2006)**

An appointment was arranged by telephone with the physician in the Province Health Directorate who was responsible of Mother-Child Health - Family Planning; information concerning the distribution of health centers in Afyon Province, the population of the region, number and qualification of personnel, number of pregnant women and follow-ups, place of births in the health center regions were requested, and this conversation was confirmed by e-mail.

1.1 Meeting with the Province Health Authorities

Province Health Director was met and he was briefed about the project. Dr. Ayşe Ekşioğlu, the Deputy Director responsible of MCH/FP in Province Health Directorate was met, a discussion regarding the project was done with her and a working plan was prepared jointly.

1.2 Determination of health centers and mapping

A discussion concerning 140 health centers in Afyon Center and its 16 districts was held with Province Deputy Health Director responsible of MCH/FP and with a health officer who is knowledgeable about the region, in terms of;

- Number of personnel
- Number of pregnant women and average number of follow-ups per women according to January - May 2006 data
- Inconsistencies in numbers
- Social structure and characteristics of the regions

Thirteen health centers, which are suitable for the purpose of project, were selected (from rural and urban areas) among the list of health centers. Selected health centers were visited to gather information regarding the following topics:

1. Number of antenatal follow-ups per pregnant
2. Socio-cultural structure
3. Transportation facilities and hours
4. The extent of using Green Card

5. Utilization of private physicians
6. Family structure in the region
7. Prevailing prejudices and beliefs about pregnancy noticed by the health personnel.

At the end of that process, the health centers that are most suitable for the purpose of project were determined finally, together with the deputy director responsible of MCH/FP.

As result of that evaluation, it was decided to consider 8 health centers. Name and characteristics of the considered health centers were as following:

A. <u>Kızıldağ Village in the region of Işıklar Health Center of Afyon Center (rural)</u>

People are poor, there is no tap water in houses, water comes three days a week from village fountains, health personnel are not willing to work there, one incident of a nurse expelled by the village-chief, mobile team from Işıklar Health Center goes to that region, no transport facility, it is possible to go there only by hiring a taxi. Province Health Director had particularly advised to include that village in the study.

B. <u>Bolvadin Central Health Center No. 3 (rural)</u>

The oldest quarter of Bolvadin, quite poor, has appearance of a rural area, it is reachable by walking through inside Bolvadin, a closed community, mother-in-law dominancy.

C. <u>Çobanlar Health Center</u>

To be reached by walking through inside Çobanlar, it was first established as a hospital, however when no need was noticed it started servicing as a 24-hour health center, a closed community, mother-in-law dominancy, the personnel of health center and the Health Directorate of the Province wanted particularly to take part in the study.

D. <u>Dinar Central Tatarlı Health Center</u>

Transport is possible through Afyon-Denizli Buses, they may not accept foreigners into their houses, the doctor of the center will ask for pregnant women to come to the center for interviewing, a closed community, mother-in-law dominancy, widespread use of Green Card for poors, it is considered as a social event to go to Isparta for every kind of health services.

E. <u>Ayazin Village in the region of Kayıhan Health Center of İhsaniye Center (rural)</u>

Transport is possible through Ayazin Buses, mobile health service is available twice a month, the people are poor.

F. <u>Konarı Village in the region of Seydiler Health Center of İscehisar Center (rural)</u>

Transportation after Iscehisar is possible by hiring a vehicle, there is no doctor for a long time, people are poor, girls marry at early ages.

G. <u>Sinanpaşa Center, Taşoluk Health Center</u>

Transportation is possible by municipality buses, pregnant women prefer to use health center, and infertility prevalence is high in the region**.**

H. <u>Şuhut Center, Yarışlı Village (rural)</u>

Transportation is possible by minibuses from Şuhut Center; the village people are poor, mother-in-laws are dominant in extended families, marriage at early ages is common, most of the girls do not attend schools.

1.3 General impressions / observations regarding the topic of the project

- All health personnel were present and on duty during the visits.
- Majority of the doctors were new graduates and were carrying out the compulsory service.
- Midwives were not available everywhere.
- The expression "they come only when they are called for" was pronounced very frequently.
- It was expressed widely that mothers-in-law have dominant roles in families in the region.
- It was stated that the visits to private physician is considered as an important event in the society.
- It was mentioned that examination of pregnant women with ultrasound was an important expectation of pregnant women.
- Some midwives preferred to register pregnancy after 2 months on the ground that "the child might be miscarried".
- It is said that the mother-in-law might be unwilling to bring the bride to the health center on the ground that "her eyes may open".
- Private obstetricians do not propose tetanus vaccination to pregnant women, since they worked under sterile conditions.

2. Activities relating to the determination of interviewers

Assoc.Prof.Dr. Himmet Hülür, the Head of Sociology Department, Afyon Kocatepe University (AKTU) was contacted by telephone before the visit, he was informed about the project, the expectations from him was stated and an appointment was asked for, for a face-to-face meeting.

2.1 Meeting with the Sociology Department of Kocatepe University (14th July, 2006)

In a meeting with Assoc.Prof. Dr. Himmet Hülür, the Head of Sociology Department and a group of lecturers from that Department, some information was given about the project. A name-list of graduates or last-class students, which were considered as appropriate by them, was prepared. Designated persons were contacted and those considering to participate in the project were invited to Afyon for interviewing.

2.2 Interviewing candidates of field-workers for the project (19th July, 2006)

Interviews were held with 6 sociologists or sociology students, which could be reached and which accepted to take part in the project; and all of them were approved as field workers.

2.3 Those approved as field workers are

- Assist. Prof. Dr. Huriye Tekin Önür (Lecturer in AKTU Sociology Department)
- Sevgi Yıldırım (graduate of AKTU Sociology Department)
- Aslı Erkal (Student in 3rd class of AKTU, Sociology Department)
- Oben Öncel (graduate of Sociology Department)
- Aygül Salman (Student in 3rd class of AKTU, Sociology Department)
- Özge Özbek (Student in 3rd class of AKTU, Sociology Department)

3. Conclusions and Evaluation

It was concluded that it would be possible to get the required support from, and to establish cooperation with, Province Health Directorate and Kocaeli University Sociology Department. Most appropriate health centers for the study and the qualified candidates for the field work were determined.

HEALTH SEEKING BEHAVIOUR STUDY
PRE-FIELD STUDIES

Province : Van
Research Coordinator : Anahit Coşkun
Dates of Visit : 12-14 July 2006

Summary

As it is stated in Inception Report, the Province of Van, which is one of the selected provinces for field study, was visited on the dates stated above in order to make preliminary preparations and to complete infrastructure studies. In this context, the Province Health Directorate and the Office of Governor were visited and "The Health Seeking Behaviour Study" was introduced together with the official letter of the MoH, General Directorate of Mother and Child Health and Family Planning services.

Central quarters of the Province and peripherical districts were visited, and the problematic regions where the research will be carried out were determined and mapped, by taking also the opinions of the authorities. The Health Centers and Mother-Child Health and Family Planning Centers, to which these regions are subordinated, were visited, the health personnel were met and explanations about the research project were given.

In order to select field workers, contacts were established with previously communicated lecturers of Yüzüncü Yıl University, Sociology Department and with the staff of NGOs that carry out projects in the Province of Van; as result of interviews with applicants, 6 field workers have been selected to be trained in Ankara on the project.

1. Activities

Necessary appointments were arranged with the officials of public institutions by contacting them before the visit to Van. In this context, meetings were held with the Province Health Directorate and the Office of Governor in the first day of the visit. Both Province Health Director and Governor were in vacation; therefore the meetings were held with their deputies who represented them. The officials were informed about the project; and statistical information regarding general characteristics of the Province, and with regards to health services and particularly to reproductive health services, statistical information regarding pre-natal care and the birth-places, primary health care services and the health staff were obtained.

- **Meetings with the Province Authorities**

Contacts were held with, the Deputy Director **Dr. Ahmet Kırgın**, **Hamit Karataş**, the deputy director responsible of Health Centers and MCH/FP Section, **Dr.**

Leyla Çelik, the Director of Health Centers Section and **Nimet Okur**, the Director of Data-Processing and Statistics Section. They were informed about the project and their opinions were learned. Statistical data concerning the general health status of the study population, primary health care services and ANC services was obtained during these contacts.

Ömer Özcan, the Deputy Governor responsible of health affairs was visited together with Dr. Ahmet Kırgın, the Province Deputy Health Director. He was informed about the project and his support was provided.

A general profile, which was prepared under the light of obtained data, is given below in form of tables.

Table 1 indicates that Van has a young population; due to migration to city center, the rural/urban rate of population is 0.91 and more than half of the population owns "green card".

Table 1: General Profile of Van Province

Surface area	19.069 km2
Population	931.779
Number of districts	12
Number of towns	20
Number of village-settlement	796
Urban population	488.531
Rural population	443.248
Child population (below age of 15)	383.108
Aged Population (age of 65 and above)	26.474
Population per household	7.2
Total number of green-card owners and their share in the population %	(486.467) 52.2%

In Table 2, information regarding the population in Van center and its districts is given.

In Van Province, there are 53 **Health Centers** in total, 19 of which are located in the city center, and there are 2 **MCH/FP Centers**.

There are 104 **"Village Health Houses"** having own buildings, 17 of which are in province center and 87 in districts. Only 10 of them were currently active and totally 10 health personnel were working.

Table 3 shows basic health indicators of the Province, Table 4 shows the birthplaces and Table 5 shows the distribution of primary health care personnel.

Table 2: Population distribution of Van by districts (2005)

DISTRICTS	Distance from the city center (km)	No of Towns	No of Villages & Settlements	No of Quarters	Urban Population	Rural Population	Total Population
Center	0	2	117	63	350207	47293	397500
Bahçesaray	118	-	19	1	2653	13692	16345
Başkale	120	-	125	11	10422	45682	56104
Çaldıran	112	-	81	4	6398	49856	56254
Çatak	80	-	43	2	4746	19148	23894
Edremit	20	1	15	3	6712	11848	18560
Erciş	100	2	122	22	78883	70177	149060
Gevaş	50	1	36	7	13456	16534	29990
Gürpınar	22	-	92	6	4911	35171	40082
Muradiye	84	1	56	4	10468	39677	50145
Özalp	60	1	64	3	6995	64401	71396
Saray	84	-	26	3	2829	19620	22449
TOTAL		**8**	**796**	**129**	**498680**	**433099**	**931779**

Table 3: Basic Health Indicators in Van *

BASIC HEALTH INDICATORS	Turkey-2004	Van-2005
Population	67.803.927	931.779
Population Increase (%)	14.9	18.06
Crude Fertility Rate (%0)	20.6	19.89
Crude Mortality Rate (%0)	7.1	1.83
Child Mortality Rate (%0)	37.4	17.54
Maternal Mortality Rate (%000)	55	21.59
Health personnel assisted deliveries (%)	81	77.51
Deliveries without health personnel (%)	19	22.49

*According to Province Health Directorate officials, these data contains misleading optimistic elements as result of the recording system and the lack of institutionalization in field observations.

Table 4: Place of births in Van

Places of declared births in the year 2005 (%)							
HEALTH CENTER	**In hospital**		**Assisted by Health Personnel**		**Without the assistance of Health Personnel***		**TOTAL**
	Number	%	Number	%	Number	%	
Total	12 277	66,23	2 091	11,8	4 170	22,49	18 538

*According to the information received from the authorities, the rate of births without assistance by health personnel do not reflect the truth and should be higher.

Table 5: Distribution of Primary Health Care Personnel in Van

Personnel	**Number**	**Population per Personnel**
General Practitioner	100	9.706
Midwife	134	7.167
Nurse	125	7.963
Health Officer	59	16.638

Province of Van has insufficient number of health personnel. According to officials, health personnel that are appointed to the Province change their places after a very short period. Therefore, regarding health personnel particularly those working in primary health care facilities, continuous replacements are observed. Consequently these replacements affect the utilization of health services negatively.

- **Determination of Problematic Regions and Mapping**

After obtaining data from Province Health Directorate, field-visits, official meetings and getting specialists' opinions, following regions/places have been determined as research sites:

- Yüniplik Quarter
- Beyüzümü Quarter
- Süphan Quarter
- Gürpınar District, Güzelsu (old name, Hoşap) town

Reasons for selecting the quarters in the Province Center

- The fact that both Van's own people and the immigrants from neighbouring provinces to Van due to terror are living together
- The fact that it represents general population and cultural values of Central-Eastern Anatolian Region such as Van, Ağrı, Hakkari, Bitlis, Muş, Şırnak etc. -
- People continue to live their rural life in the city
- The fact that people do not go to health centers to benefit from their services in spite of their presence and availability

- It represents overall economic level of the Province
- Low literacy in women and the problem of Turkish language
- High fertility rate and insufficient level of utilization of ANC services

Reasons for selecting Güzelsu town:

- It presents a cross sectional profile that reflects rural parts of the Province Van
- It is easy to reach to Center because of its location that is on the route to Hakkari
- Although the fact that "Güzelsu Health Center" is close to the village, it is not preferred by women
- Health Center personnel is subject to replacements
- High fertility rate and very insufficient level of utilization of ANC services

- **Determination of Candidate "Field Workers"**

Rectorate of Van Yüzüncü Yıl University and lecturers of Sociology Department were visited and their assistance regarding the selection of "field workers" were requested. In this respect, important supports came from **Prof.Dr. Ayşe Yüksel** the Deputy Rector, and **Associate Prof. Dr. Mehmet Emin Yaşar Demirci,** the lecturer in the Sociology Department. Furthermore, support is demanded from NGOs in the region. In this context, 8 candidates were interviewed and 6 field workers were selected as suitable for our study.

One of the candidates, which could not be included for our study project, was a research staff in YYÜ Psychology Department. That applicant, whatsoever having superior qualifications, could not be selected; because he was not able to speak local language and therefore it might be difficult for him to work as an interviewer. Another candidate with high qualifications for our subject and conforming to our selection criteria was a person graduated from Istanbul University Sociology department; he received graduate degree in social anthropology from Sorbonne University, Paris and continued his doctorate studies in the same country. He was a candidate, originally from Van, fluent in local language, and involved in various studies concerning females of the region. However, he was supposed to be abroad during the period of our study; therefore he could not be selected.

All of the candidates, who were selected as "field workers" and invited for the training programme that will be started in Ankara on 25th July 2006, were graduates of YYU Sociology Department. Three of them were 2006 graduates. Two of the remaining 3 candidates had passed to 2nd class, and one had passed to 3rd class. They were selected, since they were conforming to determined criteria, as well as their ages and personal maturity levels were suitable for the study.

- **Other Activities**

Some of the NGOs active in the region were visited and their officials were met. According to preliminary determination, following non-governmental organizations were found to be active in the region:

a. Yerel Gündem 21
b. ÇYDD (Contemporary Life Support Foundation)
c. Willow's Foundation (completed reproductive health field studies)
d. Medical Research Association
e. AÇEV (Mother Child Training Foundation)
f. Eğitim Gönüllüleri Foundation
g. ÇAREM (Child Research - Rehabilitation and Training Center, Subordinated to the Office of Governor)
h. GÖÇER (Association for Compulsory Immigrants)
i. TAYDER (Detainees' Relatives Association)

Among these organizations, Prof. Dr. Ayşe Yüksel from ÇYDD, Dr. Süheyla Dabaoğlu from Willow's Foundation and Sociologist Samet Denli from ÇAREM were contacted with, explanations about their activities and the region were received. Furthermore, their support in finding out "field workers" to be employed in our project was asked for.

- **Conclusion and Evaluation**

Contacts with Province Health Directorate and Office of Governor were very constructive and successful. Meetings were held in a hot atmosphere and with close cooperation. They promised support during the implementation stage of our project.

When selecting problematic areas in Province Center, care was taken to select those quarters which have high rate of fertility and insufficient ante-natal care, as well as those which receive immigrants and reflects the general situation of Central-East Anatolian region. Apart from that a town at a distance of 60 Km. from city center was selected, which shows the characteristics of a rural area.

It was stated that, in problematic areas where study will be carried out, assistance could be received from relevant Health Center and MCH/FP centers for accessing to pregnants who did not benefit from ante-natal care. It was also stated that, ETF data and more importantly the records of pregnants, who were understood during tetanus vaccination campaigns realized in recent weeks, not to have come for ante-natal check-ups could be utilized.

Although Yüzüncü Yıl University and public-private organizations were informed about finding out "field workers" to be interviewed, it was possible to interview only 8 persons because of the precondition that local language should be spoken, and 6 of them were selected.

The contacts with NGOs of the region were not enough during that visit; therefore it was decided to obtain, during following visits, more detailed information about NGO officials and the activities carried-out by them.

In-Depth Interview Guide

Annex 4

For Pregnant Women

GUIDE FOR IN-DEPTH INTERVIEWING WITH PREGNANT WOMEN

PERSONAL DATA

Never attended ANC:
Discontinued ANC:

Place of birth
Date of birth (Age)
Education
Civil status
Years of marriage (for how many years)
Age of her spouse
Whether or not officially married
Status of multi-marriage/second wife
Occupational status (all occupations whether or not generating income)
Place of residence
For how many years has she lived here?
Month/week of pregnancy

INFORMATION REGARDING PREGNANCY AND BIRTH

- Total number of children alive
- Total number of children dead
- Previous pregnancy history (receiving antenatal care, encountering any problem)
- Previous birth history (how, where, any problems ...)
- Number of her mother's children alive
- Number of her mother's children dead
- Birth experiences of her sisters, if any
- Whether information is shared between friends/relatives about womanhood and pregnancy
- Where did women (who are close to her) get their health services during pregnancy; where did they give birth?

INFORMATION REGARDING HEALTH-SEEKING BEHAVIOUR AND HEALTH INSTITUTIONS

- Health-Seeking behaviour in general (i.e. what is she doing in order to remain healthy; where does she receive assistance from; where does she visit if she has any health problem?).
- How does she consider pregnancy (i.e. it is a natural process; it is a normal situation that requires consultation with someone; it is a situation that requires the accessing/receiving of health services)?
- Her perceptions of childbirth (her opinions about childbirth; where childbirth should happen; who should assist during childbirth; whether childbirth is a natural/normal occurrence; if it is an occurrence that requires the accessing/receiving of health services).

- What does she pay attention to – what differences are there from normal situations as regards her health – during the pregnancy?
- What are her daily routine activities during pregnancy?
- What are her sources of information concerning pregnancy?
- How did she confirm her present pregnancy?
- How many times has she received care during her present pregnancy (from where and what kind of services)?
- In what cases are doctors/health institutions visited during pregnancy?
- How is she informed about the places where antenatal services are provided during pregnancy?
- How often does she visit health institutions? Why does she choose to use health institutions? Why does she choose *not* to use health institutions?
- Does she have faith in health institutions?
- In what cases is she assisted by a midwife?
- Recourse to healers (pilgrim, hodja, bonesetter, bonesetter, old-woman drug makers)

To be asked to those who visited a health institution during their present pregnancies:

- To which health institution has she applied to receive antenatal services during her pregnancy (its distance from her house; how many vehicles she needs to use to get there; how she got there)?
- When she goes to the health institution to receive antenatal services? Does she feel the necessity to go there alone or together with her relatives?
- What kind of services has she received from that health institution (blood pressure measured; type of examination; information regarding the condition of the baby; blood and urinary tests; if given a medical prescription; if a medical preparation of iron was prescribed)?
- The physical conditions of the health institution (if there was a waiting room/if it was ventilated/if it can be visited together with a child).
- Thoughts/opinions about health personnel.
- The provision of information/explanations by health personnel to her about pregnancy.
- Loss of time experienced when a service is received.

FACTORS RELATING TO GENDER ISSUES

- Who decides (which household members) whether a doctor/health institution is to be used (to what extent is the woman effectual/autonomous in making such decisions)?
- Whether the expectant mother's spouse has the prerogative of deciding if a doctor/health institution is used and thereby granting or withholding permission.
- Attitudes of other family members in this respect (mothers-in-law, sisters-in-law etc.).
- Expectant mother's relations with her peers and neighbours.
- Ability to attend social activities (shopping, making invoice payments, walking around hither and thither etc.).
- Training received outside school.
- Educational status of other women in the family.

- Effect of husband's education.
- In household expenditures, what the priorities in order of payment are.
- The position/priority of her health-care expenses in relation to other expenses.
- Division of duties and use of time in the family.
- Sources of income over which the expectant mother has authority (for example, if her own income, the money that her husband gives etc.)

SOCIO-ECONOMIC FACTORS

- Who in the family are working in an income-creating job (occupational status of other women)?
- Main sources of income of the family.
- Financial incapacity/problems/solutions in this respect (such as mutual assistance funds).
- Perception of his/her financial position and its correlation with others' financial position in the locality.
- Social and Health Insurance.
- Possession of Green Card.

SOCIO-CULTURAL FACTORS

- Traditions/customs regarding pregnancy (traditional practices).
- Practice of reading health news in newspapers/magazines.
- Practice of watching health programs on television.
- Influence of beliefs on health-seeking behaviour (religious, superstitious, *other*).
- Influence of language on health-seeking behaviour.

EXPECTATIONS

- Where she wants to give birth and why.
- Health services relating to pregnancy/childbirth that she expects to be available in the region she lives.

Annex 5 In-Depth Interview Guide

For Family Members

GUIDE FOR IN-DEPTH INTERVIEWING WITH HUSBAND, MOTHER-IN-LAW AND RELATIVES OF PREGNANT WOMEN

PERSONAL DATA

Place of birth
Date of birth (Age)
Gender
Relation with pregnant
Education
Civil status
Status of multi-marriage/second wife
For how many years has he/she lived here?
Whether or not he/she lives together with the pregnant woman

INFORMATION REGARDING HEALTH-SEEKING BEHAVIOUR AND HEALTH INSTITUTIONS

- Health-Seeking behaviour in general (i.e. what is he/she doing in order to remain healthy, where does he/she receive assistance from, where does he/she visit if he/she has any complaint).
- How does he/she consider pregnancy (i.e. it is a natural process; it is a normal situation that requires consultation; it is a situation that requires receiving health services)?
- His/her perceptions about childbirth (his/her opinions about childbirth; where it should be done; who should assist in the childbirth; whether the birth is perceived as a natural/normal occurrence or not; it is a situation that requires health care).
- What, being different from normal situations, ought to be borne in mind with regards to health during the pregnancy?
- Whether a pregnant woman should be supported in her daily life (If yes, what type of support should be provided?).
- In which cases are doctor/health institutions visited during pregnancy?
- General evaluation and opinions about health institutions in the locality.
- The institutions in the locality that provide services relating to pregnancy and birth, if any (what are these; opinions of them; the incidence of pregnant woman's visits to them for antenatal care; if she goes, why and when; distance of these institutions from the place of residence; transport problems, if any; scope of the service; thoughts and opinions regarding health personnel; the suitability of the buildings of those institutions etc.).
- Case of using midwife (use of midwives, traditional birth attendants in the region).
- What he/she knows about traditional practices regarding pregnancy.
- Recourse to traditional healers (pilgrim, hodja, bonesetter, bonesetter, old-woman drug makers)

FACTORS RELATING TO GENDER ISSUES

- Household members deciding on going to doctor/health institution (to what extent is the partner or pregnant woman effectual/autonomous when making such decisions?).
- Who around the expectant mother has the prerogative of deciding if a doctor/health institution is used and thereby granting or withholding permission?
- If a pregnant woman visits a health institution alone, what would be the attitudes of other family-members, neighbours?
- Relation of pregnant woman with her peers and neighbours (with whom does she meet, how often does she meet, etc?).
- Ability to attend social activities (shopping, making invoice payments, walking around hither and thither etc.).
- In household expenditures, what are the priorities in order of payment?
- What is the place of health expenditures for his wife/daughter-in-law in comparison to other expenditures?
- Division of labour and use of time in the family.
- Sources of income on which the woman in the family has authority.

SOCIO-ECONOMIC FACTORS

- Who are working in the family?
- Main sources of income of the family.
- Financial incapacity/problems/solutions in this respect (such as mutual assistance funds).
- Perception of financial position and its correlation with others' financial position in the locality.
- Social and Health Insurance.
- Possession of Green Card (who possesses a Green Card in the family).

SOCIO-CULTURAL FACTORS

- Practice of reading health news in newspapers/magazines.
- Practice of watching health programs on television.
- Influence of beliefs on health-seeking behaviour (religious, superstitious, *other*).
- The influence of his/her language on his/her health-seeking behaviour

EXPECTATIONS

- Where does he/she prefer his wife or her daughter-in-law to give birth?
- Health services relating to pregnancy/childbirth that he/she expects to be available in the region he/she stays (antenatal care services).
- The condition/quality expected from the antenatal health services provided by the government.

Annex 6 In-Depth Interview Guide

For Key Informants

GUIDE FOR IN-DEPTH INTERVIEWING WITH KEY INFORMANTS, COMMUNITY LEADERS

PERSONAL DATA

Place of birth
Date of birth (Age)
Gender
Education
Civil status
His/her present duty/job
For how many years has he/she been practising this profession?
His/her previous occupation

INFORMATION ABOUT SETTLEMENT

- Average (approximate) population (or number of households).
- Economic activities of the population living in the settlement (what kind of jobs do they do/how do they earn for their living?).
- Type of houses in the settlement (apartment houses, houses with gardens).
- Family type in the settlement (nuclear family, extended-traditional family).
- Commonness of women working outside the house.
- The commonness of women generating income at home (knitting; creating lacework and selling it; animal husbandry; other small in-house manufacturing, etc.)
- Education of girls (whether girls are sent to school).
- Public institutions/organisations in the settlement (state offices, service departments of the municipality, schools, university, etc.).
- Whether there are any premises, workshops, mills, organised industrial zones etc. around the premises (around the village or quarter).
- Associations, foundations, aid organisations, other voluntary organisations in the settlement (their activities/what are they doing, do they have many members and employees, etc.).
- Infrastructural services in the settlement (water, drainage, electricity, transport, environment, natural gas).
- Service plans being continued or planned for the future in the settlement (infrastructure, transportation, health, education, etc.).

HEALTH INSTITUTIONS IN THE SETTLEMENT

- Units in the settlement that are subordinated to the Ministry of Health (health centres, , hospital, MCH/FP Centre, etc.).
- The foundation years of the institutions subordinated to the Ministry of Health in the settlement (whether they are old or new)
- Activities, servicing capacities of the institutions subordinated to the Ministry of Health in the settlement (whether they can answer the needs).
- Is there Red Crescent in the settlement (the groups to which it provides services).

- Private health organisations in the settlement (to whom does it service mostly).
- Health services of associations, foundations, aid organisations, and other voluntary organisations in the region (whether there are briefing campaigns, and, if any, whom does it cover).
- Other health services in the settlement (university hospital, doctor's offices, etc.).
- Healers in the region (pilgrim-hodja, bonesetters, herbalists, traditional birth attendants, etc. Do the people of the region visit them when they become ill)
- Green Card demand.
- Problems relating to Green Card practices (are they sufficient/is there distribution as it should be?).
- Other assistance relating to health in the settlement.
- Health research works/health campaigns carried out by the Health Directorate, university, association/foundations and other organisations in the settlement (*to the field worker: if there are collect detailed information about them*).

EVALUATION OF HEALTH INSTITUTIONS

- Use of health organisations in the settlement (intensity/frequency).
- Who prefers which institution (female/male; child/young/old; the poor/less poor/the wealthier; new immigrants; those living there for many years; the educated; those having some type of health insurance).
- Evaluation of house visits in the settlement by health personnel.
- Courses/training programmes or campaigns relating to health organised by the municipality, if any.
- Sample cases relating to health (in particular, observation, and experiences regarding pregnancy, childbirth, and the relation between health personnel and their service receivers) (*to the field worker: Help them give this information in as detailed a manner as possible and as candidly as possible*).

Annex 7 In-Depth Interview Guide For Health Personnel

GUIDE FOR IN-DEPTH INTERVIEWING WITH HEALTH PERSONNEL

PERSONAL DATA

Place of birth
Date of birth (Age)
For how many years has he/she lived in this settlement?
Gender
Civil status
His/her present duty/job
His/her educational situation
For how many years has he/she been practising this profession?
For how many years has he/she been in this institution?

INFORMATION REGARDING HEALTH SERVICES IN THE REGION

- Social security/health insurance situation of the population in the region.
- Percentage of Green Card owners' in the population of the region (and observations, information, and opinions regarding Green Card practices).
- Health institutions being subordinate to the Ministry of Health.
- Other health organisations belonging to public institutions (university, municipality, etc.).
- Health organisations belonging to non-profit institutions such as foundations, associations, and others.
- Private health organisations (private hospitals, outpatient clinics etc.).
- Private physician offices, private midwives, nurses, etc.
- Traditional healers (such as, pilgrim, hodja, bonesetter)
- Frequency of access and utilisation of the available health services and reasons for preference (why are some providers preferred over others).
- Presence of non-governmental organisations such as foundations, and associations in the region, and their activities relating to reproductive health.
- Training programs, courses on health, organised by the municipalities (if any).

FACTORS RELATING TO HEALTH INSTITUTION

- Scope of the services provided by the health institution (for example, what sort of health services are provided, to what extent, the average number of patients per day).
- Whether the number of personnel in a health institution is sufficient (if everybody is occupied in work that conforms to his/her profession; the workload).
- The relations and contact of health personnel with their superiors.
- Whether the health institution is convenient for the purposes of services provided, in terms of physical properties such as the size and shape of the building, its equipment, the number of rooms etc.
- Whether there is a follow-up card which is filled-in regularly to follow pregnant women (or why there is *not* a follow-up card; or why it is *not* filled-in regularly).
- Whether house visits are done or not, and if done what the frequency is.
- Inspections, campaigns (vaccination, mother’s milk, etc.), informative or training programmes relating to health.

- Relations/expectations between the health institution, and the Province Health Directorate and the Ministry of Health.
- In-service training and institutional briefing programs.
- Their opinions regarding the adequacy of reproductive health services.

OBSERVATIONS/VIEWS REGARDING PREGNANT WOMEN

- How is the general behaviour of the women in the region with regard to their health (for example, whether they go to health institutions before illness; widespread practices other than visiting a health institution; the places resorted to when getting ill)?
- The frequency of antenatal care received by pregnant women (is it regular, is it sufficient?).
- How is the general knowledge level of pregnant women regarding reproductive health and their rights?
- Relations and contact between health personnel and pregnant women.
- Demands/expectations of pregnant women from health personnel.
- The commonness/use of traditional health information.
- Whether the place and position of women in the society in that region (gender role) affect the receiving of health services during pregnancy (does it positively or negatively affect the receiving of health services during pregnancy?).
- Noteworthy practices of pregnant women for their health during pregnancy and childbirth (observations that might be interesting).

PERSONAL FACTORS

- Whether the type of work done by health personnel concords with his/her education?
- Is the working environment suitable for applying their knowledge?
- Can the health personnel generally follow recent professional developments?
- Physical or psychological impacts of working conditions.
- The impact of his/her responsibilities on the family and on household life to the service he/she renders.
- Other personal factors.

OBSERVATIONS RELATING TO ENVIRONMENT

- General socio-economic observations relating to the region where the service is provided (such as, economic, education)
- Services related to infrastructure (such as, electricity, water, natural gas, transportation, drainage).
- Religious beliefs.
- Superstitious beliefs.
- Kinship relations.
- Being from the same region/neighbourhood relations.
- Traditions/customs.
- Mother tongue.
- Differences between the local population and the immigrant population.
- Observations, interesting findings regarding the general position in the society of the women in that region.

EXPECTATIONS

- His/her expectations with regards to the health services (particularly reproductive health services) in the region where he/she works.

Annex-8

Training Programme

For Field Workers

HEALTH SEEKING BEHAVIOUR STUDY
TRAINING PROGRAMME FOR FIELD WORKERS
(25 July-2 August 2006)

25 July 2006 Tuesday
09.00 – 10.00 Registration
10.00 – 11.00 Opening and Introduction
11.00 – 11.30 **Coffee break**
11.30 – 12.30 Presentation of the Project
12.30 – 13.30 **Lunch break**
13.30 – 15.00 Turkish Health System (Mehmet Ali Biliker)
15.00 – 15.30 **Coffee break**
15.30 – 17.00 Health Seeking Behaviour (Osman Hayran)
17.00 – 18.00 Evaluation of the day (Osman Hayran)

26 July 2006 Wednesday
09.00 – 10.30 Antenatal Care Services (Şevkat Bahar Özvarış)
10.30 – 11.00 **Coffee break**
11.00 – 12.30 Social and cultural aspects of health services (Muhtar Kutlu)
12.30 – 13.30 **Lunch break**
13.30 – 15.00 Qualitative Research Methodology (Metin Özuğurlu)
15.00 – 15.30 **Coffee break**
15.30 – 17.00 Qualitative Research Methodology (Metin Özuğurlu)
17.00 – 18.00 Evaluation of the day (Erhan Özdemir)

27 July 2006 Thursday
09.00 – 10.30 Interview techniques (Metin Özuğurlu)
10.30 – 11.00 **Coffee break**
11.00 – 12.30 In-depth ınterviews (Metin Özuğurlu)
12.30 – 13.30 **Lunch break**
13.30 – 15.00 Communication skills and techniques (Metin Özuğurlu)
15.00 – 15.30 **Coffee break**
15.30 – 17.00 Data collection and storage tools/Homework (Erhan Özdemir / Anahit Coşkun)
17.00 – 18.00 Evaluation of the day (Nurgün Platin)

28 July 2006 Friday
09.00 – 10.30 Presentation of the homeworks (Erhan Özdemir,Anahit Coşkun)
10.30 – 11.00 **Coffee break**
11.00 – 12.30 Presentation of the homeworks
12.30 – 13.30 **Lunch break**
13.30 – 15.00 Sampling methodology and target groups of the study (Metin Özuğurlu)
15.00 – 15.30 **Coffee break**
15.30 – 17.00 Interview guides of the study (Erhan Özdemir ve Anahit Coşkun)

17.00 – 18.00 Evaluation of the day (Anahit Coşkun)

29 July 2006 Saturday
09.00 – 10.30 Biases in qualitative researh (Metin Özuğurlu)
10.30 – 11.00 **Coffee break**
11.00 – 12.30 Research ethics (Metin Özuğurlu)
12.30 – 13.30 **Lunch break**
13.30 – 15.00 Preparation for the Field Reality Test (RC, Metin Özuğurlu)
15.00 – 15.30 **Coffee break**
15.30 – 17.00 Preparation for the Field Reality Test (RC, Metin Özuğurlu)
17.00 – 18.00 Evaluation of the day (Nurgün Platin)

31 July 2006 Monday
Field Reality Testı (Peri-urban areas of Ankara)
(Every participants will conduct at least one interview and one observation with the individuals from the study target groups)

1 August 2006 Tuesday
Field Reality Testı (Peri-urban areas of Ankara)
(Every participants will conduct at least one interview and one observation with the individuals from the study target groups)

2 August 2006 Wednesday
09.00 – 11.00 Re-fresher training (Osman Hayran,Anahit Coşkun, Nurgün Platin, Erhan Özdemir, Metin Özuğurlu)
11.00 – 11.30 **Coffee break**
11.30 – 12.30 Re-fresher training
12.30 – 13.30 Evaluation of the training programme and closing
13.30 – 14.30 **Lunch break**

Annex-9

Field Manual for

Field Workers

HEALTH-SEEKING BEHAVIOUR STUDY

FIELD MANUAL

Purpose of the study:

The objective of this study is to define perceptions of and health-seeking behaviours related to pregnancy and childbirth, and to identify the responsiveness of primary health care services to that requirement in selected urban and rural sites in Turkey.

IN-DEPTH INTERVIEW PROCESS

1. PREPARATION BEFORE THE INTERVIEW (by the interviewer and observer)

1.1.Identify the person to be interviewed (interview the pregnant women and her family members first, and then community leaders and health personnel)

1.2.Required characteristics of the persons to be interviewed:

Pregnant women: Pregnant women who never attended antenatal care (ANC) or who discontinued ANC attendance.

Pregnant women who never attended ANC: Pregnant women who are aware of their pregnancy, but who have not received any ANC in any health institution. Since they are not registered in health centres records they are termed as "difficult to reach" groups in such studies. Use the snowball sampling method to reach such women. In order to reach these women, ask each pregnant woman that you meet, whether she knows other pregnant women like herself. Use the ANNEX 1-a form for the interview.

Pregnant women who discontinued their ANC attendance: Pregnant women who are aware of their pregnancies, but who have not complied in some way with the follow-up schedule indicated below. Use the ANNEX 1-a form for the interview as well.

1st follow-up visit: in first 12 weeks (first 3 months) of pregnancy
2nd follow-up visit: between 24th - 26th weeks (6th month) of pregnancy
3rd follow-up visit: between 30th - 32nd weeks (7.5-8th months) of pregnancy
4th follow-up visit: between 36th - 38th weeks (9th month) of pregnancy

- **Do not interview pregnant women who have complied with the above follow-up schedule anywhere other than the health centres.**
- **Interview women who have completed their first trimester (three months of pregnancy).**

Pregnant women's husbands and family members: They are the husband, mothers-in-law, or close relatives of the pregnant women. Use the ANNEX 1-b form for the interview.

Health personnel: Include general practitioner or specialist, midwife, nurse, health officer, who work for the Ministry of Health in primary health care settings, where reproductive health services are provided. Use the ANNEX 2 for the interview.

Make sure that these personnel know the region, or have worked in the health centre for at least one year and are cooperative.

Community leaders: Imam, *muhktar* [Head of Village], pharmacist, teacher, journalist, representatives from non-governmental organisations, opinion leaders. Use the form in ANNEX 3 for interviewing them.

Make sure that these personnel know the region, or have worked/lived in the community for at least one year and are cooperative.

1.3. Find the address.

1.4. Inform the interviewee about the subject, and get his/her consent for the interview.

1.5. Make an appointment for the interview. (This should be done at the earliest and most convenient time taking into regard particularly the domestic and working conditions of public servants such as nurses, *muhktars*, physicians, midwives, and teachers. Interviews with these people can be done after work hours or on non-working days.)

1.6. Inform the province supervisor about the person to be interviewed.

1.7. Check the interview guides, notebook, and pen; and check that the voice recorder is fully-functional and that you have spare batteries just in case.

1.8. Be on time for your appointment.

2. PREPARATION FOR THE INTERVIEW (by the interviewer only)

2.1. Select, if possible, an environment that is quiet, and free from any interruptions such as the appearance of other personnel, and/or phone calls.

2.2. Be seated face-to-face with the interviewee.

2.3. The observer should be seated in a place from where he/she can easily observe the interviewee, the interviewer, and the environment where the interview takes place.

2.4. Check the functional status of the voice recorder and the spare batteries.

2.5. Introduce yourself and the observer to the interviewee.

2.6. When informing the interviewee about the topic of the study, say the complete title of the study. Read the purpose and target groups of the study as indicated on the informed consent form (ANNEX 4 and ANNEX 5 respectively).

2.7. Repeat the purpose of the study to the interviewee *verbatim*, and in a comprehensible manner, bearing in mind the individual characteristics of each interviewee. Tell him/her that the study is conducted for the Ministry of Health, and that you are not Ministry personnel but independent researchers. Underline the fact that what he/she is going to say will not be shared with any public or private institution.

2.8. Ask for the permission for voice recording. (When emphasizing the topics of confidentiality, be comfortable and natural.)

2.9. Place the voice recorder in a most effective position for the best recording of the voices of interviewer and interviewee. Make sure that there is no obstruction for the recording.

3. INTERVIEW

For the interviewer:

3.1. After turning on the voice recorder, begin the recording by declaring that permission was obtained from the interviewee. For example: "I begin this interview on the aforementioned topic, and for which I have obtained permission from the interviewee. Thank you for your consent. Now, please tell us about yourself?"

3.2. Do not forget to ask for information such as, age, place of birth, and education of the interviewee, at the beginning of interview.

3.3. Do not intervene with the interview if it proceeds in line with the subject.

3.4. Make a reminder or ask an appropriate question to return to the focal point if the content of the interview runs into unnecessary details or diverts from the main topic.

3.5. Do not be too orienting.

3.6. Be aware of your body language.

3.7. Do not allow harsh transitions between subjects/questions.

3.8. Do not reflect your feelings, thoughts, or judgments either verbally or kinesically (i.e. via body language such as body movements or gestures).

3.9. Clarify by using open questions (such as, *why*, *how*, *for what*) when you think the responses are unsatisfactory or unclear.

3.10. Do not interrupt the interviewee. Listen to the end. Do not move to another question before he/she finishes.

3.11. Try to understand what the interviewee means when he/she uses a word that you do not know.

3.12. Do not handle or frequently turn on and off the voice recorder; bear in mind that such toying with the equipment may distract the interviewee and cause a loss of concentration on the topic at hand.

3.13. Folk-speech, or folksay, (the traditional speech of a regional group) used in relation to pregnancy and/or childbirth can be expected to be used during the interview. A list of such terms used by region is given in ANNEX 6. If a term that is not listed is used, add it to the list.

3.14. Check the interview guide to make sure that there is no uncovered topic left. If there are any, cover them. Bear in mind that all topics under the main headings should be broached.

3.15. Pose the same question in a different way when a more satisfactory response is needed.

3.16. When concluding the interview:

- Ask the interviewee for general opinions and wishes for the future of the health services in the region.
- Ask the interviewee whether he/she has any questions or comments to make.
- Thank the interviewee.
- Turn off the voice recorder.

3.17. If the interview is interrupted from outside (when someone comes in):

- Wait until the environment returns to how it was. The observer should continue taking notes.
- When the environment returns to how it was, continue with the interview as before the interruption.
- If the disturbance is protracted:
  - End the interview.
  - Turn off the voice recorder.
  - Make an appointment for another time or day.
  - Thank the interviewee.

<u>For the observer:</u>

3.18. Sit in a place where you can observe everything.

3.19. Take notes regarding approvals, and the reactions of the interviewee either verbally or kinesically during the interview (through body language such as body movements or gestures),

3.20. Take notes about the location of the interview (street, house, community, and the environment.)

3.21. Take notes about the place and the environment where interview is carried out (house, number of rooms, kitchen, toilette, etc.)

3.22. Take notes about behaviour and attitudes of the interviewee.

4. THINGS TO DO AFTER THE INTERVIEW (by the interviewer and observer)

4.1. Inform the province supervisor if any problem arises in relation to the interview. Mobile phone number of province supervisor (*write the number here*): .....

4.2. Inform the supervisor about your interviewee.

4.3. Transfer data from the voice recorder to a computer (as voice recording, in original, and in WAV formats):

4.4. Be sure to indicate the following information at the beginning of the transcription of the voice recordings:

- Name of the interviewer.
- Name of observer.
- The province where the interview was held.
- The province centre/district centre, sub-district/village where interview is held.
- Date of interview.
- The identification of the interviewee (pregnant woman, relative, health personnel, community leader).
- Characteristics of the interviewee (age, gender, educational status, mother tongue, profession)
- Duration of interview (start and finishing time of the interview).

4.5. The interviewer will keep a diary relating to the interview held on that day.

4.6. Transcribe everything that you hear and as you hear (folk-speech, for example) from voice recorder.

4.7. Transcribe the observer notes (notes taken during the interview in relation to the attitudes and body language of the interviewee; the place and environment in which interview is held; the consistency of the interview; the reactions of the interviewee to the questions).

4.8. Transcribe the 'diary' of the interviewer (impressions about the interview; difficulties faced; the points encountered during the interview).

4.9. Return the voice and written recordings to the province supervisor.

4.10. Return the information regarding the interview to the province supervisor (ANNEX 7) by using your code (ANNEX 9).

4.11. Return the documents of the expenses (transportation; lodging; food receipts and/or cash register receipts) relating to the interview to the province supervisor (ANNEX 8) by using your code (ANNEX 9).

5. DUTIES AND RESPONSIBILITIES OF THE PROVINCE SUPERVISOR

5.1. Take part as interviewer and observer.

5.2. Is responsible from the utilisation and safekeeping of the computer and voice recorders issued.

5.3. Is responsible for the work of fieldworkers so far as to:

- Solve the problems faced by the fieldworkers.
- Report administrative problems to the research coordinator (which are related to health centres, health posts, mother and child health-family planning centres, province health directorate, and the office of governor).
- Mobile phone number of research coordinator responsible of the province (*write* the *number here*): .....

5.4. Is responsible to the fieldworkers so far as to:

- Accept the voice and written recordings from fieldworkers after each interview.
- Keep the records relating to each interview (planned interviews; interviews completed; interviews to be completed).
- Make a CD copy of the voice and written recordings of each interview.
- Keep a record of expenses for each interview and collect all the vouchers and receipts (transportation; accommodation; food receipts and/or cash register receipts) from the fieldworkers.
- Follow the completion of the sample size for the province:

Target group	*Number of in-depth interviews*		
	Adana	Van	Afyon
Pregnant Woman	35	15	15
Spouse and relative	11	5	5
Health personnel	8	5	5
Community leader	11	5	5
Total	65	30	30

- Pay the interviewers and observers.
- Meet regularly with the fieldworkers and discuss the issues faced.

5.5. Supervise fieldwork regarding the completion of the sample.

5.6. Is responsible to the research coordinator so far as to:

- Inform the research coordinator about fieldwork (written and/or oral).
- Return the voice and written recordings to the research coordinator.
- Return the expense records of the fieldworkers to the research coordinator.
- Meet regularly with the research coordinator and discuss problems faced.

6. DUTIES AND RESPONSIBILITIES OF THE PROVINCE RESEARCH COORDINATOR

6.1. Is responsible towards the province supervisor and the fieldworkers so far as to:

- Respond to the telephone or written referrals of the province supervisor.
- Collect the interview's voice and written recordings from province supervisor.
- Collect the fieldworkers' expenditure records from the province supervisor.
- Meet regularly and discuss the problems faced by the province supervisor and fieldworkers.
- Visit the province regularly.

6.2. Is responsible towards the field coordinator so far as to:

- Report in written and/or oral form on the developments, experiences, problems, and solutions to the field coordinator.

6.3. Is responsible towards the province health directorate and the governor's office so far as to:

- Report to the province health directorate and the governor's office about the research process.
- Maintain contacts throughout the research period with the health centres; health posts; mother and child health-family planning centres; and province health directorate involved.
- Inform the research team leader about the process within the province.

7. DUTIES AND RESPONSIBILITIES OF THE RESEARCH TEAM LEADER

7.1. Meet regularly with the research coordinators to update them on the research process within the provinces.

7.2. Inform the Ministry of Health, and the General Directorate for Mother and Child Health-Family Planning, about the research process.

7.3. Solve problems at the Ministry of Health level that may arise during field the work.

ANNEX 1-a

GUIDE FOR IN-DEPTH INTERVIEWING WITH PREGNANT WOMEN

PERSONAL DATA

Never attended ANC:
Discontinued ANC:

Place of birth
Date of birth (Age)
Education
Civil status
Years of marriage (for how many years)
Age of her spouse
Whether or not officially married
Status of multi-marriage/second wife
Occupational status (all occupations whether or not generating income)
Place of residence
For how many years has she lived here?
Month/week of pregnancy

INFORMATION REGARDING PREGNANCY AND BIRTH

- Total number of children alive
- Total number of children dead
- Previous pregnancy history (receiving antenatal care, encountering any problem)
- Previous birth history (how, where, any problems ...)
- Number of her mother's children alive
- Number of her mother's children dead
- Birth experiences of her sisters, if any
- Whether information is shared between friends/relatives about womanhood and pregnancy
- Where did women (who are close to her) get their health services during pregnancy; where did they give birth?

INFORMATION REGARDING HEALTH-SEEKING BEHAVIOUR AND HEALTH INSTITUTIONS

- Health-Seeking behaviour in general (i.e. what is she doing in order to remain healthy; where does she receive assistance from; where does she visit if she has any health problem?).
- How does she consider pregnancy (i.e. it is a natural process; it is a normal situation that requires consultation with someone; it is a situation that requires the accessing/receiving of health services)?
- Her perceptions of childbirth (her opinions about childbirth; where childbirth should happen; who should assist during childbirth; whether childbirth is a natural/normal occurrence; if it is an occurrence that requires the accessing/receiving of health services).
- What does she pay attention to – what differences are there from normal

situations as regards her health – during the pregnancy?

- What are her daily routine activities during pregnancy?
- What are her sources of information concerning pregnancy?
- How did she confirm her present pregnancy?
- How many times has she received care during her present pregnancy (from where and what kind of services)?
- In what cases are doctors/health institutions visited during pregnancy?
- How is she informed about the places where antenatal services are provided during pregnancy?
- How often does she visit health institutions? Why does she choose to use health institutions? Why does she choose *not* to use health institutions?
- Does she have faith in health institutions?
- In what cases is she assisted by a midwife?
- Recourse to healers (pilgrim, hodja, bonesetter, bonesetter, old-woman drug makers)

- *To be asked to those who visited a health institution during their present pregnancies:*

- To which health institution has she applied to receive antenatal services during her pregnancy (its distance from her house; how many vehicles she needs to use to get there; how she got there)?
- When she goes to the health institution to receive antenatal services? Does she feel the necessity to go there alone or together with her relatives?
- What kind of services has she received from that health institution (blood pressure measured; type of examination; information regarding the condition of the baby; blood and urinary tests; if given a medical prescription; if a medical preparation of iron was prescribed)?
- The physical conditions of the health institution (if there was a waiting room/if it was ventilated/if it can be visited together with a child).
- Thoughts/opinions about health personnel.
- The provision of information/explanations by health personnel to her about pregnancy.
- Loss of time experienced when a service is received.

FACTORS RELATING TO GENDER ISSUES

- Who decides (which household members) whether a doctor/health institution is to be used (to what extent is the woman effectual/autonomous in making such decisions)?
- Whether the expectant mother's spouse has the prerogative of deciding if a doctor/health institution is used and thereby granting or withholding permission.
- Attitudes of other family members in this respect (mothers-in-law, sisters-in-law etc.).
- Expectant mother's relations with her peers and neighbours.
- Ability to attend social activities (shopping, making invoice payments, walking around hither and thither etc.).
- Training received outside school.
- Educational status of other women in the family.

- Effect of husband's education.
- In household expenditures, what the priorities in order of payment are.
- The position/priority of her health-care expenses in relation to other expenses.
- Division of duties and use of time in the family.
- Sources of income over which the expectant mother has authority (for example, if her own income, the money that her husband gives etc.)

SOCIO-ECONOMIC FACTORS

- Who in the family are working in an income-creating job (occupational status of other women)?
- Main sources of income of the family.
- Financial incapacity/problems/solutions in this respect (such as mutual assistance funds).
- Perception of his/her financial position and its correlation with others' financial position in the locality.
- Social and Health Insurance.
- Possession of Green Card.

SOCIO-CULTURAL FACTORS

- Traditions/customs regarding pregnancy (traditional practices).
- Practice of reading health news in newspapers/magazines.
- Practice of watching health programs on television.
- Influence of beliefs on health-seeking behaviour (religious, superstitious, *other*).
- Influence of language on health-seeking behaviour.

EXPECTATIONS

- Where she wants to give birth and why.
- Health services relating to pregnancy/childbirth that she expects to be available in the region she lives.

ANNEX 1-b

GUIDE FOR IN-DEPTH INTERVIEWING WITH HUSBAND, MOTHER-IN-LAW AND RELATIVES OF PREGNANT WOMEN

PERSONAL DATA

Place of birth
Date of birth (Age)
Gender
Relation with pregnant
Education
Civil status
Status of multi-marriage/second wife
For how many years has he/she lived here?
Whether or not he/she lives together with the pregnant woman

INFORMATION REGARDING HEALTH-SEEKING BEHAVIOUR AND HEALTH INSTITUTIONS

- Health-Seeking behaviour in general (i.e. what is he/she doing in order to remain healthy, where does he/she receive assistance from, where does he/she visit if he/she has any complaint).
- How does he/she consider pregnancy (i.e. it is a natural process; it is a normal situation that requires consultation; it is a situation that requires receiving health services)?
- His/her perceptions about childbirth (his/her opinions about childbirth; where it should be done; who should assist in the childbirth; whether the birth is perceived as a natural/normal occurrence or not; it is a situation that requires health care).
- What, being different from normal situations, ought to be borne in mind with regards to health during the pregnancy?
- Whether a pregnant woman should be supported in her daily life (If yes, what type of support should be provided?).
- In which cases are doctor/health institutions visited during pregnancy?
- General evaluation and opinions about health institutions in the locality.
- The institutions in the locality that provide services relating to pregnancy and birth, if any (what are these; opinions of them; the incidence of pregnant woman's visits to them for antenatal care; if she goes, why and when; distance of these institutions from the place of residence; transport problems, if any; scope of the service; thoughts and opinions regarding health personnel; the suitability of the buildings of those institutions etc.).
- Case of using midwife (use of midwives, traditional birth attendants in the region).
- What he/she knows about traditional practices regarding pregnancy.
- Recourse to traditional healers (pilgrim, hodja, bonesetter, bonesetter, old-woman drug makers)

FACTORS RELATING TO GENDER ISSUES

- Household members deciding on going to doctor/health institution (to what extent is the partner or pregnant woman effectual/autonomous when making such decisions?).
- Who around the expectant mother has the prerogative of deciding if a doctor/health institution is used and thereby granting or withholding permission?
- If a pregnant woman visits a health institution alone, what would be the attitudes of other family-members, neighbours?
- Relation of pregnant woman with her peers and neighbours (with whom does she meet, how often does she meet, etc?).
- Ability to attend social activities (shopping, making invoice payments, walking around hither and thither etc.).
- In household expenditures, what are the priorities in order of payment?
- What is the place of health expenditures for his wife/daughter-in-law in comparison to other expenditures?
- Division of labour and use of time in the family.
- Sources of income on which the woman in the family has authority.

SOCIO-ECONOMIC FACTORS

- Who are working in the family?
- Main sources of income of the family.
- Financial incapacity/problems/solutions in this respect (such as mutual assistance funds).
- Perception of financial position and its correlation with others' financial position in the locality.
- Social and Health Insurance.
- Possession of Green Card (who possesses a Green Card in the family).

SOCIO-CULTURAL FACTORS

- Practice of reading health news in newspapers/magazines.
- Practice of watching health programs on television.
- Influence of beliefs on health-seeking behaviour (religious, superstitious, *other*).
- The influence of his/her language on his/her health-seeking behaviour

EXPECTATIONS

- Where does he/she prefer his wife or her daughter-in-law to give birth?
- Health services relating to pregnancy/childbirth that he/she expects to be available in the region he/she stays (antenatal care services).
- The condition/quality expected from the antenatal health services provided by the government.

ANNEX 2

GUIDE FOR IN-DEPTH INTERVIEWING WITH HEALTH PERSONNEL

PERSONAL DATA

Place of birth
Date of birth (Age)
For how many years has he/she lived in this settlement?
Gender
Civil status
His/her present duty/job
His/her educational situation
For how many years has he/she been practising this profession?
For how many years has he/she been in this institution?

INFORMATION REGARDING HEALTH SERVICES IN THE REGION

- Social security/health insurance situation of the population in the region.
- Percentage of Green Card owners' in the population of the region (and observations, information, and opinions regarding Green Card practices).
- Health institutions being subordinate to the Ministry of Health.
- Other health organisations belonging to public institutions (university, municipality, etc.).
- Health organisations belonging to non-profit institutions such as foundations, associations, and others.
- Private health organisations (private hospitals, outpatient clinics etc.).
- Private physician offices, private midwives, nurses, etc.
- Traditional healers (such as, pilgrim, hodja, bonesetter)
- Frequency of access and utilisation of the available health services and reasons for preference (why are some providers preferred over others).
- Presence of non-governmental organisations such as foundations, and associations in the region, and their activities relating to reproductive health.
- Training programs, courses on health, organised by the municipalities (if any).

FACTORS RELATING TO HEALTH INSTITUTION

- Scope of the services provided by the health institution (for example, what sort of health services are provided, to what extent, the average number of patients per day).
- Whether the number of personnel in a health institution is sufficient (if everybody is occupied in work that conforms to his/her profession; the workload).
- The relations and contact of health personnel with their superiors.
- Whether the health institution is convenient for the purposes of services provided, in terms of physical properties such as the size and shape of the building, its equipment, etc.
- Whether there is a follow-up card which is filled-in regularly to follow pregnant women (or why there is *not* a follow-up card; or why it is *not* filled-in regularly).

- Whether house visits are done or not, and if done what the frequency is.
- Inspections, campaigns (vaccination, mother's milk, etc.), informative or training programmes relating to health.
- Relations/expectations between the health institution, and the Province Health Directorate and the Ministry of Health.
- In-service training and institutional briefing programs.
- Their opinions regarding the adequacy of reproductive health services.

OBSERVATIONS/VIEWS REGARDING PREGNANT WOMEN

- How is the general behaviour of the women in the region with regard to their health (for example, whether they go to health institutions before illness; widespread practices other than visiting a health institution; the places resorted to when getting ill)?
- The frequency of antenatal care received by pregnant women (is it regular, is it sufficient?).
- How is the general knowledge level of pregnant women regarding reproductive health and their rights?
- Relations and contact between health personnel and pregnant women.
- Demands/expectations of pregnant women from health personnel.
- The commonness/use of traditional health information.
- Whether the place and position of women in the society in that region (gender role) affect the receiving of health services during pregnancy (does it positively or negatively affect the receiving of health services during pregnancy?).
- Noteworthy practices of pregnant women for their health during pregnancy and childbirth (observations that might be interesting).

PERSONAL FACTORS

- Whether the type of work done by health personnel concords with his/her education?
- Is the working environment suitable for applying their knowledge?
- Can the health personnel generally follow recent professional developments?
- Physical or psychological impacts of working conditions.
- The impact of his/her responsibilities on the family and on household life to the service he/she renders.
- Other personal factors.

OBSERVATIONS RELATING TO ENVIRONMENT

- General socio-economic observations relating to the region where the service is provided (such as, economic, education)
- Services related to infrastructure (such as, electricity, water, transportation, drainage).
- Religious beliefs.
- Superstitious beliefs.
- Kinship relations.
- Being from the same region/neighbourhood relations.

- Traditions/customs.
- Mother tongue.
- Differences between the local population and the immigrant population.
- Observations, interesting findings regarding the general position in the society of the women in that region.

EXPECTATIONS

- His/her expectations with regards to the health services (particularly reproductive health services) in the region where he/she works.

ANNEX 3

GUIDE FOR IN-DEPTH INTERVIEWING WITH COMMUNITY LEADERS

PERSONAL DATA

Place of birth
Date of birth (Age)
Gender
Education
Civil status
His/her present duty/job
For how many years has he/she been practising this profession?
His/her previous occupation

INFORMATION ABOUT SETTLEMENT

- Average (approximate) population (or number of households).
- Economic activities of the population living in the settlement (what kind of jobs do they do/how do they earn for their living?).
- Type of houses in the settlement (apartment houses, houses with gardens).
- Family type in the settlement (nuclear family, extended-traditional family).
- Commonness between women of working outside the house
- The commonness of women generating income at home (knitting; creating lacework and selling it; animal husbandry; other small in-house manufacturing, etc.)
- Education of girls (whether girls are sent to school).
- Public institutions/organisations in the settlement (state offices, service departments of the municipality, schools, university, etc.).
- Whether there are any premises, workshops, mills, organised industrial zones etc. around the premises (around the village or quarter).
- Associations, foundations, aid organisations, other voluntary organisations in the settlement (their activities/what are they doing, do they have many members and employees, etc.).
- Infrastructural services in the settlement (water, drainage, electricity, transport, environment, natural gas).
- Service plans being continued or planned for the future in the settlement (infrastructure, transportation, health, education, etc.).

HEALTH INSTITUTIONS IN THE SETTLEMENT

- Units in the settlement that are subordinated to the Ministry of Health (health centres, , hospital, MCH/FP Centre, etc.).
- The foundation years of the institutions subordinated to the Ministry of Health in the settlement (whether they are old or new)
- Activities, servicing capacities of the institutions subordinated to the Ministry of Health in the settlement (whether they can answer the needs).
- Is there Red Crescent in the settlement (the groups to which it provides services).

- Private health organisations in the settlement (to whom does it service mostly).
- Health services of associations, foundations, aid organisations, and other voluntary organisations in the region (whether there are briefing campaigns, and, if any, whom does it cover).
- Other health services in the settlement (university hospital, doctor's offices, etc.).
- Healers in the region (pilgrim-hodja, bonesetters, herbalists, traditional birth attendants, etc. Do the people of the region visit them when they become ill)
- Green Card demand.
- Problems relating to Green Card practices (are they sufficient/is there distribution as it should be?).
- Other assistance relating to health in the settlement.
- Health research works/health campaigns carried out by the Health Directorate, university, association/foundations and other organisations in the settlement (*to the field worker: if there are collect detailed information about them*).

EVALUATION OF HEALTH INSTITUTIONS

- Use of health organisations in the settlement (intensity/frequency).
- Who prefers which institution (female/male; child/young/old; the poor/less poor/the wealthier; new immigrants; those living there for many years; the educated; those having some type of health insurance).
- Evaluation of house visits in the settlement by health personnel.
- Courses/training programmes or campaigns relating to health organised by the municipality, if any.
- Sample cases relating to health (in particular, observation, and experiences regarding pregnancy, childbirth, and the relation between health personnel and their service receivers) (*to the field worker: Help them give this information in as detailed a manner as possible and as candidly as possible*).

ANNEX 4

BRIEFING FORM FOR INFORMED CONSENT

Invitation paragraph
We would like your participation in this research. Before you decide, it is important you understand why the research is being done and what its purpose is. Please let me know if there is any point that is not clear, or whether you need other information in addition to the information that I will provide you with. *Thank you for reading/listening to this.*

What is the purpose of the study?
The aim of the study is to explore and describe perceptions and health-seeking behaviours related to pregnancy and childbirth and the responsiveness of services provided by Primary Health Care institutions to demands in selected urban and rural sites in Turkey.

Why have I been chosen?
There is no any particular reason for your selection; it is purely chance.

Do I have to take part?
It is up to you whether or not to take part. If you do decide to take part you will be given this information sheet to keep, and be asked to sign an approval form. Even if you decide to take part in the research, you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
You will be interviewed in a relaxed place, alone, or with your close friends/relatives. This interview will be about your pregnancy, your visits to health care facilities (or your reasons for not using health care facilities, if that be the case), and how satisfied you are with the health services. No other involvement will be required from you. This study will help us understand a little more about the patterns of use of health services by pregnant women during their pregnancy. But you will not directly be benefited from taking part in the study.

Will my taking part in this study be kept confidential?
All information, which is to be collected about you during the course of the research, will be kept strictly confidential and your name will not be mentioned at any stage of the research.

What will happen to the results of the research study?
At the end of the study, all data collected will be analysed, summarised, and reported to the Ministry of Health and European Commission. You will not be identified in any report/publication.

Who is organising and funding the research?
The study is coordinated by Dr. Osman Hayran at the Medical School, Marmara University, Istanbul, with the involvement of three cities across the country. This is an EU (European Union) funded project, supported by the Ministry of Health.

Contact this address for further information

If you have any questions or issues you would like to raise with respect to this study, you should talk to **…….....** *(contact details of responsible local person of the research*).

ANNEX 5

FORM OF INFORMED CONSENT

Study title: Health-Seeking Behaviour Study

Place: (*name of city/centre*), Three provinces (Adana, Afyon and Van)

Investigators: *(name of local researcher)*
The person should complete the whole of this sheet himself/herself.

State your response

Did you understand the information/clarification given to you? YES/NO

Is there anything that you want to ask about? YES/NO

Have all the questions been answered satisfactorily? YES/NO

Have you received enough information about the study? YES/NO

Do you understand that you are free to withdraw from the study at any time if you wish to do so? YES/NO

Do you agree to take part in the study YES/NO

I have explained the study to the above interviewee and he/she has indicated his/her willingness to take part.

Signature (Researcher): Date:

Name (In block capitals):

ANNEX 6

SOME LOCAL WORDS, QUALIFICATIONS, SIMULATION, AND ASCRIPTIONS
Related to Pregnancy:

Ağır (Dallıca K./Elazığ, Kocaeli, Samsun, Karakaya B./Erbaa/Tokat)
Ağır ayak (Dallıca K./Elazığ, Kocaeli, Samsun, Karakaya B./Erbaa/Tokat, Isparta, Sinop, Çorum, Ordu, Gümüşhane, Rize, Ardahan, Erzurum, Erzincan, Tunceli, Sivas, Diyarbakır)
Ağır ayaklı (Trabzon)
Ağır canlı (Ordu)
Ağırlıklı (Isparta, Balıkesir, Samsun, Tokat, Diyarbakır, Konya, Edirne)
Akşamlık sabahlık *(son aylarda)* (Gölpazarı/Bilecik)
Arayak (Eskişehir)
Arka eteği uzamış, ön eteği kısalmış (Uluborlu/Isparta)
Ayağı ağır (Gümüşhacıköy/Amasya, Bayırköy K./Bilecik, Hatunsuyu K./Malatya, Mucur/Kırşehir, Van)
Ayağı ağırlı (Merzifon/Amasya)
Ayı günü yakın (Yozgat)
Ayı günü yitmek (Niğde)
Aylı günlü (Isparta, Aydın, İzmir, Manisa, Balıkesir, Kırşehir, Bilecik, Eskişehir, Bolu, Kastamonu, Çorum, Tokat, Ordu, Ardahan, Erzincan, Mardin, Hatay, Sivas, Niğde, Konya, Antalya, Bitlis, Kars)
Bakla Yemez (Manisa)
Bizaru (Korkut K./Muş)
Boylu (Bolu, Göynük/Bolu, Bekiralan K./İçel, Eskişehir, Kars, Ankara)
Boyunda çocuk var (Ankara)
Boynunda olmak (Bolu)
Boyu yüklü (Sille B./Konya)
Bozalacı (İçel)
Bozulacı (Ordu)
Buaz (Konya)
Buğaz (İstanbul, Amasya)
Buvaz (Tokat)
Buyalacı (Sinop)
Çatlayasıca (Kulu/Konya)
Çocuklu (Muş, Korkut K./Muş)
Doğum yapacak (Bafra/Samsun)
Doğurgacı (Susuz K./Bucak/Burdur)
Doğurgaç (Gebiz B./Serik/Antalya)
Doğurgeç (Denizli)
Doğurucu (Dereköy/Acıpayam/Denizli,Bağlama K./Niğde, Sivas)
Dolu (Edirne)
Digani (Pülümür/Tunceli)
Gargın (Adana)
Gebe (çok yaygın)
Gebeç (Sivas)
Gene neye dönmüş (Kulu/Konya)

Göbeği burnuna değecek (Kulu/Konya)
Göde (Afyon, Isparta, İçel, Antalya, Niğde)
Gözleri ışıldar (Kastamonu)
Gömanlı (İstanbul)
Gövdeli (Kayseri, Adana, İçel)
Gunnacı (Darıpınar/Adana)
Guzlacı (Dağıstanlı K./Ceyhan/Adana, Malatya, Barbuzu/Malatya)
Gümanlı (Gümüşhane, Pülümür/Tunceli, Erzincan)
Gümannı (Dallıca K./Elazığ, Bayburt)
Gümenci (Sivas)
Gümenli (Saskara K./Hanak/Kars, Sivas, Zile/Tokat, Ordu, Kayseri)
Gebe (çok yaygın)
Hunnacı (Balıkesir)
Hunnayıcı (Antalya)
İki canlı (yaygın)
Karnı burnunda (Ödemiş/İzmir, Van, Gölpazarı/Bilecik)
Karnı dolu (Şaturoğlu K./Mucur/Kırşehir, Şarkışla/Sivas)
Karnı olmak (Kerkük)
Kel (Mağara K./İçel)
Koynu dolu (Barbuzu/Malatya, Deligazi K./Sivas)
Mayalı (Kızılcasöğüt K./Çivril/Denizli)
Orta kata kiracı gelmiş (Yeşilören K./Amasya, Büyükhalkalı K./Bakırköy/İstanbul)
Orta katı kiraya vermiş (Trabzon)
Portlacı (Ankara)
Üzerli (Bekiralan K./İçel, Konya, Antalya)
Üzeri yüklü (Gebiz B./Serik/Antalya, Yarma B./Konya, Deligazi K./Sivas)
Üstü yüklü (Mucur/Kırşehir, Göynük K./Nevşehir, Şarkışla/Sivas, Niğde)
Yüğrük (Konya)
Yüklü (çok yaygın)
Yolcusu var (Yarma B./Konya)
Zimet kadın (Borçka/Artvin)

Related to birth:
Ayağı sınmak: (Yozgat)
Dovurma: (Niğde)
Döllemek: (Kocaeli, Gümüşhane, Niğde, Adana)
El ayağa kavuşmak: (Gaziantep)
Gamlamak: (Kayseri)
Gurtulmak: (Niğde)
Günnemek: (Kars, Malatya)
Hınlamak: (İzmir)
Pahlamag: (Burdur)
Uşaklamak: (Zonguldak)
Yükü yıkmak: (Bolu)

ANNEX 7 FIELD SUPERVISOR INSPECTION FORM

HEALTH-SEEKING BEHAVIOUR STUDY
FIELD SUPERVISOR INSPECTION FORM

	Date	Interviewer	Observer	Team Leader	Place of interview	Type of Interview	Gender of interviewee	Starting Hour	Ending Hour	Result of Interview	Voice recording	Transcription status	Observations Clarifications
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

CODE LISTS

Place of interview	Interview type	Gender of interviewee	Interview result	Voice recording	Deciphering situation
1. Province Centre 2. District Centre 3. Sub-district 4. Village/settlement	1.Pregnant woman 2.Relative of pregnant woman 3.Community leader 4.Health personnel	1.Male 2.Female	1.Completed 2.Interrupted 3.Postponed 4.Refused 5.Other (Explain)	1.Available 2.Unavailable 3.Other (Explain)	1.Completed 2.Interrupted 3.Not realized 4.Other (Explain)

ANNEX 8 EXPENDITURE FORM

PROVINCE TEAM
EXPENDITURE FORM

Province :
Responsible of Team :

Delivery Date of the Form : _ _/ _ _/ 2006

Order No.	Date	Fieldworker Who Spent Money	Type of Expenditure	Type of Document	Amount
1	_ _/_ _ /2006		T F S O	I CRV ER	
2	_ _ /_ _ /2006		T F S O	I CRV ER	
3	_ _ /_ _ /2006		T F S O	I CRV ER	
4	_ _ /_ _ /2006		T F S O	I CRV ER	
5	_ _ /_ _ /2006		T F S O	I CRV ER	
6	_ _ /_ _ /2006		T F S O	I CRV ER	
7	_ _ /_ _ /2006		T F S O	I CRV ER	
8	_ _ /_ _ /2006		T F S O	I CRV ER	
9	_ _ /_ _ /2006		T F S O	I CRV ER	
10	_ _ /_ _ /2006		T F S O	I CRV ER	
TOTAL					

Type of Expenditure

T Transportation
F Food
S Stationery
O Other

Type of Document

I Invoice
CRV Cash Register Voucher
ER Expense Receipt

ANNEX 9 CODE LIST

FIELDWORK CODE LIST		
CODE	**NAME-SURNAME**	**PROVINCE**
001	OSMAN HAYRAN	ANKARA-ADANA-AFYON-VAN
002	ANAHİT COŞKUN	ANKARA-VAN
003	NURGÜN PLATİN	ANKARA-AFYON
004	ERHAN ÖZDEMİR	ANKARA-ADANA
005	GÜL OKUTUCU	ANKARA
006	SELMA GÜNEŞ	ANKARA
101	ESRA ERSOY	ADANA
102	BANU YEL	ADANA
103	SİBEL SEVGİ	ADANA
104	MAHMUT YALÇIN	ADANA
105	EBRU İNDERESİ	ADANA
106	FULYA KARACA	ADANA
107	GÜNER DEMİREL DAĞLI	ADANA
108	DİLEK ÖRER	ADANA
109	ASLI ERKAL	AFYON
110	HURİYE TEKİN ÖNÜR	AFYON
111	SEVGİ YILDIRIM	AFYON
112	OBEN ÖNCEL	AFYON
113	AYGÜL SALMAN	AFYON
114	ÖZGE ÖZBEK	AFYON
115	AŞİRAN BARUT	VAN
116	ÇİLEM ENGİN	VAN
117	HAMDİYE DAYAN	VAN
118	AYTEN ÇELİK	VAN
119	NURGÜL CANGÜLEÇ	VAN
120	NURGÜL BAŞDİNÇ	VAN
Office Phone (0 312) 431 42 40		
Office Fax (0 312) 431 42 90		
e-mail hsbs@ttnet.net.tr		

Annex-10

Field Manual for

Research Coordinators

HEALTH SEEKING BEHAVIOUR STUDY
FIELD MANUAL
FOR RESEARCH COORDINATORS

Research coordinators, who carry out the Health Seeking Behaviour Study conducted under the framework of Reproductive Health Programme for Turkey, and the provinces for which they are responsible are as follows:

Research Coordinator:	***The Province he/she is responsible for:***
Prof. Dr. Anahit Coşkun	Van
Prof.Dr.Nurgün Platin	Afyon
Erhan Özdemir	Adana

Erhan Özdemir is designated as Field Coordinator. He will coordinate the project activities in the provinces and report to the Team Leader.

Field works have been started since the second week of August (8th August 2006). Important points that should be taken into consideration during field-work are listed below:

- In an official letter (letter of MCH/FP General Directorate dated 07 July 2006 and numbered 2787) sent by the Ministry of Health to the Offices of each province Governors, a brief information about the study was provided and a support for research team was asked for from province health directorates. This letter is a facilitating letter for the works to be done. In other words, Health Directorates were informed about the research; however they have not any obligation to meet any demand from us; the extent and content of support that could be received from these authorities will depend, to a great extent, on the relation that we are going to establish.

- Each coordinator is responsible for the research activities in his/her province. Main activities that research coordinator will carry out in the province are as follows:

  - Ø Organize a local kick-off meeting, get the promotion and visibility of the research activity using every occasion, and create awareness regarding the subject,

  - Ø Prepare work programme for field workers (interviewer, observer and supervisor) and secure its implementation,

  - Ø Prepare focus group interview groups for short-term experts, manage focus group interviews to be done as planned in terms of number and time, and get compilation of results,

- Ø Find solutions to any problem, which may arise during the research activities in his/her province, by intervening appropriately and timely; contact with local authorities if necessary,

- Ø Inform Team Leader, through Field Coordinator, about any problem that may arise and is either solved or not,

- Ø Inform Team Leader, through Field Coordinator, about any proposal of revision which might come out regarding interview forms and research methods.

- Ø Plan for, the provision of equipment and materials required for research activities in his/her province, covering transport and accommodation expenses, and timely payment of all experts and workers; determine needs and report them, upon the approval of Team Leader, to Eduser through Ms. Gül the Office Manager one week in advance,

- Ø Take the delivery of equipment and materials, which will be used for research activities, from the project office and hand over them to the responsible persons in the province against their signatures.

- Ø Prepare and submit reports at the end of each week to the Team Leader. The topics to be included in that report and the format of the report will be in following form:

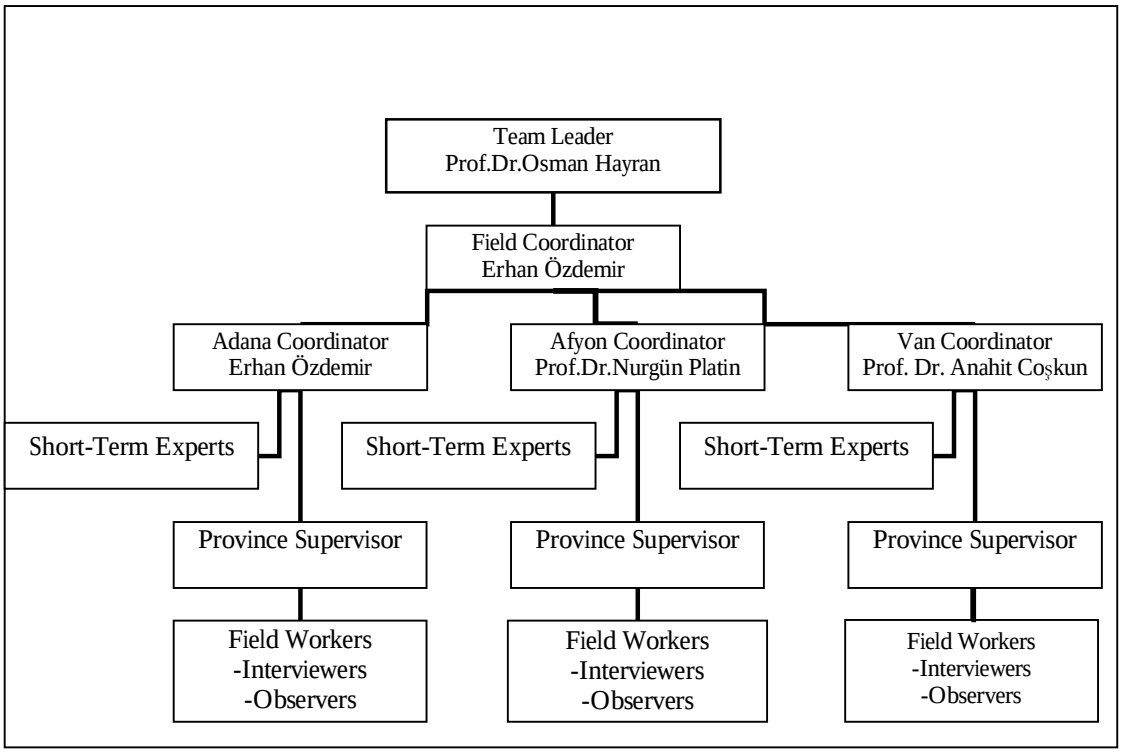
Weekly Report Form:

Reporting Period: Prepared by:

	Number of persons interviewed	Characteristics of the person interviewed*	Number of man-days worked**
In-depth interview			
Focus Group Interview			
Problems encountered and solutions			
Proposals about the problems			
Proposals about forms			
Proposals about the method			
Work plan of the following week			

*: PW: Pregnant, PP: Pregnant-Peer, PF: Pregnant's Family member,
HP: Health Personnel, CL: Community Leader
**: Total number of man-days worked by field workers and / or short-term experts

HEALTH SEEKING BEHAVIOUR STUDY
TECHNICAL ASSISTANCE TEAM
FIELD ORGANIZATION SCHEME



Annex-11 Categories and Coding List For Data Analysis

CATEGORY AND CODE LIST

- PERCEPTIONS RELATED TO PREGNANCY (GEBALG)

1. I do not have any complaints
2. Not having much pain
3. It being something that brings happiness
4. A condition that requires going for control
5. Not wanting (unwanted pregnancy)
6. Embarrassment
7. A condition that is hidden, reluctance to tell the elders of the family
8. Burden

-PERCEPTIONS RELATED TO THE HEALTH OF THE FETUS (FETALG)

1. Start moving
2. Come to life
3. Have an ultrasound
4. Not feel it move

-ASSOCIATION WITH DISEASES AROUND (ÇEVHAS)

-PERCEPTIONS RELATED TO BIRTH (DOGALG)

1. Giving birth at young ages is risky
2. Is taken to a hospital is there is a dangerous condition
3. Healthy birth
4. Could be done anywhere
5. Cesearian section perception

-PERCEPTIONS RELATED TO LIFE (YASAM)

1. World is mortal
2. World will be beautiful
3. Sickness comes from God

-GENERAL HEALTH PERCEPTION (GENALG)

1. Socio-economic factors
2. Ailments that are considered important
3. Not paying attention to health

-IMPORTANCE PALCED ON HEALTH BY WOMEN, GENERAL HEALTH PERCEPTION (SADEĞ)

1. Life is sweet
2. Safe

-PRIORITY OF HEALTH SEEKING AMONG OTHER NEEDS (SAGON)

Prioritizing going to a health care institution when there is a health problem

-WHERE PRESENT BIRTH WILL TAKE PLACE (DOĞYER)

1. Give birth at home
2. Give birth at a hospital
3. Reason for preference

-PREVIOUS BIRTH EXPERIENCE (ÖNDOĞ)

1. Normal birth at home
2. Baby died/still birth
3. Had difficult birth
4. Bad experience with health personnel
5. Caesarean section at hospital
6. Rumours
7. Normal birth at home assisted by health personnel
8. With unqualified mid wife
9. Easy
10. Normal birth at hospital

-PREVIOUS BIRTH EXPERIENCES – CLOSE SURROUNDINGS AND PEERS (ÖNDOĞ)

1. Normal birth at home
2. Sister had a still birth
3. Baby died/still birth
4. Had difficult birth
5. Bad experience with health personnel
6. Death of mother
7. Caesarean Section at hospital
8. Rumours
9. Normal birth at home assisted by health personnel
10. With unqualified mid wife
11. Easy birth
12. Normal birth at hospital

- PREVIOUS BIRTH EXPERIENCES – HERSELF AND CLOSE SURROUNDINGS (ÖNGEB)

1. Positive experiences
2. Negative experiences

-PREGNANCY AILMENTS (GEBRAH)

1. Kidney complaints
2. Nausea
3. Swelling at hands-feet and body
4. Not being able to do heavy work
5. Feeling bad
6. Heart burn and drinking a lot of water
7. Headache
8. Having a tooth pulled out
9. Stomach-ache
10. Bleeding
11. Aches in other parts of the body / other problems
12. Feeling weight on your shoulders
13. Sleeping a lot

14. Cyst

-FACTORS THAT EASE PREGNANCY PROCESS (GEBKLY)

1. Living together (household chores being done by other women, sister-in-law)
2. Having to do little and light work (not doing tiring7big work, not lifting heavy things)
3. Getting attention from the husband
4. Not having to work outside/in the fields

-THINGS NEEDED FOR PREGNANCY TO BE HEALTHY (SAĞGER)

1. Controls
2. Age at pregnancy
3. Frequency of getting pregnant
4. How a pregnant woman should be treated

- PERSONAL CARE AT PREGNANCY (ÖZBAK)

1. Nutrition
2. Cleanliness
3. Undergarment
4. Getting information
5. Being in a smoking environment/smoking
6. Not lifting heavy things
7. Healthy behaviour
8. Not using medicines
9. Not doing anything, not caring
10. Skin care
11. Not gaining weight

-WORKING DURING PREGNANCY (GEBÇAL)

1. Inside the house/house work
2. Outside the house (in the fields, in the barn etc.)
3. Outside the house (reading the Quran /washing the dead)
4. Going to other houses to help

-EXPERIENCES DURING PREGNANCY RELATED TO HEALTH CARE INSTITUTIONS - HERSELF AND CLOSE SURROUNDINGS (GEBSKDEN)

1. Positive experiences
2. Negative experiences
    - health personnel not giving any explanations regarding her condition
    - waiting for a long time
    - not telling the sex of the baby

-GOING TO A HEALTH CARE INSTITUTION DURING PREGNANCY (KURGİT)

1. Going to a private health care institution
2. Going to a health centre
3. Going to a maternity hospital/hospital

4. Going to the pharmacy
5. Call home (calling a nurse/midwife)
6. Time to go to a health care institution
7. Frequency of health care institution visits
8. Reason for going to a health centre
9. Not going to a health care institution
10. Going together with someone

-OBSTACLES IN FRONT OF GOING TO A HEALTH CARE INSTITUTION DURING PREGNANCY (GİTENG)

1. Because of not wanting to use medication
2. Does not have health insurance
3. Husband does not have a regular job
4. Concern about being reprimanded by the health personnel for having many children
5. Male doctor
6. Husband/mother-in-law not permitting
7. Transportation difficulties and distance to the health care institution
8. Being treated badly/belittling
9. Other problems stemming from the health care institution
10. Husband being away for a long time
11. Tetanus vaccination
12. Being illiterate
13. Not having time left from house work/child care
14. Not being officially married
15. Health centre not providing ante natal care services
16. Health personnel not being doctors/midwives
17. Waiting in queue/wasting time
18. Inattentive
19. Going to the meadow
20. Embarrassment
21. Not being taken care of

-ENABLERS IN GOING TO A HEALTH CARE INSTITUTION DURING PREGNANCY (GITKLY)

1. Wide spreading of and development in services
2. Going to a female doctor
3. Attitude of health service providers
4. Respect
5. Good reception
6. Healthy child birth
7. Equipment
8. Health insurance/having Green Card
9. Essay transportation/having public transport/being dropped of in front of the institution
10. Speaking Turkish
11. Economic status
12. Gender of the doctor not being important for the service users H
13. Attitude of the family

-POVERTY / FINANCIAL STATUS (EKON)

1. Husbands job/income (is it regular or temporary?)
2. Economic status of the family
3. Getting outside assistance
4. Conditional cash transfer
5. Women having own income

-HEALTH INSURANCE (GÜVEN)

1. Has no insurance
2. Green card
3. Other health insurances (Bağ-Kur, SSK, Pension Fund, Private Health Insurance)

-BELIEF / GOD / RELIGION (DİN)

1. Pregnancy-birth control relation
2. Accidentally getting pregnant
3. Death at child birth due to haemorrhage
4. To attend ANC
5. Health condition of the foetus
6. Pictures of religious figures / going to shrines….
7. Infertility treatment
8. Abortion

-TRADITIONAL BELIEFS / PRACTICES (FOLK)

1. Diet
2. Salting the baby
3. Practices for easy child birth
4. For children diseases
5. Going to a healer
6. Stress
7. To have a baby
8. In treating burns
9. Baby care (swaddling/placing earth under the baby)
10. Predicting sex of the baby
11. Practices for problems arising during pregnancy
12. Not having/knowing any traditional practices
13. In jaundice
14. Traditional birth attendant
15. Bone setter
16. Ordeal

COMMUNICATION

-LANGUAGE PROBLEMS /NOT BEING ABLE TO EXPRESS ONESELF (DİL)

1. Not being able to speak Turkish properly / Speaking Kurdish

2. Using a translator

-RELATIONS (İLİŞKİ)

1. Health personnel's view of the public
2. Public's view of the health personnel
3. Relations among health personnel
4. Health personnel's view of the state-citizen relation

-EXPECTATIONS FROM HEALTH CARE SERVICE PROVIDERS (SPBEKL)

1. Geniality
2. Find out about the health of the foetus
3. Be examined
4. Request for medicine or shots without prescription
5. Attention
6. Give birth at health centre
7. Ultrasound
8. 24 hour service provision
9. Care and drugs when ill
10. Being taken into consideration
11. Newborn follow-up and immunization

-PREVIOUS EXPERIENCES IN UTILISING HEALTH CARE (SAGBAKONDEN)

1. Positive experiences
2. Negative experiences

-PLACE OF THE WOMEN IN THE AREA (KONUM)

1. Repressed /second class
2. Fellow wife in a polygamous household

-GOING OUTSIDE THE HOUSE (SOSBASK)

1. Getting permission
2. New bride
3. Passing through certain places/walking
4. Being able to go to the health care institution alone
5. Being able to go shopping alone
6. Not going out when belly is prominent

-DECISION MAKING (KARAR)

1. To go to the health care institution
2. To call the midwife/nurse
3. For the place of child birth
4. To attend ANC
5. To hold ones own
6. To get pregnant
7. For family planning
8. For abortion

-PRIVACY / EMBERRASSMENT (UTAN)

1. Male doctor
2. Examination and interventions
3. Embarrassment / embarrassed to express herself

-VIOLENCE (ŞİDDET)

-MARRIAGE (EVLİ)

1. Fall in love and get married
2. Arranged marriage
3. Having/not having a fellow wife
4. Age difference between spouses
5. Young couples (Under 20 years of age)
6. Talk about everything with husband
7. Get married to someone from another region
8. Education level difference between spouses
9. Civil marriage/religious marriage

-HEALTH PERSONNEL'S VIEW REGARDING THE SOCIETY'S HEALTH PERCEPTIONS (SPGÖR)

1. Awareness
2. Education
3. Social structure
4. Belittling, perceptions, ignorance, filth etc.

-GENDER OF THE CHILD (CİNS)

1. Preference for the sex of the baby before the child is born (mother/father/family elders)
2. Wanting/not wanting to find out the gender with ultrasound
3. Gender of previous children

-INFORMATION SOURCES RELATED TO PREGNANCY (GEBBİL)

1. Sharing of information/problems related to pregnancy with relatives/other people around
2. Information obtained from sources like television/newspapers/books
3. Information obtained from health personnel
4. Buying magazines/books related to pregnancy
5. Peers
6. Elders

-CHARACTERISTICS OF THE REGION (BÖLGE)

1. Characteristics of the society
2. Infrastructure
3. Economic status

4. Distrust in the state
5. Woman working
6. Transportation
7. Education-training
8. Insufficient public personnel (no teachers/doctors, nurses at health care institutions)
9. No water
10. Cleanliness of the environment (air, water)
11. Temporary worker/not being settled
12. Electricity and water cuts
13. Health care institutions in the region
14. Value, importance given to children
15. Patriarchal

-HEALTH CARE SERVICES PROVIDED IN THE REGION (HİZMET)

1. Child diseases, immunization
2. Tetanus shots
3. Follow-up/examination of pregnant women
4. Out patient services
5. House visits/care at home
6. Reproductive health education
7. Screening of schools and education
8. Campaigns
9. Reproductive health services
10. Child health education
11. Environmental health

-HEALTH CARE SERVICE PROVIDERS IN THE REGION (HİZYER)

1. Hospital/maternity hospital
2. Health centre/MCH-FP
3. Private
4. None

-SUITABILITY OF HEALTH CARE ORGANIZATIONS TO PROVIFDE SERVICES (KURUYG)

1. Sufficient/suitable
2. Insufficient/unsuitable
3. Payment conditions
4. Behaviour of health care personnel
5. Working hours

-IN-SERVICE TRAINING OF HEALTH CARE PERSONNEL (HİZİÇ)

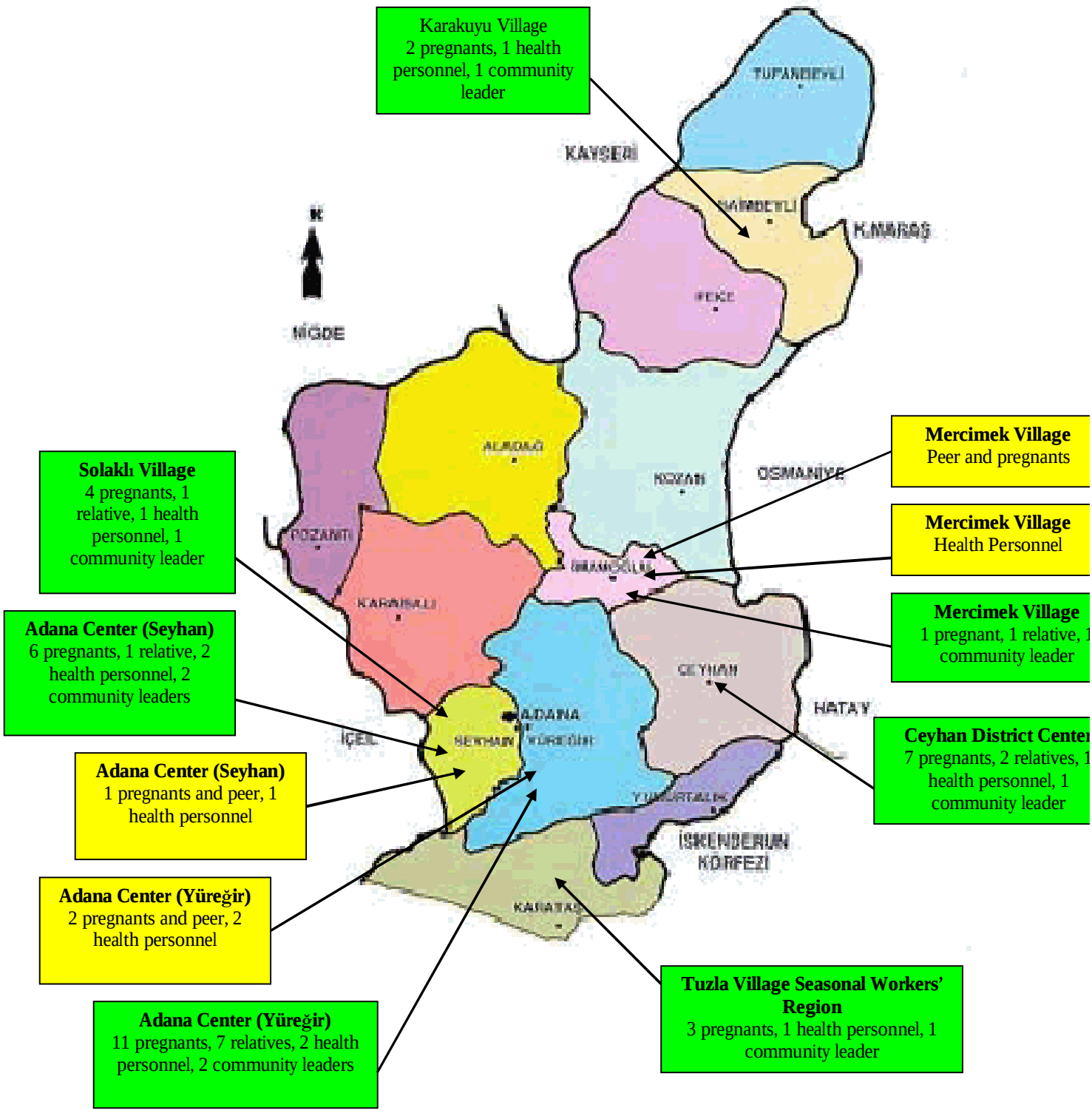
1. Did not receive any
2. Received on reproductive health
3. On other topics

-PROBLEMS OF HEALTH CARE PERSONNEL (SPSOR)

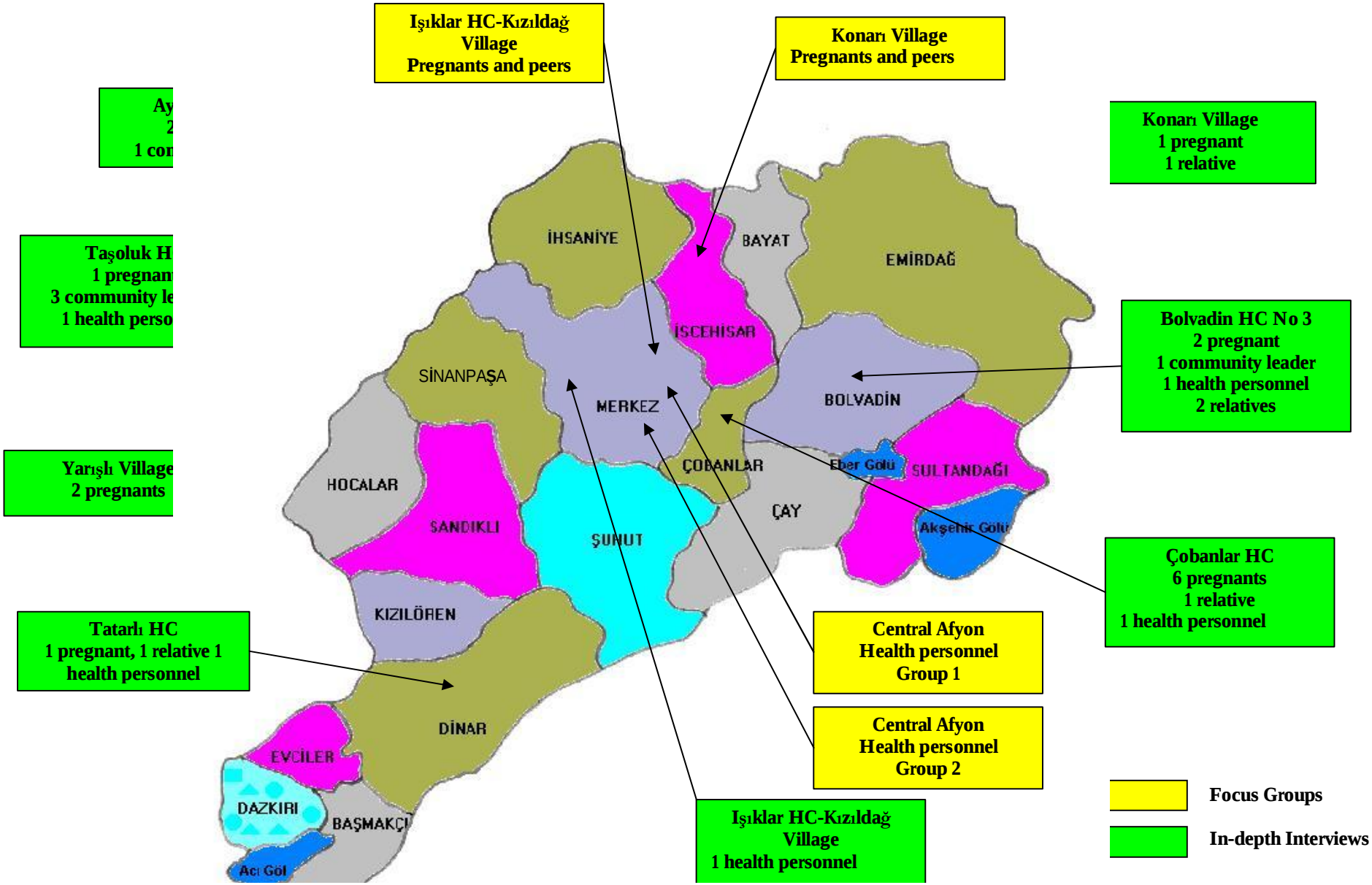
1. Problems related to the organization
2. Relations with upper management
3. Lack of materials/equipment
4. No job satisfaction/unhappiness
5. Lack of infrastructure
6. Lack of transportation vehicles (lack of an ambulance)
7. Lack of secretary/officers/office help
8. Social isolation
9. Insufficient education/professional skills/professional knowledge
10. Communication problems with people of the region
11. Insufficient health care personnel
12. Scattered settlement
13. Lack of supervision
14. Education not in line with duty
15. Perception of population regarding nurses and midwives

Annex-12 Distribution of Interviews by Research Sites

ADANA INTERVIEWS



AFYON INTERVIEWS



Central Van
2 community leaders

Beyüzümü Mah
3 pregnants
1 relative

Central Van
(Süphan+Yüniplik)
Pregnants and peers

Süphan Mah
5 pregnants, 2 relatives
2 community leaders
1 health personnel

Yüniplik Mah
2 pregnants
1 health personnel

HOŞAP-Yurtbaşı
Village
Pregnants and peers

Hoşap (rural)
5 pregnants, 2 relatives
1 community leader
3 health personnels

Central Van
Health personnel
Group 2

Gürpınar and Hoşap
Health personnel
Group 1

Focus Groups

In-depth Interviews

Annex-13 List of Researchers

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