

THE STATUS OF CHILD HEALTH AND CHILD SURVIVAL AND DEVELOPMENT PROGRAMS IN TURKEY*

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"Child Survival Activities in Turkey" are: growth monitoring programs, expanded programs of immunization (elimination of neonatal tetanus, reducing morbidity and mortality of measles, eradication of polio), control of diarrheal diseases (oral rehydration therapy), control of deaths from pneumonia (ARI), baby-friendly hospitals initiative and promotion of breast-feeding, salt iodization programs, elimination of vitamin A deficiency, safe motherhood projects, and phenylketonuria screening programs. Furthermore, family planning, nutrition and education of the mother were among the subjects covered because of their role in child health. The activities, aims and strategies related to these programs are taken up separately. The status of child health and some of the child survival and development programs (growth monitoring program, expanded program of immunization, control of diarrheal diseases, control of deaths from pneumonia, baby-friendly hospitals initiative and promotion of breast-feeding) are discussed in the article. *Key words: child survival programs, Turkey.*

The concept of "Child Survival" started gaining momentum with analysis of figures of infant deaths at the beginning of the 1980s. In 1981-82, 40,000 children were dying each day, 100 million children were hungry every day, and 10 million children were disabled in mind or body. Analysis clearly showed that deaths were largely due to diarrheal disease and consequent dehydration; vaccine preventable diseases, especially measles; and malnutrition. The idea of a revolution then gathered strength from the fact that effective techniques were already available. These were growth monitoring, oral rehydration therapy, breast-feeding and immunization (GOBI). In 1984, UNICEF declared that world-wide support had been gathering behind the idea of a revolution which could save the lives of seven million children each year, protect the health and growth of millions more and help slow population growth. The strategy of a limited number of potentially vertical programs was made as it was felt to be cutting across the Primary Health Care integrated approach, even though the Expanded Program of Immunization (EPI), Control of Diarrheal Diseases (CDD) and Maternal Child Health/Family Planning (MCH/FP) are not as integrated as was hoped. To increase the development as well as the survival elements and broaden the approach, three F's were added-food supplementation (which soon gave way

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to the better aim of food security), birth spacing, and female education, although these were recognized as more costly and more difficult. The recent consensus view on components in child survival includes: immunization, growth monitoring, oral rehydration therapy, breast-feeding, female education, family planning, food security, drinking water, control of acute respiratory infections, AIDS control, control of malaria, vitamin A supplementation, and prevention of iodine deficiency disorders¹.

The Status of Child Health in Turkey

The initial phase of any child survival program should be a detailed situation analysis of the mortality and morbidity of the mothers and children. Infant mortality, the probability of dying in the first year of life, is a sensitive indicator of social welfare to assess where the greatest need may be. Another indicator is the under-five mortality rate: the number of deaths of children under five years of age per 1,000. This is the probability of dying between birth and exactly five years of age². Today, in many countries of the world, governments are more concerned about where they are ranked among nations on infant and under-five mortality than on gross national product (GNP) per capita. Developing countries are in a process of rapid change in child survival; many register very significant improvements, others are losing momentum. The infant mortality rate shows the general health and socio-economic status of the population and is particularly sensitive to changes in environmental and social conditions. In most developing countries, there are no reliable or continuous records for estimating childhood mortality.

There are an insufficient number of doctors and health personnel in provincial and district centers outside the major cities in Turkey. For this reason, and because of the low priority given to collecting statistics in the outlying provinces, information flow from these centers is not complete. It is required, by law, to obtain a "Permission Form for Burial" for a dead person. However, this is neglected in most of the provincial and district centers. Thus, the reported rate of death is lower than the real rate of death calculated by researchers. Female deaths, especially in child mortality, are irregularly recorded in the burial permission registrations and the life expectancy of females is generally higher than that of males. Distribution of deaths by age group indicates that deaths under one year of age make up a large proportion of total deaths due to the high infant mortality rate in Turkey. The proportion of infant deaths among total deaths is approximately 15 percent in the country³.

The infant mortality rate was 154 per 1,000 for the period 1967-1968 in the survey conducted by the Ministry of Health, but there was no estimation of neonatal and postneonatal mortality rates. Basic information on the infant mortality rate was collected from Turkish Demographic and Health Surveys conducted by the Hacettepe Institute of Population Studies since 1972. According to these studies,

the infant mortality rate was estimated as 134 per 1,000 for 1972-1977, 95 per 1,000 for 1978-1983, 77.7 per 1,000 for 1985-1987, and 52.6 per 1,000 for 1988-1993^{4,5} (Table I). The estimated infant mortality rate for 1997 is 42.2 per thousand⁶. Although the present rate of infant mortality is still high, it has decreased over the years simultaneously with improved social and economic development. In rural areas, infant mortality is 65.4 per thousand, that is, higher than the national average, while the rate in urban areas (44.0 per thousand) is lower than the national average. That again could be due to more health facilities, more opportunity to use them and higher socio-economic levels in urban areas. The infant mortality rate of western Anatolia is lowest among the regions (42.7 per 1,000) while that of eastern Anatolia is the highest (60.0 per 1,000). There are inadequate health conditions and a lower socio-economic level in eastern Anatolia than in the other regions^{4,5}.

Table I: Infant, Neonatal, Postneonatal and Under-Five Mortality Rates (per 1,000) Between 1967-1993 in Turkey

Years	Infant Mortality Rate	Neonatal Mortality Rate	Postneonatal Mortality Rate	Under-Five Mortality Rate
1967-68	154	—	—	—
1972-77	134	60	74	—
1978-83	95	42	53	—
1985-87	77.7	35.5	42.2	97.5
1988-93	52.6	29.2	23.4	60.9
Declining Rate (%)	60.7	51.3	68.9	37.5
	(1967-93)	(1972-93)	(1972-93)	(1985-93)

Source: Bertan M, Özcebe H. Infant mortality trends in Turkey. *Acta Reproductiva Turcica* 1992; 14: 27-35.

Ministry of Health (Turkey), Hacettepe University Institute of Population Studies, and Macro International Inc. Turkish Demographic and Health Survey 1993; 1994.

The infant mortality rate is usually examined as neonatal and postneonatal mortality, the former covering deaths at one to four weeks, and the latter at five to 52 weeks of age. The neonatal mortality rate was 60 per 1,000 for 1972-1977 and 29.2 per 1,000 for 1988-1993. The declining rate was found to be 51.3 percent between these two periods. On the other hand, the postneonatal mortality rate was estimated at 74 per 1,000 for 1972-1977 and 23.4 per 1,000 for 1988-1993, and its declining rate was 68.9 percent in this period^{4,5} (Table I). According to the 1993 Demographic and Health Survey, the neonatal mortality rate is 29.2 per 1,000, while the postneonatal death rate is 23.4 per 1,000. The neonatal death rate is 29.9 per 1,000 in urban and 28.1 per 1,000 in rural areas. Postneonatal rates, on the other hand, are 14.1 per thousand in urban and 37.4 per 1,000 in rural areas⁵. There is no data for perinatal mortality rate for all of Turkey.

The under-five mortality rate has been designated by UNICEF as the most important indicator of the state of a nation's children. It is estimated that for the country overall the under-five mortality rate for 1988-1993 is 60.9 per 1,000. This is undoubtedly very high, implying that overall for every 100 births, almost six children did not reach their fifth birthday. There are some differences between regions and place of residence: 50.5 per 1,000 in urban areas, 76.4 per 1,000 in rural areas. The eastern part of Turkey has the highest rate among all regions, 70.4 per 1,000. Rates for the other parts of Turkey are: western Turkey 48.0 per 1,000 southern Turkey 62.8 per 1,000, central Turkey 69.2 per 1,000 and northern Turkey 49.5 per 1,000⁵.

The causes of child mortality are not known accurately for the country. Regarding causes of death, data is available for only towns and cities. Pneumonia and enteritis were the main causes between 1967-1975.

According to the State Institute of Statistics, the main causes of child mortality in Turkey are birth injury, difficult labor, and other causes of perinatal mortality. These causes make up about half of child mortality cases occurring in the first month of life. Therefore, causes which are mainly related to genetic makeup, pregnancy, and labor are the main reasons for child mortality. Among the other causes, pneumonia is the second and heart diseases the third most common causes. Causes of child deaths are given in Table II.

Table II: Percentage of Child Mortality, Under Five Years of Age, by Main Causes of Deaths in 1993

Causes of Deaths for Children	%
Other causes of perinatal mortality	36.30
Birth injury, difficult labor, anoxia and other anoxic and hypoxic conditions	16.13
Pneumonia	10.42
Heart diseases	8.64
Meningococcal infections	6.05
Enteritis and other diarrheal diseases	5.63
Congenital anomalies	2.99
Symptoms and ill-defined conditions	1.68
All other diseases and accidents	12.16

* These causes are only from cities and towns.

Source: State Institute of Statistics, Under Prime Minister Republic of Turkey. Death Statistics From Provincial and District Centres 1993. State Institute of Statistics, Printing Division. Publ. No. 1836; 1995: IX-XIII.

Some indicators of child health in Turkey (1977) can be seen in Table III, some factors affecting infant mortality in Turkey can be summarized as follows^{5,8,9}.

Table III: Some Indicators of Child Health in Turkey (1977)

Mortality and health	
Infant mortality rate (per 1,000)	42
Under-five mortality rate (per 1,000)	50
Children who are breastfed (%)	
0-1 months	99
4-5 months	80
Children 12-23 months	
Given BCG (%)	69
Given DPT (3 doses) (%)	84
Given Polio DPT (3 doses) (%)	83
Given measles vaccination (%)	84
had diarrhea in the last 2 weeks (%)	25
Had acute respiratory infections in the last 2 weeks (%)	12
Chronically undernourished (stunted) (%)	19
Acutely undernourished (wasted) (%)	3

Source: Republic of Turkey Ministry of Health. Turkey: Demographic and Health Indicators; Ankara: 1997.

- The mothers's level of education. Educated mothers tend to provide better quality care for their children, thus securing their health. Also, the educational level of the father has a bearing on the infant mortality rate. Children of mothers with no education (those who have never attended school or did not complete the primary level) experience over 1.6 times the level of infant and under-five mortality as children of mothers who have at least completed primary school.
- Maternal age at birth (under 20 and over 35 years have an adverse effect on infant mortality). The highest mortality rates are associated with children whose mothers were younger than 20 years of age or were 30-39 years, respectively. The strongest effect of the mother's age on childhood mortality occurs in the case of neonatal mortality. Children of mothers who were younger than 20 at the time of birth experienced 88 percent higher mortality risks during the first months of life than children of mothers who were aged 20-29 at the time they gave birth.
- An interval of less than two years between births is also an important factor contributing to high mortality. On the other hand, infant mortality is relatively high for women over 30 years and whose parity is four or more. The infant mortality rate for birth orders of seven and more is 2.5 times higher than that of birth orders of two to three, and the differential in the neonatal mortality rate is even greater.
- Utilization of health facilities and the daily observance of hygienic practices both work to decrease infant mortality. Prenatal care, identification of high-risk pregnancies and some economic conditions of families are also related to

infant mortality. Under-five mortality rate is 55 percent higher (77 per 1,000) among children born to women who received neither antenatal care nor delivery care from a trained health professional, compared to that among children whose mothers received either or both of these services (50 per 1,000).

Child Survival and Development Activities in Turkey

The Government of Turkey identified its health targets in the fifth five-year Development Plan and special emphasis was given to improvements in maternal and child health. One key goal is the reduction of infant and childhood mortality to less than 50 per 1,000 live births. Causes of deaths of infants and toddlers are mainly pneumonia, measles, diarrhea, birth trauma and injuries. The infant mortality rate was 95 per 1,000 live births in 1983. Total infant deaths every year are about 150,000 infants. Twenty-nine thousand children die from vaccine preventable diseases alone and more than half that number are permanently handicapped. The infant mortality rate in 1988 was 64 per 1,000. It is apparent that, to reach the WHO European Regional Office target infant mortality rate set for its own region, of 20 per 1,000 by the year 2000, is rather difficult. To meet these targets requires systematic, insistent, planned and effective management and supervision. The child and maternal health programs initiated as a result of the situation are a step towards the realization of the contents of the "Revolution of Child Survival and Development" supported by UNICEF. As a result of these consultations, a tripartite framework for a Program of Cooperation for Child Survival and Development within the context of Primary Health Care 1985-1989 was signed between the Government of Turkey, UNICEF and WHO^{10, 11}.

The program consists of immunization against the most frequent diseases seen (diphtheria, pertussis, tetanus (DPT), polio, measles and tuberculosis), encouragement of breast-feeding, provision of sufficient nutrition, growth and development monitoring, intervention in diarrheal diseases through early application of oral rehydration therapy, and controlling lower respiratory tract infections. Furthermore, family planning, nutrition and education of the mother were among the subjects covered because of their role in child health. The activities, aims and strategies related to these programs are taken up separately^{10, 11}.

The world's leaders who attended the historic children's summit agreed on a remarkable package of strategies and goals that represent what the world's leading experts and development agencies believe can be accomplished for children and women in 1990s. At the 1990 World Summit for Children, 149 countries formally committed themselves to establishing a national program for achieving the year 2000 goals adopted by the summit. Turkey's National Program of Action was finalized in December 1993 and submitted to the UN Secretary General¹². In Table IV, the defined targets of the National Plan of Actions, Child Health by the Year 2000 is given (these targets are based on the 1990s rates)¹³.

Table IV: Defined Targets of the National Plan of Actions,
Child Health by the Year 2000

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- Reducing infant mortality rate by one-third,
 - Reducing the mortality rate of children under the age of five years by 50 percent,
 - Reducing the mortality rate of children under the age of five years due to diarrheal diseases by 50 percent, and the incidence of diarrheal diseases by 25 percent,
 - Increasing oral rehydration therapy to 80 percent,
 - Reducing the mortality rate of children under the age of five years due to ARI*, particularly pneumonia,
 - Reducing the severe and moderate malnutrition of children under five years of age by 50 percent,
 - Achieving 95 percent immunization coverage for each vaccine in the under one age group,
 - Eradicating polio,
 - Eliminating neonatal tetanus,
 - Reducing measles incidence by 90 percent and the mortality rate due to measles by 95 percent.
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ARI: acute respiratory infections.

Source: Akin A, Biliker MA, Benli N. Reproductive Health Programs in Turkey (1977). Ministry of Health, General Directorate of Maternal Child Health Family Planning.

The Ministry of Health has "Child Survival and Development Activities" to meet these targets⁷. In the text, some of these programs will be discussed. These programs are:

- Growth monitoring program.
- Expanded program of immunization.
- Elimination of neonatal tetanus.
- Reducing morbidity and mortality of measles.
- Eradication of polio.
- Control of diarrheal diseases (oral rehydration therapy).
- Control of deaths from pneumonia (ARI).
- Baby-friendly hospitals initiative and promotion of breast-feeding.
- Salt iodization program.
- Virtual elimination of vitamin A deficiency.
- Safe motherhood projects.
- Phenylketonuria screening program.

Growth Monitoring Program

Growth monitoring and promotion have been extensively evaluated and assessed from the point of view of the instruments (availability and suitability of scales and growth cards), of the process (the involvement, education, understanding,

behavioral change of mothers, and incorporation of routine child care), and of the impact on nutritional status. The program is also used for growth surveillance of a community or district. The activities of growth monitoring must begin early before any faltering or malnutrition develops. Growth monitoring activity is a matter of prevention and education, rather than being curative or rehabilitative.

The aim of growth monitoring is to indicate malnutrition before it causes serious damage to a child's health. At this early stage, a nurse or a midwife can educate a family/mother on ways to improve a child's nutritional status, even when food and money are scarce. Growth monitoring is done using a chart usually coupled with an immunization record. A child is followed three times in the first two months and five times until one year. From one to three years of age the child is followed every three months and once every year from four to six years of age¹⁴.

The height-for-age index is an important indicator of chronic undernutrition. A period of at least 12 months or even 24 months is necessary to see the outcome chronic nutritional problems. According to the 1993 Demographic and Health Survey, the youngest children (under 6 months old) show no evidence of malnutrition. Among the children 24-59 months of age, 25 percent are classified stunted (weighted average of the percentages in the 24-59 months age group). According to the survey, by age five nearly one-fifth of the children are chronically undernourished and about 10 percent are severely stunted. These patterns reflect inadequate feeding practice and the presence of recurrent and chronic illness^{14, 15}.

Expanded Program of Immunization

Many infectious diseases stimulate the production of productive antibodies that usually confer long-lasting, even lifelong, protection against reinfection. Vaccines and toxoids stimulate production of these antibodies without causing disease²⁰.

Until 1985, the Expanded Program of Immunization carried out through primary health care had not reached a desired level of coverage of the target child population. In order to accelerate coverage to reach universal child immunization by 1990, the Ministry of Health, as the main governmental body responsible for the provision of health services, planned a national immunization campaign in 1985. Preparations started in 1984 included a series of high-level meetings and a preparatory workshop with participation from the Ministry of Health, other sectors as well as UNICEF and WHO. Intensive immunization against the five diseases (DPT, polio, measles) where protection can be achieved with vaccination was begun with the Ministry of Health campaign in 1985: 4.3 million children under five years of age were vaccinated against DPT, polio and measles. Thus, it was estimated that approximately 25,000 deaths from measles, 10,000 deaths from pertussis and 14,000 cases of polio were averted²¹.

Hacettepe University's Institute of Population Studies, with samples chosen before and after the immunization campaign, showed that the ratio of three doses of DPT and polio vaccine application had risen from 37 percent to 76 percent in all children below five years of age, and immunization against measles had risen from 37 percent to 83 percent. The percentage of vaccination for measles in infants less than one year old was 12 percent before and 72 percent after the campaign. In 1986, this level was not maintained due to a lack of inter-sectoral coordination and proper emphasis of training strategies. In 1987, the Immunization Program was integrated into the routine services of primary health care, while in places without a health unit, the service was provided through mobile teams. The 0 age group BCG vaccination was also integrated into routine health services in 1990¹⁴.

A "Vaccination Coverage Survey" carried out in 67 provinces during 1987 showed that 67 percent of children aged 12-23 months were vaccinated with BCG, 86 percent with DPT3/polio3 and 82 percent with measles vaccines. Total immunization rate for this age group was 60 percent¹⁴.

According to the 1993 Demographic and Health Survey, among children aged 12-23 months, the coverage rate of BCG was 89.1 percent, the coverage rate of DPT3 was 77.1 percent and the coverage of measles was 77.8 percent. The results indicate that 65 percent of the children had received all of their immunizations at some time before the survey. Only three percent had not received any vaccination at all. The remaining 32 percent were partially vaccinated. The percentage of children who were fully immunized by 12 months of age was 59 percent¹⁸.

In Turkey, the routine vaccination program at present covers six diseases: diphtheria, pertussis, tetanus, tuberculosis, polio, and measles. The EPI program in Turkey is well established, and its impact apparent from the reduction in disease incidence.

Since neonatal tetanus is an important health problem in some areas, tetanus immunization has special importance in pregnancy. The elimination of neonatal tetanus program was started in the middle of 1994, and evaluation of this program has been ongoing. According to the Turkish vaccination schedule, two doses tetanus toxoid (TT) during pregnancy are necessary for full immunization of an unvaccinated woman. However, if a woman has been vaccinated during a previous pregnancy in five years, she might only require one dose for her current pregnancy. With regard to TT coverage during pregnancy for all births in the five years preceding the survey, 16 percent had one dose, and 26 percent had two or more doses. According to the 1988 Turkish Population and Health Survey, these figures were eight percent and three percent for the last pregnancy, respectively^{18, 19}. The high drop between TT1 and TT2 was probably due to incorrect interpretation of the immunization calendar. There is not a recording card system for women, therefore the tetanus vaccination rate cannot be known among women¹⁰.

The program assessment carried out in 1988, within the context of Turkish Government/UNICEF cooperation, suggested that vaccination delivery should go beyond a mere "vaccination" program and start with the disease eradication and elimination phase. Thus, a preparatory plan for polio eradication was started in 1989, and provincial-based flaccid paralysis monitoring practices have been initiated and polio eradication activities are being implemented. "National Vaccination Days" have been held since 1995. The coverage rate of poliomyelitis was 81 percent among the children under one year old, and there were 23 polio cases in 1994⁷.

The Control of Diarrheal Diseases (CDD)

Diarrhea is a major public health problem worldwide. The prevalence and incidence of diarrhea vary from area to area, depending upon climatic and environmental factors. The incidence also differs from time to time according to seasonal variations. These factors lead to fluctuation of diarrhea incidence from one year to another¹⁶.

Diarrheal diseases are the leading cause of morbidity and death among children in Turkey. It is estimated that in general a Turkish child under five experiences an average of 2.02 episodes of diarrhea per year¹⁷. The National Control of Diarrheal Diseases Program was implemented in 1986. The main objective of the program was prevention of deaths by prevention of dehydration. For this reason, oral rehydration therapy (ORT) has been taught actively since the 1980s. It is also a fact that dehydration associated with diarrhea can be prevented by appropriate hydration therapy. Oral rehydration is one of the most effective, inexpensive and widely applicable forms of therapy^{7, 14}.

In Ministry of Health (MOH) organized training seminars for health providers oral rehydration solution (ORS) treatment has been widely practiced both in health centers, Mother and Child Health-Family Planning (MCH-FP) units and hospital outpatient departments. Some hospitals established special ORS units for daily care. An orally-taken salt and sugar solution (ORS) is only recommended for cases of dehydration. ORS use was also promoted by pharmacists^{7, 14}.

Overall, one-quarter of the children under five years had experienced diarrhea at some time in the two weeks preceding the 1993 Demographic and health Survey, and 11 percent were still having an episode of diarrhea at the time of the survey. Since the prevalence of diarrhea varies seasonally, the results do not represent the average prevalence of diarrhea throughout the year in Turkey. In the 1988 Turkish Population and Health Survey (TPHS), the two-week prevalence of diarrhea for the same period (August-September) was 24 percent. This finding suggests that measures designated to prevent diarrhea, which were introduced following the 1988 survey, did not result in any change in diarrhea prevalence over the next five years¹⁸.

The prevalence of diarrhea appears to be slightly higher among rural children (28.0%), children in the east (33.3%), and children whose mothers are without any education (28.2%) than among other children. With regard to treatment practices, 24 percent of children with diarrhea were not given any treatment; one-fourth of the children were taken to health facilities. Fluids made using packets of oral rehydration salts (ORS) were used in treating the diarrhea in 11.4 percent of cases, and 4.9 percent were given recommended home fluids. In 57.0 percent of the cases, fluids were increased¹⁸.

On the other hand, statistics of MOH hospitals reveal a definite reduction in diarrhea-related deaths. Case fatality rates also decreased by 56 percent from 4.41 in 1982 to 1.96 percent in 1988¹⁴.

Control of Acute Respiratory Infections (ARI)

Acute respiratory infections are responsible for high morbidity in children all over the world. Mortality due to ARI is unacceptably high in developing countries where the figure may reach 1,000 or more per 100,000 livebirths, compared to 30-40 per 100,000 livebirths in industrial nations. Poverty, malnutrition, ignorance, lack of and underutilization of health facilities, and predominance of bacterial pneumonia are considered responsible for this difference²².

Respiratory infections, particularly pneumonia, were the serious diseases causing mortality both within the first year of life and for those under five. Acute respiratory infections are the most prevalent diseases among children, mostly during winter months, with pneumonia ranking as the first cause of child mortality. Furthermore, both urban air pollution (which reaches high levels in cities) and indoor pollution (due to heating and smoking) contribute to the increasing number of acute respiratory infections²².

The Ministry of Health also launched a program for control of acute respiratory infections in 1986. In 1987, Çankırı was selected as a pilot province and the project was later extended to 22 provinces. By 1994, the program was extended to 11 provinces with first priority for development and 17 provinces with second priority for development and 13 additional provinces in 1994. Thus, in total, program has been extended to 63 provinces. The program covered 72 percent of the total population. The main activities of the project consisted of collection of baseline data about the knowledge and attitudes of mothers and health personnel on ARI. Training was conducted on ARI and medicine distributed. Health personnel working in primary health care were trained about ARI and other health personnel were trained on criteria for diagnosing ARI cases and the rules of treatment. Another intervention of the ARI program distribution of co-trimoxazole and penicillin was implemented in some high risk provinces. A decrease in ARI-related deaths is expected as a result of increasing immunization rates for measles and whooping cough and improvements in the health infrastructure^{7, 14}.

In the 1993 Demographic and Health Survey, the prevalence of ARI was estimated by asking mothers if their children had experienced coughing, accompanied by short, rapid breathing, in the two weeks preceding the survey. At some time preceding the survey, carried out during summer and early fall when ARI levels would be lower than in the winter, concerning treatment patterns, 37.3 percent of children with ARI were taken to a health facility, 29.6 percent were reported to have received antibiotic treatment including injections, and 43.6 percent received other medicines¹⁸.

Baby-Friendly Hospitals Initiative and Promotion of Breast-Feeding

Breast milk alone, without supplements, is the optimal choice for feeding full-term infants for the first six months. Mother's milk contains an ideal balance of nutrients, enzymes, immunoglobulins, antiinfective and antiinflammatory substance, hormones, and growth factors that protect the infant and encourage growth. Breast milk changes over time to match the changing needs of the infant. For the mother, breast-feeding facilitates the physiological return to the pre-pregnant state and offers hygienic and economic benefits over bottle-feeding. For both infant and mother, breast-feeding confers an intense opportunity for bonding and interaction²². WHO and UNICEF have issued a joint statement entitled "Ten Steps to Successful Breast-feeding" in the program of promotion and support of breast-feeding²³. The idea is to persuade all hospitals to follow the "Ten Steps to Successful Breast-feeding" which include informing all mothers of the advantages of breast-milk, keeping newborn babies in the same room as their mothers, rejecting the use of feeding bottles, and helping mothers with any problems they may have with breast-feeding in the beginning. Hospitals which follow the 10 steps are designated "baby friendly".

The Baby-Friendly Hospital Initiative was implemented in Turkey in 1989 and University Hospitals, MOH and Social Security (SSK) Hospitals still encourage the ten rules of breast-feeding. A meeting was held in Ankara with baby food companies. An official paper that supports the national health policy on breast-feeding was prepared by participants which secured their written commitment to the Government that they would also promote breast-feeding and would not distribute free breast-milk substitutes to hospitals. The necessary action for implementation, the international code of marketing for breast-milk substitutes, was also taken. In 1995, 56 hospitals were declared as "baby-friendly hospitals"; the target for 2000 is that all hospitals will be baby-friendly hospitals⁷.

Early initiation of breast-feeding is of benefit to both mother and infant. Only one-fifth of lastborn children were started with breast-feeding as early as within one hour of birth. As regards the subgroups, there is almost no variation in the initiation to breast-feeding with respects to sex of the child, residence, educational level of mother, and utilization of health services during delivery. The median duration of breast-feeding is 11.9 months.

Breast-feeding is very popular among Turkish mothers, but the proper time for introducing supplementary food to the diet of infants is not widely known. Only 18.9 percent of children were exclusively breastfed (receiving only breast milk) in the first month of life. One-third of the children (32.9 percent) are being given supplementary food as early as one month of age. The percentage of children receiving supplements rapidly increases to 53.3 percent among children two to three months of age. The median duration of exclusive breast-feeding is one-and-a-half months and the median duration of full breast-feeding (either exclusively breastfed or receiving plain water only in addition to breast-feeding) is 2.7 months. Early introduction of supplementary food to infant nutrition increases the risk of gastrointestinal infection, which is one of the leading causes of infant mortality in Turkey¹⁵.

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