Ascertaining the User Perspectives on Community Participation in Family Planning Programme in Thailand

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Abstract

The aim of this research study is to determine the extent to which community members are prepared to participate in family planning programmes and in which activities they would prefer to participate.

The study was undertaken in four regions of Thailand. Four groups of people were recruited to obtain information. They are community members, staff and managers, community-based distributors and local leaders.

The study indicated that staff and managers and the community based distributors (CBDs) valued the policy of participation as an important strategy in implementing programme. They agreed that promoting community involvement would lead to more cooperation in the community and would enable the government programme implementation reach the goals fruitfully.

Among the community members, they appreciate participation in the way that if they help each other everyone will benefit. If everyone know his/her role in participating in activities for communal benefit, i.e, having their community modernised and a better standard of living as their goal, then participation would be more attractive. Towards participation in family planning programme, the community members still think that family planning is too personal and at the same time collective action may act as a hindrance to family planning programme.

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Background and Rationale

Over the past fifteen years community participation has figured prominently in the policy statements of virtually all governments and aid agencies concerned with development; the health and population sectors are no exception to this. Community participation is seen as the cornerstone of Primary Health Care, as defined in the Declaration of Alma-Ata (WHO-UNICEF, 1978) and as a key element of population programmes according to the 1984 World Population Conference in Mexico (United Nations, 1984). Probably the most comprehensive statement made on community participation in family planning programmes was at the Jakarta Conference on "Family Planning in the 1980s".:

> "The participation of communities in the design and operation of family planning services is essential if they are to be perceived by people as culturally acceptable and responsive to their needs. Community participation provides family planning programmes with the opportunity to expand their outreach by tapping community resources and energies and is a highly effective means of promoting family planning while at the same time contributing to broader community development goals." (UNFPA et al, 1981)

To date these policy statements have been operationalised most commonly through the use of community-based providers of services, either Community Health Workers (CHWs) in the health sector or Community Based Distributors (CBDs) of contraceptives in the population sector. This interpretation of the concept is particularly characteristic of governmental programmes although some non-government organisations have tried to fulfill a broader interpretation by

seeking to involve community leaders and members in some project planning and management functions (Askew and Khan, 1990; Askew, 1989).

The distinction between the rhetoric of participation as being the involvement of community members in decision-making functions and thus exerting control over programme implementation, and the reality of most participation being through community-based distribution programmes with the active support of local leaders, has been the focus of much of the research undertaken by this Institute and others. Perhaps due to the enthusiasm of policy makers for such a politically attractive idea, much of the early research into community participation in health care concentrated on demonstrating the feasibility of the idea through case studies of "successful" small-scale, often non-governments experimented with the approach, at increasingly larger scales, the findings of researchers began to highlight some of the limitations of the approach (eg. Morgan, 1990; Bossert & Parker, 1984; de Kadt, 1983) and some have become quite sceptical of the extent to which communities can participate meaningfully, particularly in government-implemented community participation programmes (cf. Ugalde, 1985; Navarro, 1984; Askew & Khan, 1990). These limitations and scepticism relate largely to the actual or potential role of community members in decision making activities and in contributing resources for service provision activities.

The population sector has generally followed behind the health sector in terms of experience with community participation (see Oakley (1989) for a useful review). As with the health sector, however, it has been the non-government organisation, such as Family Planning Associations (FPAs), that have experimented most with the broader interpretation of the concept. The application of the community participation concept in national family planning programmes has been limited, however, compared with the expectations of policy statements.

The lack of research undertaken on the topic is also quite noticeable; whilst CBD programmes have been extensively anslysed, mostly through USAID-funded

operations research projects, (eg, Osborn & Reinke, 1981; Kols & Wawer, 1982; Foreit et al, 1978) the amount of research into community participation projects is small incomparison. Indeed, the ODA, through the Institute of Population Studies, University of Exeter (IPS) and the IPPF, has funded a large proportion of the published research into community participation in family planning programmes. Furthermore, this research (and studies undertaken by other organisations such as OECD, ESCAP and ICOMP) has focused primarily on the organisation and implementation of community participation in family planning programmes, that is, on determining how agencies can encourage and enable communities to participate in their family planning programmes and projects. The starting point for these studies has been, therefore, the providers' perspective; there has been an assumption by proponents of community participation, albeit normally implicit, that community members want to participate in family planning activities and that the programme personnel want communities to participate. Even if participation is not immediately forthcoming, there is an expectation that gentle persuasion is all that is needed for communities to perceive the benefits and start actively participating and forming committees, local organisations, etc.

The degree and extent of participation in family planning projects and programmes has been examined from the perspective of the providing organisations in two recently-completed studies; IPPF, with ODA funding, has just undertaken a study of how FPAs implement their projects (Askew, 1988) and ESCAP a similar study of national programmes (ESCAP, 1988). Both studies have identified a number of policy and organizational constraints, such as inappropriate objectives, centralised administrative structures, hierarchical decision-making, etc, that restrict the involvement of community members in programme activities, and recommendations have been made as to how programmes could be more appropriately organised to enable greater participation. These constraints cannot explain completely, however, the low level of participation found, and particularly the difficulty in sustaining the involvement of community members in family planning activities over time.

This would seem to suggest that the assumption that community members want, or can be easily encouraged, to participate in family planning activities needs to be examined more closely. More specifically, the attitudes of community members towards the idea of participating in an organised family planning programme, including who within the community should/could participate need to be explored, as do their perception of the cost and benefits of participation and the type of programme activities in which they would be prepared to participate, both collectively and individually. Furthermore, the attitudes of programme managers and staff, and of the CBDs towards greater participation need to be examined to provide a more complete picture. These attitudes could have major implications for programme planners and policymakers, because they will directly influence the structure and nature of any family planning programme that has a policy to involve community members in its planning and/or implementation.

From their statements policymakers are known to be favourable towards the participation of community members in family planning programmes. Moreover, the research studies referred to previously have shown how such an approach could be organised and implemented in family planning programmes and projects both by public and private agencies. There remains, however, an unproven assumption that the communities themselves are willing to participate in family planning programmes and that programme personnel are willing to encourage their participation, yet experience from a number of programmes and projects in beginning to indicate that this assumption is questionable. This research project has sought to gain a better understanding of these attitudes towards participation.

Aims and Objectives

The aim of this research study was to determine the extent to which community members are prepared to participate in family planning programmes and in which activities they would prefer to participate.

The research objectives for the study were:

i) to explore the perceptions and attitudes of potential and actual service users, community leaders and Community Based Distributors towards the existing programme in their community;

ii) to ascertain which IEC and service provision programme activities community members would be prepared to take responsibility for carrying out;

iii) to examine the nature of the incentives, both intangible and tangible, by which community members would be motivated to participate in the service provision activities, both individually and collectively.

Research Design

a) Research sites

The study was undertaken in four countries namely Thailand, Zimbabwe Sri Lanka and Mexico so that generalisations could be made cross-culturally. The nature and extent of participation can be strongly influenced by socio-cultural factors, such as religion, political norms, social structures etc, and so it was felt important that broad cultural variations were included within the study design. In addition to the criterion of socio-cultural variation, other criteria used to guide selection of the research sites were:

i) Fertility regulation should be a widely accepted behaviour within the country and family planning practised by a substantial proportion of the population;

ii) an organised family planning programme should exist;

iii) the family planning programme should include community-based activities, especially Community-Based Distribution, as a sizeable component;

iv) community participation should be regarded positively and encouraged by the government

The criteria were seen as important because they indicate that a national programme (including activities by both government and non-government organisations) has the potential for allowing and encouraging greater community participation; this situation must exist if realistic responses were to be obtained from community members and programme personnel concerning their attitudes towards community participation in the family planning programme.

b) Conceptual framework

The framework guiding the study is presented on page 7. The key concepts in this framework are the three dependent variables:

1) attitudes towards participation generally

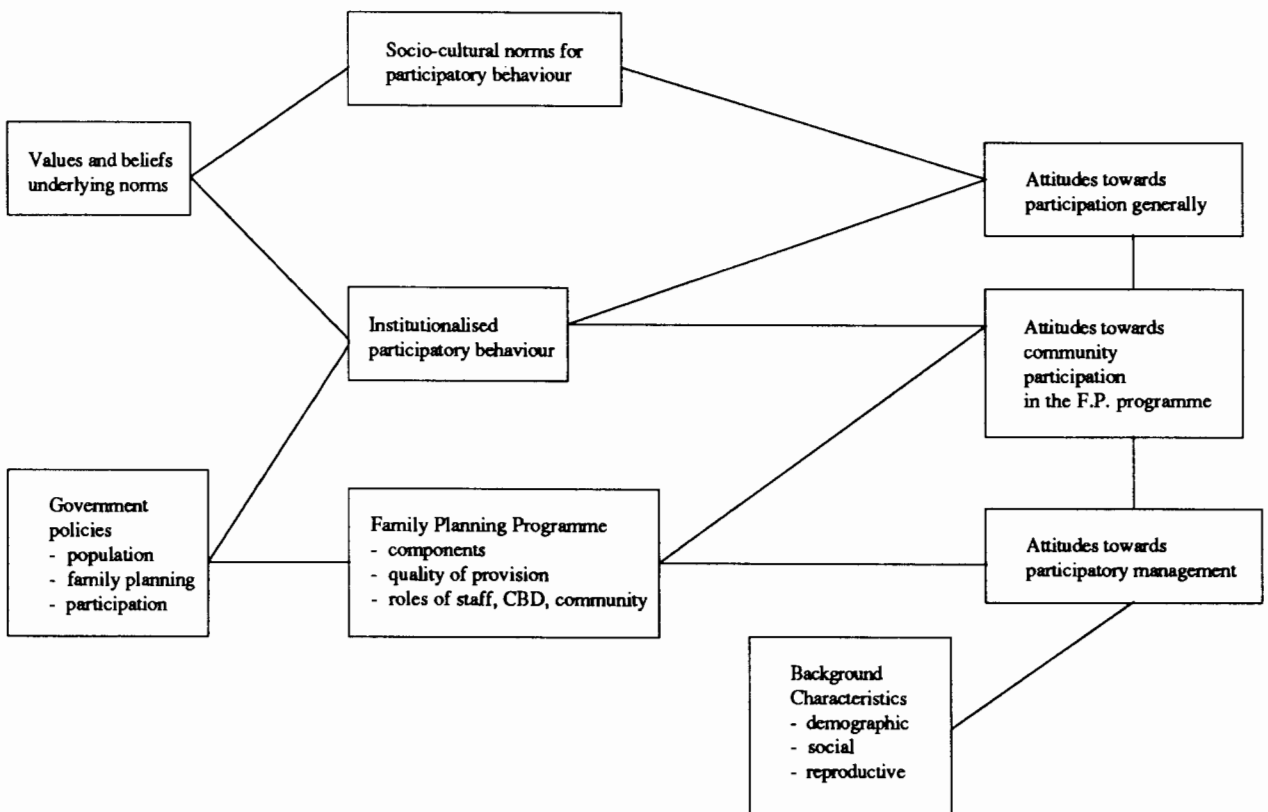
2) attitudes towards community participation in the family planning programme

3) attitudes towards participatory management

Measuring attitudes is always problematic and although it was felt that an anthropological type approach could be appropriate for collecting such data, the requirements of the overall study precluded this approach. a combination of open-end questions and agree/disagree statements were used and some Likert-type scales constructed.

The first two variables were measured for four respondent groups: community members, CBDs, staff and managers. The intention was to ascertain whether there was a difference in attitude between the four groups and the nature of any differences found. Similarities and differences between respondents from the

Analytical Framework for Study



four countries were examined in the comparative study. The relationship between the two variables was also examined.

In addition, participation in family planning programmes was considered from the perspectives of those in the community and those working in the programme respectively. Community members and CBDs were asked about their attitudes towards collective action, committees and the roles that local leaders and CBDs may play as these are the main channels through which participation occurs; these attitudes formed a sub-category of the second variable. Programme staff and managers were asked about their attitudes towards what is broadly termed 'participatory management' as such a managerial style is felt to be a pre-requisite for participation by community members in a programme's activities; these attitudes formed the third variable.

Five variables have been measured that are felt to be determinants of attitudes towards participation:

1) socio-cultural norms for participatory behaviour
2) values and beliefs underlying norms
3) institutionalized participatory behaviour
4) government policies
5) family planning programme

These variables were measured by a number of methods including focus group discussions and interviews with community leaders, programme managers and staff, documentary evidence from programme reports, and, where appropriate, a review of literature. By using a mainly non-quantifiable approach it is not possible to explore statistically the nature of the relationships between these and the dependent variables, but this does not inhibit attempts to explain the dependent variables through reference to these variables.

For community members and CBDs three background variables were measured:

1) demographic characteristics
2) social characteristics
3) reproductive characteristics

The data describing these variables were collected using questions taken from the Demographic and Health Surveys (DHS) which have been undertaken in all four countries. The relationships between these variables and some of the dependent variables has been analysed to explore any differences that may exist within the respondents.

Four data collection tools were used to obtain information from five types of respondent:

i) a questionnaire survey was undertaken amongst community members and Community-Based Distributors;

ii) focus group discussions were held with community leaders;

iii) semi-structured interviews were held with field-level programme staff and programme managers;

iv) documents describing the programme and other literature relevant to the study variables were reviewed.

Administration of the Country Study.

a) Organisation and schedule of fieldwork

This study covered samples of four regional areas of study sites. As a result, the distance from one site to another was a main concern in organising and setting a plan for field work. The research team started fieldwork in May 1989 and completed it in early July 1989. As planned, the research team spent approximately seven days in each community (village) for data collection. Advanced appointments were made through the provincial administration and local health personnel and

local leaders. Meetings with staff and managers had been arranged through the official contacts. However, due to their busy time on duty, appointments were re-scheduled several times. Meetings with the staff were usually undertaken in the afternoons when they were free from administrative and service work. In some cases, appointments were fixed after the official hours since it was the most appropriate time to interview the staff. All interviews with the staff and the managers were conducted by the principal investigator and the two supervisors.

Focus group discussions were organised a few days after fieldwork had started. This was because the local leaders who were supposed to participate in the focus group discussions helped the research team to identify the location of the households where the eligible respondents were. Another reason was to allow the local leaders to make appointments with their colleagues for focus group discussions. All focus group discussions and individual interviews with the local leaders were undertaken by the principal investigator and the two supervisors.

b) Recruitment and training of interviewers

The team consisted of eight female interviewers and two female supervisors. These interviewers were recruited from the list of those who have worked with the Institute for Population and Social Research during previous studies. They had university education and experience in fieldwork. A couple of days training by the principal investigator was organised at the Institute to ensure that interviewers were able to understand the objectives of the study and the principles of questionnaire administration. Mock interviews were attempted in the field under close supervision of the principal investigator and the two supervisors. A meeting was held at the end of the day to review and to amend whatever errors were found during the mock interviews. Interviewers were told to pay more attention to some points which were found as weak during the work interviews.

c) Logistical arrangement for fieldwork

Since the study sites covered 4 geographical regions, there were some difficulties in travelling from site to site. The research team used public transport for long-distance travelling especially in the southern region and made use of a vehicle provided by the Institute for the nearer sites.

In each case, advanced contact was made before the research team arrived. This helped the local administrators and local health personnel to have enough time to inform the community members. At the local level, health personnel assisted the research team to compile basic but useful information, eg. number and list of married women in reproductive age; available community-based distribution programmes.

During the fieldwork the research team travelled daily from their residence in town to the villages selected for the study. Fieldwork lasted from morning until evening, depending on the appointments made between the respondents and the interviewers. Some interviews were however carried out on the spot if the respondents were at home.

During the fieldwork, the principal investigator and the supervisors were responsible for field supervision, interviewing of community-based distributor staff and managers, as well as conducting focus group discussions. One or two interviewers were called to assist during focus group discussions. Thus fieldwork management was more flexible. Some of the scheduled work-plan had to be changed due to some difficulties in making the appointments with staff and managers. This resulted in more time spent to complete fieldwork.

d) Quality control and supervision procedures

Quality control and supervision procedures were undertaken with great care by the principal investigator and two supervisors. The procedures began with

identifying the eligible respondents. Supervisors checked by themselves the required characteristics of the respondents in marital status and age before allowing the interview to proceed. Random spot checks were attempted to ensure that the interview had been actually made. At the end of the day, all completed questionnaires were thoroughly checked by the supervisors to ensure that every applicable question was completed. Consistency checking was also made. Special attention was paid to all open-ended questions in order to observe that all responses were in the right tract. All open-ended responses were listed and grouped during the fieldwork. This helped coding to be easily managed at a later date.

e) Data processing arrangements

After the completion of the fieldwork, coding was done at the Institute. Two coders were employed and trained to be familiar with the coding instructions. All closed-ended responses were coded and computerised onto disc. Open-ended responses were coded as much as possible and some were left uncoded, especially the responses given by the staff and managers. This allowed the principal investigator to go into more detail in interpreting the results by referring to the original sources of information.

For the focus group discussions, data was recorded onto tapes and then transcribed. Twelve sets of transcripts were separately compiled.

f) Data analysis procedures

Frequency distributions and cross-tabulations were made to illustrate the relationships between variables. Statistical values, ie. Chi-square, T-Test and Analysis of Variance were designed to test the significance of association between variables. Responses obtained from open-ended questions were descriptively analysed rather than calculating them in percentage format since they were more subjective and the number of respondents was small.

g) Difficulties encountered with administration and/or fieldwork

There were two main difficulties encountered with administration and fieldwork. Firstly, there were difficulties in connection with appointments made with staff and managers. This was due to their busy schedules. This sometimes made interviews shorter than expected.

Secondly, there were difficulties with questionnaire administration. The community members especially found it hard to cope with the questions which required their opinions and perception. It took a lot of time for them to rephrase their responses. Some of them were unable to give their answers at the beginning but they could make it when they were given more time, after much repetition. As an example, when asked about benefits and disadvantages of more participation, community members found it difficult to come up with responses. Another difficulty was found with the attitude questions. The community members found it hard in rating their opinions about the statements given to them. However, these difficulties were overcome by allowing more time and repetition.

APPROPRIATENESS AND WEAKNESS OF DATA COLLECTION AND ANALYSIS METHODS

This study employed a multidisciplinary approach by using various methods of data collection. These included a sample survey using schedule interviews. Also, focus group discussions and in-depth interviews had been made use of to enable in-depth information to be collected which would help make the results of the study more reliable in the sense that information obtained from different sources by different methods would ensure the reliability of data. Open-ended and closed questions were designed to allow the respondents to express their opinions freely. Attitude scale techniques (Likert scale and semantic differentials) were used so that the assessment of perception and attitudes towards family planning programmes and concept of participation could be attempted.

However, some weaknesses of the methodology designed for this study are worth mentioning. Sample size (12 communities) may not be representative of the communities where the community-based distribution programme already existed. Also, the number of 16 community-based distributors recruited in this study may not represent opinions and perception of a large coverage of community-based distributors as a whole. The interpretation of data would be treated on a case study basis rather than a national survey.

SAMPLING PLAN

i) Sample structure and size

Geographically, Thailand is divided into four regions (North, Northeast, Central and South) from each of which one province was purposively selected for representative sampling. As a result, four provinces were selected, namely Pitsanulok province for the North, Chonburi province for the Central, Buriram province for the Northeast and lastly Nakornsrithamrat province for the South. This procedure was followed by selection of a district where an active community-based distribution programme was performed. Then the identification of villages were randomly drawn from the listing of villages with an active community-based distribution programme. In total twelve villages were identified. Those twelve villages included eight villages with government schemes and four villages with a scheme implemented by NGOs. (the Planned Parenthood Association of Thailand and the Population and Community Development Association).

ii) Sampling frame and sample selection

a) Community members

The sample covered four hundred married women of reproductive age group (15-44), and one hundred of their spouses. The sample took respondents equally from each of the twelve villages. At the time of the study contraceptive

prevalence rate was 69 per cent which was used as a guide for selecting the proportion of users and non-users in the sample to represent contraceptive prevalence status. By this procedure a total of 257 current users and 143 non-users were interviewed.

b) Community-based distributors

In the village where a CBD programme exists, there is one community-based distribution who works for the programme. A total number of sixteen CBDs from 12 communities were recruited in this study. Four extra community-based distributors were interviewed due to some villages with more than one CBD joining the programme. They are currently trained and assisting the current CBDs and these 4 CBDs will eventually take over the job.

c) Community leaders

One focus group discussion from each village was organised to provide qualitative data. A total of 69 village leaders were recruited. The village leaders included ten village headmen, nine headman assistants, thirty-four village committee members, nine mother club leaders and seven elders.

Twelve focus group discussions were organised, one in each of the selected villages. Focus groups were made up of five or six participants. The appointment was set one day before the actual group discussion took place. The discussions were tape-recorded for later analysis. The duration of each discussion was approximately two hours.

After the discussions, the tape recordings were transcribed. The transcripts were then summarised. The summaries were used as the basis of analysis within the framework of the stated guidelines.

d) Staff

A total of seventeen staff were interviewed. The group of staff consisted of twelve sub-district health officers who were based in the sub-district health centre and five field supervisors of the NGOs.

e) Programme managers

Two levels of programme managers were interviewed; the senior managers and the middle managers. The senior managers were the Chief of Family Planning Division, four Provincial Chief Medical Officers, the Executive Manager of Planned Parenthood Association of Thailand (PPAT) and the Operational Bureau Director of the Population and Community Development Association (PDA). The middle managers included four District Chief Health Officers and four Field Operational Officers of NGOs.

Demographic Characteristics of Community Members and Community-Based Distributors

The sampling plan of this study was set to recruit 400 married women of reproductive age (15-44) and 100 of their spouses. A total number of 400 female respondents were randomly selected from two sources of record; the household list kept by the village headman and the record of current users of family planning services kept at the health stations.

The mean age of the community members was 30 for females and 34 for males. The mean age of CBDs was 39 for females and 46 for males. Fertility level of the respondents was observed. It was found that the mean number of living children was 2.4 among the community members.

On socio-economic characteristics, it was found that most of the respondents were farmers and mostly had primary level education only. The community-based distributors were all married except one who was a widower.

About contraceptive and reproductive characteristics, data showed that the community-based distributors had a high level of knowledge about contraceptive methods. This was similar to the community members. Exception was made of some contraceptive methods which were less popular and relatively unknown to the respondents. These were diaphragm/jelly/foam and natural methods (abstinence and withdrawal). Interestingly, 'norplant', the newest method of birth control was quite popular and was the best known to the respondents. About contraceptive practices, it was found that female sterilization and the pill were the most popular methods which the respondents used to regulate their fertility while injections and IUDs ranked third and fourth. This finding was similar to the results shown in the Thailand Demographic and Health Survey (Institute of Population Studies, 1987). In addition, 3 respondents were identified as norplant users.

The respondents were also asked to mention their desired number of children. More than half stated that they did not want any more children. Among those who wanted more children, one additional child was most desirable.

The question of approval or disapproval of contraception was attempted. The respondents highly approved of contraception and their spouses felt the same. Details of demographic and reproductive characteristics were shown in Tables 1 and 2 in the Appendix.

Sample Selection

Community members		
- current users	257	cases
- Non users	143	cases
- Husbands	100	cases
Total	500	cases
Community-Based Distributors		
- Go	12	cases
- NGOs	4	cases
Total	16	cases
Leaders		
1. Village headmen	10	cases
2. Headman assistants	9	cases
3. Village committee members	34	cases
4. Mother club leaders	9	cases
5. Elders	7	cases
Staff		
Sub-district health officers (GO)	12	cases
Field supervisors (NGOs)	5	cases
Total	17	cases
Senior managers		
Chief of Family Planning Division	1	case
Provincial Chief Medical Officers	4	cases
Executive Manager of Planned Parenthood Association of Thailand	1	case
Operational Bureau Director of Population and Development Association	1	case
Total	7	cases
Middle managers		
District Chief Health Officers (GO)	4	cases
Field Operation Officers	4	cases
Total	8	cases

FINDINGS

Description of Population Policy and Family Planning Programme

Before the 1970s, Thailand was a pronatalist country due to the slow rate of population growth from 1911 until the 1960s (United Nations, 1976). Consequently, efforts to increase the size of the population had been encouraged. After 1960, a rapid rate of growth was followed by signs of over-population. Recommendations were made from a number of studies that the country's economic and social development efforts may find it hard to succeed with such a high growth rate. The Thai government issued the first official population policy statement in 1970, and since in at time voluntary family planning has been a major policy instrument of Thailand in the efforts to solve population problems. In March 1970, a national population policy was adopted officially permitting the promotion of birth control. The first objective was to reduce the population growth rate from 3 per cent to 2.5 per cent per annum by the end of 1976.

In the Fourth Five-Year Plan (1977-1981), the population policy emphasis was on population distribution and human settlements, the quality of human resources, employment, wage and earnings improvement. The aim was to achieve a 2.1 per cent per annum growth rate with a crude birth rate of 28.4 per 1000 and a crude death rate of 7.7 per 1000.

During the Fifth Five-Year Plan (1982-1986), the population objectives were a) to reduce further the population growth rate, b) to support a more balanced pattern of population distribution and human settlements and c) to improve the quality of the population. Population policy guidelines during the Fifth Development Plan period comprised the following three major aspects.

1) Attempts to reduce the population growth rate,
2) Population distribution and human settlements,
3) Improvement of the quality of the population.

As observed, the first five plans placed importance on setting targets to reduce the rate of population growth and also to improve the quality of the population with policies on migration, population distribution and human settlement in order to achieve a more balanced growth within the limits of available resources and other constraints. Thailand had passed through five plan periods and at present Thailand is in the period of the Sixth Five-Year Plan (1987-1991). The Sixth Plan has shifted the emphasis of social development away from planning at the macro level to planning at the micro level.

Special emphasis has been put on individuals, families and communities. Therefore the Sixth Five-Year Plan (1987-1991) has placed greater emphasis on human resources development than did previous plans. The direction for development of the quality of the population would be more in line with the direction for developing the economy of the country. The programme for population, social and cultural development included plans related to the size and distribution of the population and the development of quality of the population and the labour force, the promotion of community peace and improvements in the mechanism for social development. The Sixth Plan specified the following objectives, targets, guidelines and strategies for the development of the population, society and culture.

a) Objective

To reduce fertility and the population growth rate and consequently facilitate economic and social development and enable each family to improve the quality of life of its members.

b) Target

To reduce the population growth rate to 1.3% in 1991. It is projected that the population will number 57 million people with the birth rate at 19.1 per 1000 and the death rate at 5.7 per 1000.

c) Guidelines

To promote and to accelerate family planning programmes with an emphasis on the groups with high birth rates both in rural and urban areas. At the same time, other programmes will be implemented in addition to family planning which will facilitate the efforts at reducing the population growth rate.

To achieve the foregoing objectives and targets, some guidelines and measures are specified as follows:

1. To expand and to increase the efficiency of family planning services. Areas with socio-economic problems and low rates of contraception, whether in urban or rural areas, will be emphasised. Special target groups will include hilltribes people, adolescents, slum residents and factory workers.

The following strategies will be attempted

i) To allow volunteers from government and private organisations, village health volunteers, health communicators and traditional midwives to distribute oral contraceptives and condoms.

ii) To integrate family planning services with maternal and child health care and other public health promotion activities, especially in the border provinces in the South, among the hilltribes and in urban slums.

iii) To provide counselling services on family life, education and family planning and provide family planning services to adolescents.

iv) To encourage the relevant agencies to establish policies promoting family planning and to specify clearly the roles of responsible units at all levels. This will enable the agencies to find common operational guidelines.

v) To promote community participation in family planning programmes. Employers and employees organisations will be encouraged to provide family planning services and programmes to improve the quality of life of workers and their families.

The current target of reducing the population growth rate to 1.3 per cent by 1991 requires the recruitment of approximately 5.7 million continuing acceptors by the end of 1992. The following measures are suggested to achieve the goal.

1. Expansion of family planning services to all areas of the country, particularly to the north western and southern regions where fertility is still high.
2. Improvement of the capability and responsibility of paramedical personnel at each level, including the personnel of other ministries.
3. Increase efforts at information, education and communication (IEC) through a variety of media with the emphasis on disseminating information and motivating people to adopt efficient family planning methods.
4. Encourage private organisations, communities and localities to participate more in the IEC activities. Religious and community leaders as well as rural groups will be encouraged to initiate community activities that will accelerate the acceptance of family planning practices and improve the quality of life.

The National Family Planning Programme

After having considered that the high rate of population growth affects economic development of the nation, the government introduced formal National Family Planning Programme in 1972 with the following goals.

1. To reduce the population growth rate from over 3% per annum to 2.5% per annum by the end of 1976.
2. To inform and to motivate eligible women about family planning concepts.
3. To make family planning services readily available throughout the country.
4. To integrate family planning activities with overall maternal and child health services and thus to mutually strengthen the activities in these closely related health services under the following tasks:

a) Family planning programme as an integral part of overall maternal and child health activities,
b) Use of existing personnel to reduce the cost and avoid duplication. These personnel will have special training.

The organisation of the National Family Planning Programme is under the direction of the National Family Planning and Co-ordinating Committee which is responsible for policy formulation, planning and co-ordination of family planning activities in the public and private sectors. The committee is composed of the Minister of Public Health as Chairman, and about 18 representatives of various public and private organisations, both within and outside the Ministry of Public Health, the Family Health Division and Department of Health. The Ministry of Public Health serves as the committee's secretariat which is the focal point for operations and co-ordination of family planning activities throughout the country. Two sub-committees have been appointed by this committee, namely the sub-committee for co-ordination of activities between the public and private sectors and the sub-committee on research and evaluation of family planning activities.

The implementation of the policies has been largely the responsibility of the National Family Planning Programme of the Family Health Division which provides contraceptive supplies and logistical support, managing foreign assistance, training, supervision and IEC implementation. Apart from the Ministry of Public Health, there are two other ministries with vast administrative networks that are involved in public sector family planning activities. They are the Ministry of Education and the Ministry of Interior. The Ministry of Education is involved in population education and the Ministry of Interior in the promotion and provision of selective family planning services. The National Family Planning Programme also have strong support from and close co-ordination with the private organisations. These include the Planned Parenthood Association of Thailand (PPAT), the Population and Community Development Association (PDA), the Association for Strengthening Information on the National Family Planning Programme (ASIN) and the Thailand Association for Voluntary Sterilization (TAVS).

In this present study the assessment of perceptions and attitudes of the staff and the managers about population policy and family planning programmes were attempted.

Staff and managers assessed the main motives behind the government population policy as an attempt to reduce population growth and to increase a standard of living by emphasising maternal and child health (MCH), primary health care and social welfare. Reasons given for reducing population growth were highly emphasised by the middle managers. A lesser emphasis on regulating migration to urban centres was identified by staff and middle managers. These interpretations identified by the respondents were actually the main goals of population policy of the country.

Reasons for the policy were stated as follows. Most senior managers gave the idea that population growth is an obstacle to economic growth. Middle managers and staff, while agreeing with this, also see the need to ensure co-ordination between the population policy and social welfare policies as an important reason behind the policy. Among the staff, two main reasons seen as significant are population growth as an obstacle to economic growth and to increase and maintain quality of life.

All of the managers and the staff agreed with the policy. The senior managers gave the main reason as the importance of keeping a balance between population growth and national resources. The middle managers gave a variety of reasons for agreeing with the policy. The most subscribed reason was a concern for an improved quality of life. This reason was also the most popular opinion among the staff.

Concerning the aim of the family planning programme, the senior managers identified two objectives as equally important. These were its effect of reducing population growth and its effect in increasing the quality of life and maintaining a small family norm. Among the middle managers the family planning programme

effect on reducing population growth was perceived as the main contribution. Increasing the quality of life and maintaining a small family norm was seen as a significant secondary contribution. The contribution of the family planning programme was also seen as helping the nation in terms of socio-economic development at the macro and micro levels. The staff responses to the question reflected those of the managers in identifying the possible effect on population growth as the most significant contribution. Helping the nation in terms of socio-economic development was also a substantial contribution of the programme (see Table 3).

As observed from the responses given by the group of respondents, population policy and family planning programme were perceived as the main aim of reducing the growth rate and in the same manner the quality of life counted as an important goal by providing health services to the people. In their interpretation of population policy the majority of respondents emphasised the reduction of growth rate and the promotion of health services so that the people can improve their quality of life. These were the two main elements of the population policy. Less emphasis on population distribution and human settlement was observed by the group of respondents. This may be due to their work involvement in health services and this may affect their views on the elements of population policy. Nevertheless, their interpretation and perception toward population policy were still considerably related to the main aims of the national population policy and family planning programme.

The Organisation of Family Planning Activities at the Community Level

As the National Family Planning Programme is under the auspices of the Ministry of Public Health, the programme is integrated into the existing health services. The service outlets consist of existing general hospitals, medical health centres, health stations and midwifery centres. For the large rural population, the major source of service is the Ministry of Public Health, operating through the extensive network of outlets including regional health centres, provincial and district hospitals and local health stations.

Since Thailand has administratively decentralised family planning programme down to the provincial, district and community levels, health services at the village level including family planning activities are provided by both government health personnel and local resources personnel. These local resources are for example, the village health communicators (VHCs), the village health volunteers (VHVs) and traditional birth attendants (TBAs).

These volunteers work particularly in maternal and child health including family planning. They also work as motivators for maternal and child health services such as visiting homes to provide ante-natal and post-natal care, child care, referral services, distributing oral contraceptives and condoms. The village health communicators (VHCs) are responsible for providing knowledge on maternal and child health and to motivate parents to have their children immunised on a required schedule and to provide the community members with family planning information. The VHCs also co-ordinate in referral services and identify pregnant women and report to the VHVs.

The traditional birth attendants (TBAs) assist with the health needs of pregnant women and mothers in the villages and some work as oral contraceptive distributors.

The programme's policy of providing oral contraceptives through health stations and midwifery centres has meant that at least one effective modern contraceptive is reasonably available.

The expansion of services has occurred primarily in rural areas where health stations are staffed by health personnel and midwives. Pill-re-supply functions have since been extended to village health volunteers thus further expanding the network through which rural villagers can have access to modern and effective contraception. Injectable contraceptives are allowed to be provided at the health stations since 1983 (MOPH. 1987).

At the district level, besides pills and condoms, district hospitals often provide IUDs and injectables and some of the district hospitals perform male and female sterilization.

At the provincial level, the government hospitals provide a full array of methods. Referral services and mobile clinic services for family planning are routinely performed.

The contribution of the private sector is also integrated into the National Family Planning Programme. At the community level it is known as the Community-Based Family Planning Services (CBFPS) and is undertaken by the Population and Community Development Association (PDA). The programme began officially in 1974 to distribute pills and condoms with a minimum charge (PDA, 1982). Also, the Planned Parenthood Association of Thailand (PPAT) plays an active role in providing family planning services at the community level in close collaboration with the government agents. The organisation of family planning at the community level is shown in the appendix.

In providing family planning programme and providing health services at the community level the government has implemented IEC activities into the communities with the following aims:

1. Encourage local leaders to organise local groups and assist in the co-ordination of providing education and motivation in family planning and maternal and child health at the village level.
2. Increase the ability of local sources of information to assist in co-ordination of activities and provide information on family planning.
3. Provide support to the Ministry of Public Health offices throughout the country in audio-visual training and equipment.
4. Increase mass media coverage in providing information on family planning and maternal and child health throughout the country by using the mass media, eg. by organising regular radio programmes on the 24 radio stations at least 4 times per station/per month.
5. Improve co-ordination in planning and supervision at all levels of the private and public sectors.

Since the programmes are implemented according to policies based on a demographic rationale to reduce fertility, strategy planning in the programme is decentralised to the provincial and community levels.

During the interviews it was highlighted by the managers that programme target-setting aimed at reduced fertility at provincial level meant that recruiting potential acceptors and maintaining high contraceptive prevalence rates were major priorities. Nevertheless, the managerial schemes were flexible at the provincial level. This means that target-setting at the community level was designed in accordance with the actual situation in each community. In the communities with high demographic fluctuation (ie. affected by seasonal migration) the demand for supplies was uncertain. This was due to in- and out-flow of migratory labourers. In this situation programme management at the community level deals with it in line with 3 basic schemes:

1. ***Community preparation:*** This scheme helps to adjust the plan and target-setting to the actual situation which varies from community to community. So community surveys are planned in order to identify the number of married

women in reproduction age and methods used, since this is a key step to adjust plan and target. For example, during the Sixth Five-Year Plan (1987-1991), the target of having 75% current users was set from the central level. Apparently, information relating to the actual situation of each district within the province should be prepared so that the whole picture of each community would be clear and easy to set the plan for action.

2. ***Outlet and service accessibility:*** Besides the target setting which emphasises the number of users, programme organisation at the community level is set for the following services:

a) Mobile teams are organised by the provincial medical office and the district hospitals with the co-operation of health personnel at the community level. The objectives of the mobile teams include both health services and family planning.

b) Services including health education are provided according to a fixed schedule.

c) Home visits and MCH services are provided by the village health volunteers and health personnel.

3. ***Training:*** Training local health officers and the community members was regarded as one of the important elements of programme organisation at the community level. This is to expand the services at the community level. Nurses and midwives with excellent performance in their jobs are trained in IUD insertion so that health posts could provide more services. Moreover, local members are mobilised to promote self-management and self-sufficiency within the community level. In every community the village health volunteers were allowed to re-supply the contraceptive pill.

It was generally felt that the national programme at the community level has encouraged IEC programme in various forms. All activities at the community level were performed with the support of the Ministry of Public Health and with the voluntary assistance of the local people. The support from the Ministry of Public

Health included the use of radio, filmstrips, the development of nine mobile public information units to cover the rural areas. The printed materials, i.e. newsletters, calendars, posters etc., are distributed to members at the local level either through health personnel or village health volunteers. One of the aims of the organisation of IEC at the community level is to encourage local leaders to organise local groups and to assist in the co-ordination of providing education and motivation in family planning within the village a point mentioned by the staff and managers.

Policy on Community Participation.

Social development through an emphasis on the provision of basic services was fully implemented during the first five plans. In the Sixth Five-year Plan (1987-1991) specific targets and strategies for the development of population, society and culture are emphasised, for promoting public participation, especially in the plan for reducing population growth through the family planning programme and health promotion (NESDB, 1986). One of the strategies formulated in the Sixth Five-Year Plan (1987-1991) is to promote community participation in family planning programmes. Employer and employee organisations will be encouraged to provide family planning services and related programmes to improve the quality of life of the population.

Also a plan was set for encouraging private organisation, communities and localities to participate more in the IEC activities. Religious and community leaders as well as rural groups are encouraged to initiate community activities that will accelerate the acceptance of family planning practice.

In 1980, the government of Thailand launched two important projects for health and development. They are (a) the development of a primary health care systems through community participation, and (b) the intersectoral collaboration in health.

The primary health care through community participation in Thailand covers health education; nutrition; immunization, treatment of common diseases at the local level, the provision of sanitary water supplies and environmental sanitation; essential pharmaceuticals for village use; family planning and maternal and child health care and the control of local endemic diseases. All these health activities are implemented by mobilizing local people to work in collaboration with the government health personnel.

The government considered that for the rural health delivery system, the best strategy for providing health care to cover all communities is to foster the concept of community participation. Thus, a programme was introduced for training local people in the form of village health volunteers (VHVs); village health communicators (VHCs) as well as traditional birth attendants (TBAs). The involvement and participation of women in the maternal and child health care is a good example of encouraging community members to participate in programme implementation. The Model Mother Project recruited mothers with certain qualifications related to the knowledge and practice of maternal and child health care. In 1985, there were 24,516 Model Mothers selected from 11,812 villages or about one-fifth of all villages in the country and in 1986, there were 33,754 Model Mothers from 30,054 villages or 54 per cent of all villages (Debavalaya, 1988).

The Health Card Project is also another good example of community involvement in health policy. The project has two main objectives; first to improve health services by providing a proper and equitable referral system in accordance with people's medical needs. The second objective is to enable community members to participate in the management and self-financing. Two types of cards are used; one is for obtaining maternal and child health care services and the other for medical services.

In terms of population education, a work plan to promote community participation is as follows:

a) Organise training programmes for at least 15,000 government and private community workers and volunteers from all villages so that they understand the concept of population education and the use of population education and in turn educate the general public.

b) Encourage community workers and volunteers from both the government and private sectors who have had training in the field to disseminate population education to community members in every village.

The policy regarding community participation in population and development was more clearly reinforced when the National Rural Development Project was implemented in 1981. That project has integrated the health sector with other areas and has also introduced the concept of self-reliance and community involvement in identifying community health needs. The National Rural Development Committee administered the intersectoral co-ordination between the ministries in order to integrate the implementation at all levels of administrative schemes to reinforce health activities and development. The chart of the National Rural Development Committee is shown in the appendix.

The interpretation of population policy with reference to community participation was obtained by asking staff and managers to respond to four main questions. Those questions included the interrelation between programme implementation and the concept of participation; awareness of government statements or intentions; desire for changes in policy and lastly approval of policy. The responses given to those questions are discussed below.

Staff and managers agreed that the family planning programme encouraged community participation and that the government supports and promotes community involvement by mobilising local people to take part in the programme implementation. As an example, the introduction of the community-based

distribution programme at the community level proved that the government made efforts to encourage members to be more self-managing. Staff and managers also hold the view that programme organisation has made use of community leaders to motivate members to be aware of the aims of the programme and this has made programmes more acceptable to the members. Some of the staff and managers believed that the mechanism of the family planning programme allowed family members to make their own choices in programme management by having someone locally to take part in service provision and management so that more alternatives in service provision were made available to the members (see Table 4).

The awareness of government policy and community intentions to participate in family planning programme were seen as significant strategies in handling programme management. The main reasons stated by the staff and managers were the promotion of having community-based distribution programme and the allocation of training budgets to train community volunteers for health implementation at the community level. Moreover, the managers perceived that since the NGOs played an important role in family planning provision by emphasising the principle of integrated development programmes to motivate people to participate in family planning programme, the government could benefit from a similar scheme by allowing NGOs to participate in service provision. Another main reason given by the staff was the policy of recruiting community members to participate in specific programme such as group membership for village revolving funds; pharmaceutical revolving fund projects; the mother's club for nutritional promotion and MCH/family planning activities, and training local members to work as traditional birth attendants; village health volunteers and village health communicators (see Tables 5 to 8).

When asked for the approval/disapproval of the policy, all senior managers agreed with the policy in principle but one of the middle managers and two staff did not. The reasons given for disapproval of the policy concerned the participation process. They felt that it may create confusion and conflict among community members and also may lead to some problems in management and follow-up. They

foresaw that more involvement of community members might lead to less consensus among the members. For example, to recruit people for training in specific health activities from many people who desire to take part may create selection problems and could cause conflict between those who were chosen and those who were not.

Two out of seventeen staff disliked the policy of participation. They argued that participation was problematic to management in the sense that too many people involved in the programme made the staff overloaded with work in managing and supervising, for example, in the community-based distribution programme the staff had to give advice about record keeping, checking supplies and dealing with the problems of regularity and efficiency of service provision by community-based distributors. Rather, the staff preferred to provide services at health stations so that they could check and update the records easily, and if any problem of side-effects occurred, they could manage them directly.

The reasons in support of the policy given by staff and managers regarded the policy as creating a feeling of co-operation within the community members and this would make family planning programme more successful. The components of the policy may also stimulate community members to exchange ideas about what they would like to do. At the same time community involvement helps the government to save funds in health service implementation and helps to reduce the workload of the health personnel. Noticeably, most of the staff and managers reasoned that the policy would help the programme more successful.

As for a desire for changes in policy all managers but only four of the staff, wanted to see some changes. The reasons given for changes in policy by the managers were in the form of a caution that all targets and plans in promoting policy should be within the capacity of community members. They believed that the government should be aware of the real needs of the members rather than embarking on theoretical trials and errors. Close co-operation between government and NGOs should be carefully taken into consideration. This was to avoid overlap

which meant wasting time and resources. More attention should be given to personnel development since the policy of participation emphasised the involvement of more people in activities.

Personnel development in accordance with providing refresher courses, monitoring and incentives should be more emphasised. This would help to increase motivation in the community. Refresher courses for improving knowledge and information dissemination skills especially information about contraceptive methods and side-effects should be emphasised so that community-based distribution programme would gain more credibility and it would bring success to the policy. However, there were a few differences between the staff and managers; five out of seventeen staff felt that incentives should be emphasised in the policy, while the managers suggested that government should encourage community members to participate without incentives.

In view of the main reasons for encouraging participation in the programme, opinions given by community-based distributors, staff and managers were compared. According to community-based distributors, two main reasons were given: (a) the government wants people to have a better quality of life by having fewer children, as a large population restricts the land available for cultivation; and (b) participation helps the government and community to know each other and work together better (for example in a family planning programme, more participation means more accessibility for service provision).

Among the staff and managers, the benefits of making family planning programmes more acceptable and accessible to the people were raised as the reasons for encouraging participation in the programme. They observed that policy would help to encourage community members to understand the principles of the programme and so make it more acceptable, because members would have an opportunity to discuss and advise amongst themselves the family planning issues. Moreover, participation would help to increase the accessibility of information and service.

It is worth mentioning that community-based distributors, staff and managers valued the policy of participation as an important strategy in implementing the programme. They agreed that promoting community involvement would lead to more co-operation in the community and would enable the government programme implementation reach the goals fruitfully.

Attitudes Towards Participation Generally.

To examine how much the concept of participation was clear and known to the respondents, the whole group of respondents were asked to review their attitudes. A list of statements relating to participation in general were introduced to the respondents. A statistical significance at the level of 0.05 was found in the following three statements: *the government knows very well the community's need for health services; no community development programme can be successful without outside expertise; tand committees delay action by spending too much time on deliberation.* When asked about their opinions on participation by the government, the villagers and the community-based distributors strongly agreed that the government should take sole responsibility for planning and implementing all development efforts in contrast to the opinions of staff and managers, who thought that it should not be, since only 36% of staff and 20% of the managers accepted this. A similar result was seen in the opinions on the statement that *the government knows very well the community's needs for health services.* While the villagers held this opinion strongly, community-based distributors, staff and managers gave only moderate assent.

For the purpose of development, participation seemed to be important and more accepted. This was seen from the high level of agreement between the groups on the opinion that the members of the community should play an active role in planning and implementing development programmes. In terms of service provision, there was a difference between the groups. The staff and managers were neutral on the concept that the members of the community should identify their own need for services by the government, while community-based distributors and the

members thought that it should be. On the view of participation from outside, the respondents agreed that members preferred local experts rather than government experts to carry out development programmes and believed that members of the community had more knowledge about the local situation than the experts. Some disagreement appeared on the opinions within the group of the members when asked about the benefits of working in groups for development, 45% of them felt that rather than getting involved in development programmes, community members should look after their own family needs. But 97% of the members thought that it is the duty of all community members to participate in development programmes. This perhaps implied that they might not get involved in a development programme depending on what capacity was required and whether or not it interfered with their family commitments (see Table 9)

A further analysis was done by combining the attitude statements which refered to variables designed for describing characteristics of participatory process which the respondents assessed as important. These variables included attitudes toward participation generally, attitudes toward collective action; the role of leaders in development activities; the role of government in development activities and the role of the community in development activities. Tables 10 and 11 shows the mean scores and statistical significance of attitudes by characteristics of variables.

As a whole, the respondents were in favour of participation in general. But there was a difference between the groups when participatory characteristics were taken into account. On attitudes toward collective action, staff showed less appreciation of the concept than the rest of the group. community-based distributors were strongly positive to the idea that collective action is useful and it initiates participation within the community. About the role of leaders in development activities, the members are in favour of an active role by the leaders more than community-based distributors. This refered to an opinion that 93% of the members thought that all community matters should be organised by the leaders. This attitude was found among the members again when they felt that government should take an active role in development, because the members assumed that the

government knows very well the community's needs for health services and all kinds of developmental needs. From this point of view, it may be assumed that the members perceived that all help should be provided by the government. However, the members still believed that development efforts and activities can be successful if members are actively taking part in these activities. On this point, members, community-based distributors and managers, shared similar desires.

Role of Community Members Concerning Group Membership

One of the indicators of how strongly the members value participation for developmental activities can be obtained from how often people are getting involved in social groups. These groups can be either informal or institutionalised units. Surprisingly, within twelve villages in this study, only a small number of community members (21%) were members of organised groups. The most popular one was the medical savings group, followed by a credit group and a savings group, with an equal number of members. The other 4 organised groups included housewives groups; youth groups and village defence volunteers groups. Some of them do not require the members to participate frequently, and some were established many years ago without regular activities, e.g. youth groups and village defence volunteers groups. (see Table 12). Some groups require special qualities for membership, e.g. savings groups and credit groups. These two groups required the members to follow particular regulations. For example, the savings group requires members to pool money monthly. A certain amount of money requested from the group will be collected by the leader of the group, then deposited at the bank. The interest will be divided among the members annually. The credit group needs at least 5 people to form a partnership in order that they can get credit from the bank. These 5 people will be responsible for the credit. If one of them cannot pay the loan to the bank when it is due then the others have to be responsible for their counterpart.

Because of these regulations, members find it difficult to join the groups since they are not quite certain about their financial circumstances, so participation in such activities becomes difficult for some members.

The most popular group which villagers can afford to join, and at the same time be quite useful to them, is the medical savings group. The members participate in this activity by pooling money (approximately $US.50) once in order to obtain essential drugs for village use. Usually, the village health volunteers are responsible for managing this process. Members can benefit from the shares. The more they buy the more shares they receive every six months or annually.

Apart from the popularity of group membership, community-based distributors and the members were asked to provide the reason which they perceived for the fact that members want to participate in developmental activities. The majority opinion of both community-based distributors (81%) and the members (79%) was that the members want to modernise their communities. To have a better standard of living was also given as a motivation for participation, and also that developmental activities can create more convenient life. Participation was also perceived as achieving consensus and a feeling of being part of a group by community-based distributors (19%) and members (3%). Notably, as high as 15% of the members could not give the reason as to why they think people want to participate in developmental activities. (see Table 13).

In all the responses there was a reflection that members appreciated participation in the way that if they helped each other everyone would benefit. If everyone knows his/her role in participating in activities for communal benefits, ie. having their communities modernised and hevinag better standard of living, then participation would be more attractive.

The Meaning of Participation.

There was an attempt to assess how the staff and the managers perceived the significance of participation. A semantic differential technique was used in order to reflect perceptions and opinions of the staff and the managers concerning how they viewed and valued participation in programme implementation.

It was found that most of the respondents had similar ideas/perceptions about participation and were positive about participation and its significance. But there were some variations. The T-value showed six different variants in terms of interpretation. The managers had a stronger feeling than the staff towards the idea that participation is useful, helpful and important. Also, participation, in the view of the managers, could complement the process of educating people and it is essential for any kind of programme implementation. Neither managers nor staff agreed with the idea that participation has a political purpose.

However, both staff and managers agreed that the entire process of participation usually took a long time to take off. The managers in particular had strong perceptions of this. (see Table 14).

In conclusion, as can be seen from Table 14, the staff and managers perceived that participation acted as a more challenging strategy for government programmes. The managers perceived that participation has a wide range of advantages for the purpose of development activities, although they all agreed that participation to some extent is a time-consuming process. Moreover, it is quite interesting to observe that the staff and the managers perceived that the logic behind participation is less likely associated with political purposes, especially among the senior managers. They absolutely disagreed with any political purposes, whereas there was less strong disagreement among the staff and middle managers.

Focus Group Discussion on Community Participation

Apart from a quantitative data compilation for an assessment of norms, values, beliefs and experience with participatory behaviour, qualitative focus group discussion were use in this study. Twelve focus group sessions were organized in order to assess perceptions of the local leaders towards participation. Points designed for discussion during the focus group sessions were centred on types of collective behaviour; how often those collective activities are undertaken and by whom. Perceived effectiveness and relevance to the modern world were also the issues discussed among the groups.

a) Traditional Collective Behaviour

In rural Thai communities, traditional collective behaviour performed in a variety of forms and on different occasions. Types of collective activities are demonstrated particularly for religious purposes. Community members believe that contributions of labour and money for religious functions are as a part of their way of life.

Traditional collective action through religious ceremonies usually are performed throughout the year. Some of them are performed for the purpose of paying respect to their ancestors, parents, and elderly people, and some of them are practised for mental support, for example offering food to spirit or deities for good harvests.

When ceremonies take place, everybody will take part in his/her responsibilities. Young people and men are willing to handle the hard work, women prepare food and the senior members supervise to ensure that everything is done traditionally and properly.

Collective activities for communal benefits could be seen in the forms of contributions. Community members contribute money or spare their time to

constructd communal infrastructures such as bridges; roads, schools, wells, irrigation channels, temples and water reservoirs. Traditional collective behaviour can be seen in the forms of labour exchange for agricultural assistance, house building and traditional ceremonies (e.g. new year celebration, marriage, monkhood ordination, funeral ceremony). Exchange of labour between farmers for agricultural purposes is continued firmly in some communities. Members take turns to reap and thresh in the paddy field. An agreement is made between them that hosts offer food to those who work voluntarily. The reason behind this traditional practice is that farmers can help each other and save money. Unfortunately, this traditional collective behaviour has become gradually unpopular due to many reasons.

> "Nowadays, farmers do not help each other without paying wages. Labour exchange is no longer effective. We have to work hard and quick otherwise we cannot produce more. Machine are important and we need to employ labour so that we can produce more. We calculate that we pay the same or less if we employ labour. At the present time, it is quite difficult to ask for help because everyone is busy and it might be too late to harvest our produce in time if we wait for help."

To some extent the local leaders felt that they wanted to preserve this traditional collective performance since it was useful to the members and it can maintain the community relationship among the members. Those who are poor and less capable will have an opportunity to maintain their families at a basic minimum level. Without mutual help, the leaders viewed that it would create gap between the members.

> "We cannot stop the strong stream of change. The younger generation, they are different from us, the older generation. They want to work outside the field and we are lacking labour."

The persistence of traditional collective behaviour as viewed by the leaders was still preserved especially for religious functions. The local leaders believed that it helped to maintain the community. The leaders felt that the only way to bridge the gap between the senior members and the young is to socialize them to follow to the traditional way of life. Religious institutions such as temples and monks should be preserved as significant institutions.

> "We celebrate our new year. We pay merit to our ancestors. This is the only good occasion that our children, relatives and friends get together and we exchange our experience, happiness and problems. It is the best time to meet our children, friends and relatives who are away from our village working elsewhere."

Local leaders agreed with the fact that some of the traditional collective activities were reduced in significance. The effects of modernisation change attitudes, beliefs and values of people. They are influenced by a modern economic. Materialism was more important and the relationship between the members seemed unimportant.

b) Traditional communal decision making

Traditional communal decision making is still found in Thai rural communities. Contributions of labour or money to collective activities is widely practised and maintained in many Thai villages. This practice includes not only contributions for collective purposes but also for communal benefits. Local leaders usually take the role of mobilizing collective action for a specific need, and traditional communal decision-making plays an important role for action. This means that communal decision-making does not necessarily create equal benefits within to community equally. Collective action needs communal decision-making. This means that the group of leaders would organize and supervise the members to participate in collective activities. Many activities in Thai communities are undertaken through communal decision-making; for example, the contributions of labour and money for construction of infrastructures such as repair of roads,

irrigation channels, schools or temples, are controlled by the leaders. The local leaders will make decision on dividing the benefits and cost among the members. Collective action for communal benefits through communal decision-making appeared in many development activities, and local leaders give priority to those who really need help.

> "We cannot allocate resources to everyone in the village. We receive very limited resource from the government. This year we are provided materials to repair roads and we have to repair only the focal part of the road which would be useful to the majority."

Communal decision-making in some situations is made to benefit the people in specific groups and indirectly to the community as a whole. Where members have a problem of lack of security for their property, eg. if their cattle were stolen, local leaders take action to send a group to search for the thieves and the cattle.

> "It is quite hard to trace the thieves and the cattle in the rainy season. We cannot follow their footprints. Sometimes we cannot get the cattle back, but in dry season it is much easier."

To protect the members from losing their property, communal decision-making is formulated in order to call for collective action.

> "A group of volunteers work as village guards during the night time. We have 12- 15 meeting points with 4-5 volunteers to work as guards in our village. It is quite effective and we can solve our problem."

Collective behaviour and communal decision- making in Thai society, however, may not be directly appropriate for the family planning programme. The local leaders felt family planning as quite a personal matter. It is a matter between

husband and wife. They do not think that to increase the number of acceptors can be worked out through collective behaviour.

> "Family planning is a matter of the husbands and their wives. We do not think we can persuade them to practise family planning."

> "People know a lot about family planning. They accept it and we do not think that they want to have big families. They imitate each other and they know that too many children cause economic hardship."

Towards the policy of more participation in family planning, the local leaders realized the use of having a community-based distribution programme since it makes service more available. However they do not think that it would be popular and effective.

> "Nowadays there are many methods of birth control. People have more choices. They can get service easily from the health stations and they can have advice from the health personnel directly."

c) Institutionalised participatory behaviour

The Thai government facilitates decentralization to increase local participation in planning and implementing its development activities. A vertical hierarehy is established in the form of the provincial level down to district, sub-district and village level. At the village level, a village committee is officially appointed by the authorities at the district level. The committee is normally comprised of 8-10 members selected by community members. The village headmen by their status are appointed as the chairmen of the committees. The village committees work closely with the Tambon Council (sub-district council) to undertake administrative and managerial responsibilities. Members of the village committees are assigned to take roles in specific functions ie, religion, education,

development, community defence, and health. As discussed during the focus group sessions, the leaders said that they hold a meeting once a month with participation of the villagers. Meetings can be held oftener, at any time when they have important matters to discuss. The purpose of the meeting is to inform and to get together the committees and the members. During the meetings, the village headmen as chairmen lead the group and convey information from the government to members which normally cover development plans, health and agricultural advice. The committees are the representative group of the village who prepare plans and propose those plans to the Tambon Council in order to ask for resource allocation. In some situations, plans are made after a consensus between the members and the committees. They will discuss the needs of the community which require immediate assistance from the government. Plan preparations are normally assisted by teachers due to the limited skills of the leaders in presenting official documents. All proposed plans are not necessarily implemented since the Tambon Council has to screen and to set priorities among the villages, which sometimes creates conflict between those who were selected and those who were not. The dilemma which the village headmen face is that they feel they are losing credibility if plans are not fulfilled.

> "We try our best and we feel so upset when we fail to get our needs. Villagers do not understand the process. For them, gaining means they have great and efficient leaders. In contrast if we cannot make it successfully they will compare us with their neighbouring village headmen."

The village committees have to deal with development activities implemented by both government and NGOs. Development activities usually are mainly implemented by two ministries, namely the Ministry of Public Health and the Ministry of Agriculture. Implementation from Ministries of Interior and Education are not so attractive to the members. Discussion from focus group sessions revealed that most of the development activities were initiated by the government. The local government officials are mobilized to handle all activities

with close cooperation from the local leaders, volunteers and members. Within 12 communities selected for this study, various similar development activities were implemented; for example, job creation projects for development in rural areas, environmental and health improvement projects (e.g. constructing latrines, infrastructures, and activities for agricultural improvement). The points suggested for focus group discussion were made to observe how the activities were undertaken; by whom and how often such activities were taking place. Assessment of how effective/appropriate and beneficial those activities could be also served the objective of the focus group discussion.

To make the point clear, it is rational to divide development activities into two categories. First, activities with a direct involvement of the local leaders. Second, activities in which the local leaders play indirect roles to control resource allocation. Development activities in which local leaders directly control resources refer to activities implemented for the job creation projects for rural development, which is one of the main policies of the government. The implementing activities range from constructing to repairing infrastructures. Technical assistance from the government is provided in different forms (e.g. materials, monetary assistance and supervision). The village headmen sometimes have full authority to recruit labour.

> "We made a decision to select those who are in need of employment. Those who are poor. We considered them first so that they can earn some money. Sometimes we have no choice to manage the budget since the project is big and needs machinery to operate the main task. That means the private companies take part of the job. We have to agree with the authorities that manual workers will not be as useful and effective if the construction is to be durable and be done in time."

Some development activities need community participation (i.e. repairing of water reservoirs, roads, irrigation canals, temples, schools). Then, village

headmen will play an important role. The village members are called for collective performances.

> "We request them to spare their time and resources to repair roads or to deepen irrigation canals. They come and help each other. They know that if they do it, all the community will gain benefits. It is quite easy to have them in groups, and they work hard if they realize that everyone gains benefits. The heads of households, they are strong and suitable for hard work. The housewives and young people take part of food preparation and light work. We do not bother about food. They bring it with them and share among themselves."

The leaders pointed out that timing is quite an important factor for collective action. Dry season is the best time to undertake development activities because villagers have enough time to participate. Normally the government activities begin once a year during an agricultural slack season and when most of the villagers are at home.

From focus group discussions within 12 selected communities, we found that there are several organised groups with different purposes and objectives. Some of them are popular and well recognised, for example the village revolving fund, the credit group and the savings group. Each group has its own regulations and specific requirements. As an example, the village revolving fund for development is established with the assistance of the government and the co-operation of the villagers. Members can hold shares which cost them 10 baht for one share (approximately US$ 0.4). this group has a commmittee to run a small shop in the village selling essential subsistence items. Members and nonmembers buy goods from the shop and the surplus will be annually shared among the members.

Another good example of institutionalised participatory behaviour can be viewed from the popularity of the saving group and the credit group. These two groups are organised and recognised by village committees. The credit group especially needs recognition and close contact between the government and the leaders.

> "Villagers appreciate very much the credit group. They need money to invest in their land and they prefer to pay low interest."

> "The only problem they are dealing with is that not everybody can be a member. They have to form a group with 5-6 people to request loan and they have to take responsibility among the members for the loan."

Participatory behaviour is not only for the purpose of communal benefits. Individual benefit is also an interesting point to be observed. Some of the communities (the selected villages in the North) share benefits among the group by paying a certain sum of money to the authorities if they want to make use of irrigation canals for cultivation. The rates of charge vary in relation to the produce they gain. A similar process of development implementations are offered by NGOs (the villages in the North and Northeast). A loan of 3500 baht (US$ 140) and 1000 baht (US$40) is provided for those who want big water container and latrine. The amount of money will be paid back to the government or NGOs at the rate of 100 baht per month. Projects will be abandoned if no repayment are made and this means that the rest of the members will have no chance to benefit from the project.

d) Effectiveness and Appropriateness of Participation

During the focus group sessions, local leaders were encouraged to assess how effective and appropriate participation could be. Most of the leaders agreed that villagers are highly participatory in development activities particularly in the activities which fully and immediately render benefits to the community. Personal

contact is always useful in getting the members in a group to work together. Sincerity and common ideas /intentions among the members and local leaders will help the community to fulfil the aims of community development. With limited resources, participation is more appropriate.

> "We try to encourage the members to participate for the sake of everybody in our village. We are poor and it is important that everyone should help each other."

> "We do not have enough money or resources to handle all development activities. Our needs for survival must be fulfilled immediately. We cannot all the time wait for help from the government. There are a lot of villages which need help. We should help ourselves first and we will survive."

Interestingly local leaders remarked on some factors affecting participatory behaviour. They concluded that things had changed a lot compared to earlier days. Materialism and the world economy influence very much the way of people's thinking, their values and norms. The leaders felt that the erosion of traditional behaviour is visible and increasing. People become more monetary minded and this resulted in the decline of participation. In support of this observation the local leaders referred to the influence of monetary schemes for development activities. They argued that people perceived that the government has money to help them and donating free labour seems incredible because they can be employed and paid by the government. However, it may be too early to assume that development scheme reduce participatory effectiveness though it is one of the episode factors we cannot ignore.

Service Provision at the Community Level Assessment

The respondents were asked to identify who the community-based distributors were, the services they provided and services which were provided, at

the clinic. As stated earlier, 67 per cent of community members knew who community-based distributors were. Those who knew community-based distributors were asked to identify what kind of job the community-based distributors were undertaking. It was found that 90 per cent of community members were able to describe correctly and perfectly the job of community-based distributors. There were similar findings for the knowledge about services provided at the clinic. A strong emphasis on community-based distributors responsibility according to the community members' perception was that community-based distributors assisted health personnel to give advice on maternal and child health; supply information about health and family planning; advise community members about environmental sanitation and distribute basic medicine for village use.

The community-based distributors were also encouraged to describe their roles at the community level. This was to assess how accurately community-based distributors themselves perceived their roles and their responsibilities. Information obtained from interviews confirmed that community-based distributors had a clear idea about their roles and the job assigned to them. They described their job as concerned with the provision of information and advising community members about family planning, and motivating members to practise family planning in order to space births. The community-based distributors also suggested to those who want to use contraceptives to have physical check-ups at the clinic. The community-based distributors stated that they worked closely with the health personnel; assisting them to record the number of married women of reproductive age and children under 5 years of age. The community-based distributors have to follow-up children under 5 years of age for immunization and for other health-related activities such as weighing, nutritional promotion and control of local endemic diseases. The community-based distributors approached the newly-wed couples to advise them to practise family planning if they have no desire for children in the first year of marriage. The community-based distributors paid home visits to the mothers with new-born babies; kept records of pill users and re-

supplies. All the community-based distributors emphasised that they assisted the health personnel and managed whatever jobs that were assigned to them.

Staff and managers viewed the role of community-based distributors as an important part of the programme implementation in providing health services to the rural population. They believed that the main aims of having community-based distributors are to strengthen the decentralised strategy with a strong emphasis on information, motivation and services. In this respect, community-based distributors helped to reduce the work load of health personnel by disseminating information about health and family planning and by providing basic services such as dispensing basic medicine and promoting nutritional activities in the village. The community-based distributors also bridged the gap between the government outlets and community members. The staff and managers also perceived that community-based distributors were assigned to convey to the community members the message about primary health care, maternal and child health and family planning. Information disseminated to the members covered various aspects of health both preventative and curative.

On the services provided by the CBDs, the staff and managers explained that community-based distributors were authorized to re-supply oral contraceptive pills and to refer the new acceptors to the clinic for physical check-ups. Referral services provided by CBDs included assisting those who wanted to use permanent methods of birth control by referring clients to the clinic for appropriate treatment. In the villages where the CBD programme existed, CBDs obtained supplies from health personnel and dispensed to the members. Records of users were kept with CBDs and they must show the records to the health personnel whenever supplies were due.

Community members were asked to describe the services and information provided at the clinic. It was revealed that 91.4 per cent of the community members knew about services and information provided at the clinic. This figure was not as high as expected based on the assumption that health stations are the nearest

government outlet where community members seek health services and are easily accessible. As observed during the interviews, those who claimed that they had no idea about the sort of services and information at the clinic said that they never went to the clinic and could not imagine what services and information were provided at the clinic.

Among the staff and managers, not surprisingly, the responses were in detail about the activities undertaken at the clinic. They said that all activities were organised routinely within weekdays. The administration is headed by the chief health officer at the clinic which is usually staffed by at least 2 officers. Some clinics have 3 or 4 officers. All activities were divided among themselves and were performed according to work schedules. Information and services provided at the clinic included health education; immunization; provision of environmental sanitation; family planning and maternal and child health care; basic knowledge of controlling local endemic diseases and dental health. A provision of basic curative services in the form of training local people as individuals or in groups (ie. the village health volunteers, the village health communicators, the traditional birth attendants, the model mothers and the mother's club members) to disseminate information and to motivate community members to take care of health, and to maintain environmental sanitation and family planning.

Information is provided in different forms. For example, the clinic provides printed material, ie. leaflets, posters, charts and booklets. These materials are also given to CBDs to post at their houses or anywhere in the village. Health education is usually carried out on the day set for family planning services so that the health personnel could educate and motivate the mothers in a big group about maternal and child health as well as family planning. By doing so, IEC takes place simultaneously. Moreover, health personnel give talks/lectures on health education occasionally in schools when vaccination service is due. For environmental sanitation, the sanitary officers are responsible for supervising the villagers on how to keep their residential areas clean (eg. to motivate people to have a latrine for hygienic purposes). Health personnel also educate the community members on

how to protect themselves and their children against local endemic diseases which are seasonally widespread. At the clinic, basic curative services are provided. In cases of emergency or serious illness patients are referred to the district hospital for special treatment.

From the managers, details were obtained during the interview. In general their perception towards information and services provided at the clinic were the same as that of the staff. Additional information given by the managers concerned planning and policy to expand services at the community level by promoting health personnel who were very good at their jobs to enable them to have special training or attend refresher courses. This enabled them to provide more specialised services such as IUD insertion and male sterilization.

The respondents were asked to give their views on the quality of service provision at the community level. The community members were asked whether they knew CBDs. Sixty-seven per cent of the respondents knew CBDs. Based on this figure we assumed that the CBDs were not highly popular and known to the community members in the selected villages. This might be due to the fact that the community members were not quite certain when asked who CBDs were. They often stated that they were not quite sure who currently worked as CBDs because the CBDs often dropped out. This resulted in the high rate of refusal to the question. On the availability of service provision, CBDs were asked to share their opinions on the regularity of supplies, 94 per cent confirmed that they received supplies on time and 88 per cent perceived that family planning provision was easily accessible to the community members.

Staff and managers were also asked to assess the accessibility and availability of service provision, especially the availability of information about family planning programme. Sixty-three per cent of the staff perceived that it was easy for information to reach the community members while the managers (86 per cent) claimed that information was accessible to every village. This opinion was similar to the perception on the availability of services. Interestingly, the staff

perceived that information was not easily accessible when compared with the availability of services.

The community members were asked to assess the availability of CBDs. Half of the respondents said that the CBDs never visited them for the purpose of family planning but they usually met one another informally as members of the village. However, 29 per cent of community member said they could visit CBDs at any time. CBDs said that they always had time for the community members. Most of the CBDs said they were willing to meet and to give services to the members at any time. (see Table 15).

Questions on knowledge about methods of birth control and perception of its availability were asked in order to assess the level of knowledge and perception of service provision. The respondents (community members and CBDs) showed high levels of knowledge about contraceptive methods. Diaphragms/foam/jelly were the methods less known to the respondents. Concerning the perception of availability of methods, a high percentage of respondents knew the sources for every method. (see Table 16).

Probing the source of service apart from CBDs revealed that community members preferred to seek services from the health stations. Most of the members went to health stations not only for family planning purposes but also for other health needs. District hospitals and provincial hospitals were also another source of health service where the community members preferred to go when services were required. A small proportion of the respondents mentioned drug stores and private clinics as their source of health services and family planning purposes. (see Table 17).

Staff and managers were asked to assess the frequency of visits and follow-up visits made by the CBDs. The staff (73 per cent) did not expect the CBDs to make regular visit. Similarly the senior managers did not expect the CBDs to make regular visits, while the middle managers were quite positive as to the CBDs

performance. As an overall assessment, the managers did not expect that CBDs would be able to perform their duties efficiently since their job is voluntary and the quality of CBDs varies. Some may work with high efficiency and some may not, and this is quite common.

Even when the CBDs themselves were asked about the follow-up, they accepted that the follow-up was not regularly undertaken and they did not consider it as an important job. The reasons given in this respect were that some of the CBDs are also shop owners in the village (for those CBDs working for the Population and Development Association (PDA) and the Planned Parenthood Association of Thailand (PPAT) and did not have time to follow-up. The community members came for supplies every three months and if they discontinued using the pill the contact between CBDs and the members normally was over.

An assessment of relations between community members as the users and CBDs as the providers was attempted by asking the groups of respondents to evaluate the relationship between members and CBDs. Half of the staff said that community members and CBDs had a good relationship, and 60 per cent of the senior managers evaluated the relationship between CBDs and members as satisfactory. The middle managers (62 per cent) said that CBDs and members had good relations. Remarkably, there was a similarity between the staff and the middle managers who said that CBDs and members had good relations. Their perception may be more realistic than the manager's because they were closer to CBDs and evaluate it from what they actually observed. The perception of the senior managers may have be made from a far distance due to non-contact with the members and CBDs. (see Table 18).

The community members were asked to assess the relations between themselves and CBDs. They quite agreed that CBDs were friendly, helpful and respectable.

Concerning the knowledge of CBDs, 73 per cent of community members agreed that CBDs are knowledgeable while 26 per cent accepted that CBDs are highly knowledgeable. This perception was expected due to the high credibility the members gave to the health personnel. The members considered a CBD as someone locally helpful and respectable to some extent, but did not receive high credibility from the members.

It is important to know how CBDs evaluated their role in terms of being accepted by the members and whether they received good co-operation in their jobs. The CBDs stated that they were highly accepted by the members and they perceived that the members were highly friendly to them and their role. When asked about the help they received from the members, CBDs did not show any conclusive opinion. This may imply that they hod some difficulties in dealing with the members. Discussions during the interviews revealed that CBDs sometimes had to put in more effort in motivating members to participate in health activities such as joining the nutrition programme. Some of the CBDs complained that the members did not take their advice seriously and thought that CBDs were not knowledgeable enough.

Apart from the questions on perception towards their role and their credibility, CBDs were asked to give their opinions about the adequacy of the training they have been given. Most of them expressed high satisfaction with the training they have received. The reasons they gave in support of this included adequate knowledge about family planning obtained through the training. They felt they were able to provide information to the members.

Attitudes Towards Community Participation in The Family Planning Programme

Attitudes and perceptions of users and providers towards the nature of participation in family planning programme is one of the important objectives in this study. The respondents were asked to ascertain how participation could be implemented in family planning programme activities at the community level;

whether the participation could be performed collectively; through committee or through the leaders. Judging from the responses it was found that there were some differences between the groups of respondents, particularly on attitudes towards participation in family planning through collective action.

The staff showed highly inconsistent responses concerning whether it is the responsibility of the community to work together to support the family planning programme. When the members asked whether family planning is a purely personal matter and therefore collective action is a waste of time, nearly half of them (44%) agreed with this idea. The other groups were strongly against it. This result was also similar to the attitude that collective action by community members will always act as a hindrance to the family planning programme. This may imply that community members to some extent perceived that family planning is something personal.

There was a consensus between the groups of respondents on the opinion that committees are the best way for communities to plan their collective activities as well as the opinion that the committees do not affect action by spending too much time on deliberation, even though over half of the members (54%) were quite dubious, feeling that committees can only delay action by spending too much time on deliberation. When asked about participation through the leaders, especially whether that the community leaders are fully aware of the health and family planning needs of the community, the members (90%) highly respected their leaders for this while CBDs, staff and managers did not credit the leaders for it. This similarity appeared again when asked whether all community matters should be organised by the leaders; the members strongly agreed with it. (see Table 19).

Again, the concept of participation was closely observed by combined statements which conceptualised participation through collective action and committee. Table 20 shows the differences between the four groups of respondents. The differences were found on the question whether family planning is a purely personal matter and therefore collective action is a waste of time. CBDs,

staff and managers were highly in favour of participation through these channels while the members still thought that family planning was too personal and at the same time felt that collective action may act as a hindrance to family planning. This opinion coincided with the opinions given to the open-ended question when asked about problems resulting from more participation. The members stated that more participation may cause confusion and conflict between those who want to participate and those who do not wish to participate.

Attitudes Toward Participatory Management

To evaluate attitudes of the staff and managers towards participatory management, a set of statements describing concepts of participatory management was administered. Those statements were designed within five participatory management variables. They are participatory management in general', target-setting, decentralisation, teamwork and delegation.

By looking at each statement the staff and managers conceptualised participatory management in the same manner in all of the statements except the one that field staff should have full responsibility for determining the family planning activities in their area. The staff and managers did not think that decentralisation would lead to confusion and inefficiency, and this was associated with their neutral opinions that central control is essential for sufficient implementation.

The point that the national programme should be fully decentralised was strongly agreed by the staff, while the managers just agreed with this idea. The staff and managers felt that the community should be responsible for supervising their CBDs. Similarities among staff and managers were found in the following statements; programme staff are expected to plan most of the programme activities at the community level; a manager's main function is to supervise staff; staff work best if they are allowed to carry out their job in their own way; and finally, staff work best if they have a specific function that they can concentrate on. They all agreed with the concepts stated within each statement. In terms of collaboration,

staff and managers strongly appreciated that staff work best when they can collaborate with others. But they were against the idea that teamwork is time-wasting and only leads to disagreement.

The staff and managers held neutral opinions towards the ideas that the best way to manage staff is to give them targets to follow. The staff quite agreed that acceptor targets encouraged them to put undue pressure on clients to use a particular method even if they do not really want to use it. This statement was strongly disagreed with by the senior managers, but the middle managers quite agreed with it. Almost all of the staff (82%) felt that they should set their own targets, and 67% of the managers accepted it. There was a low agreement between staff and managers on the view that acceptor targets encourage staff and CBDs to make up false records. The same result appeared on the statement, `unless the country's population growth rate declines to the expected target, the family planning programme is a failure'. In contrast they approved the view that the national family planning programme is more concerned with family welfare than with population control. Again, a high consensus was found to the statement that the national family planning programme should strongly encourage voluntary sterilization.

The staff and managers were strongly against the view that field staff and CBDs should not be encouraged by managers to make suggestions about programme implementation, but the managers (80%) contradicted themselves on the view that they agreed with strong leadership and tight control from the top if new ideas are to be introduced to the programme, while 65% of the staff shared this idea. Slightly over half of the staff and managers (53% of managers and 59% of the staff) felt that the community should tell the programme staff what its family planning needs are.

A low agreement was seen again among the staff and managers on the view that it is foolish to think that communities can influence the implementation of the family planning programme. An obvious contrast between the staff (29%) and managers (53%) was observed toward the idea that to be efficient, communication

between managers, staff and CBDs should be restricted to administration matters only. With a high level of agreement the staff and managers held with the opinion that managers should spend as much time as possible consulting with each other. (see Table 21).

The next step was to assess the differences between the groups on attitudes towards participatory management. The statements were collated according to five types of participatory management. These are participatory management generally; target-setting; decentralisation; teamwork and delegation. By using T-Test to identify the differences, it was found that no statistical significance appeared in delegation and teamwork characteristics. The staff and managers shared similar ideas on teamwork as participatory management. Delegation of control was viewed as family planning programme and should be decentralised to the community level. (see Table 22).

Attitudes to Incentives for Participation in the Family Planning

The respondents were asked to give their opinions about participation in the family planning programme. An open-ended question: "Do you feel there would be any benefits with having more participation in the family planning programme by community members?" was used to allow a wide range of responses. In interpreting the responses, the views given by the community members were assessed in terms of the users, while views given by CBDs, staff and managers were assessed as the providers' views.

The members considered having more participation as a means of gaining more knowledge about family planning and participation by the members would make the programme more acceptable. The members also felt that more participation by community members, for example, having someone locally who can act as a health or family planning adviser, would help services become more accessible.

Among the providers (CBDs, staff and managers), there was general agreement that more participation would make the programme more efficient. More participation would help management to save time and money. If members do participate in the programme it could help reduce the health personnel's workload, a view shared especially by the CBDs. CBDs, staff and managers also held that having more participation would increase the knowledge of community members about the programme. CBDs also felt that more participation by the community members in the programme would help the members to exchange advice and ideas about the family planning programme. (see Table 25).

Apart from open-ended questions used to evaluate attitudes and opinions of the respondents, various statements for attitude measurement, using the Likert scale, were compiled.

It was found that CBDs and community members strongly agreed to working in groups and working collectively as incentives for participation. High levels of agreement were found again with the statement that people would willingly give up their spare time to participate for the good of the community and the statement that people who regularly serve the community deserve more than just thanks. The respondents shared a neutral attitude to the statements that people tend to do what the leader asks them and that people will participate if it is for personal benefits.

The following different attitudes were observed. The CBDs did not agree that people wanted to work as CBDs while the members perceived that people were interested in working as CBDs. Members had a neutral attitude towards the statement that most people would not do anything for nothing, while the CBDs agreed with this statement the mean score values indicated high levels of positive attitude towards incentives on all variables, particularly for social incentive and pure incentive. The tangible incentive was less significant, as perceived by the respondents. The mean score differences when classified by type of respondents suggested that social incentive was more strongly accepted by CBDs than the

members. The pure incentive was equally perceived as another significant motive among the members and CBDs.

Attitudes to Incentives for Participation in General

To fulfil one of the objectives of this study concerning the nature of the incentives both intangible and tangible by which community members would be motivated to participate in the service provision activities both individually and collectively, a list of attitude statements were administered. Findings showed that the members and CBDs were highly similar in their opinions on various statements. Almost 100% of the members and CBDs had strong positive opinions that working in groups is generally more enjoyable than working alone, and being with friends is the main benefit of working collectively. This high consensus was also found in the views that most people would willingly give up their spare time to participate if it is for the good of the community, and people who regularly service the community deserve more than just thanks.

Concerning the influence of leadership on an incentive to participate, the members and CBDs thought that it is not necessary that people participate because they want to please their leaders. However, both of the groups agreed that their leaders are respected and they tend to do what the leader asks them. As to the benefit, of participation, the members and CBDs did not think that the main reason for participation is for personal benefit. When asked about participation in family planning programme, the majority of the members (86%) and 69% of CBDs thought that the Family Planning Programme must be supported by the community; and 90% of members felt that the CBDs have an interesting job, while 75% of CBDs appreciated their jobs. (see Table 23).

To examine the nature of the incentives in accordance with types of incentives, some statements were combined and statistical tests of significance (T-Test) were applied. It was revealed that there were no statistically significant differences between the group on different types of incentives. Nevertheless they

differed in particular concepts. For example, there is a difference between the groups on the idea that the CBD has an interesting job,since the members indicated that they are interested in this job, while CBDs showed a lower interest. (see Table 24).

Benefits and Disadvantages of CBDs and Participation.

One of the main objectives of this study was to find out respondents' attitudes and opinions towards CBD programme. It was found that all four groups of respondents were positive toward of having CBDs in the communities. They were of the opinion that the community members would obtain services easily. Of the members, over half stated that having CBDs in their villages is very convenient as there is no need to travel to the health stations for services. The majority of the community members agreed that it was beneficial to have CBDs in the community. The main reason was that it makes contraceptive methods more available and there was no need to travel to the health stations. Other benefits were assessed in terms of other services being more available, such as referral assistance, advice about contraceptives and basic health care. These services can be sought from the CBDs. These reasons were also given by the CBDs themselves. (see Table 25).

Among the CBDs, more reasons were given in terms of motivating the community members to have fewer children, and that this can help to reduce population growth. Among the staff and managers there was the view that it is more convenient and safe for the community members when services are sought from CBDs. The staff and the senior managers viewed CBDs as the link between the government and the community members.

In general, some similarities could be seen from the various groups in terms of convenience as there is no need to go to the health stations; services are be more accessible to community members and that advice about basic health care and family planning can be sought from the CBDs.

In the same manner, the respondents were asked to mention some possible disadvantages in having CBDs in the communities. Among the community members,only a small proportion of respondents (15%) cited disadvantages of having CBDs. The reasons given by this group varied but the main one was that CBDs had insufficient knowledge and/or gave wrong advice. They also suspected that CBDs might be giving expired or fake pills. This implied that the community members had less confidence in CBDs.

Among the staff and managers, even though they both of supported the programme, they also thought that some possible problems (disadvantages) could be encountered. Among the staff, five out of seventeen had the view that the most important disadvantage to the community was that CBDs varied in quality, which could be disadvantageous to some communities. This was based on the assumption that the CBDs were mostly volunteers. Even though they obtained incentives like free medical care, they may not be fully motivated to perform their duties efficiently. This happened in many communities and the turnover was problematic.

Among the managers, the emphasis was on confidence. They felt that members might not fully trust the CBDs. For example side-effects of the pill, which can often occur, could bring about less confidence among the members. It may be quite hard to make members understand that it is not the mistake of CBDs. So if the programme is to maintain high confidence, one of the most important actions is to make advice clear to the community members. (see Table 26).

For the purpose of programme management, staff and managers were asked to assess benefits and disadvantages of CBDs to the programme. Various comments were made. The main comment made was that having CBDs helps to make the programme more accessible. The staff especially preferred to have CBDs so as to reduce the workload of the health personnel and thus make the programme more successful. The managers emphasized the accessibility and convenience to community members. However, apart from the contributions of CBDs to the programme, a few disadvantages were identified. The main disadvantage was lack

of continuity because of turnover of CBDs, and this caused great concern among the staff and the managers. Also, the community-based distribution programme structure of community based distribution programme can cause management problems, for example, in terms of follow-up, re-supply and record keeping. They observed that if more persons are involved, the staff at lower levels should took greater care in supervision so that CBDs would be able to perform their duties properly, since record-keeping, re-supply and follow-up take up much of the time of the staff. (see Table 27).

Benefits and Disadvantages of more Participation in the Family Planning Programme

The respondents were asked to assess the benefits of more participation in family planning programme. The community members identifieed two main benefits:increased knowledge about the family planning programme, and services becoming more accessible. If there is more participation, people will better appreciate and accept family planning since it would help remove objection to the objectives or aims of the programme. Members would have clear minds and therefore participate in all activities concerning the programme itself.

The staff and managers valued participation by the community members as an important strategy to help management and also make services more accessible. The staff said participation from among the target population is the most crucial action to make the programme successful. The managers valued participation in terms of helping management to save time and money, since it helps to reduce the cost of management.

The question on disadvantages of more participation in family planning programme was asked in order to evaluate both the concept of participation and the actual benefit offered by participation strategy. Among the community members, the responses reflected the extent of confidence they would have if more members participated in the programme. Confusion might be the main disadvantage to the

community if more people got involved. The majority felt that more participation would result in more confusion and greater conflict within the community, since too many people would be giving advice. In this situation community members preferred to be advised by the health personnel.

Among the CBDs,only two out of sixteen mentioned disadvantages of more participation. They were aware of the criteria for choosing people to work for the programme. At the same time, if more efforts were put into persuading members to participate more in the programme it might lead to conflicts within the family. For example, if the husband or wife wanted to participate more but the other did not want to, then there would be no consensus and this would make participation less effective.

Among the staff and managers, two were dubious feeling that more participation might create confusion for management and follow-up. Another big concern was that quality of participants might vary, which would be a disadvantage to some communities. (see Table 28 and 29).

Responsibility for Programme Activities

According to the objectives of this study which were to explore the perception and attitudes of potential and actual users, leaders and CBDs towards the existing programmes in their communities and to ascertain which IEC and service provision programme activities the community members would be prepared to take responsibility for carrying out, 19 activities were listed. The respondents were asked to identify who were responsible for those programme activities. Of all groups of respondents, the community members were not decided in their responses as to who is currently undertaking the activities; so also were some of the leaders. As found in the responses, the members imagined that clinic staff are those who are responsible for almost all the activities.

Table 30 describe the percentage of respondents agreeing to who is responsible for the various activities. Starting from the first activity of promoting family planning at the community level, half of the members (51%) did not make a decision about who is responsible for this activity; clinic staff and CBDs were equally perceived as doing this job. 75% of CBDs emphasised that clinic staff were responsible for this job; this opinion was shared by the staff and the managers as well as the leaders.

CBDs, staff, managers and the leaders stated that clinic staff are responsible for the following activities; educating potential users; target-setting; monitoring and supervising CBDs and training CBDs. The last two activities were highly recognised as the responsibility of the clinic staff. Again, community members showed a high rate of uncertainty towards the above activities with regard to the activity of target-setting, 55% of the members stated `undecided'. This also happened to the question as to who was responsible for training CBDs.

The respondents as a whole stated that the clinic staff were responsible for selection of CBDs, but not all the CBDs thought that they were selected by the clinic staff; two of them said that they were selected by the community members. Only 19% of the community members claimed that it was their right to select CBDs, while half of them felt undecided. Concerning record keeping, clinic staff and CBDs were identified as undertaking this job. This perception was similarly given to the activity of storing commodities and administering the supply of commodities.

For re-supply of methods, all respondents agreed that clinic staff take care of them. The community members seemed to be quite certain about this activity judging by the low percentage of undecided responses when compared with other activities mentioned earlier. The leaders also perceived that this role was equally shared among clinic staff and CBDs.

For a first supply to new acceptors, all respondents agreed that it was currently being provided by the clinic staff while the task of the identification of

potential acceptors was highly perceived by CBDs as their job. The staff and managers said that clinic staff and CBDs were sharing this job, but the members did not show a clear mind towards this job (30% identified clinic staff as those responsible, and 23% perceived that CBDs are responsible for it).

The opinion on who was responsible for financial accounting seemed to be inappropriate for the members because 63% of them could not make a decision about it. Half of the CBDs thought it was the duty of the government.

On the activity of suggesting new programmes of activity, clinic staff were highly recognised as people to perform this role better than any other group, with the exception of CBDs, who thought that it was CBDs who suggested new programme activities. Referral to clinics was also regarded as the responsibility of CBDs. The members also perceived that clinic staff refered patients to the clinic rather than CBDs. When asked about who was responsible for transportation to clinics, all the respondents agreed that community members were to provide it for themselves. However, the leaders (42%) claimed that they were responsible for this activity.

About the follow-up visits, the staff and managers perceived that clinic staff are currently providing follow-up visits, while most CBDs (82%) believed that it was their responsibility. Again the members showed high uncertainty about this role (46% could not make a decision).

In summary, it was noticeable that most activities in the programme were mainly perceived as the duty of the clinic staff and CBDs. However, a high proportion of uncertainty about who was currently responsible appeared in many activities regarding the community members. For example, more than half of the members were uncertain about the following activities; promoting family planning at the community level' target-setting; training of CBDs; remuneration of CBDs; selection of CBDs; financial accounting and planning for other activities.

Differences Between Current and Preferred Programme Responsibilities Assessed by Respondents

In order to ascertain which service provision programme activities with different groups of people (members, CBDs, staff, managers and leaders) would be preferred for allocation of responsibilities, all respondents were asked to identify who should be responsible for specific programme activities. It was found that the proportion of undecided responses were much lower for perceived roles than the current roles. Perhaps this may be due to the fact that members feel free to answer the question since there is no right or wrong answer.

By looking at each activity in terms of respondent's perception as to who should be responsible, the differences were as follows: (see Table 31).

1) Promoting family planning at the community level:

Overall the respondents preferred clinic staff and CBDs to be responsible for promoting family planning at the community level. Among the community members, 40% preferred clinic staff to take this role when compared with 20% who thought it was a current role of the clinic staff. Among the leaders, 52% desired CBDs to work for promoting family planning in their communities, compared with 10% who considered to it a current role of CBDs.

2) Educating potential users.

Staff and managers preferred different groups of people to be involved in this activity, different from what they stated for the current role (only clinic staff and CBDs). They said that community members and leaders should be involved in the programme as motivators.

3) Target-setting.

The managers felt that the government and clinic staff should be involved in target-setting, this is similar to the group they perceived as currently setting the targets. The staff did not change their opinion; they felt that clinic staff should be integrated into the target-setting group.

4) Monitoring and supervision of CBDs and training of CBDs.

Clinic staff were regarded as the group who should take care of this. There was a consensus among the whole group of respondents on this.

5) Remuneration of CBDs:

The members and CBDs strongly agreed that the government should remunerate CBDs. 75% of CBDs wanted the government to pay more attention to this, while the staff and managers thought this should be the job of the managers. The members felt that the clinic staff and government should be responsible for it.

6) Selection of CBDs:

Nearly half of the members (43%) preferred clinic staff to handle the selection of CBDs compared with 21% of them who perceived that clinic staff currently were responsible. CBDs had similar opinions concerning what they perceived and what they would preferred, that clinic staff should select CBDs. The leaders felt that clinic staff and themselves should co-operate on this matter. The staff and managers still reserved this duty for clinic staff but not as strongly as they perceived it as a current role of the clinic staff.

7) Record keeping:

The CBDs agreed that they should do the record keeping. This was similar to the leaders' opinion. The staff and managers shared their opinions that the leaders could help the programme in this activity. The members they did not show any difference between what they perceived and what they preferred.

8) Storing commodities:

The community members preferred clinic staff to perform this job rather than CBDs. The CBDs said that they should do it rather than the clinic staff (81% of CBDs preferred this job, compared to 38% of them who perceived that it was currently the responsibility of the clinic staff). The managers maintained their opinion that the clinic staff were suitable for this activity.

9) Administering the supply of commodities:

The community members again strongly believed that they wanted clinic staff to administer the supply of commodities. The leaders slightly changed their opinion from what they perceived and what they preferred; they felt that both clinic staff and CBDs should administer the supply of commodities equally. The managers preferred the CBDs to have more involvement than what they perceived.

10) Re-supply of methods and first supply of new acceptors:

Clinic staff and CBDs were the main groups the respondents wanted to manage these two activities especially the senior managers supported the clinic staff and CBDs to perform the job. However, the leaders had high preference for having only clinic staff to re-supply the methods.

11) Identification of potential acceptors:

Half of the members preferred to have clinic staff identify potential acceptors, while 74%of CBDs considered themselves suitable for this activity. Staff and managers also preferred CBDs to undertake it. The leaders chose both clinic staff and managers equally to share their responsibility of identification of potential acceptors. When compared with the opinions on current roles few differences in opinions were found among the staff and managers. The staff preferred CBDs to identify potential acceptors while the managers gave more credit to the leaders and the members to get involved. This might imply that the managers realised the significance of more participation within the community.

12) Financial accounting:

The community members had had only a vague idea about who should be responsible for financial accounting. As a result, they did not refer to any specific group. However, 36% of them mentioned clinic staff and 17% referred to the government. The managers preferred themselves to control financial matters.

13) Suggesting new programme activities:

There was a similarity within and among the groups of preferring clinic staff to suggest new programme activities, except CBDs who thought that they should take on this role rather than clinic staff.

14) Referral to clinics:

Community members agreed that clinic staff should help members for this purpose while CBDs, staff and managers gave high preference to having CBDs to perform this duty. This opinion was similar to what the other groups perceived.

15) Transportation to clinics.

The members perceived that they themselves and clinic staff should manage this duty, while CBDs suggested that they should be involved in this kind of assistance. The managers strongly preferred clinic staff to assist members with transport while the staff were unlikely to agree with this because only 41% mentioned clinic staff to be responsible, compared with 86% of the managers who thought so.

16) Follow-up visits:

All the respondents agreed that clinic staff and CBDs should play this role. Interestingly, two of the staff and one manager would like members to help each other for this activity.

17) Planning for other activities:

Due to a broad meaning of this activity the responses were quite scattered. This resulted in most of the groups mentioning that they should be involved in planning for other activities.

Apart from the activities listed, community members were asked to overview their capacity to participate more actively in the family planning programme. Their personal intentions indicated that they could actively participate in the programme in two ways; as motivators and as users. As shown in Table 32, more than half of the respondents (57.5%) were willing to be motivators, persuading and motivating their relatives and neighbours to practise family planning. As users, they would practise any method of birth control when they did not want any more children. A very small proportion of the respondents (5%) who desired to participate more actively in the programme could not identify their reasons. Based on these personal intentions it implied that community members claimed themselves to have high capacity as providers rather than just only a users.

CBDs also agreed that more participation in the programme by members could benefit both the members as individuals and the community as a whole. The reasons given in support of this concentrated on helping the community members to have more knowledge about family planning programme, then they would be able to choose the most appropriate method when the desired family size was met. The second important benefit was seen as a help to the government to be more successful with its family planning programme. Overall, CBDs felt that more active participation in the programme would help programme administration.

In conclusion, this part of the report has centred on the assessment of perception of responsibility for programme activities. The assessment was based on opinions towards current responsibilities and preferred allocation of responsibilities. Overall there was not much difference in opinion between the groups and within the groups. Clinic staff and CBDs were often mentioned as being responsible for programme activities.

Special findings regarding the responses given by CBDs are worth mentioning. CBDs judged themselves to be able to undertake most activities except some administrative activities and a few service activities, ie. first supply of new acceptors, educating potential users and promoting family planning at the community level. There was no doubt about the first activity, which CBDs had less desire to take over, but for the other two activities the responses were surprising since the activities were part of their jobs. As for community members, none of the activities were mentioned to be a responsibility of the community members, especially the transportation to clinics. This was in contrast to their opinions referring to intentions and capacity in the open-ended questions where 58% of the members stated that they are willing to be motivators.

Generally the staff and managers agreed with the policy of participation, and credited the local people as having capability to take part in the programme activities. Interestingly most of the activities in which the staff and managers relied on the community members and the leaders were dealing with IEC, such as

suggesting new programme activities, identifying potential acceptors, educating potential users and promoting family planning at the community level. The staff and managers seemed reluctant to allow local members to take on a managerial role and in target-setting.

Conclusion and Recommendations

This study, had three main objectives namely a) to explore the perceptions and attitudes of potential and actual service users and CBDs towards the existing programme in their community. b) to ascertain which IEC and service provision programme activities community members would be prepared to take responsibility for carrying out, and c) to examine the nature of the incentives, both tangible and intangible, by which community members would be motivated to participate in the service provision activities, both individually and collectively.

As for the first objective, it appeared that community members felt that community-based distribution programme would help them benefit from the programme. They felt that the existing programme in their communities made service more accessible not only for method accessibility but also having someone locally giving them advice about primary health care and related advice on health problems. The point was made earlier that community members considered community-based distributors as someone locally helpful and respectable even though they to some extent reserved higher credibility for health personnel. However, community members appreciated the participation policy. They were of the opinion that the community members obtain services more easily since they have no need to travel to the health stations. Apart from family planning service provided by community-based distributors community members mentioned the benefits of having community-based distribution programme making other services more available (ie, referral service, advice about contraceptives and basic health care). Most interestingly, community members pointed out some disadvantages in having CBDs in their communities, namely that CBDs have insufficient knowledge so might give wrong advice, and that CBDs might give expired or fake pills.

With regard to an awareness of participation among the community members, it appeared that the community members need community involvement. They said that if there is more participation, people would better appreciate and accept family planning. Also the benefits of increasing knowledge about the family planning programme and services would become more accessible.

The CBDs considered themselves useful to the community on the grounds that they motivated the community members to have fewer children and that this reduces population growth. Also they played a role in making the programme more accessible and could help the government to be more successful with its family planning programme. The community-based distributors felt that their roles were highly accepted by the community members and that the community members were highly friendly to them. It is worth mentioning here that some of the CBDs complained that they had some difficulties in dealing with the community members because the community members did not take their advice seriously and thought that CBDs were not knowledgeable enough.

As for the second objective of this study, it was revealed that most of the community members felt that activities in the programme are the duty of the clinic staff and CBDs. However when asked about their own function in the programme activities the community members felt that they would be able to be good motivators as well as users. As motivators the community members were willing to persuade and to motivate their relatives and neighbours to practise family planning. As users, the community members expressed that they would practise any method of birth control when their ideal family size was fulfilled. To evaluate intentions of the community members in participating in programme activities, specific programme activities were described to the community members and they were asked to identify their opinion on preferred allocation of responsibilities. Only a few of activities were seen as responsibilities of the community members. They were a) transportation to clinics; b) selection of CBDs c) identification of potential acceptors d) referral to clinics. On the open-ended questions community members considered themselves good at motivating their relatives or neighbours to practise

family planning which implied that they preferred the job of educating potential users.

With regard to the third objective of this study, the nature of incentives, the community members expressed their motivation as being that more participation would increase knowledge about family planning practice and make service more accessible. But some disadvantages of more participation were also observed. A few community members felt that more participation might create confusion to the community in the sense that if more people got involved more confusion and greater conflict within the community would result, since too many people giving advice would cause confusion. However, those who foresaw disadvanges of more participation were a very small proportion of the total group. In this study an attempt to measure perceptions and attitudes of the community members has been tried by using the Likert scale. It showed that the community members had strong positive opinions that working in groups is generally more enjoyable than working alone and being with friends is the main benefit of working collectively. They considered that participation for the benefit of the community especially for development inspired them to help each other. Social incentive was strongly accepted by the community members as their motivation to participate in all collective activities.

The staff and managers agreed that the government supported and promoted community participation, especially enhancing community-based distribution programme to encourage community members to be more self-reliant and self-managerial. Staff and managers were aware of government policy and intentions for community participation in family planning programme by promoting community-based distribution programme and allocating budget to train community volunteers for health implementation at the community level. Some suggestions were raised regarding programme implementation.

Managers pointed out that a policy which aims at creating a feeling of co-operation among the community members would make the family planning

programme more successful. In the same manner, the government should be aware of the real needs of the community members in the sense that all targets and plans in promoting policy should be within the capacity of community members. Also close co-operation between government and NGOs should be considered so that overlapping can be avoided. Community participation policy seeks to establish personnel development in the forms of providing refresher courses, monitoring and incentives; this would help to increase motivation in the community.

Similar conclusions were also found in a study done by the Institute of Population Studies (Sittitrai et al. 1989). That study indicated that it was generally felt that the national programme should provide more incentives (financial and otherwise) to individuals and communities to encourage greater participation. At the same time community participation might be more appropriate to the Thai situation in the sense that the community-based distribution programme can be seen as just one alternative for service provision at the community level. No matter how popular it is, there is a choice of fertility regulation. The point made here is that all implementations and activities involving community participation should not merely aim at the demographic goal of reducing population growth. In conclusion it might be useful to cite a conclusive recommendation which appeared in a UN study:

"Community participation may be an appropriate approach if it means offering a full choice of good quality services that allows people to choose the one that is most acceptable to them. Or it could mean providing family planning within a wider package of services and education that lead to improved maternal and child health and survival."

(U.N. 1988, page 23)

Recommendations :

This study leads to some recommendations for programme implementation in the future.

First, on community participatory involvement, it should be recognised that community members consider participatory involvement more effective and interesting if it shows specific development benefits. Just participating in a family planning programme seems too abstract to the members; they perceive that family planning is a personal matter. Individuals seek assistance when they feel that they are in need of service. Participation can only play an important role if basic and easy tasks are involved (for example to motivate friends or relatives to practise family planning) rather than getting involved in managerial responsibilities like storing or administering commodities, record keeping, identifying potential users and so on. Programme implementation must be needs- oriented rather than population control oriented.

Second, community participation policy should not be used as a scheme to reduce cost for programme management. Rather it seems that there will be more motivation to participate if the benefits are direct and tangible to all concerned.

Third, personal development might be an appropriate incentive to encourage volunteers to participate in the programme effectively. Personnal development can include financial incentives, training, monitoring and close supervision, so that volunteers would feel that their roles are important and necessary.

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Appendix A

Table 1 Socio-demographic characteristics of community members and CBDs

Variable	Community members		CBDs	
	female	male	female	male
Age				
mean	30.0	34.0	39.0	46.0
mode	24.0	25.0	42.0	51.0
< 19	3.8	1.0	-	-
20-24	20.8	6.0	10.0	-
25-29	21.6	23.0	20.0	-
30-34	22.3	25.0	10.0	-
35-39	16.8	21.0	10.0	17.0
40-44	14.8	13.0	20.0	17.0
> 45	-	11.0	30.0	67.0
Parity mean	2.4	-		
mode	2.0	-		
0	7.5	-	-	17.0
1	23.3	-	20.0	-
2	27.5	-	30.0	17.0
3	20.8	-	10.0	17.0
4	10.5	-	-	33.3
5	5.0	-	30.0	-
6 +	5.5	-	10.0	17.0
Total respondents by sex	400.0	100.0	10.0	6.0

(Continued)

Table 1 (Continued)

Variable	Community members		CBDs	
	female	male	female	male
Occupation				
housewives	4.0	-		
unskilled	13.0	14.0		
farmer	76.8	82.0	70.0	67.0
services	4.8	4.0	30.0	-
others	1.5	-	33.0	
Occupation of spouse				
unskilled				
farmer			80.0	67.0
services			-	17.0
skilled			20.0	-
others				17.0
Education				
none	4.5	2.0	10.0	-
informal	0.8	-	-	-
primary	8.3	85.0	70.0	100.0
secondary	5.0	10.0	10.0	-
higher	1.5	3.0	10.0	-
Marital status				
married	100.0	100.0	100.0	83.3
widowed	-	-	-	16.7

(Continued)

Table 1 (Continued)

Variable	Community members female	Community members male	CBDs female	CBDs male
Knowledge of contraception				
Pill	98.0	99.0	100.0	100.0
IUD	94.0	96.0	100.0	100.0
Injections	98.0	94.0	100.0	100.0
Diaphragm etc	4.0	5.0	30.0	17.0
Condom	91.0	95.0	100.0	100.0
Female sterilization	97.0	97.0	100.0	100.0
Male sterilization	92.0	98.0	100.0	100.0
Periodic abstinence	26.0	34.0	90.0	83.3
Withdrawal	24.0	32.0	67.0	50.0
Others*	93.0	83.0	100.0	100.0
Current family planning status				
Users	36.0		20.0	17.0
Pill	15.0		50.0	17.0
IUD	9.0		10.0	-
Injections	14.0		10.0	17.0
Diaphragm etc	0.3		-	-
Condom	0.8		-	-
Female sterilization	16.0		-	50.0
Male sterilization	6.0		-	-
Periodic abstinence	0.5		13.0	-
Withdrawal	2.0		-	-
Others*	0.8		-	-

* Norplant

(Continued)

Table 1 (Continued)

Variable	Community members		CBDs	
	female	male	female	male
Approval of contraception				
Respondent approves	85.0	85.0	100.0	100.0
Respondent disapproves	15.0	15.0	-	-
Partner approves	82.0	90.0	90.0	67.0
Partner disapproves	18.0	10.0	10.0	33.0
Fertility preference				
no more children	56.0	54.0	67.0	100.0
1 more	28.0	28.0	22.0	-
2 more	13.0	15.0	11.0	-
3 more	3.0	2.0	-	-

Table 2 Reasons for approval/disapproval of contraception by members

Reason	Percent	Number
Approval		
1. Having too many children causes economic hardship	72.4	276
2. Family planning is useful when want no more children	26.8	102
3. Less health risk with fewer children	0.8	3
Total	100.0	381
Disapproval		
1. Birth control should only be used by those who have completed their desired family size	29.4	35
2. Using contraception causes infertility and health hazards	21.8	26
3. Need seccurity in old age	6.7	8
4. Undecided	42.0	50
Total	100.0	119

(Continued)

Table 2 (Continued)

Reason	CBDs Number	CBDs Percent	Partners* Number	Partners* Percent
Approval	**15.0**	**93.8**	**14.0**	**93.8**
1. Having too many children causes economic hardship	12.0	80.0	11.0	78.6
2. Family planning is useful whenwant no more children	3.0	20.0	3.0	21.4
Total	15.0	100.0	14.0	100.0
Disapproval	**1.0**	**6.2**	**1.0**	**6.2**
1. Birth control should only be used by those who have completed their desired family size	1.0	100.0	-	-
2. Undecided	-	-	1.0	100.0
*Excluding 1 widow				
1. Partner disapproves	2.0	3.0	-	-
2. Infrequent sex	10.0	14.0	-	-
3. Postpartum/breastfeeding	10.0	14.0	-	-
4. Health concerns	17.0	25.0	-	-
5. Fatalistic	6.0	9.0	-	-
6. Want more children	48.0	68.0	-	-
7. Menopause	6.0	9.0	100.0	2.0
8. No answer	1.0	1.0	-	-
Total	100.0	143.0	100.0	2.0

Table 3 Interpretation and reasons for population policy by staff and managers.

Reasons	Staff	Middle managers	Senior managers
Interpretations for policy			
1. To reduce population growth	82.0 (14)	100.0 (8)	43.0 (3)
2. To increase standard of living by emphasising MCH/PHC and social welfare	70.6 (12)	-	57.0 (4)
3. To regulate migration to urban centres	5.9 (1)	12.0 (1)	-
Reasons for policy			
1. Population growth is an obstacle to economic growth	76.4 (13)	75.0 (6)	71.4 (5)
2. To ensure coordination between population policy and social welfare policies	35.3 (6)	75.0 (6)	57.1 (4)
3. Keep a balance between population growth and national resources.	11.8 (2)	- (2)	28.5
4. To increase and to maintain quality of life	41.2 (7)	25.0 (2)	-

(Continued)

Table 3 (Continued)

Reasons	Staff	Middle managers	Senior managers
Agreeing with policy			
1. For quality of life	41.2 (7)	50.0 (4)	14.0 (1)
2. For national economic development	23.5 (4)	12.5 (1)	-
3. To keep a balance between population growth and national resources	35.3 (6)	25.0 (2)	71.4 (5)
4. To ensure coordination between population policy and social welfare policies	11.8 (2)	25.0 (2)	28.0 (2)
5. Undecided	5.9 (1)	-	-
Aims of family planning programme			
1. It can reduce population growth	64.7 (11)	75.0 (6)	85.7 (6)
2. It can increase the quality of life and maintain a small family norm.	41.2 (7)	50.0 (4)	85.7 (6)
3. It can help the nation in terms of socio-economic development at the macro levels	47.0 (8)	37.5 (3)	14.3 (1)
4. It can maintain the activities to help women to have a good health status	11.8 (2)	-	-

Table 4 Reasons for programme encouraging community participation by staff and managers.

Reasons	Staff	Middle managers	Senior managers
1. To allow CBDs to distribute pills	47.0 (8)	50.0 (4)	100.0 (7)
2. To make use of community leaders generally for motivation	35.3 (6)	25.0 (2)	28.6 (2)
3. To increase communication so that community members become more aware of the programme	17.6 (3)	12.5 (1)	14.3 (1)
4. To allow NGOs to participate in service provision	-	12.5 (1)	-
5. To enable community members to make their own choices in programme management	17.6 (3)	12.5 (1)	-

Table 5 Reasons of awareness of government policy/intentions regarding community participation

Reasons	Staff	Middle managers	Senior managers
1. Reallocation of training budget to train community volunteers	6.0 (1)	12.5 (1)	28.6 (2)
2. Having a CBD programme	41.1 (7)	62.5 (5)	57.1 (4)
3. To let community members make their own choices	11.7 (2)	-	-
4. To allow NGOs to participate in service provision	-	12.5 (1)	42.9 (3)
5. To select community members to participate in specific programmes	41.1 (7)	25.0 (2)	-

Table 6 Reasons for desire for changes in policy by staff and managers

Reasons	Staff	Middle managers	Senior managers
1. Want to change the policy	77.0	100.0	100.0
2. Do not want to change the policy	23.0	-	-
Reasons for changes in policy			
1. Government should encourage community members to participate without incentives	-	-	29.0 (2)
2. All targets and plans should be within the capacity of community members	8.0 (1)	-	14.0 (1)
3. Promoting greater cooperation with NGOs to reduce government budget ,	-	-	29.0 (2)
4. Incentives for CBDs with good performance	38.0 (5)	-	-
5. Closed supervision and regular training are needed if more participation (ie. CBD programme will be more acceptable and efficiently if more information about side-effects of pills is emphasized	54.0 (7)	70.0 (5)	28.0 (2)

Table 7 Approval of policy and reasons by staff and managers

Reasons	Staff	Middle managers	Senior managers
Approved	87.0	88.0	100.0
Disapproved	13.0	22.0	-
Reasons for approval			
1. It creates a feeling of cooperation with the community members	8.0 (1)	12.0 (1)	14.0 (1)
2. Family planning programme will be more successful if the community participation policy is adopted	45.0 (6)	57.0 (4)	14.0 (1)
3. It can stimulate community members to exchange ideas about what they would like to do	39.0 (5)	28.0 (2)	28.0 (2)
4. To save the government budget and help reduce health personnel workload	8.0 (1)	-	43.0 (3)
Reasons for disapproval			
1. It may create confusion and conflict among community members if some are involved	-	14.0 (1)	-
2. It may have some problems with management and follow-up	16.0 (2)	-	-

Table 8 Reasons for the government encouraging participation by CBDs, staff and managers

Reason	Percent	Number
CBDs		
1. Government wants people to have a better quality of life by having few children so that economic development is easier	14	87.0
2. Participation helps the government and community to know each other and work together better (ie in family planning programme)	3	19.0
3. To make service provision more convinient to the community members	2	13.0
Total	16	100.0

Staff and managers

Reasons	Staff	Middle managers	Senior managers
1. Encourage community members to understand the principles of the programme and so make it more acceptable	41.0 (7)	38.0 (3)	43.0 (3)
2. Encourage community members to discuss family planning issues amongst themselves	18.0 (3)	13.0 (1)	-
3. To obtain more voluntary cooperation amongst community members	12.0 (2)	26.0 (2)	57.0 (4)
4. To increase accessibility of information and services	12.0 (2)	26.0 (2)	29.0 (2)
5. To help the government to fulfil its target	24.0 (4)	26.0 (2)	29.0 (2)

Table 9 Combined tables for agreement attitudes toward participation generally

		Com. Members	CBDs	Staff	Manager	F value
The government should take sole responsibility for planning and implementing all development efforts	%	96.0	87.0	36.0	20.0	86.3*
	X	1.4	1.6	3.4	3.9	
	SD	0.7	1.4	1.3	1.1	
The members of the community should play an active role in planning and implementing development programmes	%	97.0	100.0	94.0	100.0	1.7
	X	1.5	1.1	1.6	1.5	
	SD	0.69	0.34	0.77	0.52	
The community's participation is not crucial to the success of any development programmes in the community	%	23.0	13.0	18.0	0.0	2.2
	X	3.8	4.2	4.0	4.6	
	SD	1.39	1.34	1.37	0.51	
The members of the community should identify their own need for services to the government	%	87.0	75.0	65.0	53.0	10.4*
	X	1.7	1.9	2.8	2.8	
	SD	1.04	1.59	1.19	1.21	
The government knows very well the community's needs for health services	%	91.0	63.0	59.0	47.0	25.0
	X	1.6	2.4	2.8	3.0	
	SD	0.89	1.67	1.19	1.13	
No community development programme can be successful without outside expertise	%	77.0	44.0	18.0	-	20.1
	X	2.0	3.0	3.7	4.1	
	SD	1.4	1.9	1.0	0.5	

(Continued)

Table 9 (Continued)

		Com. Members	CBDs	Staff	Manager	F value
Members of the community prefer local experts rather than government expects to carry out development programmes	%	89.0	63.0	94.0	86.0	
	X	1.9	2.4	1.8	2.1	1.2
	SD	1.2	1.6	0.5	0.9	
Members of community have more knowledge about the local situation than the experts	%	89.0	87.0	100.0	0.0	66.0
	X	1.7	1.6	1.4	1.7	
	SD	1.0	1.4	0.5	0.6	
It is the duty of all community members to participate in development programmes	%	97.0	87.0	77.0	86.0	
	X	1.3	1.5	1.8	1.7	3.1*
	SD	0.7	1.2	1.1	1.0	
Rather than getting involved in development programmes, community members should look after their family needs	%	45.0	19.0	12.0	0.0	
	X	3.0	4.3	3.8	3.9	9.6**
	SD	1.4	1.2	0.9	1.0	
It is better to work as an indivdual than in a group	%	13.0	0.0	0.0	0.0	2.3
	X	4.2	4.9	4.1	4.5	
	SD	1.2	0.3	0.6	0.8	
Members of the community do not like to work together	%	11.0	6.0	18.0	0.0	2.7*
	X	4.1	4.6	3.7	3.7	
	SD	1.1	0.8	1.0	0.8	

* $P < .05$
** $P < .01$

Table 10 Mean scores for attitude variables by type of respondents

Variable		Com. Members	CBDs	Staff	Manager	F value
Attitudes to participation generally	X	4.11	4.39	4.02	4.10	2.19*
	SD	.466	.376	.325	.455	
Attitudes to collective action	X	3.87	4.44	3.63	3.93	6.695**
	SD	.555	.462	.557	.603	
Attitudes to role of Leaders	X	4.05	3.83	-	-	
	SD	.535	.769			
Attitudes to role of government	X	1.67	2.31	-	-	
	SD	.681	1.22			
Attitudes to role of members	X	4.30	4.38	3.67	4.14	9.249**
	SD	.497	.613	.587	.547	
N		495	17	16	15	

* P < .05
** P < .01

X	4.09	4.40	3.77	44.06	7.530**
SD	0.479	0.493	0.456	0.531	

Table 11 Mean score for attitude variables by type of respondent

Variable	Com. Members	CBDs	Staff	Manager	
				Middle	Senior
Control over development efforts	3.2	3.6	3.9	4.5	4.2
Responsibility for service provision	2.9	3.3	3.0	3.0	3.2
Role of 'experts'	3.5	3.7	4.2	4.2	4.0
Role of community members	3.8	4.4	4.0	4.1	4.1
Group membership	4.1	4.7	3.9	3.6	4.4

Table 12 Memberships and types of group memberships by community members

Membership	Number	Percent
1. Membership	107	21.0
2. Non membership	393	79.0
Total	500	100.0
Types of group membership		
1. Savings groups	20	18.6
2. Midical savings groups	77	71.9
3. Housewives groups	9	8.4
4. Youth groups	1	0.9
5. Village defense volunteers	2	1.8
6. Credit groups	20	18.6

Table 13 Reasons for joining group membership by CBDs and community members

Reasons	CBDs (1)	Members
1. To modernize the community	81.0	79.0
2. To have a better standard of living	31.0	5.0
3. Because development activities can create more convinient life so participation is important	-	8.0
4. To achieve consensus and the feeling of being part of a group	19.0	3.0
5. Do not know the reason	-	15.0
Total		100.0

Note (1) % distribution is based on multiple responses given by CBDs.

Table 14 Meaning of participation perceived by staff and managers

Meaning	Staff		Manager		T
	X	SD	X	SD	value
1. useful	1.5	0.6	1.1	0.3	-2.44*
2. interesting	1.6	0.6	1.3	0.5	-1.98
3. helpful	1.8	0.6	1.2	0.4	-3.20*
4. important	1.6	0.6	1.2	0.4	-2.06*
5. efficient	1.9	0.9	1.6	0.6	-1.23
6. advantageous	1.8	0.8	1.3	0.5	-2.22*
7. political	4.0	1.7	5.2	2.0	1.80
8. attractive	1.8	1.6	1.3	0.6	-1.20
9. time-consuming	3.7	2.3	4.6	2.2	1.13
10. educating	1.6	0.6	1.2	0.4	-2.40*
11. effective	1.8	0.7	1.3	0.6	-1.89
12. essential	1.8	0.7	1.3	0.5	-2.44*
13. encouraging	1.6	0.7	1.6	0.9	-0.16
14. necessary	1.6	0.6	1.3	0.5	-1.65
15. good	1.5	0.6	1.2	0.4	-1.73
Total	1.97	1.24	1.78	1.54	1.48

* $P < .05$

Table 15 Perceived availability of programme components

Variable	Community members	CBDs (N=16)	Staff (N=17)	Managers Senior(N=7)	Middle(N=8)
Supplies on time					
- yes	-	94.0	-	-	-
- sometimes	-	6.0	-	-	-
- no	-	-	-	-	-
Clinic accessible?					
- yes	-	88.0	-	-	-
- no	-	12.0	-	-	-
Availability of information					
- easy	-	-	63.0	86.0	74.0
- difficult	-	-	31.0	-	13.0
- mixed	-	-	6.0	14.0	13.0
Availability of services					
- easy	-	-	78.0	72.0	88.0
- difficult	-	-	17.0	14.0	-
- mixed	-	-	6.0	14.0	12.0
Availability of CBD (N=335)					
- no visits	55.0	-	-	-	-
- <1	23.0	-	-	-	-
- 1	10.0	-	-	-	-
- 2	8.0	-	-	-	-
- 3+	4.0	-	-	-	-
- anytime	29.0	94.0	-	-	-
- no	1.0	-	-	-	-
- sometimes	10.0	6.0	-	-	-
- never go to see CBDs	60.0	-	-	-	-

Table 16 Knowledge and convenience of source of methods

Method	Knowledge of Source		Convenience of source	
	Community members	CBDs	Community members	CBDs
Pill	98.0	100.0	98.0	100.0
IUD	94.0	100.0	97.0	100.0
Injections	99.0	100.0	97.0	100.0
Diaphragm/foam/jelly	2.0	25.0	100.0	25.0
Condom	92.0	100.0	99.0	100.0
Female sterilization	98.0	100.0	96.0	94.0
Male sterilization	96.0	100.0	96.0	94.0

Table 17 Source of services used by member if not from CBDs

	Source	Percent	Number
1	Health centre	66.0	115
2	District hospital	17.0	30
3	Provincial hospital	14.0	24
4	Other (drugstore/private clinic)	3.0	5
	Total	100.0	174

Table 18 Perception of overall client/CBD relations by CBDs, staff and managers

Variable	very	quite	neither/nor	Mean
Friendliness	81.0	13.0	6.0	1.3
Helpfulness	56.0	31.0	12.0	1.6
Respectability	81.0	13.0	6.0	1.3

	Staff	Managers	
		Senior	Middle
staff and managers			
Excellent	25.0	20.0	13.0
Good	50.0	20.0	62.0
Satisfactory	25.0	60.0	25.0
Poor	-	-	-

Variable	very	quite	neither/nor	not quite	Mean
Friendliness	51	44	4	1	1.6
Helpfulness	40	52	6	3	1.7
Respectability	38	56	5	1	1.7

	highly knowledgeable	knowledgeable knowledgeable	not knowledgeable
Knowledge			
%	26.0	73.0	1.0
N	81.0	228.0	4.0

Table 19 Attitude statements toward participation in family planning programmes by groups of the respondents

		Com. Members	CBDs	Staff	Manager	F value
It is the responsibility of the community to work together to support the family planning programme	%	91.0	100.0	29.0	93.0	2.8*
	$\bar{X}$	1.6	1.1	3.4	1.9	
	SD	0.8	0.3	1.2	0.7	
Family planning is a purely personnal matter and therefore collective action is a wast of time	%	44.0	6.0	6.0	7.0	9.4*
	$\bar{X}$	3.0	4.4	4.1	4.1	
	SD	1.5	1.1	0.9	0.9	
Collective action by community members will always act as a hindrance to the family planning programme.	%	50.0	44.0	24.0	24.0	
	$\bar{X}$	2.9	3.3	3.7	3.4	2.4
	SD	1.4	1.7	1.2	1.3	
Committees can only delay action by spending too much time on deliberation	%	46.0	12.0	24.0	6.0	6.6*
	$\bar{X}$	3.0	4.3	3.4	3.8	
	SD	1.5	1.2	0.7	0.9	
Committees are the best way for communities to plan their collective activities	%	97.0	93.0	88.0	93.0	6.8*
	$\bar{X}$	1.4	1.4	1.9	1.7	
	SD	0.5	1.0	0.7	0.6	
All community matters should be organized by the leaders	%	93.0	62.0	41.0	27.0	48.4*
	$\bar{X}$	1.4	2.3	3.2	3.5	
	SD	0.8	1.5	1.1	1.1	
The community leaders are fully aware of the health and family planning needs of the community	%	90.0	85.0	70.0	67.0	9.3
	$\bar{X}$	1.6	1.7	2.4	2.7	
	SD	0.9	1.2	0.8	1.2	
Most of the community leaders are more concerned with their personal welfare than with the welfare of the community	%	36.0	31.0	47.0	40.0	1.5
	$\bar{X}$	3.4	3.6	2.9	2.8	
	SD	1.5	1.6	1.4	1.0	

* $p < .05$

Table 20 Participation in family planning activities through collective action and committees by the respondent groups.

		Com. Members	CBDs	Staff	Manager value	F
Family planning is a purely personal matter and therefore collective action is a waste of time	$\bar{X}$	3.04	4.43	4.05	4.06	9.4*
	SD	1.48	1.09	.89	.88	
It is the responsibility of the community to work together to support the family planning programme	$\bar{X}$	1.64	1.12	3.41	1.93	2.8*
	SD	.852	.341	1.17	.703	
Committees are the best way for communities to plan their collective activities	$\bar{X}$	1.36	1.37	1.94	1.66	6.8*
	SD	.54	1.02	.74	.61	
Collective action by community members will always act as a hindrance to the family planning programme	$\bar{X}$	2.91	3.25	3.70	3.40	2.4
	SD	1.42	1.73	1.21	1.29	

* $P < .05$

Table 21 Attitudes toward participatory management by the respondent groups.

Variables	% X SD	Staff	Manager	T value
Decentralization leads to confusion and inefficiency	%	12.0	7.0	1.05
	X	3.9	4.2	
	SD	0.9	0.8	
Central control is essential for efficient implementation	%	40.0	47.0	0.33
	X	3.0	3.0	
	SD	1.1	1.1	
Field staff should have full responsibility for determining the family planning activities in their area	%	89.0	46.0	2.37*
	X	2.1	3.1	
	SD	0.8	1.3	
The national programme should be fully decentralized	%	94.0	86.0	1.16
	X	1.6	1.9	
	SD	0.6	0.9	
The community should be responsible for supervising their CBD	%	76.0	100.0	-2.03
	X	2.3	1.8	
	SD	0.8	0.4	
Programme staff are expected to plan most of the programme activities at the community level	%	82.0	73.0	0.28
	X	2.3	2.4	
	SD	1.0	1.1	
A manager's main function is to supervise staff	%	76.0	93.0	-1.08
	X	2.2	1.8	
	SD	1.2	0.8	
Staff work best if they are allowed to carry out their job in their own way	%	92.0	80.0	1.19
	X	1.8	2.1	
	SD	0.7	0.7	
Staff work best if they have on specific function that they can concentrate on	%	53.0	80.0	-1.96
	X	2.8	2.1	
	SD	1.0	0.7	

* $P < .05$

Table 21 (Continued)

Variables	% / $\bar{X}$ / SD	Staff	Manager	T value
To fulfil their full potential a person must be encouraged to try as many different activities as possible	% $\bar{X}$ SD	41.0 3.0 1.0	66.0 2.4 1.0	-1.57
Staff work best when they can collaborate with others	% $\bar{X}$ SD	100.0 1.4 0.5	100.0 1.5 0.5	0.16
Teamwork is time-wasting and only leads to disagreement	% $\bar{X}$ SD	6.0 3.9 0.8	- 4.0 0.5	0.24
The best way to manage staff is to give them targets to follow	% $\bar{X}$ SD	59.0 2.7 1.0	46.0 2.9 1.3	0.43
Acceptor targets encourage staff to use undue pressure on clients to use a particular method even if they do not really want to use it	% $\bar{X}$ SD	77.0 2.5 0.9	53.0 3.1 1.4	1.47
Field staff should set their own targets	% $\bar{X}$ SD	82.0 2.1 0.7	67.0 2.4 1.2	0.93
Acceptor targets encourage staff and CBDs to make up false records	% $\bar{X}$ SD	35.0 3.2 1.2	29.0 3.6 1.1	0.81
Unless the country's population growth rate declines to the expected target the family planning programme is a failure	% $\bar{X}$ SD	31.0 3.3 0.9	40.0 3.2 1.4	0.04

Continued

Table 21 (Continued)

Variables	% X SD	Staff	Manager	T value
The national family planning programme is more concerned with family welfare than with population control	%	81.0	87.0	-0.37
	X	2.1	2.0	
	SD	0.9	0.9	
The national family planning programme should strongly encourage voluntary sterilization	%	94.0	93.0	-0.09
	X	1.6	1.6	
	SD	0.8	0.8	
Field staff and CBDs should not be encouraged by managers to make suggestions about programme implementation	%	6.0	13.0	-0.14
	X	4.2	4.2	
	SD	0.8	0.6	
Strong leadership and tight control from the top is absolutely essential if new ideas are to be introduced to the programme	%	65.0	80.0	-0.33
	X	2.5	2.3	
	SD	1.3	1.2	
The community should tell the programme staff what its family planning needs are	%	59.0	53.0	0.33
	X	2.6	2.7	
	SD	1.2	1.3	
It is follish to think that communities can influence the implementation of the family planning programme	%	12.0	33.0	1.00
	X	4.2	4.5	
	SD	1.1	0.8	
To be efficient communication between managers and staff and, CBDs should be restricted to administrative matters only	%	29.0	53.0	-1.30
	X	3.4	2.9	
	SD	1.2	1.2	
Managers should spend as much time as possible consulting with their staff	%	88.0	87.0	-0.02
	X	1.9	1.9	
	SD	0.9	0.9	

Table 22 Combined attitudes toward participatory management by staff and managers

Variables	$\overline{X}$ SD	Staff 14	Manager 17	T value
Participatory management	$\overline{X}$	3.7	3.6	-0.56
	SD	0.3	0.6	
Target - setting	$\overline{X}$	3.2	2.9	-1.13
	SD	0.5	0.9	
Decentralization	$\overline{X}$	3.8	3.6	-0.91
	SD	0.5	0.8	
Team work	$\overline{X}$	3.9	3.9	-0.59
	SD	0.6	0.6	
Deligation	$\overline{X}$	3.6	3.7	0.22
	SD	0.4	0.6	
	$\overline{X}$	3.6	3.5	0.55
	SD	0.4	0.6	

Table 23 Combined attitudes to incentives by CBDs and community members

Variables	members			CBDs			T
	%	$\bar{X}$	SD	%	$\bar{X}$	SD	value
Working in groups is generally more enjoyable than working alone	94	1.4	0.8	94	1.3	1.0	-0.38
Being with friends is the main benefits of working collectively	99	1.3	0.5	100	1.1	0.3	-3.53*
Our community leaders are respected	94	1.5	0.8	87	1.6	1.1	0.21
People tend to do what the leaders ask them	73	2.2	1.3	81	1.8	1.2	-1.30
People want to please their leaders	49	3.0	1.3	38	3.3	1.4	0.79
The family planning programme must be supported by the community	86	1.8	1.0	69	2.3	1.8	1.10
The main reason for participating is for the personal benefits	49	3.0	1.5	38	3.0	1.5	0.14
The CBD has an interesting job	90	1.6	0.9	75	1.9	1.4	1.81
The worst thing about being on a committee is having to do the work that you are expected to do	54	2.8	1.4	44	3.1	1.6	0.91
Many community members want to work as CBDs	65	2.4	1.5	37	3.4	1.6	2.55*
Most people will not do anything for nothing	51	3.0	1.7	69	2.5	1.8	-1.16
If it is for the good of the community most people would willingly give up their spare time to participate	98	1.3	0.6	94	1.2	0.5	-0.70
People who regularly serve the community deserve more than just their thanks	94	1.4	0.8	100	1.1	0.3	-3.16*

* $p < .05$

Table 24 Attitudes to incentives by members and CBDs

Variables		Members 497	CBDs 16	T Value
1. Social incentives	$\overline{X}$	4.7	4.8	1.16
	SD	0.5	0.5	
2. Pure incentives	$\overline{X}$	3.8	3.8	0.14
	SD	0.8	0.9	
3. Purposive incentives	$\overline{X}$	3.6	3.3	-1.03
	SD	0.9	1.1	
4. Task incentives	$\overline{X}$	3.6	3.3	-1.63
	SD	0.8	0.9	
5. Tangible incentives	$\overline{X}$	3.0	3.2	1.43
	SD	0.6	0.6	
	$\overline{X}$	3.68	3.74	-0.40
	SD	0.5	0.6	

Table 25 Benefits of more participation

Benefits	Number	Percent
Members		
1. People gain more knowledge about family planning	172	35.8
2. People appreciate and accept family planning	130	27.0
3. People help each other by exchanging ideas and knowledge about family planning	36	7.5
4. Services become more accessible if people participate	49	10.2
5. People will have someone locally who can act as a health/family planning adviser	51	10.6
6. More participation in the family planning programme can help to reduce the population growth rate	10	2.1
7. Do not know	33	6.8
Total	481	100.0

Table 25 (Continued)

Benefits	CBDs	Staff	Managers	
			Senior	Middle
CBDs and Managers				
1. Help management to save time and money	6.0 (1)	18.0 (3)	25.0 (2)	29.0 (2)
2. More participation by target population will make programme more efficient / accessible	38.0 (6)	65.0 (11)	50.0 (4)	58.0 (4)
3. Would increase the knowledge of community members about the programme	56.0 (9)	35.0 (6)	38.0 (3)	15.0 (1)

CBDs = 16
Staff = 17
Middle managers = 8
Senior managers = 7
Percentage distribution is calculated from frequencies given to each benefit.

Table 26 Benefits and disadvantages to programme of CBD by staff and managers

	Benefits	Staff		Managers			
				Senior		Middle	
		N	%	N	%	N	%
1.	Make the programme more accessible	4	24.0	5	71.0	5	63.0
2.	CBD is close to the people which helps raise the contraceptive prevalence rate	5	29.0	3	43.0	2	25.0
3.	More convenient for community members	7	41.0	-	-	4	50.0
4.	Reduce the workload of the health personnel and so makes the programme more successful	5	29.0	-	-	-	-
5.	Community members gain more knowledge about family planning.	3	18.0	-	-	1	13.0
	Disadvantages						
1.	Community members may not trust the CBD	-	-	-	-	1	100.0
2.	Having a CBD structure can cause management problems (eg. follow-up, re-supply, record keeping)	1	25.0	1	50.0	-	-
3.	Lack of continuity because of turnover of CBDs	2	50.0	1	50.0	-	-
4.	CBDs vary in quality which can disadvantage some communities	1	25.0	-	-	-	-

Table 27 Disadvantages of CBD to community by respondents

Disadvantages	Number	Percent
Members		
1. CBD has insufficient knowledge and or gives wrong advice	29	39.0
2. CBD might be giving expired or fake pills	14	19.0
3. Prefer to seek services from the health centre	5	7.0
4. If contraceptive users do have complications the CBD is not able to help	8	11.0
5. No physical examination when prescribing the pills	8	11.0
6. If the CBD prescribes the wrong type of pill, this wastes time and money	3	1.0
7. Do not know	8	11.0
TOTAL	75	100.0

Staff and Managers	Staff		Managers			
			Senior		Middle	
	N	%	N	%	N	%
1. Side-effects can be a problem if unclear advice is given	-	-	2	66.0	-	-
2. CBDs vary in quality which can disadvantage some communities	5	100.0	1	34.0	-	-
3. Community members do not trust the CBDs' advice and lack of safety	-	-	-	-	1	100.0

Table 28 Benefits with having more participation in the programme by community members perceived by CBDs

Benefits	Number	Percent
1. Reduce the personnel's workload	1	6.2
2. Help the government be more successful with its family planning programme	4	25.0
3. Help the community members have more knowledge about the family planning programme and to be able to choose the most appropriate method when desired family size is met	7	43.8
4. More convinient for getting services	2	12.5
5. Community members can exchange advice and ideas about family planning	2	12.5
Total	16	100.0

Table 29 Disadvantages of more participation by four groups of respondents

Disadvantages	Number	Percent
Members		
1. Too many people giving advice causes confusion	34	26.5
2. Advice from community members cannot be trusted compared with health personnel	17	13.3
3. If many people become a CBD they will sell the pills instead of distributing them free of charge	2	1.5
4. No close supervision and responsibility for the programme if more people are involved	12	9.3
5. More confusion and greater conflict between community members	32	24.2
6. Do not know the reason	31	24.2
TOTAL	128	100.0
* **CBDs**		
1. Conflict within couples if one partner wants to participate and the other does not	1	
2. Unqualified people giving wrong advice	1	
TOTAL	2	

* Staff and Managers	Staff	Middle	Senior
1. May create confusion for management and follow-up	2	2	2
2. Quality of participants may vary which would disadvantage some communities	1	1	1
TOTAL	3	3	3

*) Figures are shown in number due to small samples

Table 30 Perception of Current roles in programme activities by actors and respondents

	ACTIVITIES																		
Actors/Respondents	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
Covernment																			
Members																			
CBDs																			
Leaders																			
Managers																			
Clinic staff	53.0				77.0									65.0					
Middle managers					55.0									71.0					75.0
Senior managers		100.0			100.0									100.0					86.0
Field staff																			
Clinic staff							53.0												
Middle managers																			
Senior managers																			
Clinic staff																			
Members											61.0	81.0							
CBDs	75.0			75.0	69.0	69.0		69.0			75.0							75.0	
Clinic staff	59.0	77.0	65.0	82.0	82.0	82.0				71.0	65.0	82.0			94.0			76.0	59.0
Middle managers	63.0	75.0	63.0	88.0	75.0	86.0				88.0		88.0			75.0			88.0	
Senior managers	86.0	71.0		87.0	71.0	86.0				57.0	100.0	100.0	86.0		100.0	71.0		86.0	57.0
Leaders				83.0	75.0	51.0				70.0	55.0	81.0			58.0			59.0	59.0

Continued

Table 30 (Continued)

Actors/Respondents	ACTIVITIES 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
CBDs																			
Members																			
CBDs																			
Clinic staff								53.0			70.0					76.0			
Middle managers							75.0	75.0			76.0					75.0			
Senior managers		57.0					58.0				71.0		71.0			71.0		71.0	
Leaders							62.0	67.0			54.0								
Leaders																			
Members																			
CBDs																			
Clinic staff																			
Middle managers																			
Senior managers																			
Leaders																			
Members																			
Members																	52.0		
CBDs																	75.0		
Clinic staff																	75.0		
Middle managers																	100.0		
Senior managers																			
Leaders																			

Table 31 Perceived respondibility by activities by four groups of respondents

	ACTIVITIES																		
Actors/Respondents	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
Government																			
Members																			
CBDs						75.0													
Leaders																			
Managers																			
Clinic staff	71.0			100.0		70.0		59.0											
Middle managers						75.0			85.0										
Senior managers			100.0			85.0		85.0											
Field staff																			
Clinic staff				50.0	59.0														
Middle managers	63.0	50.0		50.0	50.0				56.0										
Senior managers				57.0	85.0			57.0											
Clinic staff																			
Members					64.0				51.0	61.0	60.0	80.0	50.0		60.0			67.0	
CBDs					56.0		63.0			63.0	81.0							75.0	
Clinic staff				81.0	53.0					53.0		88.0			71.0			77.0	53.0
Middle managers		100.0	87.0		100.0		75.0		87.0	87.0		75.0	50.0		75.0	62.0	87.0	75.0	62.0
Senior managers	71.0	57.0			85.0		50.0		85.0		85.0	100.0	71.0		85.0	71.0	85.0	71.0	
Leaders				88.0	87.0	57.0	61.0			52.0	75.0	75.0		52.0	70.0			68.0	68.0

Continued

Table 31 (Continued)

	ACTIVITIES																	
Actors/Respondents	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**
CBDs																			
Members																			
CBDs											62.0		74.0		75.0		69.0	75.0	
Clinic staff				69.0				65.0	59.0	53.0	82.0		89.0		69.0	88.0		59.0	
Middle managers		62.0						62.0		50.0	87.0	50.0	100.0		62.0	74.0		75.0	
Senior managers		57.0									85.0		71.0			85.0		71.0	
Leaders								67.0	68.0	58.0									
Leaders																			
Members																			
CBDs		51.0																	
Clinic staff		?																	
Middle managers																			
Senior managers																			
Leaders																			
Members																			
Members																			
CBDs																			
Clinic staff				70.0															
Middle managers																			
Senior managers	71.0																		
Leaders																			

Table 32 Capacity to participate more actively in the family planning programme by members

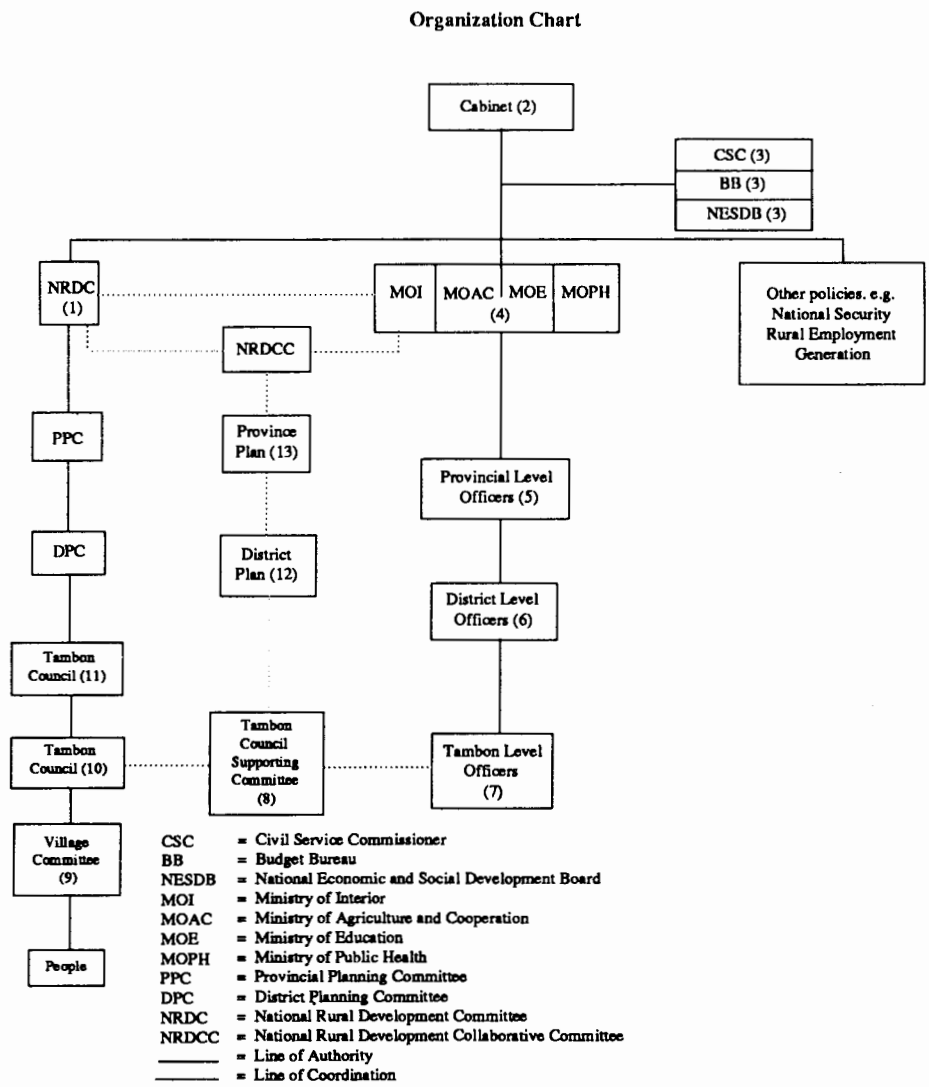
Capacity	Number	Percent
1. Will persuade and motivate neighbours to practise family planning	281	57.5
2. Will paractise family planning if desired family size is met	134	27.4
3. Will follow whatever advise is given by the health clinic staff	47	9.6
4. Do not know	27	5.5
Total	489	100.0

List of programme activities

1. Promoting family planning at the community level.
2. Educating potential users.
3. Target setting
4. Monitoring and supervision of CBD
5. Training of CBD
6. Remuneration of CBD
7. Selection of CBD
8. Record keeping
9. Storing commodities
10. Administering the supply of commodities
11. Resupply of methods
12. First supply of new acceptors
13. Identification of potential acceptors.
14. Financial accounting
15. Suggesting new programme activities
16. Referral to clinics
17. Transportation to clinic
18. Follow-up visits
19. Planning for other activities

Appendix B

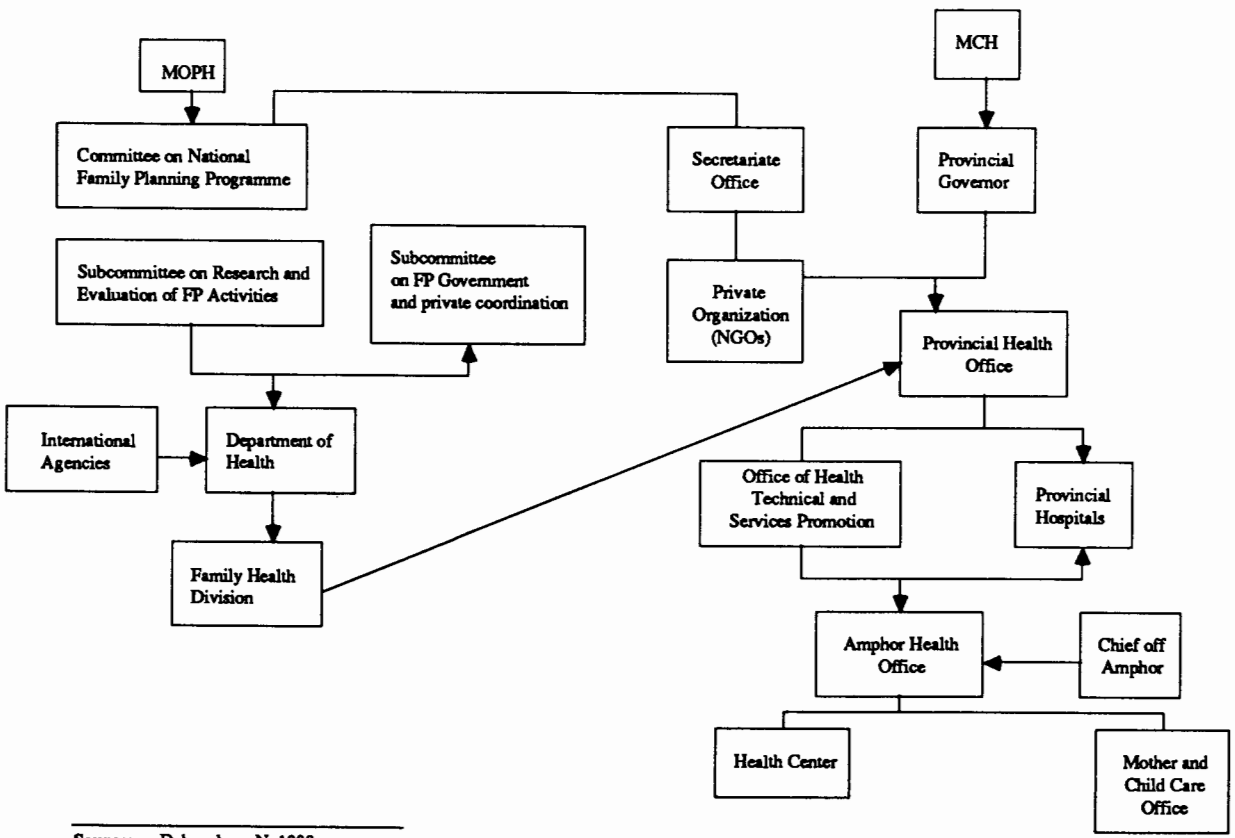
Figure 1 National Rural Development Committee (NRDC)



Number denote steps of work, starting from (1) through (13). Then, the work cycle is repeated again at (1) each year.

Source: NESDB, 1982

Figure 2 Role of National Family Planning Programme



Source: Debavalaya, N. 1988.