ASCERTAINING THE USER PERSPECTIVES ON COMMUNITY PARTICIPATION IN FAMILY PLANNING PROGRAMME IN THAILAND

การมีส่วนร่วมของชุมชนต่อโครงการวางแผนครอบครัว ในทัศนะของประชาชน

Amara Soonthorndhada

อมรา สุนทรธาดา

Orapen Buravisit

อรเพ็ญ บุรวิศิษฐ

Panee Vong-Ek

ภาณี วงษ์เอก

Institute for Population and Social Research

Mahidol University

สถาบันวิจัยประชากรและสังคม มหาวิทยาลัยมหิดล

ABSTRACT

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 (CBDs) and local leaders. The study indicated that staff and managers and the community-based distributors 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, 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.

บทคัดย่อ

การศึกษาครั้งนี้เป็นการวิจัยด้วยวิธีสำรวจประชากรตัวอย่างอันประกอบด้วยสตรีที่สมรสแล้วแต่ยังอยู่ในวัยเจริญพันธุ์ รวม 400 ราย และคู่สมรสอีก 100 ราย จากพื้นที่ 4 จังหวัดของทุกภาคในประเทศ พร้อม

ทั้งสัมภาษณ์บุคลากรของรัฐและองค์กรเอกชนที่มีส่วนเกี่ยวข้องกับการดำเนินงานโครงการวางแผนครอบครัว ทั้งในระดับนโยบายและระดับปฏิบัติการ ผลการศึกษาพบว่า บุคลากรของรัฐและองค์กรเอกชนส่วนใหญ่ให้ความสำคัญและเห็นด้วยกับนโยบายการมีส่วนร่วมของชุมชนในการเผยแพร่กิจกรรมวางแผนครอบครัว สำหรับความคิดเห็นของประชาชนในฐานะผู้ใช้บริการของรัฐมีความเห็นว่า การมีส่วนร่วมของชุมชนจะมีประสิทธิภาพดีเฉพาะกิจกรรมที่เป็นประโยชน์เชิงเศรษฐกิจต่อชุมชน ส่วนกิจกรรมการวางแผนครอบครัวนั้น ประชาชนยังมีแนวคิดว่าเป็นเรื่องสิทธิส่วนบุคคลที่ควรจะเลือกตัดสินใจเอง และยังมองไม่เห็นความสำคัญในประเด็นที่จะให้ชุมชนเข้าไปมีบทบาทอย่างเต็มรูปแบบ

INTRODUCTION

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[10] and as a key element of population programmes according to the 1984 World Population Conference in Mexico[8]. 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."[7]

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.[2,3]

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(The International Planned Parenthood Federation, with ODA (The British Overseas Development Administration) funding, has just undertaken a study of how FPA (Family Planning Association) implement their projects[1] and ESCAP a similar study of national programmes[4]. 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.

This research study aims 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 objectives for the study were:

a) 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;

b) to ascertain which IEC (Information, Education and Communication) and service provision programme activities community members would be prepared to take responsibility for carrying out;

c) 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.

METHODS

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.

The first two variables were measured for four respondent groups: community members, Community- Based Distributors (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.

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 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). The relationships between these variables and some of the dependent variables have 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 :

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

2) focus group discussions were held with community leaders;

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

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

Sampling plan

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 Phitsanulok province for the North, Chonburi province for the Central, Buriram province for the Northeast and lastly Nakhon Si Thammarat 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 Non-Government Organizations (NGOs) such as the Planned Parenthood Association of Thailand and the Population and Community Development Association.

The sampling plan of this study was set to recruit 400 married women of reproductive age (15-44) and 100 of their spouses. The respondents were taken equally from each of the twelve villages. 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.

At the time of the study contraceptive prevalence rate was 69 % 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.

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. 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. 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.

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 16 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.

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 10 village headmen, 9 headman assistants, 34 village committee members, 9 mother club leaders and 7 elders.

Twelve focus group discussions were organised, one in each of the selected villages. Focus groups were made up of 5 or 6 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 2 h.

Staff

A total of 17 staff were interviewed. The group of staff consisted of 12 sub-district health officers who were based in the sub-district health centre and 5 field supervisors of the NGOs.

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.

Sample selection

Community members		
- Current users	257	cases
- Non users	143	cases
- Husbands	100	cases
Total	500	cases
Community-Based Distributors		
- Goverment Organizations (GOs)	12	cases
- NGOs	4	cases
Total	16	cases

Leaders		
Village headmen	10	cases
Headman assistants	9	cases
Village committee members	34	cases
Mother club leaders	9	cases
Elders	7	cases
Staff		
Sub-district health officers (GOs)	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 (GOs)	4	cases
Field Operation Officers	4	cases
Total	8	cases

RESULTS

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. (Table 1)

Again, the concept of participation was closely observed by combined statements which conceptualised participation through collective action and committee. Table 2 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 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. (Table 3)

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.

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. (Table 3)

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 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. (Table 4)

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 take 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. (Table 5)

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 identified 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. (Tables 6 and 7)

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 8 describes 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. Seventy-five percent 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 programme of activity, clinic staff were highly recognised as people to perform this role better than any other groups, 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 in Table 9.

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. Seventy-five percent 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 that 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 10, 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 were 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

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. 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 and 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 that 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 cooperation 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.[6] That study indicated that it was generally felt that the national programme should provide more incentives (financial and others) 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."[9]

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.

ACKNOWLEDGEMENTS

The authors are grateful to the Overseas Development Administration (ODA) for financing the project. They wish to thank Dr. Ian Askew, the former deputy director of the Institute of Population Studies, University of Exeter who initiated and coordinated the project and also to Dr. Buhle Neube, Mr. Victor de Silva, Mr.Roberto Castro-Perez, Prof. Robert Snowden, Dr. David Phillips, Director of the Institute of Population Studies, University of Exeter and all the staff members for their moral support particularly to Ruth Preist.

They are also indebted to Dr. Aphichat Chamratrithirong, Institute for Population and Social Research, Mahidol University. Finally, their sincere thanks go also to their research associates, Sureeporn Punpeung, Kanchana Tangchonlathip and Yawaluck Jiranai.

REFERENCES

1. Askew, I. A Comparative Analysis of Community Participation in South Asia : Programme Recommendations and Policy Issues for Family Planning Associations, IPPF, London, 1988, 47 pages.
2. Askew, I. Organising Community Participation in Family Planning Projects in South Asia. *Studies in Family Planning*, 1989, **20**(4), 185-202.
3. Askew, I. and Khan, A.R. Community Participation in National Family Planning Programmes Some Organisational Issues. *Studies in Family Planning*, 1990, **21**(3), 127-142.
4. ESCAP. Report of the Study on the Organisational Issues in Community Participation in National Family Planning Programmes : A Comparative Analysis of Five Countries in the ESCAP Region. *Asian Population Studies Services No.87*, United Nation, Bangkok, 1988, 24 pages.
5. Institute of Population Studies, 1987.
6. Sittitrai, W. *et al.* A Study on Some Organizational Issues in Community Participation in the Context of a National Family Planning Programme : The Case of Thailand. Institute of Population Studies, Chulalongkorn University, Bangkok, 1989, 96 pages.
7. UNFPA, IPPE and Population Council. Family Planning in the 1980s : Challenges and Opportunities Population. Council, New York, 1981.
8. United Nations. Report of the International Conference on Population. United Nations, New York, 1984.
9. United Nations. Report of the Study on the Organizational Issues in Community Participation in National Family Planning Programmes : A Comparative Analysis of Five Countries in the ESCAP Region. Bangkok, 1988.
10. WHO-UNICEF. Primary Health Care : Report of the International Conference on Primary Health Care. WHO, Geneva, 1978.

Table 1. Attitude statements toward participation in family planning programmes by groups of the respondents

		Community 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 personal matter and therefore collective action is a waste 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	0.1	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 2. Participation in family planning activities through collective action and committees by the respondent groups

		Community members	CBDs	Staff	Manager	F value
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 3. 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 3. (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 4. 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	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 5. 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 6. 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 convenient 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 7. 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	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 8. Perception of Current roles in programme activities by actors and respondents

Actors/Respondents	Activities																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Government																			
Member																			
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
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 9. Perceived responsibility by activities by four groups of respondents

Actors/Respondents	Activities 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Government																			
Members						75.0													
CBDs																			
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
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 10. 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 practise 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