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# The Philippine Family Planning Program: Organizational Correlates of Performance

AMELIA P. VARELA*

*Third World countries have responded to the population problem by initiating family planning programs aimed at contributing to achieving national development goals. The Philippines designed a population/family planning program which opted for the integration of the different components into the sectoral activities of existing ministries rather than establishing a separate administrative structure for program implementation. The rationale for this is that the population problem cannot be solved in isolation from the other socio-economic development aspects. Continuous evaluation is needed to assess the performance of the program and be able to develop the following: (1) performance measures of the different family planning programs: (2) measures of the extent of program integration; and (3) resource-management model conducive to program performance. The variables used in this evaluation process include; (1) the socioeconomic characteristics of the environment within which the program operates; (2) the amount and nature of program inputs; (3) the organizational and management capabilities; and (4) the extent of integration being achieved in the program.*

## Introduction

Rapid population growth in the developing and thickly populated countries of the Third World is taking place simultaneously with governmental efforts for national development. Urgent measures have to be taken in order to bring down the growth rate to manageable proportions conducive to the attainment of established national development goals.

The Philippine response to its population problem is a declared population policy which intends to intervene and influence fertility behavior and to internalize small-family norms. To operationalize this policy, a national family planning program which is to provide information on contraception and distribute contraceptive supplies was launched in 1969 together with subsequent beyond family planning social measures supportive of the population policy. The national program was incorporated in the national development plans and integrated into sectoral development program structures of the departments of education, labor, health, social welfare, public information, finance, and local government and community development, as well as into the administrative systems of private institutions. This arrangement reflected not only a desire for efficiency but also an awareness by the government that the population problem cannot be solved in isolation, and that, to be truly effective, the program must link itself with a wider range of development efforts.

## Statement of the Problem

The viability of national family planning programs is always in question; more so its effectiveness to influence fertility behavior and effect population decline within the context of social and economic realities such as are presently obtaining in the Philippine setting. After almost

*Assistant Professor, College of Public Administration, University of the Philippines.

seven years of family planning program implementation experience, together with considerable mobilization of both public and private administrative systems and resources, the Philippine program shows discouraging results on two counts: (1) there has been a decline in the efficiency of the program in terms of new and continuing acceptors; and (2) there has also been a corresponding decrease in program effectiveness in terms of the shift among acceptors from the use of the more effective methods of contraception (pills and IUD) to the less effective methods of condoms and rhythm.

In the light of these disturbing developments, the need for continuous assessment of the Philippine program becomes critical. Evaluation of family planning programs brings to focus the issue of performance measures. The first task of this study is to come up with measures of performance, apply them to the national program, and, in the process, identify the correlates of performance from among the program variables.

Another critical element identified as necessary for effective program implementation is management: its dynamics and processes, its styles and characteristics, and its interaction with forces obtaining within its environment. The Philippine program has shown that rapid increases in inputs, both funds and personnel, did not generate the expected outputs in terms of acceptors. The program experience showed, however, that some implementing agencies and clinics were productive, while some were not, given almost the same resource inputs. This fact brings us to the question of what constitutes effective management of family planning programs so that inputs could be transformed into outputs as rationally and as efficiently as intended. It also points to the possibility that there are forces, other than program inputs, operating within the program and influencing performance.

Program management in family planning is the primary force within the organization which coordinates the activities of the subsystems and relates them to the environment. Essentially, management is the process whereby activities and related resources are integrated into an effective total system for objective/goal attainment. A major portion of this study consists of looking into the management characteristics of selected implementing agencies and clinics in order to assess and determine the management styles obtaining within the program and how they relate to performance.

The second major task of this study concerns developing measures of the extent of program integration, as these apply to the Philippine program, and articulating general impressions regarding the extent of integration, and if possible, its relationship with performance. Integration in this study focuses on its institutional interpretation as the fitting of family planning into the various existing programs of public and private agencies and coordinating the efforts and resources thus mobilized to achieve predetermined program goals and objectives. The present attempt to assess integration obtaining in the family planning program is limited to integration within the health network, and to analysis undertaken at the program, agency, and role levels. Integration is discussed both in its structural and behavioral dimensions.

The third task in this study relates to the development of a resource-management model conducive to program performance based on the findings and results of analyses in connection with the first two tasks mentioned above. Such

model may be useful as an alternative management strategy for more effective family planning services and may also be a useful tool for program managers and administrators at the helm of the family planning program within the existing Filipino administrative reality.

Specifically, the objectives in this study are the following:

(1) to formulate measures of performance and to apply them to the Philippine program;

(2) to examine how the variables adopted for this study (environment inputs, and organizational characteristics) relate to performance, thereby identifying the correlates of performance;

(3) to identify profiles of management styles conducive to effective performance at program, agency, and clinic levels;

(4) to develop measures of the level of integration and apply them at program, agency, and role levels and

(5) to formulate a resource-management model conducive to high performance for better program implementation and program delivery of family planning services.

### General Study Approach And Data Bases

The Philippine experience in family planning program evaluation utilizing the input-output scheme consisted of the Economic and Social Council for Asia and the Pacific/Population Commission (ESCAP/POPCOM) input-output study and the ESCAP/College of Public Administration, University of the Philippines (CPA UP) Study on organizational determinants of performance of family planning services. The present study focused on the portion of the total family planning program organization comprising the POPCOM as the central policy making and funding body and the three largest administrative and delivery systems: namely, the Department of Health, now the Ministry of Health (MOH), the Family Planning Organization of the Philippines (FPOP), and the Institute of Maternal and Child Health (IMCH). Qualitative program data from 1969 to 1975 were used to analyze program history and development using systems analysis, while quantitative data for 1975, taken from the raw data of the ESCAP/CPA UP Study, provided the basis of analysis using a linear model.

Based on existing variances in performance among the clinics, the provinces of Iloilo and Pampanga were chosen as the study samples, from which 60 clinics were selected on the basis of high and low performance. Other criteria were accessibility to the research teams in terms of transportation and communication facilities and representation of the three leading implementing agencies in the national program. Pampanga and Iloilo were also comparable in terms of the presence of regional offices in the locality, particularly those of POPCOM and MOH, and the presence of cities surrounded by semi-urban and rural settings.

Three sets of interview schedules[1] were administered by teams of interviewers to 208 respondents[2] from among

[1] Interview schedules used in the ESCAP/CPA UP Study comprised of Clinic Resources Survey, Personal Interview (Personnel Characteristics, Organizational Contacts/Support, and Attitudes) and Organizational Profile Survey.

[2] Out of these 208 respondents, only 185 were used in the analysis. Sanitary inspectors were excluded since they were not involved in the family planning program at the time of the survey.

the 60 selected clinics to generate data on clinic resources, attitudes, and personal characteristics of clinic personnel, organizational contacts and support, and management styles. The 1975 data generated figures for the environmental variables.[3] A fourth questionnaire on integration was administered to program personnel formally appointed as coordinators at central, regional, and provincial levels and to identified managers and supervisors whose functions include coordination and integration of program workers and activities.

Document analysis, library research, interviews, and service statistics [POPCOM - Management Information System (MIS)] provided the data on the history of program organization and development and shifts in program strategies, while the exposure, experience, and sensitivity of the proponent to program management dynamics and informal organizational behavior in the family planning program, gained through active involvement in program management studies and research and in executive and management development training of senior program officials, provided insights into the process and behavioral dimensions of program implementation which could not be acquired through documents review/ records analysis and other survey means.

The inputs provided by the ESCAP/CPA UP Study Advisory Council (composed of the executive directors of the four subject agencies) and of the members of the author's doctoral committee during the research design and implementation stages were invaluable to the progress and development of the present study, since they also served as interested and knowledgeable resource persons during the study.

## Theoretical Framework And Methodology

The theoretical climate for the study of family planning programs derives from the vast literature on organization and demographic theories. The specific theoretical perspective utilized in this study owes most of its concepts from organization and management theory and relates to organizational structural arrangement, behavior of people in organization in relation to technology and environment, management styles, and organizational performance.

### *Measures of Organizational Performance*

Existing family planning programs to date have evolved several measures of program performance. *Demographic impact* is a long-run measure shown by decline in birth rate. The measure, however, has met the problem of "time lag" within which the effects of family planning become visible[4] and the

[3]The figures for population density were derived from the computation of figures for 1975 obtained from the Bureau of Lands and for number of women of reproductive ages were adopted from the ESCAP/CPA UP Study; likewise for the figures for municipality classes which were obtained from the 1975 data of the Department of Finance. Literacy rates were taken from the 1975 census data; while the fifth variable was derived from the attitude scale adopted by the ESCAP/CPA UP Study of 1975 and as such represents perception of clinic personnel.

[4]O. L. Deniston, L.M. Rosenstock, and V.A. Getting, "Evaluation of Program Effectiveness," *Public Health Report*, Vol. 83, No. 4 (April 1968); O. Rarkavy, "Impact of Family Planning Programs on Birth Rate," in Proceedings of the Eighth International Conference of the International Planned Parenthood Association, Santiago, Chile, April 1967, p. 214.

problem of the lack of a sound and accurate registration system for births and deaths.[5] *Hierarchy of objectives model*[6] looks at the family planning program as having a "hierarchy of objectives" with an ultimate objective which can be achieved through necessary conditions or sub-objectives [(personnel trained, Information, Education, and Communication (IEC) materials produced, etc.)] which must be accomplished first in order that the program objective may be reached. *Diffusion measure* represents the impact of family planning program on the knowledge, attitudes, and norms of the population concerning family planning practice.

The recruitment of new acceptors and retention of users in the program is the measure that the Philippine program used. Service statistics generated by the reporting system usually reflects them. An index to measure effectiveness of the contraceptive practices or the number of births averted by these practices is called "couple of years protection" (CYP) or "months of effective protection" (MEP) as in the Philippine case.

Public administration literature on organizational performance is replete with the concepts of efficiency, effectiveness, and productivity. Productivity and efficiency, often used synonymously, refer to the ratio between output and inputs.

C.Y. Wu has differentiated productivity and efficiency as expressions of input-output relationship.[7] "Productivity," as defined by Wu to denote the relationship of output to an input (labor in terms of staff days in this study), has been adopted. "Output" is defined as goods and services produced, usually in terms of the "final product of the organization and not the intermediate or subsidiary activities performed for the purpose of achieving the final production."[8] "Effectiveness" is conceived as the degree of goal achievement or objective achievement and is appraised in accordance with the extent to which the output of an organization has fulfilled the desired goals and objectives.[9] Effectiveness is measured in this study by months of effective protection afforded by the contraceptive methods.[10]

Encompassing the concepts of productivity and effectiveness, the performance measures[11] adopted in this study were computed thus:

[5] United Nations, *Population Bulletin*, No. 7, 1963, p. 13.

[6] A.L. Knutson, "Evaluating Program Progress," *Public Health Report*, Vol. LXX (March 1955), pp. 305-310; G. James, "Evaluation in Public Health Practice," *American Journal of Public Health*, Vol. LII (July 1962), pp. 1145-1154.

[7] National Association of Manufacturers, *Productivity: Gauge of Economic Performance* (New York, 1952), p. 1 cited in C.Y. Wu, "Refining Concepts of Performance in Development Effectiveness, Profitability and Productivity," *Philippine Journal of Public Administration*, Vol. XVII, No. 3 (July 1973), p. 288.

[8] U.S. Bureau of Budget, Executive Office of the President, *Measuring Productivity of Federal Government Organizations* (Washington, D.C., 1964), p. 38, cited in Wu, *op. cit.*, p. 288.

[9] Amitai Etzioni, *Modern Organizations* (Englewood Cliffs, New Jersey: Prentice-Hall, 1964), p. 8 and James J. Price, *Organizational Effectiveness* (Homewood, Illinois: R.D. Irwin, 1968), pp. 2-3.

[10] The weighted values of each method or MEP are IUD = 40 months, pills = 20 months, condom, rhythm = 2 to 3 months. Sterilization, which has a permanent effect, was introduced later in the program and is not reflected in the performance measures adopted for this study.

[11] Correlation between the two measures was made and found to be not equal to 1, so that the study proceeded to use both measures.

$$(1)\ \text{PROD 1} = \frac{\text{sum of new acceptors per method for 3 mos. x MEP}}{\text{staff days for 3 months (May, June, July 1975)}}$$

$$(2)\ \text{PROD 2} = \frac{\text{sum of new acceptors per method for 12 mos. x MEP}}{\text{staff days for 12 months (January to December 1975)}}$$

*Family Planning Environment and Performance*

Two schools of thought have emerged regarding family planning program environment and program performance. According to the "conventional wisdom," the central purpose of population policy is to provide contraceptive services to high fertility population.[12] The obvious economic and social benefits to households as a result of lower fertility would induce rapid and widespread adoption of contraception and consequent reduction in fertility. The "new conventional wisdom,"[13] on the other hand, suggests that fertility decisions are fundamentally determined by the economic and social status of the populations concerned, and cannot be greatly affected by the provision of contraceptive services. Simmons *et al.* posited that determinants of family planning acceptance and family planning organizational performance are more complex than can be captured in either of the two models above, and that both the interventions represented by family planning programs and the socioeconomic environment into which they are introduced are important determinants of acceptance.[14]

Socioeconomic factors borne by demographic studies to affect fertility decline have been summarized by a U.N. report:

> Related to this changing attitude toward family limitation are a complex of interrelated economic and social factors such as shifts in the population from country to city, the desire to improve one's own social and economic position or that of one's children, the changes in the status and role of women in the society, the improvement of the level of living, the increasing expenses of rearing children, a decline in religious interest, and a decline in morality.[15]

Others have found a low correlation between natality and measures of development in developing countries at present,[16] while Paul Liu in Taiwan, concluded that given the present situation in the developing countries, the secular influence of socioeconomic forces on fertility reduction is obviously too small to counterbalance the unfavorable effect of

[12]Early advocates of the family planning approach include the USAID.

[13]This is represented by a diverse group ranging from Kingsley Davis and a large number of individual scholars to more recent manifestations within the U.N. and WHO.

[14]George B. Simmons, Ruth S. Simmons, B.D. Misra, and Ali Ashraf, "Determinants of Family Planning Performance at the Clinic Level in Uttar Pradesh," Ann Arbor, Michigan, 1975 (Mimeo.) p. 1.

[15]United Nations, Population Division, Department of Social Affairs, "Determinants and Consequences of Population Trends," Part III, *Population Studies,* No. 17, p. 72.

[16]Dudley Kirk, "Natality in the Developing Countries: Recent Trends and Prospects," Paper presented at the Sesquicentennial Celebration of Fertility and Family Planning: A World View at the University of Michigan, 15-17 November 1967, p. 6, cited in S. Jain, *Comparative Study of Effective and Non-Effective Family Planning Program in India* (The Carolina Population Center, The University of North Carolina at Chapel Hill, 6 April 1971) p. 32. Also Irma Adelman and Cynthia Taft Morris, "A Quantitative Study of Social and Political Determinants of Fertility," *Economic Development and Cultural Change,* Vol. XIV, No. 2 (January 1966), p. 129.

population increase in social and economic growth itself.[17] Laing and Phillips contend that the availability of family planning methods has a large influence on acceptance and continuation rates in the Philippine population program.[18]

Most developing nations cannot wait for their fertility decline to be brought about by socioeconomic changes and have thus initiated national family planning programs. Such programs are based on the assumption that a deliberate attempt to mobilize the motivation of the population toward the desire for small-size family through education techniques and the provision of contraceptive supplies and services will lead to fertility decline, and that social change could be induced through government intervention.

With this assumption and conceptual perspective, it is posited that:

(I) The performance of the family planning organization correlates with the socioeconomic characteristics of the environment wherein it operates.

By socioeconomic characteristics we mean those which are indicative of the general level of socioeconomic development of the people in the sample municipalities in the two provinces we have studied (Pampanga and Iloilo). Five environmental variables have been selected: population density, municipality classification based on income, number of women of reproductive age, literacy, and receptivity to new ideas and technology which was taken from the attitudes schedule data of the ESCAP/CPA UP Study. It is specifically hypothesized that:

(1) Population density, municipality class based on income, and the level of literacy positively correlate with the level of program performance.
(2) The number of women of reproductive age and the receptivity of people to new ideas, and technology positively correlate with the level of program performance.

To test the above hypotheses, correlation analysis was used to determine the relationship of the individual variable to performance, and the direction of the relationship on the variance in performance.

*Program Inputs as Correlates of Performance at Clinic Level.*

The interventions represented by the family planning programs and the socioeconomic environment into which they are introduced have been recognized to influence acceptance. Moreoever, the effectiveness of an intervention is not solely determined by the quantity of personnel or financial resources, but is greatly affected by the background and training of the personnel employed by the program, the techniques of social persuasion they use, organizational factors,such as the quantity and quality of supervision, support from higher levels in the organization and from other groups, and to some extent by the nature and response of the target population itself.[19]

For a more meaningful insight into management processes and dynamics, the

[17]Paul K. Liu, "Socio-Economic Development and Fertility Levels in Taiwan," *Industry of Free China*, August 1965, cited in S. Jain, *op. cit.*, p. 33.

[18]John E. Laing and James F. Phillips, "Survey Findings on Family Planning Program Effects in the Philippines, 1968-1973," Population Institute, University of the Philippines, 1974.

[19]Simmons *et al.*, *op.cit.*, *p.2.*

focus was on the clinic delivery system and clinic organization since the family planning program network translates and attains its objectives at this level. Clinic management ultimately "processes" both program inputs and clients at its level.

Performance of the clinic organization is greatly affected by decisons taken at the higher levels in the program organization, both in the case of health services and/or family planning activities, and by the activities of other development programs the organization is pushing, as well as by the client population. A family planning clinic, however, is not a simple organization. It is most often a subsystem of the health and maternal/child care system which is laden with preventive and curative medical responsibilities. In other instances, clinics are part of the administrative structures of other government development programs or of private institutions. But the clinics yield vital information not only on the existing dynamics and mechanisms for coordination and integration, but also information on the process of conversion (socio-technical system in particular) of inputs into outputs.

Transactions between clinic personnel and the community where they operate are affected by the personnel attitudes towards the family planning program, the clients, the job, and the work group. The capacity for communication, motivational forces and organizational characteristics, particularly the supervision and organizational support received are forces bearing down on the family planning workers at the clinic delivery level.

Some program inputs have been found to affect clinic performance; for instance, degree of technical training available in the clinic was a strong determinant of clinic effectiveness.[20] Reporting and control procedures affect clinic performance.[21] Organizational variables interacting with individual needs eventually increase the high level of performance.[22] Leadership behavior increased the perceived contact between family planning program and other agencies which are positively associated with program effectiveness.[23]

The conceptual perspective on performance as dependent upon the kinds of inputs the program makes available to the organization, particularly at the clinic level, becomes very relevant to this study. Accordingly, it is posited that:

(II) *Performance is correlated with program inputs (clinic resources).*

(1) The accessibility (physical distance) of the clinics is positively related to clinic performance.

(2) Adequate and timely material clinic input such as family planning equipment, IEC motivational materials, and contraceptive supplies are positively correlated with clinic performance.

[20]Stephen Chee *et al.*, "Comparative Study of the Administration of Family Planning Services in Selected ESCAP Countries: The Malaysian National Study," Paper presented during the Directors' Meeting, Bangkok, Thailand, November 1975.

[21]Peter Blau, *The Dynamics of Bureaucracy* (Chicago: University of Chicago Press, 1955).

[22]Frank K. Gibson and Clyde B. Teasley, "The Humanistic Model of Organizational Motivation: A Review of Research Support," *Public Administration Review*, Vol. 33, No. 1 (January-February 1973), pp. 89-96.

[23]Han Dae-Woo, "Leadership and Program Performance in the Korean Family Planning Program," University of Michigan, School of Public Health, 1974, Ph.D. dissertation, cited in Gayl D. Ness, "Evaluation of Integration in Family Planning Programs," Seminar Paper, College of Public Administration, University of the Philippines, Manila, August 1975.

(3) Staff inputs are positively correlated with clinic performance.
(4) The more relevant education of the clinic staff to family planning and adequate specialized training in family planning are positively correlated with clinic performance..
(5) The low social distance between the clinic staff and the clients in terms of communication capability in local dialect; and clinic staff coming from the same locality (barangay, municipality, or province) is positively correlated with clinic performance.
(6) A clinic staff which is generally: female and married; with 3 or 4 children; using the more effective contraceptive method; and an acceptor positively correlates with clinic performance.
(7) Positive clinic staff perception of good organizational contact and support through adequate logistics without shortage and delay, frequent personal contact with higher officials and levels of program hierarchy positively correlates with clinic performance.
(8) Positive clinic staff perception of good material incentives by way of traveling allowance and honoraria without shortage and delay positively correlates with clinic performance.
(9) Positive attitudes of clinic personnel toward clients, the work group, a family planning program, and the respondents' job positively correlate with clinic performance.

To test these hypotheses the clinic was used as the level of analysis. The selected variables: clinic distance from target population; staff personal characteristics; educational background and experience; specialized training in family planning; social distance in terms of communication ability in the local dialect and the staff coming from the same locality, staff perceptions of organization contact and support; and the attitudes of clinic personnel toward the clients, their jobs, their work groups, and the family planning program were drawn from the ESCAP/CPA UP Study raw data base. As indicator of physical distance, it was assumed that clinics located at the center of a municipality are "far" (from the clients' perspective) compared to clinics or health substations located in the barangays. It is also assumed that a clinic is adequate in family planning equipment if it possesses critical equipment required for intra-uterine device (IUD) insertion and pelvic examination.[24] New correlation runs for these variables were undertaken to provide tests for the above hypotheses. The program inputs which did not correlate were reanalyzed when the management characteristics were looked into to determine the intervening effect of the management style and system when it converts inputs into outputs.

### *Organizational and Management Characteristics and Performance*

*Organization and diffusion of contraceptive technology.* Family planning programs as efforts of intervention depend on the diffusion of contraceptive technology for fertility limitation and induced social change. Such intervention ultimately rests with the acceptance by couples of contraceptive techniques and

[24]These are examining table with stirrups, glass jar for IUD loops in solutions, inserters and plungers in solution, Sims bi-valve vaginal speculum, curved uterine forceps, graduated metal uterine sound, Hergar's dilator, IUD removable hook, plastic gloves, and sterilizer.

by the effectiveness of the administrative system organized to implement the programs. Rogers found that the diffusion of this technology and its related behavior pattern is influenced by the target population and by the organizational networks through which the technology is promoted.[25] Lionberger has shown that productive programs or organizations responsible for technology diffusion have the adaptive capacity to meet the requirements of the acceptors, and can extend themselves to the individual acceptors.[26] These characteristics are part of the fundamental character of the organization responsible for the diffusion. They are governed broadly by the structure of the organization and the type of work that is put into the organization.

Program extension capacities are a product of the general orientation of the program which is formed by policy makers or specific patterns of job specification and personnel inputs, of strategies of motivation adopted in the organization, and of the flow of resources that move within the organization. The capacity to adapt a new technology is a product of higher-level decisions of the specific technology to be used, and of the work performance of the lower level staff who service the program clients.[27]

*Structure and organizational performance.* The nature of family planning requires that the organization structure be so designed that it is responsive and adaptive to the demands of its environment, its members and participants, and its clients. The contingency theory of organization has direct relevance to the developing practice of family planning and population program management. The contingency view seeks to understand the interrelationships within and among subsystems as well as between the organization and its environment and to define patterns of relationships or configurations of variables. It emphasizes the multivariate nature of organizations and attempts to understand how organizations operate under varying conditions and in specific circumstances.

Contingency views are ultimately directed toward suggesting organizational designs and managerial actions most appropriate for specific situations. The contingency approach starts with the definition of an organization, or in this study, a family planning program as an open system. This system recognizes the influence of all its parts on one another and its constant interaction with the environment. As Argyris has stated, "Organizations are open systems continually influencing and being influenced by the environment. . ."[28]

Effects of the environment on organizational design have long been recognized by organizational writers. Burns and Stalker came up with the concepts of "mechanistic" and "organic" organizational structures and managerial systems.[29]

The mechanistic organization and management form is most appropriate for

[25]Everett Rogers, *Diffusion of Innovations* (New York: MacMillan, 1972), pp. 124-134.

[26]Herbert F. Lionberger, *Adoption of New Ideas and Practices* (Iowa: Iowa State University Press, 1960), pp. 12-17 and 21-25.

[27]ESCAP Revised Study Design, "Comparative Study on the Administration of Family Planning Programs in the ESCAP Region: Organizational Determinants of Performance in Family Planning Services in Selected ESCAP Countries," (Bangkok: ESCAP Population Division, July 1974), p. 6.

[28]Chris Argyris, *Understanding Organizational Behavior* (Homewood, Illinois: The Dorsey Press, 1960), p. 163.

[29]Tom Burns and G.M. Stalker, *The Management of Innovations* (London: Tavistock Publications, 1961).

routine activities, where decision-making is programmable, and where environmental forces are relatively stable and certain. The organic form is most appropriate for non-routine activities, where heuristic decision-making processes are necessary, and where the environment is relatively uncertain and turbulent.

*Management styles and organizational performance.* Organizational theorists and management writers have linked organizational performance to organizational characteristics and management styles obtaining within the organization. The organizational attributes which they have shown as influence on performance are leadership, motivation, communication, decision-making, and goal orientation. These characteristics are also management processes utilized by the organization during the conversion process of transforming inputs to outputs.

Likert advanced a theory of a new pattern of management which is characteristic of highly productive managers/organizations.[30] Utilizing a 20-point measurement scale, Likert came up with four systems of management which he termed as follows: System 1 (Exploitative Authoritative), System 2 (Benevolent Authoritative), System 3 (Consultative), and System 4 (Participative). It is System 4 or participative management which he claimed to be highly productive and contributory to organizational performance.

The three basic concepts of System 4 are: (1) the use by the superior of the principle of supportive relationship; (2) the use of group decision-making and group methods of supervision; and (3) high performance goals (of peer and members) for the organization.

Within the framework of the theories discussed above (contingency, open system, mechanistic and organic systems, and new pattern of management), it is posited that:

(III) *Program performance is correlated with the organization and management obtaining in the program.*

(1) The internal structure of the family planning program contains both *organic* and *mechanistic* attributes which allow for flexibility and adaptability of the organization.
(2) Organizational flexibility and adaptability contribute to program performance.
(3) High scores[31] in participative management (System 4) characteristics are positively correlated with clinic as well as program performance.
(4) Organizations with a participative style of management (System 4) has high level performance. Participative style of management shows the following characteristics:

(a) Superiors are *supportive* of subordinates;
(b) There is a high degree of *participation* in group decision-making and supervision;
(c) There is *mutual trust and confidence* between superiors and subordinates;

[30]Rensis Likert, *New Patterns of Management* (New York: McGraw-Hill Book Co., 1961) and *The Human Organization* (New York: McGraw-Hill Book Co., 1967).

[31]High scores of 16-20 points on the Likert scale determine the presence of the required characteristics.

(d) Superiors and subordinates have high *performance goals* which are set through group decision-making.

(5) High performing clinics can develop a distinctive management style different from that of the mother organization/agency.

To test hypotheses 1 and 2, it is assumed that in the family planning program the organization exhibits both organic and mechanistic forms of structure and management systems. The organic structural characteristics of multiple and changing hierarchies, lateral workflow/communication channels, coordination through interpersonal contacts, use of incentives, and diffused roles can be seen at the program level. The mechanistic form is also assumed since the attributes of the Weberian bureaucratic model, such as clear hierarchy, vertical communication, coordination through routine and mechanical control are visible in the structure and management systems of the implementing agencies, as well as at some points of the program organization itself.

To reenforce our assessment of structural flexibility and adaptability, the past organizational responses to environmental influence were also examined. The following environmental dimensions were selected and related each to the organizational responses experienced during program implementation: (1) interorganizational linkages, (2) boundary relationships, and (3) degree of environmental influence on the program.

Qualitative analysis of the organizational data gathered was made. Such analysis focused on the structure obtaining within the organization; the flexibility and adaptability of the structure; and the relation of the structure and its corresponding degree of flexibility and adaptability to organizational performance.

To test hypotheses 3 and 4, the data generated by the *Organizational Profile Survey* were utilized. The high scores of 16-20 points on the Likert scale indicated a System 4 or participative management style. The mean scores were analyzed at program, agency, and clinic levels. Utilizing a set of ten-characteristic indexes, the management characteristics based on the responses of clinic personnel (N = 185) were measured. Then adopting the set of six-characteristic indexes from the ESCAP/CPA UP Study, the management styles based on responses by clinic (N = 60) were measured. Correlation analysis was applied to determine the relationship of each set of factors on performance and, the direction of relationship as well as to identify particular management styles responsible for the variance in performance at the program, agency, and clinic levels.

The study looked further into the three component characteristics of the management style existing at program, agency, and clinic levels based on their mean scores (hypothesis 4). The quantitative analysis was reenforced by qualitative analysis on existing control mechanisms, communication, decision-making and planning systems, and on clinic supervision.

To test hypothesis 5, and utilizing the results of the analysis to test hypotheses 3 and 4, the study plotted the management styles and patterns of style characteristics of the implementing mother agencies (MOH, FPOP, IMCH) and those of their high and low performing clinics for comparison. Using mean scores analysis and correlation method, the results were

analyzed together with the other variables impinging on clinic performance.

*Integration and Performance*

The Philippine family planning program is anchored upon the integration of family planning into the other sectoral development programs of public and private agencies. The concept of integration as the process of achieving unity of efforts in the subsystems of the organization in order to achieve its goals and objectives partakes a special meaning within the context of family planning program requirements.[32] It implies bringing together various public and private agencies, which at times possess conflicting goals and priorities, but which must cooperate and coordinate efforts and activities toward the attainment of family planning objectives. In the process of integration, they give up some of their autonomy over the set of family planning activities, while at the same time they gain benefits resulting from the interaction and interrelation with other agencies involved in the family planning program implementation.[33]

Sectoral integration between public and private sectors, as in the case of the Philippine program, requires the creation of a set of legal and administrative procedures that permits control and resource flows from one sector to another. Agency integration concerns the extent to which separate agencies of the government are brought together to perform the single task of family planning. Role integration, on the other hand, occurs where different skills and tasks are included in the same role.

Integration can be viewed both as structure and as process behavior.[34] Structurally, it tends to be hierarchically ordered. As a process behavior, it springs from and is conditioned by the planned organizational processes reflected in the formal structure, but it is influenced more by actual operations of the processes which involve people in the organization. In this context of human interactions, the integration process encompasses both coordination and cooperation.

Means of achieving integration have been suggested by various writers. Likert underscored the integrative features of his principle of supportive relationships and even proposed a "linking pin" structural form to help with the problem of integration.[35] Litterer has come up with "the hierarchy, administrative or control systems, and voluntary activities."[36] Katz and Khan suggest that integration finds basis in role, norms, and values;[37] while Seiler has found that a relationship exists between the degree to which members of two groups share norms, values, and goals and the ability of the two groups to cooperate.[38] Litwak and

[32]Paul R. Lawrence and Jay W. Lorsch, "Differentiation and Integration in Complex Organizations," *Administrative Science Quarterly*, Vol. 12, No. 1 (June 1967), pp. 1-47.

[33]Ness, *op. cit.*, p. 3.

[34]Remedios A. Savellano, "Coordination: An Attempt at an Operational Interpretation," Term paper submitted to Dr. Raul de Guzman, P.A. 327, College of Public Administration, University of the Philippines, October 1974; also Likert *op. cit.* and Argyris, *op. cit.*

[35]Likert, *op. cit.*, pp. 113-115.

[36]Joseph A. Litterer, *The Analysis of Organizations* (New York: John Wiley and Sons, 1965), pp. 223-232.

[37]Daniel Katz and Robert Khan (eds.), *The Social Psychology of Organizations* (New York: John Wiley and Sons, 1966), p. 38

[38]J. Seiler, "Diagnosing Interdepartmental Conflict," *Harvard Business Review* (September-October 1963), pp. 121-132.

Hylton presented a theory of interorganizational coordination which is based on organizational interdependence, level of organizational awareness, standardization of organizational activities, and number of organizations.[39] The emergence of integrative devices whose effective functioning can be measured by intergroup relations characterized by open cooperation and collaboration brought about by high status groups have also been underscored.[40]

Within this conceptual framework on integration, it is posited that:

(IV) *The extent of integration obtaining in the program contributes to performance.*

(1) The extent of program integration, as evidenced by goal and objective consensus, frequent/substantive communication/contact, joint decision-making and activities, exchange of goods and services, and effectively functioning integrative devices, positively contributes to program performance.

(2) The presence and effective functioning of integrative devices, as evidenced by close cooperative and collaborative relationship (referrals, exchange of goods and services), effective coordinators of positional authority and professional/technical expertise, and effective POPCOM and Coordinating Officer for Program Execution (COPE) as top coordinators, positively contributes to program performance.

(3) The extent of integration at program, agency, and role levels positively contributes to program performance.

(4) The extent of agency integration, as evidenced by the structural location of the family planning program vis-à-vis other programs; extent of mutually shared goals and objectives; joint decision-making and activities, and homogeneity of integrated tasks, positively contributes to agency performance.

(5) The extent of role integration, as evidenced by staff inputs to family planning, specialized training in family planning, material and nonmaterial supports for role performance, and absence of role conflict, positively contributes to role performance.

Starting from the institutional point of view on integration, the study examined the following indicators to assess the extent of integration: POPCOM policy and action measures designed to effect integration; POPCOM as a central coordinating body; the horizontal and vertical integration schemes or structural arrangement (integrative devices) and processes; the mechanisms adopted for decision-making, planning, and control and the actual operations of such mechanisms; and persons who are assigned the role of integrators/coordinators at specific program levels and their interaction with those they are supposed to coordinate and integrate. The foci of analysis were the POPCOM, MOH, FPOP, IMCH, and the coordinators at the central, regional, provincial, municipal, and clinic levels.

[39]E. Litwak and L. F. Hylton, "Interorganizational Analysis: A Hypothesis on Coordinating Agencies," *Administrative Science Quarterly,* Vol. 6, No. 14 (March 1962), pp. 395-420.

[40]Lawrence and Lorsch, *op. cit.,* p. 12.

For qualitative analysis, the sources used were documents and MIS at POPCOM, records, and interviews with top officials at central and regional levels of the three implementing agencies, interviews with coordinators regarding operating practices and procedures, and the researcher's personal knowledge of existing processes gained through experience and as a result of involvement in management studies and researches, and training in national family planning program administration.

Information gathered through the *Integration Questionnaire* administered to program coordinators at the various hierarchical levels reinforced the analysis. An attempt was made to assess the extent of integration by looking at the integration indicators adopted for the program, agency, and role levels; at the functioning of the integrative devices; and at the structure and process in the integration network, including behavior of actors in the network. This analysis was related to the descriptive statistics of program outputs from 1970-1975 as performance measures so as to determine the influence of the extent of integration on performance.

To summarize the analytical approach of this study a linear model was used first, where the selected variable sets of environmental factors, program inputs, organizational characteristics, and level of integration were analyzed in a direct input-output scheme; and secondly, where the management characteristics and level of integration were utilized as intervening variables in the input-output conversion process.

## Study Findings

### *Environmental Factors*

The findings on the environmental set showed (see Table 1) that population density, number of women of reproductive age, and literacy have positive and significant correlation with the short-term performance measure (PROD 1). Municipality class showed a negative association with performance, while receptivity to new ideas and technology displayed no correlation at all. All four variables were not correlated with the long-term measure (PROD 2).

Table 1. Pearson Correlation Coefficients of Environmental Variables and Performance Measures (N = 60)

| Environmental Variables | PROD 1 | PROD 2 |
|---|---|---|
| Population density | 0.369* | -0.063 |
| Municipality class | -0.486* | -0.038 |
| Number of women of reproductive age | 0.255* | -0.029 |
| Literacy | 0.305* | -0.052 |
| Receptivity to new ideas/technology | 0.056 | -0.053 |

Significance level: * = $p < .05$.

The positive relation with population density, number of women of reproductive age, literacy, and performance does not hold true over time. The larger the target population, which is a function of high population density and large number of women of reproductive age, and the more literate this target population is, tend to result in higher performance for short periods. The inverse relation with municipality class suggests that an increase in municipal income does not necessarily generate a linear relation with family planning acceptance.

The value of the findings rests with its program implications especially in planning and organizing family planning services delivery. Population density creates

pressure on the land. It also acts either as facilitator or hindrance to communication. People in a barangay or municipality share common geographic location, resources, and facilities, such as schools, health centers, markets, community associations, and religious groups. They also share the same set of information about the outside world. Literacy functions as an effective vehicle for mass information and communication, while the number of women of reproductive age as a target group sets the framework for family planning communication and motivation package contents and service coverage.

Municipality class, although it affects program performance negatively, still serves as a measure of the general level of development and the standard of living of a locality. It gives program managers and family planning workers an insight into possible opportunities for employment of women, their role(s) in the community, and the general conditions of economic and familial values. Other areas of concern for program management to consider are policy and decisions on resource distribution, system overload, and utilizing other characteristics of the client system to work for performance.

Philippine experience has shown that family planning program management is conditioned by the size and kind of target audience and its environment. Thus, the management should continuously engender the kind of environment which complements the total development effort, and that population/family planning policies should be in complementarity with other social and economic policies pursued in the other sectors and vice-versa.

Program Inputs

(A). *Inputs with positive correlation with performance. Personal characteristics* of "female" and "married" had positive correlation with performance, with the "female" characteristic significant and becoming stronger over time, especially when all the selected personal characteristics of the study were present in the clinic staff (see Table 2).

Table 2. Program Inputs with Positive Correlation Coefficients with Performance (N = 60)

| Program Inputs | PROD 1 | PROD 2 |
|---|---|---|
| *Personal characteristics* | | |
| Female | 0.3139 | 0.2703* |
| Married | 0.2201 | – 0.0615 |
| *Attitudes Toward* | | |
| Clients | 0.1120 | 0.0640 |
| FP Program | 0.0162 | 0.0501 |

Significance level: * = $p < 05$.

*Attitudes* toward clients and family planning program tended to show positive but not significant correlation.

(B) *Inputs with negative correlation with performance. Staff inputs* belonging to doctor, nurse, midwife, and motivator categories tended to have negative correlation with performance. The results showed that high clinic personnel density tended toward low performance (see Table 3).

Table 3. Program Inputs with Negative Correlation with Performance (N = 60)

| Staff Category Inputs based on actual schedule of Family Planning (FP) services/week x number of actual posts filled | PROD 1 | PROD 2 |
|---|---|---|
| Doctor | - 0.2215 | -0.1277 |
| Nurse | - 0.2334 | -0.1727 |
| Midwife | - 0.1684 | -0.1254 |
| Motivator | - 0.0629 | -0.0535 |
| Types of Staff Inputs | | |
| Actual Posts filled | -0.2529* | -0.1849 |
| Estimated hours spent for FP | -0.1046 | -0.1703 |
| Actual schedule of FP services x number of staff posts filled | -0.2533* | -0.1801 |
| Organizational Contact & Support | | |
| POPCOM | -0.0895 | -0.1080 |
| Mother Agency | -0.2585* | -0.1922 |
| Incentives | | |
| Salaries | -0.0871 | -0.0752 |
| Travel Allowance | -0.2082 | -0.0794 |
| Logistical Support | | |
| Contraceptive supplies | -0.0373 | -0.1026 |
| IEC materials | 0.1056 | -0.0055 |
| FP Clinic Equipment | 0.1340 | -0.0632 |

Significance level: * = $p < .05$.

*Organizational contacts and support.* Results showed that the clinic staff had infrequent contacts: "seldom" and "never" with either POPCOM or their mother agency higher program officials. The infrequent contact negatively correlates with performance. The clinics, however, have adequate and frequent contacts with the provincial personnel.

Organizational support in terms of material incentives, such as honoraria and travelling allowances were viewed as "inadequate" and "very inadequate," while in terms of logistics, like IEC materials, clinic equipment, and contraceptives supplies, they are seen as either in shortage or delayed. The perception of low organization support by the clinic staff both in terms of material incentives and logistics tended to correlate with performance negatively.

*Attitudes* toward the workgroup and the respondents' jobs tended to show negative correlation but was not significant.

(C) *Inputs with insignificant correlation with performance. Clinic distance.*[41] Results of the study showed no correlation between distance of clinics to target population and performance (see Table 4).

Table 4. Program Inputs with Nonsignificant Correlation Coefficients with Performance.

| Clinic Distance | PROD 1 | PROD 2 |
|---|---|---|
| "Far" Clinics (N=51) | 0.0983 | 0.1712 |
| "Near" Clinics (N=9) | 0.1734 | 0.2071 |
| Shortage in Logistics/Supplies (N = 60) | | |
| FP Clinic equipment | 0.1340 | -0.0632 |
| IEC materials | 0.1056 | -0.0053 |
| Contraceptive supplies | 0.0373 | -0.1026 |
| Delay in Logistics/Supplies (N = 60) | | |
| FP Clinic equipment | 0.0961 | -0.0872 |
| IEC materials | -0.0640 | -0.0824 |
| Contraceptive supplies | -0.0214 | -0.0580 |
| Personal Characteristics (N = 60) | | |
| Specialized training in FP | -0.1526 | -0.141 |

[41] Clinic distance is treated here as input rather than as environmental factor because the ESCAP/CPA UP Study data used in this study considered it as clinic resource.

*Clinic equipment, IEC materials, and contraceptive supplies.* The study findings showed that neither the shortage nor delay of any of these material inputs had any correlation with performance.

(D). *Personal characteristic with no correlation with performance.* Specialized training in family planning did not show any correlation on performance.

*(3) Organizational Characteristics*

(a) *Structural characteristics.* The internal structure of the family planning program exhibited both organic and mechanistic attributes which allowed the program organization to be flexible and adaptable (see Table 5). The organizational dimensions which exhibited the mechanistic form were hierarchy, centralization, differentiation, coordination, communication, and career progression and tenure. The organic attributes were found in the task interdependency and role dimensions. The family planning organizational structure showed more mechanistic attributes.

Table 5. Structural Characteristics of the Philippine Family Planning Program Organization

| Structural Variables | Organizational Type |
|---|---|
| Hierarchy | |
| a. Single, clear, stable | Mechanistic |
| b. Number of hierarchical level-many | Mechanistic |
| c. Pyramidal form, not flat | Mechanistic |
| Centralization | |
| centralized (more of) | Mechanistic |
| Differentiation | |
| high | Mechanistic |
| Task Interdependency | |
| high | Organic |
| Coordination | |
| use of devices for coordination | Mechanistic |
| Communication | |
| vertical and authoritative rather than lateral | Mechanistic |
| Roles | |
| diffused | Organic |
| Career Progression and Tenure | |
| stable | Mechanistic |

Responses of the program to its environment were organic as evidenced by the shifts made in program emphasis, orientation, and strategies of implementation (see Table 6). The flexible and adaptive organizational structure and organic responses to environmental influences shown by the family planning organization, however, did not bring about the expected level of performance. This may be attributed to the many rapid changes in program design and implementing strategies which kept the organizational system in constant adaptive motion; but the system was not really able to internalize the positive results which such changes were designed to bring about.

Table 6. Program Changes/Shifts in Response to Environmental Influence

| Change/Shift | From | To |
|---|---|---|
| Perspective | Clinic-contraceptive orientation | Community-developmental orientation |
| Contraceptive technology | more conventional: pills, IUD, condom, foam | more permanent; vasectomy and tubal ligation |
| Area coverage and targets | urban centers | rural areas |
| | female targets | couple targets to include males |
| IEC | individuals and general audience | groups and specific audiences |
| Service delivery | stationary clinics at the center | barangay supply points and satellite clinics at the periphery |

(b) *Management characteristics.* Based on the mean scores analysis, the management characteristics as shown in Table 7 are as follows:

(1) The management system of the family planning organization belongs to System 3;

(2) The management systems of the individual agencies (MOH, FPOP, IMCH) belong to System 3;

(3) The management system of high performing clinics tended toward System 4, while that of low performing clinics tended toward System 2;

(4) The high performing clinics developed their own management style (System 4) distinct from that of their mother agency (System 3); and

(5) The management systems at

program, agency, and clinic levels did not garner high mean scores on all of the characteristics. Thus, the management systems at the hierarchical levels did not correlate with performance.

Table 7. Management Systems of FP Organization, MOH, FPOP, IMCH, High and Low Performing Clinics Measured on a Ten-Characteristics Index and Based on Responses of Clinic Personnel

| Management Characteristics | FP Organization | MOH | FPOP | IMCH | High-Performance Clinics | Low-Performance Clinics |
|---|---|---|---|---|---|---|
| Supportive Relationship | System 3 13.7 | System 3 13.7 | System 3 14.3 | System 3 13.6 | System 3 13.0 | System 3 13.3 |
| Leadership | System 4 15.1 | System 4 15.2 | System 4 15.0 | System 4 14.6 | System 4 15.3 | System 4 15.5 |
| Mutual trust & Confidence | System 3 12.3 | System 3 12.2 | System 3 13.6 | System 3 12.6 | System 3 13.0 | System 3 11.7 |
| Participation in Group Processes | System 3 14.6 | System 3 14.7 | System 3 14.0 | System 3 14.0 | System 3 14.7 | System 3 14.5 |
| Motivation | System 3 14.3 | System 3 14.5 | System 3 13.3 | System 3 13.6 | System 3 14.0 | System 3 14.5 |
| Communication | System 3 14.8 | System 3 14.4 | System 3 14.4 | System 3 13.2 | System 3 14.9 | System 3 14.6 |
| Decision-Making | System 3 14.5 | System 3 14.6 | System 3 13.2 | System 3 13.6 | System 3 15.0 | System 3 13.9 |
| Goal-Setting | System 3 12.6 | System 3 12.9 | System 3 12.6 | System 3 13.8 | System 3 13.0 | System 3 12.3 |
| Interaction-Influence | System 4 16.8 | System 4 17.0 | System 4 16.7 | System 4 15.6 | System 4 16.5 | System 4 17.3 |
| Performance Goals | System 3 13.1 | System 3 13.1 | System 3 13.9 | System 3 12.7 | System 3 13.0 | System 3 13.3 |

The mean scores analysis for each of the management subsystems showed:

(1) The leadership and motivational subsystems have transformed into System 4;

(2) The group processes of decision-making, communication, and goal-setting have remained in System 3; and

(3) The performance aspiration subsystem is characterized more by System 2.

Utilizing correlation analysis, the correlations of the management characteristics with performance shown in Table 8 are as follows:

(1) On program organization: None of the management characteristics showed any significant correlation with performance measures.

(2) On the Ministry of Health: All of the management characteristics tended to have negative correlation with the short-term performance measure, with the decision-making characteristic reaching significance level. None of the characteristics showed any significant correlation with the long-term measure, although leadership, motivation, and goal-setting exhibited positive direction; while communication, decision-making, and performance goals showed negative direction.

(3) On the Family Planning Organization of the Philippines: All of the management characteristics showed positive correlation with performance, wih the communication and decision-making processes having high and significant correlation with both performance measures. Performance aspirations showed positive and significant correlation with performance over time, but not with the short-term measure.

Table 8. Direction and Significance of Correlation Coefficient of Management Characteristics with PROD 1 and PROD 2 in Organizational Units Used in the Study

| Organizational Units | Management Characteristics | PROD 1 Direction of Correlation | | Significance of Correlation | | PROD 2 Direction of Correlation | | Significance of Correlation | |
|---|---|---|---|---|---|---|---|---|---|
| | | Positive | Negative | Significant | Insignificant | Positive | Negative | Significant | Insignificant |
| Family Planning Organization | Leadership | X | | | X | X | | | X |
| | Motivation | | X | | X | X | | | X |
| | Communication | X | | | X | X | | | X |
| | Decision-making | X | | | X | | X | | X |
| | Goal-setting | X | | | X | X | | | X |
| | Performance goal | X | | | X | X | | | X |
| Ministry of Health (MOH) | Leadership | | X | | X | X | | | X |
| | Motivation | | X | | X | X | | | X |
| | Communication | | X | | X | | X | | X |
| | Decision-making | | X | X | | | X | | X |
| | Goal-setting | | X | | X | X | | | X |
| | Performance goal | | X | | X | | X | | X |
| Family Planning Organization of the Philippines (FPOP) | Leadership | X | | | X | X | | | X |
| | Motivation | X | | | X | X | | | X |
| | Communication | X | | X | | X | | X | |
| | Decision-making | X | | X | | X | | X | |
| | Goal-setting | X | | | X | X | | | X |
| | Performance goal | X | | | X | X | | X | |
| Institute of Maternal and Child Health (IMCH) | Leadership | | X | | X | X | | | X |
| | Motivation | | X | | X | X | | | X |
| | Communication | | X | | X | X | | | X |
| | Decision-making | X | | | X | X | | | X |
| | Goal-setting | X | | | X | X | | | X |
| | Performance goal | X | | | X | X | | | X |

(4) On the Institute of Maternal and Child Health: The goal setting process and performance goals showed positive correlation with the short-term performance measure, while the leadership style and communication process showed negative correlation with the long-term measure.

(5) On the High-Performing Clinics: management characteristics could be drawn since the results have shown variances in performance in response to the existing management styles. It is suspected that the influence on performance is conditioned by the organization culture and overall management style which has not totally been transformed into a participative management system.

Table 9. Direction and Significance of Correlation Coefficients of Management Characteristics with PROD 1 and PROD 2 in High and Low Performing Clinics

| Organizational Units | Management Characteristics | PROD 1 Direction of Correlation | | Significance of Correlation | | PROD 2 Direction of Correlation | | Significance of Correlation | |
|---|---|---|---|---|---|---|---|---|---|
| | | Positive | Negative | Significant | Insignificant | Positive | Negative | Significant | Insignificant |
| High Performing Clinics | Leadership | X | | | X | X | | | X |
| | Motivation | X | | | X | | X | | X |
| | Communication | X | | | X | X | | | X |
| | Decision-making | X | | | X | X | | | X |
| | Goal-setting | X | | X | | X | | | X |
| | Performance goal | X | | | X | X | | | X |
| Low Performing Clinics | Leadership | | X | | X | X | | | X |
| | Motivation | | X | | X | X | | | X |
| | Communication' | | X | | X | | X | | X |
| | Decision-making | | X | | X | | X | | X |
| | Goal-setting | | X | | X | X | | | X |
| | Performance goal | | X | | X | | X | | X |

All management characteristics have shown positive correlation with the short-term performance measure, but only goal-setting was significant as shown in Table 9. For the long-term performance measure, all management characteristics, except motivation, showed positive correlation but none was significant.

(6) On the Low-Performing Clinics: All management characteristics have shown negative correlation with the short-term measure, leadership style, motivational and goal-setting processes showed positive relation, while communication, decision-making, and performance goals showed negative correlation. All variables did not reach the level of significance.

No concluding statement about the influence on performance of each of the

The process of management thus exerts corresponding effect on the conversion of inputs into outputs, and hence on performance. There is evidence to show that high performing clinics tended to show more characteristics of the participative system, while the low performing clinics tended to show more characteristics of the consultative and the authoritative-benevolent systems. This finding supports our assumption that the management system is an intervening variable in the input-output conversion process.

*Level of Integration*

*Integration achieved at program level.* The level of integration achieved in the program depends to a large extent on the integration achieved by POPCOM as a central coordinating body at the policy, planning, and funding levels. The results

showed that there is *limited integration* being achieved in the program. The results also showed that program activities were more of the kind which allow for less integrative activities rather than those of more integrative activities.

The integration results may be traced back to: (1) the limitation felt, by POPCOM in its coordinating role and (2) the state of functioning of integrative devices used. POPCOM's role limitation is due to the composition of the POPCOM Board whose cabinet level members are unable to regularly attend. These cabinet level members resort to the practice of sending subordinates who are neither in a position of authority to decide nor commit their respective agencies to a decision. Such a situation defeats the purpose of such terms of membership in timely decision-making and action which such high-level membership is supposed to provide. It is also occasioned by the fact that POPCOM has no direct control and supervision over the administrative systems of implementing agencies. The integration through planning and funding is also limited by the inability of POPCOM to plan and fund the total components of the national population program because of legal and positional constraints at the national level.[42] The nature of the planning process and funding arrangement leaves little opportunity for the participating agencies to enter joint activities and decision-making where they can share resources and political prerogatives which represent a high degree of cooperation and contact and hence a high level of integration.

POPCOM also utilizes coordinating devices at program hierarchical levels for purposes of integration. The devices had led to a mechanical and vertical kind of coordination rather than interpersonal and lateral coordination. The resulting coordination process showed a concentration of cooperation and contacts at central and regional levels, diminishing in frequency and substantive contents as it goes down to the provincial and municipal levels: specifically between central-regional and provincial levels; and more so between central-regional-municipal levels. The process of coordination and contacts leave the clinics almost "isolated" from the rest of the program organization and objectives so much so that their primary motivation is to achieve individual clinic targets alone.

*Integration achieved at agency level.* Based on the structural location of the program, its relative priority, the extent of mutually shared goals and objectives, communication and contacts which occur horizontally and vertically, and joint decision-making and activities as indicators of the level of integration at agency level, it was established that:

(1) the integration achievement is greater when family planning occupies a central location and does not suffer from dual supervision;

(2) the integration achievement is facilitated when the program of the agency is unifunctional rather than multifunctional because it enjoys high priority;

(3) integration is facilitated when the program covers a relatively narrow scope of operation in terms of area coverage, distance from the center, and number of clinics in operation. This is because the mutually shared goals and objectives are clear and the communication and contact which occur horizontally and vertically result in a closely-knitted group of par-

[42]POPCOM shares policy and planning responsibility with NEDA and other departments, particularly those of non-demographic and fertility considerations, such as social and economic policies.

ticipants wherein the coordinative process partakes more of interpersonal relationship rather than mechanical coordination;

(4) closer working contact and relationship among the actors in the integration network facilitates coordination brought about by shared goals and objectives, internal harmony among agency objectives, priorities, and action programs; and

(5) participants in the integrative network attribute the integration achieved to clearly defined roles, open communication and information exchange, and joint planning and decision-making. High commitment to integration was also seen to be a contributing factor.

*Integration achieved at the role level.* Integration of family planning into the health network resulted in the integration of various functions into the same role. Although family planning is closely related to maternal and child health, still each specific role function demands certain requirements from the actors in the integration network. Using the family planning clinic as the focus in assessing integration at the role level, the indicators — role inputs and personal commitment to family planning — were used. The findings of the study showed that:

(1) homogeneity of tasks at the clinic level facilitates role integration as in unifunctional programs;

(2) the adequacy of role inputs as perceived by the clinic workers influence their role performance; and

(3) professional and economic interests of family planning officials and workers are sometimes incongruent to family planning objectives and thus result in role conflict which is not conducive to role integration and performance.

*Integration achieved and performance.* The general finding is that integration has been achieved only to a limited extent. The findings presented a loose integration network where coordination is more mechanical, and where the interaction and contact showed concentration between the central and regional levels, and a breakdown between the central-regional levels on the one hand, and the provincial-municipal levels on the other.

Looking at the indicators of integration and the performance outputs during 1970-1973, it is contended that there was greater integration achieved during the early years of program implementation than during the later years of the family planning program implementation. This is attributed to a relatively narrow area coverage highly concentrated on urban and suburban centers, fewer number of agencies and activities to coordinate, and relatively less expensive integration network. The target audience being reached during these years was the more educated urban population.

The integration achieved during the more recent years is attributed to program changes in design and contents in terms of decentralization and regionalization, modification of the method mix with the introduction of sterilization, and a drastic shift in the program delivery strategy from a clinic and contraceptive-orientation to a community and development-oriented one. These changes disrupted system operation and brought about instability to which the administrative system and its participants had to respond and adjust. The program during the years 1973-1975 is reaching the hard-core rural population with the change to community - and development-oriented strategy.

## Study Recommendations

*Policy Recommendations*

(1) *Institute changes in planning and*

*funding policies to allow for more collaborative activities.* To strengthen program integration, changes in planning and funding policies could start with the restructuring of the terms of the subagreements which limit interagency collaboration by tying up agency participation to specific project plans and objectives stipulated in their respective subagreement. Likewise, funding policies preclude joint efforts, since the implementing agencies are not allowed to commit funds to activities not targetted and stipulated in the subagreements. The consequences of the policy changes are envisioned to foster closer interdependence and working relationship among the implementing agencies and to open up more human relations channels for cooperation and coordination among them.

(2) *Enlist fewer but effective agencies with expertise along program thrusts.* Multi-agency participation should shift the emphasis from enlisting the most number of agencies and entrusting to them all the functional thrusts of the family planning program ranging from clinic services, IEC/motivational activities, training to research into enlisting fewer agencies but which possesses established expertise and specialization in one or two of these program thrusts. Fewer agencies are not only easier to coordinate, but could deliver real and lasting impact on program performance because they can concentrate efforts and resources in their respective areas of specialization and expertise.

Corollary to this measure is to define the areas of operation for each of the agencies in order to effect a saturation strategy in acceptors' motivation and service delivery for higher acceptance and continuation of contraceptive means. The measure is also designed to improve the existing coordination and integration network, both structural and behavioral, as competition among the participating agencies and their personnel, together with its dysfunctions, is replaced by sincere commitment and improved performance since program participants will be working toward the same program objectives and results sans conflicting operation strategies.

*Recommendations on Program Operations*

(1) *Strengthen the coordinating role of POPCOM by improving Board composition.* The coordinating and policy making role of POPCOM should operationally be strengthened since POPCOM serves as the nerve center of total program administration. The composition of the Board could be improved by providing continuity of representation by sending regular representatives and clothing them with adequate authority. Such authority should enable them to actively participate in the Board meetings and to commit the agency to joint decisions on program implementation. The representatives should have an appreciation of population policy implications from a macro-point of view to be able to contribute meaningfully to policy and decision processes.

(2) *Engender and develop a fully participative management system conducive to high performance.* The study results have shown the positive effect of participative management to clinic, agency, and program performance. The management system exhibited by the high performing clinics which tended toward System 4 encourages the cultivation and sustenance of participative management in the program. It is therefore urged that sincere and conscious efforts to effect complete transformation of all the managerial subsystems to participative management be undertaken so as to achieve system in-

tegrity which will lead to the full positive impact of management intervention in achieving high performance.

(3) *Mobilize program inputs in an effective manner to enhance program performance.* The relevance of program inputs in family planning program performance should not be overlooked and set aside simply because there were very few significant correlations with the performance measures adopted in this study. Program inputs provide the raw materials with which the management conversion process starts with in order to produce program output. The study brought out the fact that the existing inputs do not have a direct linear influence on performance by themselves, but depend, to a considerable extent, on the manner by which they are processed, mobilized, and managed.

The indication is for the program to find more effective alternative means of utilization and management so that optimum results are obtained. The adequacies of logistics and deficiencies of the delivery systems coupled with a breakdown in organizational contacts have been shown to contribute to low performance. The allocation and delivery systems for program inputs need to be restudied in the light of numerous changes in the family planning program components and strategies. The resource make-up and management of program inputs should be made to fit the changes which have occurred in the process of program development and implementation.

More important, officials at central and regional levels should visit more often and make personal contacts with operating program workers at provincial and municipal levels. Such closer contacts could serve to motivate the clinic management toward more effective resource mobilization and use in order to achieve high performance. It is also imperative that the program foster and develop those characteristics in material and staff inputs which fit into the cultural norms and values of the acceptors.

(4) *Review and restudy program incentives for both family planning workers and acceptors.* Monetary incentives to family planning workers could "demotivate" since they were viewed to be "inadequate." If the program should continue the monetary incentives, they should be increased to make them work in motivating the workers. The program should provide a non-material incentive scheme through increased participation in the management process and recognition for their contribution to output. Recognition could be effected through frequent contacts by higher program officials, both on substantive matters and on a person-to-person basis with lower-level program personnel to eliminate the feeling of isolation and detachment and to provide a feeling of belonging and importance to the program so that full commitment and high level performance could be elicited. The non-material incentive scheme could also operate as a motivational system which may be longer lasting and effective as compared to a low monetary incentive arrangement which becomes counter-productive in long-run.

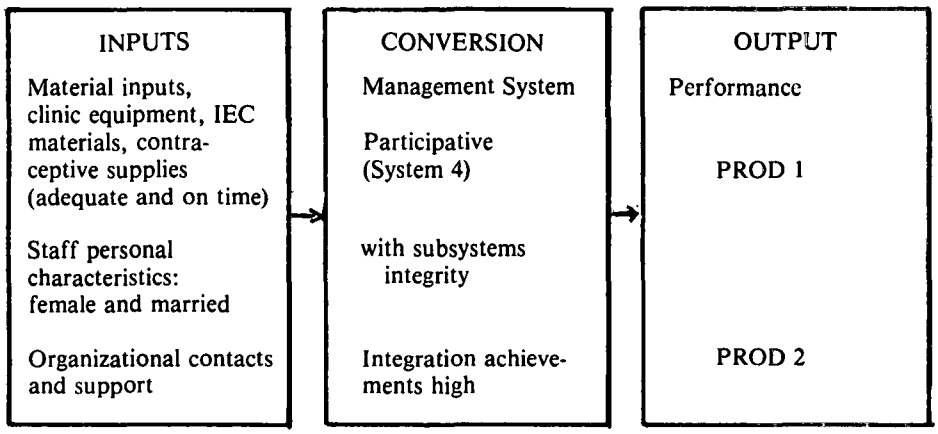
An incentive scheme which is based on community and couple self-reliance orientation is proposed for the target population. The scheme is designed to integrate family planning consideration as a part of community life and welfare. It is our contention that free family planning services and commodities provided by the government program should not be perpetuated.

To be fully appreciated and valued, a gradual shift of the costs of acceptance and continuation (services and supplies) be initiated with the ultimate aim of in-

tegrating family planning into community activity until such time as it becomes internalized as a component of the socio-economic fabric of community and family life welfare.

and felt by the clinic workers will provide them with program identification and close personal communication and interrelationship which are necessary for coordination.

Figure 1. Proposed Resource-Management Model of Performance




*Proposed Resource-Management of Performance*

Based on the study findings, the resource-management model shown in Fig. 1 is proposed.

Material inputs are necessary resources to enable the program to enlist acceptors. These resources, however, should be in adequate amounts and on time to meet the demands. It was shown by the high performing clinics that they were productive because they resort to innovative measures to ensure that these inputs are available to effectively perform roles and functions.

Organizational contacts and support should be substantive and should permeate the program organization. Such substantive and pervasive contacts and support which are positively perceived

Emphasis is placed on the management characteristics which are in the process of transformation into the participative management system. The participative management system in the model, as borne out by the study, is a critical intervening variable in the input-output conversion process. The model also includes a high achievement level of integration, which can be gained through closer interpersonal and horizontal coordination at the program, agency, and role levels, as a contributory factor to performance. The extent of integration at these levels, if high, may erode systematic conflicts, thus enabling the system to move with unity of efforts and objectives.

*Research Areas Indicated*

(1) *Expand the study on the participative*

*management system for large coverage to establish its influence on program performance.* This follow-up study is in order in the light of recent developments in the program since 1976 to the present. These developments include among others: changes in population policy; increased POPCOM Board membership to include the Departments (now Ministries) of Local Government and Labor and Employment; program changes like the total integrated development approach and the national family planning outreach program; and the change in the executive directorship of POPCOM.

(2) *Undertake quantitative and qualitative study on integration of family planning.* The policy of integration continues to be basic to the Philippine program despite the various and rapid changes experienced by the program. A quantitative measurement of the level of integration and a more refined qualitative study will be very useful in understanding the influence of integration on performance as the structural and behavioral components and characteristics of the integration process are brought to light. The results of such a study will be a very useful input to program administration in the future.

(3) *Conduct an in-depth study on staff inputs and performance.* The present study showed that high clinic density contributed to low performance. A follow-up study should focus on the following questions: At what clinic personnel density does performance peak? What is the number of clinic personnel which sets in marginal performance? What are the dimensions of the role behavior of clinic personnel which are contributory to performance?

This study anticipates to have contributed in a small way to a better understanding of the structure and process of program administration, and the various factors, both organizational and environmental, which play vital roles in attaining success in family planning programs.