



**USAID**  
FROM THE AMERICAN PEOPLE



# HUMAN RESOURCE PERFORMANCE MANAGEMENT

## DESK REVIEW

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

**SEPTEMBER 2010**

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I, USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

## **AIDS Support and Technical Assistance Resources Project**

The AIDS Support and Technical Assistance Resources (AIDSTAR-One) project is funded by the U.S. Agency for International Development under contract no. GHH-I-00-07-00059-00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in PEPFAR non-focus countries in knowledge management, technical leadership, program sustainability, strategic planning and program implementation support.

### Recommended Citation

Smith, Tamara. 2010. *Human Resource Performance Management, Desk Review*. Arlington, Va.: USAID | AIDSTAR-One Project, Task Order 1, 2010.

### **AIDSTAR-One**

John Snow, Inc.  
1616 Fort Myer Drive, 11th Floor  
Arlington, VA 22209 USA  
Phone: 703-528-7474  
Fax: 703-528-7480  
E-mail: [aidstarone-info@jsi.com](mailto:aidstarone-info@jsi.com)  
Internet: [aidstar-one.com](http://aidstar-one.com)

# HUMAN RESOURCE PERFORMANCE MANAGEMENT

Human resource performance management interventions are frequently used as a means to improve health worker performance. In general, the most commonly cited human resource management (HRM) intervention is continuing education (CE) and/or training, but other interventions include supervision, payment of incentives, and quality improvement. High-quality evaluations of these practices were surprisingly hard to find.

A review of 48 studies (Dieleman and Harnmeijer 2006) addressing HRM interventions to improve health worker performance found that HRM interventions can improve health workers' performance, but that different contexts produce different outcomes.

“Critical implementation aspects were involvement of local authorities, communities and management; adaptation to the local situation; and active involvement of local staff to identify and implement solutions to problems. Mechanisms that triggered change were increased knowledge and skills, feeling obliged to change, and health workers' motivation. Mechanisms to contribute to motivation were health workers' awareness of local problems and staff empowerment, gaining acceptance of new information and creating a sense of belonging and respect” (Dieleman, Gerretsen, and van der Wilt 2009).

According to this review, factors most important in successful HRM interventions were the following:

- Combined interventions of participatory, interactive training, job aids, and strengthening health systems
- CE was effective in the short-term and improved the performance of untrained providers, but sustained change must also address health systems and community issues
- Quality improvement by local teams, and payment combined with additional interventions such as organizational change and improved performance
- Training to identify problems, develop local solutions, and/or improve communication is not likely to be effective when local conditions are not addressed.

This “realist” review of HRM interventions, which examined contextual factors that contribute to or hinder success, showed that supervision, as evaluated in a randomized clinical trial and a case control study in public institutions, appeared to be the most effective intervention: it improved adherence to stock management and standard treatment guidelines between 14 and 47 percent (Dieleman, Gerretsen, and van der Wilt 2009). Payment of staff incentives via community cost-sharing, revolving drug fund fees, and user fee introduction was found in four quasi-experimental studies to

improve job satisfaction, staff motivation, and patient satisfaction. However, these changes were also related to the implementation of other enabling factors (like training in accounting) and the absence of negative factors (like lack of regular funding for salaries). Overall, CE improved performance of certain tasks in the short-term. Improvement of health worker performance following CE was thought to be triggered by three mechanisms: improved knowledge and skills, critical awareness on functioning of health services, and being empowered to implement change. However, to sustain change, additional interventions addressing health systems or community issues were required.

A *Lancet* review from 2005 highlighted similar conclusions: 1) dissemination of written guidelines without additional interventions was generally ineffective; 2) supervision and audit with feedback was generally quite effective; and 3) nontraditional training methods such as computer-based training might be less expensive than and as effective as traditional methods (Rowe et al. 2005).

In a review article on lessons learned on strategic management of the health care work force, the author highlights one way of thinking about how to boost work force performance: what the work force “can do” (what skills and training enables people to do) and what the work force “will do” (feels motivated to do; Fritzen 2007). While medical managers are often educated in specialized clinical knowledge, the key skills in their job require “higher-order analysis, supervision and inspection, coordination across multiple actors (including both local authorities and communities) and a range of managerial tasks” (Fritzen 2007). “Can do” interventions, such as training, are easier and less costly than “will do” interventions, such as supervision, professional regulation, and infrastructure development.

On the “will do” side, the author emphasizes that the literature reflects a broad range of factors that influence worker motivation, including overt factors like terms of service and supervision, as well as covert or “shadow” factors, like professional norms and the availability of alternative livelihoods. On both “can do” and “will do” measures, the institutional environments in which many health workers work can be more disabling than enabling:

“Workers may feel they have little to gain from working hard or being responsive to either their clients or superiors. Poor career paths and promotion opportunities lead to health workers feeling ‘stuck,’ while official salaries often cover only part of a worker’s needs or overall income. . . . Part of the reason performance management is rare in public services in developing countries is that ‘its prerequisites (such as a living wage for health workers, and the availability to them of drugs, equipment and transport) are often missing.’ When the health sector is severely under resourced it is difficult to hold people accountable for how they do their jobs. Also, workers often feel disempowered by the narrow range of authority they are granted in conducting their jobs and by their lack of consultation regarding major reform efforts affecting their jobs. Even in systems undergoing significant administrative decentralization, there is often a disjunction between formal responsibilities and requisite resources to meet minimum specified standards—a classic recipe for work force frustration and for the failure of decentralization reforms” (Fritzen 2007).

Despite these barriers, high-performing individuals and facilities share the following characteristics:

- A strong sense of mission and sense of commitment to that mission by staff.
- A relatively high level of prestige and social status accorded to those who work in the organization.
- A culture oriented toward results both individually and organizationally. All members of the group are evaluated against performance objectives regularly and are expected, both by managers

and by co-workers, to pull their weight; and the organization itself constantly evaluates its performance against external objectives and benchmarks.

- Lines of feedback from the end users of services are open and actively used to improve service delivery.

## **SUMMARY**

A summary of key points is as follows:

- Supervision has the strongest data supporting its effectiveness.
- Mechanisms that triggered performance change were increased knowledge and skills, feeling obliged to change, and health workers' motivation.
- Efforts to change what workers "can do" are often ineffective without efforts to change what workers "will do."
- CE and training, while effective in the short-term to improve performance of select tasks, is not effective in the long-term in the absence of change in other performance systems.

# REFERENCES

- Dieleman, M., B. Gerretsen, and G. J. van der Wilt. 2009. Human Resource Management Interventions to Improve Health Workers' Performance in Low and Middle Income Countries: A Realist Review. *Health Research Policy and Systems* 7:7.
- Dieleman, M., and J. W. Harnmeijer. 2006. *Improving Health Worker Performance: In Search of Promising Practices*. Geneva: World Health Organization.
- Fritzen, S. A. 2007. Strategic Management of the Health Workforce in Developing Countries: What Have We Learned? *Human Resources for Health* 5:4.
- Rowe, A. K., D. de Savigny, C. F. Lanata, and C. G. Victoria. 2005. How Can We Achieve and Maintain High-quality Performance of Health Workers in Low-resource Settings? *The Lancet* 366(9497):1026–35.