

# Refining Performance Improvement Tools and Methods: Lessons and Challenges



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**P**erformance improvement methods and tools have proven effective and are now widely used throughout the Americas, Europe, and parts of Asia. In the last five years, there has been increased interest and experience in applying these same approaches to health services work in low-resource settings around the globe. Recognizing that successful performance improvement processes require adaptation and tailoring in any given situation, interesting patterns of challenges and opportunities particular to health service delivery in low-resource settings are beginning to emerge. This article captures some of the knowledge gained through a growing body of field experience; in particular, it highlights a handful of tools and discusses existing challenges and opportunities for applying performance improvement methodologies in low-resource settings.

The nature of public health service delivery in these settings predetermines to a certain extent which tools and methodologies get used. Current trends reflect the underlying principles of performance

improvement and have facilitated its introduction. For instance, the growing practices of integration and intersectoral collaboration have reinforced expectations that a broader range of stakeholders will be involved in decisionmaking and planning processes. Increasingly, clients—in this case patients, their families, and their communities—are seen as consumers with rights to quality service, and there is a desire to engage them in efforts to improve the quality of health care. Decentralization of administrative and financial authority for service delivery provides an environment in which health providers and program managers may be held accountable by the local authorities, who determine how much money gets allocated to the health sector.

While these trends have provided fertile ground for the introduction of performance improvement, other trends present particular challenges. For example, the majority of organizations providing health services are part of the public or not-for-profit sectors. Their mandate is to serve large numbers of economically disadvantaged people—at a time when

there is great competition for government funds. Health organizations in these settings can rarely afford dedicated staff with sufficient time and technical performance improvement expertise. Information technology that facilitates collection, analysis, and sharing of data is a luxury inaccessible by most staff. Existing norms around use of performance data (for example, explicit documentation of objectives and related performance) are fueled by fear in the face of a tradition of hierarchical—and sometime paternalistic—management models. Finally, human resource practices are relatively inflexible and limited in their ability to enable hiring and motivational practices that recognize individual capacity and job performance.

Experience to date shows not only that performance improvement has begun to make important contributions to improving the quality of service delivery in low-resource settings, but also that these experiences may contribute back to the larger field of performance improvement.

### **Tools and Methodology: Examples From Practice**

The performance improvement framework developed by USAID's Performance Improvement Consultative Group is one of the most powerful and commonly used tools to date. This simple graphic framework (see page 6) has proved essential for facilitating communication from the introduction of a performance improvement process through its actual implementation. By framing the process in its most elemental terms, the framework provides a common roadmap that is easily understood by all stakeholders, thus enabling their participation in the development of a local performance improvement process.

The qualities of adaptability and stakeholder participation are the hallmark of the performance improvement framework, and they are reflected in many of the best tools for implementing performance improvement interventions in developing countries. Effective tools can be used to find the most practical solution at an affordable cost—despite a limited availability of data to inform decisions. As a result, they are highly participatory in nature. They incorporate unique perspectives and they challenge practitioners to probe familiar models further. Working in resource-poor settings poses many challenges, yet each challenge can also be viewed as an opportunity for innovation and original thinking.

In our work in developing country settings, we began using tools familiar to performance improvement practitioners around the world. For example, many practitioners have found the “Why-Why-Why” decision tree useful in facilitating root cause analysis. The following example describes this methodology and demonstrates how it has been used. The highlight of this approach is that it has proven successful in getting stakeholders to look beyond the obvious lack

of financial resources to identify true root causes for performance gaps.

### **“Why-Why-Why” Decision Tree for Root Cause Analysis**

The global PRIME II project aims to improve the performance of primary health care providers in the area of reproductive health and family planning. In Ghana, the project staff used the “Why-Why-Why” Decision Tree with supervisors of a safe motherhood program. In this instance, the performance gap was that supervisors were not conducting supervision visits.

Many supervisors' reason for the performance gap was a lack of funds for conducting visits. When challenged further, the supervisors admitted that the ultimate root cause probably was not lack of funds. Through additional probing using this technique, the supervisors determined the real problem: They did not know how to access the funds available to them, because they had never been trained in writing proposals for accessing the funds. Continuing inquiry and asking “why” forces stakeholders to discover root causes.

In Honduras, managers also said supervision was not occurring because of lack of money for transport and access to vehicles. The managers' initial solutions were to focus on ways to generate money for transport and to buy more vehicles. After continuing to ask why, and being encouraged to look beyond issues of money, many supervisors ultimately recognized the root cause to be poor planning of supervisory trips. Because the field supervisors did not plan together, often a project vehicle would leave with only one person. As a result, the others could not make trips that day because there was no car. The supervisors saw that if they organized and found out who was going when and where, they could go together—dropping people off on the way and picking them up on the way back. Now many supervisors conduct visits sharing vehicles.

One of the great difficulties of implementing performance improvement methods in developing countries is the lack of data on which to base decisions or corroborate conclusions. It is not uncommon to work in situations that lack any sort of management information system. And where such systems exist, the data collected are not always relevant to the performance factors. As a result, projects frequently need to develop their own data-collection systems to identify performance gaps and root causes and to evaluate progress later. The process of obtaining this data can be time consuming, challenging, and expensive. Fortunately, models now exist for others to use.

### **The Performance Factors Questionnaire**

The PRIME II project first created the Performance Factors Questionnaire (PFQ) in 2000 to use in conducting a performance needs assessment of health care facilities in Honduras. The objective of the PFQ was to obtain quantifiable data

about the presence, absence, and characteristics of the performance factors as perceived by health care providers.

The questionnaire contains 76 questions on six performance factors (job expectations, motivation and incentives, feedback, organizational support, environment and equipment, and knowledge and skills), plus three sections to identify the facility, the provider, and the services offered. The questionnaire is used to interview providers about the factors facilitating and/or hindering their performances. Although most questions are structured for yes or no answers, several are open ended to allow the provider to add comments and clarifications. The PFQ can be applied on its own, although it is most often used in combination with other data gathered through such means as observing actual performance of service delivery tasks.

The PFQ has been applied in a number of countries, including Ghana, Bangladesh, Armenia, and Nigeria; shortly it will be applied in Bolivia and South Africa. A shortened version of this questionnaire will become part of the standard instruments used as part of project evaluations and could also be adapted for use during a needs assessment.

Performance improvement activities in developing countries occur at all levels, from cadres of providers to overall organizational performance. Many organizations in this setting confront situations in which the most basic resources are truly scarce. Those organizations with responsive management structures are more resilient in such an environment. The following tool looks at performance in the context of organizational management.

## **MOST**

The Management and Organizational Sustainability Tool (MOST) is a participatory self-assessment process that guides an organization to conduct a management assessment and develop a plan to make organizationwide improvements. MOST was developed by Management Sciences for Health of Boston.

MOST is applied in a three- to four-day facilitated workshop in which a cross-section of staff and other key stakeholders participate. The tool uses a management development framework that describes four stages of organizational development, from an emergent to a more mature stage. The organization analyzes performance in four management areas (mission, strategy, structure, and systems) and, within these areas, 13 management components (for example, planning, management of human resources, finance and revenue, logistics, quality assurance, etc.) using objective evidence on the status each component's development. Consensus on strengths and areas for improvement is achieved and a plan of action is prepared based on this data.

MOST addresses two levels of performance: organization and systems/processes. It involves all stages of the performance improvement process:

- Assessing the organizational context
- Engaging stakeholders
- Assessing performance needs
- Identifying interventions
- Monitoring

The MOST process and the tool were evaluated in 2002–2003 by Management Sciences for Health facilitators and four non-governmental organization and public-sector institutions in Latin America. The value of the participatory process, definition of management, and key actions for improvement to achieve organizational performance goals were confirmed. Recommendations are informing a revision of MOST.

While some tools described here were developed in response to the unique challenges of resource-poor settings, some projects have successfully adapted tools from modern business or industry settings. A particular example, used by the DELIVER project, designed to provide health commodity logistics support to the health sector in developing countries supported by USAID, is utilized in the reform of large-scale distribution and logistics processes. As the DELIVER project discovered through the use of Process Mapping, the very exercise of describing actual performance can be a powerful guide for redesigning systems to improve performance.

## **Process Mapping**

DELIVER employed process mapping, a technique used in business process re-engineering, to redesign health commodity distribution systems in Ghana, Tanzania, and Malawi. The use of this technique has led to innovative solutions that would not have been possible using other techniques.

Process mapping graphically represents actual performance—the action steps used in reality to accomplish an outcome, as opposed to those reflecting how they are supposed to operate. Up to 90% of local partners' tasks are undocumented. In some instances, the use of the process mapping allowed local partners to reaffirm existing assumptions. In others, it demonstrated that duplication of tasks and unnecessary steps were overly complicating commodity distribution. In all cases, process mapping led to innovative solutions for redesigning the respective distribution systems.

DELIVER's experience with process mapping during the past two years has led to important improvements of this method. The project has refined the techniques and tools used to gather information, produced more specific guidelines for conducting interviews, and developed more systematic procedures for presenting and analyzing information. One

thing that has remained constant is the involvement of local partners at all stages. It is encouraging to note that as process mapping has been applied, local partners have been willing to propose, explore, and accept nontraditional solutions to existing problems.

A good example of this was the elimination of one level of the supply chain in Ghana. Once the redesign team recognized, through the process mapping activity, the benefits of eliminating the district level (including more rational use of resources, faster overall delivery time to the health facilities, cost savings by eliminating reserve stocks of products), the district level elimination was readily adopted as the best way to move forward, despite having been judged “politically unfeasible” at the outset of the redesign activity.

Evidence shows that performance of health workers and service delivery systems is improved with active involvement of the clients and communities they serve (O’Rourke, Howard-Grabman, & Seoane, 1998; Howard-Grabman, Willis, Queierolo, & Perez, 2002). Clients and community contribute through such actions as clearly expressing their needs and expectations, contributing solutions and resources for interventions, and providing feedback. In fact, the better their performance of such functions, the better the quality of services and higher the likelihood that the long-term objective of client satisfaction is achieved (Howard-Grabman et al., 2002). Projects that have applied performance improvement in resource-poor countries have found that simple tools that increase the active role of the client can have substantial impact.

### **Paired Performance: A Method for Providers and Clients**

Good interpersonal communication between providers and their clients is essential for quality health service provision. Improved performance in interpersonal communication requires two people, not one. In fact, evidence shows that improved communication on the part of one of the parties actually serves to improve the performance of the other (Storey & Boulay, 2001; Kim, Kols, Putjuk, Heerey, Rinehart, Elwyn, & Edwards, 2003). Recognizing the need to look at factors that impact both parts of the communication dyad—providers and clients—the Johns Hopkins University Center for Communication Programs recently tested the following approach in Indonesia. It engaged two key stakeholder groups, conducted root cause analyses, and began identification of appropriate interventions.

This method uses indepth interviews, group discussion, and observation. Short indepth interviews are conducted with individual providers and clients. Twelve open-ended questions are asked to elicit individuals’ perspectives on the presence or absence of six performance factors. While staying true to the fundamental elements of human performance technology, terminology used in discussing performance

factors is adapted to be appropriate for providers in their work capacity—as well as their clients. In this context, the six factors are role expectations, performance feedback, physical environment and communication aids, motivation, social and organizational support, and skills and knowledge. At the end of each interview, respondents rank their perception of the influence of each factor had on their ability to communicate effectively in the process of the health consultation.

Analysis of the data produces common themes and trends that are then shared with “peer” groups of providers and clients for validation. When possible, the findings are triangulated with observation and survey data. This is easier for some factors than others (such as the presence of communication aids in physical environment versus social and organizational support). It can be especially informative when positive deviant methodology is used to select interviewees. Positive deviance refers to behavior labeled “superior” as compared to an established behavioral norm and produces positive outcomes (Heckert, 1997). In this specific program context, existing data on performance of desired behavior enabled researchers to identify the “top performers” among the full sample of providers and clients and to compare the factors present for them with those present for average performers. Application of this methodology in Indonesia led to the realization of the importance of family and community in motivating improved performance of both providers and clients and has resulted in the development of innovative interventions.

### **Lessons Learned**

There are a number of lessons learned from this work in applying tools in the field:

- Stakeholder involvement plays a key role in the various performance needs assessment stages. On the plus side, initial evidence from our projects in the field indicate that this kind of involvement increases quality, transparency, and ownership of the process. Because it involves a greater number of stakeholder counterparts during the process, it also enhances the possibilities for sustainability. The downside of wide involvement is that it may mean the performance needs assessment processes take longer and that some of the key, larger stakeholder meetings are more difficult to facilitate. However, experience indicates that the benefits far outweigh the disadvantages.
- An ongoing challenge that future work on performance improvement methods and tools may focus on is *maintaining* effective engagement of a range of stakeholders—on an ongoing basis rather than in stages. In the context of decentralization, the buy-in and support of the community and local government authorities is key in finding locally appropriate solutions and resources to address performance challenges. Improved methods and tools that enable community and local authority

involvement in other stages such as monitoring and evaluation, as well as repetitions of the whole cycle, are necessary to increase the impact and sustainability of performance improvement.

- Performance improvement methods and tools need to be systematized through integration with standard management practices for sustainability. Achieving this requires a level of capacity building and systems building that allow continuity despite relatively high rates of transfer and redeployment of program management and service delivery staff. We need to incorporate this into pre-service training and larger systems to avoid a small-scale, project focus of working.
- Much activity is occurring in the field where performance improvement tools are being used, adapted, and refined. While many lessons are learned in the process, the knowledge gained is largely tacit. An efficient way to share this knowledge is needed. When this happens, it still occurs largely as a result of face-to-face contact, often followed by electronic communication.
- There are many useful tools that have been applied to carry out the various steps in a performance needs assessment. While individual tools have been refined through experience, many people have observed that the performance needs assessment stage of the performance improvement process appears to take too much time. Moreover, as we adapt performance improvement for future use, the perception that a needs assessment is time and resource intensive could cause stakeholders to be cautious about choosing to use the approach.

## Recommendations

Looking to the future, there are certain methodological and tool refinements or developments that will help performance improvement serve clients and stakeholders more effectively in low-resource settings. Perhaps the most urgent need points to two areas: means of conducting rapid needs assessments and improving stakeholder involvement throughout the performance improvement process.

### A Rapid Needs Assessment Toolkit

Most practitioners would agree that the various stages of performance needs assessment are at the heart of performance improvement. Many different kinds of tools have been adapted and developed for use in low-resource health settings. Yet it is also clear that the needs assessment component sometimes requires too much time and too many resources. This can result in a loss of project momentum, dampened enthusiasm, stakeholder impatience, and dwindling or withdrawn funding.

Fortunately, our growing collective level of experience in applying a variety of tools has provided the capacity to develop a more powerful, experience-based toolkit. Besides helping

everyone increase the quality of performance needs assessment work, it might allow us to streamline processes. This toolkit would include a set of tools that we have tested throughout our many performance needs assessment uses, such as:

- An agenda for a performance needs assessment planning meeting (and other stakeholder meetings)
- A sheet of tips to help decide on reasonable sample size
- A streamlined but powerful survey questionnaire
- Ways to collect data in a quick and cost-effective manner
- Criteria for prioritizing among performance factors

### Tools to Assist in Working With Stakeholders

The degree and complexity of stakeholder involvement is one of the major differences between performance improvement work in, say, North America or western Europe and in lower-resource settings. Work with service delivery in low-resource settings is ultimately aimed at the sustainability of solutions and building capacity of local practitioners. This requires that a range of stakeholders be involved throughout the life of a project. The performance improvement model reflects the importance of this. However, there are still a number of challenging questions to answer. For example, how many stakeholders should be involved, and at which point in a project? How do we design meetings to get stakeholder input (which would allow larger participant numbers) as opposed to those aimed at decisionmaking (smaller, key stakeholders) or information sharing? What are some effective tools to help stakeholders focus on root causes? What about simple techniques for prioritizing intervention choices, instead of deciding to do them all?

Practitioners are dealing more or less successfully with these challenges every day in the field. Tools are being used, refined, and adapted by individuals to address these questions. Right now, the knowledge base in the stakeholder area is largely tacit—if a practitioner is asked, he or she might share a revised tool or approach. But this knowledge is not widely available. We recommend that efforts be made to collect tools systematically to involve stakeholders. This could ultimately be a series of approaches and job aids that help all practitioners, and would especially increase the likelihood of building local capacity.

### Simpler, More Cost Effective, Faster...

Whatever progress is made in developing tools, continued emphasis needs to be placed on finding ways to do things simpler, faster, and with greater cost-effectiveness. While it was necessary initially to be deliberate and to allocate adequate funding to test out, adapt, and develop performance improvement methodology in low-resource settings, we now must refine the tools so they can practically and effectively add value to improving client services. Some of these early tools were elaborated and required extensive time and

resources to use. Now we need to streamline them or to document the way they are already being streamlined in practice.

In addition to documentation, there is a need for an energetic dissemination effort now and on a sustained basis. This will be a challenge, as it requires busy practitioners to take time to document effective tools *and* it means other practitioners need to make the effort to *look* for the latest and best tools. Finally, a simple mechanism for accessing a library or database of tools that allows easy submission and retrieval is critical and will undoubtedly require a dedicated resource.

## Achieving Substantial Gains

In a fast-paced work environment where the individual benefit for documenting tools may not stand up to the pressures to move on to the next task, knowledge sharing will remain a challenge. Yet it is so important to undertake; the greater use of performance improvement and powerful performance improvement tools offer the possibility of achieving substantial gains in the quality and access of health services in low-resource settings. 🏠

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