

8 Improving motivation and performance among frontline healthcare workers in rural India

The role of team-based goals and incentives

Rustin D. Meyer, Ruth Kanfer and Carla Burrus

One of the most robust findings in all of industrial-organizational (I-O) psychology is that, when enacted properly, goal setting improves performance. This simple idea is supported by decades of theory and thousands of empirical articles covering diverse work settings, cultures, and outcomes (Locke & Latham, 2002). Despite the validity of this general claim, however, few studies have examined the effects of goal setting in underdeveloped societies. Further, the effects of team-based goals are less well understood than the effects of goals on individuals (DeMatteo, Eby, & Sundstrom, 1998). The present chapter represents the intersection of these ideas by describing how a team-based goals and incentives (TBGI) program was used in remote areas of the Indian state of Bihar to improve the motivation and performance of three types of Frontline Healthcare Workers (FLWs) as they worked to reduce child mortality rates (MDG4) and improve maternal health (MDG5).¹

Project background

The Ananya Program

The TBGI project is one part of a larger intervention in Bihar known as the “Ananya Program” (*Ananya* is a Sanskrit word meaning “unlike the others”), which is sponsored by the Bill & Melinda Gates Foundation. The Gates Foundation (along with other organizations including the United Kingdom’s Department for International Development [DFID] and the United Nations Children’s Fund [UNICEF]) made a large financial investment in Bihar for at least two primary reasons. First, Bihar is one of India’s most populated states (with more than 100 million people), as well as one of its poorest and least developed. For example, Bihar has the highest gender disparity index score (which quantifies gender-based differences in access to education) of any Indian state (GDIGE Report, 2009), has a female literacy rate of less than 33% (censusindia.gov), and only 34% of women report receiving any antenatal care (Singh, Kishor, & Singh, 2008). Second, in 2005, the Rashtriya Janata Dal political party, which had held a majority in Bihar state politics for 15 years, was voted out of power and replaced by the Janata Dal

(United) Party, headed by a reformist Chief Minister named Nitish Kumar. Kumar ran on a platform of reducing crime, increasing security, and improving access to basic services. As such, Kumar's government represented a profound sea change focused on transparency and socially minded populism.

The Gates Foundation presumably saw this change as an opportunity to help facilitate grassroots improvements via an influx of capital and expertise. The Cooperative for Relief and Assistance Everywhere (CARE) was selected to help facilitate these efforts given their emphasis on poverty reduction, improving health access, and a general focus on women's empowerment. It is through CARE that the present authors became involved in the TBGI project. Before describing how our I-O psychology expertise was used to inform this project and its connections to the MDGs, however, it is first important to provide some context about the role of FLWs in the communities in which they live.

Frontline healthcare workers (FLWs)

In general, healthcare services in Bihar are provided through two pathways. The first is a network of feeder hospitals that vary in size and the level of services provided. As shown in Figure 8.1, Primary Health Centers are the most numerous facilities and each serves roughly 30,000–100,000 people; Community Health

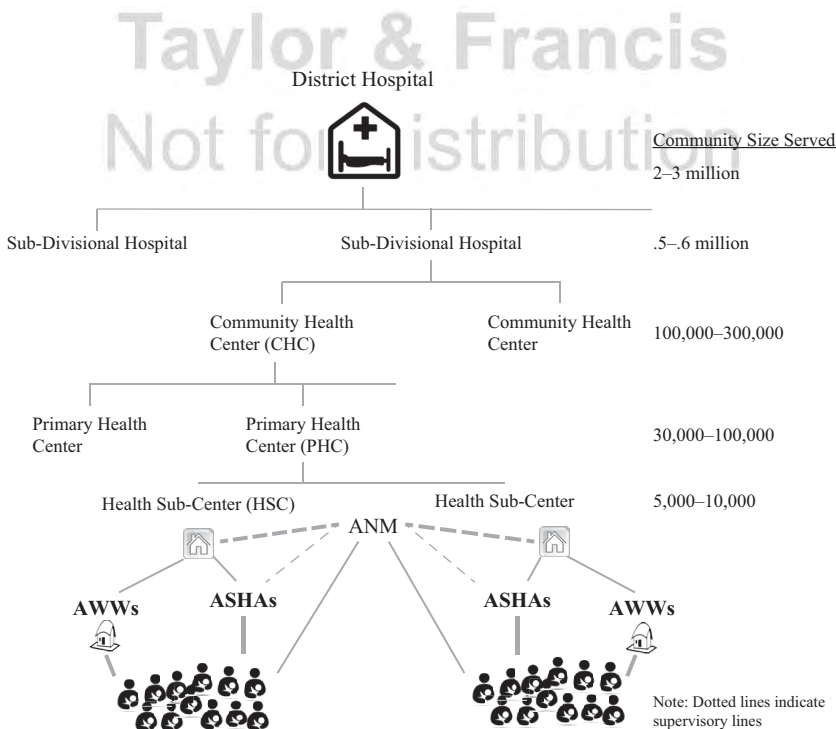


Figure 8.1 Community Healthcare Services Flow in Bihar, India.

Centers serve populations of 100,000–300,000; Sub-Divisional Hospitals serve populations of 500,000–600,000; and District Hospitals serve populations of 2–3 million.

Although this network of hospitals and the people who staff them play a critical role in the provision of healthcare services in India, most day-to-day delivery of care and information to pregnant women and their children is provided by FLWs, who are all female and live in the communities they serve. As shown in the lower half of Figure 8.1, FLWs are organized into Health Sub-Centers (HSCs), each of which serves a single community (between 5,000 and 10,000 people). Three types of FLWs operate out of these HSCs: Anganwadi Workers, Accredited Social Health Activists, and Auxiliary Nurse Midwives.

First, *Anganwadi Workers* are trained (but unpaid) members of the Integrated Child Development Services branch of the Indian Health Bureaucracy. Historically, Anganwadi Workers have focused on providing (a) informal preschool education to village children and (b) supplementary nutrition (i.e., rations) to children and lactating mothers. Anganwadi Workers operate out of facilities called Anganwadi Centers, where children can come to learn and socialize as desired.

In contrast, *Accredited Social Health Activists* are members of a different branch of the Indian healthcare bureaucracy (i.e., the National Rural Health Mission), and are responsible for communicating directly with expectant and new mothers about modern child delivery and care options. Accredited Social Health Activists are also not paid a salary, but they are provided with incentives from the National Rural Health Mission for engaging in a variety of health-related activities with women in their communities (e.g., registering pregnant women, creating a birth preparedness plan with pregnant women, facilitating deliveries in modern health facilities).

Finally, *Auxiliary Nurse Midwives* are also members of the National Rural Health Mission and serve multiple roles in HSCs. First, Auxiliary Nurse Midwives typically oversee five to six HSCs and supervise the Accredited Social Health Activists therein. In addition to their supervisory duties, Auxiliary Nurse Midwives are also responsible for providing direct healthcare services to community members, including immunizations, antenatal care, and other family health counseling services. Auxiliary Nurse Midwives are paid a salary and may live many miles from a given village or HSC under their supervision due to the large geographic area they cover.

Health sub-center (HSC) meetings

Although these three cadres of FLWs have existed as key healthcare providers in India for generations, the fact that they are members of two different parts of the Indian healthcare system has heretofore prevented them from viewing themselves as a team. Recognizing the potential benefit of meetings between the three cadres, FLWs were instructed in the 1970s to hold monthly HSC meetings to facilitate discussion of important healthcare delivery issues, problems they were experiencing, and potential solutions.

According to our conversations with FLWs, however, several barriers prevented these meetings from being particularly useful and in many villages they were rarely held. First, although each HSC is ideally a physical building to be used exclusively by FLWs, in practice HSCs were often public spaces shared with other community groups/organizations. Second, because Auxiliary Nurse Midwives do not directly supervise Anganwadi Workers, they often had a difficult time convincing them to attend monthly meetings. Third, FLWs were not provided with the requisite skills training or preparation for participating in monthly meetings, and as a result, meetings were often not well-structured or informative. Fourth, Auxiliary Nurse Midwives also often lacked the technical and interpersonal information necessary to adequately train Anganwadi Workers and Accredited Social Health Activists to better perform their tasks. Finally, because the different FLW cadres were members of different parts of the health bureaucracy, they performed different duties, had different responsibilities, and were on different reward structures. These differences often served to foster a sense of competition rather than cooperation among the cadres, which in turn led FLWs to view HSC meetings as antithetical to each group's primary mission.

The team-based goals and incentives (TBGI) program

The lack of a shared purpose among FLW cadres was recognized by CARE as a major obstacle to the coordinated provision of quality healthcare. Thus, improvements in intergroup relations among the FLWs were viewed as an efficient means of improving maternal- and child-health outcomes. CARE personnel therefore began exploring ways to utilize extrinsic team-level rewards to not only incentivize performance but also to help develop a shared sense of purpose and to improve the regularity and quality of HSC meetings. This line of reasoning led CARE to develop the initial framework for the TBGI program, wherein integrated FLW cadres within each HSC would work together to earn meaningful non-monetary incentives (i.e., household goods) by achieving of a variety of shared outcome-oriented healthcare delivery goals. That is, all members of a given HSC would earn incentives if the HSC in question achieved a targeted level of performance.

It was at this point in the initial development of the TBGI program that CARE sought assistance from the present authors. Specifically, a CARE representative had heard about I-O psychology through a personal connection with one of this chapter's authors and thought that we might have expertise relevant to the TBGI program they were developing. From an intervention design perspective, this timing was ideal because it allowed for the development of a program that drew heavily from evidence-based best practices in work motivation and team building. From a scientific perspective, however, this timing was somewhat problematic because the tools necessary to test the psychological processes underlying the success of the program had to be custom-designed and there was little time for pilot testing. Although the lack of time for scale development is a common problem in this type of research, the difference between the American culture in which the scales were developed and the Indian culture in which the scales were to be

used created a number of conceptual and psychometric challenges. Accordingly, this issue leads us to our first “lesson learned.”

*Lesson Learned #1: **Get involved as early as possible.** HWP has much to contribute to global development efforts from both a practical and scientific perspective. Designing research in cultures different from those in which measures were developed involves negotiation, the development of a shared understanding of the project, and modification of assessment procedures based on a clear understanding of host culture norms and constraints. The earlier I-O psychologists get involved, the more likely the project will reflect our field's best practices.*

Team-based goals

Although the centerpiece of the TBGI program was the provision of team-based non-monetary incentives, it is important to highlight that the intervention as a whole was quite comprehensive and far-reaching in its scope. Specifically, in order to ensure that the team-based incentives could be realistically earned by the HSC team, it was necessary to estimate relevant baseline levels of performance and the various barriers associated with improving upon these levels. First, based upon previous analyses and priorities, the team goal was organized in terms of seven specific public health outcomes for the pregnant mother and her newborn child:

- 1 Establish two explicit transportation plans with each pregnant woman to ensure delivery in a modern health facility – one plan for a normal delivery and another in case of emergency.
- 2 Provide at least 90 Iron Folic Acid (IFA) tablets to women during the final trimester of pregnancy.
- 3 Help new mothers begin breastfeeding within one hour of delivery.
- 4 Implement clean umbilical cord care practices.
- 5 Provide appropriate complementary feeding to children between ages 6 and 11 months.
- 6 Adopt a modern method of post-partum family planning within 6 months of delivery.
- 7 Administer Diphtheria, Pertussis, and Tetanus (DPT3) immunization by 6 months after birth.

These outcomes were incentivized not only for their public health merit, but also because they represent a balance of tasks that a single FLW can accomplish independently and those that require FLW coordination. This latter point is an important one because the present project focused not only on improving the targeted outcomes, but also on developing teams of FLWs that worked together to solve common problems. For each outcome, we applied the principles of goal-setting theory to ensure that difficult but attainable goals were set. However, because

the component outcomes varied in terms of difficulty (e.g., making sure mothers received at least 90 IFA tablets during pregnancy is relatively easy whereas persuading clients to adopt a modern method of post-partum family planning is quite difficult given a host of socio-cultural issues involved), we established an overall team goal that allowed for higher levels of performance in one component goal to compensate for lower levels of performance in another component goal.

A sequential quasi-participative method was then used to arrive at the specific target for each goal component. First, each HSC was assigned quarterly goals by CARE staff for each of the seven components based on previously collected baseline data. The component goals were assigned to the HSC team in order to ensure that they were difficult, but attainable (specifically, goals were set to levels 20% above baseline). In order to earn the non-monetary incentive, a given HSC team had to surpass the stated goal in at least five of the seven components outlined previously. In instances where five or more components of the team goal were attained, *all* members of the HSC were provided the incentive, not just those HSC members who performed particularly well (a feature of the incentives that was insisted upon by the FLWs themselves, likely due to the collectivistic nature of Indian society). If a given HSC team achieved four of the seven component team-level goals, a partial incentive was offered to each HSC team member.

Second, all HSC teams were encouraged (but not required) to set their own informal (i.e., non-incentivized) monthly goals. The purpose of these monthly goals was twofold: to encourage team members to (1) monitor their progress toward the incentivized quarterly goals and (2) discuss their successes and challenges in attaining these informal goals during the monthly team meeting. Additionally, yearly goals were also established based on team accomplishment of successive quarterly goals. The purpose of the yearly goal was to maintain the motivation of those teams that did not meet a particular quarterly goal, thereby encouraging sustained high levels of performance throughout an entire year. In contrast to the non-monetary home-goods provided to HSC team members who met quarterly goals, all HSC team members who met yearly goals received public recognition from community leaders, but no tangible incentive.

Health sub-center (HSC) meetings

In order to ensure that the necessary structure was in place to permit motivated teams of FLWs to attain these goals, it was necessary to re-conceptualize the structure and function of HSC meetings. Although HSCs existed on paper as a place where FLWs could meet on a monthly basis to discuss pertinent issues, only minimal investments had been made in the physical and (more importantly) organizational infrastructure necessary to ensure that meetings would occur in a way that led to practical problem solving. Using recommendations from I-O psychology research on teambuilding and teamwork (e.g., Adler & Borys, 1996; Aubé & Rousseau, 2005; Babcock, Bedard, Charness, Hartman, & Royer, 2012; Cohen & Bailey, 1997; Franco, Bennett, Kanfer, & Stubblebine, 2004; Kirkman & Rosen, 1999), the present authors helped local colleagues craft a monthly

meeting process that would encourage teamwork toward shared goals. Specifically, meetings were structured to achieve three broad goals: (1) develop a sense of team cohesion, (2) establish Auxiliary Nurse Midwives as team leaders, and (3) report on/facilitate progress toward target attainment. The specific activities used to achieve each of these goals are as follows, with key components described in greater detail in subsequent paragraphs:

- Recitation of the HSC pledge
- Review progress toward the previous month's informal target goals
- Review quarterly goals and progress toward them
- Set targets for the next month
- Yearly target goal reminder and progress review
- Standard meeting/educational activities

The first component added to these meetings was the “HSC Pledge” – a written statement that the HSC team could recite together at the beginning of each meeting. Because many FLWs are illiterate, most HSC teams use a call and response format in which the Auxiliary Nurse Midwife reads a line of the pledge and the FLWs repeat her words. This recitation format has the added benefit of establishing the Auxiliary Nurse Midwife as someone of particular importance and authority. Specifically, the HSC Pledge states:

We are vital members of our Health Sub-Center Team. We pledge to uphold our HSC Code, thereby improving the health and well-being of our entire community, irrespective of caste, religion, or geographic distance. Achieving this mission will require hard work, cooperation, and a shared willingness to help our Sub-Center sisters at all costs. By achieving this mission, we provide a valuable service to the Nation of India, the State of Bihar, our communities, our team, our families, and ourselves. We also pledge we will work with dedication and will not breach the faith of community. We will make every effort to provide services to all the beneficiaries of the community and achieve at least the given target.

Consistent with the concept of team charters, which represent “an agreement among members as to how the team will work as an empowered partnership in making binding decisions and sharing accountability for delivering quality products/services that meet user/customer needs in a timely and cost-efficient way” (Mathieu & Rapp, 2009, p. 92), the HSC pledge was designed to stress the importance of the work the FLWs perform and the need for shared commitment to it (Aubé & Rousseau, 2005). Further, a concerted effort was made to implement concepts that are already key components of Indian society (e.g., community, duty), while also stressing less solidified concepts (e.g., the notion that FLWs are important service providers, the importance of healthcare coverage irrespective of beneficiary caste membership). These efforts, which were intended to develop a sense of “team” (i.e., of shared perspective among interconnected personnel),

appeared to work in that some HSCs started their own rituals when reciting the pledge. For example, during one visit to Bihar, the authors spoke with an HSC team that lights a candle when they say the pledge, which they said makes it feel like they are saying a prayer.

The present authors also recommended that each HSC develop its own unique set of formally adopted norms/expectations in areas such as general performance, event attendance, teamwork/coordination, and integrity. Again, the primary goal of this activity was to encourage FLWs to think and plan as an autonomous team, which is an example of a stage of team development known as “transition processes” (Marks, Mathieu, & Zaccaro, 2001). Teams were informed that the norms they adopted (known as “The HSC Code”) would be printed for them and hung in their HSC meeting space, which each team member would then sign as a continual visual reminder to their commitment. Unfortunately, however, the process of each team developing its own unique set of norms was prohibitively difficult, so a single HSC Code was developed by CARE personnel and given to each HSC team.

The previous two portions of the intervention were designed to help encourage FLWs to adopt specific changes to the way they view their team – namely, to transition from a loose collection of independent actors to a cross-functional unit with interdependent goals and responsibilities (Denison, Hart, & Kahn, 1996). Other changes, however, were put in place to improve the meetings themselves. For example, despite being the most senior members of the HSC teams, Auxiliary Nurse Midwives have traditionally not been viewed as “leaders” in the Indian health bureaucracy because they are (a) female and (b) rather low-level members of the bureaucratic hierarchy. As a consequence, several steps were taken to help begin the process of getting them comfortable with assuming leadership roles. Most importantly, “meeting facilitators” were hired at the onset of the intervention to provide on-the-job training to Auxiliary Nurse Midwives by helping them plan team meetings and to develop leadership skills. These meeting facilitators were typically college-educated and had specialized knowledge in public health. Thus, meeting facilitators served not only as subject matter experts, but also as role models for the Auxiliary Nurse Midwives.

Additionally, several meeting improvements were implemented to help FLWs monitor and remain focused on their goals. First, FLWs were provided with record books to track their monthly activities. Those FLWs who were not able to read and/or write were paired with an FLW who could, in order to complete their monthly record book. FLWs were originally asked to state their progress aloud during the HSC meeting in an effort to increase public accountability. However, this behavior was ultimately rejected by the FLWs because they were uncomfortable with the prospect of stating their monthly accomplishments in front of their fellow FLWs. Instead, the Auxiliary Nurse Midwives compiled the contents of FLWs’ record books, announced whether the informal monthly team goal had been met, and then led a discussion of progress toward the incentivized quarterly goal. At this point, HSC team members were encouraged to discuss their experiences toward goal progress for that month and to share their perspective and

solutions with one another. After discussing these issues, team members were asked to set informal goals for the next month given (a) the present month's progress, (b) foreseeable opportunities/obstacles in the next month, and (c) remaining progress necessary to reach the upcoming quarterly goal.

In summary, the system we helped craft used evidence-based best practices in I-O psychology research on goal setting and team effectiveness. These practices were integrated into the fabric of the community and the HSC structure in ways that were comfortable to the FLWs involved. Developing this integrated motivational system required several trips to India where the authors spent the majority of their time listening to FLWs and learning about existing bureaucratic structures and emerging ideas. Thus, as opposed to attempting to reinvent the wheel, our efforts were guided by the assumption that even minor changes in process have the potential to lead to large changes in outcomes, which brings us to our second lesson learned.

Lesson Learned #2: Understand existing structures as well as the constraints and opportunities that they afford. Wherever possible, focus on improving existing structures – rather than redesigning them – by modifying evidence-based principles to fit the existing circumstances on the ground.

Assessment Challenges. The most detrimental effect of not having been involved in this project from the onset pertained to our inability to help inform the design and, more importantly, the content of the program's assessment procedures. The decision had already been made to assess the TBGI program via a randomized controlled trial in Bihar's Begusarai District (a district is a governmental division one level below a state) but the planned assessment focused solely on public health outcomes and did not include an evaluation of the mediating processes by which team-based goals might accomplish such outcome improvements. Ideally, we would have preferred to collect pre-test team-process data in order to examine the extent to which the TBGI intervention affected these considerations in those HSCs in the intervention group compared to those in the control group. Unfortunately, however, pre-existing timelines did not permit us to do so.

One of the primary reasons why obtaining pre-test data was not possible was because (a) there are essentially no existing measures that have been validated in this unique population and, even more fundamentally, (b) many of the processes we were interested in assessing reflect psychological constructs that may have little relevance for this population. For example, during one of the initial focus groups with FLWs, the authors asked the question "if there was one thing about your job that you would change, what would it be?" We asked this question with the intention of "breaking the ice" – getting the FLWs to begin talking about the ways in which their jobs could be done in a more efficient and/or enjoyable manner, so that we could probe deeper and expand on these themes. After many attempts to translate this question differently, our hosts/interpreters informed us that it had never occurred to the FLWs that they might be able to change the way they work. Thus, what we thought would be a discussion-provoking question that all of the FLWs

would be able to relate to, turned out to pertain to an issue that did not register with the target population. This experience, in turn, caused us to more carefully consider which constructs would be relevant for assessment (e.g., team-efficacy, group decision making, procedural justice) given the cultural norms in this population.

We also learned that the target population is accustomed to thinking in terms of concrete ideas, so abstract/hypothetical questions about work were very difficult for the FLWs to answer. Unfortunately, this cognitive schema not only applies to the content of potential questions, but also to response options. So, for example, it was not possible to use Likert-type rating scales because FLWs prefer to answer in terms of dichotomies (e.g., yes vs. no; all vs. none). To further complicate matters, the hierarchical structure of Indian culture and presence of a strong acquiescence bias us led to not only re-evaluate the process-oriented constructs we wished to measure, but also the tools we would use to do so. The strategy with which we ultimately had the most success involved asking behaviorally anchored questions (e.g., “we discuss potential solutions to problems”) with temporally oriented (e.g., “rarely,” “sometimes,” “often,” “always”) or dichotomous (yes vs. no) response options.



*Lesson Learned #3 – **Be prepared to reinvent your psychometric toolbox.** Because international development initiatives such as the MDGs pertain primarily to efforts in non-Western cultures, I-O psychologists/humanitarian work psychologists should be prepared to critically evaluate the cultural assumptions that often accompany research in Western organizations as well as taking into account local (non-Western) cultural assumptions. This includes exploring the burgeoning literature on tools developed for use in non-Western settings.*

Implications

Connections to Millennium Development Goals (MDGs)

The Gates Foundation places a strong emphasis on using independent program evaluators to (a) ensure that interventions are executed in the intended manner and (b) collect independent outcome data to determine intervention success. As such, the ultimate impact of this program on MDG4 and MDG5 will be quantified in a rigorous manner via data collected by an independent agency. Although specific results have not yet been released to the public, all accounts suggest that the TBGI program is having a robust impact on the seven health outcomes it was intended to improve. This conclusion is consistent with changes we have witnessed regarding the overall effectiveness and cohesion among teams. Indeed, Melinda Gates herself recently highlighted improvements in coordination among FLWs as one of the most tangible changes she has seen occur in the last few years (IBNLive, 2013). Thus, it would appear that HWP is being used to not only improve teamwork among FLWs, but that improved teamwork is helping to improve local progress toward achieving MDG4 and MDG5.

AuQ2

The potential for advances in I-O/HWP research

In addition to the exciting prospect of applying one's craft to improve the lives of underserved populations, we suggest that HWP in general, and its role in progress toward implementing the MDGs specifically, also provides a unique opportunity for I-O psychologists/humanitarian work psychologists to contribute to our scientific understanding of organizations in the following novel ways.

First, although the populations in the development arena that HWP is primarily interested in helping are unique in several important ways, they are nonetheless employees and members of organizations. As such, the conclusions drawn on the basis of their experiences have the potential to contribute to the general I-O knowledge base. Whereas all but one of the MDGs were purely outcome-oriented (the exception being MDG8, aimed at developing a global partnership for development), the projects designed to address them oftentimes create natural laboratories for I-O/HWP researchers to more carefully examine the processes underlying progress toward these outcomes.

It is in this distinction between outcomes and processes that we believe one of HWP's main opportunities for a contribution to global development efforts exists. We would argue that our field's ability to understand the behavioral and coordinative processes through which various constructs affect various outcomes is a characteristic we often undervalue in ourselves. Specifically, evidence-driven answers to the questions of "Why?" and "Under what conditions?" put HWP in a position to ensure that organizationally-based interventions that are successful in one area/region/culture can be understood and potentially modified in a way that will increase the probability that they will be successful in other areas/regions/cultures. Fortunately, such a focus is a natural part of I-O psychology/HWP, but is less common among those with a background in public health. As such, we see this emphasis on process as an area where I-O psychologists/humanitarian work psychologists are particularly likely to add value.

*Lesson Learned #4: **Think and communicate in terms of processes, not just outcomes.** Development organizations often focus on the latter, but perhaps this focus is due to a lack of exposure to process-based thinking/research and its critical importance for creating generalizable organizational solutions.*

Second, international development projects often tend to be large-scale field studies, thereby creating opportunities for I-O/HWP researchers to conduct intervention-based research, which has traditionally made up only a small portion of the I-O literature. In the case of the present efforts, the original pilot test of the TBGI program was a randomized controlled trial across an entire district with hundreds of FLWs. And, although we were not ultimately in a position to test the process-based model we wanted to test, the TBGI's success led to the decision to roll it out to another 10 districts, thereby creating the possibility that we can test our process model during the rollout. Thus, the large-scale interventions like those that often characterized MDG-oriented projects have the potential to create I-O/

HWP intervention research on a scale unlike what the field has traditionally seen, which leads us to our fifth lesson learned:

*Lesson Learned #5: **Think big.** The MDGs represent large-scale changes. As such, the efforts that go into developing interventions to address them and the research to test them will require a scope greater than what I-O typically experiences. Although this scope surely presents many challenges, it also creates many opportunities to draw scientifically valid inferences and craft interventions that substantively improve people's lives.*

Advice for I-O psychologists/humanitarian work psychologists interested in international development projects

We hope the present chapter (as well as the others contained in this volume) suggests that the MDGs represent not only important progress for the global community, but also an opportunity for HWP to play a valuable role in global development efforts and to contribute to the greater knowledge base of I-O psychology/HWP. In our experience with the TBGI program, there have been numerous occasions when we have received a very positive reaction from those in the broader development community after explaining HWP, I-O psychology, and our perspective and areas of expertise. Further, of the seven projects involved in the Ananya program, initial results suggest that the TBGI program is not only having strong effects, but is also having these effects based on a relatively small monetary investment. As such, we believe the next decade represents a critical time for the growth and recognition of HWP.

In this regard, we suggest that I-O/HWP researchers interested in becoming involved in development work generally (such as the forthcoming Sustainable Development Goals [SDGs]) contact development organizations in their area and offer to give a talk about I-O psychology/HWP and the ways it can be used to help further development efforts. Within the US, we have found that Guidestar (<http://www.guidestar.org>) is a useful way to search and sort by location, mission, size, and reputation. The results of a Guidestar search can then be used to find relevant contacts on potentially relevant organizations' webpages. To the extent that I-O psychology/HWP is successfully able to build bridges to development organizations, we believe positive outcomes will occur for our field's knowledge base, the operations of development organizations themselves, and (most importantly) the health and well-being of the billions of people whose lives are positively affected by progress on international development initiatives like the MDGs.

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Note

- 1 It is important to note that we do not exhaustively describe the TBGI project in this chapter because future CARE publications will likely be dedicated to doing so. Instead, we provide only enough detail to enable a specific focus on its I-O/HWP-relevant contributions.

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