

**Factors for mid level provider's motivation: the Malawi health workers and district management perspectives**

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## **Abstract**

### **Background**

Human resource shortage is a major problem facing the Malawian health sector where more than 50% of the population lives in rural areas. Most of the district health services are provided by clinical health officers specially trained to provide services that would normally be provided by fully qualified doctors or specialists. As this cadre and the cadre of enrolled nurses are the mainstay of the Malawian health service at the district level it is important that they are supported and motivated to deliver a good standard of service to the population. This study explores how these cadres are managed and motivated and the impact this has on their performance.

### **Method**

Focus group discussions and key informant interviews were held with health workers, members of district health management teams and human resource officers in the Ministry of Health. The health workers interviewed were selected from a number of different cadres. Motivating and de-motivating factors in the work environment, continuous education, career progression and supervision were amongst the aspects of human resource management that were discussed.

### **Results and discussions**

The results show that health workers are primarily motivated by a sense of duty to provide assistance both to the country and to the community. Continuous education and career progression strategies were considered inadequate. Standard human resource management practices such as performance appraisal, job descriptions were not present in many cases. Health workers feel that they are inadequately supervised with no feedback on performance. Discussions of the results were held with the District and the Ministry to seek means of improving on the existing strategies so as to improve the performance and retention of these cadres of health workers.

### **Conclusion**

Training and distribution of the health workforce that is focused on local conditions to address the human resource issues and improve access to healthcare is necessary and can help to limit workforce attrition

## **Introduction**

It is widely acknowledged that Africa's health workforce is insufficient and will be a major constraint in attaining the Millennium Development Goals (MDGs) for reducing poverty and disease [1]. The World Health Report 2006 has shown that in general, countries with fewer than 2.3 doctors, nurses and midwives per 1000 people fail to achieve an 80% coverage rate of measles immunization, or the presence of skilled birth attendants during childbirth. Fifty-seven countries fall below this minimum threshold, mainly in sub Saharan Africa and Asia. This has a major impact on infant and maternal mortality.

One of the major challenges facing health systems in sub-Saharan Africa is the migration of health staff from rural to urban areas, leaving most of these areas underserved and resulting in inequitable access to health care in these countries [2]. Various African governments have initiated activities and incentives to attract health personnel to these underserved areas though there are no available data to indicate that these incentives have been effective.

The main health services provider in Malawi is the Ministry of Health (MOH), which provides approximately 60% of all services. The Christian Health Association of Malawi (CHAM) is responsible for the provision of about 37% of all services. Other providers include both private-for-profit and private not-for-profit, local government, the military and police health services and small clinics offering care for company employees and their families [3]. The shortage of health workers in Malawi is severe even by African standards, with fewer than 4,000 doctors, nurses and midwives serving a population of approximately 12 million in 2003. There are 156 physicians working in MOH and CHAM. There are 10 districts without an MOH doctor and four districts without any doctor. [4] The average number of nurses in health centers is approximately 1.9, an indication that many are run with one or none at all. 15 of 26 districts have less than 1.5 nurses per facility, and 5 districts have less than 1 [5]. The Human Resource (HR) crisis has created a lack of capacity to deliver health services, especially in rural areas where primary health care is severely compromised. Staffing levels are also inadequate for the planned roll out of anti-retroviral treatment (ART) and other HIV/AIDS related services. Essential Health Package (EHP) scale up has been critically slowed with only 10% of the 617 facilities satisfying the HR requirements for delivering EHP.

In 2005 the Malawi government with support from donors initiated a six year programme, the Emergency Human Resources Programme, to alleviate the human resource crisis in the health sector. The key components are a salary increase for health professionals; measures to enhance the capacity of training institutions; and, in the short term, additional recruitment of expatriate volunteer doctors and nursing tutors [6]. Of the three components, the salary top-up scheme is designed to improve the working conditions for existing staff, and aims to increase retention of health workers in the public service.

Substantial emphasis has been placed on training doctors and nurses as a solution to the human resource crisis in Africa but there are several constraints to training in Africa. Some African countries like Malawi have, as a response to staff shortage and distribution problems, trained certain cadres of health workers to provide services that were originally the preserve of specialists.. The documentation and evaluation of this cadre is quite limited, although those few studies exploring their effectiveness have been positive [7].

These cadres tend to be paid less than fully qualified doctors and nurses. Therefore there are potential economic benefits from their use. However, the

danger is if they are not adequately motivated, they may migrate out of the health sector or seek employment with NGOs and the private sector providers. Hence this study not only examines the motivation of nurses and doctors, but also includes an exploration of the motivating factors for these cadres who receive shorter training and lower salaries.

## **Method**

This exploratory, qualitative study was conducted in the context of a broader human resources for health situational analysis in the districts and was aimed at helping to develop strategies to improve health workers performance and retention in the districts.

Respondents were chosen from the three district hospitals covering the administrative regions in Malawi. Data was collected from the district health facilities in Karonga, Dowa and Thyolo districts. One focus group was held per district each consisting of 7-12 participants and lasting between 1.30 to 2 hours. Different cadres of health staff working in the government district hospitals from enrolled nurse, to staff nurses, to clinical officers were selected to participate in the focus groups. Conscious effort was made to ensure that the groups were balanced in terms of gender and marital status. A pilot revealed no difficulty mixing the different cadres or genders of health workers.

13 Key informant interviews were held, 9 with members of District Health Management teams, and 4 with the Human Resource Department of the Ministry of Health to further explore issues raised by health workers and to describe current human resource policy and practice. Those interviewed included the District Health Officer, District Nursing Officer and Hospital Administrator in each of the districts studied.

The government facilities were chosen because they provide up to 64% of health in the country and have problems retaining health workers, particularly in rural areas. The focus groups were conducted using a prepared focus group guide and the interviews were semi-structured. The analysis of the survey helped inform the contents of both instruments.

The objectives of the study were initially explained to participants and confidentiality assured. They were also asked to maintain confidentiality of discussion and opinions raised by colleagues.

Two research team members conducted the discussion which explored perceptions of what motivates or de-motivates these cadres of health worker to work in the public sector. Specific issues surrounding continuous education and in-service training, performance management: supervision/staff appraisal/job

description, work condition, deployment/transfers and retention factors were also discussed. Participants were also asked to identify what action the government might take to retain district staff in their posts.

The FGDs and interviews were tape recorded and transcribed.. A thematic analysis was conducted to identify the key themes arising focusing on issues that were mentioned frequently, received particular emphasis or on issues where there were very divergent views. .

## **Results**

All those that participated in the FGD were permanent staff in full time employment and had worked in the public sector for at least 5 years. Minor differences were observed between the various cadres in terms of their opinions on career development and continuing education. There were no differences between the views of men and women and marital status did not seem to affect their views.

One of the major motivating factors for respondents is the opportunity and ability to assist mankind coupled with a spirit of patriotism. They are specifically motivated to remain in the districts because of the cheaper cost of living, the significant impact they make within the communities they serve and the fact that they learn faster on their jobs in the districts compared to their other colleagues in the urban areas. They explained that the limited number of medical officers within the districts means that they handle difficult and complicated challenges that their colleagues in the urban centers are not allowed to handle. One major de-motivating factor mentioned by all cadres of health workers was monetary. Other de-motivating factors mentioned are lack of proper assistance from the MOH and poor human resource management practices including lack of supervision and continuous education.

Most of the managers believe that health workers are motivated to take up careers in the health sector as a personal choice they have made, the dignity that goes with the profession, good career prospects and on humanitarian grounds. Most perceived health workers working in their facilities to be moderately motivated. They perceived their motivation to be due to a better salary compared to their colleagues in the teaching profession, better chances for professional development, availability of in-service training, better job security than in the private sector, access to loans and good team work. They mentioned lack of supply (equipments and drugs) in the facilities, low salary, lack of promotion or delay in promotion often up to 5 years, high workload, lack of basic amenities like electricity and water and problems with accommodation as major de-motivating factors.

Managers see themselves as having little role to play in motivating health workers as most policies are controlled at the central level. They discussed a

range of policies that they were instituting in their facilities to help motivate staff. These include the introduction of locums, an additional top up of 2000Mk for medical assistants, being responsive to the needs of health workers e.g. advocating for their promotion as well as having a caring attitude, having a clean and orderly working environment, organizing more in-service training, providing staff with uniforms, taking staff from the health centers once a month for shopping (money for shopping is not made available by the districts), providing transport for those in the health centers, giving staff time off as well as providing transport for them to attend funerals of their relatives, availability of equipment (though not adequate sometimes), changes in the procurement procedures within the facilities and the introduction of monetary rewards for the best department each month.

#### Salary/Allowances

The ministry of health in accordance with the Programme of Work increased salaries of health workers (mid-level inclusive) by 52% in 2005. The district health facilities introduced locums where health workers off duty or on holiday are paid between 600-900MK to cover for shortages. The most significant issue that arose for all cadres was salary. They mentioned that their salary is quite poor and does not enable them to meet their individual and family needs. The top-up allowance of 52% did not translate into a 52% increase in take home pay because of the tax structure in the public service. They indicated that actual increase is within the range of 30-35%. A Medical Assistant stated

*“The salary I am paid is too small. I have been a Medical assistant for 11 years and I earn the same salary with school leavers”.*

The locum scheme introduced by the districts was initially seen to be effective but the impact is diminishing as inflation rises. Health workers complained that the money has lost value due to inflation and additional needs. The District Health Management Team especially those in Thyolo mentioned that they are constantly being approached by staff to increase their locum allowances. Increasing these allowances from the management’s point of view is not feasible because of funding constraints.

#### Continuous education/In-service training

Health worker training at the level of certificate, diploma or degree is operated by the MOH. The MOH develops plans for continuous education though these plans are not always fully funded due to budget constraints. Recommendation and selection for training is done by the DHMT and ratified by the MOH. All the managers interviewed in the districts and the MOH agreed that continuous education does not necessarily follow government or health needs but are individually driven. This is captured in a statement made by one of the interviewees in the MOH

*“training needs is on individual basis, it is like you are training and preparing the person for exit from the public sector and the country”.*

The process of selection for continuous education was considered unfair by health workers. They indicated that opportunities are limited and coordination is lacking. Usually one needs to be in service for between 8-10 years before having access to continuous education. The situation is worse for some cadres especially the ophthalmic technicians, medical assistants and clinical officers. It is not the same for Environmental Officers (including assistants) who indicated that they obtain training normally within 5 years. They also mentioned the lack of reward for staff who have gained additional qualifications or training as dissatisfying. An enrolled nurse mentioned that since she completed a diploma more than a year ago, she has not had any promotion or bonus. Another issue that was very frustrating to health workers especially the enrolled nurse is the change in policy by Government to offer diplomas instead of certificates to new sets of graduates. They indicated that new graduates have a better salary and grade on joining the public sector compared to those with certificates who have served for a longer period of time i.e. qualifications are rewarded, but experience is not.

The in-service training which represents training on specific topics to enhance performance is organized within the districts. Training needs are identified by programme managers and proposals are made to the DHMT for approval. Such training is often organized to fill identified gaps in knowledge in providing patient needs and the process of selection is seen as fair and equitable from the managers' perspectives. From the health workers' perspective in-service training improves their job performance but they mentioned that new skills acquired by staff are sometimes not utilized. Favoritism seems also to feature in regards to both continuous education and in-service training. An enrolled nurse stated

*'managers even hide information on training from staff, then they give out the information to the people they like such that sometimes only a set workers are receiving most of the training.'*

#### Career progression

The MOH maintains a career structure which narrows at the top. The ministry advertises for staff promotion based on vacancy and staff are promoted following their performance at the promotion interview with the MOH. Those staff interviewed indicated that the Ministry does not have any form of performance appraisal. Two of them were of the opinion that appraising health workers does not make any significant impact to their performance or to their motivation.

Discussion with health workers suggested limited career progression opportunities. They related this to the absence of a performance appraisal system and a good career structure within the MOH. A medical assistant stated

*"I have been in this position for the past 13 years without promotion or increment. People that went for their diploma after me now earn more*

*salary than I do. I am so frustrated by this that I have considered resigning even to sell something”.*

An Ophthalmic Technician said

*“I have been in this position for the past 11 years, it seems I have been forgotten, the worst of all is that I do not have any opportunity for continuous education”.*

They expressed concern that promotion opportunities are based on educational qualification only and not on performance. One nurse expressed this as

*“Basing promotion on qualification is very wrong, sometimes you have to wait for 10 years to get further education; that means you remain in the same position for about 10-15 years”.*

They expressed their unhappiness with current Government policy of calling staff for promotion interviews very infrequently and then basing promotion solely on the health worker's performance at the promotion interview. Sometimes when staff are promoted they are asked to resume the new post in another area thus forcing people to relocate. They indicated that this relocation is not specified in the advertisements and one is usually only told after being offered the new position. This has resulted in some people having to live without their families or to forfeit the promotion. Health workers complained about the lack of performance appraisals within their facilities, hence there is no positive staff reinforcement and reward.

Supervision and feedback

The DHMT is responsible for supervising staff. Managers interviewed mentioned that they have written standards of performance which do not cover all cadres of health workers. The standards are in the form of a checklist that was made available from the central level. There are no targets or timelines to allow progress to be measured..

During the FGD health workers expressed dissatisfaction on the supervision they receive from the management. A nurse said

*“I need to know when I am being supervised and what will be supervised”.*

In general health workers felt that management and their professional bodies do not give appreciation or recognition for the job they are doing and this demotivates them. This system is not systematic or organized and they would appreciate having standard practices in place. They perceive their professional bodies as not being effective in promoting their interests

*“our association is just consuming our money but not protecting our interest. They are there as watch dogs looking out for mistakes”.*

They also complained of not receiving any feedback from supervisory visits. When this was discussed with management they agreed that supervision received by staff is often inadequate. They are often limited in this task because of the high workload they have. They also expressed their lack of autonomy in creating and following their own supervision standards. One of the DHMT said *“we do supervise but most of the standards need to be updated, some items are missing in the checklist”*. Another said *“we are limited in this task because of our workload. We do not have any way of recognizing good performance, we give them a pat on the back and discuss with those not performing”*.

#### Workload and work conditions

Managers acknowledged that the workload within their facilities is high especially for enrolled nurses and medical assistants in the health centres and that staffing numbers are not adequate for workloads. They perceive the workload to have negative impacts on staff as some of them are often agitated and exhausted. This in their opinion affects their performance and relationship with patients. Thyolo District Health Team observed that because of the high workload some health workers often delegate duties to people not adequately trained for such roles. They have had cases where ward assistants are suturing wounds, dispensing drugs and cleaners preparing slides for laboratory technicians. Apart from the problem of medical supplies most managers interviewed believe the working conditions within their facilities are good. Managers perceive the lack of supplies (equipments and drugs) in the facilities as a major de-motivating factor for health workers.

Health workers described their workload as being relatively high which often leads to work stress. An enrolled nurse said

*“Sometimes on night duty I have to cover 3-4 wards all by myself. This makes me to choose on the ward where I will pay more attention because of the needs of the patients”*

They indicated that there is shortage of staff in almost all the facilities and that the introduction of various new programmes like the HIV/AIDS treatment took staff from the existing pool. An enrolled nurse in Thyolo stated

*“The HIV clinic increases our workload even though we work with MSF in the clinic. We sometimes complain about treating only HIV/AIDS”*.

They also said that the workload affects their performance sometimes and when this happens, the council/management perceives it as negligence. Throughout the discussion health workers complained about the lack of basic supplies to provide adequate and quality care for the patient.

The officials interviewed in the MOH agreed that workload is high but they have problems with deploying health professionals due to shortages in almost all the cadres. Though deployment is often based on needs the Ministry does not maintain any standards for deployment. They noted that health workers often do not want to serve in rural districts where basic facilities are lacking.

#### Job descriptions

All the managers interviewed in the 3 districts said there are no job descriptions for some cadres of health workers especially the enrolled nurse and midwives. The job descriptions available to them are very old and have not been revised, they are waiting for revised copies from the national government. Managers talked about the fact that some staff are not adequately prepared for the roles they are expected to perform.

Most of the health workers indicated that they do not have job descriptions. Those that answered in the affirmative said they got their job description from their college of training. Most of those with job descriptions said they are doing much more than what is specified in the description. Those without descriptions said they adapt to the situation and have to follow what others before them do. One of them said

“We follow what our senior colleagues do and any other (any other task assigned by supervisors), so we are doing more than we are supposed to do”.

They find this situation to be frustrating as they are expected to do more than what is specified or what they are trained to do. They believe it will be necessary to have orientation at the national level after recruitment.

#### Other Amenities

Lack of accommodation and other infrastructure within the rural area is another de-motivating factor for health workers within the district. They complained that the majority of them live in squatter camps because the district facilities do not provide them with accommodation. A few mentioned that they have to live with families and relatives which is not conducive for them. The lack of basic amenities like electricity and water was also of major concern to them.

When these issues were raised with the Ministry, those interviewed said that job descriptions are being revised by the ministry and once this is formalized official copies will be available to the districts.

#### Intention to leave

Of all the managers interviewed only one indicated that she would have left for the UK but had to change that decision due to the news she got from those that have migrated. In her words

*“I was told that houses were expensive and you have to jump from work to work and no rest. I also realized that home is the best, it is better to serve*

*relatives than outsiders and there is reformation in the government i.e. people are being promoted, improvement in salary, increments and continuous education”.*

Most of the health workers indicated that they had thought about leaving their job in the past year. A clinical officer said

*“once I finish my internship I will leave the public service to the NGO. My colleagues in the NGO earn 80,000Mk a month while I earn 21,000MK a month. Though I have better chances to further my education in the public sector, I can still do the same working with the NGO by saving more than half of my salary for 2 years. My colleague did the same and is back in the university while his mates in the public sector are still waiting for their turn to be trained from the MOH”.*

A medical assistant indicated his preoccupation with leaving

*“I consider leaving this job on a daily basis especially since after our former DHO left. I have even thought of going to sell in the market”.*

From the viewpoint of an enrolled nurse

*“staying here is not by choice but because of circumstances. I have been applying to NGOS but have not been offered a position by any”.*

The environmental health officers indicated that they would not want to leave the public sector; one said

*“we have very good chances to further our education within the public sector. Most of my colleagues that graduated before me are already back in school and that is motivating me to stay”.*

Respondents were asked by consensus to rank the various incentives that will motivate them to remain in their present job, they mentioned

1. Improved salary and allowances
2. Access to training according to skills need
3. Promotion and salary increment policies should be updated and made available for all cadres of health workers
4. Health Service Commission should change promotion criteria of calling people for one day interview, assessing and promoting people based only on their performance in the interview
5. Provision of accommodation and facilities within the rural area
6. Provision of a definite career structure for all cadres of health workers
7. Better supply of drugs and equipments
8. Improved work conditions in the health centre
9. Government should upgrade nursing certificates to diplomas for those that are already in the service
10. Supervision system should be intensified and feed back given
11. Improved communication between the districts and the MOH

## **Discussion**

There has been some debate in the literature on motivating and retaining health workers in sub Saharan Africa [8,9,10]. From the management's perspective the main de-motivating factors are lack of essential supplies (equipments and drugs) in the facilities, low salary, lack of promotion or delays of up to 5 years in promotion, high workload, and lack of basic amenities such as basic accommodation serviced with water and electricity. The findings from the focus group discussions indicate additional factors including training, supervision, and performance appraisal.

Many health workers indicate that they are motivated to remain for patriotic reasons, coupled with their ability to help others and the impact they have within their communities. This has been found to be true in other motivation studies in developing countries [8, 9,10,11,12] where recognition or appreciation by community members were important motivating factors for staff. Most of them are proud of their jobs and the services they render but are frustrated by the inadequate human resource management at government level and also within the districts. The managers perceive staff to be motivated by their choice of profession, the dignity that goes with the profession, good career prospects and on their humanitarian instincts.

The findings of this study indicate that managers and health workers perceive motivation differently. WHO (1993) has shown that managers and workers do not necessarily perceive motivation in the same way. It is important that these differences are made explicit, as false assumptions on the part of managers may lead to motivational incentives that do not work for staff.

Health workers expressed concern about the lack of continuous education and career progression, something which is particularly frustrating for clinical officers and medical assistants. The clinical officers undergo 4 years of training and can only progress to medical officer level by entering first year of medical school and going through another 6 years of medical training. Clinical officers feel that they have been trained and forgotten about, leaving them without any future prospects. Clinical officers, medical assistants and enrolled nurses who were interviewed have few opportunities for refreshing or upgrading their skills. In addition they can find themselves permanently stationed in the rural areas. This eventually impacts on morale and service delivery and in the longer term results in these professions becoming unattractive choices for school leavers. Though the rural areas are where services are needed more it may also be necessary to offer staff opportunities to rotate to peri-urban areas or provide incentives for rural postings. It could be argued that increased training will impact on staff mobility, more qualifications giving them greater opportunities to migrate. A major de-motivating factor for physicians and nurses is lack of career prospects. As Buchan (2004) pointed out, the primary purpose of using these health workers must not be to create workers who cannot migrate because they have different or lower skills than required by international standards. The chances are that some

will migrate in any case: well qualified nurses from developing countries are working as unqualified care assistants in care homes in developed countries where their qualifications are not recognized. The Government of Malawi is in the process of re-organizing its training programme for health workers to ensure training is provided to all cadres in line with national and local health needs.

Health workers also highlighted the lack of systematic supervision and appraisal or feedback. Inadequate supervision, inadequate funding, and poor regulation and monitoring undoubtedly impacts on the effectiveness of these cadres of health workers and often results in their carrying out task and functions beyond their capabilities. Studies by Ahmed et al, Ben Salem have shown that joint problem solving between supervisors and health workers is essential for quality improvement and job satisfaction.

Salaries of health workers in Malawi are quite low. There is some anecdotal evidence that use of provider incentives and enablers can improve performance under specific circumstances. Opportunities to engage in other income generation activities as family size increases and numbers of dependents increase due to deaths and HIV/AIDS may also have some positive effects.

Some human resource management activities such as supervision, promotion and training are done as mere rituals with little or no attempt to match needs, while others like performance appraisal are completely absent. Dieleman et al (2006 [9]) found this to be the case in Mali where integrated performance management is lacking. The Malawi government needs to put in place a strong human resource management function that operates at the district level to improve worker motivation and performance.

## **Conclusion**

Training and distribution of the health workforce that is focused on local conditions to address the human resource issues and improve access to healthcare is necessary and can help to limit workforce attrition. The introduction of new cadres of health staff have some implications which were highlighted in the discussions and these need to be addressed in order to maintain these cadres in the public health system; education and training, career paths, scopes of practice and the needs of the workers. This highlights the importance of laying down necessary criteria to guide the training and use of health workers. Clear career paths and a continuous education strategy must be established and these need to be monitored and evaluated through a functioning, integrated performance appraisal system

## **Contributors**

Ogenna Manafa participated in the literature review, study design, and data collection/analysis and drafted this paper. Cam Bowie participated in the study design and data collection. Eilish McAuliffe participated in the literature review, study design, data collection/ analysis and edited this paper. Fresier Maseko

participated in the data collection, data cleaning and preliminary analysis. Charles Normand and Malcolm Maclachlan edited the paper.

### **Competing interest**

We declare that we have no competing interest.

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