Employees Perception of Enabling Environment for Motivation of Human Resource for Health in Selected Public Hospitals in Tanzania

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Abstract

Shortages of human resource for health (HRH) has been a subject of concern not only in the developed world but also in Africa. There has been a number of explanations on why there are persistent shortages despite prevalence of various strategies to recruit, develop, allocate and reward staff. Obviously, all these strategies will work better if there are equally good strategies in place to retain those already employed and employees perceive them as good enough. By using qualitative and quantitative research data, the paper explores and examines employees' perception of available motivational factors for staff attraction and retention in hospitals. It is observed that despite well intentioned government strategies to motivate staff they have potentials for attracting and retaining only a small portion of staff working in public hospitals. This raises alarm for more work to be done in this area.

Keywords: *Human Resource, Motivation, Retention, Health care*

Introduction

Attraction and retention of employees is one of the challenges facing many public and private organisations. In USA, organisations spent 200 billion USD in recruiting and replacing lost health professionals annually while in Asia, the turnover rate was 14 to 16% per year (Samwel, 2008). In the United Kingdom, the turnover rate was estimated to reach 29% by 2020 (Sellgreen & Ekvall, 2007). Since 2000, about 16,000 nurses from African countries registered to work in the UK alone (GCISM, 2010) while more than 20,000 HRH were migrating every year from African countries to the UK and USA (Sikika, 2014). As a result, 38 African countries do not meet the WHO standards of 20 physician and 100 nurses to attend 100,000 people (WB, 2013).

In Tanzania, it is estimated that HRH turnover is around 300 per annum (AHSR, 2010) and there is no more recent record in Tanzania to suggest that the record has significantly changed. So, while some countries and organisations are able to attract more than others, others loose more than they are able to recruit. The mainstream literature has unearthed multitudes of motivational strategies adopted by countries and organisations to attract and retain staff. However, the bottom line is whether such employees perceive the strategies as being good enough to motivate them. By using both quantitative and qualitative data from selected public hospitals, the paper explores and examines employees perception of the extent to which strategies to motivate staff have potentials for attraction and retention of human resource for health. It starts with the literature review followed by methodology, discussions, conclusions and policy implications.

Theoretical perspective

Osteraker (1999) has examined mental, social and physical factors that may explain why employees may be motivated to take certain jobs, join certain organisations than others and enjoy working for a reasonable time. The mental factors include work characteristics whereby employees' can have flexible preference for working by using their knowledge and see the results of their efforts. Employees can have more freedom in performing their job and see the rewards of their mental effort, the social dimension consists of the contacts that the employees have with other people, both internal and external. Positive internal social contacts are expected to smooth the working environment for employees to stay in the organisation. Likewise, external social contacts may have positive impact if they discourage an employee from changing the job and the organisation. Finally, physical factors have to do with equipment and health facilities. The more the availability of physical working environment and facilities, the more employees will be attracted to join and the less the temptation to leave.

However, Walker (2001), Kehr (2004) and Hytter (2007) have agreed on seven factors some of which support and compliment the above dimensions to enhance employee attraction, motivation and retention. These include: compensation and appreciation of the performed work, provision of challenging work, chances to be promoted and to learn, invitational atmosphere within the organisation and positive relations with colleagues. It may also include health balance between the professional and personal life as well as good communication among health workers within an organisation.

More so, are a set of workplace regulations and practices that might be taken as inviting employees engagement. Such regulations include those which deal with provision of accommodation to an employee. While Kehr (2004) divided the motivation factors into three variables: power, achievement and affiliation, on his part, Hytter (2007) found that factors such as personal premises of loyalty, trust, commitment, identification and attachment with the organisation have a direct influence on employees motivation and retention.

Motivation has as well been associated with what is realised by employees at work place and other personal factors. For example, issues of performance rewards, leadership style, career opportunities, training and development, physical working conditions, and the balance between professional and personal life are to do with prospects employees have in their career development (Pritchard, 2007), which counts not only in motivation but also retention. In some ways this view is also complimented by Kyndt et al. (2009) who observes that level of education, seniority, self-perceived leadership skills, learning attitude, appreciation, stimulation, and pressure of work are of great relevance in employees retention. These influencing factors can be effectively managed through a number of strategies to improve motivation and retention in public hospitals in any country.

Public hospital system in Tanzania

According to MOHSW (Country profile of 2013), health system in Tanzania, especially the government referral system, has a pyramidal structure, that is, starting from village health services

and dispensaries to consultant/specialist hospitals at national level. Figure 1 shows the organisation of health facilities by type and ownership for proper delivery of health service in public health hospitals. Following this hospitals hierarchy, the aim of the government is to deliver health services close to the people (Jamie *et al*. 2015). To realise this aim, the government issued a national treatment guideline that specifies, what type of health services to be offered at a specific health facility and what cases should be referred to a next higher level of health facility. So, systematically that referral system is of a pyramidal shape. Patients are referred from a lower level unit to a higher level following skills that are required to address a problem at hand: Explanation of this hierarchy follows hereunder:-

Village health services

This is the lowest level of health care delivery in the country. It includes preventive services which can be provided at home and usually consists of two village health workers (HRH) chosen by the village government. After being chosen, they are given some basic training before they can start providing services.

Dispensary services

This is the second level of health services. A dispensary (D) caters for population between 6,000 and 10,000 people and supervises all the village health posts in its area. Basically, a dispensary is headed by a clinical officer, and it has a setup of two clinical officers, two nurses and one medical attendant (MOHSW, 2013). However, in practice, many dispensaries in Tanzania do not even have one qualified nurse, let alone a clinical officer. Most of them are run by unqualified medical practitioners (SOLIDER MED,

2011). This is due to unconducive working environment which demoralise most of the qualified ones to work in rural areas.

Health centres services

A health centre serves 50,000 people which is about the population of one administrative division knows as a ward. The services are headed by an assistant medical officer and include 24 beds, inpatient services and can conduct minor surgeries. It is the first referral for dispensaries in catchment areas. It constitutes a minimum of 24 and a maximum of 38 HRH in different cadre levels. Notably, the reviewed literature informs us that, most health centres in rural areas lack the required number of HRH compared to health centres situated in urban areas. Most of health centres in rural areas have less than 5 HRH and are headed by clinical officer instead of assistant medical officer. Unfortunately, some of health centres are headed by nurses (SIKIKA, 2010).

District hospitals

Normally, there is one public hospital for each district. For districts which do have a public hospital, a voluntary hospital is designated as a district hospital (DH) and gets subsidy from the government. A district hospital is headed by a medical officer and is assisted by the district health management team (CHMT). The CHMT constitutes a minimum number of 204 HRH and a maximum of 302 HRH. The district hospital is the referral hospital for health centres. Among other functions, district hospitals are responsible for coordinating preventive, curative, rehabilitative, supervision and promotion of health activities. According to various government reports, the said number of

HRH has never been maintained in district hospitals for various reasons, especially brain drain (MOHSW, 2013).

Regional referral hospitals

Basically, there is one Referral Region Hospital (RRH) for each region. Usually, this is a referral hospital for district hospital in the region and the last referral point at a region level. It is headed by Regional Medical Officer (RMO) assisted by the Regional Health Management Team (RHMT) that deals with the management of health services at a regional level. Like the district hospital, the RHMT coordinates and promotes health activities in the region. It manages beds ranging from 176 to 450, with nine or more wards (MOHSW, 2011). A hospital constitutes a minimum number of 441 HRH and a maximum number 699 HRH, which involves; at least six specialists for internal medicine, paediatrics and child health, obstetrics and gynaecology surgery, psychiatry and public health. However, the reality on the ground is that most hospitals in Tanzania have less than 3 specialists. The good example is the regional referral hospitals in Lindi, Rukwa, Kigoma, Singida Mtwara and Shinyanga (SOLIDARMED Report, 2011). Moreover, almost all regional referral hospitals lack some cadres of HRH, let alone the available number of HRH against the proposed number by the MOHSW (SIKIKA, 2011).

National, consultant and specialist hospitals

Muhimbili National Hospital is the only (MNH) national consultant hospital in the country, which constitute other wings such as Muhimbili or orthopaedic hospital and Ocean road cancer institute. Other specialist hospitals include; Milembe hospital (Psychiatry), Bugando, Kilimanjaro Christian Medical Centre

(KCMC) and Kibong'oto Hospital (Tuberculosis). These hospitals offer super specialist health services to outpatients and inpatients as well as training and research. The staffing level of these hospitals varies according to their size and capacity. For stance, it ranges from 3,600 HRH at Muhimbili a national hospital, 1,153 HRH at Mbeya consultant hospital, 1,557 HRH at Bugando hospital and 1,634 HRH at KCMC hospital. Despite the fact that these hospitals offer super specialist services, patients are usually referred abroad on government subsidy, especially for services which are not readily available in Tanzania (MOHSW, 2013). The next section gives a brief description of the methodology adopted to get data.

Methodology

Data on which the article is based were collected through cross sectional survey design which covered Dar es Salaam, Lindi and Mbeya regions. Probability and non-probability sampling techniques were used to get a sample of 278 respondents from the three regions. Interviews, questionnaires and documentary review were the main methods of data collection. Data were analysed by using descriptive statistics, content analysis and discourse.

4. Results and Discussions

Demographic and other Characteristics of Respondents

A total of 278 interviews were conducted to health workers who work in public health facilities and 22 interviews were conducted to health workers who had left the public health sector. The

sample compositions were almost equally divided between sexes and people of different other characteristics as shown in Table 1

Table 1: Demographic and other characteristics of the respondents (N: 278)

Item	Number	Percentage
Gender		
Male	160	57.6
Female	118	42.4
Age		
18 – 25	18	6.5
26 – 35	80	28.8
36 – 45	82	29.5
46 – 55	81	29.1
56 above	17	6.1
Education		
Primary education	15	5.4
Secondary education	50	18.0
Diploma	126	45.3
First degree	65	23.4
Master's and above degree level	22	7.9
Marital status		
Married	198	71.2
Single	61	21.9

Item	Number	Percentage
Window/Divorced	19	6.8
Position/ cadre		
Medical specialist	6	2.2
Medical officer	48	17.3
Clinical/Medical assistant	59	21.2
Dentist	6	2.2
Nurse officer	63	22.7
Assistant nurse	58	20.9
Other specialist/cadre	38	13.7
Year of working experience		
4 Years	65	23.4
5-15 years	103	37.1
16-25 years	61	21.9
26 years and above	49	17.6

Source: Constructed from field data, 2014

Perceptions on motivational factors

For a start, the following factors which are key in creating an enabling environment for staff motivation were used to explore and examine the extent to which employees perceive them as having strong potential to attract and retain staff. These are categorised into two major clusters of personal advancement and working conditions. The findings are as summarised in Table 2 below:

Table 2: Perceptions on the various motivation strategies to motivate staff

Motivation strategy	**Not Effective(%)**	**Slightly Effective(%)**	**Neutral(%)**	**Effective(%)**	**Very Effective(%)**
Personal advancement					
Good training and development opportunity	22(7.9)	81(29.1)	70(25.2)	81(29.1)	24(8.6)
Recognition of employee training and achievement	34(12.2)	69(24.8)	85(30.6)	74(26.6)	16(5.8)
Promotion based on performance and competence	50(18.0)	77(27.7)	83(29.9)	48(17.3)	20(7.2)
Clear human resource development plan	38(13.7)	60(21.6)	113(40.6)	50(18.0)	17(6.1)
Succession of leadership	46(16.5)	55(19.8)	105(37.8)	57(20.5)	15(5.4)
Improvement of working condition					
Up to date technology to perform	44(15.8)	76(27.3)	91(32.7)	48(17.3)	19(6.8)
Enough and up to date working equipment	53(19.1)	78(28.1)	102(36.7)	27(9.7)	18(6.5)

Source: Constructed from field data, 2014

Personal advancement

On personal advancement, 75.5 % of employees were not convinced that promotion was based on performance while 74.1% were not satisfied with leadership succession plan and 62.3% felt that training and development was not good enough to motivate and even retain staff. Commenting on training one of the interviewees complained that:

> *...At our place, it is the same people who are chosen for the same training, even more than five times. They are attending training for the sake of getting Per-diem not for capacity building. What is the value of training if the same people attend the same training every year? This is discouragement to health workers"*

Further, on salary packaging, supervisory and leadership styles, the results shows different perceptions as indicated in Table 3:

Table 3: Perceptions on Salary, supervision and leadership styles

Employees retention strategy	**Not Effective(%)**	**Slightly Effective(%)**	**Neutral(%)**	**Effective(%)**
Salary package				
Competitive salary package offered	54(19.4)	62(22.3)	109(39.2)	37(13.3)
Equal pay for work of comparable value	69(24.8)	61(21.9)	107(38.5)	29(10.4)
Supervisory and leadership styles				
Allows participation in decision making	59(21.2)	59(21.2	78(28.1)	61(21.9)
Objectivity of performance evaluation and feedback	41(14.7)	56(20.1)	103(37.1)	62(22.3)

Source: Constructed from field data, 2014

Salary Package

Competitive salary package and equal pay of comparable value of the job are one of the important motivators and hence why most people apply for jobs and even willing to be employed for lifetime. Data from Table 3 indicates that the majority, 80.9% and 85.3% respectively, did not perceive salaries as fair. As such some claimed to be psychologically absent from their working station. Interview responses categorically supported the quantitative data where by one of the respondents from Mbeya in Vwawa district hospital desperately said that:

> *...Staying in this office doesn't mean that I am satisfied with the government salary. It is not enough to cater for my basic needs; to pay for my children school fees and help my relatives. To attain these requirements, I have to do other jobs not related to medical field to subsidize my income. For me I am engaged in maize and coffee farming. ... I spend most of my time doing my business rather than the work I was employed for...*

Regarding supervisory and leadership style the data indicate that on participation in decision making, 28.5 of respondents thought the strategy was effective while 71.5% thought it was ineffective. This implies that the majority of respondents are not satisfied with participative decision making practices as a strategy in public health sector. Moreover, 28.1% of respondents believed that objectivity on performance evaluation was an effective strategy for retention. This data leaves the majority (71.9%) of the respondents dissatisfied.

Salary and Fringe Benefits

One of the problems which the government of Tanzania discovered to have affected performance in the public service including the health sector was the issue of salary and other fringe benefits.

The results from the survey indicated that 54 (19%) respondents disclosed that competitive salary package is important in explaining retention. However, it does not mean that all surveyed HRH were satisfied with the current salary package and fringe benefits offered by the government. This is because more than 80

percent of respondents were against this view. From the field visits, it was observed that only specialists were relatively satisfied with the salary packages offered by the government. One respondent from Vwawa district hospital in Mbeya had this to say:

> *...Staying in this office does not mean that I am satisfied with the government salaries. It is not enough to cater for my basic needs, pay for my children's school fees and help my relatives. To attain these requirements, I have to do other jobs not related to medical field so as to subsidize my income. For me I am engaged in maize and coffee agriculture. Therefore, I spend most of my time doing my businesses rather than the work I was employed for...*

This suggests that the strategy of using salary adjustment (SASE) has not helped to encourage HRH to stay in public hospitals. This can further be explained by lack of other fringe benefits like on call allowance, overtime allowance, extra-duty allowances, risk allowance and the like.

There were also some complaints related to the issue of equal pay for work of comparable value and fairness. Interviews with doctors and nurses revealed that there was no fairness in salary structures for employees of different cadres in the government. The medical practitioners felt that they were not adequately remunerated compared to other government employees. They regard their profession as subjected to higher level risks than other staff, especially those working with financial institutions like the Bank of Tanzania and Tanzania Revenue Authority. One of the interviewees had this to say:

> *...Is there any fairness for a person working with TRA to be paid five million per month compared to a medical doctor who is paid less than three million per month regardless of the risk involved in the job?" This is unfair and it discourages us from continuing working with the government...*

Such grievances indicate that medical staff are dissatisfied with pay packages. As such, it is not only about the amount paid, but it is about fairness and how the available national cake is shared to avoid employees' truancy.

Leadership and management

Public health reforms programmes of 2000s established that improved leadership and management of public hospitals would improve health service provision. Leadership and management have been conceptualized to mean showing interest and concern for the hospital staff, knowing their expectations, giving them roles that correspond with their capability and provide positive feedback and recognition.

Data in Table 3 shows dissatisfaction while data from interviews on the state of leadership in most hospitals and health centres show mixed feelings. Most interviewees were pessimistic about their leadership. Thus, poor leadership seemed to contribute much on their grievances. One of respondents from Mingoyo dispensary in Lindi had this to say:

> *...We are here as if we are orphans, leaders do not listen to our genuine demands and concerns, especially rights of health workers. Our leaders are mere agents of oppressors (government), we*

> *are denied of our rights, such that the action of our leaders frustrates us to the extent of hating them...*

The reported complaints imply that, if the leadership acts in a manner that discourages employees, it leads to dissatisfaction because they feel that they are not given due value. Under these circumstances, staff will have higher propensity to leave the organisation than stay. Therefore, reforms requirement to enhance leadership and management in terms of being accountable, results oriented and participation of staff in decision making seem to be impracticable in public hospitals.

To conclude this section, effectiveness of government strategies to retain employees seemed to be questionable. Personnel advancement, working condition, salary and fridge benefits, and issues of leadership and management of hospitals seemed inadequate to warrant retention of employees. One of the major lessons that may be drawn from the field is that, most HRH in public hospitals are physically present at workplaces but not psychologically present

Working conditions

Regarding improved working environment as a strategy to motivate staff, data indicate that 75.9% considered it as ineffective while 83.8% felt that working equipment was not part of good motivation. One of the interviewees had the following to say on equipment;

> *...It is difficult to attend emergency cases related to women labour at our dispensary because we do not have delivery equipment and special delivery room, but we usually take*

> *the risk of attending them, because we cannot let them die under pretext of not having equipment...*

It was observed that equipment was readily available at referral and district hospitals only. The situation in dispensaries and health centres was pathetic. For example, in Kilwa dispensary there were no gloves, chairs, delivery equipment and uniforms. One respondent in Kilwa dispensary said that:

> *...It is difficult to attend emergency cases related to labour at our dispensary because we do not have delivery equipment and a special delivery room, but we usually take the risk of attending them, because we cannot let them die under pretext of not having equipment...*

Figure1: Expecting mothers at Muhimbili national hospital

Source: Picture taken from Muhimbili national hospital

Figure 1 shows expectant mothers sharing beds and some sleeping on the floor at Muhimbili national hospital. More or less the same environment was observed in hospitals, health centres and dispensaries where patients, especially expectant mothers were required to carry or buy delivery equipment. That was only possible for those who were financially capable of buying such equipment. In one of the health centres in Mbeya one expectant mother passed away because of delay to provide services mainly due to lack of delivery kit. Nurses were cautious about HIV/

AIDS scourge as statistics indicated that more than 40 percent of expecting mothers in the area were infected.

The situation reveals hazardous working environment for HRH in Tanzania. It also implies that doctors and nurses are working in unsecured environment, which ultimately discourage them from staying. Perception of insecurity due to lack of equipment may prompt staff to leave the organisation as cautioned by Phillips and Connell, (2003). Respondents emphasised on the work environment as one of the key factors for better service provision, especially in Lindi. Findings from this study concur with those from a study by Munga and colleagues, (2013), pointed out that secured working environment proper working gears are key factor for HRH retention at a place of work. On the same issue, one of the medical officers at Kilwa District hospital lamented that;

> *...We are overburdened, no.... not with my medical practice ... there are hardly about 150 – 200 patients in this hospital daily, Still we are performing without adequate supplies and equipment, It is a terrible working environment, I Sometimes I work for more than 12 hours per day, because I cannot leave the patients in queue and close the office as you see them now!! All of them are waiting for my service, I am tired my brother...*

The comments show that HRH are highly concerned about their working environment. As a result, the situation affects not only service delivery but also attraction of new job seekers and retention.

Figure 2: patient waiting for laboratory service in Kilwa district hospital

Source: Picture taken from Kilwa district hospital

Furthermore, equipment and tools used at the hospital were very old. Only 67(24%) respondents thought that there was requisite technology. The highest indication is that, technology used,

especially in health centres and dispensaries in all three regions were very poor and outdated. Laboratories were not found to be computerized; only a few diagnostic tests for malaria, as well as diarrhoea together with urine and stool tests could be conducted. The doctors in such situation used their intuition to diagnose some diseases due to absence of up to-date laboratory equipment to test diseases. Thus, even simple cases would be referred to regional and district hospitals. Lack of modern technology dilutes the essence of public health reforms, which aimed at providing health services close to people. For example, one of the laboratory technicians in Mlowo dispensary in Mbeya complained that:

> *...As a Laboratory technician, I learnt to test and examine various patients' samples, but due to lack of up-to-date equipment, unreliable electricity and test regards, I am sometimes forced to guess, a pattern that makes the test results unreliable...*

The implication is that, if an employee feels that he/she cannot use his/her knowledge, skill and abilities due to lack of up-to-date technology he or she ends up being stressed and ultimately quit from his/her job.

Discussions

The findings indicate that the Government of the United Republic of Tanzania has overtime been devising different strategies for retaining health workers in public hospitals. Beginning with the public health reform programmes of 2000 to present all strategies aimed at improving health provisions to achieve the Millennium Development Goals (URT, 2000). The major objective was to

improve health services by making sure that public hospitals have enough and qualified human resources. It entailed increasing and retaining adequate number of medical doctors, specialists and nurses. These interventions by the government were charted as a result of poor service delivery in public hospitals (URT, 2000). As such, person advancement, improved working conditions, improved salary package, fringe benefit, improved management and leadership were major strategies used by the government to enhance retention of HRH in Tanzanian public hospital.

For more than a decade down road of reform efforts, still there is no desirable enabling environment for staff motivation, performance and retention. As noted earlier; for example much as in principle training aims at capacity building than any other thing else, it was thought to be a way of getting per diems. One may argue that training is not based on proper human resource development plans because the visited regions depended on ad-hoc training which benefit few members of staff without regard to performance requirements. This observation rhymes with Sikika's (2013) observations that training is not taken as a capacity building tool, rather it is taken for granted by those who are usually after per diem and allowances. The strategy is not properly implemented which result into discouragement and thus does not help to improve health service delivery in terms of capacity building for human resources for health sector. At most for the majority who do not benefit frequently it creates tensions, divisions and grievances.

Regarding staff promotion in public service and particularly in public hospitals, the situation appear to be equally undesirable. This has inadvertently contradicted the Public Service

Management and Employment Policy of 1998/99 which requires employers to promote their staff based on merit and performance. The possible explanation of this could be that most public hospitals have no proper and systematic system of performance management which would be linked to staff performance and promotion. This situation demotivates staff and in fact they do not feel like staying in the public service sector because there is no career advancement. In this situation, one would argue that if human resource development plan is not clearly stated, there will be no clear promotion lines, capacity development and indeed succession plan will be poor. These misalignments of plans discourage human resource for health sector to remain in public hospitals because career growth in the organisation cannot be realised as suggested by Dockel (2003) and Ng'ethe *et al*. (2012).

With respect to working conditions, issues like working equipment, improved technology, office space and housing facilities surfaced during the study in the three regions visited. Our findings indicate that more than half of respondents lack adequate working equipment. Unlike dispensaries and health centres, the research observation indicated that equipment are readily available at referral and district hospital only. This perception of insecurity due to lack of equipment may prompt staff to leave the organisation as cautioned by Phillips and Connell (2003). This finding concurs with other studies in Tanzania which show lack of equipment in health facilities (Penfold *et al*., 2013). Furthermore, delivery services have been found to be a problem in health facilities at the reception because of no delivery equipment (Penfold *et al*., 2013, Dogba, 2009). Lack of equipment is very much involved and affects health worker performance. As a result, this situation affects service

delivery, working environment and retention of human resource to health sector. Perception of insecurity due to lack of equipment may prompt staff to leave the organisation as cautioned by Phillips and Connell, (2003). Data also concur with those from a study by Munga and colleagues, (2013) which pointed out that secured working environment proper working gears are key factor for HRH retention at a place of work. As well advised by Sinha (2013) employers and policy makers should put more effort on improving working condition because stressful working condition is a key factor which causes higher dissatisfaction to many employees in organisation and this prompts employees to go slow or quit the organisation. This argument is supported by numerous studies which show that dissatisfied employees ar nbbbbbbbbbbe more likely to quit the jobs physically or psychologically. (Michael and Chipunza 2009; Sikika 2010; Baghael 2011).

Regarding the salary and other financial rewards, the data reveal that more than 70% of respondents were of the view that salary is not a motivating factor. Salary as a strategy for enhancing retention has appeared to be effective among medical specialists as compared to other cadres in public hospitals. Therefore, it can be argued that performance in public hospitals in Tanzania has been affected by low salary and inadequate fringe benefits. Although some writers like Baghaei (2011) would argue that salary is not the only factor, he agrees that good pay plays a significant role in influencing job satisfaction, thus encourages retention. In due regard, the introduced strategy of using salary adjustment (SASE) has not helped to encourage HRH to stay in public hospitals. This can further be explained by lack of other fringe benefits like on call allowance, overtime allowance and extra-duty allowances, risk allowance.

Furthermore, issues of equal pay for work of comparable value and fairness are important. Doctors and nurses thought that there was no fairness in salary structures for people of different cadres in the government. Such grievances indicate that medical staff are dissatisfied with pay packages. As such, it is not the question of the amount paid, but it is about fairness and how the available national cake is shared to avoid employees' truancy. As observed by Asnake, (2007) employees are satisfied when pay systems are fair to all workers that are based on individual skill level, job demand as well as job weight and market value. Contrary to argument raised by Asnake (2007), the available literature claim that many organisations raise pay based on experience and skill levels. This traditional way of pay increment has created more frustration and cynicism to workers. According to employees, this is not a significant pay raise, because as argued by Sinha (2013) it only benefits leaders and managers who are richly rewarded.

Other important strategy for enhancing motivation and retention in public hospitals was leadership and management practices. It was observed that poor leadership was a stumbling block to enhance retention in public hospitals. Grievances regarding poor leadership dominated various encounters during data collection. The the implication is that poor leadership greatly discouraged employees and thus it was among the major factors for not only inadequate motivation but also retention. In this regard, human resource for health who felt not valued have highest propensity to leave the organisation (see also Raymond *et al*, 2009; Dockel, 2003 and Lyn, *et al*., 2005). Participation of staff in decision making seems to be impracticable in public hospitals and adds salt to the wound.

Conclusion

Two main conclusions are deduced from data and discussions made. The first one is that much as the government and hospital management aspire to attract and retain staff through a number of strategies around motivation, employees perceptions are by large negative. Although the article does not consider the impact of low morale on employee performance, certainly patients concerns raised through other literature reflect high levels of low staff morale and ineffectiveness. Secondly, much as the above strategies are aimed to among others create an enabling environment for attraction of more staff to join medical profession and be willing to work in public hospitals as permanent and pensionable staff, constant hunt for greener pastures and moonlighting is the order of the day and there are no indications that the trend will reverse in the near future. In fact, most new job seekers are employed by public hospitals not because of choice but indeed as last resort. The major challenge still is the extent to which the government can create a better enabling environment for staff working as medical personnel given limited resources. Certainly, there are areas which can be addressed with very limited or no money at all but with significant impact on staff motivation. These include personal advancement, fair staff treatment, good work relations and more participatory approaches in the management of hospitals which have already been discussed at length. This can be in partnership with local authorities and private sector in a win-win situation framework.

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