SUPPORTIVE SUPERVISION IN RELATION TO INCENTIVES, MOTIVATION AND PERFORMANCE OF HEALTH CARE WORKERS IN DAR ES SALAAM PRIMARY HEALTH CARE FACILITIES

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SUPPORTIVE SUPERVISION IN RELATION TO INCENTIVES, MOTIVATION AND PERFORMANCE OF HEALTH CARE WORKERS IN DAR ES SALAAM PRIMARY HEALTH CARE FACILITIES

By

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A Dissertation Submitted in Partial Fulfilment of the Requirements for the Degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***Supportive Supervision in Relation to Incentives, Motivation and Performance of Health Care Workers in Dar es Salaam Primary Health Care Facilities***, in partial fulfilment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

13/11/2008

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Date: 13/11/2008

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I, **Filomena Namuba,** declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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DEDICATION

This work is dedicated to my beloved husband, Elgin and my daughter Elke for bearing with a busy wife and mother.

ABSTRACT

Human resources crisis is rampant in developing countries. The crisis is exacerbated by the poor performance of health workers due to low motivation. The effectiveness of supportive supervision as a panacea to this problem leaves a lot to be desired. This study was conducted to explore the elements of motivation embedded in supportive supervision that affect performance of health care workers (HCWs) in primary health facilities in Dar es Salaam. A cross sectional descriptive study was conducted using semi structured questionnaires with both closed and open ended questions administered to health care workers of primary health care facilities in Dar es Salaam from July - August 2008. A total of 306 health care workers from 25 facilities were interviewed out of whom 80.7% were female. Female health care workers were found to be more motivated to perform (91%) compared to male workers. HCWs who had been employed in less than a year's time were found to be motivated to perform (94%) compared to those employed in 1 or 2 years' time. Majority (83%) of respondents developed a feeling of liking their job more since they were supervised the last time. Awareness of supportive supervision among health care workers of different categories was found to be generally low (26 - 38%) Supervision was perceived to motivate HCWs to perform and develop a feeling of liking their job more (83%). Supervision incentives that influence performance significantly are recognition, mentorship, guidance and counseling ($p < 0.05$). Since there was low level of awareness of supportive supervision among health care workers, there is a need to orient and sensitize them about supportive supervision. A study should be conducted to find the level of awareness among supervisors so as to ensure there is a common understanding between the supervisor and the supervisee about supportive supervision. Supervisors should be cooperative and fair, recognize, mentor, guide, value, care and counsel supervisees as incentives during supervision as these have been found to influence performance of HCWs in primary health care facilities in Dar es Salaam.

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LIST OF ABBREVIATIONS

CHMT	Council Health Management Team
DHMT	District Health Management Team
DSMPHDS	Dar es Salaam Public Health Delivery System
FGD	Focused Group Discussion
GTZ	German Technical Cooperation
HCW	Health Care Worker
HRH	Human Resources for Health
HRM	Human Resources Management
MNH	Muhimbili National Hospital
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MUHAS	Muhimbili University of Health and Allied Sciences
PHC	Primary Health Care
PHCF	Primary Health Care Facility
RHMT	Regional Health Management Team
SPHSS	School of Public Health and Social Sciences
SPSS	Statistical Package for Social Scientists
WHO	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Human resources crisis in the health sector is a serious problem in Africa. Shortage of personnel, geographical imbalances in the availability of health care workers (HCWs) and weak productivity and performance of the available workers at health facilities are rampant in these countries (Mæstad, 2006). With respect to existing human resources, the low level of health worker motivation has often been identified as a central problem in health service delivery (Mathauer and Imhoff, 2006).

The most important of the health system inputs include knowledge, skills and motivation of those individuals responsible for delivering health services (WHO, 2000). The workforce which is the most important input to any health system has a strong impact on overall health system performance. Mathauer and Imhoff (2006) argue that low motivation has a negative impact on the performance of individual health workers, facilities and the health system as a whole.

Motivation in the work context is defined as "an individual's degree of willingness to exert and maintain an effort towards organizational goals". Work motivation refers to the psychological processes that have direct implications for individual behavior in the

context of work, and in particular those processes that influence the individual's accomplishment of workplace goals and tasks (Kanfer, 1999).

Workers' motivation in the health care sector is an acute problem in many countries, which adversely affects the delivery of quality and quantity health care services (Bennett *et al.*, 2001). Lack of motivation has been found to be one of the factors that exacerbate the crisis by affecting productivity (Mæstad, 2006). In a situation whereby available human resources for health are not sufficient to meet the needs, it is very important to ensure that the available Health Care Workers (HCWs) are supported to do their jobs effectively and efficiently. A prerequisite of a well functioning system is a well motivated workforce (Dieleman *et al.*, 2003) and proper management of human resources is critical in providing a high quality of health care (Kabene *et al.*, 2006). To provide good quality health care services, it is important to develop strategies influencing staff motivation for better performance (Dieleman *et al.*, 2003).

A number of solutions in human resources area have been searched to apply motivation to improve workers performance. There is an argument that an employee adoption of, and motivation to accomplish organizational goals requires that those goals be associated with personally desired outcomes, such as a sense of achievement or monetary gain. Therefore, employees must perceive a match between their own goals and those of the organization in order for the organization's goals to have a positive impact on worker behaviour, and ultimately on performance (Kanfer, 1999). To enable

workers to fulfill that match, supervision where workers' performances are assessed was suggested and implemented in different countries.

Several factors affecting motivation of HCWs include pay, promotion opportunities, clear job expectations, up to date knowledge and skills, adequate equipment and supplies, supervision, training, performance appraisal and career development. Among these factors, supervision has been one of the key approaches to improving the quality of health care and the performance of health care providers, especially given the labor-intensive nature of health service delivery.

As per Ministry of Health (MoH) supervision guidelines, supervision is a management function planned and carried out in order to guide, support and assist staff in carrying out their assigned tasks (MoH, 1999). It involves on job transfer of knowledge and skills between the supervisor and the one being supervised through opening of administrative and technical communication channel. The aim of supervision is to determine staff performance in relation to quality and standard in implementing planned activities (MoH, 1999).

Despite all the good characteristics of supervision as spelled by the Ministry of Health (1999), supervision had not proved to achieve these. Supportive supervision was therefore suggested as a different approach to make supervision more conducive to improvement in health worker performance. A key concept in supportive supervision is

that it is a process implemented by many parties, including officially designated supervisors, informal supervisors, peers, and health providers themselves. Supportive supervision is supposed to promote quality outcomes by strengthening communication, focusing on problem-solving, facilitating teamwork, and providing leadership and support to empower health providers to monitor and improve their own performance (Marquez and Kean, 2002).

Instead of occurring only when an external supervisor visits a facility, supportive supervision takes place continuously, as ongoing performance monitoring and quality improvement become a routine part of HCWs' jobs. Supportive supervision has to occur in multiple places: on the job, both formally and informally; in one-on-one meetings; in peer discussions; in meetings outside the work site; and when health workers review their own performance against standards. In addition it incorporates self as well as peer assessment and community inputs (MoHSW, 2008).

However, despite all the good characteristics of supportive supervision, a number of studies have shown that with supportive supervision, motivation of health care workers has remained low. Supervision is seen as an exercise of control with no feedback given, it is negative, unstructured and non supportive with no appreciation and respect from the community, no recognition or appreciation and no responsibility. It is irregular, infrequent, unreliable and non participatory (Dieleman *et al.*, 2003; Manongi *et al.*, 2004; Mathaeur and Imhoff, 2006; Manzi *et al.*, 2004).

Given the fact that the few available HCWs in Tanzania are mainly concentrated in urban settings especially in Dar es Salaam it was worth exploring if what have been found from other studies also apply in an urban setting. Furthermore, available studies have been looking at supervision in a blanket or as only a component in a much broader context of motivation of HCWs; they have not explored different aspects of incentives and motivation that are in principle supposed to be expected outcomes of supportive supervision.

Gaining a better insight of the incentives, motivating elements and supervision characteristics embedded in supportive supervision from the perspective of the HCWs, this study has therefore tried to explore these factors to understand the structure of supportive supervision by identifying important elements of supportive supervision that need to be considered in creating incentives that motivate HCWs to improve performance since factors such as the availability of resources and the technical competence of the worker are not sufficient in themselves to always produce desired work behaviour.

This study found that awareness of supportive supervision among health care workers of different categories is generally low. Supervision is perceived to motivate HCWs to perform and develop a feeling of liking their job more and incentives in supervision that influence performance significantly are recognition, mentorship, guidance and counseling. As well, being given a job description, evaluated on the work and provided

with feedback have a positive influence on HCWs' performance and that supervision improves performance.

This dissertation starts with an introductory chapter where there is background, statement of the problem, and rationale of the study. Literature review follows in chapter two. The methodology then follows in chapter three and thereafter the results in chapter four. The final parts comprises the discussion, and, conclusions and recommendations in chapter five and chapter six respectively.

1.2 Statement of the problem

Human resources for health (HRH) play a key role in improving the quality and quantity of health care services. There is a general understanding that productivity of the health workforce is low and that performance is poor (Mæstad, 2006). Poor quality of services can be contributed by different factors that influence performance outcomes. Such factors include knowledge and skills, working environment, salaries, workload, administration of rewards and punishment for work related behaviour, availability of working gears, extent to which the worker feels cared for, job satisfaction, motivation, job expectations, performance feedback, incentives and participation in decision making.

The improvement of the quality and quantity of health care services is therefore influenced by motivation of health care workers among other factors. A motivated workforce is important in increasing performance and productivity hence provision of quality and quantity of health care services in Tanzania.

Supportive supervision of staff in health care has been initiated to respond to poor motivation to ensure the quality of operations and enabling staff to perform to their maximum potential. As per supervision guidelines, during supervision supervisors are supposed to guide, mentor, counsel and coach their subordinates (Ali *et al.*, 2001) as incentives to increase motivation to perform.

Hence supportive supervision has been argued to improve motivation and hence performance. However, despite of the implementation of supportive supervision studies have suggested that levels of productivity and performance among HCWs are low due to lack of motivation among other factors, as a consequence only 57.5% of HCWs' time is spent on productive activities (Kurowski *et al.*, 2003). A study done at Muhimbili National Hospital (MNH) shows that the overall staff motivation level is low. Only 50% of doctors and nurses were satisfied with their working conditions (Leshabari *et al.*, 2008; Dominick and Kurowski, 2005). It is also being reported that most of the HCWs in some low level health facilities have low motivation (Manzi *et al.*, 2004).

Furthermore, the presence and introduction of supportive supervision in health facilities in Tanzania aimed at enabling HCWs to improve performance has not been found to be motivating enough leading to poor performance (Manzi *et al.*, 2004). Despite the fact that supportive supervision is being done in many regions of Tanzania including Dar es Salaam, there is evidence that staff is not motivated and there is an apparent deterioration of the quality of health services.

Therefore it can be argued that supervision has not been proved to motivate HCWs working at primary health care facilities (Manongi *et al.*, 2006). The question is whether supervision creates incentives to motivate HCWs to improve performance given the environment that they are working in or otherwise. These studies have not explored the role of supportive supervision in the urban areas and have not studied elements of motivation that are embedded in supportive supervision which this study addressed.

This study therefore specifically explored the kind of incentives, motivating elements and supervision characteristics embedded in supportive supervision that affect motivation and hence performances of HCWs in primary health care facilities of Dar es Salaam so as to understand their influence on motivation of HCWs to perform. The information is important for understanding how workers value supportive supervision, and to evaluate the extent to which elements of supportive supervision would contribute to encouraging HCWs to perform.

1.3 Rationale of the study

This study has generated information that may be used to improve supportive supervision guidelines by identifying important elements of supportive supervision that need to be considered in creating incentives that motivate HCWs to improve performance, other things remaining equal. The study also contributes to the debate of motivation and types of management exercised.

1.4 Definition of terms

Motivation	Is an individual's degree of willingness to exert and maintain an effort towards organizational goals.
Performance	Is accomplishment of a given task measured against preset standards of accuracy, completeness, cost and speed.
Incentive	An activity to motivate people to achieve pre determined health sector objectives.
Supportive supervision	Is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources.

1.5 Research question

Is supportive supervision creating incentives and therefore a motivating action to the supervised HCWs to improve performance?

1.6 Objectives of the study

1.6.1 Broad objective

To explore the elements of incentives and motivation embedded in supportive supervision that may affect performance of HCWs in primary health facilities of Dar es Salaam.

1.6.2 Specific objectives

1. To explore awareness of supportive supervision among HCWs.
2. To assess HCWs' perception on supervision motivation.
3. To explore the incentives in supervision that influence performance.
4. To assess the perception of HCWs on supervision in improving performance.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Determinants of motivation

Staff motivation is determined by factors at various levels namely at an individual level, at an organizational level and at the socio-cultural level (Franco *et al.*, 2002). At an individual level there are factors such as a person's job expectations, his or her self-esteem to be able to do a certain job and his/her own goals compared to the goals of the organization i.e. goal congruence. At an organizational level there are two types of motivation that can be distinguished according to Herzberg's theory of motivation at the workplace (quoted by Franco *et al.*, 2002).

One, motivation to accept and to remain at a post, which is related to meeting needs of job security, salary, and the like, called "factors for dissatisfaction (dissatisfiers)" or the "can do" factors. Dissatisfiers are mainly extrinsic factors. Two, motivation to improve performance, linked to a feeling of self-fulfillment, achievement and recognition called satisfiers. These feelings can be influenced by effective performance management, through which managers ensure that staff is competent and motivated in their job. It involves supervision, training, performance appraisal and career development.

Satisfiers also called motivators or "will do" factors are based on intrinsic motivation. At the larger socio-cultural level there are motivating factors such as the relationships

between health workers and clients, support from community leaders and perception of community members with respect to services.

Mathaeur and Imhoff (2006) agree with Franco *et al.* (2002) and in addition state that motivation develops in each individual as a result of the interaction between individual, organizational and cultural determinants. To supplement this, Castle *et al.* (2006) stipulate motivation determinants to include the work environment and the personality of workers whereby in operationalizing the work environment, it is most often split into multiple factors (or domains) such as supervisors, pay, and promotion opportunities.

Furthermore, D'Souza (2007) highlights that many variables influence people's desire to "do something" in the work environment. These variables include their own needs, factors present or absent in the environment itself, and the behaviour of their immediate managers. This corresponds to what has been said by Mathauer and Imhoff (2006) and Franco *et al.* (2002). On the other hand, Parsons *et al.* (2003) found four factors associated with nurse aide job satisfaction to be personal opportunity, supervision, benefits, and coworker support.

At another level, Chou *et al.* (2002) found caregiver satisfaction to be related to workload, team spirit, and professional support. In another study of nurse aides, job satisfaction was associated with job security, potential for job growth, socialization, and challenging work (Atchison, 1998). The different studies across different settings have

therefore been observed to single out more or less the same factors as far as health care worker motivation is concerned and thus have a lot of commonalities.

Some scholars argue that workers need motivation, especially when some of the other factors that support good performance are lacking (Luoma, 2006). Such factors include clear job expectations, up-to-date knowledge and skills, adequate equipment and supplies, constructive feedback and a caring supervisor (Luoma and Crigler, 2002). Luoma (2006) argues that highly motivated individuals can often overcome obstacles such as poor working conditions, personal safety concerns and inadequate equipment. This is evidenced by results of a study done in remote areas of Zimbabwe which found out that despite lack of financial incentives and hard working conditions, health workers frequently exhibited a high level of motivation to perform well which was due to good leadership and supportive management, among other factors (Stilwell, 2001).

On the other hand, even with good leadership other organizational factors are important. On exploring experiences of health workers in the primary health care facilities in Kilimanjaro region in terms of their motivation to work, satisfaction and frustration Manongi *et al.* (2006) found that from the viewpoint of service providers, the main factors identified that caused demotivation among health care workers working at primary health care facilities were workload paired with staff shortages, lack of interprofessional exchange and lack of positive supervision, including transparent career goals.

Furthermore Manongi *et al.* (2006) study indicates that apart from organization, physical infrastructure and equipment available to staff in the PHC setting did sometimes affect morale - and certainly services - but overall the findings from the focus-group discussions indicate a need for individual staff to feel valued and supported and to develop in their roles. However, these finding were specific to Kilimanjaro and could not be generalized to be applying to Tanzania and in this case to Dar es Salaam unless a study is conducted to prove so. Moreover, findings from various studies show that supervision has been mentioned quite frequently to affect HCWs performance but its influence on the motivation of HCWs to perform particularly in an urban setting has not been well explored.

2.2 The importance of financial vis à vis non - financial incentives

Qualitative studies looking at motivation of health workers in developing countries indicate that there are limitations of financial incentives on motivation and show the importance of non-financial incentives (Mutizwa - Mangiza, 1998; Franco *et al.*, 2000; Schmidt-Ehry and Seidel, 2003; Dielemann *et al.*, 2003; Bennett *et al.*, 2004). Non-financial incentives comprise the human related quality management tools, namely supervision, feedback, staff appraisals, staff satisfaction surveys, clear leadership and guidance, clear organizational objectives and missions, and staff participation mechanisms (including staff meetings), adequate training, as well as self assessments. Ultimately, these quality management tools aim at improving staff working conditions,

targeted improving of their skills, and also their motivation through clear acknowledgement and recognition of (psychological) staff needs (Mathauer and Imhoff, 2006).

A study done in Viet Nam by Dieleman *et al.* (2003) showed that motivation is influenced by both financial and non-financial incentives. The main motivating factors for health workers were appreciation by managers, colleagues and the community, a stable job and income and training. The main discouraging factors were related to low salaries and difficult working conditions. Mathauer and Imhoff (2006) argue that there is empirical evidence that even with an adequate salary, health workers may not be motivated: more money does not automatically imply higher motivation. On the other hand, even without an adequate salary and under poor working conditions, there are highly motivated and performing health workers. In fact, there is common agreement that financial incentives are insufficient; non-financial incentives are hence an essential component to increase staff motivation.

Furthermore, Stilwell (2001) suggests that certain non-financial incentives can have a beneficial effect on motivation, even under adverse conditions of insufficient pay and equipment, understaffing, etc. A study by Manongi *et al.* (2006) has indicated that although financial incentives are important, they are not sufficient to motivate health workers. Supportive supervision, performance appraisal, career development and transparent promotion have been prioritized by primary health care facility workers for

improving the services they deliver in Tanzania. Studies therefore suggest that non financial incentives should go hand in hand with financial incentives when issues addressing HCWs are considered.

Most of these studies were conducted in rural settings and thereby left the question of whether the same applied in an urban setting where HCWs need money to buy almost everything to be desired. It was therefore important to find out what the case was in a city like Dar es Salaam when only non financial incentives particularly supportive supervision is analyzed.

2.3 What is meant by supportive supervision

Marquez and Kean (2002) define supportive supervision as a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources. The supportive supervisor brings people and resources together to pursue clear objectives, assess results, and identify and solve problems, and develops relationships based on trust and responsiveness.

Supportive supervision focuses on the results of processes as well as individual performance. It encourages open communication and building team approaches that facilitate problem-solving. It focuses on monitoring performance against expectations

and using data for decision-making. Measuring performance also allows supervisors to be held accountable for results and helps foster continuous improvements in quality at all levels of the health system (Marquez and Kean, 2002).

Another key aspect of supportive supervision is an explicit concern for meeting the needs of clients; both external and internal staff members. Supportive supervision expands the scope of supervision methods by incorporating self-assessment and peer assessment, as well as community input. A key concept in supportive supervision is that it is a process implemented by many parties, including officially designated supervisors, informal supervisors, peers, and health providers themselves. Supportive supervision promotes quality outcomes by strengthening communication, focusing on problem-solving, facilitating teamwork, and providing leadership and support to empower health providers to monitor and improve their own performance (Marquez and Kean 2002).

Instead of occurring only when an external supervisor visits a facility, supportive supervision takes place continuously, as ongoing performance monitoring and quality improvement become a routine part of health workers' jobs. Supportive supervision occurs in multiple places: on the job, both formally and informally; in one-on-one meetings; in peer discussions; in meetings outside the work site; and when health workers review their own performance against standards. Finding out what the scenario was in Dar es Salaam where the headquarters of the Ministry of Health and Social

Welfare responsible in ensuring adherence of supervision guidelines is important for comparing with what has been found in other regions.

2.4 The link between motivation and supervision

Supervisors and leaders are supposed to play a coaching, mentoring and counseling role to their subordinates and in this way they play a big role to motivation of employees. Supervisors get things done through their subordinates and therefore need to know what motivates them and creating conditions where HCWs will motivate themselves and be satisfied with their jobs. Mathauer and Imhoff (2006) found that non-financial incentives and HRM tools, supervision being one among the core, play an important role with respect to increasing motivation of health professionals.

This is emphasized by results from a qualitative study done in Kilimanjaro reported by Manongi *et al.* (2006) that shows that on supervision, more negative comments were received than positive ones. The health workers reported that there was little or no on-site supervision from their immediate superiors and the external supervision from District Health Management Team (DHMT) was irregular and not supportive; that it was not friendly and not lovingly done, not well planned and more of policing and faults-finding. Many complained that they had never received any written or oral feedback from supervisory visits and in this way it is not easy to think the supervisors are useful when reported problems remain and no feedback is given.

These findings are collaborated with studies conducted in Kenya and Benin which found HCWs are demotivated and frustrated due to inadequate or inappropriately applied human resources management tools (Mathauer and Imhoff, 2006).

2.5 The link between motivation and performance

It is also argued that performance is a function of ability, motivation and resources. Without motivation performance is usually below potential. It is not possible to observe directly how the various factors influence worker motivation as motivation is an internal psychological process. However, the effect of these various influences can be seen indirectly as worker motivation will affect worker performance (Bennett and Franco, 1999). Workers' motivation may directly affect all aspects of performance from basic measures such as attendance, to more complex measures such as willingness to learn new skills or follow new treatment protocols, or adopt new methods of planning and organizing service delivery (Bennett and Franco, 1999).

Nahavandi and Malekzadeh, (1999) (quoted in Dunbar, 2003) associate the concept of motivation with management issues related to organizational performance. They define motivation as a "state of mind, desire, energy, or interest that translates into action". This action is viewed as work performance. The belief is that this performance can be influenced when employee motivation is influenced. They continue saying that employee motivation can be influenced due to motivation being a flexible state of mind.

Bennett and Franco (1999) add to this by pointing out that workers' individual needs, self-concept, and expectations for outcomes and/or consequences are some of the more important individual-level determinants of work motivation that when coupled with the individual worker's technical and intellectual capacity and resource availability, lead to worker performance. Low motivation has a negative impact on the performance of individual health workers, facilities and the health system as a whole (Mathauer and Imhoff, 2006).

Manzi *et al.* (2004) on exploring the influence of workplace trust over health worker performance found that one reason for poor performance and motivation was limited supervision and monitoring. They found that out of the seventeen staff interviewed, 70% had low levels of motivation. There were no clear motivation differences between more and less highly trained staff. Health workers with low motivation levels generally stated that they liked their jobs and gained some satisfaction from helping people. However, all were identified as either behaving rudely towards patients, being unwilling to work out of hours (perhaps even demanding informal charges for such services) or refusing to be cooperative in the workplace.

In contrast, those with high motivation levels clearly demonstrated not only positive feelings about their work and workplace, but also positive behaviours towards patients and colleagues. These include routinely arriving early for work, being willing and available to provide care after hours, regularly providing support to colleagues and

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actively seeking to strengthen facility performance. The underlying commitment seemed, however, to be to the nature of the work involved in their jobs rather to their organization's goals, as very few health workers were familiar with those goals.

Mathauer and Imhoff (2006) show that highly motivated staff will not only perform better and provide a higher quality of health services but may also be less inclined to leave their job or even their country behind in search of alternatives, such as a higher salary as well as better working conditions and perspectives for career development.

Leonard *et al.* (2005) on assessing the performance of a sample of 80 clinicians in Arusha region by comparing actual behaviour with what health workers have demonstrated that they are capable of doing in a prior test found that motivation among health workers is weak; that some clinicians routinely misdiagnose and mistreat common illnesses because they do not provide the effort necessary to find the correct diagnosis. Even clinicians who demonstrated in the test that they knew what to do did not actually do the right thing in practice more than 53% of the time. If such workers were provided with the ideal and recommended supportive supervision that would have given them the incentives such as guidance, mentorship, coaching and the like, arguably their motivation level would have been improved and so their performance.

2.6 What should be done to motivate health care workers to perform

Supportive supervision is one of the suggested actions to strengthen the motivation of staff. Mathauer and Imhoff (2006) suggest that a mix of financial and non-financial incentives to be most effective. Apart from supportive supervision, other actions suggested are payment schemes, performance targets for individuals and groups, and individual career development plans. Furthermore, Mathauer and Imhoff (2006) report that giving health care workers a voice really matters to them and has the potential to increase their motivation and job satisfaction and thus, ultimately, performance.

Participants in a study conducted in Kilimanjaro by Manongi *et al.* (2006) identified positive supervision and improved feedback from referral hospitals as two achievable measures to improve both morale and quality of health care delivery. A study by Dieleman *et al.* (2003) found that to improve motivation and thereby increase staff performance, attention should be given to motivating factors, for example by increasing the individual's sense of achievement and to demonstrate recognition of that achievement. The same study gives an indication that although financial incentives are important, they are not sufficient to motivate personnel to perform better.

To achieve better staff motivation, attention should also be paid to incentives that focus on showing appreciation and respect. This can be achieved through performance management (supervision, training, performance appraisal and career development) and feedback from the community. Developing mechanisms that assure regular information

on perception of clients on service delivery seem to be important for health workers. This should be used additionally to the existing human resources management (HRM) tools for performance management. Health workers in a study done in Benin and Kenya by German Technical Cooperation (GTZ) consider supervision useful and desirable to the extent that it helps improve personal performance, to avoid mistakes and to update knowledge. When personal needs and concerns are taken seriously, in principle supervision provides the feeling of being cared for and of appreciation and this aspect appears particularly important for health workers posted to remote facilities with little contact with other professionals (Inke and Imhoff, 2006).

There is a large potential for improvement in the supervision process, according to the respondents' suggestions: Apart from a more frequent, regular and reliable supervision, many respondents ask for a different approach, in that supervision should be more supportive, instructive, needs-oriented, participatory and should provide a direct and timely feedback on their problems. There was also a call for more meetings to discuss problems and solutions. Direct observation of health worker activities is considered helpful to identify the bottlenecks in service delivery, provided that health workers are not criticized in front of the patients. Research has shown that managers and workers do not necessarily perceive motivation in the same way (WHO, 1993).

Given the fact that most of the studies have been conducted in small towns and rural areas settings and have not addressed motivation and supportive supervision elements, it

was therefore important to conduct a study on the influence of supportive supervision on motivation of HCWs in PHCFs in Dar es Salaam. Results of studies are context sensitive: each region and even each facility may need its specific incentive schemes (Mathauer and Imhoff, 2006).

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study site

The study was conducted from July to August 2008 in public primary health care facilities of Dar es Salaam region, Tanzania. Dar es Salaam is the largest city in Tanzania and has a total population of more than 3 million. Dar es Salaam has three municipalities of Ilala, Temeke and Kinondoni. The Dar es Salaam Public Health Delivery System (DSMPHDS) has two levels of service. First line of service is delivered at dispensary and health centres, and second line is delivered by municipal hospitals. Currently, the DSMPHDS comprises of 79 public health facilities (70 dispensaries, 5 health centres and 4 hospitals). The national hospital and private hospitals are also accessible to the Dar es Salaam population.

3.2 Study design

A cross - sectional study was conducted in Dar es Salaam using semi structured questionnaires with closed and open ended questions. Dar es Salaam being the largest city in Tanzania was selected and hence an urban setting.

3.3 Study population

The study population was health care workers of different cadres working in public primary health care facilities of Dar es Salaam. These cadres were categorized into clinicians, nurses, clinical support staff and support staff. Clinicians included medical officers, assistant medical officers, clinical officers, assistant clinical officers, dental therapists and optometrists. Nursing staff included nursing officers, nurse midwives, public health nurses, nurse assistants, and maternal and child health aides. Clinical support staff included a nutritionist and staff from laboratory, pharmacy and records sections. Support staff included medical attendants, dental auxiliaries, drivers, watchmen, secretaries, receptionists and data entry clerks.

3.4 Sample size and sampling procedure

The target of 300 HCWs to be interviewed was preset. This resulted from the calculation that Dar es Salaam had a total of about 3000 HCWs and therefore a 10% representation could suffice given the financial and time constraints. All the public health centres of Dar es Salaam city were purposively included in the sample (i.e. five health centres) while twenty dispensaries were randomly selected. In selection of the dispensaries, two dispensaries were randomly selected from each division with the exception of two divisions of Ilala municipality which had one and two dispensaries respectively thus necessitating selection of more dispensaries from the division that had much more dispensaries in order to come up with the required total number of dispensaries from all

the divisions. All the staffs that were available and willing/ consented to participate in the study during the study period in the selected health facilities were interviewed.

3.5 Inclusion and exclusion criteria

Health care workers who had worked at primary health care facilities in Dar es Salaam for not less than six months were included in the study. This is because the questionnaire was designed in such a way that the respondents needed to have an experience of being supervised and it was assumed that six months would have been enough time for someone to be able to answer the questions in the questionnaire. For the same reasons, individuals who had worked at the facilities for less than six months were excluded from the study. Eighteen out of 25 heads of health facilities that were available during the period of study were included in the study.

3.6 Selection and training of research assistants

Research assistants with previous experience in data collection were recruited after being interviewed for the task. The research assistants were given an orientation for two days focusing on understanding the study objectives, understanding the questions, recording responses and interviewing skills. Emphasis was put on consistency in asking questions and recording the answers in order to avoid interviewer bias. The research assistants were supervised everyday in the field to ensure accuracy and completeness of

the questionnaires. At the end of the day, principal researcher and research assistants checked all the questionnaires to ensure no missing information.

3.7 Data collection instruments

Data was collected using semi - structured questionnaires with closed and open ended questions. The questionnaire was developed in English, translated in Kiswahili and back to English. When the right translation had been established both versions were used for interviews depending on the language which the respondent was comfortable with though many respondents preferred a mix of the two languages and therefore interviewers mostly filled in the English questionnaires even when Kiswahili answers were given. These were later translated to English.

3.7.1 Pre - testing

Before starting data collection, pre testing of instruments was done by the principal investigator and research assistants. The pre test questionnaire was administered to 30 respondents from three dispensaries of Ilala municipality to check for accuracy, consistency, coherence and validity of questions. These dispensaries were not included in the actual study.

3.7.2 Final instruments for data collection

Following the pre test, the questionnaire was revised by changing the wording of the questions that were not understood during the pre test and changes were incorporated in the final version that was used in the actual study.

3.8 Data collection procedure

Data collection started after obtaining administrative permission from relevant authorities. In the process of data collection, the facilities in charge were visited before the interviews began to explain about the purpose of the study and to ask for their assistance in identifying the respondents. Eligible individuals were interviewed at their place of work after they had been asked for their written consent to participate in the study and upon acceptance. The interview was conducted privately between the interviewer and individual HCW. In case of absence of some workers, interviewers returned on either the next day or a day proposed by the facility in charge. The information collected included socio-demographic characteristics and information on the incentives in supervision that influence performance, the perception of HCWs on the link between motivation and supervision and motivation and performance.

3.9 Study variables

Both closed and open ended types of questions were asked. The responses given were either pre-coded numerical, ordinal or nominal, or post coded at the end of data collection.

The dependent variables in this study were:

1. Reported motivation
2. Reported performance
3. Incentives in supervision

Independent variables included:

1. Age of respondents
2. Sex of respondents
3. Marital status of respondents
4. Education level of respondents
5. Worker categories of respondents
6. Qualification of supervisor
7. Frequency of supervision
8. Duration of supervisory visits
9. Recognition by supervisor
10. Guidance from supervisor
11. Being valued by supervisor
12. Feedback from supervisor
13. Appreciation from supervisor

3.10 Data management and analysis

During field work, the principal researcher supervised the research assistants in the field by inspecting the collected data on the same day, errors detected were corrected immediately. Qualitative information collected with questionnaires was coded, classified and tabulated to adjust for any missing information and correcting for outliers.

The questionnaires were given serial numbers before data entry. Data was entered using EPI Info 6 then transferred to and analyzed using SPSS whereby frequency tables were run followed by cross tabulations of different variables. Proportions were compared using Chi square test at a significance level of 0.05. Chi square test was used to calculate p - value whenever less than 20% of cells had expected count less than 5. In cases where more than 20% of cells had expected count less than 5 then p - value was calculated using Fisher's Exact test. Reliability of the scales used in the study was measured by Cronbach alpha test. Data from this study was stored in an electronic form.

Assessment of the level of awareness of elements of supportive supervision was done by categorizing respondents into 0% aware in case a respondent did not mention any component of supportive supervision, 25% aware in case a respondent mentioned any one of the four components of supportive supervision, 50% if s/he mentioned any 2 of the components, 75% if she mentioned any 3 of the components and 100% if all the 4 components were mentioned. The unprompted responses were checked off on the list of four components of supportive supervision.

Assessment of whether supervision gave incentives to health care workers was done by using 8 closed ended questions. Questions were based on the feelings that HCWs felt as a result of the last supervision they had received. Responses were 'Yes', 'No' and 'Don't know'. In order to assess the level by which HCWs perceived supervision to give them incentives, the 8 responses were recorded as 0 = No (for 'No' and 'Don't know' responses) and 1 = Yes (for 'Yes' responses). Then, incentive variables were added to form an index (incentive index) with the minimum possible score of 0 and the maximum possible score of 8. Further categorization into 3 categories namely low level of incentives (0 - 2), moderate level of incentives (3 - 5) and high level of incentives (6 - 8) was done.

In order to find the arithmetic mean for perceived value for work, the way respondents thought different people valued their work was put into a scale of 0 - 5 where 0 = very valueless, 1 = valueless, 2 = I don't know/ neutral, 3 = moderately valuable, 4 = valuable and 5 = very valuable.

In order to assess the influence of supervision on performance, perceived influence of supervision on performance was rated in a scale of 1 to 5 where 1 = very negative, 2 = negative, 3 = neutral, 4 = positive and 5 = very positive.

3.11 Ethical consideration

The proposal was processed through School of Public Health and Social Sciences (SPHSS). Ethical clearance to conduct the research was sought from Muhimbili University of Health and Allied Sciences (MUHAS) Research and Publication Committee. Permission to conduct research was requested from relevant authorities; Municipal Executive Directors of the three municipalities of Dar es Salaam before carrying out the study.

Written individual consent to participate was sought after the study's aim, methods and benefits had been explained to prospective participants. Refusal to participate was also accepted and involved no penalty. No risk was expected to happen to HCWs because of participating in this study. Participants who agreed to participate will benefit from the results from this study that may be used to improve supportive supervision guidelines by identifying important elements of supportive supervision that need to be considered in creating incentives that motivate HCWs to improve performance.

3.12 Limitations of the study

1. The study population was conveniently chosen and hence results can not be generalized to other health facilities in the country.
2. Motivation is also influenced by some other factors which could have been mixed up with supervision by respondents and thereby bring confounding

effects. In order to overcome this limitation, respondents were given explanations of the objectives of the study and emphasis was put on concentrating on supervision.

3. Since motivation is a psychological process which is dynamic in nature, the same individual could have given different answers on different days for the same question and hence jeopardize the reliability and validity of the study.
4. This study relied on reported information. There was a possibility that respondents could have given responses that do not reflect the reality and hence biased.

CHAPTER FOUR

4.0 RESULTS

4.1 Socio-demographic characteristics of the study population

A total of 306 health care workers from 25 facilities (5 health centres and 20 dispensaries) were interviewed. Facilities that were surveyed include 2 health centres from Ilala Municipality, 2 from Kinondoni Municipality and 1 from Temeke Municipality. 20 dispensaries were 6 from Ilala, 6 from Temeke and 8 from Kinondoni Municipalities. Out of the 306 health care workers interviewed 247 (80.7%) were female. Most of the respondents (76.5%) were married/ cohabiting. The age of respondents ranged between 22 and 63 years with a mean of 41.44 years (SD ± 9.88).

Table 1 summarizes the socio-demographic characteristics of the sample interviewed. The table indicates that majority of respondents (42.1%) had ordinary secondary education.

The distribution of healthcare workers (HCWs) who were involved in this study by type of health facility and municipality was as summarized in Table 2.

Table 1: Socio-demographic characteristics of the study sample by sex

Characteristic	Respondents' sex		
	Male n (%)	Female n (%)	Total n (%)
Age groups in years			
20 – 29	11 (26.2)	31 (73.8)	42 (13.8)
30 – 39	18 (19.6)	74 (80.4)	92 (30.3)
40 – 49	15 (16.5)	76 (83.5)	91(29.9)
50 +	15 (19)	64 (81)	79 (26.0)
Total	**59 (19.4)**	**245 (80.6)**	**304 (100) ***
Marital status			
Single	15 (29.4)	36 (70.6)	51 (16.7)
Married/ Cohabiting	42 (17.9)	192 (82.1)	234 (76.5)
Separated/ Divorced/ Widowed	2 (9.5)	19 (90.5)	21 (6.9)
Total	**59 (19.3)**	**247 (80.7)**	**306 (100)**
Education level			
Primary education	10 (10.3)	87 (89.7)	97 (31.9)
Secondary education: O- level	18 (14.1)	110 (85.9)	128 (42.1)
Secondary education: A- level	2 (11.8)	15 (88.2)	17 (5.6)
Diploma	10 (38.5)	16 (61.5)	26 (8.6)
Advanced Diploma/ Degree/ Postgraduate	19 (52.8)	17 (47.2)	36 (11.8)
Total	**59 (19.4)**	**245 (80.6)**	**304 (100) ****
Worker categories			
Clinicians/ Prescribers	29 (39.7)	44 (60.3)	73 (24.1)
Nursing staff	3 (2.2)	134 (97.8)	137 (45.2)
Clinical support staff	15 (53.6)	13 (46.4)	28 (9.2)
Support staff	11 (16.9)	54 (83.1)	65 (21.5)
Total	**58 (19.1)**	**245 (80.9)**	**303 (100) *****

Key:

* Two respondents did not wish to disclose their ages

** Two respondents did not disclose their education level

*** Worker categories were not recorded for three respondents

Table 2: Distribution of health workers by type of health facility and municipality

Type of facility	District/ Municipality			
	Ilala	Kinondoni	Temeke	**Total**
Dispensary	37 (30.3%)	53 (43.4%)	32 (26.2%)	**122**
Health centre	90 (48.9%)	72 (39.1%)	22 (12%)	**184**
Total	**127 (41.5%)**	**125 (40.8%)**	**54 (17.6%)**	**306**

4.2 Relationship between motivation and respondents' characteristics

Relationships between motivation and respondents characteristics were analyzed. Table 3 shows that the youngest (20 – 29 years) and the oldest (50 + years) HCWs were more motivated (about 91% and 90% respectively) compared to middle aged HCWs ($p = 0.766$). However, there was a significant difference between female and male health care workers as far as motivation to perform was concerned (Chi square test, $p = 0.000$). A higher proportion of female health care workers (91%) were motivated to perform than male workers, (74.1%).

With respect to marital status, about 16% of the single HCWs were demotivated while majority (95%) of their counterparts who were separated/ divorced/ widowed was motivated. Considering the education level, the proportion of HCWs with advanced diploma, degree or postgraduate level of education who were motivated (74.3%) was low compared to those who had primary and secondary education; about 92% and 88% respectively (Table 3). Across the worker categories, the proportion of support staff and

nursing staff who were motivated was higher (above 90%) compared to other categories. About 19% and 21% of clinical support staff and clinicians respectively were demotivated (Chi square test, p = 0.042).

Table 4 shows the relationship between motivation and health care workers' and employers' characteristics. Majority (94%) of HCWs who had been employed in less than a year's time were motivated to perform compared to those employed in 1 or 2 years' time (81% and 67% respectively) while those who had been employed in more than two years' time (88%) were motivated than those employed for one or two years (Fisher's Exact test, p = 0.048). Most heads/ supervisors of sections, wards or units (95%) and their assistants (90%) were motivated compared to facility in charges (71%) (Fisher's Exact test, p = 0.153).

In relation to workload, respondents who were overworked (heavy workload) were motivated (90%) compared to those who reported low workload (75%), moderate workload (87.5%) and very heavy workload (82.4%). However, the difference was not statistically significant (p = 0.307). A significant proportion (95.2%) of HCWs who perceived their employer cared for their welfare were motivated to perform compared to the ones who perceived only some extent of care (83.8%) and those who perceived no care at all (79.3%). The difference among reported levels of care from the employer was statistically significant (p = 0.008).

Table 3: Relationship between motivation and respondents' characteristics

Characteristics	Are you motivated to perform?			
	Yes n (%)	No n (%)	Total n (%)	p - value
Age groups in years				
20 – 29	38 (90.5)	4 (9.5)	42 (14)	0.766
30 – 39	75 (85.2)	13 (14.8)	88 (29.3)	
40 – 49	80 (87.9)	11 (12.1)	91 (30.3)	
50 +	71 (89.9)	8 (10.1)	79 (26.3)	
Total	264	36	**300**	
Gender				
Male	43 (74.1)	15 (25.9)	58 (19.2)	**0.000**
Female	222 (91.0)	22 (9.0)	244 (80.8)	
Total	265	37	**302**	
Marital status				
Single	42 (84.0)	8 (16.0)	50 (16.6)	0.441
Married/ Cohabiting	204 (87.9)	28 (12.1)	232 (76.8)	
Separated/ Divorced/ Widowed	19 (95)	1 (5)	20 (6.6)	
Total	265	37	**302**	
Education level				
Primary education	88 (91.7)	8 (8.3)	96 (32)	0.144*
Secondary education: O-level	111 (88.1)	15 (11.9)	126 (42)	
Secondary education: A-level	15 (88.2)	2 (11.8)	17 (5.7)	
Diploma	23 (88.5)	3 (11.5)	26 (8.7)	
Advanced Diploma/ Degree/ Postgraduate	26 (74.3)	9 (25.7)	35 (11.7)	
Total	263	37	**300**	
Worker categories				
Clinicians/ Prescribers	58 (79.5)	15 (20.5)	73 (24.4)	**0.042**
Nursing staff	123 (91.1)	12 (8.9)	135 (45.2)	
Clinical support staff	22 (81.5)	5(18.5)	27 (9)	
Support staff	59 (92.2)	5 (7.8)	64 (21.4)	
Total	265	37	**299**	

Key:

* Fisher's Exact test was used to calculate p - value since more than 20% of cells had expected count less than 5.

As far as supervision was concerned, there was no statistically significant difference ($p = 0.392$) in motivation to perform between the supervised and non-supervised health care workers. Table 4 also shows that supervisors' education level had no significant effect on reported motivation of the health care workers ($p = 0.265$) although those who were supervised by supervisors of low level of education were more likely to report to be motivated than those who were supervised by more educated supervisors.

Table 4: Relationship between motivation and health care workers' and employers' characteristics

Characteristics	Are you motivated to perform?		Total	p - value
	Yes n (%)	No n (%)		
Years of employment			**n**	
< 1	31 (93.9)	2 (6.1)	33	**0.048***
1	13 (81.3)	3 (18.8)	16	
2	10 (66.7)	5 (33.3)	15	
> 2	211 (88.7)	27 (11.3)	238	
Total	265	37	**302**	
Position				
Facility Incharge	12 (70.6)	5 (29.4)	17	0.153*
Head/ Supervisor of section/ ward/ unit	19 (95.0)	1 (5.0)	20	
Assistant Head/ Supervisor	17 (89.5)	2 (10.5)	19	
None	217 (88.2)	29 (11.8)	246	
Total	265	37	**302**	
Workload				
Low	9 (75.0)	3 (25.0)	12	0.307*
Moderate	133 (87.5)	19 (12.5)	152	
Heavy	109 (90.1)	12 (9.9)	121	
Very heavy	14(82.4)	3 (17.6)	17	
Total	265	37	**302**	
Employer cares for staff welfare				
Yes	119 (95.2)	6 (4.8)	125	**0.008**
To some extent	83 (83.8)	16 (16.2)	99	
Not at all	46 (79.3)	12 (20.7)	58	
I don't know	16 (84.2)	3 (15.8)	19	
Total	264	37	**301**	
Have a supervisor				
Yes	254 (88.2)	34 (11.8)	288	0.392*
No	11 (78.6)	3 (21.4)	14	
Total	265	37	**302**	
Supervisor's education level				
Primary	2 (100)	0 (0)	92	0.187*
Secondary: O - level	65 (95.6)	3 (4.4)	124	
Secondary: A - level	17 (85)	3 (15)	17	
Diploma	19 (90.5)	2 (9.5)	26	
Advanced Diploma/ Degree/ Postgraduate	77 (82.8)	16 (17.2)	34	
Don't know	75 (88.2)	10 (11.8)		
Total	255	34	**289**	

Key:

* Fisher's Exact test was used to calculate p - value since more than 20% of cells had expected count less than 5.

4.3 Health care workers' awareness of supportive supervision

Table 5 indicates the relationship between worker categories, length of employment and awareness of supportive supervision. The table shows that across the different worker categories, clinicians followed by nursing staff were more significantly likely to report positive awareness of what supportive supervision was and support staff were less likely to report being aware of what supportive supervision was (Chi square test, p = 0.005). However, majority among the clinical support staff (54%) and support staff (69%) were not aware of what supportive supervision was.

Table 5: Relationship between worker categories, length of employment and awareness of supportive supervision

	Do you know what it means by supportive supervision?			
	Yes n (%)	**No** n (%)	**Total**	**p - value**
Categories				
Clinicians/Prescribers	43 (58.9)	30 (41.1)	73	**0.005**
Nursing staff	74 (54.0)	63 (46)	137	
Clinical support staff	13 (46.4)	15 (53.6)	28	
Support staff	20 (30.8)	45 (69.2)	65	
Total	**150**	**153**	**303**	
Years of employment				
<1	13 (39.4)	20 (60.6)	33	0.300
1	6 (37.5)	10 (62.5)	16	
2	6 (40.0)	9 (60.0)	15	
>2	127 (52.5)	115 (47.5)	242	
Total	**152**	**154**	**306**	

Table 5 also shows that awareness of the elements of supportive supervision was reported to increase with increase in the number of years of employment with the exception of respondents who had been employed for less than a year. HCWs who had

been employed in less than a year's time were more aware of the elements of supportive supervision than those employed in one year's time. However, the difference was statistically not significant (Chi square test, p = 0.300).

As far as the coverage of supportive supervision was concerned, about 59% (88) mentioned self assessment as a component of supportive supervision, 64 (42.7%) mentioned peer assessment, 75 (50%) mentioned internal supervision and 63 (42%) mentioned external supervision. Furthermore Table 6 shows that more than a quarter of the clinicians and support staff and nearly one third of nursing staff who said they knew what supportive supervision meant were aware of the elements of supportive supervision by 75% or more whereas one third of the clinical support staff were aware (Chi square test, p = 0.850).

Table 6: Level of awareness of supportive supervision by categories of workers

Categories of workers	**Levels of awareness**						
	0% n (%)	**25%** n (%)	**50%** n (%)	**75%** n (%)	**100%** n (%)	**Total**	**p - value**
Clinicians	4 (9.30)	20 (46.51)	7 (16.28)	4 (9.30)	8 (18.60)	43	0.850
Nursing staff	5 (6.94)	30 (41.67)	14 (19.44)	6 (8.33)	17 (23.61)	72	
Clinical support staff	2 (15.38)	3 (23.08)	3 (23.08)	1 (7.69)	4 (30.77)	13	
Support staff	1 (5.26)	7 (36.84)	6 (31.58)	3 (15.79)	2 (10.53)	19	
Total	12	60	30	14	31	**147**	

4.4 Health care workers assessment on supervision motivation

Assessment was done on the general level of motivation. Figure 1 shows that 80% of respondents were motivated.

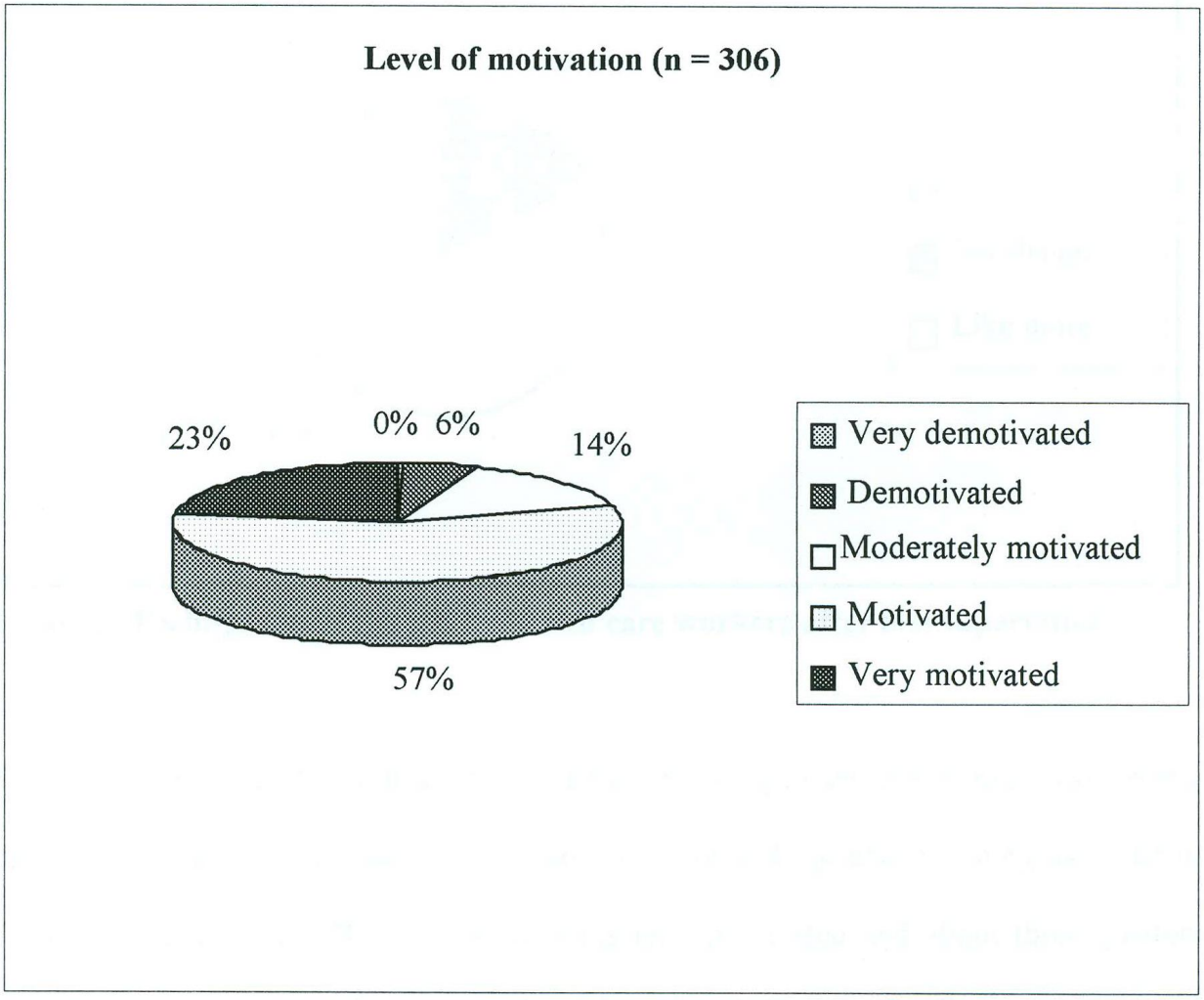


Figure 1: Level of motivation of health care workers

Feelings about the job following the last supervision were assessed. 249 (82.5%) developed a feeling of liking their job more since they were supervised the last time (Figure 2). About 16% reported to have developed no change on the way they felt about their job and 1% reported to have developed a feeling of dislike towards their jobs.

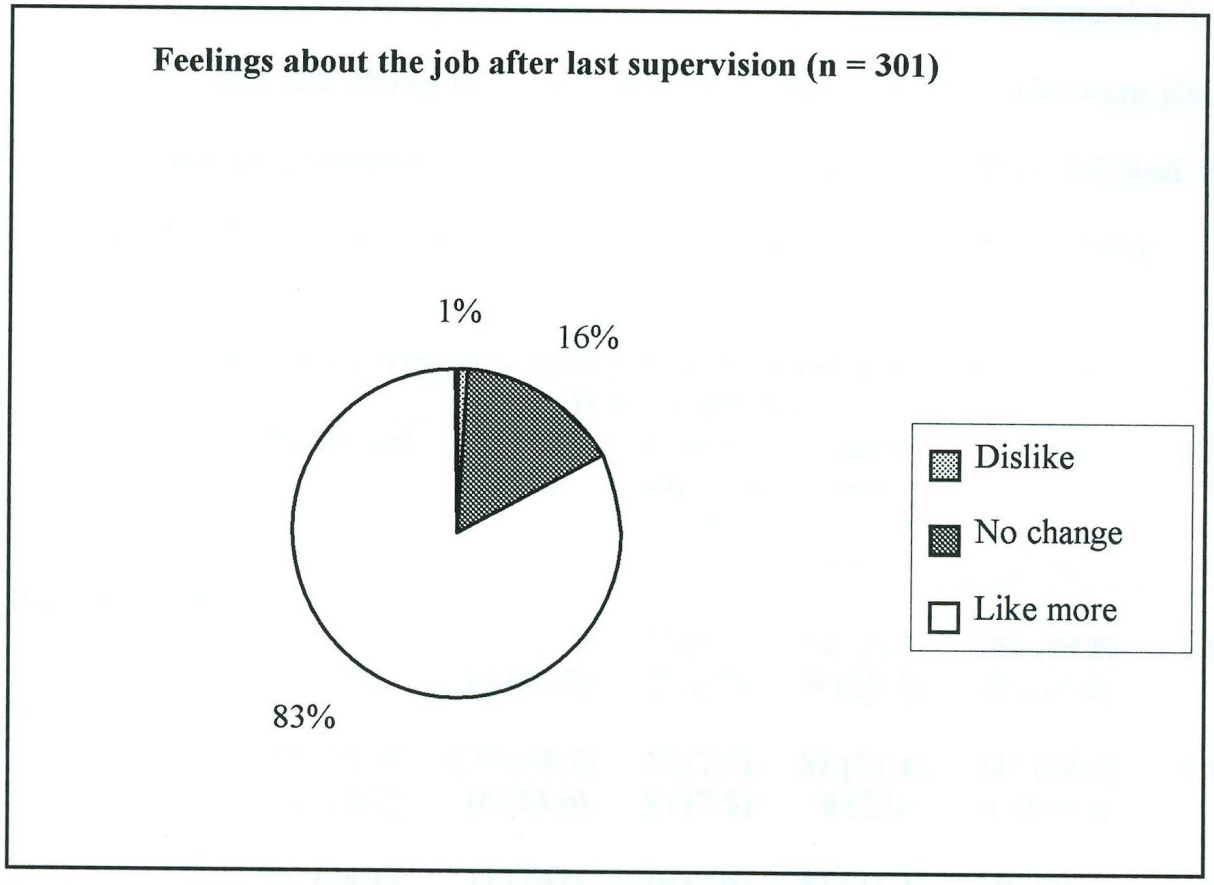


Figure 2: Feelings about the job by health care workers after last supervision

Supervision has been found to give HCWs the following incentives: appreciation, being valued, recognition, care, mentorship, guidance, counselling and coaching as listed in Table 7. The majority (90%) of respondents felt appreciated and about three quarters were mentored during the last supervision. More than 80% felt valued, recognized, cared for, guided, counselled and coached.

Table 7 also shows the different incentives given by supervision where a high proportion of nursing staff were given the different types of incentives in supervision compared to other categories but the difference was not significant (for appreciation ($p = 0.818$);

being valued (p = 0.102); recognition (p = 0.455); care (p = 0.582); and mentorship (p = 0.103). The Table also shows that a significant percentage of those who were given different types of incentives by supervision were nurses (45 - 48%) followed by clinicians (23 - 29%), support staff (18 - 22%) and clinical support staff (8 - 10%).

Table 7: Perceived incentives given by supervision by categories of workers

Incentive	Worker category					p-value
	Clinicians	Nursing staff	Clinical support staff	Support staff	Total	
	n (%)	n (%)	n (%)	n (%)	n (%)	
Appreciation						
Yes	64 (24.2)	121 (45.8)	25 (9.5)	54 (20.5)	**264 (89.8)**	0.818
No	6 (20)	14 (46.7)	2 (6.7)	8 (26.7)	30 (10.2)	
Being valued						
Yes	58 (23.5)	119 (48.2)	18 (7.3)	52 (21.1)	**247 (84.6)**	0.102
No	12 (26.7)	16 (35.6)	8 (17.8)	9 (20)	45 (15.4)	
Recognition						
Yes	60 (24.1)	117 (47)	19 (7.6)	53 (21.3)	**249 (86.5)**	0.455
No	9 (23.1)	17 (43.6)	6 (15.4)	7 (17.9)	39 (13.5)	
Care						
Yes	55 (23.1)	110 (46.2)	22 (9.2)	51 (21.4)	**238 (83.5)**	0.582
No	13 (27.7)	23 (48.9)	5 (10.6)	6 (12.8)	47 (16.5)	
Mentorship						
Yes	50 (28.6)	79 (45.1)	14 (8)	32 (18.3)	**175 (75.4)**	0.103
No	8 (14)	27 (47.4)	8 (14)	14 (24.6)	57 (24.6)	
Guidance						
Yes	64 (25.4)	113 (44.8)	22 (8.7)	53 (21)	**252 (86.2)**	0.411
No	6 (16.2)	20 (54.1)	5 (13.5)	6 (16.2)	37 (13.8)	
Counselling						
Yes	57 (23.6)	112 (46.3)	20 (8.3)	53 (21.9)	**242 (84.6)**	0.482
No	11 (25)	21 (47.7)	6 (13.6)	6 (13.6)	44 (15.4)	
Coaching						
Yes	57 (23.6)	110 (45.5)	21 (8.7)	54 (22.3)	**242 (83.2)**	0.734
No	12 (24.5)	23 (46.9)	6 (12.2)	8 (16.3)	49 (16.8)	

Level of incentives provided by supervision to health care workers was assessed. About 72% of the respondents had high incentives, about 19% had moderate incentives and about 9% had low incentives from supervision as per the criteria set in this study. Table 8 shows the level of incentives given by supervision across gender.

Table 8: Health care workers levels of incentives provided by supervision by sex of the health care workers

Level of incentive	Male n (%)	Female n (%)	Total n (%)	p - value
Low (0 - 2)	5 (8.47)	22 (8.91)	27 (8.82)	0.581
Moderate (3 - 5)	14 (23.73)	44 (17.81)	58 (18.95)	
High (6 - 8)	40 (67.80)	181 (73.28)	221(72.22)	
Total	**59**	**247**	**306 (100)**	

4.5 Effects of supervision incentives on performance

Table 9 shows that high percentages (66% to 70%) of respondents who were given different incentives by supervision also improved their performance. Respondents who were counselled by their supervisors were more likely to report that supervision improved their performance while those who were appreciated by their supervisors were least likely to have reported improvement in their performance. Generally, most respondents (more than 60%) reported positively on the main variables that were categorized as comprising incentives in supervision to be influencing their performance: recognition, guidance, mentorship, being valued and cared for. Table 9 also shows that a

good number of respondents (about 30% and more) were given incentives by supervision but this did not have any positive effect on their performance i.e. they had either no change on performance or declined performance more significantly with recognition (p = 0.000), mentorship (p = 0.011), guidance (p = 0.000) and counseling (p = 0.000).

Table 9: Perceived influence of supervision incentives on work performance

Incentive	Influence of supervision on performance			Total	p - value
	Improved performance n (%)	No change on performance n (%)	Declined performance n (%)		
Appreciation					
Yes	171 (65.8)	75 (28.8)	14 (5.4)	260	0.304
No	15 (53.6)	12 (42.9)	1 (3.6)	28	
Being valued					
Yes	161 (66.3)	69 (28.4)	13 (5.3)	243	0.208
No	23 (53.5)	18 (41.9)	2 (4.7)	43	
Recognition					
Yes	168 (68.9)	65 (26.5)	11 (4.5)	244	**0.000**
No	13 (34.2)	22 (57.9)	3 (7.9)	38	
Care					
Yes	157 (66.6)	66 (28.1)	12 (5.1)	235	0.234
No	24 (54.5)	18 (40.9)	2 (4.5)	44	
Mentorship					
Yes	119 (69.2)	46(26.7)	7 (4.1)	172	**0.011**
No	27 (50.0)	20 (37.0)	7 (13.0)	54	
Guidance					
Yes	171 (68.7)	67 (26.9)	11 (4.4)	249	**0.000**
No	11 (31.4)	20 (57.1)	4 (11.4)	35	
Counselling					
Yes	167 (70.2)	61(25.6)	10 (4.2)	238	**0.000**
No	14 (33.3)	24 (57.1)	4 (9.5)	42	
Coaching					
Yes	159 (66.3)	70 (29.2)	11(4.6)	240	0.198
No	24 (53.3)	17 (37.8)	4 (8.9)	45	

Supervisors' characters that influence subordinate workers' performance on the job were assessed. Table 10 shows that cooperative character was mentioned to influence subordinate workers' performance by more than half of the respondents (59.7%) followed by a fair supervisor (44.4%) and a supervisor with a character of learning from the supervisee was least mentioned (4.6%).

Table 10 also shows that across the worker categories with the exception of 'learning from you' character, the other different characters were mentioned more frequently by nurses, clinicians, support staff, clinical support staff and others in that order but these differences are statistically not significant.

Health care workers performance is also influenced by how different people value their work. Respondents rated how they thought other health workers valued their work. A significant proportion (more than 70%) of HCWs perceived that their work is valuable to other workers of different levels (Table 11). About three quarters of respondents perceived their immediate supervisors to value their work, more than 72% perceived that their external supervisor valued their work and nearly 80% perceived that their co-workers valued their work.

Table 10: Supervisors' characters that influence performance across worker categories

Character	Worker category					p-value
	Clinicians	Nursing staff	Clinical support staff	Support staff	Total	
	n (%)	n (%)	n (%)	n (%)	n (%)	
Learning from you						
Yes	5 (35.7)	8 (57.1)	1 (7.1)	0 (0)	**14 (4.6)**	0.142*
No	68 (23.5)	129 (44.6)	27 (9.3)	65 (21.5)	289 (95.4)	
Cooperative						0.225
Yes	45 (24.9)	77 (42.5)	14 (7.7)	45 (24.9)	**181 (59.7)**	
No	28 (23)	60 (49.2)	14 (11.5)	20 (16.4)	122 (40.3)	
Acts as a communicator						
Yes	6 (28.6)	12 (57.1)	1 (4.8)	2 (9.5)	**21 (6.9)**	0.466*
No	67 (23.8)	125 (44.3)	27 (9.6)	63 (22.3)	282 (93.1)	
Guiding						
Yes	14 (16.7)	46 (54.8)	8 (9.5)	16 (19)	**84 (27.7)**	0.149
No	59 (26.9)	91 (41.6)	20 (9.1)	49 (22.4)	219 (72.3)	
Advising						
Yes	23 (21.3)	58 (53.7)	8 (7.4)	19 (17.6)	**108 (35.6)**	0.172
No	50 (25.6)	79 (40.5)	20 (10.3)	46 (23.6)	195 (64.4)	
Respectful						
Yes	21 (21.9)	50 (52.1)	8 (8.3)	17 (17.7)	**96 (31.7)**	0.424
No	52 (25.1)	87 (42)	20 (9.7)	48 (23.2)	207 (68.3)	
Listener						
Yes	26 (24.5)	46 (43.4)	9 (8.5%)	25 (23.6)	**106 (35)**	0.902
No	47 (23.9)	91 (46.2)	19 (9.6)	40 (20.3)	197 (65)	
Confident						
Yes	11 (23.9)	22 (47.8)	3 (6.5)	10 (21.7)	**46 (15.2)**	0.915
No	62 (24.1)	115 (44.7)	25 (9.7)	55 (21.4)	257 (84.8)	
Fair						
Yes	32 (23.5)	69 (50.7)	9 (6.6)	26 (19.1)	**136 (44.4)**	0.245
No	41 (24.6)	68 (40.7)	19 (11.4)	39 (23.4)	170 (55.6)	

Key:

* Fisher's Exact test was used to calculate p - value since more than 20% of cells had expected count less than 5.

Table 11: Extent to which other health workers of different levels value HCWs' work

Type of health worker	Extent to which work is valued (n = 306)					
	Very valueless n (%)	Valueless n (%)	Moderately valuable n (%)	Valuable n (%)	Very valuable n (%)	Don't know n (%)
Immediate supervisor	1 (0.3)	1 (0.3)	71 (23.2)	153 (50.0)	75 (24.5)	5 (1.6)
External supervisor	3 (1.0)	7 (2.3)	70 (22.9)	155 (50.7)	66 (21.6)	5 (1.6)
Co-workers	0 (0)	4 (1.3)	52 (17.0)	145 (47.4)	98 (32.0)	7 (2.3)

Table 12 shows the arithmetic mean values (averages) of scores showing how health care workers thought different people valued their work. The arithmetic means were all valuable for immediate supervisors, external supervisors and co-workers.

Table 12: Arithmetic means of how HCWs perceive other health workers value their work (n = 306)

Type of health worker	Mean	Median	Standard deviation	Minimum	Maximum
Immediate supervisor	3.96	4	0.79	0	5
External supervisor	3.85	4	0.92	0	5
Co-workers	4.07	4	0.84	1	5

4.6 Health care workers assessment on supervision in improving performance

A total of 174 (87.9%) of the respondents who had ever been evaluated for the work they did were motivated to perform their jobs by the kind of supervision received from their immediate supervisors. Table 13 shows that 90% of respondents who were given a job description by their supervisor were also motivated by the kind of supervision they

received from their immediate supervisor (Fisher's Exact test, p = 0.079). About 90% whose performance was influenced by supervision also evaluation did influence their performance (Fisher's Exact test, p = 0.131). Regarding whether feedback after evaluation had any influence on motivation to perform, Table 13 shows that although most of the respondents (88%) had been given feedback after evaluation, however the feedback had statistically no significant influence on motivating them to perform on their jobs (Chi square test, p = 0.861). Of those respondents who feedback did help, most of them (about 92%) also reported that supervision received from immediate supervisor motivated them to perform their job significantly (Fisher's Exact test, p = 0.001).

Majority (90%) of respondents who had ever been rewarded were motivated to perform by the supervision received from the immediate supervisor (Fisher's Exact test, p = 0.790).

The influence of routine supervision on respondents' work performance was assessed by respondents mentioning it and 189 (64.5%) had improved performance while 16 (5.7%) had reduced performance (Figure 2). Figure 2 also shows that routine supervision does not significantly add anything to the performance of 35% of respondents.

Perceived influence of supervision on performance was rated in a scale of 1 to 5 where 1 = very negative and 5 = very positive, the mean was 3.7, median 4 and standard

deviation 0.75 meaning that majority of respondents had an improvement in performance following routine supervision.

Table 13: Relationship between supervision and improving performance

Types of motivation elements in supervision	Supervision from immediate supervisor motivates performance		Total	p - value
	Yes n (%)	No n (%)		
Ever given job description				
Yes	148 (89.7)	17 (10.3)	165	0.079*
No	25 (78.1)	7 (21.9)	32	
Total			**197**	
Ever given feedback after evaluation				
Yes	110 (88.0)	15 (12.0)	125	0.861
No	61 (87.1)	9 (12.9)	70	
Total			**195**	
Feedback helped				
Yes	109 (91.6)	10 (8.4)	119	**0.001***
No	2 (33.3)	4 (66.7)	6	
Total			**125**	
Evaluation influences performance				
Yes	149 (89.8)	17 (10.2)	166	0.131*
No	24 (80.0)	6 (20)	30	
Total			**196**	
Ever rewarded				
Yes	36 (90)	4 (10)	40	0.790*
No	138 (87.3)	20 (12.7)	158	
Total			**198**	

Key:

* Fisher's Exact test was used to calculate p - value since more than 20% of cells had expected count less than 5.

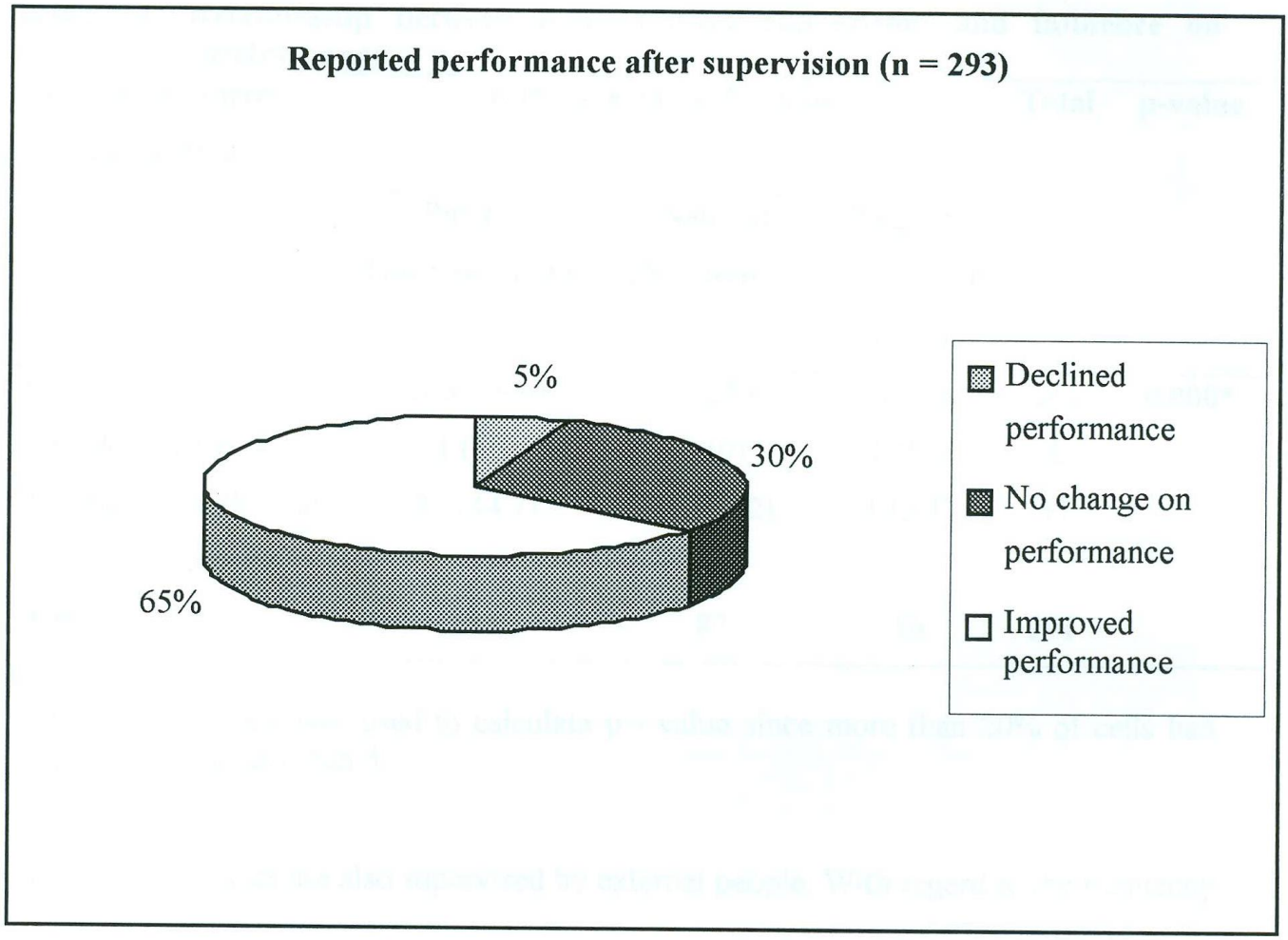


Figure 3: Reported effect (influence) of supervision on work performance

Respondents' feelings after last supervision visit were assessed. Table 14 shows that about 69% of respondents who liked more their job also reported that the last supervision visit had a positive influence on work performance (improved performance). Half of those who disliked their job reported to have had improved on work performance while nearly 45% of those who reported to have had no change of feeling about their job following last supervision reported to have had an improvement in work performance (Fisher's Exact test, $p = 0.000$).

Table 14: Relationship between feelings after supervision and influence on performance

Feelings following last supervision	Influence on performance			Total	p-value
	Positive (Improvement)	Neutral (No change)	Negative (Decline)		
	n (%)	n (%)	n (%)		
I like my job more	166 (68.6)	62 (25.6)	14 (5.8)	242	**0.000***
I dislike my job	1 (50)	0 (0)	1 (50)	2	
No change on the way I feel about my job	21 (44.7)	25 (53.2)	1 (2.1)	47	
Total	**188**	**87**	**16**	**291**	

Key:
*Fisher's Exact test was used to calculate p - value since more than 20% of cells had expected count less than 5.

Health care workers are also supervised by external people. With regard to the frequency of external supervision, although Table 15 shows that the frequency of external supervision was positively related to being motivated to perform, this Table indicates that external supervision had little effect on HCWs motivation to perform (Fisher's Exact test, $p = 0.482$). Number of hours (duration) of external supervision did not necessarily increase motivation (Fisher's Exact test, $p = 0.214$).

Table 15: Frequency and duration of external supervision in relation to motivation to perform

Variable	Motivated to perform		Total	p - value*
Reported frequency of external supervision in last 6 months	**Yes** n (%)	**No** n (%)		
Never	6 (75)	2 (25)	8	0.482
Once	12 (85.7)	2 (14.3)	14	
Twice	35 (89.7)	4 (10.3)	39	
More than twice	119 (90.8)	12 (9.2)	131	
Don't remember	17 (94.4)	1 (5.6)	18	
Total			**210**	
Duration of last supervision				
< 1 hour	64 (91.4)	6 (8.6)	70	0.214
1 - 2 hours	85 (88.5)	11 (11.5)	96	
3 - 4 hours	14 (100)	0 (0)	14	
5 - 6 hours	2 (66.7)	1 (33.3)	3	
> 7 hours	3 (75)	1 (25)	4	
Total			**187**	

Key:

*Fisher's Exact test was used to calculate p - value since more than 20% of cells had expected count less than 5.

Therefore, neither frequency nor duration of external supervision had significant positive influence on motivation to perform (Fisher's Exact test, p = 0.482 and 0.214 respectively).

CHAPTER FIVE

5.0 DISCUSSION

This study has explored incentives, motivation elements and supervision characteristics embedded in supportive supervision in the perspective of the supervised health care workers.

Findings from this study show that female health care workers were motivated to perform than male workers. In an African context, generally males have more family tasks and responsibilities compared to females. There is a general perception that females are not meant for formal employment.

Across the worker categories, nursing staff and support staff were more motivated compared to other categories. These results differ from those by Dunbar (2003) whereby no statistical difference was found regarding perception of work motivation across worker categories. In the present study, majority of the respondents were female and almost all (98%) of the nursing staff were also female thus bias and confounding results. These findings may be due to the fact that in this study the sample was not randomly selected; all those HCWs available and willing to participate during the study period were included in the study. There is therefore a need for further study that will use random sampling and isolate factors contributing to this observation so as to find out if the difference is real or just by chance.

Results from this study revealed that HCWs with higher level of education were less likely to be motivated compared to those who had primary and secondary education. Generally, with higher education, individuals tend to have higher expectations and when these expectations are not fulfilled, they may be demotivated. However, Manzi *et al.* (2004) found no clear motivation differences between more and less highly trained staff. In the current study, other factors apart from supervision could have also contributed to the demotivation.

Years spent on the job does matter. HCWs who had been employed in less than a year's time were motivated to perform compared to those employed in 1 or 2 years' time. New and inexperienced employees tend to be more motivated as they have not yet gone through the challenges that their fellows who have stayed for one to two years have. Also, on accepting a job, an individual has higher expectations and hopes that with more experience s/he is likely to get promotion and is under pressure that s/he may get easily fired. With 1 or 2 years of experience, individuals are in the process of adapting to the new environment while with more years of experience they have adapted to the environment and probably they have got used to the hassles and find it an ordinary experience.

This study shows that heads/ supervisors and their assistants were motivated. However surprisingly, their supervisors (facilities in charges) were less motivated. It is expected that the higher the position the more motivated an individual would be. An explanation

could be that the facilities in charges have more workload and face a lot of administrative and management challenges such as organizational conflicts hence more work and less leisure. Furthermore, the motivation of the facility in charges is also contributed by the achievement of the facility. Being a facility in charge one might have higher expectations and once these are not met then s/he may be demotivated.

The proportion of motivated health care workers increased with reported heavy workload with the exception of those who reported to have very heavy workload. This is not surprising given the fact that most respondents reported to have chosen the profession in order to serve patients and interest/ liking the job. Similar findings were obtained in a study done in Benin and Kenya whereby health workers were strongly guided by their professional conscience and similar aspects related to professional ethos (Mathauer and Imhoff, 2006). A person who is more motivated is more likely to work harder and longer hours. It could also be due to the fact that those who work extra time are paid over time/ extra duty allowances which motivate them to perform.

Employer caring for the employees' social welfare improves motivation to perform their jobs. Majority of HCWs who perceived their employer cared for their welfare were significantly motivated to perform compared to the ones who perceived care to some extent and those who perceived no care at all. With more care from the employer, an employee would be more motivated and that a caring supervisor is one of the factors that support good performance (Luoma and Crigler (2002).

This study found that some respondents (about 5%) had no supervisors. It was not in the scope of this study to find out what the term supervisor meant to the supervisees, however with or without a supervisor did not make much difference in reported motivation to perform. But, Parsons *et al.* (2003) found that supervision had an effect on nurse aides' performance probably because the study population included nurses only. In the event that such a difference is not observed in a study that comprised a variety of worker categories, it calls for a study to find out what is wrong with the supervision process.

Supervisor's level of education matters in motivation of HCWs. This study found that supervisees with supervisors of low level of education were more likely to be motivated than those who were supervised by more educated supervisors. Most likely more educated supervisors adhere to principles of supervision more hence are not preferred by the supervisees. Also, it is difficult for a lowly educated person to supervise confidently a highly educated colleague.

Supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to improve efficiency in the allocation of resources. It focuses on the results of processes as well as individual performance. It is implemented by multiple parties, including officially designated supervisors, informal supervisors, peers, and health care workers themselves (Marquez and Kean, 2002).

Results form this study showed that about half of the respondents said they knew what supportive supervision meant out of whom majority (91%) reported it was being done in their facilities. However, this finding should be looked at with caution since further categorization of the awareness levels revealed that generally the awareness level was as low as only less than one tenth of the respondents were actually aware of supportive supervision per the criterion set in this study. It could be that what most health care workers perceive to be supportive supervision is something quite different.

This study also revealed that awareness of supportive supervision increased with increase in the number of years of employment, surprisingly with exception of respondents who had less than one year of employment who were more aware of supportive supervision than those employed in one year's time. It has to be overemphasized here that these findings on awareness need to be concluded with great care given the actual awareness levels found using the criteria set in this study.

Workers motivation is influenced by supervision. However, Manzi *et al.* (2004) found that out of the seventeen staff interviewed, 70% had low levels of motivation. In the current study, the case is for 20% of respondents. If two out of ten workers are demotivated, it is a good reason to raise concern because these can affect the remaining staffs who are motivated. Manzi *et al.* (2004) pointed out that the demotivated staff were identified as either behaving rudely towards patients, being unwilling to work out of hours or refusing to be cooperative in the workplace while in contrast, those with high

motivation levels clearly demonstrated not only positive feelings about their work and workplace, but also positive behaviours towards patients and colleagues. The difference observed in Manzi *et al.* (2004) study and the current study can be explained by design since Manzi *et al.* (2004) did a qualitative study with few respondents while the present study was more of a quantitative one with quite a larger sample size. A study should therefore be conducted to find out why the 20% in the current study are demotivated since the aim of any organization is to have its entire staff motivated.

Supervisors are supposed to guide, mentor, counsel and coach their subordinates (Ali *et al.*, 2001). This study revealed that supervision causes people to develop a feeling of liking their job more. Non-financial incentives and human resources management (HRM) tools, supervision being one among the core, play an important role with respect to increasing motivation of health professionals (Mathauer and Imhoff (2006). This may be true when supervisees are given incentives by their supervisors. Such incentives include being appreciated, valued and recognized (Manongi *et al*, 2006). Also counselling, coaching and mentoring (Ali *et al.*, 2001).

Results of this study revealed that nearly three quarters of the respondents were found to be given such incentives by supervision. The concern should be on those who were not given the incentives since they may negatively affect others' motivation as such incentives have been found to influence performance (Mathaeur and Imhoff, 2006). In the current study, respondents who were given different incentives were more likely to

report that supervision improved their performance. Despite the fact that a good number of respondents had a positive perception towards supervision, there is a need to find means that will ensure that all workers get the incentives that should be found in supervision so as to get the intended level of motivation from supervision and in the end improve performance since low motivation has a negative impact on the performance of individual health workers, facilities and the health system as a whole (Mathaeur and Imhoff, 2006).

Supportive supervision of staff in health care has been initiated to respond to poor motivation to ensure the quality of operations and enabling staff to perform to their maximum potential. Supervisors have a role to play in achieving this since supervisors' characters have been found to influence performance on the job (Mathaeur and Imhoff, 2006; Dieleman *et al.*, 2003; Manongi *et al.*, 2006; Manzi *et al.*, 2004). Cooperative and fair are among the supervisors' characters that were frequently mentioned as important in motivating respondents in this study to improve performance. Such supervisors make a supervisee perceive a match between their own goals and those of the organization in order for the goals of the organization to have a positive impact on worker behaviour and ultimately on performance (Kanfer, 1999). Otherwise if such a match is not perceived, negative impacts on worker behaviour and consequently low performance results.

Being valued of what you perform has been found to motivate workers. A big proportion of HCWs in this study thought that their work is valuable to other workers of different levels and this can be used to explain the general high level of motivation observed since majority of HCWs perceive their work is valued. If employees feel their work is valued, then they are more likely to be motivated to perform better (Manongi *et al.*, 2006) and thus deliver quality and quantity health care services which are the ultimate goal of any health care system.

A job description is an important tool in measuring one's performance and feedback is an essential ingredient in effective supervision. Results of the present study indicate that majority of respondents who had ever been evaluated for work were motivated to perform. Furthermore, findings showed that majority of respondents who reported to have been given a job description by their supervisor also were motivated by the kind of supervision received from their immediate supervisor. 90% who reported that supervision influenced their performance perceived that evaluation did influence their performance thus highlighting the importance of job description and evaluation in supervision as also found by Dieleman *et al.* (2006). Immediate supervisors should therefore emphasize on job description, evaluation and feedback as these have proven to work in bringing about motivation to perform.

Supervision should be expected to result into performance improvement. This study indicates that majority of respondents reported to have improved performance following

supervision. The influence on performance was highly positive among HCWs who reported to like their job more following supervision thus reconfirming the positive perception that HCWs have on supervision. Supervisors have a great part to play in achieving organizational goals through their supervisory role.

External supervision is part and parcel of supportive supervision. It is a process used to oversee the operations and performance of individuals and facilities within a larger system such as a district, regional or national health system. External supervisors (National level, RHMT, CHMT) re-orient to set program goals and standards, make site visits, jointly define performance expectations with supervisees, assess performance against the set standards, allocate resources within the system, facilitate supervision to lower level of the system and follow up actions on problems that require intervention from within the same facility and higher levels of the health system (MoHSW, 2008). Findings revealed that with increased frequency of external supervision, motivation to perform increased. The findings are similar to those of a study in Kilimanjaro by Manongi *et al.* (2006) where irregular supervisions were undesirable. External supervisor should note that with regular and supportive supervision, it is expected that HCWs will have the guidance, encouragement and resources they need to perform (Tavrow *et al.*, 2002).

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

From the results of this study the following conclusions can be made:

- Female health care workers are motivated to perform than male workers, support staff and nursing staff are more motivated compared to other categories of workers and more educated HCWs are less likely to be motivated compared to those less educated though the differences were not significant.
- Newly employed HCWs are more motivated to perform compared to those employed in 1 or 2 years' time while heads/ supervisors of sections, wards or units and their assistants were likely to be motivated than facilities in charges.
- Awareness of supportive supervision among health care workers of different categories is generally low.
- Supervision is perceived to motivate HCWs to perform and develop a feeling of liking their job more. As well, perceived being cared for by the employer motivates HCWs to perform.
- Incentives in supervision that influence performance significantly are recognition, mentorship, guidance and counseling. Being given a job description, evaluated on the work and provided with feedback have a positive influence on HCWs' performance.

- Many respondents in this study perceive that supervision improves performance and that with increased frequency of external supervision, motivation to perform also increases.
- Cooperative and fair supervisors' are important in motivating HCWs to improve performance.
- Majority of respondents perceive their immediate supervisors, external supervisors and co-workers value their work.

6.2 Recommendations

- Since there is low level of awareness of supportive supervision among health care workers, there is a need to orient and sensitize them about supportive supervision.
- A study should be conducted to find the level of awareness among supervisors so as to ensure a common understanding between the supervisor and the supervisee about the supportive supervision as a management tool used.
- Supervisors should be cooperative and fair, recognize, mentor, guide, value, care and counsel supervisees as incentives during supervision as these have been found to influence performance of HCWs in primary health care facilities in Dar es Salaam. As well, supervisors should be regular in supervision and provide supervisees with job description, evaluate them and give them feedback as these have also been found to have a positive influence on supervisees' performance.

- Further research is needed in order to explore the perception on supportive supervision among supervisors who were trained in supportive supervision compared to those who did not receive such training. The study would help in providing information on the utility of supportive supervision compared to other forms of management in health care provision.

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