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The Nurses' Perception of Their Immediate Supervisors' Servant Leadership Behaviors and Their Sense of Work Effectiveness in a Selection of Dar es Salaam Public Hospitals of Tanzania

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Abstract

This study focused on the relationship between nurses' perceptions of their immediate supervisors' servant leadership behaviors and their sense of work effectiveness in a selection of Tanzanian public hospitals. I utilized servant leadership theory, which has its roots in Greenleaf (1977). Greenleaf proposed that leaders adopt a servant position in their relationships with their followers. In analyzing servant leadership behaviors, I utilized the Essential Servant Leadership Behavior (ESLB) scale (Winston & Fields, 2015). I also used the Conditions of Work Effectiveness Questionnaire (CWEQ) II (Laschinger et al., 2001) to assess work effectiveness. Winston and Fields (2015) stated that the ESLB provides a valid theory and technique for measuring leaders' servant leadership behaviors, showing a strong relationship between servant leadership behaviors and followers' judgments on outcomes such as job satisfaction, trust, and low burnout, which are characteristics measured by the CWEQ II. I also chose the CWEQ II because it was specifically designed to measure nurses' perceptions of their direct supervisor's bureaucratic behaviors. The CWEQ II has also been proven to be valid and reliable, which fits the purpose of this study. Tanzania has shown interest in adopting servant leadership (Chandaruba, 2019). The study results suggest that there are perceived positive and statistically significant relationships between servant leadership and work effectiveness in Tanzania and differences in access to CWEQ II constructs by hospital size, except for access to opportunities, where no significant differences by hospital size were found. This study is the first known servant leadership study in the Tanzanian hospital system, thereby closing the gap in servant leadership theory and practice. Additional studies are recommended to replicate this study and to include other regions of Tanzania and other parts of the world. Using qualitative and mixed methods, together with other instruments for analyzing servant leadership and work effectiveness, is also recommended.

Keywords: servant leadership, essential leader behaviors, work effectiveness

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Greenleaf (1977) proposed that servant leaders should assume the servant position in their association with their followers. Since then, more researchers have emphasized the importance of servant leadership (Chandaruba, 2019; Dennis & Bocarnea, 2005, 2007; Farling et al., 1999; Patterson, 2003; R. Russell & Stone, 2002; Sendjaya et al., 2008, 2020; Wong & Page, 2000, 2003). Servant leadership emphasizes serving others and practicing shared goals, enabling followers to grow to their full potential (Sfetcu, 2021). Servant leaders practice power sharing, total quality, work teams, and participative leadership while giving followers opportunities and support for both personal and organizational goals (Sfetcu, 2021; Wong & Page, 2000). According to van Dierendonck and Nuijten (2011), servant leaders are stewards of resources for their organizations who focus on improving the welfare of their followers, supporting the needs of others, and with a dutiful approach to work, power sharing, and giving a voice to their followers while focusing on the long run instead of short-run performance.

Research in servant leadership has evolved from a conceptual development phase (Greenleaf, 1977; Wong & Page, 2000), followed by a measurement phase (Dennis & Bocarnea, 2005, 2007; Ehrhart, 2004; Laub, 1999), developing instruments and testing relationships between servant leadership and follower outcomes; this has been followed by a model development phase testing more sophisticated designs (Eva et al., 2019). The theoretical foundation for servant leadership research was pioneered by Graham (1991). Since then, it has demonstrated its uniqueness as a leadership theory, different from other forms of leadership (Peterson et al., 2012).

Servant leadership research has appeared in prominent management and leadership journals (Chen, Y. et al., 2015; Liden, R. C. et al., 2014; Neubert, M. J. et al., 2016). Research in servant leadership has expanded to other disciplines, including natural behavioral sciences (Waterman, 2011), hospitality (Lin et al., 2016), schools (Cerit, 2009), and public service (Chandaruba, 2019). Due to its interdisciplinary nature, servant leadership research appears in prominent journals such as *The Leadership Quarterly* and the *Journal of Management* (Eva et al., 2019; Liao et al., 2021). There are about 16 known servant leadership measures; among them are those by the authors Laub (1999), Ehrhart (2004), Dennis and Bocarnea (2005, 2007), Barbuto and Wheeler (2006), Patterson (2003), Liden et al. (2008, 2015), and Winston and Fields (2015).

The current study utilized the Essential Servant Leadership Behavior (ESLB) scale (Winston & Fields, 2015) to find the perceived relationship between servant leadership and the nurses' perception of their sense of work effectiveness in Tanzanian hospitals. I defined essential servant leadership behaviors the those of the focal leader or the immediate supervisor of the nurse participants, and I defined work effectiveness as positive attitudes, reduced burnout, and increased motivation to work (Laschinger et al., 2001).

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I chose the ESLB scale (Winston & Fields, 2015) because it is simple and reliable, with a convergent validity of 0.96%. The instrument was designed to measure servant leaders' behaviors, and its questions address behaviors that followers can easily relate to, for example, emphasizing leaders practicing what they preach or seeing their mission as a responsibility to others. The ESLB asks 10 questions to rate followers' perception of the observable behaviors in servant leadership of their immediate supervisors on a 5-point Likert scale ranging from *definitely no or not at all* to *definitely yes or often*. I used the ESLB scale to measure followers' sense of their leader's bureaucratic behaviors (structural empowerment, such as feedback, guidance, or expertise from superiors and peers), as detailed in the research questions and hypotheses.

I also utilized the Conditions of Work Effectiveness Questionnaire (CWEQ) II (Laschinger et al., 2001). The CWEQ II is a 19-item tool with six subscales measuring (a) opportunities, meaning the extent to which one has the opportunity to learn new skills; (b) information, referring to the extent to which one has access to the hospital information; (c) support, which is the extent to which one is provided with problem-solving advice; (d) resources, referring to the extent to which one has time to do the job requirements; (e) informal power, meaning the extent to which one is sought by work peers; and (f) formal power, referring to the extent to which one is rewarded for innovation in their role (Laschinger et al., 2001). I chose the CWEQ II because it extends the Hackman-Oldham job characteristics model (Garg & Rastogi, 2006). The CWEQ II opens the notion of critical psychological states, such as experienced meaningfulness (skill variety, task identity, and task significance), experienced responsibility for the outcome of the work (autonomy), and the knowledge of actual results of work activities (feedback from the job). The CWEQ II was initially designed to measure nurses' sense of bureaucratic behaviors (structural empowerment); therefore, it fits the purpose of this study.

Background

I selected Tanzania as my study area due to its history as a stable African country in terms of both economic and political stability (Hirschler & Hofmeier, 2019). Tanzania became independent as Tanganyika in 1961 under the charismatic leadership of Julius Kambarage Nyerere (Hirschler & Hofmeier, 2019). In 1964, Tanganyika united with Zanzibar to form the United Republic of Tanzania (Hirschler & Hofmeier, 2019). Tanzania's economic development began with Nyerere's African socialism (Ujamaa) in 1967; however, by 1985, the country was forced to make major reforms at the recommendation of the World Bank, the International Monetary Fund, and international donors (Hirschler & Hofmeier, 2019).

Since the 1990s, Tanzania's economy has grown from a GDP of 0.4% per year to 5.2% in 2023 (Regulatory Capacity Review of Tanzania, 2010). From 2019, the microeconomic

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changes in Tanzania have led to societal changes with an impressive performance of 6% to 7% GDP growth (Hirschler & Hofmeier, 2019). Conversely, the quality of health and education has been generally poor, especially in rural areas (Hirschler & Hofmeier, 2019). Structural transformations in Tanzania have been slow, constrained by several challenges, including declining industrial productivity and competitiveness (African Economic Outlook, 2024). Other challenges include alleged stalled reforms and power tussles within the ruling party, which were blamed for the 2025 post-election protests (Muia, 2025).

To compete on the global stage, Tanzania would need to restructure its leadership and workforce to share common goals and embody the qualities of structural empowerment (Chandaruba, 2019). Empowerment also involves a clear understanding of the lines of responsibility between workers and leaders, including fostering moral and just behaviors, and ensuring that workers have sufficient awareness of their responsibilities and accountability (Mdee & Mushi, 2021). Structural empowerment has been widely used in nursing practice to reflect a perception of work effectiveness through access to resources, information, opportunities, and support, including formal and informal power (Havaei & Dahinten, 2017).

The background for structural empowerment has already been introduced in the Tanzanian hospital systems via the adoption of Kaizen in 2008 (Ministry of Health, 2013). Kaizen is a total quality management philosophy adopted from total quality management (TQM). TQM is an approach developed in Japan and authored by W. E. Deming (Deming, 1982; Gitlow, 1994). Since 2008, structural changes have been made in the hospital system, including training in shared governance, quality circles, and service culture (Ministry of Health, 2013).

Statement of the Problem

Tanzania is interested in grooming ethical leaders who are patriotic and devoted to serving their followers (Chandaruba, 2019). There is scant documented evidence of the practice of servant leadership in the country. Only a few studies have been done to study leadership behaviors and employee motivation in Tanzania. The public sector's only comprehensive servant leadership study indicated an increased interest in adopting servant leadership principles (Chandaruba, 2019). Servant leadership evaluation and measurement of work effectiveness will increase leaders' and followers' confidence in their work attitudes (Chandaruba, 2019). There is currently no known study on servant leadership in the Tanzanian healthcare sector (Chandaruba, 2019). Finally, research has found a relationship between followers' perception of their immediate supervisor and followers' sense of empowerment (Winston & Fields, 2015). In this study, I filled the gap in promoting servant leadership as Chandaruba (2019) proposed. I also demonstrated that servant leadership behavior is related to practical

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nurses' perceived leader behavior in the Dar es Salaam region public hospitals in Tanzania.

Studies That Have Addressed the Problem

Problems of job satisfaction and turnover intentions have been widely reported in Tanzania. For example, in his study at the Kilimanjaro Christian Medical Center referral hospital, Modest reported a 60.2% dissatisfaction among nurses influenced by promotion criteria, salary, decision-making process, supervision, career advancement, and the nature of work. Modest also reported a severe shortage of health personnel.

Msacky and Assey (2024) used a cross-sectional research design to study job satisfaction in Dodoma, Tanzania. They found that overall job satisfaction was 80.87% with 25.65% stemming from nurse employees. Msacky and Assey listed the lack of healthcare workers, heavy workloads, limited budgets, and infrastructure shortages as major limitations. The researchers also highlighted working conditions as a critical issue.

Similarly, Naburi et al. (2017) examined job satisfaction and turnover intentions in public healthcare facilities in Tanzania and revealed that over 54% (114 out of 213) nurses were dissatisfied with their jobs, and 35% planned to leave. Naburi et al. stated that "job dissatisfaction and turnover intention are highest in the Dar es Salaam public health facilities" (p.4). The main causes of job dissatisfaction were pay, workload, equipment, job security, and management.

Kisumbe and Mashala (2020) studied job satisfaction at Shinyanga health facilities and found that job dissatisfaction was only 32%, but there was a lack of employee support at 51.5%, a lack of resources, including a mismatch of assigned responsibilities. Mdee and Mushi (2021) studied the gap between theory and practice for the social accountability approach in Tanzania. Drawing on ethnographic investigations, the researchers found a wide gap between formal lines of accountability and actors' perceptions of blame for performance failure. According to Mdee and Mushi, building a collective understanding of this divergence will provide an effective starting point for interventions to improve work performance.

Van Winkle et al. (2014) investigated the relationship between followers' perceptions of their immediate supervisor's servant leadership and followers' sense of empowerment in small businesses. Servant leadership was strongly correlated with both structural and psychological empowerment. Van Winkle et al. suggested that the unique behavioral characteristics of the servant leader create empowerment, which leads to work effectiveness. Chandaruba (2019) suggested an interest in adopting servant leadership in Tanzania, but noted challenges such as ignorance, lack of patriotism, lack of political will, and other reasons. He also suggested training and emphasis on ethical codes of conduct.

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Other studies have found a positive relationship between servant leadership and job-related attitudinal outcomes (Eva et al., 2019), for example, team effectiveness (Irving & Longbotham, 2007), employee engagement (van Dierendonck et al., 2014), enhancement of follower psychological needs (van Dierendonck et al., 2014), learning and job satisfaction (Cerit, 2009; Mayer et al., 2008), prosperity at work (Awasthi & Walumbwa, 2022), employability (Chughtai, 2019), perceptions of meaningful work (Khan et al., 2021), personal development of followers (Graham, 1991), relationship between leaders and followers (Graen & Uhl-Bien, 1995), minimizing dysfunctional stress (Roberts, 2020), psychological well-being (Rivkin & Schmidt, 2016), inclusive organizations (Gotsis & Grimani, 2016), and enhancing trust (Reinke, 2004). Servant leadership was also negatively associated with emotional exhaustion (Rivkin et al., 2014), burnout (Walumbwa et al., 2019), and turnover intention (Hunter et al., 2013).

Servant leadership has been linked with increased personal and organizational fit (Irving, 2018) and individual job fit (Babakus et al., 2010). Positive relations were also found between CWEQ II and psychological empowerment (Hässler et al., 2022). In the Tanzanian public sector, Chandaruba (2019) found there are many prospects for adopting the principles of servant leadership; however, Chandaruba also found several challenges, including ignorance of servant leadership philosophy, self-interest, lack of political will, lack of patriotism, and lack of a legal framework to enforce public ethics.

Deficiencies in the Studies

Kisumbe and Mashala (2020), Msacky and Assey (2024), Modest (2020), and Naburi et al. (2017) have a common denominator—they focused on multiple worker specialties in healthcare. They did not specialize in a specific cadre of specialization. Being more specific would make it easier for policymakers to design the best strategies for improving job satisfaction in a specific field of specialization. My study focused on nurses to enable policymakers to implement targeted policies addressing the issue of job satisfaction among this particular group of employees.

The deficiency of the Van Winkle et al. (2014) study is that the sample's geographic area was confined to two counties in California, limiting the results' generalizability. In addition, some biases were related to inaccurate representation. The deficiencies in the Chandaruba (2019) study were that it focused mainly on the public sector and did not consider the private sector or other nongovernmental organizations. The study could also have benefited from a qualitative methodology.

Study Objectives

The main objective of the current study was to survey and explore nurses' perceptions in the public hospitals of the Dar es Salaam region, Tanzania, to determine if there is a relationship between their immediate supervisor's servant leadership behavior and

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their job outcomes. Additionally, the study aimed to learn if there is a difference in these job outcomes based on hospital size while controlling for employee tenure. The specific objectives follow:

1. Explore the relationship between nurses' perception of servant leadership and their perceived access to work opportunities, such as challenging work and opportunities to learn new skills.

2. Determine the relationship between nurses' perception of servant leadership and their perceived access to work resources, such as needed equipment and materials.

3. Explore the relationship between nurses' perception of servant leadership and their perceived access to work information, such as their willingness to share information.

4. Determine the relationship between nurses' perception of servant leadership and their perceived access to work support, such as feedback on job activities.

5. Determine the relationship between nurses' perception of servant leadership and their perceived formal power, such as work flexibility, decision making, creativity, or visibility.

6. Determine the relationship between nurses' perception of servant leadership and their perceived informal power, such as social connections and communication.

7. Explore variations in servant leadership and work effectiveness influenced by the size of the hospitals and the tenure of the employees in the selected hospitals.

Significance of the Study

This study is significant in several ways. First, it is the first attempt to measure nurses' sense of their immediate supervisor's servant leadership behaviors and their sense of structural empowerment or work effectiveness in the Tanzanian healthcare system. Second, the study addresses the impact and contribution of servant leadership philosophy in enhancing integrity, patriotism, ethics, and moral standards in the public sector, as Chandaruba (2019) suggested. Third, the study helps close the gap in the need to evaluate the impact of servant leadership on the perception of employee job engagement and job satisfaction in the Tanzanian health sector (Chandaruba, 2019). Finally, the study is significant because it gives the hospitals a golden chance for both leaders and nurses to employ self-evaluation and quality improvement.

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Purpose Statement

At the center of the actions to improve the economic capacities of Tanzania are the recommendations to build a regulatory management system that establishes clear objectives, accountability, and frameworks for implementing regulations (World Bank, 2012). According to Mkunde (2019), the Tanzanian regulatory regime needs effective engagement and coordination to provide for local needs, close the gaps in skill-based or infrastructural resources, close the accountability gap, and clarify unclear or overlapping responsibilities across and between different levels of public service. In this study, I determined the relationship between supervisors' servant leadership behavior and the work effectiveness of their followers in the Tanzanian tertiary hospital (large-size hospital), compared to three secondary hospitals combined (medium-size hospitals), and whether ESLB and CWEQ II constructs differ by tenure and hospital size. Work effectiveness in this study refers to positive work behaviors and attitudes leading to job satisfaction, commitment, less burnout, and trust. This will help guide leadership in determining the resources needed to improve their organizational competitiveness.

Literature Review

In this study, I determined the relationship between supervisors' servant leadership behavior (ESLB) and the work effectiveness of their followers (CWEQ II) in the Tanzanian tertiary hospital (large-sized hospital). I compared it with three regional referral hospitals (medium-sized hospitals). I also learned that there were differences in ESLB and CWEQ II constructs, even after controlling for employee tenure and hospital size. I defined work effectiveness as positive work behaviors and attitudes leading to job satisfaction, commitment, low burnout, and trust. In this section, I review previous studies on servant leadership and work effectiveness and summarize their findings, the significance of the studies, and the lessons learned.

Trastek and Niles (2014) studied leadership models in healthcare and found that servant leadership was the best model for healthcare organizations because it focuses on team leadership, trust, and serving patient needs (p. 374). Under servant leadership, governments are spending many resources to minimize patient healthcare costs (Trastek & Niles, 2014, p. 375). In addition to lowering costs, healthcare personnel must increase outcomes, safety, and service (Trastek & Niles, 2014, p. 376). Healthcare personnel practicing servant leadership are also expected to extend their leadership beyond patient care to teamwork. Trastek and Niles posited that team leadership is an integral part of adequate healthcare. Leaders must nurture the development of their fellow workers and instill appropriate standards. Autonomy is needed to develop both healthcare organizations and individuals. Autonomy allows providers to build

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motivation and improve employee personal growth and effectiveness (Trastek & Niles, 2014, p. 378).

Van Winkle et al. (2014) investigated the relationship between essential servant leadership behaviors and followers' perceptions of their immediate supervisor's sense of empowerment in small-scale enterprises. Using the ESLB and CWEQ II, Van Winkle et al. found a relationship between servant leadership and empowerment and associated empowerment with work effectiveness.

According to Laschinger et al. (2001), structural empowerment includes providing opportunities to followers, which has been positively related to servant leadership. Van Winkle et al. (2014) stated that structural empowerment is associated with effective leadership (Greenleaf, 1977) and effective behaviors (Kanter, 1977, 1993).

Irving and Longbotham (2007) studied the relationship between servant leadership and team effectiveness. Using the Organizational Leadership Assessment (Laub, 1999) and Team Effectiveness Questionnaire (LaFasto & Larson, 2001), they established a positive association between servant leadership and team effectiveness. Irving and Longbotham stated that the servant leadership notion of a servant intentionally means that the leader does what is best for the follower. Irving and Longbotham stated that team effectiveness has evidence as far back as 4000 B.C.; however, literature on team effectiveness only began with the work of Elton Mayo in the 20th century (Parker, 1990, p. 16), and the importance of leaders building effective teams only started with the work of Blake and Mouton (1964). From then on, Deming (1982), Furman (1995), Kuo and Yu (2009), Longbotham (2000), and Scholtes and Hacquebord (1988) promoted the importance of team effectiveness.

Access to Opportunities

Access to opportunities allows individuals to advance within the organization and develop their knowledge and skills. Employees in high-opportunity jobs are more proactive and innovative at solving challenges in their work, while those needing more opportunities are less motivated to succeed and less productive. Irving and Longbotham (2007) stated that servant leaders hold their followers accountable for reaching team goals. R. Russell and Stone (2002) posited that providing accountability is synonymous with stewardship. It involves developing others and encourages commitment and responsibility, which is related to the CWEQ II item of providing opportunities, including, among others, giving the followers challenging work and opportunities to learn new skills and new knowledge and to advance to better jobs (Irving & Longbotham, 2007; Laschinger et al., 2001).

Van Winkle et al. (2014) found a positive relationship between followers' perception of being empowered through access to opportunity, which produced a correlation of r =

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.22 (p = .02) with the perception of the supervisor's servant leadership. According to Laschinger et al. (2010), the servant leader may create opportunities for followers. However, followers may not consider it tangible or may not observe it immediately, resulting in a low perception of empowerment. Information from Trastek and Niles (2014), Van Winkle, B. et al. (2014), Irving, J. A., and Longbotham G. J. (2007) led to my first hypothesis:

H_1: When controlling for tenure and hospital size, there is a positive relationship between nurses' perception of servant leadership and their perceived access to opportunities.

Access to Resources

Access to resources is discussed regarding information as a power base and the ability to accomplish assignments. According to Kanter (1977), leaders who create environmental structures that provide information, resources, and support to their workers empower them to achieve their work. This virtue of empowerment also provides growth opportunities and shared formal and informal power (Miller & Chapman, 2001). In this sense, empowerment can either be structural (Kanter, 1977) or psychological (Conger & Kanungo, 1988).

In their efforts to modify Kanter's (1977) views, Laschinger et al. (2001) stated that structural empowerment leads to psychological empowerment, which leads to positive work behaviors and attitudes (work effectiveness), rationalizing the CWEQ II instrument. For example, Laschinger et al. (2010) defined empowerment as "a response to a structurally empowering work environment" (p. 2739). This definition combines theoretical structural empowerment (Kanter, 1977) and psychological empowerment (Conger & Kanungo, 1988; Thomas & Velthouse, 1990; Zimmerman, 1995).

Irving and Longbotham (2007) also supported leaders' responsibility to give support and resources to their followers. Irving and Longbotham related support and resources to achieving goals and tied this to empowerment, stating that a servant leader gives support by ensuring workers have the materials and resources needed to fulfill their goals. Irving and Longbotham's views were also supported by Patterson (2003), who equated empowerment to helping followers realize their dreams. Likewise, giving support and resources also helps to influence and empower followers (R. F. Russell, 2001).

Empowerment leads to work effectiveness and motivation (Pollard, 1996). The relationship between access to resources and their superiors' leadership behavior was studied by Van Winkle et al. (2014). Van Winkle et al. found that supervisors' servant leadership behavior produced a correlation of r = .45 (p = .00), indicating a positive relationship between supervisors' servant leadership behavior and access to resources

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such as technology, finances, or skill development. Resources are critical to accomplishing tasks (Johnson & Johnson, 1991). This led to my second hypothesis:

H_2: When controlling for tenure and hospital size, there is a positive relationship between nurses' perception of servant leadership and their perceived access to resources.

Access to Information

Access to information is discussed as a source of power and the ability to complete tasks. According to Kanter (1977), leaders who develop environmental structures that provide information, resources, and support empower their workers to succeed. Both Van Winkle et al. (2014) and Irving and Longbotham (2007) promoted communication as another key role for a servant leader. For example, Irving and Longbotham stated that a servant leader must share their plans and goals, and that communication shows followers where the organization is heading because it provides a clear picture that guides strategies, decisions, and actions. Effective communication is also crucial in guiding an organization's vision (Irving & Longbotham, 2007). Clear communication helps followers understand organizational goals and boosts their engagement and effectiveness within the organization (Irving & Longbotham, 2007). The more information a person has, the greater their influence (Johnson & Johnson, 1991).

Carmeli et al. (2011) also found a relationship between empowerment and willingness to share information. Therefore, access to information is critical for a servant leader. Van Winkle et al. (2014) accessed information and generated a correlation of $r = .59$ ($p = .00$) between the follower's perceived empowerment and the perception of their immediate supervisor's servant leadership behavior. These results showed that there was a positive relationship between access to information and empowerment. This led to my third hypothesis:

H_3: When controlling for tenure and hospital size, there is a positive relationship between nurses' perception of servant leadership and their perceived access to information.

Access to Support

Access to support is defined as critical feedback or information that allows the follower to maximize effectiveness (Kanter, 1977). Here, support is described as information demonstrating that servant leaders consistently support their employees to reach their goals (Van Winkle et al., 2014). According to Cooper-Thomas et al. (2018), offering employees resources such as vision, purpose, and teamwork, or creating value, long-term growth, and relationships with colleagues, can lead to job engagement. This means you can create job meaningfulness, safety, and availability (Kahn, 1990).

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In their search for the interrelationships between servant leadership, job demands, and resources, Coetzer et al. (2017) studied the views of both Cooper-Thomas et al. (2018) and Kahn (1990). Coetzer et al. found a positive relationship between servant leadership and job resources and a negative one between servant leadership and burnout. Coetzer et al. found that job resources significantly explained an increase in work engagement levels and a significant proportion of burnout reduction. Van Winkle et al. (2014) also found a positive correlation between perceived empowerment and access to support, $r = .52$ ($p = .00$). This led to my fourth hypothesis:

H_4: When controlling for tenure and hospital size, there is a positive relationship between nurses' perception of servant leadership and their perceived access to support.

Access to Formal Power

Access to formal power refers to specific characteristics such as flexibility, adaptability, creativity, decisionmaking, visibility, and the centrality of purpose and goals. Drysdale et al. (2009) called this type of power sustainable leadership focused on long-term development and consider individuals, business communities, or global markets intending to achieve welfare. By respecting value-based strategic decisions, leaders build communities and foster collaborations (Avery & Bergsteiner, 2011). On the other hand, Robert Greenleaf and Tom Marshal called it legitimate power (Tangen, 2019, p. 2).

Peterlin et al. (2015) conducted a study on the sustainable leadership approach to ensure its long-term sustainability. Peterlin et al. found a relationship between servant leadership and strategic decisionmaking. Further research is needed on managing relationships with various stakeholders and making influential and ethical decisions. New studies should focus on practical programs that enhance strategic decision making while reinforcing value-based leadership (Peterlin et al., 2015).

Another crucial element of formal power is creativity. Yang et al. (2017) studied servant leadership and creativity; their purpose was to explore the influence mechanism of servant leadership on employee and team creativity based on efficacy theory. Using a sample of 466 employees and 83 team leaders from 11 Chinese banks, Yang et al. found that servant leadership promotes employee creative self-efficacy and team efficiency, which leads to employee and team creativity. They suggested that managers should be encouraged to engage in servant leadership behaviors, which would improve the creative outcomes of employees.

Jaiswal and Dhar (2017) studied servant leadership's influence on trust in leaders and employee creativity. Their purpose was to investigate how servant leadership

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influences trust in leaders and how SL drives employee creativity. They found that servant leadership instills trust, which predicts employee creativity.

Van Winkle et al. (2014) found that formal power correlated at $r = .39$ ($p = .00$) with the supervisor's servant leadership behavior. Van Winkle et al. suggested that servant leaders use less institutional power to control while shifting authority to their followers. Servant leaders use formal power to empower others (Tangen, 2019). This led to my fifth hypothesis:

H_5: When controlling for tenure and hospital size, there is a positive relationship between nurses' perception of servant leadership and their perceived formal power.

Access to Informal Power

Informal power refers to power earned by leadership skills or personal skills such as charisma. Informal power also refers to social connections, communication, and information channels with sponsors, peers, subordinates, and cross-functional groups. Zoghbi-Manrique-de-Lara and Pablo Ruiz-Palomino (2019) called social connections social capital. The researchers studied servant leadership and wanted to learn whether it led to the development of social capital or whether it led followers to have more connections with their fellow workers, their peers, and subordinates. They also wanted to learn whether followers had known channels of communication and whether these relationships led to cross-functional growth. With a sample of 403 participants from 59 Spanish hotels, the researchers used structural equation modeling to test their hypotheses. They found that servant leadership could bond and bridge social interactions among workers, their peers, and outside their groups.

In the same way, in their study on servant leadership and empowerment, Van Winkle et al. (2014) found a positive relationship between followers' perceptions of being empowered through access to informal power. Their findings generated a correlation of $r = 23$ ($p = .01$). Despite yielding a positive outcome, Van Winkle et al. stated that informal power from servant leadership may have been overshadowed by individual follower traits and charisma, which could prevent the follower's ability to access informal power. This led to my sixth hypothesis:

H_6: When controlling for tenure and hospital size, there is a positive relationship between nurses' perception of servant leadership and their perceived access to informal power.

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Literature on Group Comparisons

Heyns et al. (2020) compared servant leadership groups across demographic groups. The analysis in terms of group comparison was limited to age and gender. Levene's test for homogeneity was insignificant for any variables; therefore, an analysis of variance (ANOVA) was done for gender groups assuming equal variance. Heyns et al. indicated that only stewardship revealed any statistical differences when comparing the means between males and females ($p < 0.01$); the male group recorded higher observations for stewardship than the female group. The remaining gender comparison was not significant. The age group test for homogeneity comparison was substantial for the age group. According to Heyns et al., multiple comparison tests were performed using ANOVA and Tamhane (equal variances were not assumed).

Özdemir and Yazici (2022) investigated the relationship between servant leadership perception and organizational cynicism and burnout among employees at the Ankara Directorate of Provincial Agriculture and Forestry. The researchers answered the differences between various demographic groups (sex, marital status, and age). Using ANOVA and the Sidak dual-comparison test, they determined the correlations between servant leadership, burnout, and cynicism levels. They found that servant leadership and burnout were negatively related, as were servant leadership and cynicism, at $p < 0.05$.

McDougle (2009) studied servant leadership in higher education, analyzing the perceptions of higher education employees regarding servant leadership practices at various institutions. She grouped her employees according to seniority and type of institution. The seniority groups were divided into management and working groups, and the institutions were represented by Urban City University and Southwest Community College. McDougle showed that the management group perceived the occurrence of servant leadership practices more frequently than the workforce group. Using ANOVA to determine the significance of the perception, McDougle found that the management group had the highest perception of job satisfaction compared to the workforce group. When comparing the differences in perceptions between the different institutions, McDougle found statistically significant differences between employees' perceptions at varying types of institutions on most dimensions of servant leadership practices.

My study compared differences in perception of servant leadership as well as work effectiveness constructs, while utilizing tenure and hospital size as control variables for the research hypotheses. For the research questions, my study used tenure as the control variable and hospital size as the independent variable. The following are the research questions:

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RQ1: When controlling for tenure, is there a difference in nurses' perception of servant leadership by hospital size?

RQ2: When controlling for tenure, is there a difference in nurses' perceived access to opportunity by hospital size?

RQ3: When controlling for tenure, is there a difference in nurses' perceived access to resources by hospital size?

RQ4: When controlling for tenure, is there a difference in nurses' perceived access to information by hospital size?

RQ5: When controlling for tenure, is there a difference in nurses' perceived access to support by hospital size?

RQ6: When controlling for tenure, is there a difference in nurses' perceived formal power by hospital size?

RQ7: When controlling for tenure, is there a difference in nurses' perceived informal power by hospital size?

Methodology

In this study, I employed a quantitative nonexperimental and descriptive methodology to determine the relationship between supervisors' servant leadership behavior and the work effectiveness of their followers in the Tanzanian public hospitals to learn if there were differences in ESLB and CWEQ II constructs by hospital size. Work effectiveness refers to positive work behaviors and attitudes, leading to job satisfaction, commitment, and trust. Data analysis utilized hierarchical regressions to test the hypotheses and an analysis of covariance (ANCOVA) for the research questions.

Sampling

This study used a purposive sampling method. A convenient sample of 110 out of the anticipated 100 participants was collected using the snowball method from the estimated total number of nurses in the participating hospitals (2,000), comprising 1,000 from the tertiary hospital and 1,000 from three regional referral hospitals in Dar es Salaam. This was a 10% increase in the number of participants. I applied a 1:1 design, or at least 50 participants for each hospital group size. The number of 100 participants is a convenient sample generated using the minimum sample size formula for hierarchical regression derived from Hair et al. (2019) and the minimum sample for ANCOVA. Hair et al. stated that the sample size for hierarchical regression depends on the number of predictors in the study. I had three predictors; thus, my sample size for the regression

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model was $N = 3 \times 20 = 60$ (Hair et al., 2019). The study had two control variables and one independent variable, making three predictors.

For ANCOVA, I calculated the sample size using GPower with an effect size of 0.40 (which allows for the detection of large effects). For alpha = .05 and statistical power = .80, given the two hospital size groups and the one covariate (tenure), the total sample size I needed was 64. Thus, I had at least 50 respondents per hospital size, resulting in a total of 110. This sample size also covered the minimum sample for a balanced ANCOVA.

An open invitation was sent to the hospital directors, and they gave a letter confirming their consent. After the hospital approval, I used the snowball method to reach the eligible participants. The research tools consisted of the ESLB scale (Winston & Fields, 2015) and the CWEQ II questionnaire (Laschinger et al., 2001) in English and Swahili. Back translation was used to translate the tools from English to Swahili.

The surveys were composed of five Likert-like questions ranging from *not at all* (1) to *often* (5) for the ESLB and *none* (1) to *a lot* (5) for the CWEQ II. Furthermore, the surveys included basic demographic questions, including gender, age, and tenure. There were 30 male and 79 female participants, while one participant was missing. The predominant age group was 31–50 years old (50.9%), while the 18–30 and 51–60 age groups formed 23.6% each, respectively. The mean for tenure was 9.86 with a standard deviation of 7.61. I visited the various hospitals and issued hard-copy surveys for those who consented to participate. The participants' nursing categories included nursing practitioners, registered nurses, diploma holders, and certificate holders.

Instrumentation

The current study used the ESLB scale (Winston & Fields, 2015) and the CWEQ II (Laschinger et al., 2001). I used the ESLB to measure servant leadership observable behavior (independent variable) and the CWEQ II to measure the followers' sense of their leader's bureaucratic behaviors, as detailed in the research questions and hypotheses (dependent variable).

I measured servant leadership using the ESLB scale (Winston & Fields, 2015). The ESLB was chosen for its simplicity and reliability. Nine scales using ESLB have demonstrated test–retest reliability, with Cronbach's alpha scores ranging from .92 to .98, indicating strong scale reliability, and Pearson's *r*, ranging from .83 to .91, demonstrating strong validity. The instrument was designed to measure behaviors unique to servant leaders, and its questions address behaviors easily observed by followers.

For example, the follower is asked about the perception that the leader practices what they preach and about the leader seeing the mission as a responsibility to others. The

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ESLB was used as a global instrument with 10 questions that followers used to rate the behaviors of their immediate supervisors on a 5-point Likert scale, ranging from *definitely no* to *definitely yes*. An example of a question follows: "The leader practices what she preaches, sees serving as a mission of responsibility to others, and seeks to instill truth rather than fear of insecurity."

I measured the conditions of work effectiveness using the CWEQ II (Laschinger et al., 2001) I chose the CWEQ II because it extends the Hackman and Oldham job characteristics model (Garg & Rastogi, 2006, p. 576), which opens the notion of critical psychological states, such as experienced meaningfulness (skill variety, task identity, and task significance), experienced responsibility for the outcome of the work (autonomy), and the knowledge of actual results of work activities. The CWEQ II is a global instrument with six items. According to Laschinger et al., structural empowerment refers to the structure of power in the workplace that comes from three primary sources: (a) access to information, (b) access to support, and (c) access to resources required for realizing organizational goals; the other three items in CWEQ II are (d) access to opportunity, (e) access to formal power, and (f) access to informal power. I chose the CWEQ II because it has shown consistent validity of Pearson $r = .56$ and Cronbach's alpha scores of reliability ranging from .67 to .89 when CWEQ II was correlated with a global measure of empowerment (Laschinger et al., 2001).

According to Laschinger et al. (2001), access to opportunity refers to the opportunity for growth and movement within the organization, and to increase knowledge and skills. Access to resources relates to acquiring the financial means, materials, time, and supplies required to do the work. Access to information refers to having the formal and informal knowledge necessary to be effective in the workplace (technical knowledge and expertise needed to accomplish the job, and an understanding of organizational policies and decisions). Access to support involves receiving feedback and guidance from subordinates, peers, and superiors. Access to formal power is derived from specific job characteristics such as flexibility, adaptability, and creativity associated with discretionary decision making, visibility, and centrality to organizational purpose and goals. Access to informal power is derived from developing social connections, communication, and information channels with sponsors, peers, subordinates, and cross-functional groups (Kanter, 1977, 1993). The CWEQ II was initially designed to measure nurses' sense of bureaucratic behaviors; therefore, it fit nicely in a hospital environment (Laschinger et al., 2001).

Data Collection

I collected data ($N = 110$) using snowball and direct personal contact with participants. Hard copies were used to survey the nurses at their hospital sites. Out of the 110 participants, 56 (50.9%) were from Group 1 (the large stand-alone hospital), and 54

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(49.1%) were from Group 2 (the three medium-sized referral hospitals). The participant age groups were 31–50 (50.9%), 18–30 (23.6%), and 51–60 (23.6%). The participant gender was 30% male and 79% female; 1% was missing.

To collect data, an open letter of invitation was first sent to the hospital directors requesting their consent, followed by the snowball method to reach the eligible participants. The survey tools included the consent to participate and paper-based formats of the ESLB scale (Winston & Fields, 2015) and the CWEQ II questionnaire (Laschinger et al., 2001) in English and Swahili. Back translation was used to translate from English to Swahili.

Results

I employed hierarchal regression in my hypotheses to show whether servant leadership as a global construct (independent variable), while controlling for tenure and hospital size, explains a statistically significant amount of variance in each of the six CWEQ II items (dependent variables) of opportunity, resources, information, support, formal power, and informal power (Hair et al., 2019). For the research questions, I used ANCOVA to show the differences between servant leadership and the CWEQ II variables by hospital size while using employee tenure as the covariate and hospital size as the independent variable.

Hierarchal Regression

I used hierarchical regression to explore the relationships between servant leadership using the ESLB and CWEQ constructs while using tenure and hospital size as control variables. These were three predictors regressed against the corresponding dependent variable item of CWEQ II (Hair et al., 2019). As predictors, the two control variables were entered first. In the second step of the hierarchical regression, the independent variable ESLB was entered as the third predictor. The dependent variable items of CWEQ II were numeric, and the independent variable (servant leadership) and the control variable (employee tenure) were also numeric. However, the control variable, hospital size, was categorical (Hair et al., 2019). Tenure was specified in terms of years and months to provide continuous data and was rounded to years in service (Hair et al., 2019).

Using hierarchical regression, I tested the hypotheses to determine whether a two-step hierarchical regression collectively demonstrates that, when controlling for tenure and hospital size, there is a positive relationship between nurses' perception of servant leadership, as measured by the ESLB, and their perceived access to one of the CWEQ II constructs. The null hypothesis follows:

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H_0: Controlling for tenure and hospital size variables does not significantly improve the prediction of the relationship between servant leadership (the independent variable) and the CWEQ II construct (dependent variable).

The results of my study indicated that the null hypothesis for each output variable, which stated that controlling for employee tenure and hospital size does not significantly improve the prediction of the CWEQ II dependent variables, was rejected. Significant relationships between servant leadership (independent variable) and CWEQ II dimensions (dependent variables) were observed in the R^2 results ($R^2 = 0.50$ for access to resources, $R^2 = 0.44$ for access to information, and $R^2 = 0.51$ for access to support), indicating a moderate servant leadership explanation for the outcome variables. For access to opportunities, formal and informal power, the R^2 explained less than 30% of the variability in opportunities, formal and informal power. On the contrary, standardized beta (β) coefficients showed a moderate to strong influence between the predictor and outcome variables. For example, in Hypothesis 2, access to resources (outcome) would change by 60% for every one-unit predicted change in servant leadership (predictor) after controlling for hospital size and tenure.

ANCOVA

The research questions were tested to show differences in perception of servant leadership and CWEQ II constructs by hospital size, tenure being the covariate, while hospital size was the independent variable.

The ESLB and the CWEQ II constructs were the dependent variables, one at a time. A balanced design (at least 50 per hospital size group) ensured an appropriate sample size (Hair et al., 2019). The research questions asked whether there was a significant difference in nurses' perception of the output variable by hospital size while using tenure as the covariate and hospital size as the independent variable. The results were that the nurses perceived statistically significant differences for all the dependent variables, including servant leadership, access to resources, information, support, and formal and informal power by hospital size, except for access to opportunities, which yielded a $p = 0.19$. The results suggest that there are perceived statistically significant differences in access to the output variables by hospital size, except for access to opportunities.

Discussion

Contribution to the Scholarly Literature

This study is the first known servant leadership study in the Tanzanian healthcare system. The study adds to the body of knowledge and covers the gap in leadership theory and practice. The study dealt with the inquiry about the existence of specific

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behaviors required of a servant leader and how they influence structural and psychological empowerment. The result of my study supports the existence of servant leadership in a selection of public hospitals in Tanzania, confirming that servant leadership is a theory with unique behaviors understood by both leaders and their followers and is consistent with Winston and Fields' (2015) study, which confirmed that there are essential behaviors required of servant leaders and that these behaviors can be measured with a scale.

This study is also consistent with the findings of Chandaruba (2019), who postulated that Tanzanian leaders showed interest in adopting a new type of leadership that emphasizes shared goals for both personal and organizational benefits. Likewise, the results are consistent with van Dierendonck and Nuijten (2011), who stated that servant leadership is best for organizations that are focusing on improving the welfare of their followers, including a dutiful approach to work, power sharing, giving a voice, as well as developing a long-run performance perspective.

Practical Recommendations Based on Theoretical Findings

Servant leadership has been associated with healthcare and found to provide the best models for healthcare organizations because of its focus on team leadership, trust, and patient care (Trastek & Niles, 2014). Therefore, I recommend that health organizations in Tanzania employ leaders who practice servant leadership behaviors, and as posited by Chandaruba (2019), Tanzania could also focus on training aspiring leaders to develop behaviors associated with servant leadership. These behaviors have been measured and confirmed to bring about work effectiveness. Work effectiveness has been associated with providing opportunities, resources, and support, including formal and informal power. Effective work environments would also help organizations solve work-related problems associated with job satisfaction, commitment, burnout, and intentions to quit.

Strengths and Limitations of the Study

The sample size for this study was 110 participants, which was 110%. The large sample size improves the reliability of the study results. However, the weakness of the sample is that it was mainly composed of females, with only a few male participants (79% female and 30% male). The ratio of male-to-female participation may have influenced the study results. The study was also originally intended to include another region (Pwani) and to include a third layer of hospital size (the small or district hospitals), but the plan did not materialize.

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Recommendations for Future Studies

Future studies should replicate this study for generalization and include not only public but also private and nongovernmental organizations in all the regions of Tanzania. This means it should also include hospitals in the whole United Republic of Tanzania. My original study area had included a three-tier hospital level, including the main hospitals, the regional referral hospitals, and the district hospitals, but I was not able to go that far. An evaluation of the whole hospital system may give better results and allow generalization of findings. The study should also be done in other countries to provide comparable data.

Conclusions

The current study focused on the relationship between nurses' perceptions of their immediate supervisors' servant leadership behaviors and their sense of work effectiveness in a selection of Tanzanian public hospitals. I utilized servant leadership theory, which has its roots in Greenleaf (1977). Greenleaf proposed that leaders adopt a servant position in their relationships with their followers. In analyzing servant leadership behaviors, I utilized the ESLB (Winston & Fields, 2015). I used the CWEQ II (Laschinger et al., 2001) to assess work effectiveness. Winston and Fields (2015) stated that the ESLB provides a psychometrically valid approach for gauging leaders' servant leadership behaviors and shows a strong relationship between ESLB and the followers' judgment on outcomes, such as job satisfaction, trust, and low burnout, which are characteristics measured by the CWEQ II. I also chose CWEQ II because it was specifically made to measure nurses' perception of their direct supervisor's bureaucratic behaviors. The CWEQ II has also been proven to be valid and reliable, which fits the purpose of this study.

Data analysis used hierarchical regression for testing hypotheses and an ANCOVA for answering research questions. The study results suggest that there are perceived positive relationships between servant leadership and work effectiveness in Tanzania. Still, there are challenges regarding access to resources, support, information, and formal and informal power between hospital groups. Regarding access to opportunities, there were no statistically significant differences by hospital size.

Tanzania has shown interest in adopting servant leadership (Chandaruba, 2019). This study is the first known servant leadership study in the Tanzanian hospital system. It helps to close the gap in servant leadership theory and practice. Additional studies are recommended to include other regions of Tanzania and elsewhere in the world. Using qualitative and mixed methods and other instruments for analyzing servant leadership and work effectiveness is also recommended.

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