Supervisors' Knowledge and Use of Clinical Supervision to Promote Teacher Performance in basic schools

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Abstract
The study was designed to find out the knowledge of supervisors in clinical supervision and how they use it to promote teacher performance in basic schools. The study further aimed at determining the professional relationship between supervisors and teachers. The design was descriptive survey and data was collected using quantitative and qualitative methods. One hundred and eleven (111) participants were sampled comprising 83 teachers, 22 head teachers, five circuit supervisors, and one district head of supervision. A five-point likert scale questionnaire was used to collect the quantitative data while focus group discussion was used to collect the qualitative data. Descriptive statistics and chi square analysis were used to analyse the quantitative data while a content analysis was used to analyse the qualitative data. Findings from the quantitative data indicated that most basic school supervisors are knowledgeable in clinical supervision and use it in basic school supervision. On the contrary, evidence from the interview showed that they are unable to apply such knowledge adequately and effectively as required in supervising teachers. In addition, the result showed that supervisors do have cordial professional relationship with teachers. However, the results from the interview revealed that teachers think that most of them have the same qualifications and expertise as their supervisors so such teachers are not comfortable with the supervision from the supervisors. Based on the findings and discussions the study recommended that basic school supervisors must be trained in the use of clinical supervision and shed off some of their classroom and administrative responsibilities in order to use clinical supervision effectively to help improve teacher performance.

Key words: Clinical supervision, instructional supervision, basic school, head teachers, supervisors, circuit supervisors, professional relationship, teachers' performance

1. Introduction

Quality teaching and instruction are the necessary conditions for successful learning in schools and institutions worldwide. Supervision in schools is accepted as a general leadership function intended to improve the performance of teachers' teaching and instruction. Glickman, Gordon and Gordon (2004) have placed supervision as the backbone towards determining the effectiveness of school. A good supervision involves activities that aid, direct and inform teachers of what should be done or have been done and not

merely finding faults in the teachers teaching. In the literature on instructional sciences, clinical supervision is a type of supervision that meets the stated requirements of a good supervision.
In contemporary supervisory practice clinical supervision is more preferred to general supervision due to its thorough and help-oriented nature. It brings about mutual understanding and cooperation between the supervisor and supervisee because in clinical supervision the supervisee is more willing to assist and cooperate with the diagnosis and prescription process ((Adentwi & Barfi-Frimpong, 2010).

Supervision of instruction in the Ghanaian education system dates back to the early twentieth century in the then Gold Coast schools when inspectors were appointed to visit schools (Mankoe, 2002). During the 1940s mission school authorities appointed visiting teachers to assist the increasing number of untrained teachers particularly those in rural areas. The government later followed it up in 1952 with the appointment of visiting officers to provide on-the-job training for the large number of non professional teachers who had been employed following the introduction of the fee-free education in 1951. By 1974, when the Ghana Teaching Service (now Ghana Education Service) was established, two types of supervisors were operating in the Ghanaian educational system. These were the Assistant Education officer (AEO) and the Principal Teacher (PT), both visiting officers with the responsibility of raising the standard of teaching. The introduction of the New Educational Reforms Programme (NERP) in 1987, and later the Free Compulsory Universal Basic Education (FCUBE) in 1995 saw the appointment of circuit officers (now circuit supervisors) who were put in charge of circuits to provide professional assistance and guidance to teachers with the view to raising standards in the schools. Instructional supervision in pre-service training, induction training, and in-service training of teachers as well as teachers' classroom practices before NERP and FCUBE was basically focused on management practices whereby supervisors used to control, give instructions and direct teachers in their teaching practices

Since the introduction of the Free Compulsory Universal Basic Education (FCUBE) in 1995, there have been several measures put in place by the government to improve supervision of instruction in public basic schools. Key among these measures is the redesignation of the office of circuit officers to circuit supervisors (Mankoe, 2002; Sekyere, 2003). This places a special responsibility on circuit supervisors to not only inspect schools but also to guide and provide leadership to teachers as indicated by Glanz, (1994). In effect the work of circuit supervisors and heads of schools has been expanded to administering schools under their jurisdiction and providing instructional support, guidance and leadership to teachers (MOE, 1990, cited in Mankoe, 2006).To facilitate their work, supervisors and head teachers were provided with manuals which contained guidelines of clinical supervision. Clinical supervision as supervisory practice for continued teacher development became part of the curriculum of most of the teacher education institutions.

In recent years, however, several concerns have been raised by a number of Ghanaians over the performance of teachers in public basic schools leading to the falling standards in education in the country. Research conducted by Oduro (2008) and Opare (2009) indicate that most members of the public and other stakeholders attribute this partly to weak and ineffective supervision in Ghanaian public basic schools. According to Oduro (2008), and Opare (2009) public perception about the attitudes of school heads and teachers towards supervision in Ghanaian public basic schools is rather poor. A similar problem has been identified in many countries including the United State of America. In New York (United State of America) a teacher who teaches five period a day (900 periods a year) is observed or supervised only once and 99% of the teachers teaching is not properly supervised (Marshal, 2005). Generally, the nature and quality of instructional (clinical) supervision within a school is presumed to have effects on the expertise, practice and job satisfaction of teachers and, by extension ultimately, on student learning outcomes such as achievement. There is consistent evidence in the literature that clinical supervision if effectively implemented improve the performance of teachers' teaching and increase students' learning (e.g., Khalid, Komuji, & Veloo, 2013; Holland & Adam, 2002; Zepada, 2007; Mohd & Zawaki, 2002). Research indicates that to practice clinical supervision effectively, school supervisors must possess the requisite knowledge and ability to use contemporary supervision models. As suggested by Glickman, Gordon and Gordon (2004), heads of institutions and any person entrusted with the responsibility of supervising instruction should possess certain

knowledge and skills to plan, observe, assess and evaluate teaching and learning processes. In the literature very little is known about supervisors' knowledge and use of clinical supervision as well as teachers' professional relationship with supervisors.

The purpose of this study is to find out the supervisors' knowledge and use of clinical supervision as a way of promoting teacher performance to improve instruction in basic schools in Ghana**.** Consequently the study is designed to answer the following questions:

1. What is the knowledge of supervisors about clinical supervision?
2. How do supervisors use clinical supervision to promote teacher performance?
3. What professional relationship exists between teachers and supervisors as a result of the use of clinical supervision?

The main goal is to contribute to the adoption and the effective use of clinical supervision to improve the quality of teachers' instructional practices for the development of 21st century competencies in students.

2. Literature on clinical supervision

In common usage, supervision means overseeing, and it is a fundamental component of counselling. In other words, supervision is described as interpersonal process in which the skilled practitioner or supervisor helps the less skilled practitioner in relation to their professional growth (Barber and Norman, 1987).

Goldhammer (1969) and Cogan (1973) borrowed the term clinical supervision from the medical profession, where it has been in use for decades, to describe a process for improving specilised knowledge and skills of instructional practitioners. The clinical part, as indicated by Goldhammer, Anderson, and Krajewski (1980) refers to the hands-on or eyes-on aspect of the supervisor who is attempting to intervene in a helpful way. Based on this derivation, Goldhammer et al. (1980) define clinical supervision as one of the aspects of instructional supervision which draws upon data from direct observation of actual teaching and involves face-to-face interactions between the teacher and the supervisor in the course of analyzing the observed professional behaviours and activities and seeking to define and/or develop next steps towards improved performance of the teacher**.** Clinical supervision is a classroom supervision which focuses upon the improvement of instruction by means of systematic cycles of planning, observation and intensive intellectual analysis of actual teaching performance in the interest of rational modification (Acheson and Gall, 1980). It can be deduced from the definitions that clinical supervision takes its principal data from events in the classroom. The analysis of the data and the relationship between teacher and supervisor, form the basis of the programme procedures and strategies designed to improve the student's learning by improving the teacher's classroom behaviour. Clinical supervision is problem-solving and is usually used in curriculum implementation (Chivore, 1995).

Clinical supervision is one of the techniques used to improve teachers' competencies in classroom instructional practices. The concept of clinical supervision in the context of teachers' personal and professional development in schools was originated by Morris Cogan (who was the mentor of Goldhammer) and Goldhammer at Havard University in the 1960s. Their efforts were stimulated by frustrations they experienced as university supervisors trying to help teachers who were beginners to succeed. As indicated by Goldhammer(1969) in Goldhammer, Krajewski and Anderson (1980, pp)

"When I wrote my book, schools were in great need of immediate instructional improvement. I thought it more useful to present a basic method to which teachers and supervisors could turn, thereby spreading up the growth of clinical supervision within the school systems. (Goldhammer et al. 1980, pp 441)". As also declared by Sullivan and Glanz (2000), the concept of clinical supervision emerged as a result of contemporary views of weakness and dissatisfaction with the traditional education practice and methods of supervision. Under clinical supervision the focus of supervision is on the teacher as an active member of the instructional process (Cogan, 1973). According to Cogan (1973), the central objective of the process of clinical supervision is to help develop a teacher who is professionally responsible, can analyse his/her own performance, ready to open up to others to help him/her, and also be self directing. Indeed, the advocates of the concept are of the belief that its focus is a face-to-face interaction between the teacher and supervisor

with the intent of improving instruction and increase the teacher's professional growth (Acheson & Gall, 1980; Goldhammer, 1969; Abiddin, 2010).

Clinical supervision is based on the assumption that without guidance and assistance, teachers are not able to change and improve (Oliva & Pawlas, 2004). Through careful and systematic observation, analysis and dialogue with a supervisor, effective teaching can be reinforced leading to improvement in teachers' pedagogical capabilities (Okafor, 2012). Since the objectives of clinical supervision are clearly stated by the actors (both the supervisor and the teacher) before the observation and the methods of data collection are discussed in mutually trusted manner by the key actors, it reduces much of the anxiety or tension associated with traditional classroom observation or inspections by supervisors. This is because everything works better in the climate devoid of tension and mutual suspicion.

In order to give supervisors and teachers something solid to grasp and use, Goldhammer, Anderson & Krajewsky (1993) suggested five phases in administering clinical supervision in a classroom context. They are 1) pre-supervision conference; clinical supervision (classroom observation); analysis and strategy; post-supervision conference; and post-supervision analysis.

Pre-supervision conference is also referred to as pre-observation conference by Glickman (1990). This is the preparatory stage where the supervisor meets with the teacher and spells out the reason and purpose for the observation, focus, method and form to be used, and fix time for post-observation conference. The supervisor asks probing and clarifying questions at this stage not with intention to embarrass the teacher but to clarify and assist where need be (Okarfo, 2012)

Clinical supervision stage which is also known as lesson or classroom observation stage (Glickman, 1990) involves the actual lesson presentation and observation. As the teacher teaches, the supervisor documents or captures the teaching as accurately as possible by using chosen method. According to Goldhammer et al. (1993), the principal purpose of this stage is to explicitly identify and capture the realities of the teaching objectively and comprehensively enough to enable supervisor and teacher to reconstruct the lesson as validly as possible afterwards, in order to analyse it (Okafor, 2012). Methods may include participant observation, focused questionnaire, and space utilisation.

In the third stage 'analyse and strategy', the supervisor, after observing the lesson leaves the classroom to analyse and interpret the observation data alone and develop a plan for the conference.

Post-supervision conference or Post observation conference by Clickman (1990) is the 4th stage where both the supervisor and teacher discuss the observation and analysis and try to produce a plan or suggestions for instructional improvement. The supervisor's objective is to help the teacher to make more functional use of his own resources and therefore perform more effectively within the classroom. This stage is also designed to help the teacher to critically examine his or her own teaching in a fair minded way and to tentatively plan for the next lesson.

Post-supervision analysis is also termed as critique of the previous four phases by Clickman (1990). This last phase is where the supervisor and teacher review the format and procedures from the conferences to find out whether they were satisfactory or not and whether there was the need for revision. This stage is designed to stimulate the teacher to provide honest feedback to the clinical supervisor about how the clinical supervision cycle went (Goldhammer, 1969; Okafor, 2012). This stage also helps the supervisor to critically examine his performance during the clinical supervision cycle/process.

The entire clinical supervision as described above should be systematic. However, there are times when the teacher and supervisor must be flexible and not stick to a rigid pattern day in day out as described (Goldhammer et al. 1980). The methods are probably always changing, or should allow changing in accordance with changes occurring in outside factors, such as technological and societal changes, affecting

both teachers and students which are beyond the control of educational system but do affect students learning and interest. But what is important is that, as acknowledged by Goldhammer et al. (1980), for clinical supervision to achieve its pedagogical purpose, its implementation has to follow some plan which is owned by both the supervisor and the teacher.

By its nature, the method or model of clinical supervision looks more detailed in approach and seeks to create collaboration between supervisor and teacher. Some researchers therefore believe that clinical supervision, when used properly has a greater potential of improving teachers' instructional delivery. It tends to encourage innovation from teachers rather than remaining dependent on the supervisors. According to Thomas (2008), clinical supervision needs a great deal of time to be enforced effectively but this practice proves to be worthwhile to increase teachers' teaching performance. Khalid, Komuji, and Veloo (2013) conducted an empirical study using 33 secondary school teachers (11 females and 22 males) to determine the effectiveness of clinical supervision. The findings of the study indicated that clinical supervision helps teachers in schools to find out the shortcomings and advantages of their teaching performances. In addition, the findings showed that clinical supervision helps teachers improve their teaching and makes learning more effective.

To be able to engage in clinical supervision, school site supervisors as well as external supervisors need to be equipped with some knowledge and skills about clinical supervision. For clinical supervision to be more effective the supervisor must have more expertise in the analysis of teaching and in applying principles of learning than the teachers (Goldhammer et al. 1980). The supervisor should be a teacher of teachers. Carroll (1996) confirmed this by indicating that a good supervisor is a good teacher, who has access to a range of teaching and learning methods and can adapt to individual supervisees (teachers). Adequate knowledge of the concept of clinical supervision and possessing adequate skills in delivering the methods are essential elements for effective implementation of clinical supervision as the two work hands in hands. To support this proposal, Butterworth, Faugier and Burnard (1992) state, clinical supervisors require training in supervision as an integral part of their professional development. The literature is replete with a number of theoretical knowledge and concepts which supervisors must have, as well as skills needed to use clinical supervision (e.g., Butterworth, Faugier & Burnard 1992; Carroll, 1996). However, there seems to be little or not much research that focuses on empirical evidence on the supervisors' knowledge and use of clinical supervision as observed by the American Board of Examiners in 2004. According to the Board this seemingly lack of adequate empirical evidence in the practice of clinical supervision in schools has led to a renewed interest in the United States of America in rigorous evidence-based research about approaches to practice, but only few results are known.
A similar observation was made from an empirically based research conducted in the United Kingdom by Milne & Westerman (2001). Their research did not produce evidence of practice by school supervisors. It rather emphasized instructional and methodological components of clinical supervision, and was tested in the field of mental health nursing and education. In a more specific term, Kelehear (2010) notes that supervisors with such skills as observation skills, analytical skills, data collection skills, counseling and mentoring skills have better influence on their clients' success. To him, teachers whose supervisors used their knowledge about the stages of clinical supervision effectively with these skills saw some improvement in their professional practice.

Specifically, Goldhammer et al. (1980) revealed that the supervisor must establish and maintain rapport between self and teacher and that the rapport must extend throughout the entire supervision. Similarly, Berger and Bushhholz (1993) state that supervisors should be flexible in their relationship with supervisee. There are a number of supervisors' roles and tasks in clinical supervision (Abiddin, 2008); some of which relate to mentoring and counseling. In this regard mutual trust, mutual respect, and effective supervisory relationship are critical elements for successful clinical supervision. In fact, supportive relationship has been shown to be perhaps, the essential ingredient of effective supervision (Abiddin, 2008; Simm, 1993). According to Abiddin (2008), there is much more literature on the supervisors roles in terms of supervisory relationship than the supervisees role in terms of supervisory relationship.

It is evident from what has been discussed that much more research is needed in the supervisors' knowledge and use of clinical supervision in schools as well as the teachers professional relationship with the supervisors, especially in the Ghanaian context so as to fill the knowledge gap in the literature and also to contribute to effective implementation of clinical supervision in schools to maximize students' learning.

3. Methodology

3.1. Research Design

The study is a descriptive survey to find out how supervisors' knowledge and use of clinical supervision promote teacher performance in schools. According to Ary, Jacobs, Razavieh & Sorensen (2006), a descriptive survey uses instruments such as questionnaires and interviews or quantitative and qualitative methods to gather information from people or subjects. To have in-depth understanding of supervisors' knowledge and use of clinical supervision as well as the relationship of teachers with their supervisors, a mixed method survey design was employed and data was collected using qualitative and quantitative instruments.

3.2. Participants

Participants for the study were supervisees (teachers) and supervisors (head teachers, circuit supervisors and a district head of supervision) from basic schools of the Sekyere South District Directorate of the Ghana Education Service, who were drawn from a population of 1720 personnel representing 1597 teachers, 115 head teachers, seven circuit supervisors and one district head of supervision.

The total sample size for the study was 111 participants comprising 83 teachers (male= 53, female=30) with average of 3; 22 head teachers (male=15, female7) with average of 43, five circuit supervisors (male=5) with average age of 49, and one male district head of supervision of 55 years. Ninety- nine percent of the teachers have professional status and 55% of them have first degree and above, the remaining 45% have diploma qualification. All the head teachers have professional status and 57% of them have first degree and above. All the circuit supervisors have professional status and have first degree and above. The district head of supervision is a professional teacher with masters degree. The teachers were selected through a simple random technique whiles the head teachers and circuit supervisors were sampled using the convenience and purposive sampling techniques.

3.3. Instruments for data collection

Instruments used for the data collection were questionnaire and focus group discussion. These two instruments were used to enable the researchers gather enough quantitative and qualitative data to answer the research questions.

There were two sets of questionnaire: one set for the teachers and other for the supervisors. Each set of the questionnaire consisted of three main sections. These were: 1) Introduction, 2) Demographic data of the participants and 3) Set of items for measuring the research questions. The questionnaire for the supervisors and teachers consisted of 10 statements and six statements respectively that asked supervisors and teachers to indicate their level of agreement on a five-point likert scale which was arranged as ' 1 strongly agree (SA) agree (A), undecided (U), disagree (D) and strongly disagree (SD)'. According to Borg and Gall (1983) this scale is popular, easy to construct, administer and also to score. The statements covered variables selected from the literature which were related to: 1) knowledge of supervisors about the use of clinical supervision (e.g., *I know that I must meet my teachers for discussion before lesson observation),* n= 6, Alpha = 0.86; 2) supervisors use of clinical supervision (e.g., *I give immediate feedback to teachers after lesson observation*), n=4, alpha =0.79; and 3) teachers relationship with supervisors (e.g., *my supervisor treats teachers with love and respect*), n=6, alpha = 0.87. The coded statements were further rated as follows: 5=strongly agree, 4= agree, 3=undecided, 2=disagree, and 1=strongly disagree.

In order to find out more about the knowledge supervisors have in clinical supervision and how such knowledge is being used to promote the performance of teachers a focus group discussion (FGD) was conducted for the supervisors (head teachers and circuit supervisors) to help the researchers probe further into the responses on the questionnaire items. Similar focus group discussion was conducted to probe further the responses of the teachers about the relationship with their supervisors. A focus group discussion is a group interview of approximately six to twelve people who share similar characteristics or common interests. A successful focus group discussion relies heavily on 'the development of a permissive, non-threatening environment within the group' where the participants can feel comfortable to discuss their opinions and experiences without fear that they will be judged or ridiculed by others in the group (Hennink 2007). Focus group discussions are more akin to natural social interaction among participants. For the sake of convenience, 13 head teachers who willingly agreed to participate in the interview were put into three groups (FGD2, *n = 4; FGD3, n=4; FGD4, n=5*) and three circuit supervisors who accepted to participate in the interview were put into one group (FGD 1, *n=3*). It is important to note that the District Head of supervision was interviewed alone. Moreover, 11 head teachers willingly submitted themselves for the interview and they were grouped into two (FGD5, n=6; FGD6, n=5).

3.4. Data collection procedure

After a pilot study has been conducted permission was sought from the Sekyere South (Ashanti Region of Ghana) District Director of Education to use the supervisors and teachers in the district as participants of the study. The appropriate sampling techniques were used to select the participants for the study. The questionnaires were administered to the participants and one week period was agreed upon as date for collection. Of the 126 questionnaires distributed to participants 111 were returned showing a return rate of 92% which was high. To be able to extract further detailed information about the supervisors' knowledge and use of clinical supervision and the professional relationship existing between the supervisors and teachers a focus group discussion was conducted for six groups (four groups for the supervisors and 2 groups for the teachers) of the participants. Each group was met separately at the agreed venue. They responded orally to the questions and permission was sought by researcher(s) to use tape recorders to record their responses. Notes were also taken so that the main points in their responses would not be lost. The audio recordings were later transcribed and coded.

3.5. Data Analysis Procedure

The data collected from the returned questionnaires were collated, edited and coded into the Statistical Package for Social Science (SPSS). Data were analysed by using descriptive statistics and inferential statistics were to analyse the qualitative data. Data from the interview was also analysed using content analysis. Inferential statistics using chi square and descriptive statistics were used to analyse the quantitative data.

4. Results

Two types of data were collected to measure the supervisors' knowledge and use of clinical supervision and the professional relationship between teachers and supervisors. These were quantitative and qualitative data. The quantitative data was put into three sections with the first part designed to answer questions on knowledge of supervisors about clinical supervision; the second to answer questions on how supervisors use clinical supervision as a supervisory model; and third to respond to the professional relationship between the teachers and supervisors.

Six supervisors representing 22% of the participants strongly agree that they have knowledge about the use of clinical supervision while 14 of them representing 54% also merely agree. None of them strongly disagreed, but 9% disagreed while four of them representing 15% was undecided (Table 1 highlights on this). A chi-square analysis showed that majority of the participants (76%) agree (strongly agree and agree) that they have acquired knowledge to use clinical supervision - χ^2 (4, N=27) =22.73, $p \leq .05$

Table 1: Frequencies and percentage of supervisors knowledge on clinical supervision to promote teacher performance (N=27)

Statements	Responses					
As a supervisor	SA	A	U	D	SD	Total
	F (%)	F (%)	F (%)	F (%)	F (%)	F (%}
1. I have adequate knowledge about clinical supervision	8 (29.7)	15(55.5)	4 (14.8)	0 (0)	0 (0)	27(100)
2. I have been adequately trained to use clinical supervision	7 (25.9)	10 (37)	7(25.9)	3 (11.1)	0 (0)	27(100)
3. I know that clinical supervision is more about teachers' classroom practice	4(14.82)	19(70.37)	1(3.70)	3(11.11)	0 (0)	27 (100)
4. I know that I must meet my teachers for discussion before lesson observation	5 (18.5)	14(57.9)	4(14.8)	4 (14.8)	0(0)	27(100)
Total (Average)	6 (22.22)	14.5(53.70)	4 (14.81)	2.5 (9.27)	0 (0)	27 (100)

A total of 12 supervisors representing 45% of the participants strongly agree that they use clinical supervision to improve the teaching of basic school teachers; 43% merely agree while only one supervisor representing 2% also disagree. None of them strongly disagreed but three of them representing 9% were undecided (Table 2 highlights on this). A chi-square analysis of the results- χ^2 (4, N=27) =26.87, p $\leq$.05 shows that majority of the participants (88%) agree that they use clinical supervision in schools.

Table 2. Frequencies and percentages of supervisors' use of clinical supervision (N=27)

Statements	Responses					
As a Supervisor	SA	A	U	D	SD	Total
1. I note down teachers' mistakes in lesson delivery for discussion.	14 (51.9)	10 (37)	3 (11.1)	0 (0)	0 (0)	27(100)
2. I give immediate feedback to teachers after lesson observation	10 (37)	13(48.2)	3 (11.1)	1 (3.7)	0 (0)	27(100)

3. I help teachers to analyse their own lesson delivery	8 (29.7)	15(55.5)	1 (3.7)	3 (11.1)	0 (0)	27(100)
4. I create room for teachers' suggestions on improving lesson delivery	12 (44.5)	11(40.7)	4 (14.8)	0 (0)	0 (0)	27(100)
5. I usually have pre-observation meeting with teachers	9 (33.3)	14(51.9)	4 (14.8)	0 (0)	0 (0)	27(100)
6. I use post observation meetings to discuss teachers' performance	20 (74.1)	7 (25.9)	0 (0)	0 (0)	0 (0)	27(100)
Total (Average)	12.17(45.07)	11.67(43.22)	2.5(9.26)	.67(2.48)	0(0)	27 (100)

Seventeen teachers representing 20% of the participants strongly agree that there were open and trusted professional relationship between teachers and supervisors while 35 of them representing 42% merely agree. In contrast, 6 teachers representing 7% strongly disagree while 13% merely disagree with 15 of them representing 18% being undecided (See table 3). A chi-square analysis- χ^2 (4, N=83) =29.48, p $\leq$.05, showed that majority (62%) of teachers in the study strongly agree and/or agree that there was an open and trusted professional relationship between supervisors and teachers

Table 3. Frequencies and percentages of professional relationship existing between teachers and Supervisors (N=83)

Statements My supervisor	**Responses** S A (F %)	A (F%)	U (F%)	D (F%)	SD (F%)	Total (F%)
1. Has cordial relationship with teachers	29 (35)	34 (40.96	17(20.48)	1 (1.2)	2 (2.4)	83 (100)
2. Treats teachers with love and respect	26 (31.3	35 (42.2)	13 (15.7)	7 (8.4)	2 (2.4)	83 (100)
3. Acts as a counsellor to teachers	9 (10.8)	39 (47)	24 (28.9)	8 (9.6)	3 (3.6)	83 (100)
4. Provides platform for dialogue and understanding	20 (24.1)	36 (43.4)	20 (24.1)	4 (4.8)	3 (3.6)	83 (100)
5. Acts as mentor and supports teachers	15 (18.1)	40 (48.2)	9 (10.8)	14(16.9)	5 (6.0)	83 (100)
6. Does not expose my fault and humiliate me	1 (1.2)	25(30.12)	8 (9.6)	30(36.14)	19(22.9)	83 (100)
Total (Average)	16.67(20.08)	34.83(41.96)	15.17(18.28)	10.67(12.86)	5.66(6.82)	83 (100)

Results of the qualitative data

Results gathered from the focus group discussion on the supervisors' knowledge and use of clinical supervision to promote teachers' teaching in the basic schools to some extent contradicted that of the quantitative data. The results from the FGD indicate that although supervisors in the study do know what

clinical supervision is about as they had agreed in the quantitative data, they are unable to use such knowledge as they said.

"We know what clinical supervision is and we actually understand it, but we are not able to use it to supervise our teachers because what goes into it is very tedious and involves a lot of time and preparation" (quoted from FGD 3).

FGD1 and FGD4 also supported and said: *"we all know about clinical supervision and we understand that it is good and we have to use it, but we cannot use it in our schools because the process is quite involving"*

Some supervisors also indicated that once they teach in their various schools it will be difficult for them to supervise teachers using clinical supervision.

"If you look at what goes into clinical supervision you realise that it is a good model of supervision. We have learnt about this in our various trainings but we cannot use it because some of us teach as subject or class teachers in addition to the administrative work". (quoted from FGD1 & 4).

Other supervisors one way or the other supported the responses raised above.

"It takes a longer time (minutes and hours) and some days to do clinical supervision on one teacher in a particular school. But apart from our office work we have to supervise more teachers in several schools in the District; meanwhile we don't have any vehicles to facilitate our rounds" (quoted from FGD 1).

The responses above by the supervisors were corroborated by the Head of Supervision in the district. He also conceded that supervisors were unable to use clinical supervision as required of them and intimated that once parents continue to seek better results from their wards it was incumbent on supervisors to improve their work through constant training.

As it has already been indicated, in order to establish in-depth understanding about the relationship existing between teachers and supervisors a focus group discussion was designed for teachers.

Generally, the teachers revealed that supervisors show them respect whenever they meet and this has deepened the cordial relationship between them and the supervisors. They were however of the view that some head teachers and circuit supervisors lack the courage to sit in their class and observe them during teaching and because of that they (supervisors) do not meet the teachers to discuss problems affecting their delivery.

" *Because some of us are graduates just as our supervisors they do not have the courage to sit in our classes. We also think that we are all equal so we don't feel comfortable when head teachers talk about our lesson presentation. May be that is why they don't even sit in our classes and also have post observation discussion with us" (quoted from FGD 6)*.Another group also observed that:

" These days all our head teachers and circuit supervisors show us some respect and treat us nicely. Sometimes they try to help you write your lesson notes well but they actually don't sit in our classes to observe our teaching. They do that only for newly trained diploma teachers because most of us are all graduates" (quoted from FGD 5).

On the question of supervisors acting as superiors and finding faults to expose teachers' mistakes respondents indicated in the interview that only few supervisors try to do that and this affects their relationships with teachers.

"Few of them still act as bosses and only find faults with what we do but many of them especially head teachers are quite good. In fact, they are our counselors and surrogate parent:s (quoted from FGD 5).

Teachers were unanimous on the point that supervisors seem to understand the concept but they as teachers don't see that it is being used.

"The way they treat us and speak to us especially about our lesson notes, and sometimes on lesson presentation is very respectful. It indicates that they know about clinical supervision. However we don't see them using it because circuit supervisors visit once a while and head teachers also don't go round "(quoted from FGD 5& 6).

In sum the interview has revealed that supervisors have knowledge about clinical supervision but actually do not use clinical supervision satisfactorily.

5. Discussion and conclusion

The main aim of the study was to find out the knowledge of supervisors about clinical supervision and how they apply the knowledge to promote teacher performance in basic schools so as to maximize students learning. The study also sought to find out the kind of professional relationship that exists between teachers and supervisors. Findings from the quantitative data indicate that supervisors have the requisite knowledge on clinical supervision and they use clinical supervision in basic schools. Evidence from the quantitative data further indicate that most of the supervisors have an open and trusted professional relationship as a result of supervisors' knowledge in clinical supervision. The finding of the study that supervisors seems to have knowledge about clinical supervision confirms the empirical evidence by Milne and Weterman (2001) that supervisors in the health and education sectors have knowledge about clinical supervision.

One possible explanation for this finding is that all the supervisors in the study are professional teachers who hold either a diploma or bachelor's degree in education. Few of them also have second degrees and that they have learnt about clinical supervision in their various institutions of learning, as indicated by them during the interviews. Furthermore, guidelines in their manuals relating to models of supervision also discuss clinical supervision (Ministry of Education, 2010; 2002). However, the result of the present study that supervisors practice clinical supervision in basic schools contradicts the research finding of Milne and Weterman (2002) that supervisors in the health and education sectors do not practice clinical supervision. It can be argued that the supervisors in the present study admission that they practice clinical supervision in schools might derive from the fact that it is part of their duties.

On the contrary, findings from the interviews indicated that the supervisors are unable to put their knowledge in clinical supervision to effective use. This qualitative finding supports the findings of Marshal (2005) that teachers teaching in New York (USA) are not properly supervised. The result also confirms Oduro (2008) and Opare (2009) that in Ghana supervision in public schools is rather poor. Some reasons cited by the supervisors, as depicted in the FGD data, inability to use clinical supervision effectively were the size of circuits, other administrative duties and the tedious nature of the process of clinical supervision. Circuit supervisors who complained about the size of their circuits indicated that the number of teachers in a circuit was too many for them to use clinical supervision as a model; and there are no vehicles to facilitate their movement. Due to this they are unable to support teachers as effectively and regularly as may be required.

Even head teachers who are in charge of fewer teachers in terms of numbers also complain of other administrative schedules as well as teaching in the classrooms. Most of the reasons for the supervisors inability to conduct clinical supervision satisfactorily in basic schools confirm Thomas (2008) assertion that clinical supervision needs a great deal of time to be enforced effectively in schools to improve teachers teaching performance.

As indicated, evidence from the quantitative data indicates that most of the supervisors have an open and trusted professional relationship with teachers. This finding aligns with what Pajak (2002) has theorised as the characteristics of modern supervision. A possible explanation for this finding could be the supervisors' years of practice as most of the head teachers and circuit supervisors have worked for a longer time, which has helped to erode the negative perceptions of teachers about supervision. This notwithstanding, data from the quantitative questionnaire indicates that about 38% of the teachers are undecided, disagree or strongly disagree that supervisors have open and trusted professional relationship with teachers. Interestingly, results from the qualitative data showed similar findings. Teachers response from FGD data indicates that supervisors, especially head teachers show them respect, treat them nicely, are their counselors and surrogate parents, help them (teachers) to write their notes, sit in the class of diploma teachers, and know clinical supervision. On the other hand, data from the FGD revealed that: some of the supervisors still act as bosses and find fault with what the teachers do and since most of the teachers are also degree holder they (supervisors) do not have the courage to sit in their classes to support them; teachers feel that they and supervisors are equal so they don' feel comfortable when their supervisors talk about their lessons. The responses from the FGD data confirmed Mohd (2002) findings that supervisors neglect supervise teachers

and if they do the supervision is autocratic and fault finding. These findings also support Baharom (2002) discovery that teachers' inefficient attitudes and relationship including head teachers' unreadiness to supervise are the issues that should be solved. Teachers thinking, in the present study, that they and the supervisors are equal (they have the same qualification and expertise) confirmed the proposition by Goldhammer et al. (1980) that for clinical supervision to be more effective, the supervisor must have more expertise in the analysing of teaching and in applying principles of learning than the teachers.

It can be concluded from the findings that even though supervisors are knowledgeable about clinical supervision, and are aware of its effectiveness on teachers teaching and its use in basic schools to improve teachers' pedagogical practices, they are unable to use it to improve the quality of teachers' teaching to maximize students learning as expected. As revealed in the FGD data supervisors' inability to use clinical supervision effectively in schools are attributed to the following factors:

- Supervisors' classroom and administrative responsibilities
- The demanding of clinical supervision
- Inadequate training of the supervisors
- Large number of teachers to be supervised in the district/circuit
- Inadequate logistics to facilitate the movement of the supervisors
- Teachers attitudes and perceptions

It is also clear from the findings of the study that some supervisors do have cordial professional relationship existing between them and the teachers but the teachers do not feel comfortable when these supervisors who are their colleagues are supervising them as superiors. They would rather want the supervision to be done by experienced officers from the district office. This situation also contributes to the inability of most head teachers and circuit supervisors to use clinical supervision in schools satisfactorily.

The findings from the present study and that of others (e.g., Rogers, 2009; Tyagi, 2009; Pansiri, 2008) imply that supervisors can effectively use clinical supervision in schools if other administrative and classroom engagements are reduced and they are provided with adequate training and logistics. Finally the findings also imply that the desired effect of successful and effective clinical supervision in classroom necessitates further research on teachers' conceptions and perceptions of qualifications and expertise of supervisors who supervise their (teachers) teaching in (basic) schools.

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