CHAPTER ONE

INTRODUCTION

1.0 Introduction

The main objective of this study was to determine the organizational factors affecting delivery of pediatric antiretroviral therapy at TASO Uganda. This topic was chosen after a realization that few studies definitively linked organizational factors to the delivery of services in organizations. Chapter one reviews the background of the epidemic/scourge, the statement of the problem, the purpose of the study, the research and corresponding objectives, research questions and hypothesis, the conceptual framework highlighting the major study variable, the scope of the study, significance of the study and key definitions. The second chapter focuses on review of literature covered in previous linked studies and the third chapter focuses on the methodology. The fourth chapter looks at data collection, presentation, analysis and interpretation of the research findings. Chapter five is a summary of the conclusions and recommendations of the findings, the study ends with the study references and appendices.

1.1 Background to the study

World Health Organization [WHO], (2007) named HIV/AIDS the fourth major cause of mortality in the world; 33.3 million people were living with the disease worldwide in 2009 and 2.5 million were children; 2.6 million were newly infected with HIV in 2009 worldwide while 1.8 million people died of AIDS-related illnesses worldwide (WHO/UNAIDS 2010). The impact of HIV/AIDS was felt in economic growth, income and poverty levels of nations as it claimed highly trained expertise that were not easy to replace. The high mortality rates contributed to tremendous increase in funding aimed to combat the disease; in 2007 global funding increased to US $ 8.9 billion, President's Emergency Plan For AIDS Relief [PEPFAR]

contributed US $ 4.7 billion (www.pepfar.gov) and UNAIDS through World Bank contributed US $ 1.5 billion (www.worldbank.org).

By the end of 2009, 68% of all people living with HIV were in sub-Saharan Africa; sub-Saharan Africa suffered a great deal as millions of children were left behind as the disease killed their parents and guardians. Over three-quarters of all deaths that occurred in 2007 were in sub-Saharan Africa, retarding economic growth and destroying human capital as the per capital income of households was greatly reduced; the numbers of people in the working age-bracket reduced whereas the dependants increased with the orphans that were left behind. At the end of 2007, women accounted for 50% of all adults living with HIV worldwide, and for 61% in sub-Saharan Africa. In developing and transitional countries, 9.7 million people were in immediate need of life-saving AIDS drugs; of these, only 3.9 million received drugs in 2009 (UNAIDS/WHO, 2007/2010). Analysts predicted that, by the end of 2010, 18 million children worldwide would have lost one or both parents to HIV with the number of double orphans increasing by 2 million (UNAIDS, 2004).

Research discovered a number of factors that made households in sub-Saharan Africa more vulnerable to the epidemic, such as, culture, migration tendencies, education and economic status. Social norms in many sub-Saharan Africa societies gave men absolute power to dictate sexual decisions and have more than one sexual partner often resulting in inconsistent condom use (Gillespie, Kadiyala & Greener, 2007). The situation was worsened by the economic inequality, as majority of the women in sub-Saharan Africa were totally dependant on the men for economic support. There were mixed relationship between HIV transmission and socioeconomic status, that is, the degree to which one's socioeconomic status was associated to HIV transmission. One's wealth and other factors such as urban residence, age, education and

difference in sexual behavior posed mixed effects on the risk of HIV. It should be noted though that the measure of wealth was never easy to determine as the wealthiest groups in one community actually fell below an absolute poverty line in another.

The effect of wealth on HIV risk was statistically proved to be insignificant when all other factors were controlled (Gillespie, Kadiyala & Greener, 2007). In most societies even though, relatively rich and educated men and women had a higher rate of partner change; they also had better access to reproductive health care (Hargreaves & Glynn, 2002). Poverty increasingly placed individuals from poor households at a greater risk of exposure to HIV because of their adoption of risky behaviours. Women especially engaged in transactional sex so as to be able to procure food and other basic requirements for their households. Poor nutrition on the other hand weaken the immune system, which greatly exposed one to HIV transmission incase of unprotected sexual encounter.

A study done in a rural South African community concluded that when other factors remained constant, education advancement reduced HIV infection, education exposed individuals to preventive promotional messages that empowered them to negotiate use of protection with their sexual partners (Bärnighausen, et al, 2007). Migration from one area to another increased vulnerability to high-risk sexual behaviours as migrants left behind the socio-cultural norms controlling behaviours within society. Migration tendencies posed a challenge when executing preventive, care or treatment services. Bärnighausen, Hosegood, Timaeus and Newell (2007) describe the risk of HIV infection to be higher near roads especially for households with migration experience or migrant sexual partners.

In 2007, Uganda's population stood at 30,884,000 (UN Population Division, 2008), with an adult literacy rate of 72% (UNESCO/UNAIDS, 2008); at a population growth rate of 3.2% per annum and a total fertility rate (TFR) of 7. Uganda's population in 2010 was 31.8 million (UNFPA, 2010); the impact of the epidermic became greater with the challenges of a big population and reduced literacy rate (69%) in 2010.

The first case of AIDS was first diagnosed in 1982 and was commonly known as the slim disease a name given after the characteristics of the disease (Serwadda, 1985). 940,000 of the country's population were positively living with HIV/AIDS, 480,000 women and 130,000 children below age 15 and 77,000 deaths were recorded in 2007 (http:/hivinsite.ucsf.edu/global). Even though the country has no new published data, UAC (2010) reported that Uganda had a generalized HIV epidemic with a prevalence of 6.4% in adults and 0.7% in children and 1.1 million people infected with the disease.

The epidemic depleted the country's labour force, reduced agricultural output and food security, and weakened educational and health services. The large number of AIDS related deaths amongst young adults left behind over a million orphaned children. (Government of Uganda, 2008). Households in Uganda with orphans had 77% per capital income of those without orphans; the economic situation within such households became hard, as the already constrained resources had to be shared further amongst everybody (Wakhweya, 2002). "The key pathway through which HIV/AIDS impacted on households' well-being was through the socioeconomic impact of death" (Collins & Murray, 2007, s75). The impact of death was felt strongest through the high cost of funerals and loss of income from a breadwinner. Funerals costed large sums of money usually many months of one's income and given the frequency of occurrence of these funerals in poor communities household resources were highly depleted.

Most households stood a risk of losing over half of their monthly income if the highest income recipient in the household died, not even selling of their assets would help maintain pre-death living standards for a year or more (Collins & Lei, 2007).

Almost 200,000 African infants were born infected with the HIV virus (Kinoti, 2009). Bellamy (2005) agreed that children did not have to be HIV positive to be devastated by the disease. When children were exposed to HIV/AIDS, whether infected or living with an infected person many of their rights were compromised. The greatest impact of HIV/AIDS on children was exposure to the disease; children were infected through mother-to-child transmission and during breastfeeding. When a parent/guardian/care-taker succumbed to the disease, children were at a loss of family and identity. If they were lucky, they would be distributed into other families but most of them remained on their own resulting in child-headed households. Death of parents or guardians exposed children to violence, abuse, exploitation, stigmatization and discrimination. Many children affected by HIV were forced to pull out of school to begin earning an income for basic needs but also for medical bills of the guardians or even funeral costs of these parents. The pain was even greater for the girls as they faced the possibility of either being forced into early marriages, domestic work or exposure to sexual exploitation, which robbed them of their right to play. Children were also affected psychologically due to segregation in school and sometimes even at home.

To combat this disease experts devised a combination of drugs commonly known as antiretrovirals that were administered through a therapy known as antiretroviral therapy (ART). HIV antiretroviral is the main type of treatment for HIV or AIDS as they suppress the virus in the blood. In 2006, 15% of the 780,000 children living with HIV in low and middle-income countries were receiving Antiretroviral Treatment (WHO, 2007). By the end of September

2009, there were 200,213 people on ART country wide that is, 8.5% children and 91.5% adults over 15 years of age (UAC, 2010). Govtmaker, Hughes and Cervia (2001) detail a study done in the United States that found the mortality rate among a sample of infected children to have reduced from 5.3% to 0.7% per year after antiretroviral treatment was administered. In 2000, the Ugandan government through its Ministry of Health collaborated with UNAIDS in an effort to provide access to antiretroviral therapy. The collaboration led to a formation of a 15 member advisory board resulting in the introduction of ARV therapy and the roll out of a more comprehensive approach to the medical management of people with HIV/AIDS. Uganda today had 330 active ARV therapy centers and out of these, 110 were able to provide paediatric HIV care services (Kinoti, 2009).

TASO is the largest indigenous NGO in Uganda responding to the HIV/AIDS epidemic through care and support services. TASO contributes to the process of HIV prevention, restoring hope and improving quality of life for persons affected by HIV/AIDS. The organization operates in 11 service centers spread in a number of districts, and has 15 mini-TASOs situated in government hospitals/health centers outside the service center radius. Over 10,000 HIV positive persons have received free ARVs from TASO including 500 children since the therapy was rolled out in June 2004 (TASO Annual report, 2005). Paediatric care AIDS management remains a challenge gauging from the low registered numbers of children onto the programme and to our knowledge no programmatic research-based explanations has been documented. Previous studies have placed emphasis on the clinical explanation of children's reactions or non-reactions to the therapy but not the factors that affect the delivery of paediatric antiretroviral therapy. The study aimed at examining organizational factors responsible for contributing to this disturbing trend and facilitate NGO management to improve service delivery to their clients.

1.2 Statement of the problem

WHO (2007) predicted that the world was at increasing risk of disease outbreaks, epidemics, industrial accidents, natural disasters and other health emergencies. Bärnighausen, et al (2007) identified the HIV epidemic to be one of the greatest health and development challenge facing sub-Saharan Africa. In Uganda, even though there were noticeably significant gains in the response to HIV/AIDS among adults, the burden with children still posed great concern to the health sector. With the relatively high prevalence of HIV among women of reproductive age at 6.5%, HIV infection as high as 20,000 among children could occur each year in the absence of effective interventions for preventing transmission (MOH/ACP-HSPII, 2010). UNAIDS (2008) approximated the number of children living with HIV in sub-Saharan Africa by 2007 to have been 2 million; 130,000 of this statistic belonging to children in Uganda alone.

In 2000, the Government of Uganda through the MOH assumed sole responsibility for managing access to ART. Almost ten years after the therapy (ART) was started in Uganda, the number of children in Uganda with advanced AIDS and therefore eligible for ART is at 55,000 and yet only 13,000 access antiretroviral drugs (Dr.Watiti, 2008, Monday August 25). Without treatment, half of all infected babies will die before their second birthday (info@geneva.msf.org).

Few studies have definitively established a clear connection between organizational factors and delivery of paediatric HIV care; minimal attention has been attached to the programmatic issues affecting paediatric HIV treatment. This study examined the organizational factors affecting the delivery of paediatric treatment in NGOs in Uganda, a case of TASO Uganda, best practices of this service provision were documented.

1.3 Purpose of the study

The purpose of the study was to examine the organizational factors that affect delivery of paediatric antiretroviral therapy by Non Government Organizations in Uganda.

1.4 Objectives of the study

The study sought to examine the following specific objectives:

1. To determine the relationship between systems and delivery of paediatric ART at TASO Uganda.
2. To find out how leadership styles affect delivery of paediatric ART at TASO Uganda.
3. To find out how staff contribute to the delivery of paediatric ART at TASO Uganda.
4. To determine the relationship between policies and delivery of paediatric ART at TASO Uganda.
5. To examine the effect of socioeconomic factors on the effect of organizational factors on delivery of paediatric ART at TASO Uganda.

1.5 Research questions

The study sought to answer the following research questions:

1. Is there a relationship between systems and delivery of paediatric ART at TASO Uganda?
2. Do leadership styles affect delivery of paediatric ART at TASO Uganda?
3. What is the contribution of staff to the delivery of paediatric ART at TASO Uganda?

4. Is there a relationship between policies and delivery of paediatric ART at TASO Uganda?
5. What is the effect of socioeconomic factors on the effect of organizational factors on delivery of paediatric ART at TASO Uganda?

1.6 Research hypothesis

The study was based on the following hypotheses:

1. There is a significant relationship between systems and delivery of paediatric ART at TASO.
2. Leadership styles do not affect delivery of paediatric ART.
3. There is no significant relationship between policies and delivery of paediatric ART.
4. Staff significantly contribute to the delivery of paediatric ART at TASO Uganda.
5. Socioeconomic factors greatly contribute to the effect of organizational factors on delivery of paediatric ART at TASO Uganda.

1.7 Conceptual Framework

Conceptual model for the study

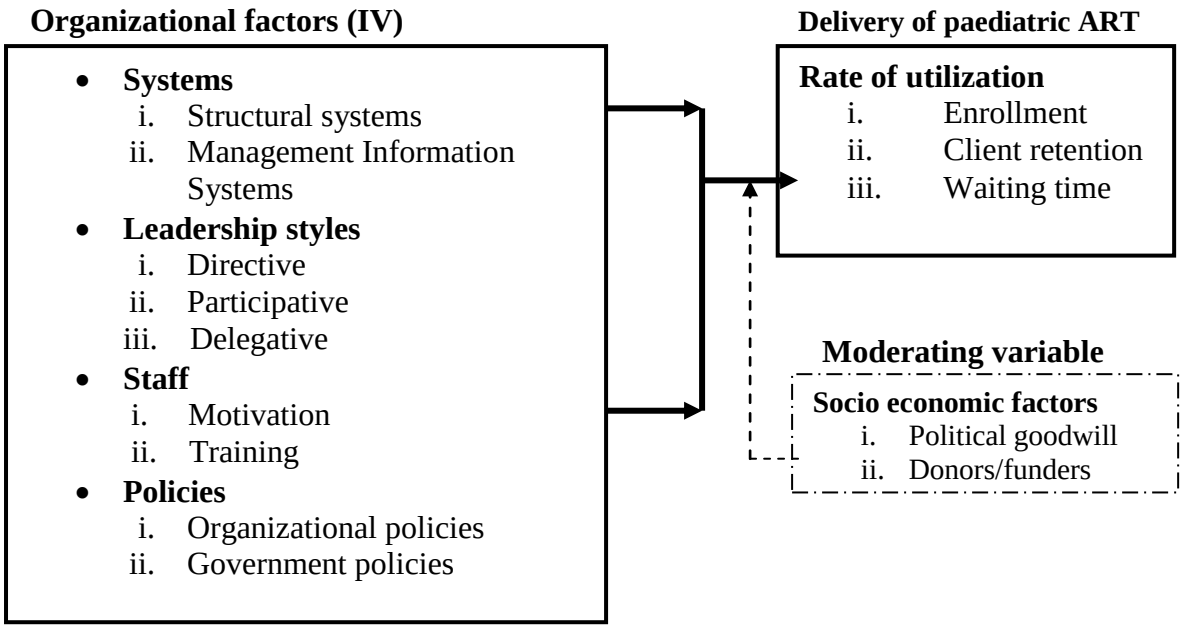

Figure 1: Conceptual Framework

Source: Waterman, Peters & Phillips (1980) 7-S Model; Brackertz and Kenloy (2002), Service delivery approach to measuring facility performance in local governments

There two main variables; the Independent variable (Organizational Factors) caused the Dependent variable (delivery of Paediatric ART), a causal effect relationship. The Moderating variable affected the relationship between the Independent and Dependent variable. Organizational factors were adopted from Mckinsey's 7-S Model, this Model outlined seven key elements that contributed to the effectiveness of any organization which included; Strategy, Structure, System, Staff, Skills, Style and Shared values (Waterman, Peters & Phillips, 1980). The researcher, however studied similar elements together such as, systems and structure; staff and skills, shared values and strategy, hence the four dimensions of organizational factors (systems, leadership styles, staff and policies). Delivery of services elements were adopted from a study that identified performance measures to be ; interim milestones, physical performance metrics, utilization rates, community/customer perspective (Brackertz & Kenloy, 2002).

The study considered Systems theory as discovered by Barnard Chester. Systems Theory divided the natural world into two parts, that is, the environment and systems (Charlton & Andras, 2003). The theory stated that to fully understand the operation of an organization one needed to view the entity (organization) as a system that is, a set of interrelated parts arranged in a unified whole.

1.8 Significance

The study findings enhance the knowledge of the factors that affected the delivery of paediatric antiretroviral therapy, which is important to NGOs in taking on of best practices in paediatric ART provision. The study increased the researcher's knowledge and skills in the area of research, HIV treatment especially paediatric treatment and was a partial fulfillment of a Master's degree in Management Studies from the Uganda Management Institute.

1.9 Scope of the study

1.9.1 Geographical scope

The study was carried out in TASO centers in the central region and these included; Entebbe, Mulago and Jinja. TASO Entebbe is in Wakiso district boardering Lake Victoria; Entebbe town is 37 kilometers southeast of Kampala, the capital city of Uganda. The center is found on Plot 15-17 Lugard Avenue. TASO Jinja is found at Jinja Referral hospital in Jinja district, its catchment area spreads as far as Kamuli, Iganga, Mayuge and parts of Mukono district. TASO Mulago is located inside the national referral hospital, Mulago hospital in Kampala district.

1.9.2 Contexual scope

The researcher determined to study organizational factors as they affected the rate of utilization of paediatric antiretroviral therapy at TASO Uganda and this was studied through dimensions such as client enrollment, client retention and waiting time of clients at centers during clinic days.

1.9.3 Time scope

The study covered a period between 2004 to 2010 and this is because TASO Uganda rolled out antiretroviral therapy in June 2004.

1.10 Justification of the study

The research findings detail organizational factors and the extent to which they affect delivery of paediatric ART. The recommendations are meant to facilitate the management of NGOs to improve service delivery of antiretroviral therapy of children and improve children enrollment into HIV care, hence contribute to realization of the Millenium Development Goals 2015 aiming at universal coverage.

1.11 Operational definitions of terms

AIDS : Acquired Immune Deficiency Syndrome; a set of symptoms/infections caused by damaged human immunity system.

ART : Antiretroviral Therapy; approved treatment for HIV/AIDS.

Case study: A methodology that focuses on understanding the situation in a single setting. It seeks to study and understand a particular environment or organization.

HIV: Human Immunodeficiency Virus, the virus that causes AIDS**.**

Organizational factors: Internal elements that contribute to the performance of the organization.

Paediatric: A medical term referring to children's treatment, care and support.

PLWHA: People Living With HIV/AIDS

Therapy: Approved set of treatment

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter focused on the review of various data related to the area of study variables. The chapter reviewed information on the study variables and their effect on delivery of pediatric antiretroviral therapy. The variables covered included the dependent variable (delivery of pediatric ART); independent variable (organizational factors – systems, staff, leadership styles, and policies) and the moderating variable (political goodwill and donor support). The theory that guided this research was also included in this chapter.

2.1 Theoretical review

The study considered The Systems Theory as discovered by Barnard Chester. Systems Theory divided the natural world into two parts, that is, the environment and systems (Charlton & Andras, 2003). Systems theory stated that to fully understand the operation of an organization one needed to view the entity (organization) as a system that is, a set of interrelated parts arranged in a unified whole. Weihrich and Koontz (2005) explained that two kinds of forces/environment exist with systems, the internal and external forces/environments and that these two push against each other. The internal environment/force works inside the system and pushes outward against the external, likewise the external environment/force is outside the system pushing inward against the internal. This research viewed the organization, in this TASO as a system and the two environments/forces to be organizational factors working within the organization and that there were external forces (such as political goodwill, donor support) working outside the organization and affecting the overall performance of the organization. For the organization to function properly both the internal and external forces

had to be equal, if one force was greater than the other then the organization struggled to realize its intended strategic focus.

2.2 Systems and service delivery

2.2.1 Structural systems

Every human activity requires division of labor into tasks which need to be coordinated to result into an activity. Organizations also known as systems according to systems approach bring together people under a defined structure for the purpose of achieving predetermined outcomes with the availability of necessary resources. Structure is considered essential in large organizations where face-to-face communication is not frequent; these are graphically represented by the position relationships on an organizational chart. Structure ensures management action, encourages efficiency, communication, and optimum use of organizational resources as well as stimulating creativity and job satisfaction establishing the ability to delegate authority, communicate, control and account for resources (Prasad, 2000).

Weber (1947) introduced the Classical Theory of management emphasizing efficiency and production, this approach worked with principals such as; chain of command, unity of command, span of control, specialization, and the use of a scalar chain or vertical levels of authority. This theory divided work into standard specialized tasks that made up departments; the hierarchy of authority became the right to direct; and responsibility the obligation to perform yielding into a chain of command. Line authority was linear and derived from position; staff authority was an advisory relationship, and Span of control the number of employees a manager effectively supervised. Many structural changes have happened over the last 30-40 years, organizations have moved from the stand alone centralized organizations to decentralized.

There are many ways of structuring an organization; they may sometimes be arranged according to the functions of the employees or according to the divisions/departments within that organization or both known as matrix. Functional structures helped in reduction of duplication of activities and encouraged technical expertise but can be difficult to coordinate. These are recommended for small and centralized organizations that offer few goods and services. Divisional on the other hand improved decision-making, increased coordination of activities and fixed performance accountability but often fostered rivalry among divisions. A divisionalized form was characterized by a number of independent divisions with one administration such as an integrated system, this type of structure proved excellent for relatively large, geographically dispersed organizations that provided a variety of good/services. Weihrich and Koontz, (2005) suggested that organizations ought to consider the size, technology and the requirements of its environment when structuring.

TASO Uganda adopted a divisional type of structuring clearly marked out in their organization chart; at the top of the chart is the board of directors who are nominated and selected/elected on an annual basis and these supervise the Executive director. For delivery and direction of services, TASO is divided into six Directorates each headed by a Director and assisted by either one or two Deputy Directors. The different Directorates include; Program management, Planning and Strategic Information, Advocacy and Networking, Capacity Development, Human resources and Administration and the Directorate of Finance.

The Directorate of Program Management provides overall leadership, coordination and management and technical support of TASO programs; pediatric services such as social support, counseling and medical services are housed in this directorate. Planning and Strategic

Information (PSI): handles functions such as, Planning, Research, Monitoring and Evaluation, and Information Services in the entire TASO. "Specifically, this Directorate is to ensure that TASO research Agenda is developed and implemented, Research Priorities are identified and documented, evidence-based information for HIV/AIDS programming is available, and research findings are disseminated, among other things." Directorate of Capacity development provides strategic and policy guidance to TASO, the capacity development function develops TASO's training curricula and programs and is the go between TASO and its external partners especially those that handle capacity Development. Advocacy and Networking is responsible for maintaining of TASO's Public image; Finance looks at the organization's financial resources and ensures that they are adequate, well managed and properly utilized for effective implementation of the planned activities. Human Resources and Administration oversees the management of the human resource and administrative functions in TASO, and develops and monitors use of supportive systems (http://www.tasouganda.org/).

In an effective organization, individuals are clear about their responsibilities and their contribution, policies, linkages, and lines of authority are well-defined. Without such a structure, people become unsure about what they are supposed to be doing and the result is confusion, frustration, and conflict. When an organization has the right structure and people understand it, the organization can achieve its goals and individuals can be effective in their roles. If a chosen structure fostered easy communication between all management levels and gave employees an opportunity to understand and effectively contribute to organizational objectives then one would consider that a good structure. Unfortunately structure cannot stand alone but requires the presence and balance of other elements for effective service delivery to be realized.

2.2.2 Management Information Systems [MIS]

Management information systems (MIS) are a combination of hardware and software used to process information; MIS are used within organizations to allow many individuals to access information. Management information systems usually have their own staff whose function is to maintain existing systems .Within a clinical setting, quality medical care procedures rely on a coordinated flow of information from many specialty areas, making efficiency, accuracy and privacy necessary components within an information system. Clinical information management systems are designed to integrate the different areas of patient care and service delivery within a clinical setting. Every aspect of a patient's care from medical history, existing conditions, and upcoming tests and appointments is laid out within a structured and continuous framework within the system (www.eHow.com).

At the heart of most clinical information management systems lies the electronic medical record (EMR). Whenever a nurse or doctor goes to access patient information, an EMR database is set up for every patient, containing any and all information pertaining to each patient. As the system is designed to be continuously updated, clinicians can base their treatment decisions on the most current information available regarding the patient's condition. Clinical information management systems are designed to integrate different types of information, which works to automate administrative and clinical functions within a clinical setting (www.eHow.com).

TASO Uganda is not any different, as clients get enrolled into care and later onto ART, their medical details are entered into a database an equivalent of EMR. The system automatically assigns a unique number to every client entered into the system; the database contains a field that helps to tell active clients from inactive and those that are deceased. The data team

provides the different forms to the counselors and the medical team (doctors, clinicians, pharmacy and laboratory people). For every service provided for the client, there is a form used to capture the details. At the end of each visit the forms are returned to the data office that input the details into the database and also add the next date for appointment. This method not only helps to keep the medical details of each client but also when used well can help in following up of clients by their counselors.

MIS in this case enabled quick provision of information necessary for decision making (hence effective management). The effect of technology on the delivery of services became increasingly prevalent as it helped in reducing costs related to labor-intensive manual activities and eliminated/reduced errors, enhanced information sharing between employees hence increasing efficiency of existing processes and enabled entirely new processes responsible for transforming the organization while supporting organization's strategic goals and direction. The presence of an MIS helped enhance job performance at all levels of the organization's structure; at senior levels it ensured constant supply of information for strategic decision making, at other levels it served as a means of monitoring, controlling and administrative activities.

2.3 Leadership styles and delivery of services

Shukla (2009) noted that leadership was simply a process that resulted in another person influencing others to achieve a goal and direct the organization to become rational and consistent; and that the process started when traits such as, values, ethics and knowledge came into play. Great Man Theory focused his assumptions about leadership on the idea that leaders were born and not made and that great leaders arose when there was a great need; leaders possessed a special quality that sets them apart from common folk. He verified this assumption

by pointing to leaders such as Jesus, Moses, Mohammed and the Buddha (www.changingminds.org).

Leaders and their preferred choice of management were in most cases grouped into three groupings, namely, authoritative, participative and delegative leadership styles. A study done by Farrell (2001) revealed that the adoption of leadership styles by managers increased the quality of interaction between the organization and its customers/clients. One's adopted style often determined employee behavior and attitude while executing work; the characteristics of the style either empowered to inspire, motivate and change the organization (Swart, 2005). Effective leadership was the one attribute that separated a successful organization from an unsuccessful one because the adopted style affected interrelationships between employees, managers and customers/clients. However there were many factors that positively or negatively affected the leadership style adopted by a manager, for example, Oshagbemi (2004) singled out one's age as one of the factors that greatly affected the selection /adoption of leadership styles and behaviors of managers.

Results from this study revealed that older managers did more consultation and valued the participation of everybody on the team as compared to their younger counterparts. Older workers studied problems in light of past experience/practice so as to minimize risks and repeat of past mistakes. Younger workers however consulted less and were quick to make decisions. Heller (2006) disputed that neither age nor long service influenced one's ability to lead but that a leader had to possess inward strength coupled with outward processes so as to maximize their contribution to an organization. He identified inward strength attributes to be, vision, self-belief, results focus, courage and integrity teamed with outward processes such as teamwork, visibility, communication, attention and commitment.

The study considered behavioral and situational approaches to better explain leadership styles. The behavioral approach of leadership emphasized the fact that strong leadership was a result of effective role behavior and that four elements contributed to suitable behavior. The elements included, the leaders themselves, the followers, set goals and the environment under which leadership was being exercised. Unfortunately, behavioral approach did not consider time as an influencing factor, that is, the fact that particular behavior was effective only for a particular situation and time. Situational approach also known as contingency approach believed that leadership varied with the situation under which it was being exercised (Stoner, Freeman & Gilbert, 2005). Research limited situational variables to, the culture of the place or followers, difference between individuals and the difference between jobs and organizations.

The set back of this approach was that it only identified good leaders but did not put in place mechanisms of developing the identified leaders. The leadership style employed affected employee's ability to share organization's values and their understanding of their role in the organization, which later affected employee job satisfaction and quality in the service (Clark, Hartline & Jones, 2009). Bushman (2007) concluded that the effectiveness of each style for a particular manager depended on the manager's personal preference, the type of work performed by employees, and the knowledge, skill, and level of motivation of employees but the culture within the organization also played its part. Each leadership style had specific advantages and risks and complemented each other when applied together to realize organizational objectives (Krause, Gebert and Kearney, 2007).

2.3.1 Directive/authoritarian leadership style and service delivery

Authoritative leaders are often characterized as having firm views on how and when things should be done; they usually give no room for change in methods and schedules, do not invite subordinates to contribute their ideas and are strongly led by their own opinions (Clark, 2005). Employees under an authoritarian leader played no major role in decision-making and were usually uninformed of key organizational strategies. This leadership style permitted very quick decisions and was a source of motivation to the manager(s) exercising the style but promoted conflicts and low morale for work for employees. Bushman (2007) points out some of the likely situations when this leadership style would be appropriate, for example, in situations where the manager had all the necessary information to solve the problem, was operating under tight deadlines or strict donors or in the absence of time and when employees were well motivated.

TASO Uganda applied this type of leadership style when trying to realize high-level objectives. Respondents highlighted the fact that many of them were not involved during the formulation of both the past and current strategic plan. The finished product was simply introduced to staff, leaving no room for any modifications. The low level staff at TASO did not view the strategic plan as part of their business; they simply viewed it as a senior management tool. Authoritarian leadership style when applied on a new employee who was just learning the job would probably motivate him/her to learn a new skill, however the leader had to be competent and a good coach. Directive leadership was quite useful when completing specific tasks, was usually detail-oriented although fostered unambiguous communication and was a predictor of passive-aggressive behaviour in the workplace even though other changes in the organization contributed to the same behaviour (Johnson & Klee, 2007).

2.3.2 Participative leadership style and service delivery

Participative leadership was sometimes referred to as consultation, empowerment, joint decision-making, democratic leadership, Management by Objectives [MBO] or power sharing. This leadership style involved all team members in identifying essential goals and developing procedures and strategies to attain those goals; it relied heavily on a leader functioning as a facilitator (Tatum, 2009). Participative leadership style was more involving both mentally and emotionally as managers decentralized decision-making and sought the opinion of employees/subordinates when making decisions. Clark (2005) suggested that this leadership style would better be applied in situations where the leader had part of the information and the employees had the other part making it necessary to work together. Employees under this style had to know and understand their role in relation to the project or organization, as this not only motivated them but enabled them to contribute heavily to organizational goals.

There was bound to be organizational stability as future leaders who could serve the organization at a later date were developed but this style also required low-level subordinates to thoroughly understand the nature of the organization or their contribution would be meaningless. Working as a team brought out people's abilities and talents alerting the organization of employees within the team who should be given the opportunity to further develop some skill or ability for future use. Involvement in decision-making improved the understanding of the issues involved by those who had to carry out the decisions. Employees at the selected TASO centers were informally divided into teams through their routine work. If we take staff that did counseling as an example, they were directly or indirectly forced in to the counseling team headed by a counseling coordinator. The team selected a day when they met to discuss successes and challenges of their team outside the big center team. The overall team under the leadership of the center manager met once every week to discuss general issues or

sometimes asked a technical team to lead with a presentation. Great as this activity seemed, the center heads were located in the middle of the organization chart and it was not so clear whether the issues rose during their team meetings were reflected in the top management decisions.

Participative leadership style when applied appropriately yielded people's commitment to actions since they had been involved in the relevant decision-making; employees were less competitive and more collaborative when working on joint goals and this style expanded the range of possibilities for the team. When employees made decisions together, the social commitment to one another was greater and thus increased their commitment to the decision. Several people deciding together made better decisions than one person. Major benefits of this style of leadership style were that employees became part of the team and the leader made better decisions. The disadvantage was the time factor because it consumed a lot of time having to consider every one's opinion. Participative leadership flopped if the leader solicited for employee opinions and then ignored them often leading to cynicism and feelings of betrayal.

2. 3.3 Delegative/free reign leadership style and service delivery

Free reign allowed employees to make decisions even though the leader took full responsibility for those decisions. This style was often used when employees were well able to analyze a situation and determine what needed to be done and how to do it hence setting of priorities and delegating tasks. This leadership style in many ways told the employees that they were trusted, often resulting in better morale. Bushman (2007) expressed that a good manager would know when to apply delegative leadership style although when excessively used painted a negative picture of laziness of the manager and stressed the employees making the decisions.

A newly appointed manager to a new location could opt to use delegative style because it gave him and his subordinates enough time to learn. This helped break barriers between him/herself and the people he/she was leading. Delegative style was great with a worker who knew more about the job than the leader/manager, it gave the employee an opportunity to take ownership of his/her job.. Also, the situation might call for you to be at other places, doing other things hence freeing up time for leaders to do other things (Clark, 2005). Bottom line was that even though employees made the decisions, the leader was entirely responsible.

This kind of leadership style was not very common in African setting; at TASO in particular employees got promoted within (based on expertise and years of experience) at the organization. It was therefore very rare for a situation where an employee possessed much more knowledge about an issue than the manager. The only sections of the organization where free reign was used were the information technology section and the monitoring and evaluation (data section). These two areas required the used of very technical skills to realize outputs, center managers entirely depended on the reports that these officers offered without much question. Once every quarter a supervisor from TASO headquarters went to the centers to work with the data officers to clean up their data. One of the setbacks with this style was that even though the officers generating the deliverables (reports) were motivated, it was very easy for a manager to feel undermined.

2.4 Staff and delivery of services

Human capital is the most important factor of production; they move the organization to the direction of meeting societal needs that is why the importance of human capital to the success of the organization presents a great challenge in its proper management. Douglas McGregor's theory Y agreed that employees had a lot to offer an organization but needed to be persuaded

to accept organization's objectives through motivation and training. Employees were predominantly responsible for client's perception since they represented the organization to clients during the course of service provision (Lytle, Hom & Mokwa, 1998). Organizational effectiveness was largely determined by the quality of employees and their ability to reach their highest job performance potential. Management of this human resource required; recruiting, training, supporting, supervising, evaluating and retaining of these resources. It was essential to hire employees who displayed the appropriate behavioral characteristics, for example, willingness to work as part of a team, ability to adapt behaviors compatible to clients' expectations, promotion of behaviors that appealed to clients in the course of service delivery. Organizations had to adopt innovative measures to meet changing needs with time and bridge the gap between goals and actual performance of employees. It had to be in the interest of every organization to develop its human resource base so as to realize their set objectives.

2.4.1 Employee motivation

Shah and Shah (2008) compared motivation, satisfaction and inspiration from their definitions; they defined motivation as the drive and efforts to satisfy a want/goal; satisfaction as the contentment experienced when a want was satisfied and inspiration as change in the thinking pattern.. Muneera (2005) looked at motivation as a process of arousing behavior, sustaining and channeling that behavior in a specific course. It was essential to embark on a deliberate and systematic human resource development programme (HRD); Dada (2006) defined this development as a vehicle for developing personnel competence; skills and understanding to enable the organization achieve its mission and goals.

Development was bent on how well the human element was motivated to work hence attaining organizational objectives. Dada in his research on “motivating the public service for improved service delivery” attributed the present poor service delivery in African public service to poor motivation therefore resulting in the present state of the continent’s under development. It was necessary to involve staff in all organization’s improvement initiatives and motivating them to remain service focused. Motivation went way beyond provision of incentives but worked well with the presence of other factors such as; leadership traits/styles, social satisfaction.

Dwyer (2008) however differed from earlier suggestions when he insisted that employees could not be motivated by others but rather chose within themselves to be motivated and that leaders were responsible for the provision of a conducive environment for people to motivate themselves. As part of the environment, organizations were required to understand the motivational needs of their employees, that is, determining the “what’s in it for me” for individual employees that were in line with goals and strategies of the organization.

Motivation theories

Theories such as Maslow’s theory and Herzberg theory were a good starting point in establishing what motivated human beings. Maslow's theory stated that people were motivated by a hierarchy of needs: that is, physiological needs, safety needs, belonging (social) needs, esteem (ego) needs and self actualization needs (Maslow, 1943). With the various levels of staff at TASO centers, it was easy to think that the lower cadres would start out at having their physiological needs met first. Physiological needs made up the very basic needs such as air, water, food, sleep, shelter, etc. Safety needs dealt with personal safety and security for example, job security. Belonging was the desire to identify with others such as clubs, work groups, religious groups, family, gangs, etc.

There were two types of esteem needs: self-esteem that resulted from one's competence to handle a task and then the attention and recognition that came from others. The need for self-actualization was "the desire to become everything that one was capable of becoming." When one level of need was fulfilled then people stopped being motivated by that level but would yearn to get fulfillment of needs in the succeeding level, that is, people who had fulfilled a particular set of needs were not likely to be motivated by an environment that fulfilled needs at lower levels. On the other hand, people were not motivated by an environment which fulfilled needs at a much higher level when their lower level needs had not been fulfilled. For example, a new employee who was fresh from University would not be motivated by self actualization, characterized by seeking knowledge and "inner peace", similarly, an employee who had been on the job for quite some time with a safe home, a secure family and an accumulation of material goods was less likely to be motivated by the provision of financial rewards.

For adequate workplace motivation, it was important that management understood which needs were active for individual employee motivation. Many studies showed that even though employee needs would indeed be grouped in a hierarchy, their order of satisfaction varied significantly and hence the need to establish what worked well for different groups of employees.

End of year/contract evaluation/performance appraisal or was one of the ways TASO centers tried to establish motivational needs of their employees. Every supervisor was required to have their subordinates appraisal form filled out at the end of a performance year, starting with the assigned responsibilities/activities and comparing them to the actual performance. When done well and done in time, this activity gave a manager/leader as well as the employee to identify performance gaps and how well to motivate the employee. Unfortunately because TASO is mainly dependent on donor support, it became very difficult to promise or even consider

financial rewards/incentives. Donor obligations to indigenous organization and other contractors were steadily reducing each year.

Herzberg's theory was about the hygiene factors needed to stop employees from being de-motivated and the factors which if the taken care of would provide an environment to motivate people. Herzberg's work categorized motivation into two factors: motivators and hygienes (Herzberg, Mausner, & Snyderman, 1959). Motivator or intrinsic factors, such as achievement and recognition, produced job satisfaction; hygiene or extrinsic factors, such as pay and job security, produced job dissatisfaction. The hygiene factors included the job environment surrounding the company, its policies and its administration, the kind of supervision which people received while on the job, working conditions interpersonal relations, salary, status and security. Even though these factors did not lead to higher levels of motivation without them there was dissatisfaction. Herzberg's motivation theory involved what people actually did on the job, more motivators included; growth or advancement and interest in the job (Dwyer, 2008).This was by far the cheapest way to motivate people and TASO had to some extent adopted this kind of motivation. Every center was allowed to close the year with a Christmas party at a location of their choice and during this party the best employee would be announced. The study did not pay particular attention to what happened to the best employee after the announcement but this kind of recognition was a good start to ensure intrinsic motivation.

Motivation types and their effect on delivery of services

Randel and Ranft (2007) considered two kinds of motivation, that is, relationship motivation responsible for maintaining friends at work and job facilitation motivation responsible for maintaining workplace relationships to the extent of affecting an individual's job performance. They noted that individuals with job facilitation motivation engaged more in inter-organization exchange of information, showed more interest in the organization and what transpired in it

than their counterparts with relationship motivation. Such employees would be helped by motivational factors such as, reciprocal benefits, knowledge self-efficacy and enjoyment in helping others so as to contribute to employee knowledge sharing attitudes and intentions. Employees' expected organizational rewards often had no effect on one's attitudes and behavior intentions to share knowledge (Lin, 2007).The study discovered it was quite difficult to tell these two kinds of motivation apart.

Smythe (2008) introduced other kinds of motivation; primary and secondary motivation. Primary also known as basic motivation bore primary motives such as, hunger, thirst, warmth, sex and avoidance of pain (generally influenced by one's need for self-preservation).These primary motives were a lot similar to the physiological needs discussed in Maslow's hierarchy of needs. Secondary motivation also known as learned motivation differed from one person to another, it involved an individual's sense of value and priority. Secondary motivation was further broken down into extrinsic and intrinsic motivation. Extrinsic motivation referred to the desire to perform a task for all of the rewards that an individual received from the outside world such as more money, a promotion, or anything else that the individual received from someone or something else.

Extrinsic motivation was likely to involve the concept of rewarded behavior hence by engaging in a particular type of activity or behaving in a particular manner, one was "rewarded" by a desired end result. Intrinsic motivation referred to the desire to perform a task for all of the intangible rewards that the individual received from himself or herself such as the satisfaction of completing a task, the joy of achieving a goal, the gratification of learning something new that the individual wanted to learn, or the pride associated with living up to one's own values. Intrinsic motivation did not offer the same physical rewards that were often associated with extrinsic motivation such as money or good grades, but it could still be a

powerful motivational tool for individuals that were attempting to achieve a smaller goal with no apparent extrinsic reward.

Other motivation types as described by other scholars included; achievement motivation, which was the desire to pursue and achieve goals that led to one's advancement in the ladder of success irrespective of the rewards and was likened to Kaizen approach. Affiliation motivation; the drive to associate with people on a social basis, such individuals excelled every time they were complimented for their co-operation and attitude. Competence motivation; desire to be very good at something, people with such motivation had good problem solving skills and were usually very creative. Power motivation; desire to influence others and have their impact felt on the organization. Attitude motivation also known as self-confidence, inner drive of an individual. Incentive motivation; drive based on rewards attached to successful completion of an activity, that is, you did this and got that. Fear motivation; coercion against one's will only helped when one want to get the job done quickly (Shah and Shah, 2008). Employee motivation is not always the easiest of tasks, but it does pay off for you, your customers and the employee.

Urichuck (2010) concluded that recognition was ranked the number one motivating factor for employee motivation in the workplace. Recognizing employees publicly saved the organization time and money of having to find and re-train new staff. He believed that one of the best techniques to build and maintain employee motivation was to make it a practice to have an event or period end staff meeting and conclude it with staff recognition awards. Recognition in this case was related to good performance/service delivery or exceptional work.

2.4.2 Employee training as a means to service delivery

McNamara (2008) defined training as a process where an expert worked with learners so as to transfer to them knowledge or skills to improve their current jobs. He went on to describe Human Resource Development as an on-going training coupled with other activities to enable employees to effectively handle a new role or improve an old job. Training was closely related to performance management, which was the approach of delivering sustained success or meeting organizational goals by improving the performance of people who worked in them and developed capabilities of both team and individual contribution (Armstrong & Baron, 1998).

Employee training was meant to bridge the gap between current and desired performance of employees and could only yield results when conducted continuously as organizational changes arose but had to be based on a thorough research of training needs at all levels of the organization. The contribution of training to employee performance and organizational management resulted in retaining of employees by preparing career paths for them, developing and institutionalizing a management system that brought stability and growth, helped develop employee commitment and loyalty to the organization and created a culture of cooperation among employees as it gave them a sense of belonging and motivated them to do their best. Other results included; increased job satisfaction and morale among employees, increased efficiencies in processes, increased capacity to adopt new technologies and methods, increased innovation in strategies and products, reduction in employee turnover, reduction in risks and enhanced company image.

Ferrell (2001) thought that training should not be limited to making one's career better but to changing the behaviors of employees to suit expectations of clients during service delivery. However, Krivanek (1999) argued that poor employee performance could not necessarily be

resolved by training but rather a thorough check of contributing factors. She introduced a Performance Assessment Checklist tool believed to help management uncover the real performance issues. The tool was divided into performance factors such as, employee ability (mental and physical capacity of employees), organizational standards (employee awareness of their expectations, procedures and goals), knowledge and skills (previous trainings and their impact on employee performance), measurement (task performance and measurement of objectives/tasks), feedback (receipt of performance feedback), environment (availability of necessary resources) and motivation (incentives in place). All the above-mentioned factors had to be accurately investigated if meaningful training was to be carried out.

The major aim of training was improving organizational and program performance but in many cases it was difficult to demonstrate a direct link between training and its desired impact because there were other factors other than training involved. Since trained individuals had little power to change systems or performance beyond their own job role there was need to consider other organizational factors such as organization structure, management styles and levels of motivation etc. McNamara (2008) suggested that training had be done in situations such as; performance appraisal indicated so, was part of employee development program, when executing a succession plan like changes in roles, when introducing a new performance management system to mention but a few.

An organization had to consider either individual employee development or increased effectiveness when choosing training options. Individual development required, identification of one's training need, providing the necessary training with the assumption that change to individual's knowledge, skills or attitudes would result in improved performance hence increased organizational effectiveness. On the other hand, increased effectiveness considered organizational objectives to be achieved, measurement of those objectives, skills/resources

necessary for achievement of objectives, assessment of existing skills/resources and incase of variations between necessary and existing skills then training and later evaluation was done. There was an assumption with the first model that individual training automatically translated into effectiveness at the workplace. The second model gave opportunity to supervisors to identify performance problem areas and to decide whether training would bridge the gap or whether to apply other organizational factors. Trends in health services were constantly changing as health professionals worked towards discovering treatment for the HIV virus. Training was very crucial both to the employee/care provider and the organization as it exposed them to recent and therefore relevant ways of combating the disease.

It was possible to demonstrate the impact of training on individual staff skills and performance using a Training Impact Evaluation (TIE), (Family Planning Manager, 1996). TIE helped managers to identify and strengthen links between training and staff performance. Information from TIE helped managers to make recommendations to decision makers, improve training courses and find solutions to performance problems. The assumption was that good individual performance would result into better client services and eventually make a significant contribution to realization of organizational goals. TASO is very keen at training of its employees; there is a training manual in place and many of those that received training that they considered essential to their careers went ahead to become excellent performers. The set back though was when employees simply followed what their leaders suggested and went for training just for the sake of it. It was indeed a good idea for the leaders to guide the staff but if people attended trainings it was very important that TASO consider feedback from staff before sending more of their employees to attend courses.

2.5 Policies

Policies were general understandings, which provide guidelines in decision-making to members of an organization in respect to any course of action (http:/en.wikipedia.org). Policies ensured consistency and improved quality; they avoided repeated analysis and gave a unified structure of doing things.

2.5.1 Organizational policies

These were defined as, agreed upon set of principles that were used to govern behavior while carrying out organizational activities (Gunnedah, 2007). Organizational policies cultivated a workplace environment that fostered delivery of services to the community in the most efficient and effective manner. Policies were crucial when: addressing the negative effects of employee conflict, measuring of individual or organizational performance, avoiding focus on meeting individual wants rather than organizational needs, incase of limited resources and high demand for services. These policies resulted in: improved communication in relation to organizational goals, clear direction in the line of service delivery, focus on long term planning and the future, continuous improvement through awareness and promotion of best practices cultivated professionalism and provided an overall environment of confidence.

Quality improvement was critical in health care to achieving success and attaining the competitive edge. Commitment to quality improvement by the governing body and senior-level management fostered quality initiatives and thereby transforming the organization (Guo, 2001). An organization with clearly stated guidelines avoided repeated mistakes and was differentiated from other organizations by its policies. There was a difference between policies and procedures: procedures were descriptive clearly giving guidelines on how a course of

action was to be undertaken, policies simply showed the acceptable or expected course of action. Organizational policies were considered sound if formulated in the context of organizational objectives; clear, consistent, balanced and had no room for ambiguity. Since policies were used by many people in the organization, they had to be written and never implied, employees had to be able to refer when need arose. Quite often policies were restrictive as they clearly demarcated what course of action was allowed to be taken to realize organization's goal.

TASO displayed a number of policies formulated to define expected outcomes; these rules which were established with the help of technical teams were used to guide the organization's direction, employees and their decisions, and to regulate, direct and control employee actions and conduct. TASO policies served as a direct connection between the organizations' Vision and its daily operations and the underpinnings to the organization's culture. The research put emphasis on TASO's Human Resource (HR) policies because they directly determined how employees joined, were retained and eventually separated from the organization. HR policies were a combination of many specific policies, for example, the recruitment policy, compensation policy, training policy etc. The TASO recruitment policy detailed the recruitment process, the source of recruitment (internal or external source) the unique recruitment situations, the selection process after applications were received, the job descriptions and the terms and conditions of the employment.

The compensation policy unlike the recruitment was defined by top management at TASO; top management not only reserved the right to define roles and responsibilities of other units and managers in the individual compensation components but also owned the bonuses and employee incentives. The employee base salaries were affected by Human Resources even though the overall decision making lay with top management. HR monitored the market and

provided top management with the data and analysis about the costs of the alignment with the external market. The managers were made responsible for the efficient use of the bonuses and incentives while Human Resources carried out the monitoring.

Well defined policies were necessary for TASO to be able to respond to their objectives in time, take for example, their recruitment policy, its timely execution enabled HR effectively to recruit the best talent pool for the selection of the right candidate at the right place quickly. A clear and concise recruitment policy helped ensure a sound recruitment process because it focused on recruiting the best potential people, ensured that every applicant and employee was treated equally with dignity and respect, encouraged employees in realizing their full potential, ensured transparent, task oriented and merit based selection and defined the competent authority to approve each selection. A properly written policy and/or procedure allowed employees to understand their roles and level of responsibility and conduct their job by making decisions within predefined boundaries. By implementing policies, management provided guidance to employees without needing to micromanage, freeing managers to focus on strategic thought.

2.5.2 National policies

National policies were considered to be theoretical, experiential assumptions or guidelines' detailing what was acceptable to resolve a particular issue or problem, that is, course of action from among alternatives to guide and determine present and future decisions. These policies set the minimum standards required to achieve results in a country. The national Constitution (*General framework usually interpreted through court decisions and appropriate bills released by leaders)* is supreme to all other policies. The Constitution is the supreme law of Uganda with the the present constitution having been adopted on 8 October 1995, It is Uganda's fourth constitution since the country's independence from Britain in 1962. All other sectors, organizations and individuals formulate/derived their policies from the Constitution with

consideration of national policies and allocated resources accordingly. Policies were implemented through rules and regulations, manuals, requests, contractual agreements and enforcement actions.

The Republic of Uganda had a National Health Policy (NHP 1) drafted in September 1999 by both Ministry of Health and other health professionals. This policy recognized poverty as the main underlying cause of poor health situations in the country; other associated factors to poor health situations included, illiteracy, high prevalence of communicable diseases, emergence of diseases of lifestyles, for example diabetes and obesity, inadequate provision of social services and underdevelopment of services infrastructure. The overall objective of the NHP was to reduce mortality, morbidity and fertility through provision of reliable statistics of the national disease and death burden which were used in planning of health care, decision making and management. The government through the NHP focused on health services that were both cost effective and had the largest impact of morbidity and mortality reduction.

The policy viewed STI/HIV/AIDS as one of the major contributors to the burden of disease at all levels and was therefore given high priority. The cost effective interventions used to address the priority health problems collectively constituted the National Minimum Health Care package (NMHCP). The NMHCP comprised of control of communicable diseases such as, malaria, HIV/SID, tuberculosis; integrated management of childhood illnesses; sexual and reproductive health and rights; other public health interventions such as, immunization; strengthening mental health interventions and essential clinical care, for example, dental health and palliative care. There was great emphasis placed on the health care delivery system through organization and management of the national health systems, establishment of service infrastructures and health sub-District. The national health system management assigned roles and responsibilities of Ministry of Health and other key partners in the health sector.

NHP II released in 2010, was adopted from NHP I and informed by the National Development Plan (NDP). Unlike NHP I, the revised version emphasized health promotions, disease prevention and early diagnosis and treatment. This policy still promoted the effective delivery of the Uganda National Minimum Health Care Package (UNMHCP), efficient use of health resources while strengthening public and private partnerships and strengthening district health systems. Together with the NHP, Uganda used other nationally approved policies such as; policy of prevention of mother to child transmission, child labour policy adopted from the constitution Article 34(4). National childcare related policies included: The Uganda Constitution; the national orphans and vulnerable children (OVC) guidelines and the national child labour policy. The child labour policy was inspired by the constitution Article 34(4) and also related to the draft national employment policy and the Social Development Sector Strategic Investment Plan.

TASO Uganda and its staff recognized and applied all national policies even though child related policies took preference. The medical teams in particular applied International guidelines (WHO guidelines to treatment) in addition to the Uganda policies. These guidelines were adopted by the Technical Working Groups seating at the Ministry of Health in collaboration with Health Development Partners. The challenge though with TASO was the fact that they only hired one Pediatrician and he sat at headquarters; he was tasked to update all the eleven centers and this he did during his quarterly visits. Apart from the fact that this seemed extremely overwhelming work, three months was along time to catch medical errors/challenges happening at the centers.

Challenges faced with adoption of national policies

Lieberman (2007) believed that ethnic politics often played a negative role on real life issues and other policies; this was because ethnic divisions prevented mobilization of societies

around a risk area, for example, AIDS. Individual ethnic groups worried about reputation consequences and in such situations government policies were more likely to face lower demand even political resistance. Fournier, Kipp, Mill, & Walusimbi (2007) argued that having good policies did not guarantee realization of objectives since there were other factors affecting delivery of targets, such as, poverty, insufficient resources, lack of on-going education, and if ignored would lead to moral distress, staff turn over aggravating the acute shortage of professionals.

Failure to involve the concerned professional during policy development often led to mismatched policies. Some of the reasons why certain professions did not get involved in policy formulation were; gender issues, financial issues, lack of skills training in policy development, political incompetence associated with policy development responsibility and the ability to use research to influence policy making (Deschaine & Schaffer, 2003). In Uganda's case 5-10 years was a relatively long time to wait for policy change incase the environment changed and the policy had become obsolete and by this time service delivery would have been affected immensely.

2.6 Utilization of services as a measure of performance

Utilization reflected the extent to which "potential access" was converted into "realized access" (Aday & Andersen, 1981). Rate of utilization was the degree to which a service was used to achieve its intended purpose; this was reflected by the frequency in use of a service (client enrollment/registration), the amount of time one spent at the organization (centre- waiting time) and one's ability to return to that particular centre for another/similar service (client retention). How good a service is can only be determined by its utilization rate by its intended beneficiaries.

TASO centers had in the recent past taken their services close to the people through their mini-TASO's, located 75kms outside their original catchment area. The medical team carried out outreaches to communities at the mini-TASOs once every week, which greatly increased their numbers of clients and popularity for their services. Unfortunately with the donor drive to rationalization and the ever increasing reduction in funding, this activity may have to be dropped. The need to better utilization for TASO services explains why they created many regional centers in the country. Hearld (2008) agreed that the contribution of organizations in the delivery of health care had significantly risen over the recent years. The challenge faced by researchers, practitioners and policy makers necessitated identification of ways of improving care through improvement of organizations that provided the care irrespective of the complexity of health care organizations and the role played by organizations in influencing systems. The success of health providers (organization) depended on their ability to provide high quality, high impact and highly ethical family based HIV/AIDS prevention, care and treatment services.

2.6.1 Client enrollment/engagement

"Engagement in HIV primary care and the receipt of antiretroviral therapy when clinically indicated offered patients the opportunity to experience HIV disease as a chronic illness" (Cabral et al, 2007, S-59). TASO's home based counseling and outreach programs were a sure way of enrolling children into care and eventually onto pediatric treatment. For mothers and fathers already enrolled, counselors often advised them to bring their children to the center for testing. There were cases that were referrals from other TASO centers or other partner organization but these were really small numbers. Despite the availability and evidence that HIV medical treatment delayed the progression of HIV disease, many individuals were not engaged into regular HIV medical care and antiretroviral medications.

In Uganda, mother to child transmission of HIV is virtually the only way that children under five years of age acquire the virus. In December 2009, out of an estimated 1.5million pregnant women 1,079,214 attended antenatal care for the first time during this pregnancy at a facility providing PMTCT services; only 968,157 were tested for HIV which was 65% of all pregnant women. (MOH/ACP-HSPII, 2010) Tobias, Cunningham, Cunningham and Pounds (2007) argued, that individual who were hard to enroll into HIV interventions shared characteristics such as, minority status, homelessness, mental illness, substance abuse and the youth. Harris et al (2002) agreed that indeed youth were hard to engage and retain into care and could only be retained in care with intensive efforts and increase in outreach and case management.

Molitor, Crump, Walsh and Leigh (2001) discovered that the race/ethnicity of a client to some extent contributed to their decision to enroll in a publicly funded care and treatment center even though races that enrolled into a treatment and care center the same-day of learning of their infection benefited more. There were barriers that had to be overcome in order to realize improvement in engagement/enrollment of clients for comprehensive care, these include; circumstances surrounding a client's life, fear of status being revealed (stigma) especially if HIV care and treatment was not integrated into mainstream care, the hidden costs even though the medication itself was free (for example, child care and transportation to the treatment center), time commitment and lack of knowledge by the closest health professionals to the communities about the other available services and their exact locations.

Organizations devised strategies on how to increase and reach more children for HIV care, take for example, BIPAI (2009) launched a "know your child's HIV status strategy" in the northern parts of Uganda; the status day(s) were aimed at quick diagnosis and enrollment of HIV infected children into care. The campaign intended for mobilization of HIV positive adults to bring children in their care/families for HIV counseling and testing and eventually

enrollment into HIV/AIDS care and treatment. The strategy was a huge success and since then about 150 HIV infected children have been enrolled into care in the northern sites every quarter. TASO introduced a two purposed clinic day handling family issues; this family clinic day ensured that members from the same household turned up for services at the center on the same day. This innovation was two purposed in such a way that it gave TASO an opportunity to test children of HIV positive clients (enroll) while ensuring retention for the adults.

2.6.2 Client satisfaction/retention

HIV-infected individuals whose immune systems were damaged by the virus were required to take antiretroviral drugs regularly for the rest of their lives. If ARVs were taken irregularly or stopped altogether, patients/clients became sicker or died, or they became resistant to the drugs (Rosen, Fox & Gill, 2007). Highly active antiretroviral therapy (HAART) adherence rates of 90%–95% or more was required to be effective at treating the virus and preventing drug resistance (Shelton, Golin, Smith, Eng & Kaplan, 2006). WHO (2001) linked client satisfaction hence retention to provider behavior especially respect and politeness to clients/customers. These two aspects were found to be far more reaching than technical competence of the provider although the cultural background of the people also played a significant role. It was important that health care providers met both medical and psychosocial needs of their clients although in reality care that met all medical needs failed to meet the client's emotional or social needs. Conversely, care that met psychosocial needs left the clients medically at risk.

TASO hired some of its clients to provide mostly non-technical support at its centers, some of these tasks included; cleaning, cooking of tea, counseling, community follow-up and most times they handle the triage (file retrieval) with supervision from a TASO counselor. This initiative was geared towards creating ownership and ensuring retention (lowering or

eliminating lost to follow up) of clients already enrolled onto the program. Walensky (2009) defined loss to follow up as "not showing up for care for at least one year; when these clients later returned they experienced adverse effects such as; a significant drop in CD4 count by 24%, increase in AIDS defining events by 16%, risk of death by 5.14 times higher than those clients who were never lost. Rawson and McCann (2007) listed a number of ways they thought service providers would ensure client retention; A warm welcoming non-stigmatizing clinic environment, frequent assessment of client needs, creating networks that is linking up clients residing in similar locations, providing rewards for clients who continuously turned up for treatment (contingency management) and individualizing or negotiating treatment plans and where possible extension of care to the client's family members. Conwell, Mosher, Khan, etal (2007) identified unstable housing and cultural factors as great contributors of loss to follow up. They suggested use of incentives during treatment so as to ensure clients turned up for their appointments.

Harries (2009) identified steps to reducing loss to follow up namely; (1) using a simple standardized monitoring and evaluation system that arranged clients according to alive and on ART or dead, defaulters and transferred out then consider rewarding good performance. (2) establishing a national deaths registry detailing treatment outcomes of the deceased and frequency of clinical attendance (3) Consider use of prophylaxis and tuberculosis case finding as ways of reducing death rates (4)ensuring uninterrupted ART supplies (proper drug forecasting and timely placement of procurement orders); replacing toxic ART with non-toxic, simple (once- a day) regimens (5)decentralizing ART clinics and reducing the frequency of visits for stable patients (6)linking ART services to community because community support helped people to live longer (7)reduction of indirect patient costs (transport costs to the clinic) (8)using ART services to deliver other useful interventions such as anti-malaria treatment, nutritional support, agricultural proceeds (9)consider thinking outside the box by involving

other methods of ensuring adherence such as involving the media. A study done by Shepard, et al (2006) involving counselors of a mental health facility, discovered that provision of incentives to counselors whose clients attended at least five aftercare sessions (the "milestone" which was considered the minimum adequate dose of the aftercare curriculum) improved client retention by 26%. The motivated counselors did everything possible to ensure their clients turned up for their treatment.

Rajabiun, Tobias, Bradford and Cabral (2007) associated retention in HIV care with decrease in structural barriers, client unmet needs, absence of negative health beliefs accompanied by medical visits and improved relationship with health care providers. Rosen, Fox & Gill (2007) in their study on retention concluded that large scale ART programs in Africa managed to retain 60% of their clients by the end of 2 years through proper understanding of loss to follow up, applying better methods of tracing patients and early initiation of ART so as to reduce mortality as ways of improving retention.

Prof. Harries (2009) noted that there was a steady decrease in retention in ART programmes in sub-Saharan Africa; at six months after the start of ART 79% were still in treatment, at 12 months the number decreased to 75% and by 24 months to 62%. Despite all the global failure statistics, TASO Uganda noted a steady decrease in loss to follow up of its children through assigning of counselors based on location, that is, a counselor was able to locate her assigned children right from their homes since they resided in the same location.

2.6.3 Client waiting time as a determinant of service utilization

Client waiting was regarded as the most critical aspect of service quality, even though satisfaction with the service did not necessarily result in client retention (Shell & McHaney & Babbar, 2003). Waiting time, not only determined service satisfaction but contributed to

loyalty because it affected perceptions of the service and satisfaction with information provided incase of delays. Bielen & Demoulin (2007) emphasized that service providers had to pay attention to delay because it contributed to negative effects on client service satisfaction. Foreman and Hanna (2000) argued that waiting time contributed a substantial but complex impact on intention of clients to attend appointments; there was a maximum limit of time beyond which clients and their families gave up on a service all together.

Conner-Spady, et al (2008) in her study of the "willingness of patients to change surgeons for a shorter waiting time for joint arthroplasty" revealed that many patients indicated willingness to travel to another hospital in anticipation of a shorter waiting time but very few actually took the step. Factors influencing their choices revolved around the hospital's reputation, follow-up care and travel time to the new hospital and so in the long run they gave up on the service itself. Client waiting time affected perception of clients either positively or negatively depending on how long the clients waited. Service providers were better off combining ethical considerations with client waiting time, that is, what was ethically right. Special consideration had to be given when providing services to HIV/AIDS clients as regards waiting time because of their already failing health.

Abdallah (2007) in his research about client waiting time at TASO centers in 2007 concluded that clients spent an average of 6 hrs: 36mins (duration of a service) receiving a particular service and an average of 12hrs:27mins total time at the center on a clinic day. This study showed that the longest time spent in session was longer that 1 hour. This meant that an unfortunate client spent the whole day at the center waiting to receive all the necessary services; this in turn would be reason enough for him/her not to turn up for a refill or any other service. Clients' psychology was altered over the course of time and if their perceptions had been negatively affected they decided to abandon the intervention altogether. A study done in

Bangladesh revealed that reduction in waiting time (on average to 30 minutes) was more important to clients than prolongation of the consultation time (on average 2min, 22 seconds). Rawson and McCann (2007) believed some of the ways of reducing client waiting time were; ability to offer walk-in assessments to clients by eliminating redundant paper work and finding out from clients some of the barriers to their coming for appointments and helping them to find solutions. Differences in how waiting time was perceived between individuals and care sectors was essential as a building blocks for the development of more tailor-made policies aimed at reducing the burden of waiting time (van Exel, de Ruiter & Brouwer, 2003).

2.7 Political goodwill

Goodwill required making correct decisions in reference to other people; political goodwill on the other hand was the power granted by the ruling government to an organization to freely operate in that country and it was paramount for the existence of any organization. In the past there were situations where countries were blacklisted, for example, United States of America blacklisted Iraq and Libya for terrorism, none of the projects funded by USA were allowed to purchase items from those countries. USA drafted rules for allowable and disallowable transactions and these were sent down to the smallest/furthest country that received aid from them, political goodwill greatly impacted the efficiency and effectiveness of any organization.

NGOs contributed to socioeconomic development of nations as they expand government's interventions such as access to health care, poverty alleviation. NGOs bring and teach innovative techniques and solutions from various societies and may provide public goods to sections of populations that could be socially excluded (Lawrence & Nezhad, 2009). Government and NGO sectors were complementary in disease control because their collaboration was an effective way of improving access to and quality of health care services (Ullah, Newell, Ahmed, Hyder & Islam, 2006). However the impact of the government on the

NGO greatly depended on the government's contribution to the realization of NGO objectives. In Lesotho, which was a democratic country almost no assistance was given to NGOs by the Government and so NGOs depended almost entirely on donor assistance to survive (Lesotho Council of NGO's, 2006).

This eventually resulted in NGO's having more confidence in donor funding for their programmes than in their own governments ability to back and fund projects. The setback established by a noncommittal government was mistrust in the NGO causing a collapse of those NGOs as donors/funders pulled out citing poor performance. Today many funding countries channel funds through government/civil societies as a requirement of the Paris declaration; it was therefore essential that the recipient government worked hand in hand with NGOs as the major implementers.

Lawrence and Nezhad (2009) singled out ways in which governments co-opted with NGOs, these included;

- Government letting NGOs step into situations and filling government's place temporarily, usually done in situations of extreme failure of government, for example, peace-building in conflict societies.
- Government contracting out certain projects to NGOs, usually done where NGOs were better equipped to do a more efficient work.
- Government completely stepping out of a particular sector because of the presence of an NGO in that sector. This left many communities at the mercy of NGOs.

2.8 Donor support

"Much of the moral authority of NGOs, as well as their political strength, came from support from funding and facilitator organizations" (Steinberg, 2003). Donors had a responsibility to

ensure that their funds and support was used for the required purpose and not directed in covert ways to support terrorism or political campaigns. An example was sighted where many well-meaning donors unknowingly contributed ammunition to the "war against Israel by continuing to finance NGOs that used human rights facade to conduct a campaign to delegitimize Israel" (Steinberg, 2003). Many funding organizations placed great emphasis on financial-transparency mechanisms in order to avoid misappropriation of money while the substantive work that the NGOs engaged received far less scrutiny.

HIV/AIDS funding had been increasing every year with various funding institutions putting monies together for a common cause. Kurokawa, Tembo and Willem te Velde (2008) outlined three levels through which donors provided support; Macro level which was shaped by government policies and the country's regulatory framework, Meso level which was aimed at improving functioning of markets or micro level which was in form of business development services at a single business unit. Aidsmap (2002) was concerned with the fact that the nature of donor funding complicated and undermined the scaling up process of NGOs. For situations where organizations received funds from more than one donor, which was the best way of reducing the risk of relying on a sole source, there were competing objectives of programming imposed on the organization. A more fundamental critique of donors was that they ignored existing community initiatives addressing HIV/AIDS and even unknowingly undermined them. The risk of such a trend was greater in situations where there was an increased influx of resources devoted to HIV/AIDS.

In most African countries, health funding was channeled as aid to the recipient government through Ministry Of Health or it came directly to NGOs through the civil society. Funding in the past had been given with many donors placing strict conditions to it, which conditions in many instances were found to be contrary to national policies/priorities. The situation often

caused poor quality aid accountability and frustrated many projects. On many occasions, poor quality aid was attributed to lack of monitorable targets and poor ways of holding each other accountable for the availed resources (http://www.worldvision.org.uk). Accountability was often times affected by the relationship between donors and recipient governments rather than recipient governments and their own civil society (www.worldbank.org).

Donor countries, recipient countries and their organizations endorsed the Paris Declaration on Aid effectiveness held in France on March 2 2005. The declaration may times viewed as an international agreement was established to improve efforts in managing aid by both donors and recipient countries and eliminate challenges of poor quality aid and accountability (OECD, 2005). Many countries were optimistic that the declaration would make significant impact because it seemed to go beyond previous agreements as it detailed a practical and action-oriented roadmap involving key principles such as, ownership, alignment, harmonization, managing for results and mutual accountability. The declaration was believed to properly monitor progress in realizing results as it listed twelve indicators aimed at effective monitoring of both donor and recipient country performance (www.aidharmonization.org/ah-overview) and ensuring delivery of services.

Tandon (2008) argued that the main aim of the declaration was to improve transparency and accountability in the use of development resources. This declaration resolved that developed and developing countries would take more seriously monitorable actions so as to reform delivery and management of aid to nations. The declaration rendered both donor and recipient countries mutually accountable and responsible for monitoring compliance. Whereas the volume of aid had to be increased in order to achieve Millennium Development Goals (MDG) so did its effectiveness in order to help partner countries to strengthen governance and improve performance. At country level both donors and recipient countries were responsible for

assessment of the progress. Commitments from the Paris Declaration on Aid Effectiveness include:

- Developing countries would exercise effective leadership over their development policies, strategies, and to coordinate development actions;
- Donor countries would base their overall support on receiving countries' national development strategies, institutions, and procedures;
- Donor countries would work so that their actions are more harmonized, transparent, and collectively effective;
- All countries would manage resources and improve decision-making for results;
- Donor and developing countries pledged that they would be mutually accountable for development results.

Unfortunately many countries expressed dissatisfaction at the declaration, Tandon (2008) singled out the fact that this declaration penalized recipient countries that didn't perform but was lineate on donor countries that failed to perform and in the long run passed all the risks involved onto the recipient country. Although there was a significant improvement from the past, indicators from the declaration were more reflective of how donors rather than recipient countries wanted aid to improve; civil society organizations were only minimally engaged with the processes. The general outcry was that all beneficiaries would be fairly represented and that the declaration would be more effective.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter addresses the methodology of the study. It presents the research design, methods and techniques of data collection and analysis. The methodology helped the researcher to collect valid data on organizational factors and their impact on the delivery of paediatric ART using reliable methods and instruments. The methodology established the appropriate research design, population of the study, sample size and selection methods, data collection methods and instruments, pre-testing, measurement of variables and analysis.

3.1 Research design

The study took on a cross-sectional survey because the researcher believed that it would enable her to collect the right data to answer the research questions and test-hypothesis. Amin (2005) defines cross-sectional design as surveys that gather data from a sample of a population at a particular time, a snapshot of one point in time.

The study used a triangulation of qualitative and quantitative approach even though it was predominantly qualitative in nature. Amin (2005) defined qualitative approach as a study geared to collecting narrative data from key respondents; subjective in nature collecting data using both interviews and direct observations whereas quantitative approach collects structural data using questionnaires and is objective and focused. Quantitative methods measures the researcher is distant and independent of the research and only aims at establishing the relationships between selected variables. Quantitative methods were used to establish presence of relationship between organizational factors and delivery and qualitative methods were used

to facilitate the interpretation of relationships between variables, that is, determine the degree of relationship.

3.2 Population of the study

The population of the study was all the staff in the three selected clusters totaling 194 that is, (TASO Mulago, TASO Entebbe and TASO Jinja). TASO Mulago had 70 staff; Entebbe had 55 and Jinja 65 and 4 staff specifically assigned to ART at headquarters.

3.3 Sample Size and Selection

The researcher used purposive sampling to select the staff that were directly linked to the study; staff from the three selected centers who worked directly with the children were selected. Out of the total population of 194, 112 staff worked directly with the children and these were referred to as the accessible (target) population. Seeing that the target population was relatively small, the researcher decided to select all the target population as the sample for the study.

Table 1: Sample size selection table

Category	**Population**	**Accessible (target) population**	**Sample size**
TASO Mulago	70	50	50
TASO Entebbe	55	26	26
TASO Jinja	65	32	32
TASO headquarters	4	4	4
Total	**194**	**112**	**112**

3.4 Sampling Methods and Procedure

Using single stage cluster sampling, the centers were arranged into clusters a total of eleven (11) clusters were formed. Time and resource constraints influenced the researcher's decision to consider the three clusters located in the central region. Purposive sampling as a technique was used to select the sample for the research, this enabled consideration of people with the necessary information in relation to the objectives of the study. These were hand picked and the advantage of this technique is that it enabled representation of an extreme group although the results from this method of sampling could easily be dismissed as extreme/biased.

3.5 Data collection Methods

Qualitative data was collected through a semi-structured interview of key informants using interview guide and more data was collected using library search. The key informants were selected from the sample and these were staff that held key positions such as, heads of departments or center managers. Semi-structured interviews were more flexible and they allowed for additional comments and avenues to be explored. These interviews provided in-depth data, guarded against confusion caused by unclear questions, yielded higher response rates and enabled the researcher to collect more information from the environment and gestures of the interviewee. The shortcomings of the semi-structured interview was that it became more time consuming because the interview time was set by the interviewee and also required a lot of skill to be able to get relevant information. Library search involved review of the researches conducted in the past about TASO.

Quantitative data was collected through a structured (closed ended), five-Likert scale questionnaire. This method was easy to administer, easy to code and analyze but was very easy to lead to misleading conclusions because of the limited options. Closed ended questionnaires

were very economical in terms of resources (time and money) but were a challenge to construct because they represented many options.

3.6 Data collection instruments

The researcher used both structured and semi-structured questions, the instruments included;

- Self-administered questionnaires,
- Library search checklist
- Interview guide

The self-administered questionnaires were applied to the staff responsible for children's affairs at TASO centers; the interview guide was applied to staff that were part of the sample and held key positions at the selected centers such as center managers and heads of departments. TASO data statistical reports were used to compare the registration trends of children onto pediatric ART as well as monitor the attendance of children over the years.

3.7 Pre-testing

Pre-testing also known as piloting is the process of administering the research instruments on a few people before using it for the actual study; this is done in order to establish their repeatability/consistency and ability to measure what they are supposed to measure. The questionnaire was pre-tested on twelve (12) staff at Baylor College of medicine in Mulago; Baylor was chosen because they handle pediatric HIV/AIDS infected children and their families. Pre-testing helped the researcher to make the necessary corrections on the instruments so as to avoid problems/errors during data analysis and interpretation.

3.7.1 Validity

Validity helped the researcher to tell whether the research including the measuring instrument measured what they were supposed to (Coombes, 2001). There were two kinds of validity, internal and external validity. Internal validity encompassed whether the results of the study were legitimate. The UMI based supervisor and the work-based supervisors advised/guided in ensuring subject variability of the research. The researcher also ensured internal validity by selecting a relatively small sample; large samples were believed to reduce the validity of the research (http://linguistics.byu.edu/faculty/henrichsenl/ResearchMethods/RM_2_18.html). External validity also known as Generalizability helped determine whether results from the study were transferable to other groups of interest (Last, 2001). One of the ways the researcher ensured external validity was ensuring variety of characteristics of the respondents, for example, choosing various options/categories of staff at the TASO centers.

3.7.2 Reliability of the instrument

Reliability also known as consistency/repeatability of the instrument is the extent to which the instrument used in the research yields the same results when repeated (Key, 1997) The researcher applied the Split Half method to the piloted instrument in order to determine the reliability of the instrument. The answers per instrument were divided into two by assigning the odd numbered items to one half and the even numbered items to the other half of the test. Pearson (r) between the scores on the two halves of the test was computed and the reliability of the instrument was found to be 0.79. One drawback of the split-halves method was that the correlation between the two halves was dependent upon the method used to divide the items. Amin (2005) concluded that reliability closer to one implied that the instrument was reliable.

3.8 Procedure of data collection

The researcher received an introductory letter from the Uganda Management Institute, which she presented to the management at TASO headquarters. The management at TASO issued the researcher with another introductory letter to each of the three centers managers. At the individual centers, an assistant was identified to help with distributing and later collecting of the filled questionnaires. The researcher made appointments with the key respondents for administration of the interview guide, these included, heads of departments of the selected clusters, center managers and the ART professional at headquarters.

3.9 Measurement of variables

The research used nominal and ordinal scales; nominal scale allowed a researcher to assign subjects to certain categories or groups, these categories were collectively exhaustive. In other words there was no third category into which respondents would normally fall, for example, with gender one was either male or female and no middle ground. Thus nominal scales categorized individuals or objects into mutually exclusive and collectively exhaustive groups. Nominal scales were used to measure general information of respondents. Ordinal scales were used to measure variables in the questionnaires, using a five-Likert scale with a list of options such as; strongly agree, agree, undecided, disagree and strongly disagree**.** An ordinal scale not only categorized the variables in such a way as to denote differences among the various categories, it also ranked the categories in some meaningful way.

3.10 Data analysis

Raw data from the field respondents was checked and cleaned through edits in order to remove any errors and ensure completion. Data coding, entry was done with the application of the Statistical Package of Social Science (SPSS).

3.10.1 Quantitative data analysis

Frequency tables with percentages and totals for various items were calculated and used for data presentation, analysis and interpretation. Univariate data analysis was used to describe general characteristics of respondents and interpret nominal data. Frequency counts (goodness of fit) were also used in the analysis of ordinal data; frequencies were numerical values which represented total number of observations for variables under study; these were arranged in frequency distribution tables. Bivariate data analysis was used to compare two variables of the collected data. The researcher used correlation analysis technique in order to determine the relationship between variables and to measure the degree of the relationship. The degree of relationship was expressed as a correlation coefficient (r). The researcher cross-tabulated more than one variable, data was displayed in tables and presented using graphical forms, From this data, the researcher compiled all the other necessary tabulations, for example, coefficient, standard deviation, mean.

3.10.2 Qualitative data analysis

Qualitative data was organized under specific categories; a relationship amongst these categories was established. The study objectives formed the basis of the themes for analysis. Content analysis was used to analyze established patterns, trends and relationships from the collected data to evaluate usefulness of the information gathered. “Content analysis is a research tool used to determine the presence of certain words or concepts within texts.” (http://writing.colostate.edu/guides/research/content/). This analysis summarizes any form of content by counting the various aspects of the content. Qualitative data analysis helped to determine useful conclusions and recommendations of the study. Information from qualitative data analysis was completed through continuous consultations with experienced stakeholders in the study area during data gathering.

CHAPTER FOUR

PRESENTATION OF FINDINGS, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter presents the findings, their analysis, interpretation and summary. The main aim of the study was to examine the organizational factors that affected the delivery of paediatric antiretroviral therapy by Non Government Organizations in Uganda a case of TASO Uganda. The analysis of the study was both qualitative and quantitative based on the variables of the study: Organizational factors (Independent variable) and delivery of paediatric ART (dependent variable) and the dimensions as presented in the conceptual framework. The study subjects comprised of counselors, Laboratory technicians, nurses, pharmacy technicians, field officers, medical officers, aromatherapy and clinicians. A self administered questionnaire was given to respondents and was supplemented by interviews and documentary reviews.

Response rate

A total of 112 questionnaires were distributed to the sample and 69 were returned representing a response of 62%. Jarret (2007) suggested that any number of responses was considered acceptable provided the element of non-response bias was taken care of; non response bias is a situation where the population who did not respond display characteristics different from the population that responded. Curtin et al. (2000) concluded from his research that a low response rate did not guarantee lower survey accuracy but instead simply indicated a risk of lower accuracy.

4.1 Demographic description of the sample

The questionnaire measured 6 personal items: position/job title, gender, age, marital status and religion and employment status which are measured as single items. Below are the summaries;

4.1.1 Job title/positions

Table 2: Positions of respondents

Characteristic	Frequency	Percent
Counselor	18	26.0
Laboratory technician	5	7.2
Nurse	15	21.7
Pharmacy technician	7	10.1
Field Officer	11	15.9
Clinical field services	7	10.1
Medical officer	4	5.7
Research Assistant	1	1.4
In charge child care	1	1.4
Total	**69**	**100.00**

Source: Primary data

It was a mixture of titles and positions that made up the respondents; this was because the therapy involved a number of technical activities. Counselors made up the biggest number; this was because a client went through some kind of counseling at every stage of the epidemic.

4.1.2 Age

Table 3: Age of respondents

Characteristic	Frequency	Percent
18 –25 years	2	2.90
26 – 33 years	47	68.12
34 – 41 years	13	18.84
42 – 49 years	4	5.80
50 years and above	3	4.35
Total	**69**	**100.00**

Most of the respondents at TASO centers were middle aged, that is, 26-33 years. Empey and Peskett (2008) argued that older employees tended to have less current knowledge and were less likely to follow guidelines but the general outcome of their work was not bad. Younger employees on the other hand had much more current knowledge but no experience; older employees had experience as a compensating factor and usually reached conclusions faster. A mix of ages like the case of TASO gave the organization a rich blend of both current knowledge and experience, enabling the organization to realize its set objectives.

4.1.3 Religion

Table 4: Religion of respondents

Characteristic	**Frequency**	**Percent**
Catholic	20	28.99
Protestant	27	39.13
Muslim	1	1.45
Born Again	19	27.54
Seventh day Adventist	1	1.45
Jehovah Witness	1	1.45
Total	**69**	**100.00**

It is believed that religious beliefs affect behavioral outcomes and performance at the level of individual/group or nation (Noland; Religion, culture and economic performance). Anderson (1998) contended that membership in a good sect provided legal means of establishing trust in community hence reducing uncertainty and improving efficiency. All the respondents belonged to one religion although the largest group was Protestants (27) 39.13% and least were muslims, Seventh day Adventists and Jehovah Witness each (1) 1.45%.

4.1.4 Center participation

The study population consisted of staff at TASO centers in the central region that directly handled childcare. A self-administered questionnaire was sent out to the sampled staff in the three centers and an interview conducted with the center coordinators and medical coordinators of the selected centers. Of the 69 respondents, TASO Jinja had 31 (44.93%), TASO Entebbe had 20 (28.99%) and TASO Mulago had 18 (26.09%). Jinja attained the highest number of respondents because great effort had been placed on ensuring that every staff did child counseling training making everybody eligible to handle child clients.

The numbers of respondents from TASO Mulago were affected by the presence of a Memorandum of Understanding between TASO Mulago and Baylor College of Medicine allowing Baylor to handle paediatric ART at their extension branch in Kanyanya. The MOU gave Baylor Uganda the right to actively involve their employees in the treatment of child clients at the center and this greatly affected the number of respondents. Only a few counselors at TASO Entebbe had undergone the necessary training making them eligible for handling children's issues.

4.1.5 Gender distribution of respondents

The sample comprised of 55.1% (38) female and 44.9% (31) male, figure 3 shows the distribution of respondents by gender.

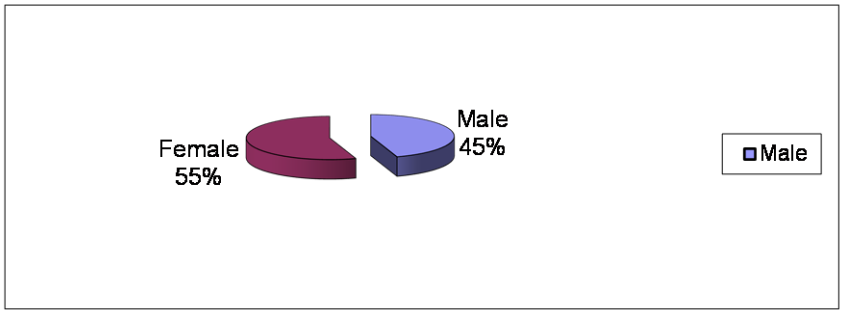

Figure 2: Gender of respondents, N=69

4.1.6 Marital Status

Figure 3 shows that majority of the respondents were married 71% (49), a good number were single 28% (19) and the rest were separated 1.4% (1). Malik, Ghafoor and Naseer (2011) concluded that marital status had no impact on productivity and encouraged organizations to consider focus on employee personal matters, hoping that this would boost the outcome of the organization.

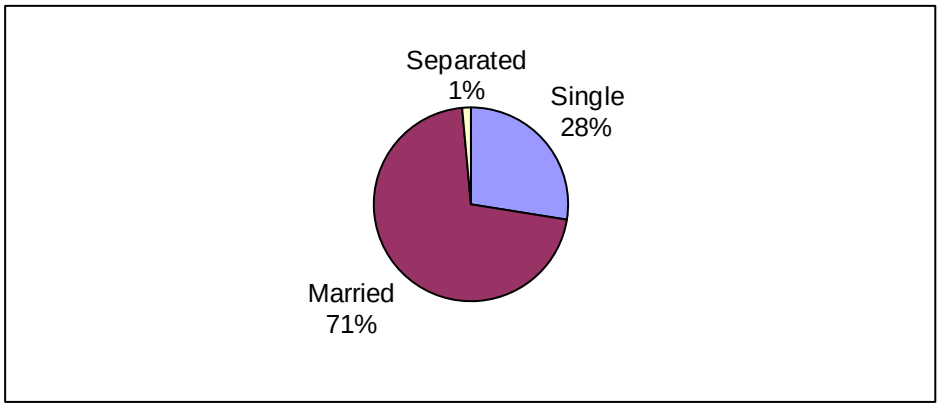

Figure 3: Respondents by marital status, N=69

4.1.7 Employment status

The status of respondents shows that almost all respondents were full time 65 (94.2%) in comparison to volunteers 4 (5.8%).

4.2 Empirical findings

The study was designed to examine the organizational factors that affect delivery of paediatric antiretroviral therapy by Non Government Organizations in Uganda a case of TASO Uganda. Organizational factors (Systems, Styles of leadership, Staff, Policies and Socioeconomic factors) were measured through multiple items on a five-point Likert –types scale. Descriptive method was used through pictures in form of charts, tables, percentages and averages;

inferential method involved use of descriptive statistics whose aim was to draw implications from the data with regard to a body of knowledge.

Each variable was analyzed and interpreted and results presented in descriptive tables showing distribution of responses, correlation analysis was then used to establish the relationship between variables. Qualitative results were compared to quantitative because qualitative provided a complete and detailed rich description of the study and provided a better explanation of the precise measurement of quantitative data (Neill, 2007). The findings were arranged as; Structural systems, Management Information Systems, Directive leadership, Participative leadership, Delegative leadership, Motivation, Training, Organizational policies, National policies, Political goodwill and Donor support on delivery of paediatric ART.

4.2.1 Organizational systems

The study sought to determine the relationship between systems and delivery of paediatric ART at TASO Uganda. Systems were divided into structural systems (organogram) and management information systems and the results are described below;

4.2.1.1 Structural Systems

Respondents were asked to opine on whether structural systems/organogram affected delivery of paediatric ART. Table 5 summarizes the findings;

Table 5: Structural systems and delivery of paediatric ART

Category	SA	A	U	D	SD
The in-charge paediatric HIV care in TASO is at a level of decision-making	12	27	13	11	6
I am content with my position on the TASO organogram	11	38	9	9	2
My tasks and responsibilities as regards childcare are clearly spelt out for me in the job description.	8	19	7	29	6
I am accountable and report to one supervisor.	19	33	2	12	3
My tasks at TASO are clearly aligned to my career and interest	21	31	3	12	2

SA = Strongly Agree, A= Agree, U= Undecided, D= Disagree, SD= Strongly Disagree

TASO has a formal functional organizational structure in place presented in form of an organization chart. The organization has a central location also known as the headquarters where top management, heads of department and support staff are located. The centers are clustered according to their geographical location to form regions with a regional office overseeing them. Each center is headed by a center manager who manages with the help of functional heads, for example, medical coordinator, counseling coordinator, data people etc. The organizational chart graphically shows the structure of authority, roles and responsibilities of personnel, control mechanism, that is, the degree of centralization and the span of control, communication channels and information flow at the organization.

With the above background, the numbers of respondents who were content with their positions on the organogram were 71% (49), whereas 75.3% (52) were accountable and reported to one supervisor. Employee contentment coupled with one reporting line brings about job security and leads to staff retention. One reporting line helps in quick achievement of set targets as it closes the doors of many instructions which are often conflicting and confusing. Employee

contentment contributes to effective service delivery because employees are willing and happy to stay with the organization, saves the organization time and money replacing employees who leave due to discontentment. Respondents whose tasks at TASO were clearly aligned to their career and interest were 75.3% (52). The respondents who thought that the in-charge paediatric HIV care in TASO was a level of decision making were 56.5% (39) and only 49.1% (27) had their tasks and responsibilities as regards childcare clearly spelt out in their job descriptions.

Many of the key informants did agree that the center had full capacity to handle children because of the availability of the necessary laboratory equipment, trained staff, conducive environment like the child play center and the vast experience of TASO (over twenty years). The major challenge was the fact that the only pediatrician in the organization was located at headquarters and only came to the centers on a quarterly basis, which led to referral of complicated cases of child clients to the nearest government pediatrician. Results of further bivariate analysis are shown in table 6 below;

Table 6: Structural systems and client enrolment and retention

Characteristic	**Client enrolment**	**Client retention**
	Children enrolled for Paediatric ART in last 3 months	**Children who turned up for their second visit**
	Frequency	Frequency
I am content with my position on the TASO organogram		
Strongly agree	18	17
Agree	103	57
Undecided	14	15
Disagree	13	12
Strongly disagree	0	0
Total	**148**	**101**
My tasks and responsibilities as regards childcare are clearly spelt out for me in the job description		
Strongly agree	13	8
Agree	68	51
Undecided	16	14
Disagree	39	19
Strongly disagree	12	11
Total	**148**	**103**
My tasks at TASO are clearly aligned to my career and interest		
Strongly agree	68	41
Agree	58	30
Undecided	1	0
Disagree	21	16
Strongly disagree	0	0
Total	**148**	**87**

Results in table 6 show that respondents who agreed to the three statements, that is, were content with their positions on the TASO organogram, had tasks and responsibilities as regards child care clearly spelt out in their job descriptions and had their task clearly aligned to their

career and interest enrolled more children onto the program and also had more children returning for the second visit more than those who disagreed. Respondents who were content with their positions on the organogram enrolled 121 children for paediatric ART in a period of three months out of the total 148 children enrolled in the same period. 74 out of the 101 children who returned for the second visit were clients of those respondents that were content with their positions on the organogram. These respondents were happy and willing to work and had clear direction on what to do which led to service delivery.

Respondents whose tasks and responsibilities as regards childcare were clearly spelt out in their job descriptions enrolled 81 children onto ART in a span of three months in comparison to 51 enrolled by those who thought their job description did not spell out their childcare related responsibilities. Staff who disagreed to having tasks at TASO aligned to their career and interest enrolled 21 children out of the 148 children enrolled in a span of three months; only 16 of the enrolled children by the same group out of 87 returned for their second visit. Second visit represented some level of client retention. In conclusion, the results show that staff who were content, had their responsibilities clearly spelt out and whose tasks were aligned to their careers were more productive than their counterparts.

4. 2.1.2 Management Information Systems

The study sought to examine the relationship between systems and delivery of paediatric ART, the results of Management Information Systems and the results are shown in table 7,

Table 7: Management Information Systems and delivery of paediatric ART

Category	SA	A	U	D	SD
There is a system for monitoring patients at this center.	40	26	2	1	0
There is a system to specifically monitor children at the center.	12	28	9	17	3
There is a system that uniquely identifies children for follow – up	7	27	12	18	5
The system for monitoring and tracking children is computerized	15	24	12	12	6
TASO has a special system for monitoring children on ART	11	32	11	13	2

SA = Strongly Agree, A= Agree, U= Undecided, D= Disagree, SD= Strongly Disagree

TASO has functional systems at its centers and has services to ensure their strengthening: Almost all respondents agreed that TASO had a system for monitoring patients at the center 66 (95.7%). The activities that were monitored on a clinic day varied from, medical appointments to service delivery such as (counseling, laboratory, pharmacy). Manual processes were established to feed into the computerized monitoring system such as, all clients received a book where records of their medical history, services provided, medication given and date of next appointment were recorded.

There were mixed reactions on whether TASO had a system that specifically monitored children and uniquely identified those for follow up, 40 (58%) said that the system was in place while 34 (49.2%) agreed that there was a system that uniquely identified children for follow up. A specialized system in this case would be used to capture the trends of paediatric services and the level of utilization. Brackertz and Kenley (2002) identify performance measures leading to effective service delivery as utilization rate of a service. Utilization is measured by

the degree of engagement/usage (enrollment) and client satisfaction (retention). Only half 39 (56.5%) of the respondents agreed that the system for monitoring children was computerized. MIS (1995) concludes that automation/computerization enhances job performance, making it easy to process and utilize information for decision making and planning. Computerization in health care management enhances performance of employees by reducing the workload while ensuring efficiency often resulting in reduced waiting time for the client which is interpreted into client satisfaction. 42 (62%) agreed that TASO had a special system for monitoring children on ART. However 34 (49.2%) agreed that TASO had a system that identified children for follow up, which ensures children's retention onto the system.

Other endeavors done by TASO centers to ensure retention include; continuous provision of health talks, home based counseling and testing, adequate preparation for ART (put in place the necessary equipment such as CD4 machines), continuous supply of drugs, provision of free services for caretakers, home visits and family clinics where parents come in with their children for services on the same day.

The findings were further analyzed using Pearson's correlation coefficients and the results are presented in table 8 & 9 below;

Table 8: Correlation of structural systems and delivery of paediatric ART

	The in-charge paediatric HIV care in TASO is at a level of decision making	I am content with my position on the TASO organogram	My tasks and responsibilities as regards childcare are clearly spelt out for me in the job description.	I am accountable and report to one supervisor.	My tasks at TASO are clearly aligned to my career and interest
On average, how long does a client (child) spend with you in session?	.099(.436)	.239(.057)	.265(*)(.035)	.033(.798)	.053(.679)

* Correlation is significant at the 0.05 level (2-tailed)

Table 9: Correlation of Management Information Systems and delivery of paediatric ART

	There is a system for monitoring patients in this center.	There is a system to Specifically monitor Children at the center.	There is a system that uniquely Identifies children for follow - up	The system for monitoring And tracking Children is computerized	TASO has a special system for monitoring children on ART
How many children did you enroll for paediatric ART in the last three months?	-.311(**)(.010)	-.222(.069)	-.205(.093)	.029(.813)	.072(.559)
How many of the enrolled children turned up for the second visit?	-.247(*)(.042)	-.128(.299)	-.182(.138)	.069(.576)	.118(.338)

**** Correlation is significant at the 0.01 level (2-tailed).**

*** Correlation is significant at the 0.05 level (2-tailed).**

The values in parentheses are p-values/level of significance and the first value is the Pearson value

Hypothesis 1: There is a significant relationship between systems and delivery of paediatric ART at TASO. The Pearson correlation results in table 8 showed a correlation coefficient of .265, significant at the p= .035 level (structural systems). A significant correlation of -.311 was found at the p= .010 level and a correlation coefficient of -.247 at p= .042 level (table 9; MIS), proving that having a system for monitoring patients is significantly correlated with the

number of children enrolled onto paediatric ART and the number of children who turn up for the second visit. Remembering that 5 on the five-point scale meant strongly agree and 1 signified strongly disagreed, we find that as hypothesized, systems and delivery are significantly correlated, this hypothesis was substantiated (accepted).

4.2.2 Leadership styles

The research sought to establish how leadership styles affected delivery of paediatric ART at TASO Uganda. Three leadership styles were considered, that is, directive, participative and delegative leadership styles and the results are displayed in the table below.

Table 10: Leadership styles and delivery of paediatric ART at TASO Uganda

Directive leadership style					
Category	**SA**	**A**	**U**	**D**	**SD**
My supervisor continuously checks my work to assess my progress and learning.	9	45	5	9	1
My supervisor sets down performance standards for each aspect of my job.	6	40	5	17	6
Organizational changes are communicated directly from top management with no consultation.	17	22	5	19	6
TASO has set aside clear rewards and punishments in order to complete tasks and meet goals.	2	15	17	23	12
When i make a mistake, I am reprimanded or punished.	1	11	15	31	11

Participative leadership style					
	SA	**A**	**U**	**D**	**SD**
For a major decision about a child to pass in my department, it must have the approval of each individual or the majority.	3	24	6	23	13
I participated in developing the organization strategic objectives for the current period.	13	15	7	30	4
I am allowed to determine what needs to be done and how to do it regarding the health of a child.	14	23	8	18	6
TASO has a qualified and committed coordinator of paediatric HIV care and treatment.	19	24	11	11	4
I meet with my supervisor regularly to discuss performance needs as regards childcare.	9	19	6	29	6
Delegative leadership style					
The supervisor delegates childcare related tasks to me in order to implement a new procedure or process.	4	23	8	27	7
I am provided with clear responsibilities and allowed to decide on how to accomplish them.	14	34	8	11	2
TASO emphasizes the importance of quality childcare but allows me to establish my performance standards.	14	24	10	17	4
I am expected to create my own goals and objectives and submit them to the supervisor in finished form.	5	18	11	28	6
I am allowed to give my opinion before organizational changes are introduced.	4	21	15	17	12

SA = Strongly Agree, A= Agree, U= Undecided, D= Disagree, SD= Strongly Disagree

There is no preferred leadership style at TASO centers; the study however tried to measure the variations in application of the three leadership styles that is directive, participative and delegative in relation to employee empowerment and participation.

4.2.2.1 Directive leadership style

Table 10 shows that, 54 of the 69 respondents (78.2%) had supervisors who continuously checked their work so as to assess their progress and learning; 46 (66.7%) had supervisors setting performance standards for each aspect of their jobs. Performance appraisals/checks as a management tool not only measured how well an employee was doing towards realizing set objectives but ensured open communication channels in terms of feedback between the manager and the managed. Heathfield (2009) identified provision of frequent feedback to employees as one of the principles of employee empowerment: people deserve constructive feedback too so they can continue to develop their knowledge and skills. Empowerment thrives in environment of continuous improvement and employees worked more effectively when allowed to use their brains (Heller, 2005).

More than half of the respondents 39 (56.5%) agreed that organizational changes were communicated directly from top management with no consultation. Implementation of such changes would most likely face resistance from the employees: Sverke, Hellgren, Naswall, Goransson and Ohrming (2008) concluded that employee participation was positively associated with employee work attitudes. Participation as a strategy of empowerment ensured that employees voluntarily agreed to the rules and structures that govern them (Heller, 2005).

39 (50.7%) disagreed with the statement that TASO had set aside clear rewards and punishment in order to complete tasks and meet goals; 13 (17.3%) agreed that they were reprimanded and punished when they made a mistake which was such a small number for an organization that has continued to grow. Results showed that support for employee improvement/growth at TASO was limited and uncoordinated; Fredrick Taylor's school of thought advanced the stick and carrot approach as the only way to get results out of people.

This approach preached rewarding good performance and punishing bad behavior where necessary in order to encourage improvement in performance. In so many ways employees need boundaries set for them in order for the organization to achieve results from them, this is where the stick and carrot approach becomes applicable to carter for both extremes.

4.2.2.2 Participative leadership styles

Effectiveness of human resource can only be realized by exercising necessary authority and supporting of staff. 27 (39.13%) agreed that major decisions about childcare were passed with the approval of each individual; 28 (40.6%) agreed to meeting with their supervisors regularly to discuss performance needs as regards childcare; 43 (62.3%) agreed that TASO had a qualified and committed coordinator of paediatric HIV care and treatment. The paediatric focus person was located at headquarters and worked hand in hand with the medical coordinators at the center in order to coordinate issues related to children. The challenge with this arrangement was solving complicated case but the center worked in coordination with the government paediatric focal person at the major hospitals. Slightly above average (53.6%) agreed that they were allowed to determine what needed to be done and how to do it regarding the health of a child, this displayed some degree of employee participation and empowerment that TASO accords to their staff.

Health care management is quite delicate and one needs to understand TASO's reservation in empowering its staff, but with certain controls in place even TASO should be in position to enjoy the benefits of employee empowerment.

4.2.2.3 Delegative leadership styles

Results show that 48 (69.6%) were provided with clear responsibilities and were allowed to decide on how to accomplish them; 38 (55.1%) said that TASO emphasized the importance of quality childcare and gave employees opportunity to establish their performance standards. Today organizations providing health care management are embracing continuous quality improvement through maintenance of their workforce. William (2006) agreed that employees were every organization's livelihood and so their motivation determined the stability of that organization and an unstable organization ultimately under-performed. Productivity once established without empowerment was never lost but was often transferred to aspects that did not relate to the organization's work, for example, prolonged lunch and gossip at work.

The study showed that27 (39.1%) had their supervisors delegating childcare related tasks to them when implementing new procedures or process and 23 (33.3%) were expected to create their own goals and objectives and submit them to their supervisors in finished form; 25 (36.2%) agreed that their opinion was sought before introducing organizational changes. Changes/results capturing employee opinion/thoughts are changes that will be embraced and implemented easily.

Table 11: Correlation between leadership styles and delivery of paediatric ART

Directive leadership style					
	My supervisor continuously checks my work to assess my progress and learning.	My supervisor sets down performance standards for each aspect of my job.	Organizational changes are communicated directly from top management with no consultation.	TASO has set aside clear rewards and punishments in order to complete tasks and meet goals.	When i make a mistake, I am reprimanded or punished.
On average, how long does a client (child) spend with you in session?	-.202(.110)	-.285(*)(.023)	-.038(.763)	.154(.224)	-.001(.996)
Participative leadership style					
	For a major decision about a child to pass in my department, it must have the approval of each individual or The majority.	I participated in developing the organization strategic Objectives for the current period.	I am allowed to determine what needs to be done and how to do it regarding the health of a child.	TASO has a qualified and committed coordinator of paediatric HIV care and treatment.	I meet with my supervisor regularly to discuss performance needs as regards childcare.
How many health education sessions were you involved in, the last three months?	-.111(.368)	.073(.556)	-.033(.789)	.094(.444)	.057(.643)
Delegative leadership style					
	The supervisor delegates childcare related tasks to me in order to implement a new procedure or process.	I am provided With Clear Responsibilities and allowed to decide on how to accomplish them.	TASO Emphasizes the importance of quality child care but allows me to establish my performance standards.	I am expected to create my own goals and objectives and submit them to the supervisor in finished form.	I am allowed to give my opinion before organizational changes are introduced.
How many health education sessions were you involved in, the last three months?	-.021(.865)	.037(.768)	-.056(.652)	.137(.272)	.052(.675)

Hypothesis 2: Leadership styles do not affect delivery of paediatric ART. Results in table 11 indicated that correlation between leadership styles indicators and delivery of paediatric ART is not significant. The hypothesis "leadership styles do not affect delivery of paediatric ART" was accepted.

4.2.3 Staff

Staff and its contribution to delivery of services was measured by staff motivation and staff training; table 12 displays the research results.

Table 12: Staff and delivery of paediatric ART

Employee motivation					
Category	**SA**	**A**	**U**	**D**	**SD**
I receive regular feedback from my supervisor.	16	44	3	5	1
TASO pays more attention to the positive things done other than the negative.	8	20	11	25	5
There are clear and achievable goals in place about paediatric ART.	20	30	8	9	2
I am aware of the system for handling discontent and feel encouraged to use it to address problems.	3	33	16	13	4
TASO ensures that I have the necessary tools & a healthy working environment to deal with children.	12	41	7	9	0
Employee training					
Induction/orientation training is given adequate importance at TASO	27	34	1	6	1
The procedures and guidelines for dealing with children are clearly explained to the new employees during the induction process.	6	21	15	23	4
I am helped to acquire technical knowledge and skills through training.	32	30	3	4	0
I am sponsored for training programmes on the basis of carefully identified developmental needs.	19	25	6	14	5
I participate in determining the training I need.	10	30	9	17	3

4.2.3.1 Employee motivation

Table 12 revealed that 60 (87%) of the respondents received regular feedback from supervisors; feedback tried to answer the most common employee question, "how am I doing?" and helped to improve employee performance, decreased staff turn over, motivated self-improvement while building trust between the supervisor and the supervisee (Erven, 2001). The percentage that had clear and achievable goals in place about paediatric ART were 50 (72.5%) and 53 (76.8%) had the necessary working tools and a healthy environment that enabled them to deal with children. However 28 (40.6%) of the respondents thought that TASO placed more attention on the positive things done by employees other than the negative and (36) 52.1% of respondents were aware of the system for handling discontent and felt encouraged to use it when addressing problems. American heritage (2000) describes discontent as a restless longing for better circumstances.

Kim, Rosen and Lee (2009) opine that employee attitude (cynical versus trusting) and employee communication (aggressive versus diplomatic) affect supervisor's reaction to employee discontent. Lack of systems for handling discontent may result in low morale for work and individuals with low morale may return to work each day with a pervasive sense of unhappiness and will enjoy trying to ensure their coworkers are equally unhappy. In health care environments, low morale can contribute to negative outcomes in patient care leading to lower standard of practice, for example, not paying attention to details when providing care (Beyea, 2004). TASO has put in place employee motivation strategies so as to improve performance and service delivery. Staff motivation strategies common to TASO include; modest timely salaries, comfortable working environment and use of values to increase the bond between employees, ensuring clear policies, continuing medical education sessions, team building events such as staff parties, providing time off work in form of sick, study, compassionate,

paternity leave, providing free phones and car loans for senior staff, trainings and financial incentives such as transport refunds and provision of lunch during field work days.

4.2.3.2 Employee training

Training has become a great strategy for retaining employees as it prepares their career paths and develops commitment which creates a culture of cooperation among employees (McNamara, 2008). A culture that gives a sense of belonging to employees not only motivates them to do their best, but also makes them hesitant to leave the company, even with more lucrative job offers. Staff described the training policy as general with only a few areas emphasizing childcare for example, child counseling.

TASO has a well designed training policy aimed at providing its employees with direction in technical knowledge and skills. The study revealed that many of the respondents preferred to consult with the human resource office incase of training queries instead of referring to the training manual/policy. To most respondents, all training was done by TASO so they did not really see the need for a policy; 61 (88.4%) agreed that orientation/induction training was carried out and given adequate importance; however the procedures and guidelines for dealing with children were not clearly explained during orientation/induction evidenced by the 27 (39.1%) who agreed.

IAPA (2006) notes that in the first three months of one's employment, they suffered a disproportionate number of work related injuries which necessitated training. Orientation whether for new employees, transferred or promoted employees helped to balance the organization's need for productivity with the worker's need for self-esteem and security. In older adults orientation training promoted independent functioning and improved one's

participation and quality of life (Kempen, 2009). Respondents who were helped to acquire knowledge and skills through training were 62 (89.9%); 40 (65.7%) benefited from TASO trainings because they were based on the individual's identified developmental needs and 44 (58%) participated in determining the training they needed which shows why the policy was not widely known and used. The necessary trainings were pre-determined by the organization or the supervisors making consultation of the policy quite irrelevant.

Table 13: Correlation between staff and delivery of paediatric ART

	I receive regular feedback from my supervisor.	TASO pays more attention to the positive things done other than the negative.	There are clear and achievable goals in place about paediatric ART.	I am aware of the system for handling discontent and feel encouraged to use it to address problems.	TASO ensures that I have the necessary tools & a healthy working environment to deal with children.
How long does a client (child) spend at the center on a clinic day?	.261(*)(.034)	-.087(.487)	.083(.508)	-.068(.585)	-.023(.852)
On average, how long does a client (child) spend with you in session?	-.026(.841)	-.063(.623)	.032(.804)	.289(*)(.022)	-.149(.244)
Employee training					
	Induction/ orientation training is given adequate importance at TASO.	The procedures and guidelines for dealing with children are clearly explained to the new employees during the induction process.	I am helped to acquire technical knowledge and skills through training.	I am sponsored for training programmes on the basis of carefully identified developmental needs.	I participate in determining the training i need.
How many children did you enroll for paediatric ART in the last 3 months?	.105(.397)	.087(.483)	-.261(*)(.033)	-.008(.950)	-.128(.301)
How many of the enrolled children turned up for the second visit?	.123(.323)	.046(.709)	-.254(*)(.038)	-.040(.748)	-.151(.222)

* Correlation is significant at the 0.05 level (2-tailed).

Hypothesis 3: "Staff significantly contribute to the delivery of paediatric ART at TASO Uganda." Table 13 shows that the correlation between receiving regular feedback from the supervisor and the amount of time a client (child) spends at the center on a clinic day is significant at correlation coefficient .261, p =.034 level. There is a significant relationship between awareness of the system for handling discontent and the average time a client (child) spends in session (r = .289; p = .022). At a correlation coefficient of -.261; p = .033 level and r = -.254; p = .038, there is a significant correlation between acquiring technical knowledge and skills through training and the number of children enrolled for paediatric ART and acquiring technical knowledge and skills through training and enrolled children that turned up for the second visit. Thus the hypothesis was substantiated.

4.2.4 Policies

Policies were divided into organizational and national, table 14 displays the results;

Table 14: Policies and delivery of paediatric ART

Organizational policies					
Category	**SA**	**A**	**U**	**D**	**SD**
TASO has clear SOPs for handling children that are HIV positive.	15	34	13	6	1
TASO has well documented policies and guidelines regarding provision of paediatric ART.	22	39	5	1	2
Iam well versed with TASO policies and guidelines regarding provision of paediatric ART.	15	31	10	11	2
National policies					
There are well-documented national policies and guidelines regarding provision of paediatric ART care accessible to TASO	23	34	8	3	1
Iam well versed with national policies and guidelines regarding provision of paediatric ART.	14	27	16	11	1
Uganda put emphasis on proper paediatric care for its citizens.	9	36	16	7	1

4.2.4.1 Organizational policies

TASO has clear Standard Operating Procedures (SOP) for handling HIV positive children; according to Heathfield (2008) SOPs ensure a safe, organized, empowering and non discriminatory work place. Results in table 14 showed 49 out of the 69 respondents (71.0%) agreed that TASO had clear SOPs for handling children that were HIV positive, 61 (88.4%) agreed that the policies and guidelines for provision of paediatric ART were well documented while 46 (66.6%) were well versed with TASO policies and guidelines. The paediatric focal person at TASO was mandated to provide regular updates of guidelines and procedures regarding treatment of children. The paediatric focal person was expected to carry out quarterly support supervision at each center; however it was difficult to ascertain that this was being done. When there was need, the medical team at the center referred complex cases to the nearest paediatrician at the government hospitals.

Some of the internal polices applied to TASO are; children are considered to be those persons between the ages 0-18years, once discovered positive a personal file was opened and for the negative children, services were offered on the mother's account (file). All positive children were started on septrin (daily dose) and those that were malnourished received food supplements which included; millet porridge mixed with enkejje, oddi (pounded groundnuts and simsim), and maize flour. The children's package was a lot similar to the adult package and TASO used the ART pathway for enrolling children onto the ART. The pathway included activities such as, routine clinic visit, outreaches for provision of basic information on ART, several counseling sessions (pre-test, individual, TB counseling, disclosure counseling, adherence and refill counseling), case conference, home visits, laboratory sessions (screening for CD4) and clinical assessments for TB and other opportunistic infections screening. There existed a child play center opened daily at every TASO center as well as a resting place for

sick children. The center provided refreshments for the children as well as entertainment. Unlike the adults, children received their treatment and refills from the center.

4.2.4.2 National policies

Many challenges limited the effectiveness of ART in Uganda and so the line ministry (MOH) formulated guidelines to provide a standardized and simplified guide for the use of ARVs in a comprehensive HIV/AIDS service delivery setting. A good number of national policies have sections that are adapted from International guidelines, such as WHO HIV treatment guidelines. The various guidelines and plans are used for both planning and training as well as reference material for health service providers and people living with HIV/AIDS. Results in table 14 showed that the national policies and guidelines regarding provision of paediatric ART were accessible to TASO; 57 (82.6%) agreed that there were well-documented national policies and guidelines regarding provision of paediatric ART. Unfortunately only 41 (59.4%) were well versed with these national policies and guidelines regarding provision of paediatric ART. Even though Ministry of Health formulated the guidelines and updated them regularly, results showed that respondents did not access them.

It became a total waste of resources when guidelines were provided but not accessed by the people that had to. Updates to treatment guidelines for example, would result in many other changes such as, procuring of new drugs and dropping of others, quantifications of commodities, change of budgets etc.

Table 15: Correlation of policies and delivery of paediatric ART

Organizational policies			
	TASO has clear SOPs for handling children that are HIV positive.	TASO has well documented policies and guidelines regarding provision of paediatric ART.	Iam well versed with TASO policies and guidelines regarding provision of paediatric ART.
How long does a client (child) spend at the center on a clinic day?	.263(*)(.033)	.312(*)(.011)	.022(.860)
National policies			
	There are well documented national policies and guidelines regarding provision of paediatric ART care accessible to TASO	Iam well versed with national policies and guidelines regarding provision of Paediatric ART.	Uganda put emphasis on proper paediatric care for its citizens.
How many children did you enroll for paediatric ART in the last three months?	.275(*)(.024)	.143(.247)	.090(.469)
How many of the enrolled children turned up for the second visit?	.248(*)(.043)	.087(.482)	.078(.530)

* Correlation is significant at the 0.05 level (2-tailed).

Hypothesis 4: "There is no significant relationship between policies and delivery of paediatric ART." Table 15 shows the correlation significance between policies (organizational and national policies) and delivery of paediatric ART. At r = .263; p = .033 level there was a significant correlation between having clear SOPs for handling children and the time a client spends at the center on a clinic day. There was a significant correlation between having well documented policies and guidelines regarding pediatric ART and the time a client spent at the center on a clinic day with r = .312; p = .011 level. There was a significant correlation between having accessible, well documented national policies and guidelines regarding provision of paediatric ART and the number of children enrolled onto paediatric and children who returned

for the second visit at coefficient .275; p = .024 level and r = .248; p = .043 level respectively. The results in table 15 did not match the set hypothesis and so the hypothesis was rejected.

4.2.5 Political goodwill and the effect of organizational factors on delivery of paediatric ART

Table 16: Political goodwill and delivery of paediatric ART

Category	SA	A	U	D	SD
TASO has strengthened the capacity of the local communities to prevent, prepare for and respond to any crisis.	20	37	5	5	2
TASO has ensured that communities are better able to coordinate effectively with other NGOs providing related services	20	40	4	3	2
TASO's actions are independent of political objectives.	19	16	12	12	10

TASO has ensured over the years that communities are better able to coordinate effectively with other NGOs that provide related services; 60 (87.0%) of respondents agreed to this. Networking with other NGOs is very essential both for TASO as an organization and the clients that they serve. The donor budget keeps dwindling every year and the priorities are slowly changing from stand alone organizations like TASO to strengthening of host country's health systems. Eventually clients will be able to receive some services from the nearby health centers (especially the new clients); another advantage of networking is ease in referral of clients to other NGOs for services that are not available at TASO. This coordination on the other hand has enabled other NGOs to have access to TASO services especially the laboratory; TASO purchased most of the equipment such as CD4 machine, which very expensive for most health centers. The TEACH programme goes an extra mile to export knowledge and establish networks with individuals from other organizations and other countries.

However, TASO does not entirely act independently of political objectives 35 (50.7%) of respondents agreed; this is because the gravity of the epidemic does not allow one to work in isolation. Advancing political objectives is easily triggered by working with the public sector and the government of Uganda; many of the TASO centers are built on government land in major hospitals, TASO uses the MOH ART pathway, national OVC policy and the ART treatment guidelines formulated by MOH for the advancement of their work.

TASO centers have a mechanism where community members living with HIV/AIDS actively participate in the day to day running of some center activities such as, counseling. Uganda has always considered the ABC prevention strategy; TASO adopted this strategy as well; AB standing for Abstinence, Being Faithful and C for Condom use. The effectiveness of this and other strategies depends entirely on the reception of the communities. TASO has strengthened the capacity of the local communities to prevent, prepare for and respond to any crisis; 57 (82.6%) agreed to this.

Table 17: Correlation of political goodwill and delivery of paediatric ART

	TASO has strengthened the capacity of the local communities to prevent, prepare for and respond to any crisis.	TASO has ensured that communities are better able to coordinate effectively with other NGOs providing related services	TASO's actions are independent of political objectives.
On average, how long does a client(child) spend with you in session?	-.048(.705)	.352(**)(.004)	-.111(.381)
How many health education sessions were you involved in, the last three months?	.350(**)(.003)	.152(.215)	-.062(.616)
How many children did you enroll for paediatric ART in the last three months?	.277(*)(.022)	.281(*)(.020)	.071(.563)
How many of the enrolled children turned up for the second visit?	.249(*)(.041)	.221(.070)	.068(.580)

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Hypothesis 5: "Socioeconomic factors greatly contribute to the effect of organizational factors on delivery of paediatric ART at TASO Uganda." Table 17 shows that at r = .350 at p = .003 level the number of health education sessions held in the last three months strengthened the capacity of the local communities to prevent, prepare for and respond to any crisis; There is a significant correlation between communities being able to coordinate effectively with other NGOs providing related services and the number of children enrolled for paediatric ART at correlation coefficient ..281; p = .020 level.. The hypothesis is therefore accepted.

4.2.6 Donor support

Table 18 shows the results of donor support and delivery;

Table 18: Donor support and delivery

Category	SA	A	U	D	SD
There are specific donors that support children's activities in TASO.	11	27	26	5	0
Donor's objectives are consistent with saving lives of children and maintaining human dignity.	25	34	8	2	0
Donor's objectives are consistent with strengthening the capacity of NGOs to respond to crises of HIV in children.	19	38	9	2	1

Donors are all stakeholders providing support/help (whether physical or financial) in order to realize organizational goals. TASO has enjoyed continuous funding for close to twenty years from various donors. Different donors have different interests; the US government through CDC and USAID at the beginning of this research required that 10% of all registered clients should be children; this may have changed by now. Responses from Table 18 showed that many of the respondents were ignorant about donor support 38 (55.0%); but donor objectives were consistent with saving lives of children and maintaining human dignity 59 (86.5%). 57

(82.6%) thought donor's objectives were consistent with strengthening the capacity of NGOs to respond to crises of HIV in children. Funding sources in Uganda were sometimes given directly to the partner or placed in a pool also known as a funding basket where different service providers competed for that money.

Donor support contributed to the organizational factors affecting delivery of paediatric ART; donor support ranged from money to guidance to capacity building and technical assistance which indeed boosted performance. Pearson's correlation coefficient results are displayed in the table 19 below;

Table 19: Correlation of donor support and delivery of paediatric ART

	There are specific donors that support children's activities in TASO.	Donor's objectives are consistent with saving lives of children and maintaining human dignity.	Donor's objectives are consistent with strengthening the capacity of NGOs to respond to crises of HIV in children.
How long does a client (child) spend at the center on a clinic day?	-.075(.546)	.217(.078)	.274(*)(.025)
How many health education sessions were you involved in, the last three months?	-.129(.296)	.369(**)(.002)	.259(*)(.033)

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

It is very clear from table 19 that the consistence of donor's objectives with strengthening the capacity of NGOs and saving lives of children while maintaining human dignity influenced on how long a client (child) spent at the center on a clinic day and the number of health education sessions held at 0.05 level at r = .274 and r = .259 respectively.

4.3.7 Utilization rates

Further bivariate analysis was done to find out how demographic factors contributed to effective paediatric ART; the results are displayed below;

Table 20: Demographic factors and service delivery of paediatric ART

	On average, how long does a client (child) spend with you in session?				
TASO center	**10 - 29 min**	**30 - 49 min**	**50 - 1hr 09 min**	**Longer than 1 hr 10 min**	
TASO Mulago	5	10	1	0	16
TASO Jinja	11	14	3	0	28
TASO Entebbe	11	5	3	1	20
Total	**27**	**29**	**7**	**1**	**64**

TASO center		**How many children did you enroll for pediatric ART in the last three months?**	**How many of the enrolled children turned up for the second visit?**
TASO Mulago	Mean	1.5000	0.8889
	N	18	18
	Sum	27.00	16.00
TASO Jinja	Mean	2.7000	2.1000
	N	30	30
	Sum	81.00	63.00
TASO Entebbe	Mean	2.0000	2.0000
	N	20	20
	Sum	40.00	40.00
Total	Mean	2.1765	1.7500
	N	68	68
	Sum	148.00	119.00

How many children did you enroll for pediatric ART in the last three months? How many of the enrolled children turned up for the second visit? * gender of respondents

Gender of respondents		**How many children did you enroll for pediatric ART in the last three months?**	**How many of the enrolled children turned up for the second visit?**
Male	Mean	1.8000	1.6000
	N	30	30
	Sum	54.00	48.00
Female	Mean	2.4737	1.8684
	N	38	38
	Sum	94.00	71.00
Total	Mean	2.1765	1.7500
	N	68	68
	Sum	148.00	119.00

How many children did you enroll for pediatric ART in the last three months? How many of the enrolled children turned up for the second visit? * age of respondents			
Age of respondents		**How many children did you enroll for pediatric ART in the last three months?**	**How many of the enrolled children turned up for the second visit?**
18 - 25 years	Mean	0.5000	0.5000
	N	2	2
	Sum	1.00	1.00
26 - 33 years	Mean	1.3043	1.2391
	N	46	46
	Sum	60.00	57.00
34 - 41 years	Mean	3.6154	2.6154
	N	13	13
	Sum	47.00	34.00
42 - 49 years	Mean	8.5000	6.0000
	N	4	4
	Sum	34.00	24.00
50 years and above	Mean	2.0000	1.0000
	N	3	3
	Sum	6.00	3.00
Total	Mean	2.1765	1.7500
	N	68	68
	Sum	148.00	119.00
How many children did you enroll for pediatric ART in the last three months? How many of the enrolled children turned up for the second visit? * Marital status			
Marital status		**How many children did you enroll for pediatric ART in the last three months?**	**How many of the enrolled children turned up for the second visit?**
Single	Mean	1.1667	1.5000
	N	18	18
	Sum	21.00	27.00
Married	Mean	2.5918	1.8776
	N	49	49
	Sum	127.00	92.00
Separated	Mean	0.0000	0.0000
	N	1	1
	Sum	0.00	0.00
Total	Mean	2.1765	1.7500
	N	68	68
	Sum	148.00	119.00

TASO Entebbe had hildren stay the longest t the center on a clinic day (staying longer than 1 hour 10 minutes). TASO Jinja enrolled the highest number of children for paediatric ART in a span of three months; TASO Entebbe had all the enrolled children return for a second visit

indicating good follow up strategy (retention). Female respondents enrolled more children more than their male counterparts; so did the married in comparison to the single respondents. Respondents aged 26-33 years enrolled the highest number of children but on average each individual enrolled 1 child in a span of three months; although respondents aged 34-41 years enrolled a fairly big number of children overall, on average each enrolled 4 children for paediatric ART in three months.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter is based on the findings of the study of organizational factors affecting the delivery of paediatric ART by NGOs in Uganda a case of TASO Uganda. It presents summary of findings, their discussion, conclusions and recommendations of the study.

5.1 Discussion and conclusion of findings

Despite the many challenges that the HIV/AIDS epidemic paused and the numerous campaigns done earlier aimed at controlling the disease, a number of indicators had less than average levels of accomplishment. Take PMTCT for example, Mother to child transmission of HIV is still virtually the only way that children under five years of age acquire the virus in Uganda. In deed there have been significant gains in the response to HIV and AIDS among adults in the country; however the burden among children remains of great concern to the health sector. It is estimated that with the relatively high prevalence of HIV among women of reproductive at 6.5%, up to 20,000 HIV infections among children are likely to occur each year unless effective interventions for preventing vertical transmission are implemented (MOH/STD-ACT, 2010).

At TASO all children enrolled onto ART pick their medication from centers, outreaches or community drug distribution points. Paediatric ART is grouped under the medical care; other services included in the group include counseling, formal education (primary and secondary) apprenticeship, AIDS challenge youth clubs (ACYC) and food support. TASO is guided by the National Orphans and Vulnerable Children (OVC) policy and child support strategy (Kiboneka, 2008)

5.1.1 Systems

Structural systems

Organizational structural systems were explained by statements/attributes such as; (1) level of decision making, (2) employee contentment with position on the organogram. (3) Clarity of tasks and responsibilities in the job description, (4) reporting line and (5) alignment of one's tasks to career and interest. The results show that respondents between the ages 26-33years were the most content and those above 42 years were the least content with their positions on the TASO organogram. Employees over four two years were believed to have been in TASO or elsewhere for a long time and so over the years management techniques changed in the organizations, the older respondents who had been with the organization a long time were less likely to welcome the change hence the lack of contentment. The in-charge pediatric HIV is a middle management level position; this presented him fewer chances of affecting decisions at top management level. The absence of pediatricians at the centers created a dependence of the center on the government specialist that was often referred to. The clear reporting line at TASO was a good management strategy and it gave employees a chance to work under less pressure and without conflicting instructions.

The positive correlation between systems and delivery of paediatric ART (hypothesis 1 that was substantiated) is attributed to factors such as; clarity of child care tasks and responsibilities in one's job description. The employees will know and understand what is required of them from inception (on receipt of a job description); this in return may determine how well they do their job other factors remaining constant. The results provide various ways of ensuring structural systems contribute to delivery of paediatric ART. Selecting and employing people whose interest and career direction is in line with the tasks assigned to their positions. Ensure that the interests of children are presented to decision makers; this may require that the in-

charge/focal person for paediatric services is part of the decision making team (top management).

The sampling method used (single stage cluster sampling) hence leading to selection of centrally located centers was noted as one of the limitations to this study**;** however given the fact that these centers were among the pioneers of paediatric ART in TASO, the researcher believed that their experience would represent the experience at the other centers.

Management Information Systems

MIS was represented by variables such as; (1) presence of a system for monitoring patients (2) Specifically monitoring children (3) ability to identify children for follow up (4) computerization of the system (5) ability to monitor children on ART. The correlation between the presence of a system for monitoring patients and the number of children enrolled for paediatric ART plus the number of enrolled children that returned for their second visit meant that when a system for monitoring children/patients was established, its presence determined and affected the number of children enrolled and whether they returned for their next visit. The results show ways that MIS can be used to ensure delivery of paediatric ART. Acquire a system that is computerized and can capture more than the basic information about clients such as; medical history, maps to clients' places of residence, clients' skills and anything that could be used to pursue the client to return for services. The study was limited to establishing whether the system existed and whether it captured specific data and not on how well it was used and employee attitude towards the system.

5.1.2 Leadership styles

Directive leadership styles

Directive leadership styles was explained by variables, such as; (1) supervisory checks (2) presence of job performance standards (3)employee consultation and communication channels (4) Rewards and punishment for meeting goals (5) reprimand for mistakes. The correlation between performance standards set by the supervisor and the average amount of time a child spent in session is linked to the fact that the set performance standards provide a benchmark against which to measure individual performance. One will be able to determine his/her performance and decide on how best to improve.

The results provide ways of making directive leadership styles work better; recognition for good work and punishment for gross behaviour, while it is perfectly okay to reward good performance it creates a balance to have avenues for reprimanding mistakes. This eliminates conflicts resulting from feelings of unfair treatment, that is, where gross behaviour goes unpunished. Enhance good supervisor-subordinate relationship in order to create an environment where employees can be committed to their jobs.

Participative leadership styles

Participative leadership was explained by variables such as; (1) employee participation in decision making (2) participation in strategic objectives formulation (3) flexibility in determining child care activities (4) presence of paediatric coordinator (5) supervisor-supervisee discussion of child care performance needs. The non significant correlation between participative leadership styles and delivery of paediatric ART is attributed to factors such as; top management and a few technical people are involved in strategic planning and decision making and the rest of the organization is mandated to implement and also provide

feedback to the decision makers. The organization has a set policy and schedule when to review performance of the employee (annually) and this is when performance needs are dealt with; in the course of the year no effort is made to ensure supervisor- supervisee regular interaction regarding performance. Incase of grievances, the supervisee waits for supervisor's appraisal commonly known as the 360 appraisal to punch back at the supervisor and by this time its too late to affect service delivery.

The various avenues for enhancing participative leadership include; encouragement of employees to formulate their own work objectives in relation to childcare and later discuss with their supervisors and obtain approval; they can also be helped to express their grievances on a periodic basis; the organization can solicit every body's opinion when planning for the future. The study targeted employees that directly worked with children and since no one from top management met this criterion, their opinion was not captured; this was one of the limitations to the study.

Delegative leadership styles

Variables such as (1) supervisor delegation of child care tasks (2) providing of clear responsibilities and flexibility on their accomplishment (3) quality child care (4) letting employees set their own goals and objectives with minimal imposition from supervisors (5) seeking employee opinion for organizational changes explained delegative leadership styles. There was no significant correlation between delegative leadership styles and delivery of paediatric ART; it is clear that organizational changes were done by top management and simply communicated to employees for implementation; the employee status was not considered when emphasizing quality of care and no delegation to subordinates was done for

special assignments which limited development of employee (confidence). Leadership styles did not affect delivery of services.

5.1.3 Staff

Employee motivation

Employee motivation involved both external and internal drive that pushed employees to go an extra mile to realizing organizational goals. Employee motivation was explained by the following variables; (1) receiving feedback from supervisor (2) emphasis on positive things (3) clear and achievable goals (4) handling employee discontent (5) providing tools and a healthy environment for work. There was a positive significant correlation between receiving feedback from the supervisor and the time a client spent at the center on a clinic day. One way of fostering open communication is through provision of feedback; feedback tells the employee that he/she is important which boosts morale and improves one's will to work. The positive correlation between awareness of the system of handling discontent and the amount of time a child spent in session can be attributed to the regular staff meetings where employees are allowed to express themselves. Cultural and behaviour differences are often areas of conflict if not handled well, encouraging of employee dialogue may help in change of assumptions and attitudes while improving morale and productivity.

The results give various avenues for improving employee motivation at a low cost; apply similar standards for everybody in the organization, for example, similar allowances (per diem) regardless of one's position and salary scale, vacation for everybody; recognize good performance by giving of awards at the end of a financial year; encourage employees to plan and organize their work and set their own goals.

Employee training

The following variables explained employee training; (1) importance attached to induction/orientation (2) content of the training manual (3) assistance in skills building (4) sponsorship and flexibility in identifying developmental needs (5) encouraging employee in determining which training they need.

There was a significant correlation between being helped to acquire technical knowledge and skills through training and the number of children enrolled onto pediatric ART as well as the number of children who returned for the second visit. Technical knowledge is specifically aimed for realization of work objectives and not necessary career building. TASO uses the results from the annual employee performance appraisals to map out training needs and schedules, these trainings are directed towards better performance and therefore realization of organizational goals. The results show that even though orientation/induction training was done for the new employees, the syllabus/content did not necessary capture childcare procedures and guidelines.

The training manual was developed and its contents are aimed at helping employees to acquire the necessary trainings both for realization of work objectives and shaping one's career and interest, however the employees did not know its content and therefore did not use it as often and they should. Talking to some of the employees subsequently indicated that they did not see the reason to consult the manual because all their trainings was done by TASO itself.

5.1.4 Policies

Organizational policies

The relatively large number of respondents who disagreed to being well versed with TASO policies regarding provision of paediatric ART may be attributed to the short orientation period and the fact that pediatric/childcare guidelines are not covered as part of the orientation package. Policies can be related to manuals which are sent together with an item so as to ensure proper use; in an organization setting, policies act as a checklist against which employees measure themselves against and the positive correlation between presence of clear SOPs for handling children that are HIV positive and the amount of time a client (child) spends at the center on a clinic day and the well documented policies and guidelines regarding provision of paediatric ART and the amount of time a client (child) spends at the center on a clinic day is attributed to this characteristic. Organizational policies was explained by variables such as; (1) clarity and availability of procedures for handling children that are HIV positive (2) availability of documented policies and guidelines for provision of paediatric ART (3) familiarity with TASO policies and guidelines regarding paediatric ART services. During the interviews it was made clear that indeed the policies are available but their use was minimal (mainly the clinical team) the other teams did not use them much and some did not even know they existed.

National policies

National policies were the main reference documents used when designing individual organizational policies. The results show that respondents were not familiar to most national policies, further researcher revealed that the necessary policies were available from the ministry but the respondents did not know the content hence unable to use them effectively. National policies was explained by variables such as; (1) availability of documented national

policies regarding provision of paediatric ART (2) respondents' familiarity with national policies (3) Uganda's interest in paediatric services for its citizens. Uganda's way of showing interest in the paediatric services was through provision of a standard (policy/guideline) against which to measure existing or upcoming services.

The results showed a positive correlation between well documented national policies regarding provision of paediatric ART and the number of children enrolled onto paediatric ART as well as the number of children that returned for their second visit; availability of these policies ensured effectiveness of measures.

5.1.5 Socioeconomic factors

Political goodwill

Political goodwill was explained by variables such as: (1) strengthened capacity of local communities (2) enabled environment to network (3) independence from political objectives. Results show that TASO works hand in hand with the host government (Uganda); TASO even though the largest indigenous HIV/AIDS support organization in the country was not big enough to handle the overwhelming number of HIV/AIDS cases. The significant correlation between political goodwill (TASO has strengthened the capacity of the local communities to prevent, prepare for and respond to any crisis) and delivery of paediatric ART (the number of health talks held; the number of children enrolled onto paediatric ART and the number of children who returned for the second visit) was a result of community ownership created by involving communities right from inception. However the research entirely depended on the opinion of the service provider and did not get the opinion of the host government.

Donor support

Donor support was explained by the following variables: (1) specific donors supporting children's activities (2) consistency of donor's objectives to saving lives of children (3) consistency of donor's objectives to strengthen capacity of NGOs. The main donors to TASO at the time of the research were Center for Disease Control (CDC); they required that 15% of all clients registered are children. Further results show that continuous donor support through funding was interpreted as consistency in strengthening NGO capacity and saving lives of children. However this variable over time was feared to result in laxity on the side of government regarding provision of health care for its citizens. This funding mechanism was considered unsustainable and a clear timing bomb.

5.2 Recommendations

Based on the conclusions drawn from the conclusion section above, the researcher suggests the following alternatives/recommendations for enhancing organizational factors to affect delivery of paediatric ART at TASO Uganda.

5.2.1 Organizing childcare

Childcare interests need to be fronted to senior management team if the intervention is to work effectively, this may be done through the elevation of the current in-charge paediatric position to a position where he/she can affect decisions. Organizing child care also requires that the organization hires people with prior childcare knowledge and career interest, this save the organization time and money spent trying to mould employees in that direction.

5.2.2 Provide enabling environment

Enabling environment for employees is cultivated by; establishing systems to measure performance: allow employees to set individual work objectives with minimal contribution from supervisors: open up communication channels and involve employees to initiate change: offer continuous feedback after completion of tasks: recognize and reward good performance and punish/reprimand gross behaviour.

5.2.3 Provide comprehensive orientation package

The current orientation package and period should be enlarged so as to fit in a slot to child care and its implementation. This period can also be used to learn both the organizational and national policies required for effectively delivery of services

5.3 Areas for further research

The researcher suggested further research in determining factors affecting the adopted leadership style: the limitation of time and constraints in resources could not permit the researcher to investigate further to why the managers chose to use one leadership style over another.

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