

To Examine the Influence of Human Resource for Health (HRH) on Patient's Care at Family Hope Centre Clinic, Kampala.

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ABSTRACT

Human Resources for Health (HRH) are essential for delivering quality healthcare services and improving patient outcomes. This study examined the influence of Human Resources for Health on patient care at Family Hope Centre Clinic, Kampala. A cross-sectional survey design employing both quantitative and qualitative approaches was used. Data were collected from 52 respondents, including board members, management, staff, and patients, through questionnaires and document review. The findings revealed that effective recruitment and selection procedures, staff competence, training, ethical practices, and clear job descriptions positively influence patient care and healthcare service delivery. Regression analysis showed that Human Resources for Health significantly influence patient care, accounting for 82.7% of the variation in patient care outcomes (Adjusted $R^2 = 0.827$). The study established that improved human resource management contributes to enhanced patient satisfaction, treatment adherence, staff productivity, and quality of healthcare services. The study concludes that Human Resources for Health are a critical determinant of patient care and a key component of health systems strengthening. It recommends increased investment in staff recruitment, retention, training, continuous professional development, and workforce management to improve healthcare outcomes.

Keywords: Human Resources for Health, Patient Care, Health Systems Strengthening, Healthcare Service Delivery, Workforce Management, Family Hope Centre Clinic, Kampala, Uganda.

INTRODUCTION

Frenk (2010) defines Health Systems Strengthening (HSS) as the recognition and packaging of systems, structures, strategies and activities that support and improve core elements and functions termed by the World Health Organization (WHO, 2007), 'health building blocks'. The health systems building blocks are: leadership and governance, health care financing, human resources for health, health management and information system (HMIS), procurement and supply chain management, and service delivery. "Strengthening national health systems as the next Step for global health progress". Three circumstances make the present phrase unique for global health. First, health has been increasingly recognized as a key element for of sustainable growth and economic development, global security, effective governance, and human rights promotion. Second, due to the growing perceived importance of health, unprecedented— albeit still insufficient—cumulative investment by different donors to the health sector that requires risk management. Third, there is a burst of new initiatives coming forth to strengthen national health systems as the core of the global health system and a fundamental strategy to achieve the health-related Millennium Development Goals. (Frenk J, 2010). It is significant to mention in this study that both the World Health Organization and the World Bank and in general the United Nations have considered health and economic indicators as tools for monitoring implications of economic growth and development globally, with an agenda to structure sustainable investments and a funding framework.

The WHO and the World bank (WB), both identify and recognize globally the contributions of health systems strengthening towards better or improved health status and the protection of citizens from economic loss, poverty, famine, conflict over access to resources by both male and female and impoverishment as a result of ill health arising from the very high cost of treatment. Furthermore, health systems strengthening promotes efficiency in service delivery, effectiveness, and attainment of uniform access and distribution of health services

and consumer loyalty, attraction, retention, follow up and satisfaction (WHO, 2007). However, there is need for emphasis that ‘health systems strengthening’, HSS, has evolved over time and the most recent interest globally has been due to liberalized world economy and competition for market, demanding for value addition: a long supply chain mechanism. The rapid rise in global population calls for overall access to medicine, high level and specialized training for health care workers, improved healthcare financing, decentralized health service delivery system and overall leadership and institutional governance.

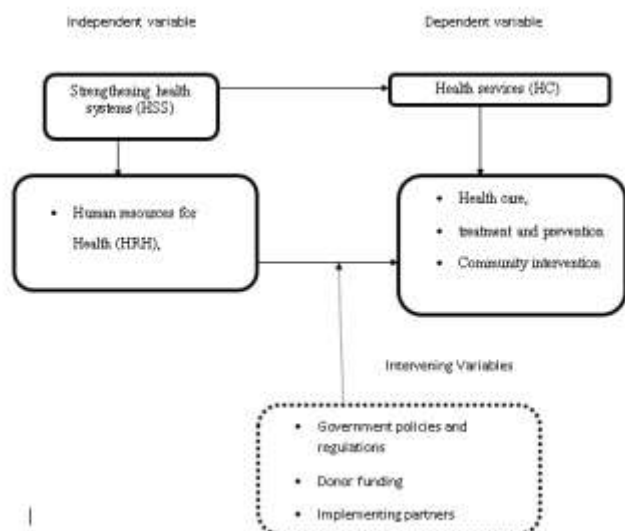
In addition, re-emergence of cases that were eradicated in the 1960’s coupled with large volumes of research has raised the profile of health systems strengthening. Investments in health and service delivery means investors continue to look for a major breakthrough hence a cost-effective way of delivering services, productivity, continuous quality improvement through research and innovation. Health systems strengthening is defined through what is commonly referred to as “building blocks”. In Africa, Uganda in particular, the HIV/AIDS epidemic and a number of other infectious diseases coupled with a narrow resource base, low access and utilization of technology and electricity and government priorities especially on infrastructure development like roads, electricity distribution and generation, means that the health sector continues to get less than 10% of the national budget as demonstrated in financial years 2012/2013, 2014/2015, 2015/2016 and this can further be confirmed from the Uganda budget framework 2016/2017 allocation per key sector. This is despite the very high level of engagement and dialogue between government and the private sector and civil society organizations, CSOs. In Uganda, just like in a number of African countries one critical building block for health systems strengthening is health care financing designed to accelerate access to care under major interventions. The ever increasing oversight functions by boards of healthcare institutions in all sectors of service delivery (public, private for profit, private not for profit and faith based institutions) is promoting demand for accountability and transparency in resource allocation, distribution and utilization enhance value for money. The concept and application of result based funding (RBF) is being implemented and coordinated with compliance to policies, procedures and processes while minimizing risk to ensure universal health coverage. In the case of Uganda, user fee(s) has been abolished to encourage increased enrollment to care, treatment and prevention services by all public health facilities. In addition, private for profit and private not for profit institutions gets annual supplementary funding though not sufficient but just a demonstration that access to healthcare is a fundamental entitlement.

Results based funding culture is deepening and Uganda ministry of health in collaboration with development partners; CDC, USAID and PEPFAR has rolled out health management information systems approach for monitoring and evaluation of health projects under whose scope, expenditure analysis, results Vs targets are analyzed and allocation of resources to core program areas of intervention prioritized. Despite ongoing investments and reforms aimed at strengthening health systems, many health facilities in developing countries, including Uganda, continue to experience significant human resource challenges such as staff shortages, inadequate skills, poor motivation, high workload, and uneven workforce distribution, which negatively affect the quality of patient care, efficiency of service delivery, and patient outcomes. At Family Hope Centre Clinic, Kampala, although interventions such as Clinical Assessment for Health Systems Strengthening (CLASS) have been implemented, persistent gaps in service delivery and patient care suggest that Human Resources for Health may not be optimally managed or fully effective in improving outcomes. A comparative survey was also carried out at Family Hope Centre Clinic, Jinja Centre, where management staff were selected purposively and interviews were employed to obtain in-depth qualitative insights. While existing studies have examined various aspects of HRH such as staffing, training, and motivation, most have focused on public hospitals and treated these factors in isolation, with limited evidence from private-not-for-profit facilities in Uganda and little understanding of their combined effect on patient care. This study therefore addresses this gap by examining how staffing adequacy, staff competence, training and development, motivation, and workforce management collectively influence patient care at Family Hope Centre Clinic, Kampala, with comparative insights from Jinja Centre.

Objectives

To examine the influence of Human Resource for Health (HRH) on Patient’s care at Family Hope Centre Clinic, Kampala.

CONCEPTUAL FRAMEWORK



Source: Researcher modification

Fig 1 Conceptual frame work showing the impact of strengthening health system on Health services in Uganda.

The conceptual framework under this study provides an opportunity to understand and investigate the relationship between independent and dependent variables and the implications of the moderating factors on the variables.

This study has developed the above conceptual framework within which to understand issues regarding health system strengthening, HSS, and health services, HS. The independent variables will be studied in terms of human resource for health, health management information system and procurement and supply chain. The dependent variable will be studied in terms of health care, treatment and preventions and community intervention. The intervening variables will be considered in terms of Government policies and regulations, economic situation, Donor funding and implementing partners

LITERATURE REVIEW

Influence of Human Resources For Health on Patient's Care

Human Resources For Health Care

The concept of Human Resources for Health (HRH) constitutes one of the building blocks for health system strengthening. Human resources to health care, can be defined as a multidisciplinary professional team comprising of the different kinds of clinical and non-clinical staff responsible for public and individual health interventions or epidemic response and control. Several human resource initiatives for the health sector reform also include attempts to increase equity or fairness. Strategies for promoting equity in relation to needs require more systematic planning of health services. Some of these strategies include the introduction of financial protection mechanisms. All these strategies consider the fact that resources are scarce and must be used sparingly (de Savigny and Taghreed, 2009).

Within several health care systems worldwide, there is increased attention on human resources management (HRM) also widely referred to as human resources for health (USAID, 2015). Specifically, human resource is one of the principle health system inputs, with the other two major inputs being physical capital and consumables. For over two decades, similarities and differences between the human resources and health care has always been ignored and sometimes confusing and/or complex (Edmund, 2006).

Globally, the impact of human resources on health sector reform is always a critical consideration and an essential factor to consider when analyzing the impact of human resources on health sector reform. Whereas the

specific health care reform and measures varies from country to country, some trends can be identified. The common known outcomes are efficiency, equity, access, affordability of health care services (USAID, 2015). In Uganda, human resources for health have multiple and complex managerial and logistical/operational challenges for attraction and retention, ethics of health professionals, low morale and poor pay and reward schemes. Moreover, the implications of weak or poor health systems on the quality-of-service delivery and health status of the population require improvement (Frenk, 2010). Efforts are urgently needed to analyze the influence of Human Resources for Health on Patient's care in order to understand the relationships between the quality of the services, impact, acceptability and patient's level of satisfaction (Gostin and Jacobson, 1999).

Research Design

The research employed a mixed-methods approach, integrating both quantitative and qualitative designs to provide a comprehensive understanding of the study problem. A cross-sectional survey design was adopted, with a quantitative correlational approach used to measure variables in numerical form and analyze those using statistical procedures in order to determine the impact of health systems strengthening on health service delivery in Uganda, with specific reference to Family Hope Centre Clinic, Kampala City (Mugenda and Mugenda, 1999). The cross-sectional design was appropriate as it allowed data to be collected from different respondents at a single point in time, enabling a snapshot of relationships among variables based on random sampling of participants. In addition, a comparative survey was conducted at Family Hope Centre Clinic, Jinja Centre, where management staff were selected purposively and interviewed to obtain qualitative insights that complemented the quantitative findings. This combination of methods enhanced the depth and validity of the study by allowing triangulation of results from both numerical data and interview responses.

Reasons for the Choice of a Survey Design

The research was in position to collect data from a larger section of respondents and whereas, a case study research design was chosen and picked on the basis that it allows the study investigator to follow, analyze and interrupt the quantities in fairly simpler and smaller units of analysis. (Saunders, Lewis & Thornhill, 2003). In addition, qualitative data obtained from interviews at Jinja Centre were analyzed thematically to complement and validate the quantitative findings. This triangulation enhanced the robustness, credibility, and depth of the study findings by integrating numerical statistical evidence with contextual managerial perspectives.

Study Area and Population

This research was carried out in "Family Hope Center Clinic", Kampala and Jinja, a treatment and care facility, where staff, management and patients were interviewed. The facility was chosen due to its population and activities that relate fairly well with the subject under investigation or study. The research involved a study population of 60 people.

Family Hope Centre Clinic Kampala is a private not for profit organizational facility registered by Children's AIDS Fund Uganda and accredited by the Ministry of Health. It is funded by the United States Government (USG) through a cooperative agreement with funding from United States Government's - President's Emergency Plan for AIDS Relief (PEPFAR), Centre for Disease Control and Prevention (CDC) and Office of the Global AIDS Coordinator to promote and facilitate provision of comprehensive HIV/AIDS care, treatment and prevention services in collaboration with indigenous health facilities in the Republic of Uganda. The health facility is presently under a 5-year cooperative agreement with the United States Government to provide care, treatment and support services to over 3,600 HIV/AIDS clients and employing a team of multidisciplinary professionals.

Study Sample

Sample Design

A random sampling and purposive sampling techniques were used. Random sampling technique was used when selecting patients. This was done to avoid bias. Purposive sampling was applied when selecting staff because there was a need to specifically get information from those members of staff who deal directly with the patients.

Sample Size

The sample size was selected using Morgan's (1970) formula. The decision was based on estimation of the number of staff, management, board of directors and patients were the composition of the sample study.

Sample Size Determination

Respondents	Population	Sample Size	Sampling method
Board	10	6	Purposive sampling
Management and staff	35	32	Purposive sampling
Patient	15	14	Random sampling
Total	60	52	

Source: Primary data

Data Collection Methods

Data was collected using both primary and secondary sources. Primary sources provide first hand data directly from respondents through interviews and questionnaires. On the other hand, secondary sources provide secondary data from the records of previous relevant studies, selected text books and most recent journals and reports from MOH and Children Aids Fund, monthly, quarterly and semi-annual reports.

Questionnaires

Pre-determined, self-administered questionnaires, containing a written set of questions were used to obtain data from respondents. Self-administered Questionnaires were preferred in the study because they are a convenient method since respondents give their responses independently and secretly.

Reliability and Validity of the Instruments

Reliability

To ensure reliability, the test-re-test method was used for the self-administered questionnaires. The same questionnaires were administered to the same group after one week and again the score was recorded manually and compared to determine similarity. Pearson Product moment formula for test-re-test was used to compute correlation coefficient in order to establish consistency in eliciting the same responses every time it was administered. According to Mugenda and Mugenda (1999) one tenth of the sample size is sufficient for pilot testing.

Limitations of the Study

This study was limited by its cross-sectional design, which restricts the ability to establish causal relationships between Human Resources for Health (HRH) factors and patient care outcomes. The reliance on self-reported data from respondents may also introduce response bias, particularly social desirability bias among health workers and management staff. In addition, the study was conducted in only two facilities (Family Hope Centre Clinic, Kampala, and Jinja Centre), which may limit the generalizability of findings to other private-not-for-profit or public health facilities in Uganda. The relatively small sample size used in the quantitative component may also affect the statistical power of some inferential tests. Furthermore, the qualitative interviews were limited to purposively selected management staff, potentially excluding perspectives from frontline health workers and patients, which could have provided additional depth.

Introduction

This chapter represents, interprets and analyses findings of the study in line with the objectives of the study. It includes descriptive statistics namely; sample size (N), Mean as a measure of central tendency, SD (standard deviation) which is a measure of variability. The strength of relationship was measured using Pearson correlation coefficient (r / r^2).

Table 4.1 Health System Strengthening

	Human Resources For Health	MEAN	SD
B1.1	Are the existing HR selection policies satisfactory?	3.948	1.2231
B1.2	There are recruitment and selection policies and procedures written down and known to staff?	3.8385	1.1786
B1.3	Are there considerations of health virtue in recruitment and selections of new staff in this clinic?	3.6276	1.0642
B1.4	Do you agree with the selections procedure?	3.6693	1.1042
B1.5	Are these recruitments improving health services?	3.5781	1.2001
B1.6	Clinical job vacancy is normally advertised	3.1849	1.174
B1.7	Advertisement for HR staff in Hope clinic is designed very attractively	3.1588	1.2041
B1.8	The media used for making vacancy advertisement is very appropriate.	2.9974	1.349
B1.9	Job description is clearly spelt out for clinic staff which improves on their services	3.7656	1.155
B2.0	Person specification for health staff is thoroughly prepared.	3.1042	1.2945
B2.1	The number of health staff and their distribution per patient is directly related to their level of performance.	2.7838	1.3797
	Overall Respondents rating	3.4232	0.0965

According from the findings on Table 4.1, the existing satisfactory HR selection policies indicated by a mean 3.948. There is a good policy of recruiting the right staff also shown by means of above 3. The recruits are believed to be improving health services (mean= 3.5781). The number of health staff and their distribution per patient is fairly directly related to their level of performance (mean= 2.7838). Whereas, there is confirmed mean of 3.6693 which supported the position that the respondents established recruitment and selection procedures and processes is clearly in place and correctly observed.

The mean of 3.5781 implied strong indicator of improved performance in relation to service delivery from fresh staff recruited. The means of 3.7656 implied strong confirmation of existence of design job description which led to improved performance.

The mean of 3.1849 implied that clinical positions at Family Hope Centre Clinic are recruited through an open competitive advertisement process. The mean of 2.9974 implied moderate use of approved standard media

platform for advertisement of the different available career positions within the organization. This showed that more than one form of media could have been employed.

The observed mean of 3.6276 implied that Family Hope Centre Clinic took into consideration ethical considerations, qualifications, required set of skills, experience and job specifications in the recruitment processes, procedures and policies.

Regression Analysis

Table.4.2. Regression analysis

Variables Entered/Removed: ANOVA testing the Influence of Human Resource for Health on Patience Health Care

Model	Variables Entered	Variables Removed	Method
1	Human Resource for Health a		Enter

a. All requested variables entered., b. Dependent Variable: Patience Health Care.

Table.4.2.1. Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate:
1	.919	.845	.827	.218

Predictors. (Constant), Human Resource for Health a.

The model summary according to the adjusted R square indicates that Human Resource for Health predict 82.7% variations in Patience Health Care. Further, ANOVAs result indicates that Human Resource for Health does significantly predict Patience Health Care as revealed by the (sig value 6.27 and F value =49.10) which led to the rejecting of the hypothesis and pointing to the effect that Human Resource for Health does significantly influence Patience Health Care. However, according to regression value (Residual value which is .428), it indicates that although Human Resource for Health strongly influenced Patience Health Care, there are other factors, which also influenced Patience Health Care. Interview about human resource management policy at Family Hope Centre Clinic Jinja branch, revealed that there is human resource management policy guided by a human resources management manual/handbook. This is a collection of tools that provides guidelines for operational management, namely: annual leave, performance appraisal, promotion, and payment of bonuses, selection and recruitment, job description for the different job positions, payroll management and management of staff time management.

“This facility has a human resource management policy that is used to guide all human resource operations”
Participant 4

Table 4.2.2. ANOVAb

Model	Sum of Squares	Df	Mean square	F	Sig.
1 Regression	2.338	1	2.338	49.10	6.27a
Residual Total	.428	9	.047		
	2.766	10			

a. Predictors: (Constant), Human Resource for Health

b. Dependent Variable: Patience Health Care.

Coefficients a

Table.4.2.3 Standardize coefficient

Model 1	Unstandardized Coefficients		Standardized Coefficient	T
	B	Std. Error	Beta	
(Constant): Human Resource for Health	-3.355 1.759	.919 .251	.501	-.3.648 7.007

From the tables of the regression analysis, the F-test is statistically significant, which means that the model is statistically significant. The R-squared is .84.5, which means that approximately 85% of the variance of Patience Health Care is accounted for by the model. The t-test equals 7.007 and is statistically significant, meaning that the regression coefficient for Patience Health Care is significantly different from zero which implies that for an improvement in the human resource, there is an improvement in the Patience Health Care and the constant - 3.355 is the predicted value when the Patience Health Care equals zero. These are the Standardized regression coefficients. These are the coefficients that you would obtain if the predictors and the outcome variables were standardized prior to the analysis. Since all of the predictors are standardized, they are measured in the same units, so the standardized regression coefficients are useful for comparing the size of the coefficients across variables.

“This facility has a human resource management policy that is used to guide all human resource operations”
Participant 4

To examine the influence of Human Resource for Health (HRH) on Patient’s care at Family Hope Centre Clinic, Kampala

The mean of 3.948 confirmed existence and satisfaction with the human resources selection and recruitment procedures and policies by staff at family hope center –clinic. Whereas, the confirmed mean of 3.8385 agreed that the human resources standard operational and procedural polices are known and accessible by staff.

The finding of 3.6276 agreed with the consideration and/or emphasis on the value of prior health working experience and ethical qualities in selection and recruitment interviews and in addition, the outcome level of 3.6693 confirmed level of agreement with the job selection/recruitment procedures and processes at Family Hope Centre Kampala.

The 3.5781 level of confirmation is an indicator that the recruitments at the care facility is improving services.

On the assessment to confirm if the clinical job vacancies are normally advertised, the finding level of 3.1849 established somewhat lack of knowledge/information about this (not sure). When almost a more similar question on attractiveness of the advertisement for human resource positions at the facility was asked, the level of 3.1588 confirmed a not sure or clear position on the matter. The following question on appropriateness of the media platform used for advertisement of the vacancies, the 2.9974 level of confirmation is a result indicator by audience who is not sure of the status.

On the scope of job description for clinic positions and if this improves on their performance and service, the finding of 3.7656 agrees with the question. However, the 3.1042 findings on specifications and level of preparation confirmed a not sure position.

There is a disagreement by finding of 2.7838 on staff patient ratio. The overall respondents rating of 3.4232 confirmed a finding status which is not sure.

The model summary according to the adjusted R square indicates that Human Resources for Health predict 82.7% variations in Patience Health Care. Further, ANOVAs results indicate that Human Resources for Health do significantly predict Patience Health Care as revealed by the sig value (6.27) and F value (49.10). This leads

to the rejection of the null hypothesis showing an effect that Human Resources for Health do significantly influence Patient Health Care. This supports the fact that there is an increasing improvement in the health system through human resource for health investments as one of the building blocks. This is different from the past where human resources as a means of improving health care was neglected in developing countries (Shrikant et al., 2011). Efforts of human resources personnel were found to improve health worker's engagement and thus the quality of service (Harris Interactive, 2011). This is in agreement with the findings in this study. The ways through which human resources improve health care may include: recognizing employees to boost their morale, monitoring and evaluation of the health care performances while implementing any necessary changes deemed fit, encouraging staff training through establishing pre-service training and in service training for continuing professional development, ensuring a sufficient number of employees. However, according to regression value (Residual value which is .428), it indicates that although Human Resources for Health strongly influences Patient Health Care, there are other factors which also influence Patient Health Care. The other factors may include a good health information system which is supported by the right technology, personnel and sufficient finances, a good procurement and supply chain management that enables good access to essential medical materials, and all these could be possible due to a good health financing system by the CDC, an agency of the United States Government. Staff attraction and retention has been a huge complex managerial challenge yet the cost of training has remained extremely high. Management employed an innovative approach of refresher and orientation courses. Recently, a continuous professional development through continuous medical education has facilitated the

lifting of staff morale, hence high level of productivity namely patient care, retention, adherence follow-up and value addition along the health care chain.

CONCLUSION

Strengthening health systems does contribute to improvement of the quality of health services as evidenced by this research at FHCK.

Specifically:

From the findings there existed human resources selection and recruitment policies and procedures and the staff at Family Hope Center Kampala are satisfied with the system which has made standard operational procedures accessible.

The institution considers value addition and best practices has evidenced by evaluation of prior experience, ethical and/or governance issues related to confidentiality in the management of health information a core issue in the decision on selection and recruitment of staff at the facility. The findings further confirmed that recruitment is not only improving health worker patient ratio, attraction and retention but significantly to the quality of health care namely; waiting time, patient retention, clinical outcome and more fresh enrollment in care. It can be concluded though that staff members are either not sure on advertisement of clinical positions or if the media platform is attractive to generate interest. It's of interest to note that the clinical position job description contributed to good job performance by the staff in achieving key result areas.

RECOMMENDATIONS

The is narrow range of services provided beyond the scope HIV care, treatment and prevention services and expansion of the service scope requires investment in healthcare infrastructure, human resources for health attraction and retention strategies and improved laboratory and pharmaceutical commodities distribution and supply and these are major requirements that should be termed investments not cost. The institution should undertake strategic business development to raise the profile of health care financing and in addition encourage strategic donor and government relations to scale up advocacy, networking and sustainable referral services.

The institution needs to promote open, transparent and competitive in selection and recruitment of staff by investing in advertisement thereby enlarging media platform to cover social media, website, traditional media,

institutional network and membership, head hunting and for purposes of organizational development adopt a culture of promotion from within.

The lack of knowledge about existence of procurement policy at the facility calls for need to improve staff capacity development including promotion of a culture of open communication across departments and operations. A decentralized organizational structure is recommended with mandate to lower level departments to take part in budget development including major procurement decisions.

The lack of information about treatment and management of opportunistic infections means approved OI policy is not shared with both the staff and patients and it's important that the approved and revised OI policy be shared and standard operational procedures manual be developed. In addition, counselling department should be incorporated in the process of communication with patients for smooth coordination and follow up.

The service level in relation to HIV testing and counselling services should be comprehensively documented through monitoring and evaluation and reports shared. If results is as a result of lack of information, then there is suggestion that not much is done to inform both patients and staff on the range of services provided including the targeted population.

Data utilization by management for strategic decision making is a best practice that I recommend even for lower level team to encourage and promote efficiency, proactive execution and coordinated follow up including efficiency in resource allocation.

More efforts and strategic investments should be put in improving the supply chain by establishing good procurement and supply policies and making sure that the policies are adhered to, so as to improve community intervention services.

Improvement of HMIS is recommended through staff capacity development/improving skills of employees and investing in appropriate technology including adaptation of innovative techniques. The HMIS should be considered whenever planning for any improvements in the health care services.

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