Ministry of Health, Community Development, Gender, Elderly and Children
President Office Regional Administration and Local Government

Guideline for Regional Referral Hospital Advisory Board (RRHAB)

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FOREWORD

This is a guideline which guides the health stake holders at different levels to support the operationalization of Regional Referral Advisory Boards. Advisory Boards are formed at all Regional Referral Hospitals therefore need to operate with clear instructions and standardized templates.

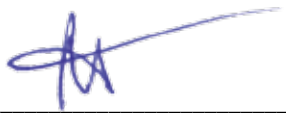
The "Regional Referral Advisory Board guideline" was developed by the Ministry of Health Community Development, Gender, Elderly and Children in collaboration with the JICA project named Tanzania-Japan Technical Cooperation in Capacity Development for Regional Referral Hospital Management in December 2015. Before the introduction of the foresaid Project, there was another project which focused on RHMT strengthening. Under that project, RHMT functions were established and function eight is to backstop the functioning of the Regional Referral Hospitals thus active RRHAB becomes inevitable as the Tanzanian health needs to strengthen its management system.

MOHSW through the Hospital Reform section had prepared the guideline for HABs but was not officially endorsed. Following the realized necessity of introducing the new Guideline to meet the reality and current situation, RRHM Project decided to support the process. It took some time in preparation for involving many health sector stakeholders through a series of fruitful discussions, the test trails and the feedback. Therefore this publication has already been proven as a very practical and user friendly guide for RRHABs.

This Guideline includes more consideration and information on Regional Referral Hospital Advisory Boards, Regional Referral Hospital Management Team (RRHMT), and enriched instruction for formation, qualifications and functions of RRHABs.

It is my sincere hope that the relevant authorities and people related to the regional health understand the purpose and the use of this Guideline and support RRHAB to accomplish their roles and function for contributing the health management in Tanzania.

Dr. Mpoki M.Ulisubisya
Permanent Secretary,
Ministry of Health, Community Development,
Gender, Elderly and Children



Eng. Musa I. Iyombe
Permanent Secretary
President Office, Regional Administration
and Local Government

ACKNOWLEDGEMENT

The Ministry of Health, Community Development, Gender, Elderly and Children would like to express its sincere appreciation to the JICA through RRHMP for the technical and financial support.

The ministry extends its appreciation to RRHM Project for technical contribution by facilitating the trainings, discussions and field test visits that resulted to completion of this guideline.

It is not possible to mention by name all those who contributed to the development of this RRHAB in one way or another. However, ministry wishes to acknowledge the contribution of all Hospital Reform members who participated in the process and RRHMP support staff who contributed in the development of this guideline

Furthermore, the MOHCDGEC recognizes the outstanding contribution made by the following individuals in providing the leadership, guidance and technical assistance and advice throughout the development process of RRHAB guideline: Chief Advisor RRHMP- H.Ishijima; H-RHSU-D.R. Mutagwaba, H-Advocacy F.J.Masaule

It is my aspiration that the guideline will effectively help the RRHAB to function better and support health systems to address health issues in Tanzania

Prof. Muhammad Bakari Kambi
Chief Medical Officer
Ministry of Health, Community Development,
Gender, Elderly and Children

HOW TO USE THIS GUIDELINE?

This guideline is intended to guide Regional Health Management Team (RHMT) and Regional Referral Hospital Management Team (RRHMT) to establish Regional Referral Hospital Advisory Board (RRHAB) in line with National health policy. Steps for establishment of RRHAB have been well described in this guideline. RRHMT and RHMT should read, internalize and understand the steps and process. Six steps are elaborated and should be read, discussed and adhered to by both RRHMT and RHMT.

After establishment of RRHAB, this includes appointment of the members, a process that is well explained in Chapter 2. 3, the members of the Boards must be equipped with knowledge and mastering of their roles and functions. This guideline will therefore, be used as a tool for orientation of the members on their roles and responsibilities. In this aspect, RRHMT and RHMT with support from central level should prepare an orientation package for the RRHAB members covering Chapters one to three of this guide. The teams will use the package to prepare schedule and conduct orientation to the members.

Furthermore, the guide is a reference tool for use by board members in implementation of their roles and responsibilities. The RRHMT should ensure this guideline together with other tools is availed/provide to each board member.

The purposes of developing this guideline are as follows;

1) To clarify the Regional Health System and have common understanding among key stakeholders.
2) To Guide the establishment of RRHAB and standardize the orientation program for newly appointed Hospital Advisory Board members
3) To provide adequate knowledge and skills to Hospital Advisory Board members to carry out their given tasks.

This guideline should be accessible and kept in the office of Regional Administrative Secretary (RAS), Regional Medical Officer (RMO) and Medical Officer In-charge of RRH to serve these purposes. RAS Office and RHMT can utilize this guideline to orient the newly appointed RRHAB members. Hope this guideline will help to establish functional Hospital Advisory Board and run the board effectively and efficiently to support RRH for proper provision of health services to communities.

CHAPTER 1: HEALTH SYSTEMS IN TANZANIA

1.1. Background

The current systems and procedures for delivery of health services have changed following the reforms which have taken place. In 2007, policy review was made aiming at starting new health delivery and management system at regional and district levels. In the review, involvement and participation of community in health service provision was recognized and given due respect. In this regard, administration of health service delivery was delegated to Regional Secretariats and Local Government Authorities in order to promote participation of the community in management and ownership of resources for health. Within this context the Government in the 2007 National Health Policy stated clearly its intention to establish hospital boards to oversee RRHs.

In addition, under the same policy, Council Health Service Boards will be established to coordinate and oversee health services delivery at District level while Hospital Governing Committee will be established for the District Hospitals and Health Facility Committees for health center and dispensary levels respectively.

In principal, the reforms have been the impetus behind the establishment of these governance structures specifically at council level. Through Local Government Reforms, Local Government Acts were reviewed to allow the structures at this level to be established legally through instruments and by laws. Surprisingly, at regional level, the Act to establish Regional Referral Hospital Boards (RRHB) lagged behind and is yet to be completed. As a result of the incompleteness of the Act, the RRHB are established administratively and published in the Government Administrative Gazette. The Boards thus, assume the role of administratively advisory, hence the name Regional Referral Hospital Advisory Board (RRHAB). The name will change to RRHB once the Act is passed.

Currently, Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) in collaboration with the President's office Regional Administration and Local Government (PORALG) through Japan International Cooperation Agency (JICA) technical assistance are currently strengthening the RRH services, making RRHMTs, and RRHABs the focus on development and Quality of health services delivery in the Hospitals.

1.2. Institutional Arrangements of Health Systems in Tanzania

The national health system operates in decentralized system of governance. It is organized in a referral pyramid, made up of three main levels namely, I) Primary level, II) Secondary level and III) Tertiary Level. The referral chain of the private health facilities, follow the criteria of the national health system.

Primary Level:

At primary level, council hospital and all other hospitals at this level are referral centers for all primary health facilities that include public and private dispensaries and health centers. The facilities at this level are fully fledged to give services both for the in patience and out patience clients.

In current arrangement, the Local Government Authorities have full mandate for planning, implementation, monitoring and evaluation of health services within the council. The responsible structure for services delivery at this level is the Council Health Management Team (CHMT) headed by District Medical Officer (DMO). The team is accountable to Council Executive Director through the DMO

and is responsible for planning, implementation, monitoring and evaluation of health, community development, gender, elderly and children in the council.

Secondary level:

RRH including other referral hospitals at this level is secondary level referral centers for all primary level facilities both public and private within the region. The Regional Secretariat (RS) oversees the day-to-day management of health services in the region. The Regional Health Management Team (RHMT), which headed by the Regional Medical Officer (RMO) as Assistants Administrative Secretary (AAS)-health coordinates health, community development gender, elderly and children services within and at the level of region. As an extended arm of the central ministries, team ensures that policies, strategies, guidelines and plans are in line and correspond to national and local priorities. It provides technical back up to RRHMT and CHMTs.

Tertiary Level:

At national level, zonal consultant referral hospitals are tertiary level referral centers for secondary level facilities while specialized hospitals are national referral centers for specialized services such as -Kibong'oto hospital for TB and leprosy, Mirembe hospital for mental health, Ocean Road Cancer Institute for cancer, Jakaya Kikwete Cardiac Institute Services for orthopedic, and Muhimbili Orthopedic Institute for Trauma services.

While Muhimbili National Hospital and MUHAS (Mloganzila) remains the national referral center. All tertiary level referral health facilities are overseen and managed by MoHCDGECthrough different institutional arrangement.

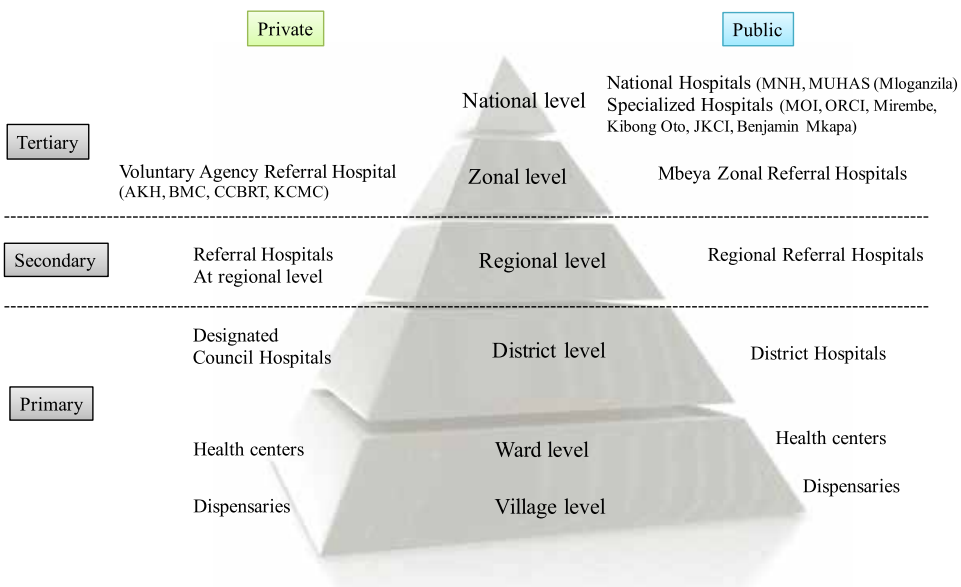


Figure 1-1: Health System Pyramid in TZ

CHAPTER 2: REGIONAL HEALTH MANAGEMENT SYSTEM

In the ongoing health sector reforms, the regional health management system composes of RHMT coordinating health services delivery within the region, RRHMT overseeing the day-to-day health services delivery in the RRH. The Regional Referral Hospital Advisory Board (RRHAB) supporting the RRHMT in provision of quality health services in the RRH.

2.1. Regional Health Management Team (RHMT)

Please note that detailed information about RHMT is well documented in the "Roles and Function of Regional Health Management Systems" of May 2014 which is also a reference document in development of this Guide.

2.2. Regional Referral Hospital Management Team (RRHMT)

The RRHMT is guided by ten functions to the RRH. Each function has a list of responsibilities to be fulfilled by the team as indicated in the table 2-1 below;

Table 2-1: Responsibilities of RRHMTs under each function

Function	Responsibilities
Function 1: Planning	• To prepare a 5-year strategic plan and submit it to RMO on time • To review the strategic plan at the mid-term and update if necessary • To prepare participatory and evidence based Comprehensive Hospital Operation Plan (CHOP) based on the data collected at the hospital, and submit to RMO on time • To share the strategic plan and CHOP with stakeholders including the Hospital Advisory board and all hospital staff • To ensure availability of health services to all, particularly vulnerable groups according to the policies
Function 2:	• To prepare a quarterly and annual reports (financial and technical) and submit it Monitoring and reporting to the Hospital Advisory Board and the RHMT • To coordinate and monitor implementation of planned activities • To conduct monthly monitoring meetings and keep record of results • To monitor performance of a Quality Improvement Team (QIT) and Work Improvement Teams (WITs) • To regularly monitor implementation of exemption and waiver procedures • To track clients complaints and suggestions to take necessary action for Improving services
Function 3:	• To conduct overall analysis of human resource in the hospital, through utilization Human resource of HRHIS that is regularly updated management • To ensure sufficient staff are allocated to the hospital

Function	Responsibilities
	• To improve Staff performance in each working place through implementation of Open Performance Review and Appraisal System (OPRAS) • To develop task descriptions for all staff and regularly oversee them • To ensure all staff understands their job and task description • To conduct training needs assessment • To identify, plan and carry out innovative retention schemes (e.g., housing, P4P, rewards, continuous education, etc.) • To manage conflicts and disciplinary measures • To coordinate training opportunities between the hospital and training institutes
Function 4:	• To monitor monthly, quarterly and annual financial reports including all Financial management resources and share them with relevant stakeholders and submit to the RHMT • To analyze and evaluate monthly income/expenditure • To improve hospital revenue collection (e.g. NHIF, cost sharing, exemption) • To improve resource mobilization from stakeholders (e.g. fund raising activities, donations) • To respond on time to the audit recommendations • To review user-charge regulations and propose revised regulations to the hospital advisory board for approval • To establish and maintain electronic revenue collection system
Function 5: Material Resource Management and Infection hospital Prevention Control, etc.) rational use	• To ensure implementation of quality improvement approaches (e.g. 5S- KAIZEN • To ensure Therapeutic Committee is functional • To procure and distribute medicines and medical supplies within the • To maintain medical stock and equipment regularly and ensure within the hospital • To manage the infrastructure, motor fleet and estate in the hospital. • To implement PPM practice on equipment, ambulances, other vehicles, and infrastructure • To ensure proper record keeping of resources (e.g., ledges, tally/bin cards, issue vouchers etc.) is in place in each department
Function 6: Information management and Research	- To ensure each department and ward keeps record of OPD / IPD Health Management Information System (HMIS) books - To prepare HMIS reports and submit to RHMT and other relevant stakeholders - To discuss and utilize HMIS data for improving service delivery

Function	Responsibilities
	- Encourage hospital staff to conduct operational research and utilize results for improvement of services
Function 7: Referral system services)	- To ensure that the referral system operates properly by maintaining good communication and the means of transportation (including laboratory - To ensure provision of emergency care - To keep record of the received and referred patients - To keep record of patients returned from the upper levels - To ensure RRH has the capacity to their respective duties as referral hospitals
Function 8: Supportive Supervision staff and coaching)	- To plan and implement managerial and clinical SS to all departments, wards and non-clinical services in the hospital and feedback the results to relevant stakeholders - To plan and arrange clinical Supportive Supervision (mentoring and to district hospitals in the region - To provide supportive supervision feedback both written and oral to RHMT and CHMT - To provide supportive supervision to CHMT
Function 9: Health Promotion and Disease prevention and functional	- Provide health information / education on disease prevention to clients visiting the hospital - To ensure that Infection Prevention Control (IPC) system is in place functional - To ensure proper hospital waste management is in place and functional - To ensure effective disease surveillance mechanism is in place and
Function 10: Emergency Preparedness and Responses	- To prepare the hospital emergency preparedness plan based on the National guide/manual - To ensure the implementation of the hospital emergency preparedness plan - To establish Standard Operation Procedures (SOPs for emergency preparedness) - To establish an emergency response team - To ensure medicines and supplies for emergency responses are in place at all times

2.3. Regional Referral Hospitals

RRH is the last referral point at the regional level offering more specialized services than level one hospitals at district level. It comprises of beds ranging from 176 to 450 with 9 or more wards; usually, with the following: Surgical (male and female) Medical (male and female), Pediatric, Labor, Post-Natal, Ante-Natal, Obstetrics and Gynecology and I.C.U. The regional hospital also has other units which includes X-Ray, Main pharmacy, Physiotherapy, Laboratory, Kitchen, Laundry, Mortuary, Stores, Operating Theatre, Administration and Outpatient.

Based on the GAZETTE, issued on November 05, 2010, regional hospitals and three municipal hospitals for the Dar es Salaam were upgraded to become "Regional Referral Hospital". Additionally, 10 hospitals owned by Faith Based Organization were also officially recognized as "Referral Hospital at regional level".

Table 2-2: List of Regional Referral Hospitals and Referral hospitals at regional level in Tanzania Mainland (GOT, GAZETI: Nov.2010)

SQ#	***Name of hospitals***	***Location***
Regional Referral Hospitals		
1	Amana Regional Referral Hospital	Dar es Salaam
2	Temeke Regional Referral Hospital	Dar es Salaam
3	Mwananyamala Regional Referral Hospital	Dar es Salaam
4	Tumbi Regional Referral Hospital	Pwani
5	Morogoro Regional Referral Hospital	Morogoro
6	Ligula Regional Referral Hospital	Mtwara
7	Sokoine Regional Referral Hospital	Lindi
8	Bukoba Regional Referral Hospital	Kagera
9	Seko-ToureRegional Referral Hospital	Mwanza
10	ShinyangaRegional Referral Hospital	Shinyanga
11	KiteteRegional Referral Hospital	Tabora
12	MusomaRegional Referral Hospital	Mara
13	Maweni Regional Referral Hospital	Kigoma
14	Geita Regional Referral Hospital	Geita
15	BariadiRegional Referral Hospital	Simuyu
16	BomboRegional Referral Hospital	Tanga
17	Dodoma Regional Referral Hospital	Dodoma
18	SingidaRegional Referral Hospital	Singida
19	Manyara Regional Referral Hospital	Manyara
20	Mt. Meru Regional Referral Hospital	Arusha
21	Mawenzi Regional Referral Hospital	Kilimanjaro
22	Mbeya Regional Referral Hospital	Mbeya
23	Songea Regional Referral Hospital	Ruvuma
24	Sumbawanga Regional Referral Hospital	Rukwa
25	Iringa Regional Referral Hospital	Iringa
26	Kibena Regional Referral Hospital	Njombe
27	Mpanda Regional Referral Hospital	Katavi

SQ#	Name of hospitals	Location
Referral hospitals at regional level		
1	Nyangao Hospital	Lindi
2	Peramiho Hospital	Ruvuma
3	St Gaspar Hospital	Singida
4	Arusha Lutheran Hospital	Arusha
5	Ilembula Hospital	Njombe
6	Nkinga Hospital	Tabora
7	Kabanga Hospital	Kigoma
8	St Francis Hospital	Morogoro
9	Ndanda Hospital	Mtwara
10	Hydom Hospital	Manyara

2.3.1. PDCA cycle for operation of RRH

Plan-Do-Check-Act (PDCA) cycle is defined as "repetitive four-stage model for continuous improvement in business process management". This cycle can be applied for process management of operating RRHs. Activities for managing a hospital that are implemented at RRH can be fit in this cycle as shown below:

Plan

Each RRH supposed to develop Comprehensive Hospital Operation Plan (CHOP) annually. RRHMT must develop it based on the previous year experiences and expenditures

Do

RRHMT implement activities listed in CHOP. During the implementation of CHOP, *Internal Monitoring Supportive Supervision* monitors all activities in CHOP.

Check

It is necessary to evaluate the achievement of activities planed in CHOP. The evaluation can be done by external hospital performance assessment as well as improvement Key Performance Indicators in CHOP

Act

Based on the assessment results and outcome of the activities, it is necessary to identify weak and strong points. Then react to improve the weak points. it is also important to prioritize action to be taken and, reflect those actions into next year's CHOP. This PDCA cycle need to be well understood by both RRHMT and HAB members so that tasks given to RRHMT and HAB are well connected for smooth implementation.

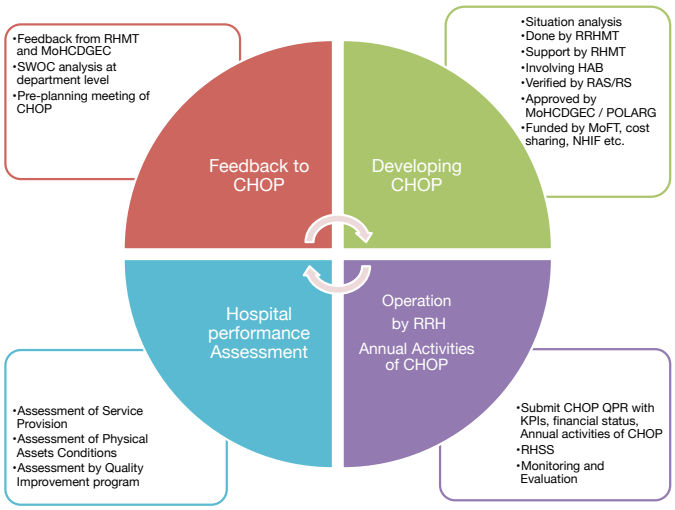


Figure2-1: PDCA cycle for RRH operation

2.3.2. Roles and responsibilities of RRHs

According to the "Standards for Health Facilities per Level in Tanzania – Volume 3 of 2015," the regional referral hospital shall have the following functions:

- To support health services and for health care in general in the region
- To provide wide-ranging technical and administrative support and education and training for lower levels of health Facilities
- To provide for an effective, affordable health care service for a defined population, with their full participation, in cooperation with agencies in the region that have similar concerns

In line with the above-mentioned functions, RRH shall provide three major categories of services: 1) Clinical services, 2) Support services, and 3) Research and training services as shown in Table 2-3.

Table 2-3: Services provided at RRH

Category of Service	Sub category of Services	Services provided
Clinical services	Care and Treatment	• Outpatient service • Inpatient service • Casualty • Emergency services • Diagnostic services; (Laboratory, radiology and imaging • Pharmaceutical supply service • Internal medicine • Surgery • Obstetrics and Gynecology • Pediatrics

Category of Service	Sub category of Services	Services provided
		• Orthopedic, • Physiotherapy, • Ophthalmology) • Mental, • Oral health, • Otolaryngology, and Dermatology
	Health promotion and disease	• Health education • Environmental Health
	Rehabilitation and Maintenance of patients with chronic illnesses	• Rehabilitation and Maintenance of patients with chronic illnesses
Support service within the hospital	Support service within the hospital	• Mortuary services • Health • Periodic preventive maintenance (PPM) • Administration, Accounts and stores • Medical record and hospital information system • Information and Communication Technology (ICT) • Public relations and customer services • Transport • Catering services • Laundry • Security • Social Welfare
	Support services outside the hospital in collaboration with RHMTs and CHMTs	• Clinical mentoring • Supportive supervision of districts hospitals • Mobile and Outreach clinical service • Social Welfare
Research and Training		• Operational research in collaboration with RHMT, CHMTs with support from Zonal Health Resource Centers (ZHRCs) • Field research in collaboration with academic institutions • Advocacy of appropriate use of research results • Support training to health institutions within the region by receiving student's to practice in the hospital and by RRH experts to

Category of Service	Sub category of Services	Services provided
		teach in respective institutions in collaboration with RHMT

2.4. Regional Referral Hospital Advisory Board (RRHAB)

RRHAB is defined, as "Is the group of skill mixed people who have been recommended and appointed by the relevant authority to oversee the health service delivery at the RRHs".The National Health Policy 2007 clearly stipulates the need for establishment of boards in the referral hospitals at regional in order to instill sense of ownership to the community, and enhance positive relationships and transparency in service provision and work relations. In this regard all public regional referral hospitals are charged to establish hospital boards to oversee the day-to-day functions and roles of the hospital in support of the RRHMT.

2.4.1. Objectives of establishing RRHAB

RRHAB is established with the following objectives:

- *To instill and strengthen good governance for service provision at RRH and ensure participation of the community in ownership and delivery of quality services within the region*

2.4.2. Establishment of RRHAB

The process of establishing RRHAB involves various stages that the Regional Secretariat has to follow. The Act to establish Regional Referral Hospital Boards is still in process as a result the Boards are established administratively as Regional Referral Hospital Advisory Boards and will be mandated by publishing its establishment in the Government Official Gazette. Nevertheless, this guide provides step by step process that Regional Secretariat will use to establish and operationalize the boards.

2.4.2.1. Steps for establishment of Hospital Advisory Board

There are some steps, which requires for establishment of RRHAB. The steps need to be followed by Regional Administrative Secretary (RAS) to establish the Boards, are as per the Table 2-4 below:

Table 2-4: Steps for Establishing RRHAB

Steps	*Process*	*Responsible section/person*
Step 1	Advertise the position of membership for the board in the Media	Regional Medical Officer/Assistant Administrative Secretary for Health (ARAS-Health)
Step 2	Shortlist the names of applicants to get those suitable for the position of Board membership	RRHMT and RHMT
Step 3	Discuss the list of shortlisted names suitable for RRHAB membership at RHMT special meeting	RRHMT and RHMT
Step 4	Prepare a list of 45 suitable applicants for the membership of RRHAB	RRHMT and RHMT

Steps	*Process*	*Responsible section/person*
Step 5	Scrutinize the shortlisted members, propose at least 20 suitable names and submit proposed names to RAS with quantifying minutes and their CV	Regional Health Management Team (RHMT)
Step 6	Recommend 15 Qualifying names of members	RAS
Step 7	Submit the list of 15recommended members Development, to the Ministry of Health Community Development, Gender and Children,	Ministry of Health, Community Gender, Elderly and Children
Step 8	Scrutinize the submitted 15 members to rule out anomalies	Permanent Secretary
Step 9	Officiate appointment of the15 members of Development, HAB recommended by the regional authority	Minister of Health, Community Gender, Elderly and Children
Step 10	Inform RAS for the particular region regarding Development, appointed members of RRHAB	Ministry of Health, Community Gender and Children
Step 11	Inform the appointed members and ask them whether they accept the appointment	RAS
Step 12	Submit the names of the appointed members with their task descriptions to the Government Printers to be published in the Official Gazette	RAS
Step 13	Board inauguration	Regional Commissioner (RC)

Note: Gender balance should be importantly considered in the step by step process of obtaining suitable members of the Board. After Establishment of the Board, The Regional Commissioner (RC) will oversee the function of HAB on behalf of Minister for MoHCDGEC.

2.4.3. Membership and representation of RRHAB

2.4.3.1. Requirements

RRHAB members will be drawn from a wide spectrum of public figures within the region whose qualities will, among others, be a personnel interest and commitment to voluntarily serve in the HAB giving advises for improving hospital service delivery. The Advisory Board membership shall have a mix of different Professional background with academic credentials not less than a basic degree and/or relevant experience and expertise in the subject that justifies his or her relevance to RRHAB.

2.4.3.2. Number of members

The number of members of advisory board shall not exceed 15 drawn from multi-dimensional disciplines of public figures within the region

2.4.3.3. Composition of RRHAB

The total number of RRHAB members shall not exceed 15, and they are nominated from multi-dimensional disciplines of public figures within the region. Nomination of the members will be conducted in closed circle and its post is not advertised in public. Therefore, previous HAB members and RAS office needs to discuss and nominate 3 possible candidates for each post, and come up with short-list for the selection of 15 members. It is also important to consider on representation of the Community. Suggested members of RRHAB are listed in the Table 2-5.

Table 2-5: Suggested members of RRHAB

SQ#	***Suggested member of RRHAB***
1	Representative from the Private sector
2	Legal Officer Advocate
3	Prominent retired health /Social welfare personnel
4	Representative from recognized women Organization
5	Representative from CSOs
6	Prominent financial Management Expert
7	Regional Assistant Administrative Secretary-Health (RMO)
8	Representative from Health Workers Union
9	Representative from Districts-(Council/District Medical Officer In charge)
10	Representative from lower level health facilities in the vicinity
11	2 representative from the community representing users from the community representing users of the facility
12	The Medical Officer In charge of the Hospital will be the Secretary to the Board.
13	2 Members from Faith based organization

2.4.3.4. Roles and responsibility of RRHAB members

Roles and responsibilities of each RRHAB member are stated in the Table 2-6.

Table 2-6: Roles and responsibilities of each RRHAB member

	Suggested members	***Roles and Responsibilities of each members***
1	Representative from the private health sector	• To resolve conflicts on medical treatment • To approve contract and record of discussions from individuals, private sectors, organizations which are contracted to improve the health services • To receive all grants donations and gifts from various stakeholders
2	Lawyer/Legal expert	• To review and approve policies, guidelines and regulations relating to health services provision • Responsible all legal matters relating to RRHAB activities

	Suggested members	***Roles and Responsibilities of each members***
		• To approve contract and record of discussions from individuals, private sectors, organizations which are contracted to improve the health services • To request the hospital board of enquiring on specific investigations as means of providing advise on issues which are challenging the hospital for the purpose of improving quality health service delivery
3	Prominent retired health /social welfare personal	• To create enabling environment for information sharing. In relation to Health services delivery, motivation, regulations and staff welfare
4	Representative from recognized women organization	• To create enabling environment for information sharing. In relation to Health services delivery, motivation, regulations and staff welfare • To receive all grants donations and gifts from various stakeholders
5	Representative from Civil Society Organization or Representative from faith based Organization CSOs	• To create enabling environment for information sharing. In relation to Health services delivery, motivation, regulations and staff welfare
6	Prominent Financial Expert	• To approve budget for emergences, incase disaster and accidents • To approve Hospital annual budget • To receive all grants donations and gifts from various stakeholders
7	Regional Assistant Administrative Secretary- Health (RAAS)	• To ensure effective management of Hospital resources (Medicine, Equipment and supplies) • To resolve conflicts on medical treatment • Identify new income sources for the Hospital • To receive all grants donations and gifts from various stakeholders
8	Representative from Health Workers Union	• To create enabling environment for information sharing. In relation to Health services delivery, motivation, regulations and staff welfare
9	Representative from Districts	• To resolve conflicts on medical treatment • To receive all grants donations and gifts from various stakeholders

	Suggested members	*Roles and Responsibilities of each members*
10	Representative from lower level health facilities in the vicinity	• To create enabling environment for information sharing. In relation to Health services delivery, motivation, regulations and staff welfare
11	Two representative from the community representing users of the of the facility	• To create enabling environment for information sharing. In relation to Health services delivery, motivation, regulations and staff welfare
12		
13	Two members from FBO	• To create enabling environment for information sharing. In relation to Health services delivery, motivation, regulations and staff welfare
14		
15	The Medical Officers In charge of the Hospital	• Secretary to the Board • To resolve conflicts on medical treatment • Identify new income sources for the Hospital • To receive all grants donations and gifts from various stakeholders

2.4.3.5. Competencies and qualities

In order to have effective and functional RRHAB, board members should be selected based on set criteria. The following competencies will assist the regional teams to do the needful in obtaining the required members

- Commitment to serve voluntarily in the advisory board
- Personal interests in health service development and delivery
- Advises that are implementable according to regional environment
- Attribute to encourage and provide wise counseling for improved quality hospital Services delivery
- Should have academic credentials not less than a basic degree
- Should have relevant experience and expertise in the subject that justifies his or her relevance as a professional member of the RRHAB

2.4.3.6. Chairperson

The chairperson of the Board shall be elected among the board members, who do not belong to RS/RHMT. His/her tenure of office will be three-years, however there will be annual performance assessment by RRHAB members to allow continuation of chairmanship if the performance assessment is lower the average the chairman will be changed Additionally, medical officer in charge of the hospital will be an ex officio member, serving as the Secretary to RRHAB.

2.4.3.7. Structure of RRHAB

Answerability, linkage and relationship of RRHAB, RAS, RHMT and RRHMT is as shown in the figure 2-2. RRHAB's activities and performances are monitored and controlled by RAS office through RHMT members. Since RRHAB has an advisory role to RRHMT, RRHAB need to be established and operated outside of routine (day to day) communication between RRHMT and RHMT. Detailed working relation will be explained in Section 2.5. and 2.6.

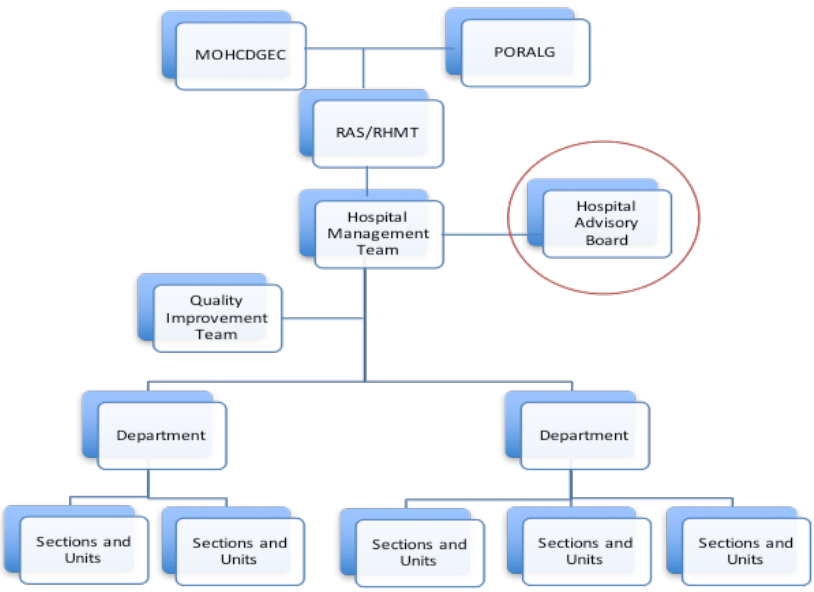


Figure 2-2: Structure of RRHAB in regional health system

2.4.4. Duties

The RRHABhas access to the information and data on the health resources for running of all hospital services at the Regional Referral Hospital. Moreover, RRHAB has several responsibilities to provide appropriate guidance to RRHMT.

2.4.5. Responsibilities of RRHAB

- To advise formulate and set up hospital policies, approve hospital objectives and strategic plans, monitor and evaluate their implementation according to government policies and guidelines.
- To advisee and oversee the management and administration of movable and immovable propertiesand assets of the hospital
- To oversee and adviseRegional Secretariaton financial management of the Regional Referral Hospital
- To ensure that the hospital is sensitive tothe priority health needs of the community it serves
- To ensure that the hospital is accountable to the government and meets its contractual obligations and reporting requirements of the Ministry of Health and President Office Regional Administration and Local Government through the Regional Secretariat

- To recommend suitable members fro RRHMT including Medical Officer in charge andheads of departments and recommend appropriate measures.
- To advise the Regional Secretariat on on appointments and disciplinary measures for heads ofsections and units by the hospital management
- To advice on staffestablishment, conditions of services, employment packages and staff development plans prepared by the hospital management team within the financial resources of the hospital.
- To receive. Discuss and advice on hospital annual, quarterly plans and budget technical and financial progress report.
- To receive on behalf other hospital grants, donations gifts services charge fees and other resources
- Approve major expenditures and disbursements to departments sections and units of the hospital
- To establish committees which it considers necessary to fulfill the responsibilities of the board or those of the hospitals in order to enhance service efficiency.
- To make recommendations to the RAS on the rates of sitting allowances for the board its committees forapproval before they are submitted to RAS
- To approval proposal for contracts, memorandum of understanding and terms of references for individuals Ministries and other organizations for better and efficient functioning of the hospital.
- To discuss and Advice on major issues, endorse decisions and approve recommendations before they are submitted to RAS
- To approve Comprehensive Hospital Operational Plan (CHOP) before it is submitted to RAS

2.4.6. Mandate of Hospital Advisory Board

The mandate of the RRHAB to operationalize the ascribed roles and functions are ignited and embedded in the act of being administratively published in the Government Official gazette

2.4.7. Limits of the Advisory Board

- The Advisory Board shall not interfere, but may intervene, during the execution of professional health care services activities, when there is apparent inefficiency
- Irresponsibility and mismanagement of health resources and/or misconduct or unethical practice by hospital personnel in the delivery of regional referral hospital services
- In instances where the Advisory Board gets the report or witnesses any act that amounts to or relates to unethical and professional misconduct by the hospital staff, the Board shall notify the relevant organs for further investigation and action. The decision of the authority taking action shall be communicated to the Board through a letter and it will be recorded in Board meeting's minutes
- If member decides to resign, he is obliged to give one-month notice before the next meeting for discussion.

2.4.8. Tenure

- The office tenure for the appointed Advisory Board members is three years from the date of publication in the Official Government gazette shall be eligible for reappointment to the board after the expiration of the first term.
- Notwithstanding the above provision a member shall not be eligible for reappointment for a third term except for a member by virtue of his/her position
- If the Advisory Board fails to fulfill its objectives as expected, it will be reminded to fulfill its objective and if it fails again, the appointing authority after consultation with the RAS will dissolve the Board and will then appoint a new Board immediately
- Tenure of representative from secretaries for CHSB who are on rotational basis will determined by the RS in line with prevailing environment in the region
- If a member leaves a tenure due to resignation, health problems, death or any other reason, the vacancy left will be filled by another elected member who will serve the office for the remaining period

N.B: Letter for appointment of the representative should state the rotational cycle within the region.If a RRHAB member is transferred from respective region, he must resign his membership in the Board

2.4.9. Cessation

A member of the board shall cease to be a member if

- The Member is absent from three consecutive meeting of the board without a good cause
- The Member ceases to hold the office or position for which he was appointed
- The Member is suffering from mental illness or long-time illness
- The Member tenders a one-monthresignationnotice in writing to the appointing authority
- The Member passes away
- The Member move out of the region

NB This has to be clearly stated during inauguration that it is important to all RRHAB members to fully participate in all RRHAB activities.

Where a vacancy occurs in the Board the appointing Authority shall appoint another person to fill that vacancy and such person shall hold office/position for remaining period of the office/ position and upon the same term as the member in whose place he is appointed.

CHAPTER 3: OPERATION OF RRHAB

Roles and responsibilities of RRHAB were explained in Chapter. However, it is important to know how to operate RRHAB practically and effectively. Therefore, actual operation of duties and tasks given to RRHAB members will be explained in this chapter.

3.1. Roles and Responsibilities of RMO/RHMT to operationalize RRHAB

ARAS-HSW (RMO) and RHMT has roles and responsibilities to operationalize the RRHAB.

- Nominate RRHAB members and submit RAS for endorsement
- Conduct orientation session to the newly appointed HAB members on; Roles and responsibilities of RRHAB, Development procedures of Comprehensive Hospital Operation Plan, Current situation of resource management at RRH and Monitoring and evaluation of RRH activities.

3.2. Roles and Responsibilities of RRHMT to operationalize RRHAB

RRHMT have the following roles and responsibilities to operationalize the RRHAB

- Establish a mechanism of utilizing RRHAB within the hospital
- Involves the RRHAB in CHOP preparation
- Prepare and submit quarterly report to RRHAB
- Involves RRHAB in annual evaluation.
- Keep all records of RRHAB activities
- Develop RRHAB annual schedule with RRHAB members
- Develop agenda for RRHAB meeting before the actual meeting

3.3. Annual schedule of RRHAB activities

The Figure 3 is the sample of annual schedule for RRHAB activities. Development of annual schedule is important to understand the coming events and monitoring of progress of activities. Therefore, it is recommended RRHAB to develop the annual schedule with RRHMT.

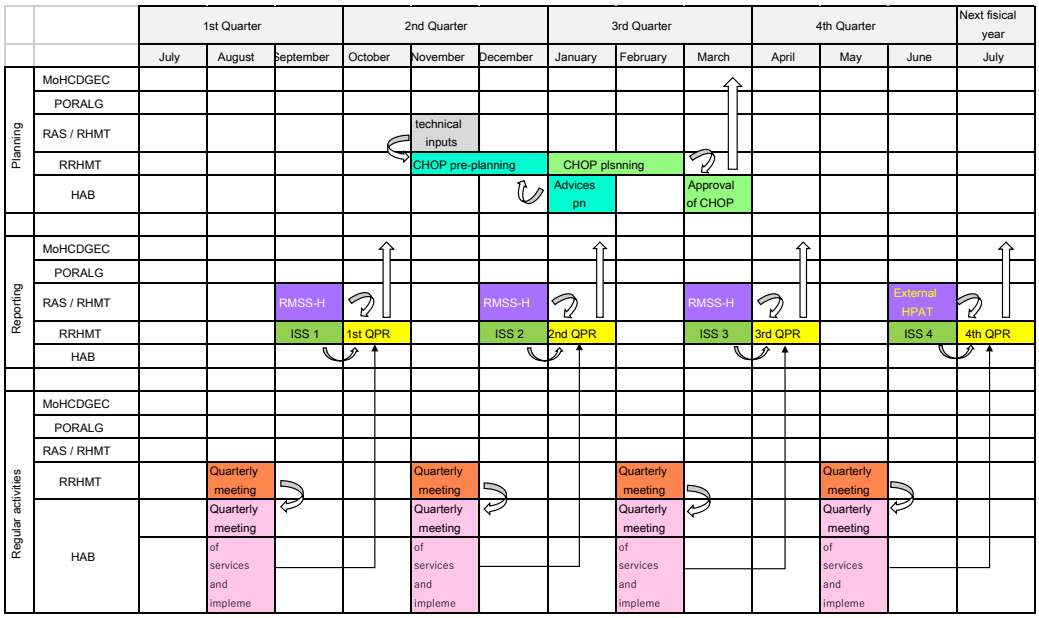


Figure 3-1: annual schedule of RRHAB

3.4. Regular RRHAB meeting

The Chairperson or any member conducts the meeting at least once in every three months or any other time when necessity arises and will be called by making a special request to the Chairperson. The meeting quorum will be met when half of the members have attended. Ideally, regular RRHAB meeting supposed to be held 4 times in October, January, April, and July as shown in Figure 2so as to match with RRHMT quarterly report submission:

- The advisory member will be paid travelling and sitting allowance according to prevailing laws, regulations and rates
- In the instances where decisions made by the Board would need the voting by members to arrive to a consensus, the members who have the rights to vote are all members except the officials who sit in the Advisory Board by virtual of their position at the hospital or from RAS office. In the event of an equality of votes, the person presiding over the meeting shall have a casting vote in addition to his deliberate vote.

3.5. Reporting of RRHAB meeting

3.5.1. Record keeping of RRHAB activities

All activities and other relevant information of RRHAB activities should be recorded and kept well by RRHAB secretary as future references. The Secretary will keep records of all the meetings and report back on implementation of resolutions, as reported by the responsible person (s), at each meeting of the Board. RRHMT procure few files and provide together with other stationeries to RRHAB for record keeping of RRHAB activities.

The following documents must be kept in RRHAB files:

- RRH strategic plan and CHOP
- Official letters related with RRHAB activities
- Minutes of RRHAB meeting
- CHOP Quarterly Progress Report
- Health policies, regulations and guidelines
- RRHAB Guidelines
- Any other information relevant to RRHAB activities

3.5.2. Reporting responsibility

Secretariat of RRHAB has responsibility of keeping the Minute of Meeting (M/M) on every RRHAB meeting.

The following issues should be recorded clearly;

- Date of the meeting
- Venue of the meeting
- Attendants of the meeting
- Agendas of the meeting
- Matters aroused on the discussed agendas during the meeting
- Way forwards
- Closing time of the meeting

Secretariat of RRHAB must open a file (preferably hardcover ring file), and filing every M/M of the meeting. Since RRHAB does not have an office in the hospital. Medical officer in-charge will keep the file on behalf of RRHAB.

3.5.3. Transparency and Feedback of RRHAB to Community

RRHAB is established with the view to support RRHMT to manage RRH properly and improve quality of health services delivered to the community they represent. Community/Customer satisfaction of the services delivered is the key for successful QI interventions. Thus, RRHAB should maintain transparency of its undertakings and always provide feedback to the community so as to pick up their voices. To achieve this, theRRHAB should discuss and ensure that what has been discussed in theirmeeting sand consensually agreed is for public consumption, is displayed on the RRH notice board by the Boards' secretary. The same should also be communicated in writing and electronically to all CHSBs, Facility Committees and other stake holders within the region.

Table 3-1: Steps for record keeping of RRHAB activities

Steps	***Action to be taken***
Step 1:	Draft of M/M must be developed within two days after the meeting.
Step 2:	Then, it is circulated to the members by e-mail. All members must respond within few days if anything to be added or deleted from the M/M.
Step 3:	If no response within a week, Secretariat of RRHAB should consider it as "No objection from participants of the meeting", and obtain signature from the chairperson of the meeting.
Step 4.	Secretariat of RRHAB submits M/M to RAS, RHMT and RRHMT.
Step 5.	Make three copies of the M/M, and display the M/M on notice boards in RAS, RHMT, and OPD of RRH to open the M/M to the community
Step 6.	RRHAB discuss and ensure that what has been discussed in their meetings and consensually agreed is for public consumption

3.6. The Roles of RRHAB in development and implementation of Comprehensive Hospital Operation Plan(CHOP)

3.6.1. Development of CHOP

RRHAB is responsible for supporting RRHMT to develop Comprehensive Hospital Operation Plan (CHOP) annually. CHOP is developed based on the Timetable showing in Table 6.

According to the CHOP guideline, it is clearly stated that RRHAB is a part of CHOP Planning Team. Therefore, RRHAB members shall take the following tasks;

- Nominate a representative for CHOP planning in October every year.
- The representative participates CHOP planning process.
- RRHAB to approve CHOP final draft before sending to RAS/RHMToffice

Table 3-2: Timetable for developing the CHOP

S/No	***Activity***	***Responsible***	***Completion Deadlines***
Step 1	Collect all necessary data and information on incomes, expenditures, and key performance indicators from previous fiscal year for evidence based planning and analyze them.	RRHMT	By the end of September
Step 2	Hospital departments/sections/units, and all stakeholders identify priorities and needs to include in the annual plans	RRHMT	October
Step 3	Gap analysis between actual results from previous fiscal year data and requirement from previous year.	RRHMT	October
Step 4	Pre-planning meeting should take place with all stakeholders before the planning process so as to take into account all recommendations.	RRHMT	October
Step 5	RRHMT collect priorities/ needs from Hospital departments and other stakeholders to accommodate them in the CHOP	RRHMT	Early November
Step 6	RRHMT notified or collect information of resources available for Health Block Grant, Health Basket Funds user fee, NHIF and other partners for the next financial year	PMO-RALG, MoHCDGEC RAS Partners	End of November
Step 7	The RRHMT develop its CHOP and submit it to Regional Hospital Advisory Board for endorsement	RRHMT	December to January
Step 8	RHMT receive CHOP and submit to RAS	RHMT	End of January
Step 9	CHOP entered into Regional MTEF	RAS	Middle of February
Step 10	CHOP submitted to RS for conformity with national guidelines	RS	End of February
Step 11	Final CHOP submitted to RS (5 hard copies and electronic copy)	RHMT	Mid –March

S/No	*Activity*	*Responsible*	*Completion Deadlines* Step 12
	CHOPs are assessed. The assessment reports and the documents themselves are forwarded to PO-RALG with copy to MoHCDGEC (hard and soft copies)	RS/RHMT	End of March
Step 13	PO-RALG and MoHCGEC consolidate the reports from RS and recommend the CHOP for funding approval	PO-RALG / MoHCDGEC	End of April
Step 14	Distribution of papers and recommendations for funding approval based on CHOP and quarterly financial and performance progress report for current financial year	PO-RALG / MoHCDGEC	1stweek of May
Step 15	Final summary and analysis of CHOPs report presented at JAHSR	PO-RALG / MoHCDGEC	End of May
Step 16	RRHMT should provide feedback to RRHAB and Hospital staff on the approved plans and budget according to cost center.	HMT	June

3.6.2. Reporting of CHOP Implementation

RRHMT is supposed to develop "Technical and financial report (QPPR))" every quarter. Ideally, the report is produced in October, January, April and July. QPR must be approved by RRHAB before submission to RAS office. The report will be assessed by RHMT, and give feedback to RRHMT. Therefore, RRHAB members need to check the contents of QPR properly before submission to RAS office.

3.7. Technical and Financial Quarterly Report

Rerated with the above, RRHMT is supposed to prepare technical and financial report quarterly using the forms in Appendix 3 and 4. Quarterly technical and financial reports should be submitted to RRHAB for further inputs before submit RAS/RHMT, PMORALG and MOHCDGEC.

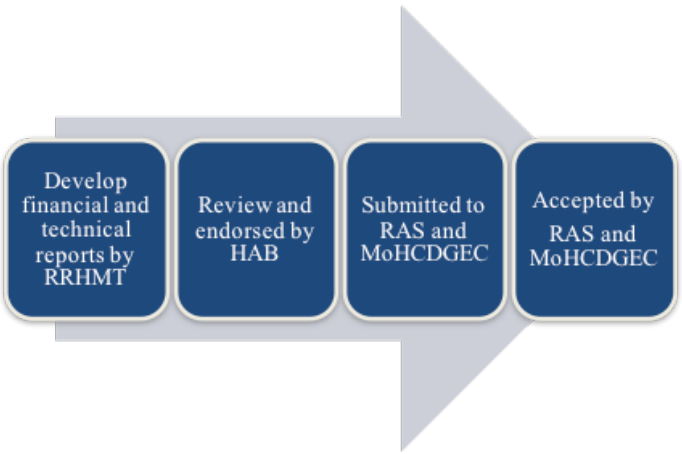


Figure3-2: Reporting of progress of work

3.8. HRH planning and management

As attached in Appendix 1 and 2, RRH supposed to have minimum of 481 staff to operate RRH for provision of services mentioned in Section 1.2.3.

Therefore, RRHAB need to monitor the HRH management of RRH and advise RRHMT on HR recruitment, deployment and retention HRH at RRH. Feedback of HRH management should be reflected on HRH Planning in CHOP.

The following activities are important as RRHAB to improve HRH planning and management in RRH.

- Analyze report on current existing staff
- Advices on the exiting gaps by professional/Cadre
- Advices on personal emolument for filling the identified gaps
- Analyze report on deployment status
- Analyze of staff distribution in the hospital
- Advice of allocation of staff in the hospital according to the staffing level
- Monitor staff retention rate
- Advise on staff retention mechanism
- Study on attrition (reasons why staff are leaving) of the hospital

3.9. Monitoring and evaluation of RRHAB performance

3.9.1. Monitoring of RRHAB performance

Performance of HAB is reflection of performance of RRH.Therefore, it is necessary to monitor and evaluate their performance in existing supportive supervision and hospital performance assessment. Measurement of HAB performance is carried out by RHMT. Currently, very few item to monitor and evaluate their performance in RMSS-H and other hospital performance assessment tools. Thus, it is suggested to use the following monitoring checklist for M&E of HAB performance;

Table 3-3: Monitoring checklist for RRHAB performance

	Items to check RRHAB performance	*No*	*Partially*	*Yes*
1	Is RRHAB established and actively working with RRHMT?	0	1	2
2	Do RRHAB members clearly understand their roles and responsibilities?	0	1	2
4	Are RRHAB meeting quarterly to monitor progress of CHOP implementation?	0	1	2
6	Are RRHAB checking CHOP quarterly progress reports and approves on time?	0	1	2
7	Are RRHAB keeping record of their activities properly?	0	1	2
8	Did RRHAB nominate a member to be a member of CHOP Planning Team?	0	1	2
9	Did RRHAB receive final draft CHOP for endorsement?	0	1	2
10	Do RRRRHAB have orientation package for new RRHAB members?	0	1	2
11	Do RRHMT organize orientation seminar to new RRHAB members?	0	1	2
12	Do the members elect chairperson every yearthree ?	0	1	2
13	Did RRHAB review RMSS-H register book and internal monitoring SS results?	0	1	2
14	Did RRHAB review technical and financial reports before submission to RS	0	1	2

3.9.2. Monitoring of RRH performance

There are two type of monitoring the performance of RRH. Administrative performance of RRHMT is monitored by RHMT through Regional Management Supportive Supervision for Hospital (RMSS-H). Another monitoring activity for RRH is Internal Monitoring Supportive Supervision, which is conducted quarterly to monitor clinical performance of RRH. Results of RMSS-H and Internal Monitoring SS must be reviewed through RRHAB quarterly. Therefore, RRHAB need to schedule quarterly meeting based on progress of monitoring activities.

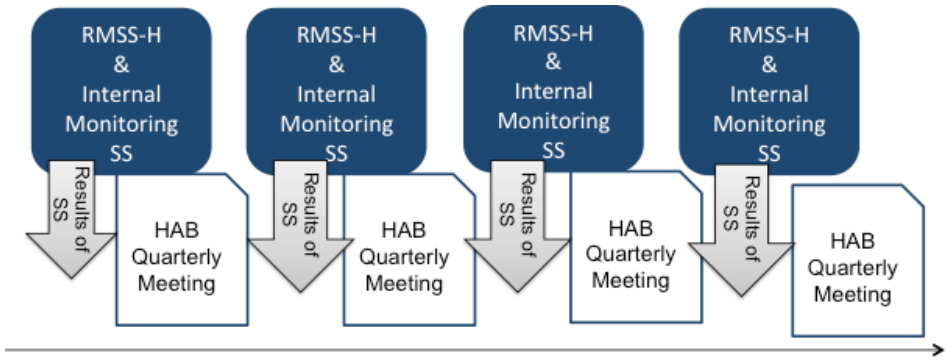


Figure 3-3: Monitoring activities and RRHAB quarterly meeting

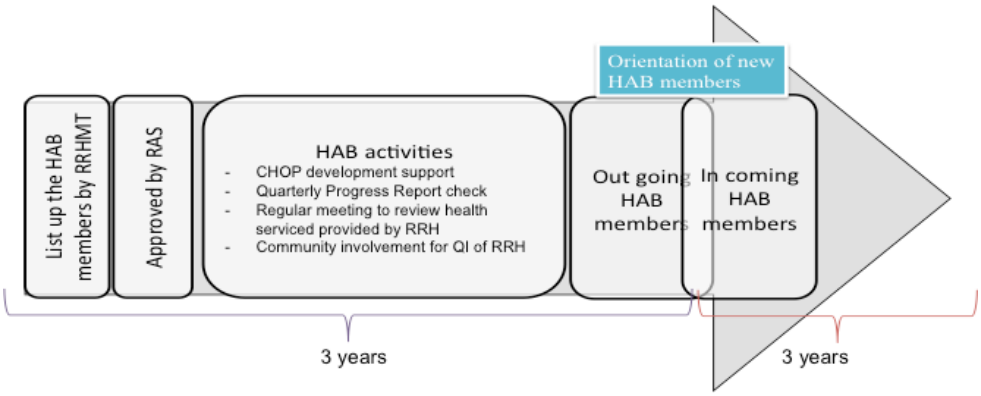
3.10. Succession plan of RRHAB

Based on the regulation of HAB, the office tenure is three (3) years, so selection is conducted where by some of them, members are selected again, and others not. In the light of the above, it is important to have the succession plan and possible succession activities are as follows;

- Develop orientation package for new HAB members
- Orientation program for new HAB members
- HAB succession plan (How to handover the HAB's activities to in coming HAB members)

Note that selection of incoming HAB members should start at least 3 months before the end of the term of the current HAB members

Figure 3-4: Succession plan of RRHAB



References supposed to be with RRHAB

- MoHCDGEC, 2015 Health Sector Strategic Plan IV
- MoHCDGEC 2015, Comprehensive Hospital Operation Plan guideline
- Hospital Performance Assessment Guideline for RRHs
- MoHSW2014 Basic Standards for Health Facilities, Volume 3, Hospitals at Level I and II
- MoHSW, 2014 Functions of Regional Health Management System Second edition
- MoHSW2014 Staffing level for MoHSWdepartments, health service facilities health training institutions and agencies
- MoHSW2005: Guideline for Reforming Hospitals at Regional and Districts Level

APPENDIX

Appendix 1: Summary of staff for Regional Referral Hospital

Sq#	Cadres	Minimum Number	Maximum Number
1	Accounts	1	2
2	Accounts Assistant	2	3
3	Anesthesiologist	1	3
4	Assistant Accountant	1	2
5	Assistant Dental Officer	3	4
6	Assistant Environmental Health Officer	2	4
7	Assistant Laboratory Technologist	6	10
8	Assistant Medical Officer	24	20
9	Assistant Nursing Officer	75	131
10	Assistant pharmaceutical Technologist	5	14
11	Assistant Physiotherapist	2	4
12	Assistant Radiographer	2	3
13	Assistant Supplies Officer	1	2
14	Assistant Technician –civil	1	2
15	Assistant Technician –Electrical	1	2
16	Biomedical Engineer	1	0
17	Biomedical Technician	1	2
18	Cook	2	4
19	Data Clerk	1	2
20	Dental Laboratory technologist	2	4
21	Dental Officer	2	0
22	Dental Surgeon	1	2
23	Dental Therapist	2	4
24	Drivers	8	9
25	Environmental Health Officer	1	1
26	Epidemiologist	1	1
27	Health Laboratory scientist	1	1
28	Health Laboratory Technologist	8	10

29	Health Secretary	1	1
30	ICT Technician	1	2
31	Kitchen Attendant	2	2
32	M&E Specialist	1	1
33	Medical Attendant	98	133
34	Medical Officer	30	32
35	Medical Record Technician	2	4
36	Medical recorder	1	2
37	Mortuary Attendant	2	4
38	Nurse	91	137
39	Nursing Officer	31	39
40	Nutritionist	2	2
41	Obstetrician / Gynecologist	3	1
42	Occupational Therapist	1	1
43	Ophthalmologist	1	1
44	Optometrists	2	3
45	Pediatrician	1	0
46	Personal Secretary	1	2
47	Pharmaceutical Technologist	3	5
48	Pharmacist	1	2
49	Pharmacist	1	4
50	Physiotherapist	1	2
51	Procurement & Supplies Officer	1	1
52	Prosecutor (Mortuary)	1	1
53	Radiographer	1	4
54	Radiologist	1	1
55	Security guard	12	14
56	Social Welfare Officer	6	7
57	Specialist	23	21
58	Technician (Prosthetic)	1	3
	Total Number of staff for RRH	**481**	**678**

Appendix 2: Staffing Level for Regional Referral Hospital

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum number
OUT PATIENT DEPARTMENT				
General Clinics	Specialist	1	12	Average of 500 outpatient per day, Specialists for following specialties: □ 2 Surgery □ 3 Pediatrics □ 3 Gynecology & obstetrics □ 3 Physician □ 1 ENT 5 MO for each specialty (Surgery, Pediatrics, Gynecology & obstetrics, Medical)
	Medical Officer	2	20	
	Nursing Officer	2	2	
	Assistant Nursing Officer	3	24	
	Medical Attendant	2	12	
NHIF Services	Specialist (Physician)	1	1*from General Clinic	Average of 100 Patients per day
	Medical Officer	2	1*from General Clinic	
	Assistant Nursing Officer	1	2	
	Nurse	2	6	
	Medical recorder	1	2	
	Medical Attendant	1	2	
Casualty and Emergency	Specialist - Surgeon	1	1*fromOPD	Average of 100 emergency cases per day and 3 shifts per day
	Medical Officer	2	3*fromOPD	
	Assistant Medical Officer (Anesthesia)	2	3	
	Nursing Officer	1	1	
	Assistant Nursing Officer	3	9	
	Nurse (Anesthetist)	3	12	
	Medical Attendant	4	4	
Surgery Services	Specialist	1	2	
	Medical Officer	2	1	
	Assistant Medical Officer	2	2	
	Nursing Officer	1	1	
	Assistant Nursing Officer	2	2	
	Nurse	2	2	
Internal Medicine	Specialist	2	2	
	Medical Officer	2	2	
	Assistant Medical Officer	2	2	
	Nursing Officer	1	1	
	Assistant Nursing Officer	1	1	
	Nurse	1	1	
	Medical Attendant	1	1	
Orthopedic	Specialist (Orthopedic)	1	1	2 shifts per day

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum
clinic	Medical Officer	1	2	30 patients per day
	Assistant Medical Officer	1	0	
	Assistant Nursing Officer	1	2	
	Nurses	2	4	
	Technician (Prosthetic)	1	3	
	Medical Attendant	3	2	
Obstetrics and Gynecology	Specialist	2	2* from OPD	
	Medical Officer	2	4* from OPD	
	Assistant Medical Officer	1	1	
	Nursing Officer	1	1	
	Assistant Nursing Officer	2	4	
	Nurse	3	3	
	Medical Attendant	1	3	
Physiotherapy	Physiotherapist	1	2	Average of 20 patients/day 2 shifts per day
	Assistant Physiotherapist	2	4	
	Occupational Therapist	1	1	
	Medical Attendant	From OPD	From OPD	
Pediatric	Specialist	2	2	
	Medical Officer	2	2	
	Assistant Medical Officer	1	1	
	Nursing Officer	1	1	
	Assistant Nursing Officer	2	1	
	Nurse	3	1	
Dental clinic	Dental Surgeon	1	2	Average of 30 patients/day 2 shifts per day
	Dental Officer	2	0	
	Assistant Dental Officer	3	4	
	Dental Therapist	2	4	
	Dental Laboratory technologist	2	4	
	Assistant Nursing Officer	1	1	
	Nurses	2	3	
	Medical Attendant	2	2	
CTC Clinic	Medical Officer	1	2*from OPD	Average of 115 patients/day 1 shifts per day
	Assistant Medical Officer	1	2* from OPD	
	Nursing Officer	2	3	
	Assistant Nursing Officer	3	2	

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum
	Nurse	4	4	
	Medical Attendant	4	4	
	Social Welfare Officer	2	2	
	Data Clerk	1	2	
ENT Clinic	Specialist ENT	1	1	Average of 30 patients/day 1 shifts per day
	Medical Officer	1	2	
	Nursing Officer	1	1	
	Assistant Nursing Officer	1	2	
	Nurses	1	3	
	Medical Attendant	1	2	
RCH clinic	Obstetrician/Gynecologist	1	2*from OPD	Average of 65 patients/day 1 shift per day
	Pediatricians	1	2*from OPD	
	Medical Officer	1	2*from OPD	
	Assistant Medical Officer	1	2*from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer (public health)	4	4	
	Nurses	4	6	
	Medical Attendant	1	3	
Elderly/Geriatric services	Medical Officer	1	2	
	Assistant Medical Officer (Psychiatrist)	1	2	
	Pharmacist	1	2	
	Nursing Officer	1	2	
	Social Welfare Officer	1	1	
	Medical Attendant	1	2	
Eye Care Services	Ophthalmologist	1	1	Average of 70 patients/day 1 shifts per day
	Assistant Medical Officer (Ophthalmology)	1	2	
	Assistant Nursing Officer (Ophthalmology)	1	1	
	Optometrists	2	3	
	Medical Attendant	2	2	
Psychiatric clinic	Specialist - Psychiatrists	1	1	Average of 20 patients/day 1 of shifts per day
	Assistant Medical Officer(Psychiatrists)	1	2	
	Nursing Officer	1	1	
	Assistant Nursing Officer(Psychiatrists)	0	3	
	Nurses	0	3	

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum
	Social Welfare Officer	1	2	
	Medical Attendant	2	2	
	Medical Record Technician	2	4	
IN PATIENT SERVICES				
Male Surgical ward	Specialist (Surgeon)	1* from Male ward	3* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	1* from OPD	5* from OPD	
	Assistant Medical Officer	1	1	
	Nursing Officer	1	1	
	Assistant Nursing Officer	4	3	
	Nurses	5	4	
	Medical Attendant	6	6	
Female Surgical ward	Specialist (Surgeon)	1* from OPD	3* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	1* from OPD	5* from OPD	
	Assistant Medical Officer	1	0	
	Nursing Officer	1	1	
	Assistant Nursing Officer	4	3	
	Nurses	5	4	
	Medical Attendant	6	6	
Pediatrics ward	Pediatrician	1* from OPD	3* fromOPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	1* from OPD	5*from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer	2	3	
	Nurses	4	4	
	Medical Attendant	4	4	
Orthopedic Female ward	Specialist (Orthopedic)	1*fromOrthopaedic Clinic	1* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	1*fromOrthopaedic Clinic	2* from OPD	
	Nursing Officer	1*fromOrthopaedic Clinic	1	
	Assistant Nursing Officer	1*fromOrthopaedic Clinic	2	
	Nurses	1*fromOrthopaedic Clinic	5	
	Medical Attendant	1*fromOrthopaedic Clinic	3	
Orthopedic Male ward	Specialist (Orthopedic)	1*fromOrthopaedic Clinic	1* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	1*fromOrthopaedic Clinic	2* from OPD	
	Nursing Officer	1*fromOrthopaedic Clinic	1	
	Assistant Nursing Officer	1*fromOrthopaedic Clinic	2	
	Nurses	1*fromOrthopaedic Clinic	5	
	Medical Attendant	1*fromOrthopaedic Clinic	3	

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum
Obs/Gynecology (Antenatal ward)	Obs/Gynecologist	1	2* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	4	2* from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer	3	5	
	Nurses	3	3	
	Medical Attendant	3	3	
Labor ward	Obstetrics & Gynecology	1* from ANT ward	2* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	1* from ANT ward	4*from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer	4	4	
	Nurses	8	8	
	Medical Attendant	4	4	
Obs/Gynecology (Postnatal ward)	Obstetrician Gynecologist	1	2* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 16 patients/day 3 shifts/day
	Medical Officer	4*from ANT ward	2* from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer	3	3	
	Nurses	2	2	
	Medical Attendant	3	3	
Obs/Gynecology (Neonatal ward)	Obstetrician / Gynecologist	1* from OPD	1	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	1*fromANT ward	2* fromOPD	
	Assistant Medical Officer	2	0	
	Nursing Officer	2	1	
	Assistant Nursing Officer	4	8	
	Nurses	3	8	
	Medical Attendant	3	8	
Male medical ward	Specialist (Physician)	1* from OPD	4* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 20 patients/day 3 shifts/day
	Medical Officer	4	6*from OPD	
	Assistant Medical Officer	1* from OPD	0	
	Nursing Officer	1	1	
	Assistant Nursing Officer	1	3	
	Nurses	4	5	
	Medical Attendant	4	3	
Female medical ward	Specialist (Physician)	4	4* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 16 patients/day 3 shifts/day
	Medical Officer	1* from OPD	6* from OPD	
	Assistant Medical Officer	1* from OPD	0	
	Nursing Officer	1	1	

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum
	Assistant Nursing Officer	5	3	
	Medical Attendant	4	3	
Psychiatric male ward	Specialist (Psychiatrists)	1	1* from OPD	NO/ANO/Nurse to patient ratio 1:1 Average of 5 patients/day 3 shifts/day
	Assistant Medical Officer (Psychiatrists)	2	3* from OPD	
	Nursing Officer	1	2	
	Assistant Nursing Officer	4	7	
	Nurses	6	6	
	Social Welfare Officer	1	1	
	Medical Attendant	2	3	
Psychiatric Female ward	Specialist (Psychiatrists)	1	1* from OPD	NO/ANO/Nurse to patient ratio 1:1 Average of 5 patients/day 3 shifts/day
	Assistant Medical Officer (Psychiatrists)	2	3* from OPD	
	Nursing Officer	1	2	
	Assistant Nursing Officer	4	7	
	Nurses	6	6	
	Social Welfare Officer	1	1	
	Medical Attendant	2	3	
TB Male ward	Specialist (Physician)	1	1* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 16 patients/day 3 shifts/day
	Medical Officer	1* from OPD	2* from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer	1	2	
	Nurses	2	3	
	Medical Attendant	6	8	
TB Female ward	Specialist (Physician)	1	1* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 16 patients/day 3 shifts/day
	Medical Officer	1* from OPD	2* from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer	1	2	
	Nurses	2	3	
	Medical Attendant	6	8	
Grade I ward	Specialist (Physician)	1* from OPD	1* from OPD	NO/ANO/Nurse to patient ratio 1:8 Average of 16 patients/day 3 shifts/day
	Medical Officer	1* from OPD	2* from OPD	
	Nursing Officer	1	1	
	Assistant Nursing Officer	2	2	
	Nurses	3	3	
	Medical Attendant	4	4	

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum
Theatre	Specialist (Surgeon)	1	3* from OPD	
	Medical Officer	1	4* from OPD	
	Anesthesiologist	1	3	
	Assistant Medical Officer (anesthetist)	1	4	
	Nursing Officer (Theatre N)	1	4	
	Assistant Nursing Officer	4	7	
	Nurses	4	7	
	Medical Attendant	3	4	
ICU	Specialist	1	1* from OPD	NO/ANO/Nurse to patient ratio 1:1 Average of 3 patients/day 3 shifts/day
	Medical Officer	1	2* from OPD	
	Assistant Medical Officer	1	0	
	Nursing Officer	1	1	
	Assistant Nursing Officer	3	4	
	Nurses	4	9	
	Medical Attendant	4	4	
Central sterilization	Assistant Nursing Officer	1	3	Average of 120 trays per day
	Nurses	3	4	
	Medical Attendant	3	4	
Laboratory	Health Laboratory scientist	1	1	Average of 148 specimen per day
	Health Laboratory Technologist	8	10	
	Assistant Laboratory Technologist	6	10	
	Medical Attendant	3	5	
Mortuary	Medical Officer (Pathology)	1* from OPD	1* from OPD	Average of 8 bodies per day 2 shifts per day
	Prosecutor (Mortuary)	1	1	
	Mortuary Attendant	2	4	
X- Ray	Radiologist	1	1	Average of 42 x-rays per day Average of 25 ultra sounds
	Radiographer	1	4	
	Assistant Radiographer	2	3	
	Medical Attendant	1	1	
Pharmacy	Pharmacist	1	4	Four Pharmacist 2 Dispensing 1 Storage 1 ARV 14 Assistant Pharmaceutical Technologist
	Pharmaceutical Technologist	3	5	

Function	Cadre	Minimum number	Maximum number	Criteria for Maximum
	Assistant pharmaceutical Technologist	5	14	8 for dispensing 2 for infusion 1for compounding 3 ARV Average of 223 prescription per day
	Medical Attendant	2	2	
Procurement	Procurement & Supplies Officer	1	1	
	Assistant Supplies Officer	1	2	
Maintenance	Biomedical Engineer	1	0	
	Biomedical Technician	1	2	
	Assistant Technician –Electrical	1	2	
	Assistant Technician –civil	1	2	
Transport	Drivers	8	9	
Catering	Nutritionist	2	2	
	Cook	2	4	
	Kitchen Attendant	2	2	
Environmental Health &, food Safety and Sanitation	Environmental Health Officer	1	1	
	Assistant Environmental Health Officer	2	4	
Epidemiology & M&E	Epidemiologist	1	1	
	M&E Specialist	1	1	
ICT	ICT Technician	1	2	
Administration	Medical Officer in charge	1	1	
	Nursing Officer (matron)	1	1	
	Health Secretary	1	1	
	Personal Secretary	1	2	
	Accounts	1	2	
	Assistant Accountant	1	2	
	Accounts Assistant	2	3	
	Security guard	12	14	
Total		**481**	**678**	

Appendix 3: Report format for Summary of Quarterly Financial position

Sources of Funds	Opening Balance	Approved Budget per quarter	Received this quarter	Total funds available	Expenditure this quarter	Closing balance end of quarter
Block Grants(PE)						
Block Grants (OC)						
Cost sharing (CS)						
Drug Revolving Fund(DRF)						
Student Fees (Placement Fees)						
Mortuary Fees						
On Call Allowances						
NHIF Medicine Shop						
MSD						
Receipt in Kind						
EGPAF						
Total						

Appendix 4: Report Format for Summary of Quarterly Technical Progressive

Department	Activity No.	Planned activities	Status of implementation based on M & E reports	Achievements in %	Comments
Medical	1.		.		
	2.				
	3.				
Administration	1.				

	2.	.			
	3.	.			
	4.				
	5.				
Obstetrics & Gynecology	1.				
	2.				.
	3.				
Surgical	1.				
	2.				.
	3.				
Pediatrics	1.				.
	2.				
	3.				

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