Project Planning Workshop
Proceedings

Compiled by: Naoki Take, JICA Consultant/Facilitator of the Workshop

1. Introductory Presentation

The planning workshop for the Project on Improvement of Health Services through Health Infrastructure Management (the workshop) was opened at 09:50.

In commencing the workshop, the leader of detailed planning survey team of Japan International Cooperation Agency (JICA) described a project in the context of health systems and emphasised ownership of the project and sustainability of the outcome.

Subsequently, the technical advisor summarised achievements and challenges of the previous project and points to be pondered for the planning, including communication between users and technicians, evidence-based management for medical equipment with use of quarterly reporting system.

2. General Instruction

The facilitator of the workshop instructed the goal, contents of works, methodology and material used for the workshop, principles and rules and the timetable.

3. Process of the Workshop

The workshop consisted of the three sessions:

Session 1: goal identification

Session 2: problem analysis

Session 3: formulation of action plans.

Session 1 was implemented jointly, while two groups were formed to analyse problems and formulate action plans for 5S-TQM (quality of care) and medical equipment respectively.

4. Results of the Workshop

(1) Session 1: Goal Identification (10:30-11:15, 11:40-12:00)

All participants were jointly involved in identifying the outcome of the Project and brainstorming on indicators to assess the outcome.

1) Expected Outcomes

All participants agreed on the following outcome of the Project:

- Improved delivery of quality healthcare services

And that the above outcome would be achieved by the following:

- Better working environment through 5S-TQM;
- Reduce breakdown of medical equipment through user trainings; and
- Better maintenance of medical equipment through better health infrastructure management.

2) Indicators

The participants expressed the following ideas on the indicators to assess the outcome. They will be used for further discussion between MOH and JICA.

[Quality of clinical services]

- Reduced mortality rate
- Reduced sepsis
- Number of clients seeking healthcare and treatment
- Enhanced problem-oriented planning and delivered quality healthcare
- Number of exams
- Percentage of health facilities delivering services according to the standards
- Increased client turn up
- Number of clients/patients receiving services
- Organised working environment
- Better organised hospitals
- Improved user care knowledge
- Number of cases of cross infection after receiving healthcare
- Reduced errors of treatment

[Patient satisfaction]

- Increased patient satisfaction
- Number of patients satisfied with received healthcare

[5S-TQM]

- Health environment remains clean
- Clean environment

[Equipment]

- Reduced breakdown of medical equipment
- Equipment down time
- Improved inventory taking
- Reduce breakdown of medical equipment due to misuse
- Number of medical equipment functional
- Strengthened capacity of regional workshop to carry out proper maintenance and to provide advice
- Number of CME conducted on user trainings

[Others]

- Level of employee satisfaction
- 5S and ME maintenance improvement team within hospitals and regions organised / set up / continue

activities

- Sustainable mechanism of 5S and ME maintenance has been developed integrated into MOH policy and strategy
- A lot of drugs in stores

(2) Session 2: Problem Analysis (12:00-13:20, 14:00-14:30)

The participants were divided into two groups for problem analysis and formulation of action plans in terms of 5S-TQM and medical equipment. Each group selected a chairperson and a secretary for their works and appointed a presenter to present the results.

1) 5S-TQM

[Core Problem]

- High morbidity and mortality from hospitals, due to "poor quality of health service delivery" and "poor quality of healthcare services"

[Direct Causes]

a. Poor referral system, caused by:

- Poor management of fuel
- Lack of training in HIM, resulting from "lack of CME"

b. Inadequate use of standard operations procedures (SOPs)/standards, caused by:

- Lack of standards of management
- Standards not disseminated

c. Error of treatment, caused by:

- Disorganised working environment

d. Bad management of medical consumables, caused by:

- Lack of knowledge and skills in stock management
- Lack of storage space

e. Long waiting time in health facility, caused by:

- Health workers do not keep time (poor time management), due to "Health workers do not have good motivation for their work", "no accommodation for health workers" and "poor supervision"
- Low workforce
- Bad patient flow

f. Negative attitude in staff, caused by:

- Work overload

2) Medical Equipment

[Core Problem]

- Improper functioning of medical equipment (ME)

[Direct Causes]

a. Delay in repair of equipment, caused by:

- Aged mobile workshop vehicle
- Much workload on Regional Workshops (RWs)
- Limited knowledge and technicians skills to maintain/repair, because of "disorganized RWs stores"
- Lack of essential tools in the maintenance workshop
- Lack of spares, because of "high cost of spares" and "limited availabilities of spare parts"
- Poor communication between users and maintenance department, because of "Committee in the hospital to handle the issue is not organised" and "responsible person for user training in the hospital is not assigned"

b. Limited capacity to prepare adequate maintenance planning, caused by:

- Lack of up-to-date inventory data for proper planning for equipment maintenance budgeting

c. Breakdown of ME, caused by:

- Users lack basic knowledge and skills how to use equipment: that is, Healthcare providers are using equipment without enough user training
- Aged equipment
- Poor quality equipment and spare parts
- Poor attitude of users in the handling of medical equipment

Additionally, the group discussed the following issues:

- A lot of equipment is not utilised.
- Storage facilities are either lacking or poor.

(3) Session 3: Formulation of Action Plans (14:30-17:10)

Based upon the problem analysis, two groups formulated action plans to overcome the problems including activities, implementers and inputs.

1) 5S-TQM

Dividing the output of 5S-TQM into six, the group discussed the action plans.

Output 1: Reduced waiting time

Activities	Implementers	Inputs
1. Put in place signboards and sign posts; and flow charts	Health Administrator (HA)	Laminator, stationery, sign posts, human resource (HR)
2. Timely declaration of vacant posts	Personnel Officer (PO)	Existing HR
3. Institutionalise the use of attendance registers	PO	Existing HR, registers and pens
4. Provide supervision guidelines and tools	Medical Superintendent (MS) / MOH	Fuel, transport, allowances, guidelines
5. Carry out support supervision	MS/All Unit Managers	Checklists, HR
6. Prioritise accommodation of clinical staff in or near the hospital	HA	Stationery, refreshment
7. Establish and implement reward system	MS	Funds, HR, stationery, prizes

Output 2: Improved client/provider interaction

Activities	Implementers	Inputs
1. Training in communication skills	PO	Training materials, trainers
2. Hold staff meetings	MS	Venue, HR, stationery
3. Sensitise political leaders and other stakeholders on their roles and responsibilities	MS	Training materials, trainers
4. Train staff in 5S-TQM	Focal person (FP) 5S-TQM	Training materials, trainers

Output 3: Improved management of medical consumables and space

Activities	Implementers	Inputs
1. Training in 5S for all staff	FP 5S-TQM	Training materials, stationery, projector, manuals, camera, venue, guidelines, allowances, meals, facilitators
2. Implement of 5S	All staff	Camera, checklists, relevant materials (e.g. shelves, cabinets, files, stationery), funds, 5S awards
3. Supervision and monitoring of 5S implementation	JICA, MOH FP 5S-TQM at facility level	Fuel, checklists, supervisors, allowances, vehicles, stationery

Output 4: Reduced medical errors and wastage

Activities	Implementers	Inputs
1. Continue medical professional development	PO	Stationery, venue, projector, facilitator
2. Disseminate standards and guidelines	MS	Transport, fuel, allowances, personnel
3. Operationalise libraries	PO	Space, books, shelves, librarian
4. Conduct medical audits	In-charge (I/C)	Stationery, personnel

Output 5: Timely referral of patients

Activities	Implementers	Inputs
1. Maintenance and repair of ambulances	HA	Funds, provision of service
2. Provide fuel for ambulance	HA	Fuel
3. Establish referral guidelines	MS I/C	Stationery, human resource, referral forms

Output 6: Roll out 5S-TQM in 7 regions in Uganda

Activities	Implementers	Inputs
1. Establish coordination structures	CHS QA	Stationery, refreshment, venue
2. Develop national guidelines for implementation of 5S-TQM	JICA CHS QA	HR, consultant, technical advisor, stationery, fees, literature
3. Identify show case hospitals in 7 regions	JICA CHS QA, CS	HR, transport, fuel, allowance, camera, stationery
4. Conduct TOT for national and regional trainers	National FP 5S-TQM	Training materials, venue, trainers
5. Sensitisation of key stakeholders at national and regional level	National FP 5S-TQM	Training materials, venue, trainers
6. Develop and cost work plan	JICA MOH: QA, CS, Planning	Venue, stationery, refreshment
7. Develop M&E framework	QA, Planning	HR, stationery, allowance
8. Develop training manuals	JICA CS, QA, Nursing	HR, stationery, allowance
9. Implement 5S	Target hospitals	Camera, stationery, medical consumables relevant for 5S-TQM implementation, checklists, HR, transport, fuel

2) Medical Equipment

Dividing the output of medical equipment into four, the group discussed the action plans.

Output 1: Medical equipment periodically maintained, repaired and utilised.

Activities	Implementers	Inputs
1. Procure spare parts of consumables	MoH, Regional workshops and hospital technicians	Human resource, tools and equipment financier, spares
2. Carry out routine maintenance		
3. Lobby for additional funds		
4. Train technician/Engineer in biomedical engineering		
5. Train hospital based technicians		
6. Procure regional workshop tools and mobile workshop vehicles		
7. Implement 5S for regional workshop stores management		
8. Equip hospital based technicians with basic tools		

Output 2: Trained users of equipment

Activities	Implementers	Inputs
1. Carry out training needs assessment	MoH, hospitals, regional workshops	Financier, human resource, equipment, training manuals
2. Select trainees		
3. Conduct ToT for user trainers		
4. Carry out training of equipment users		
5. Carry out support supervision and monitoring		
6. Review and update of training of manuals		

Output 3: Effective communication strengthened between equipment users and maintenance teams

Activities	Implementers	Inputs
1. Develop medical equipment maintenance guide/manuals	MoH, hospitals and regional workshops	Human resource, financier, TA
2. Establish medical equipment committee in hospitals		
3. Disseminate maintenance guide/manual to stakeholders		
4. Strengthen regional workshop committee meetings		
5. Carry out support supervision and monitoring of use of maintenance guide/manuals		

Output 4: Enhanced problem oriented planning for medical equipment maintenance

Activities	Implementers	Inputs
1. Carry out and update medical equipment inventory	Regional workshops, hospitals	Human resource, financier, computer equipment and software
2. Analyse medical equipment inventory data		
3. Prepare work plans and budgets for the regional workshops		
4. Train hospitals technicians and regional workshops to collect and analyse inventory data		

5. Closing Remarks by CHS

In closing the workshop, the Commissioner of Clinical Service Department gave the following remarks:

- It is critical for us to realise changes through the implementation of the 4-year Project, in order not to waste precious resources.
- In spite of constraints of funds, it is requested to do what should be done for improvement of services.
- For quality services, change of attitude of health workers and interaction of doctors and nurses is requisite. Improvement of the quality will result in increase of confidence and satisfaction of clients/patients. Quality services can ensure the funds.

The workshop was closed at 17:30.

6. Way Forward

Based upon the outputs of the workshop, further discussion will be done between MOH and JICA for detailed design of the Project and its compilation in the Project Design Matrix (PDM).

Project on Improvement of Health Services through Health Infrastructure Management
Programme of Planning Workshop

Date: 2nd September 2010
Venue: Fairway Hotel, Kampala
Participants: See the next page (p. 10)
Goal: To formulate the Project with collaboration between Ugandan and Japanese stakeholders

Process of Workshop:

Session 1: To agree upon the goal of the Project (Project Purpose and Overall Goal)

1) To agree upon the description of Project Purpose and Overall Goal on Project Design Matrix (PDM)
2) To identify indicators to evaluate the Project Purpose and Overall Goal

Session 2: To analyse problems on "quality of services" and "health infrastructure management"

Session 3: Based on the above problem analysis,

1) To formulate the action plan to sort out the problems
2) To identify indicators to evaluate the Outputs of the Project

Timetable:

9:00-9:30	Registration
9:30-9:40	Welcoming remarks (MOH/JICA)
9:40-10:00	General Instruction of workshop methodology (JICA Consultant)
10:00-11:00	Session 1: Goal of the Project
11:00-11:20	Tea break
11:20-13:00	Session 2: Problem Analysis
13:00-14:00	Lunch break
14:00-16:30	Session 3: Project Formulation
16:30	Closing (MOH)

Participants of the Project Cycle Management Workshop

	Name	Title	Organisation
MOH			
1	Dr.Amandua Jacinto	Comissioner	Department of Clinical Services, MoH
2	Dr.Amone Jackson	Assistant Commissioner	Department of Clinical Services, MoH
3	Dr.Opar B Toliva	Principal Medical Officer	Department of Clinical Services, MoH
4	Dr. Sarah Byakika	Assistant Commissioner	Department of Quality Assurance, MoH
5	Mr. A. Klalimbwa	Senior Health Planner	Department of Planning, MoH
6	Ms.Betrice Alupo	Principal Nursing Officer	Department of Nursing, MoH
7	Ms.Maikut Irene	Principal Nursing Officer	Department of Clinical Services, MoH
8	Eng.Kannyana Stephen	Principal Engineer	Health Infrastructure Division (HID), MoH
9	Eng.Sitra Mulepo	Senior Engeneer	HID, MoH
10	Mr.John Kateera	Assistant Engeneer	HID, MoH
11	Mr. Fred Tibayungwa	Assistant Engeneer	HID, MoH
Hospitals			
1	Dr.Obonyo John Hyacinth	Medical Superintendent	Tororo General Hospital
2	Ms.Dorothy Ajiambo	Clinical officer, 5S manager	Tororo General Hospital
3	Dr. Lule Haruna	Medical Superintendent	Gombe General Hospital
4	Ms.Asege Janice Jesca	Nursing Officer, 5S coordinator	Mbale Regional Referral Hospital
5	Mr.Kaggwa Prosper	Engeneer/Workshop Manager	Mbale Regional Workshop
6	Mr. Sekayita Stephen	Engeneer/Workshop Manager	Hoima Regional Workshop
7	Ms.Anne Olaro	National User-training Coordinator	Masaka Regional Referral Hospital
Civil Society			
1	Mr.Festus Kahiiguwa	Programme Administrator	CCfA
JOCVs			
1	Ms.Eri Kobayashi	Public Health Nurse, JOCV	Tororo General Hospital
2	Mr.Kenichi Fujikawa	Public Health Nurse, JOCV	Gombe General Hospital
3	Ms. Ribeka Shima	HIV/AIDS Prevention, JOCV	Busolwe General Hospital
4	Ms.Satsuki Fukai	JOCV	CCfA
JICA			
1	Mr.Watanabe	Leader of the preparatory study team	JICA HQ
2	Ms.Sonoko Takahashi	Member of the preparatory study team	JICA HQ
3	Dr.Takuji Date	Menber of the preparatory study team	College of Healthcare Management
4	Mr.Naoki Take	Consultant, Facilitator of the Workshop	KMC Inc.
5	Mr.Shintaro Takano	Representative	JICA Uganda
6	Ms.Kie Kanda	Technical Advisor	MoH/JICA
7	Ms.Asiimwe Clare	Consultant	JICA Uganda

３．主要面談録

面談先	トロロ県病院（Tororo General Hospital）
日時	2010 年 8 月 24 日、14 時 00 分～17 時 00 分
参加者 (敬称略・順不同)	Dr. John Obonyo, Medical Superintendent Mr. Amos Oboke, Senior Health Administrator Ms. Agnes K. Onyango, Principal Nursing Officer Ms. Dorothy Ajiambo, Clinical Officer (5S Programme Manager) 小林　絵梨　協力隊員（保健師） 調査者：竹　直樹

5S に関しては、Ms. Dorothy Ajiambo が Report を作成してくれていたので、詳細は次ページ以降を参照（“Report on 5S-KAIZEN-TQM Programme in Tororo General Hospital”）。調査者の関心を引く点は、以下。

- 5S は臨床指標にインパクトを与える。（「他の要因も考慮すべきでは？」との当方の指摘に対しては）今後考慮に入れて分析をする必要があると思う。
- （Infection Control 担当が 5S トレーニングを受けたことで、それについての指標について尋ねてみたところ）それも今後インパクトを測るよう検討したい。
- 機材の故障は、ユーザーの知識不足によるところが大きい（→ユーザートレーニングに対するニーズは非常に高い）。ユーザートレーニングは、地域医療機材維持管理ワークショップ（Regional Medical Equipment Maintenance Workshop：RWS）が担当するのがよい。
- 5S 推進に必要な資材の調達に問題あり。時間がかかりすぎ（→しかし、調達は病院ではできず、DHT が行うため、リスク要因のひとつ）。

また、医療機材については、

- RWS のスキルがどの程度 JICA プロジェクトで向上したかはよくわからない。日本の無償により更新されたことで多くの機材はまだ故障を経験していない（→ちなみに、インベントリーは更新されていないように思われる）。RWS は定期点検やそこで発見された問題には対応できるが、緊急対応ができない。
- 病院に、医療機材に 24 時間対応ができる体制があるとよい。しかし、人材の確保が難しい。
- （RWS に予算がついたことについては）大きな改善と考える。

REPORT ON 5S-kaizen-TQM PROGRAMME IN TORORO GENETAL HOSPITAL

5S programme is a gate way to improve quality of care in our health facility of Tororo General Hospital.

Background of 5S programme in Tororo General Hospital

5S programme was first introduced in August 2007 to all staff present by then through a sensitization training given by the team that went to Japan and Sri Lanka (M/S, S.H.A and PNO)

The main concern of this programme is to improve quality of care to patients/our customers through providing safe, efficacious and quality care characterized by patient and health worker satisfaction.

After health education and knowledge added to the basic training get before we were challenged to

1. Have a big positive attitude towards our work, customers and fellow workers.
2. Build a positive self esteem.
3. Not to give up despite obstacles.
4. Have involvement by the whole workforce/staff.
5. Have continued commitment and dedication.
6. Have team work in all units.
7. Take our response to one another to situations and to our customers as a fundamental for quality care.

What helped us reach and where we are in implementing 5S programme

1. Committed and supportive hospital administrators.
2. Involvement of everyone/staffs' participation.
3. Formation of WIT with leader chosen by the unit staff.
4. Regular weekly (WITs) and monthly meeting (QIT committee)
5. Reorientation training given to staff on 5S. Eg; on 9/12/2009, 92 staff had such training and on 17/3/2010, 54 staff had similar training, then on 30/3/2010 basis on 5S was given on 5S-kaizen day launching, then 21 were trained on 10/6/2010.
6. Continued monitoring and evaluation by the steering committee (QIT).
7. Prize award to be competed for.
8. 4 units (Records, Male ward, Female ward 2 and Pharmac) identified as show case in hospital for other units to learn from.
9. Support form JICA with funds that enable the facility to have facilitation of trainings, drip stands, pallets, sign boards, notice boards, infection control/prevention buckets, all furniture for quality improvement office, seats with backrest for patients, signs and symbols in corridors. JICA volunteer Eri has physically been in involved in implementing 5S programme especially more so in sorting and setting including labeling.

10. Visitation by JICA official and MOH official with their continued evaluation and coaching to staff on how to do the sorting and setting. Eg; On 3/2/2010 during monitoring and evaluation way forward from wrap up has caused much improvement.
11. Visitors by staff from different hospitals have highly motivated the steering committee and other staff to continue with 5S programme as feedback of finding has been so useful to cause improvement.

Achievements

1. A QIT consisting of facility management, unit managers, WIT leaders in place since Dec 2009. The number is 31 persons.
2. High patients turn up since introduction of 5S-TQM programmes.

	2007	2008	2009
OPD new patients	32264	36186	39011
Bed occupancy	78.2%	91%	83%
Maternal death	8	6	4

3. 5S-CQI concept has been scaled up to all units of hospital to add on the 4 targeted areas of 2007.
4. Working environment has improved in cleanliness.
5. Creation of space for operation by staff in all units through sorting.
6. Motivated staff in performance due to awards given.
7. More than 90% of staff have been trained on 5S concept. Manager 5S programme and Eri have been trained as TOT on kaizen in Tanzania. M/S had training on kaizen-TQM in Japan and Sri Lanka. Alayo Hellen, Connie Bwire and Kassajja Charles had TOT training in Tororo.
8. Improved team work strengthened through regular meetings.
9. Enough drip stands in place.
10. Patients now are guided well by signs and symbols in corridors.
11. Comfort to patients as they sit to wait for service instead of standing.
12. Improved record management.
13. Improved staff to staff relationships.
14. Creation of friendship with staff from other hospitals in the country through their visitation to the facility.
15. Established 5S office.
16. Increased segregation of wastes.
17. Improved interaction between administration and hospital staff.

18. Increased competition in performance due to prize awards.
19. Staffs and units have been awarded due to good performance.
20. Customers have access to information displayed on the notice boards improvised outsides the units.
21. Danger to the community through mixture of wastes at the find disposal has been minimized.
22. Waste disposal strategy is maintained in all units.
23. Regular meetings with minutes as indicator are carried out.
24. Now 6 facilitators for the units are available who include M/S, SHA, manager 5S programme, in charge of infection control and in charge of records.

General challenges during the implementation so far

1. Negative attitude from some staff who feel and express interference with their environments by telling them to sort and set and those who express that there is much money given to do all the sorting and setting which money is eaten by committee yet trying to involve them to work for what they are not paid for. Others express it is additional work.
2. Patient flow still challenge because of long waiting time patient takes to be seen by clinician due to the increase in patient turn up with same number of staff in Lab, Pharmacy and clinicians.
3. Lack of enough seats for patients more so at the Lab and ART clinic.
4. Shortage of cleaning material due to lack of a central storage for materials still messes up the environment.
5. System of tender awards to contractor for cleaning service still hampers the 3S.
6. Some units still lack notice boards and drug cupboards plus drug trolleys and tray.
7. Units with no machintosh to cover mattress makes the shining not to be visible.
8. Disposal of unwanted medical tools and expired chemicals takes long. Procedure involves outsiders that do not see the urgency.
9. Double labeling on casualty department as Grade A&B (paying unit) and casualty over shadows the visibility of 5S in Grade A&B.
10. Cleaners report off duty very early.
11. Knowledge on how to use medical equipment is little amongst staff.
12. Wastage of electricity due to failure to switch off light.

Solution to challenges

1. Budget for 5S activities in Tororo General Hospital has been included in general budget / PHC budget.
2. Continued reorientation trainings.

3. The tender awards for cleaning service needs to be revisited by CAO.
4. Equipment user training workshops to be given to staff.
5. 5S activities have been integrated with other activities aimed at quality improvement.
6. 5S concept to be scaled up to lower units.
7. Provide hangers for nurses' clothes in the nurses' changing room.
8. The hospital administrator and CAO's office to ensure availability of detergents all the time.
9. Staff to be responsible and use resources well.
10. Grade A & B be allocated another place.
11. Administration to help ensure disposal of all expiry drugs/chemical and medical tool not in use through procurement units.
12. The room is to be allocated for cleaning materials in each unit.
13. A store assistant controlled by senior A/C officer be availed to hospital daily for supplies and sundries.
14. Person to take charge in equipment maintenance and users be trained on equipment maintenance.
15. Outreach to lower units starting with H/C 4.
16. Procedures / protocols be put in place to reduce on wastage. Eg; drugs getting expired and electricity not being switched off.
17. Every unit to develop check list for daily monitoring of the implementation of 5S at unit level.
18. QIT to develop a vision and mission for the hospital and get committed to achieve them.
19. Regular monitoring and evaluation by QIT.
20. Display of progress in implementation of 5S-CQI-TQM for the whole hospital at 5S corner and their progress be given to MOH.

By Dorothy Ajiambo, Manager of 5S programme,Tororo General Hospital 23/08/2010

面談先	ムバレ地域中核病院［Mbale Regional Referral Hospital (RRH)］
日時	2010 年 8 月 25 日、9 時 00 分～11 時 30 分
参加者 (敬称略・順不同)	Sr. Jesca Janice Asege, Senior Nursing Officer (5S Coordinator) Sr. Anne Marie Atayo, Nursing Officer (Regional User Trainer) 藤川　兼一　協力隊員（医療機器） 調査者：竹　直樹

5S について（Sr. Jesca）

- 5S 活動の本格的な開始は 2010 年 4 月から。
- 5S 実施体制：5S Manager が最高責任者で、その下に Deputy Manager と Secretary も配置。実施の全体的なコーディネーションを行うのが 5S Coordinator。この 4 名を含め、各科の長である計 18 名が Area Managers。ここまでが 5S Committee を組織し、毎月 1 度の会合を行う。Area Managers の指揮の下で、各 Ward にリーダーが任命されている。
- 各 Ward には Suggestion Box が設置され、そこに投函された意見は 5S Committee の議題の 1 つとなっている。
- 毎週月曜日の 1 時間を「5S hour」と称し、整理・整頓・清掃の時間に充てている。
- 病院全体で施設改修が実施されていることが、5S 実施を遅らせているという点はある。
- （5S の診療活動へのインパクトについては）医薬品・物品・機材の所在を見ればわかるような状態にしておくことで、医薬品を必要以上に使用期限切れにしてしまうとか、ストックアウトという事態は減ると思われる。また、このことが医療ミスの減少や患者満足度の向上につながっていくことが期待される。
- （5S 推進の今後の課題 1）一部スタッフの態度→最も難しい問題。変容に向けて粘り強く取り組むしかない。
- （5S 推進の今後の課題 2）スタッフのモチベーション→2010 年の末までには、Supportive supervision や Awarding の立ち上げを考えたい。
- （5S 推進の今後の課題 その他）活動の持続性；PC 不足；オフィススペース

調査者の印象：全体的に「整理・整頓のレベルでも 5S は始まったばかり」という印象。ほとんどのスタッフは今年（2010 年）トレーニングを受けており、5S コンセプトの浸透も十分でない。

ユーザートレーニングについて（Sr. Atayo）

- 1996 年に Mbale 地域のユーザートレーナーとして任命され、1996/97 年度の 4 カ月間デンマークで医療機材の研修に参加。その後、活動開始。Regional Workshop とともに、ユーザートレーニングと Supportive Supervision を実施。しかし 2005 年、支援の停止に伴い活動は停滞、というかほぼ停止。
- （ユーザートレーニングのニーズについて）総論としてはもちろん必要。ムバレ RRH に限っては、無償で入った機材については業者のトレーニングがあったので、大きな問題はない。ただし、滅菌器は使いすぎ。
- （ユーザートレーナーが Nursing Officer だったことで、本来業務との兼ね合いでトレーニン

グが難しかったことはなかったか、の問いに対しては）幸い、自分は院長（Medical Superintendent: M/S）からトレーニング実施のため外を回る許可をもらっていたので、問題は少なかった。しかし、トレーニングを実施することで、そのための手当が出ることはなかった。

- （誰がユーザートレーニングを実施するのが適切か、の問いに対して）Regional Workshop がよい。必要があれば自分もサポートを行うが、機材の知識は Workshop のほうがある。

医療機材について（藤川隊員）

- 前任の隊員の努力もあって、RRH に Engineering Department が設置されている。スタッフは自分も入れて 4 名（Electrician と Carpenter と Plumber）。Department には予算も配分されている。
- RRH では、問題のある機材に対して 4 色のタグを貼りつけて、対応を行っている：緑…RRH で対応可能、黄…RWS に対応を依頼、赤…故障して使える状態にならないが、一部の部品は他の機材のスペアパーツとして使えるので、それらをキープするもの、黒…使える部分がまったくないため、廃棄。
- RWS とともにカバーエリアの病院を訪問する機会があったときには、配置されている Electrician（各病院に少なくとも 1 人はいる模様）をトレーニングして、最低限の対処をできるようにすることを計画している。
- また、病院を訪問する際に、なされていないインベントリーの更新を行っていきたい。

面談先	ムバレ RWS
日時	2010 年 8 月 25 日、11 時 30 分～12 時 00 分
参加者 (敬称略・順不同)	Eng. Prosper Kaggwa, Workshop Manager Mr. Mohammed Abdallah, Engineering Technician Mr. Absolom Emudu, Technician Mr. Lawrence Oriebo, Technician (Volunteer) Ms. Malisa Arot, Volunteer 藤川　兼　協力隊員（医療機器） 調査者：竹　直樹

Eng. Kaggwa が作成した Report（“Problems and challenges associated with medical equipment maintenance in the Region”）も参照されたい。

【人材】

- （“sophisticated equipment”とは？）ECG、放射線、モニター等のこと。
- （RWS の人材配置基準はあるのか？）Engineer、Technician、Artisan 各 2 名だったと記憶している（→調査者からは「短期的にはそのような人材が満たされるのは難しい」との見解を示す）。

- （ユーザートレーニングについて）絶対に必要。
- （トレーニングすべき機材は？）保育器、ラボの滅菌器、モニター、酸素濃縮器（→マラウイでニーズの高かった吸引器については、「とくに問題はみられない」とのこと）。
- （誰がユーザートレーナーになるべきか？）機材によるのではないか。自分たちで対応可能な機材も多いが、（上述のような sophisticated equipment については）業者でないとできない。

【予算】
- 予算が配分されたのは大きな改善。しかし、RWS 一律に予算が配分されるのは不適切。この RWS はカバーすべき病院がほかに比べて多く、配分される額（年間で 1 億 2,500 万 UGX）では到底まかなえない。
- 会計年度の第 1 四半期（7～9 月）には予算が十分に配分されず、活動が滞る。他の四半期については問題ない。

【5S の医療機材への貢献】
- ユーザーによって、医療機材へのケアが改善することを期待している。

【インベントリーの更新】
- 病院を訪問する際に、地道にやっていきたいと考えている。

面談先	World Bank
日時	27 August, 2010
参加者 (敬称略・順不同)	Dr. Peter Okwero, Senior Health Specialist Interviewers: Ms. C. Asiimwe and Mr. N. Take

Dr. Peter Okwero was briefed by the JICA team on the up coming Technical Cooperation team. He then took them through what World Bank is doing in the Health sector such as Uganda Health Systems Strengthening Project.

[Dr. Okwero's view on maintenance]
Reviewing the current systems of maintenance of medical equipment, it is necessary to:
- Put policies in place
- Put in place a good inventory system (Dr. Okwero thinks it is a responsibility of hospitals, not workshops.)
- Train technical engineers for maintenance
- Set up a system for procurement of essential equipment listed in the standard list.

Dr. Okwero has a lot of doubts on current capacity of HID and workshops in terms of capacity of

engineers and technicians and availability of budgets: “Small budget for the workshops”, “Poor performance by the workshops”, “Incompetent technicians”, etc.

Dr. Okwero thinks there should be a budget in each hospital (NOT workshop) for medical equipment maintenance and then the workshop (in the hospital) does minor repairs. “Workshops are doing what is beyond their mandate”.

[Public-Private Partnership for maintenance]
Dr. Okwero suggested that firms that supply medical equipment should be contracted by the government to maintain the equipment for a certain period of time say 4-5years.The same firm would repair medical equipment and would be paid by the government. He also thinks that maintenance of equipment can be fully contracted out if such capable firms are around. The World Bank has funds to support these measures under the Uganda Health Systems Strengthening Project.

[Performance-based management]
- Policy on output-based management and budgeting is there, but simply it is not implemented.
- Under the World Bank Project, some health workers (e.g. medical superintendent) are paid based upon their outputs under the contract.
- It is still necessary to discuss how to assess the outputs. One of the ideas that Dr. Okwero has is to establish independent verification agents jointly organised by selected health workers and auditors like Price Waterhouse Coopers.

面談先	University Research Co., LLC
日時	27 August, 2010
参加者 (敬称略・順不同)	Dr. Nigel Livesley, Chief of Party, Health Care Improvement Project Dr. Augustin Muhwezi, National Quality of Care Coordinator Interviewers: Ms. K. Kanda, Mr. S. Takano, Ms. C. Asiimwe, Mr. N. Take

[Quality Improvement Programmes (QIPs) of URC]
URC has been in Uganda for 5 years to support MOH quality of care initiative through operating 183 health facilities including regional referral hospitals.

[Evaluation of USAID for QIPs of URC]
Currently the final report is not received by URC, but the following discussions are anticipated.
- Lack of harmonisation
- More capacity development
- More integration with national policy

[Next steps for quality improvement by URC]

There is need to institutionalise QIPs into MOH. Following is based upon the discussion in the evaluation. After finalising the evaluation report, all stakeholders will be invited for a meeting to see how all QI approaches can be harmonised.

- HIV/AIDS: capacity development for 100 facilities through strengthening supervisory function and coaching/mentoring of MOH and Districts
- Palliative care at district level
- Neonatal care at district level
- Development of a model for better management of chronic illnesses

[Revitalisation of Quality Assurance]

- Previously the quality of care initiative by MOH did not function and the Department of Quality Assurance (QA) was "disaster". Therefore, URC focused on the Clinical Department for quality improvement (QI). Now is good time for revitalising QI and URC shifts to QA.
- URC recognises necessity of "unified approach" for QI. Especially in the phase of continuous quality improvement, it is necessary to harmonise 5S-TQM with the other vertical approaches as URC are doing.

[Indicators to monitor and evaluate QI]

- Before onset of health care improvement programmes, MOH said they monitor 4 mandatory indicators.
- It is also necessary to harmonise all the QI approaches for better management and ensuring accountability. But it is a difficult part for harmonisation.

面談先	World Health Organization (WHO)
日時	30 August, 2010
参加者 (敬称略・順不同)	Dr. Solomon Fisseha, Project Manager in charge of Emergency Mr. Andrew Bakainaga, Technical Advisor Interviewers: Ms. C. Asiimwe and Mr. N. Take

Minutes

- We were briefed on what WHO does. That WHO is a member of HPAC which is chaired by the Director General of Health services together with the Ministry of Health.
- Health Policy Advisory Committee (HPAC) is comprised of different technical working groups.
- WHO also attends HDP meetings and is a technical agency that sets norms and standards and advice.
- Dr. Fisseha said that as far as physical infrastructure is concerned, there is even distribution of health centres with at least a minimum distance of 5km from the population.
- The health centres however are not functional as they lack human resources for health and medical equipment and emergency obstetric care.
- They lack 60% of the minimum requirements especially at health centre IVs.

- Mr. Andrew Bakainaga said there is poor management of medial equipment.
- The equipment that are functioning are not utilised due to lack of user training, incompetent staff in the workshops and poor management.
- He said there is need to put in code strict code of operation for the equipment in order to minimise breakdowns.
- There is dire need for essential equipment especially in the health centres thus when donating equipment, priority shod be given to the essential equipment especially theatres especially at health centre IVs.

Positive Practice Environment

- The positive practice management addresses management in health facilities especially poor delivery of services by health workers.
- It also deals with management of finances in the health facilities, leadership issues and environmental management in health facilities.
- PPE addresses issues of management and in HSSP III it is recommended that managers of regional referral hospitals should undergo a management course.

Other Issues

- The WHO Team also advised that in order to address quality issues, health information management systems should also be considered.
- Information that comes in and goes out should be properly managed and should be related.
- HMIS should be strengthened and brought to realisation that quality assurance involves under cross cutting issues as opposed to vertical issues.
- Management of hard to reach areas, how to attract, motivate and retain staff.
- WHO and CDC are already supporting the e-HMIS and it has been piloted in 34 districts, mainly in North.
- Resources such as provision of internet, computers and training have been done. This has taken four years.
- Stake holders in the e-HMIS get together and share out the urgent needs of the health centres and see how to address them.
- The Ministry of Health, regional workshops and District Health officers have been involved in this exercise.
- Mr. Bakainaga pointed out that the regional workshops were not coping with the changes such as inadequate capacity, large number of districts and incompetent staff.
- WHO advised that it is imperative to strengthen capacity of workshops at regional level.
- Support supervision and monitoring in the district hospitals and health centre IVs is necessary.
- Management issues have to be well though about too.
- A training package for each department is necessary.
- With the new project, user training is necessary of the equipment and personnel for hospital management are also a vital issue.

面談先	African Development Bank
日時	30 August, 2010
参加者 (敬称略・順不同)	Dr. Jason Mosomi Mochache, Education Specialist and Architect Interviewers: Ms. C. Asiimwe and Mr. N. Take

[Support of health sector by ADB]

Under the mid-term strategy covering 2008-12, ADB has supported improvement of health infrastructure within a scope of the programme called "Health 2" such as:

- Rehabilitation of health facilities and provision of medical equipment for 38 health centres and Mbarara Hospital. The equipment includes CT.
- Improvement of mental health management for 7 hospitals including Mbarara
- Training of health workers was also done including operation and use of medical equipment (user training)
- User training is conducted whenever ADB provides equipment.
- Programme 70% completed

[Support under "Health 3", the next programme after "Health 2"]

- Current status: "pre-finance study" on progress (almost completed)
- Improvement of Mulago Hospital and decentralisation of service provision
- Two "specialist hospitals" with 300 beds for each are going to be constructed.
- Training of hospitals management will be also covered for these hospitals. Therefore, JICA and ADB can collaborate in this respect.
- Following detailed design, the programme will be started in July 2010 after approval of funds

[Maintenance]

- Always challenge due to lack of capacity
- More courses for medical engineering like Kyambogo University are badly needed.

会議名	大使表敬
日時	8 月 31 日（火） 10 時 00 分～11 時 00 分
場所	在ウガンダ共和国日本国大使館
参加者 (敬称略・順不同)	加藤大使 小川書記官 調査団 高野所員

（概要）

● 挨拶及び調査方針の説明（高野・渡部）

- 保健医療分野では無償・技協プロジェクト・JOCV により支援を行ってきた。技協プロジェクトとしては終了済みの「医療機材保守・管理プロジェクト」の成果があり、病院 5S の普及活動を含めた新規の技協プロジェクトを立ち上げることとなった。
- 他ドナーとの連携・協調に留意したプロジェクトとなるよう留意する。

● 加藤大使コメント

- 病院への協力は、日本のほかは、中国（施設・機材）、韓国（機材）、インド（医療技術）などがある。
- 保健大臣は日本の協力を理解しており、無償のハンドオーバーの際に「きれいに活用せよ」と発言していた。
- ウガンダに限らないが途上国では医療機材のメンテナンスという発想がなく使い捨てになっている。頭ではわかっていても実践は難しい。
- 保健セクターへの米国の支援は莫大でありほとんどが人口・エイズ分野に注がれている。
- ウガンダは人口が年間 100 万人増加しており、15 歳以下の人口が約半数を占めており、今後数年間に就職、住宅、医療その他さまざまな社会問題に直面することとなろう。経済成長は 8%と高い水準であるが、働く場所の確保は進んでいない（公務員、IT 業界が主な就職先）。医療セクターでも頭脳流出が起こっている。
- 北部の復興に関し、和平後に避難民が戻っているが水や医療が問題になっている。
- 地方の医療は課題が大きく、人々の医療への信頼が薄く病院に行きたがらない、電化が進んでいない、医師が少数しかおらず人材や薬の管理にも問題がある、など。救急医療の体制が整備されていないことも課題。
- 草の根無償により北部のヘルスセンターへの支援を行っている。USAID の支援と組み合わせることも検討している。
- 保健医療協力では、保健人材のものの考え方、意識の変化を図ることが必要。また、AU サミットでも重視されている母子保健の改善につなげていくことが大切である。
- 5S 活動に関し、数年後に協力の成果がなくなってしまわないように、「見える」成果も必要である。院長のリーダーシップがないと長続きしないので、成果を認識して活動の継続にインセンティブをもたせることが大切。他のアジア諸国の成果をみることも重要。大きく広げるより、慎重に進めるのがよい。モデルを確立して、出口・目標をもって進めるのがよい。
- 他ドナーが北部支援を重視しているなかで、人材・電気・水の課題に取り組む北部復興のモデルプロジェクトが検討されていることから、これとの連携も検討願う。

会議名	MOH 主要カウンターパートとの打合せ
日時	8 月 31 日（火）　15 時 00 分～16 時 00 分
場所	MOH
参加者 (敬称略・順不同)	Dr. Amandua Dr. Amone Dr. Opar Dr. Sarah 調査団員 高野所員、クレア在外専門調査員 神田専門家

（概要）

● 挨拶及び調査方針の説明（渡部団長）

保健システム全体の中でどのような意義を果たす協力であるかをウガンダ側とともに考えることにより、持続性につなげたい。すなわち、MOH の全体戦略や医療の質に関する政策との統合、政府予算の確保に向けた PDCA（Plan, do, check, act）サイクルの統合、財政支援型を含む他ドナーとの連携・協調、政府の M&E との統合、などが課題である。

● Dr. Amandua 発言要旨

日本は無償資金協力による病院インフラ支援、終了済みの医療機材保守・管理プロジェクト、JOCV、各種の研修など、重要なパートナーである。要請済みの西部ウガンダ医療施設改善計画（無償）についても着手を待ち望んでいる。

● Dr. Amone 発言要旨

病院 5S 活動はコストをかけずに拡大できることがメリット。新しいストラクチャーを構築しなくとも他の病院で実践できる。課題としては、他のリソースの巻き込みであり、評価を共同で行うことも病院 5S のロールアウトのために重要。

● Dr. Sarah

病院 5S 活動はリソースが少なくても実施でき、前進するためのエネジーが得られる。医療の質局と治療サービス局が共同で取り組むことが重要。

● 伊達団員

コンサルタントの調査報告では、医療機材保守管理プロジェクトが終了してもワークショップ報告書が、一定期間ごとに MOH HID に提出されるようになったことは成果である。しかし、6 種類のステッカー及び医療機材の定期的な更新がなされていないようである。ステッカーの意義は、医療機材の使用者と技術者の間をつなぐ媒体だと考えている。過去のプロジェクトは、医療機材運営を中心にしていたが、次のプロジェクトでは医療機材の運営が Healthcare や Health Service に結びつけることができるような視点が必要である。

JICA が行っている医療機材と 5S を連携させたプロジェクトは、まだ数も少なく成功していると言えるプロジェクト例がまだない。

● Dr. Amandua

Health service の視点を取り入れたいと考えている。ウガンダのプロジェクトが最初の医療機材

と 5S プロジェクトの成功例となるよう努力する。

● 竹団員

1. 5S のインパクト

視察したトロロ、ムバレともに、5S 活動が自分たちの診療活動、診療指標にインパクトがあるという信念をもっている。5S を通じた改善が報いられるシステムができることを望む。

2. ユーザートレーニング

ニーズは非常に高い。これを具体的にどのように実施していけばいいか、9 月 2 日の計画策定ワークショップで、参加者とともに考えていきたい。

3. 保健インフラマネジメント

各ワークショップに予算がついたのは大きな進歩。しかし、一律配分には不満が表明されている。（注：この 1 日後、予算配分方法が今年度から変更になり、ワークショップがカバーしている施設数に応じた配分となったことを、資料より確認）

4. Quality Improvement の harmonisation

URC における聞き取りから、この流れを強く感じた。プロジェクトもしっかりついていくことが不可欠。

5. 保健計画との整合性

ウガンダでプロジェクトをやる以上、上位計画との整合性を保つのは当然。一方、プロジェクトの成果を上位計画（例えば次期の HSSP）へフィードバックできるようにすることも重要。

● 高橋団員

詳細計画作成調査のスケジュールを説明。

● 高野所員

高まりをみせている病院 5S 活動と医療機材維持管理をどのように融合するかが課題。医療機材維持管理を担う Workshop の人材がネガティブにならないようにうまく巻き込みたい。

● Dr. Sarah

医療の質に関する複数のイニシアティブへの取り組みが開始されているが、これまで別々に動いているので統合を図ることが課題。また、パフォーマンスベースインセンティブの導入と医療の質への取り組みをどのように活用するかを検討する必要が生じている。

● Dr. Amone

医療の質に関する各種のアプローチを統合することにより、リソースの有効活用を図ることが課題である。また、レポーティングシステムを整えることによりアカウンタビリティを高めることも重要。

面談先	CWS
日時	9 月 1 日（水）　9 時 00 分

機材の活用とメンテナンスが重要であり、前回の技プロはユーザートレーニングまではカバーできなかったので、本プロジェクトがめざす包括的なアプローチは非常に良いと考える。

面談先	ムラゴ NRH
日時	9 月 1 日（水）　12 時 00 分

スペアパーツの入手とその購入のための予算確保が課題である。いろいろな国から医療機材が来ているため、スペアパーツもそれぞれの国から購入しなければならない。高度な機材、たとえば X 線や超音波などはエージェントに頼んで修理してもらっているが、一般的な機材は病院内のテクニシャンで修理している状況だが、スペアパーツ確保の問題がある。ユーザートレーニングについてはワークショップ内のエンジニアで対応するには人員が不足している。新しい機材が入ったときには研修しているが、看護師が異動してしまうと、後任にまた研修が必要。過去 2 年予算なく研修は実施していない。修理の技術はあっても修理するための器具を買う資金が不足している。

面談先	エンデベ GH
日時	9 月 1 日（水）　16 時 00 分

- 5S 活動を実施しているエンテベ GH へのフォローアップ活動に同行したもの。非常に努力して 5S 活動を進め進展していることが視察で確認できた。
- 5S の効果として院内感染率が減ると言えるといいと思うが、今は安全性を確保することに注力した方がよい。ごみ箱の分別などはもう少し改善の余地がある。チーム力が強いことは非常によいと思う。マネジャーを選び、より強いリーダーシップの下で 5S を続けるとよい。
- 患者数が増えていることは記録からもわかっており、特にミドルクラスの来院が増えている。ミドルクラスは以前は病院が汚いからと言って来院していなかったが、増えているので評価が高くなったということだと思う。患者に対する職員の態度も良くなっており、患者の待ち時間も整理が進んだことで減っている。

会議名	Post PDM workshop meeting between the Ministry of Health and JICA
日時	3rd September 2010, 14:30
場所	Ministry of Health Board room level IV

Participants

	Name	Title	Department
1	Dr. Jacinto Amandua	Commissioner	Clinical Services
2	Dr. Jackson Amone	Ass. Commissioner	Integrated Curative services
3	Dr. Sara Byakiika	Ass. Commissioner	Quality Assurance Department
4	Dr. Peter Okui	Principal Medical Officer	Malaria Control Program
5	Eng. S.S.Wanda	Ass. Commissioner	Health services
6	Eng. Sitra Mulepo	Snr. Engineer	Health Infrastructure Division
7	Sr. Beatrice Alupo	Senior Nursing Officer	Nursing
8	Mr. Kozo Watanabe	Leader of survey team	JICA HQ
9	Ms Sonoko Takahashi	Member	JICA HQ
10	Dr. Takuji Date	Member	JICA HQ
11	Mr. Naoki Take	Consultant	
12	Mr. Shintaro Takano	Representative	JICA, Uganda
13	Ms. Kie Kanda	Technical Advisor	JICA/MOH
14	Ms. Asiimwe Clare	Health Consultant	JICA,Uganda

1. The meeting kicked off at 14:53 with Mr. Kozo Watanabe giving an insight of what transpired in the workshop. He said the project was to be designed using the existing resources and mechanisms.

- The project focus will be on guidelines for development, human resource development and training of key persons.
- Implementation of the project activities will be by each hospital.
- There is need to integrate 5S, user training and health infrastructure management under the technical cooperation project.
- Policy guidelines for training on medical equipment and maintenance should be put in place.

2. Mr. Take took the members through the high lights of the workshop. He informed members that the PMD workshop was a participatory one whereby the workshop consisted of three sessions namely:

- Goal identification,
- Problem analysis
- Formulation of action plans.

3. The identification of the goal was done jointly by all members as improved delivery of healthcare services and it was agreed that the above outcome would be achieved through;

- Better working environment through 5s-tqm.
- Reduced breakdown of medical equipment through user training
- Better health infrastructure management.

Action plans were formed by the two groups regarding medical equipment and 5s-TQM.

4. Training of users for Medical equipment.

- The users of medical equipment might not handle equipment beyond a certain level.
- Training of users looks at operation, care and handling. These aspects need to come out clearly.
- Equipments that can be handled by every body should be well defined.

5. The participants from the ministry of health were concerned about the major aspects of health infrastructure management not being clear. They raised a question of whether health infrastructure management included only medical equipment or included the buildings.

6. Dr. Sara Byakiika

- Dr. Sara raised a question on how many hospitals would be trained in 5S-TQM.She was informed that so far hospitals like Gombe, Mbale, Kapchorwa and Busolwe had leant form Tororo the pilot hospitals through observing what they had done and implemented 5s in their hospitals.
- Members were also informed of the first TOT on 5S –TQM that took place in Tororo from 16^{th}-19^{th}.3 people were trained from each hospital and these would in turn train people in their hospitals first.
- They were also looking into pre-service or in service training on 5S and its importance.

7. Dr. Jacinto Amandua Trainers for medical equipment.

- Dr. Amandua said the existing user trainers for medical equipment would be used.
- He said basing on the past experience, User trainers would not be withdrawn from their work stations because it would cause the system to collapse.
- A needs` assessment for user triaging for medical equipment needs to be done.
- Other hospitals should also be trained.
- There needs to be development of guidelines for 5S and TOT

8. Eng. Sitra Mulepo

Said there was need to agree on the minimum package of all the activities.

He said training for only hospital technicians would not be of great help since hospitals rely mainly on regional workshops and technicians.

He called for enforcement of capacity of the workshops.

9. Policy issues

There should be horizontal linkages between departments and supervision guidelines.

10. Dr. Amandaua expressed concern on the 7 regions as targets by JICA and was proposing that they stick to the traditional 4 regions to avoid confusion. The designated regions should be considered for now.

11. There is need to develop a user and training manual of Uganda. Training Materials for Uganda are necessary.

12. Indicators used at the moment are by the joint assessment framework (JAF).the indicators should be related to the national development plan.

- The ministry of health uses 6 of them.
- There are already guidelines in place for quality improvement and there should be a borderline between policies.

13. Training should be a long term institutional arrangement because TOT trainers will be borrowed or recruited form their institutions, this includes 5S and user training.

- There should be a reference points for workshops, mobile workshops and there is need to look at how they are going to be replaced.
- Current user training for 5s will use the TOTs based in hospitals and it should continue working.

At the moment, Tororo is the only hospital on the national budget for support supervision.

14. Integration of 5S should be slotted into HSSP III so that it can be budgeted for and implemented.

- It should also be captured in the National health policy
- There should be one system of quality improvement.
- In the quality improvement aspect, 5s is one of the strategies and it needs to go beyond hospitals, Tororo hospital has been incorporated into the district health system.

15. There will be a presentation on 5S in Lira at the Joint Medical superintendents` meeting on 6th September and a discussion would be held on how to roll out to other hospitals and health centres.

16. The meeting was concluded by an agreement that the draft project design and minutes of discussion would be sent to the concerned persons to make comments and submit them electronically to Mr. Watanabe.

面談先	マサフ GH
日時	9 月 6 日（月）　11 時 00 分

無償「東部ウガンダ医療体制改善計画」で整備した病院を視察したもの。

- X 線は現在、放射線技師がまだ雇用されていないため、使用されていない。機械的に動きにくいなどの問題もあった。放射線技師の人選は終わっており、正式な手続きを待っているところ。面談時には同技師が既に病院に来ていた。
- 超音波は使える状態だが、プリンターはない。
- 保育器は使われており、訪問時には 2 人の赤ちゃんが寝ていた。
- 天井は外れやすい状況
- 医療機材は課題である。施設のメンテナンスのための費用や薬の購入は問題で、薬については全国的に不足している。スタッフの住居は建設中だが、まだ不足している。
- 5S によって、院内感染をコントロールするのは難しい。整理、整頓なら簡単にできるし、関心もあるので、チームをつくって始めるところ。

・ JICA の支援で医療機材は改善した。
・ 地方分権化の動きは保健分野ではあまりよいことではない。人材は中央に戻され、地方政府の重点分野は保健でなかったりするため。7 名医師がいることになっているが実際には 1 名しかいない。人材不足は大きな問題。
・ 医療機材で問題があれば、ムバレ RWS に依頼して対応してもらっている。以前は病院にお金があるときしか来てもらえなかったが、今は問題があればまずアセスに来て、その 2 週間後に修理に来る体制ができた。

面談先	トロロ GH
日時	9 月 6 日（月）　14 時 40 分

5S 活動を AAKCP の枠組みでパイロット病院として実施している病院を視察したもの。

・ 2008 年より 5S を開始したが、外来部門など患者にとっても職員にとってもきれいになり、職場環境は改善、チームワークも進み、医療サービスは早く提供できるようになり、患者の待ち時間も減って、患者の満足度も向上している。意識の改善が重要。ステアリングコミティをつくり毎週開催してチェックリストをレビューし議論している。パイロット病院なので、他の病院もトロロに来て学んでほしいと考えている。
・ 医療機材についてはメンテナンスもユーザートレーニングも課題である。機材をどう使うのかきちんと知っている必要がある。メンテナンスについては技術的なギャップがある。ムバレに RWS があるが、トロロ病院内にもテクニシャンはいるが簡単なものしか扱えない。RWS はカバーしている範囲が広く、緊急時には対応してもらえない。そのため、ユーザートレーニングの実施や、RWS のスタッフ増員が必要だと思う。
・ 医療機材は高価で、スペアパーツは場合によっては海外から取り寄せる必要がある。
・ 5S と医療機材を統合していく考え方はとても良いと思う。
・ 薬はナショナルメディカルストアから来るが、遅れることもあり、在庫管理が重要。

面談先	HC IV
日時	9 月 6 日（月）

ミニホスピタルとも言われている HC のうち一番上の HC IV を訪問したもの。

- 2000 年から HC IV となり、8 : 00～17 : 00 までの診察時間、入院、産婦人科は 24 時間対応。月に 30 件の出産があるが、45 件が目標なのでそれを下回っており、実際には TBA（traditional birth attendant：伝統的産婆）介助による自宅出産が多い。
- 県保健局がほぼ毎月来てモニターしている。HC からは毎月レポートを提出している。

面談先	ムバレ RRH
日時	9 月 7 日（火）　9 時 00 分

5S については 2010 年 4 月から整理を始めた。プライベート病棟では診療費を病棟の活動に充てることが可能。マネジメントの高いレベルから低いレベルまで研修を始めたところ。

面談先	MOH
日時	9 月 8 日（水）　14 時 30 分

翌日の M/M サインに向けて、M/M 協議、PDM に関する協議を行った。7 地域の考え方と区分、ターゲットグループとコア病院の考え方、5S の地方展開などについて、協議を行った。

面談先	MOH
日時	9 月 9 日（木）　11 時 00 分

M/M 署名。次官からは、ストラテジックな友人である日本から多くを学びたいと考えているとの発言が寄せられた。

The Project on Improvement of Health Service through Health Infrastructure Management

- Ownership, Sustainability, Integration
  – 3 Priorities to be Shared
- Project Image　Overview
- Project Implementation Structure of MOH
- Stakeholders Structure by Multi-Levels
- Project Implementation Plan

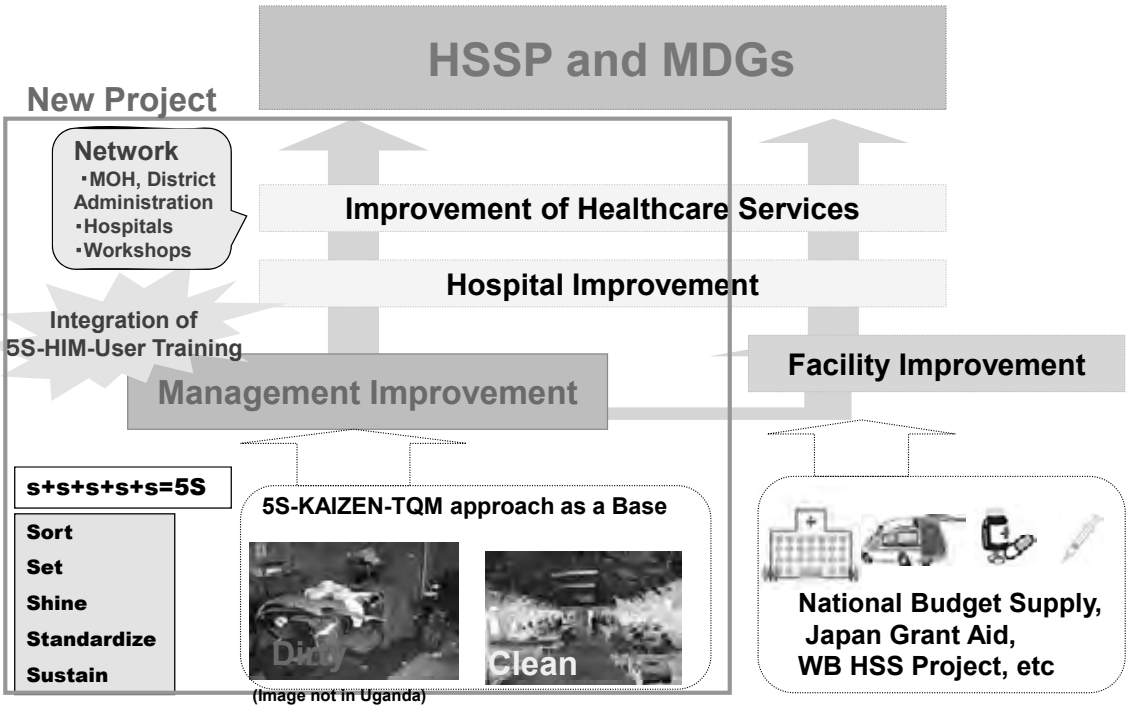
Note; Contents of this Presentation is “DRAFT” to be developed by the MOH side Imputs.

Three Priorities to be shared

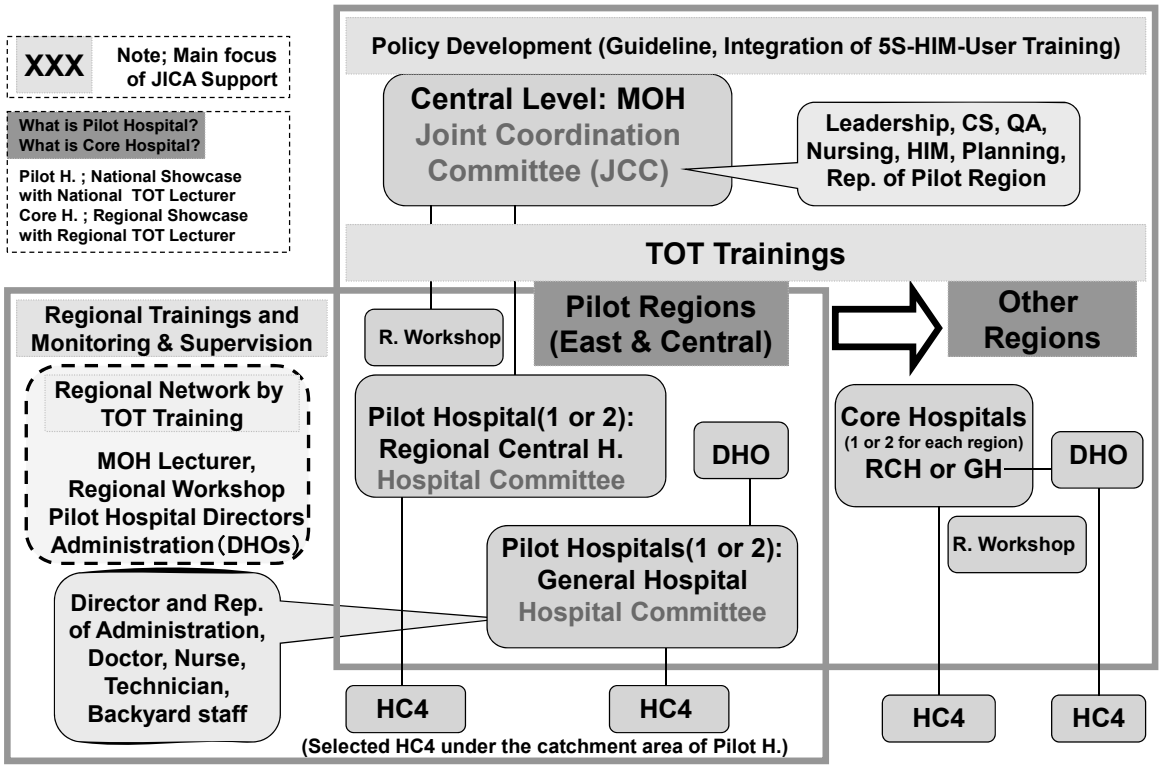
• Ownership →	• Self-effort activities with Leadership and Team-Building • Harmonized in the HSSP
• Sustainability →	• Harmonized in the Uganda’s Health Systems • Full Use of Existing Resources (Workforce, Budget, HIM Guidelines, Information, etc.) • Align with existing PDCA Cycles (Health Policy, National Budget Allocation, Monitoring & Supervision activities, etc.)
• Integration →	• Merge 3 components of 5S-HIM-User Training by policy and stakeholders’ network • Consistency of National Policies, Guidelines, M & S system, etc. • Appropriate Modification among Quality Improvement Initiatives • Collaboration with Dev. Partners

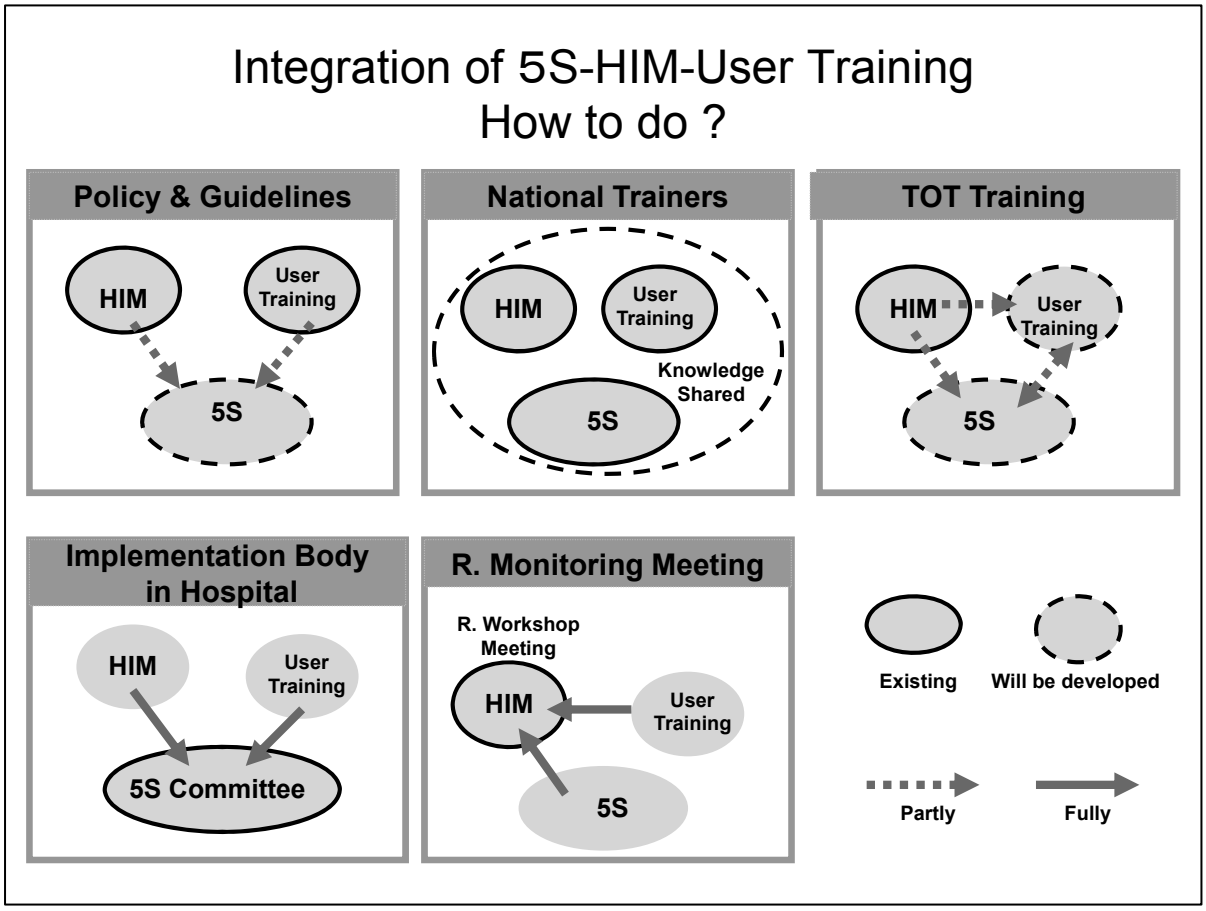
Improving Hospital Management by 5S-HIM-User Training

The Project on Improvement of Health Service through Health Infrastructure Management



Stakeholders Structure by Multi-Levels




Integration of 5S-HIM-User Training
How to do ?
Policy & Guidelines
HIM
User Training
5S
National Trainers
HIM
User Training
Knowledge Shared
5S
TOT Training
HIM
User Training
5S
Implementation Body in Hospital
HIM
User Training
5S Committee
R. Monitoring Meeting
R. Workshop Meeting
HIM
User Training
5S
Existing
Will be developed
Partly
Fully

The fundamental process for implementing the project

JICA Detailed Planning Survey Team

September 2010

Before August 2010

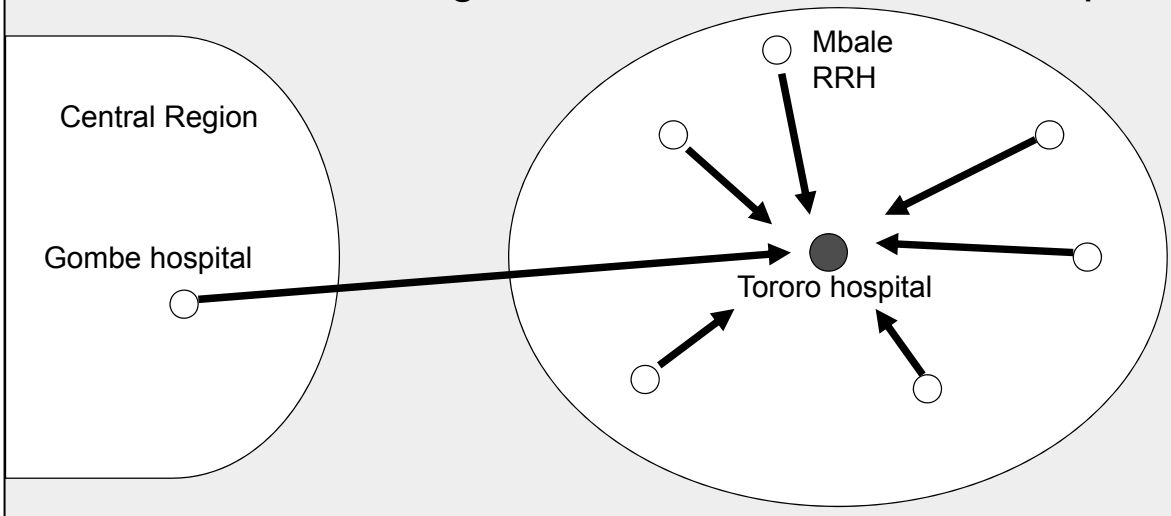
National facilitators are trained outside of Uganda such as in Japan, Sri Lanka, Tanzania and etc.

- Ministry of Health: 3 staff members
- Tororo hospitals: 4 staff members
- Mbale regional referral hospital: 1 staff member

Total 8: staff members are national facilitators

Eastern Region in August 2010

5S-CQI-TQM training was conducted at Tororo hospital



- 3 staff members from 6 hospitals =18 (2 were absent)
- 7 from Ministry of Health including 2 from maintenance workshops
- Total 23 staff members attended the 5S-CQI-TQM training

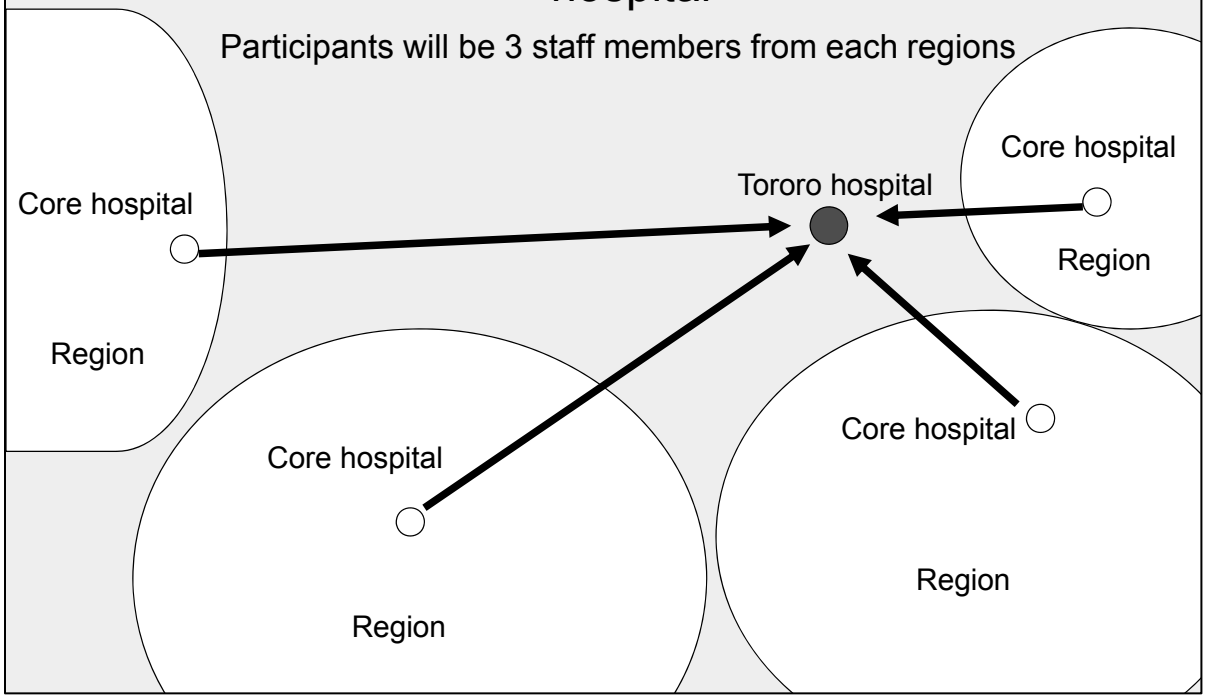
Main contents of the 3.5-day training at Tororo hospital

- Observation of Tororo hospital
- 5S-CQI-TQM training of trainer (TOT)
- Implementation planning

After the project started

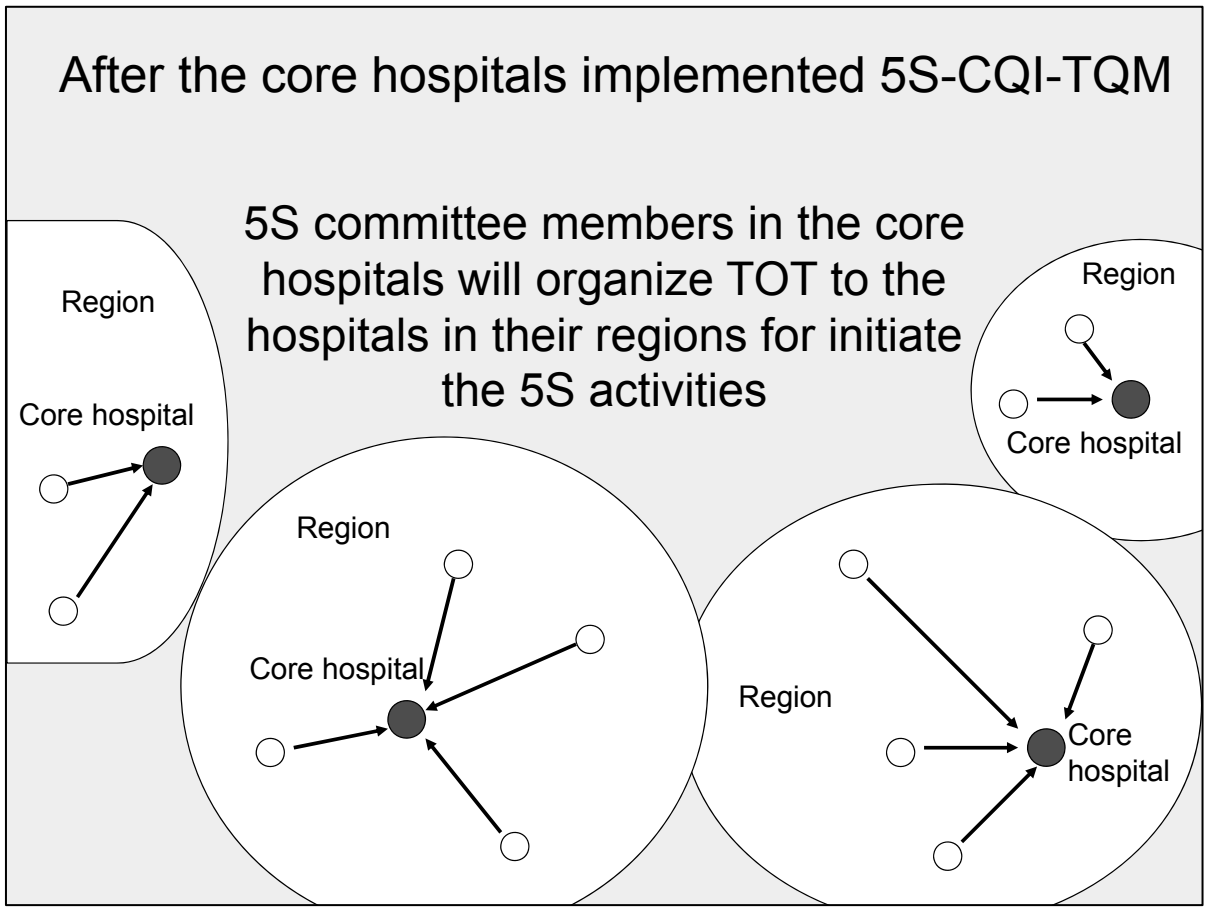
5S-CQI-TQM TOT will be conducted at Tororo hospital

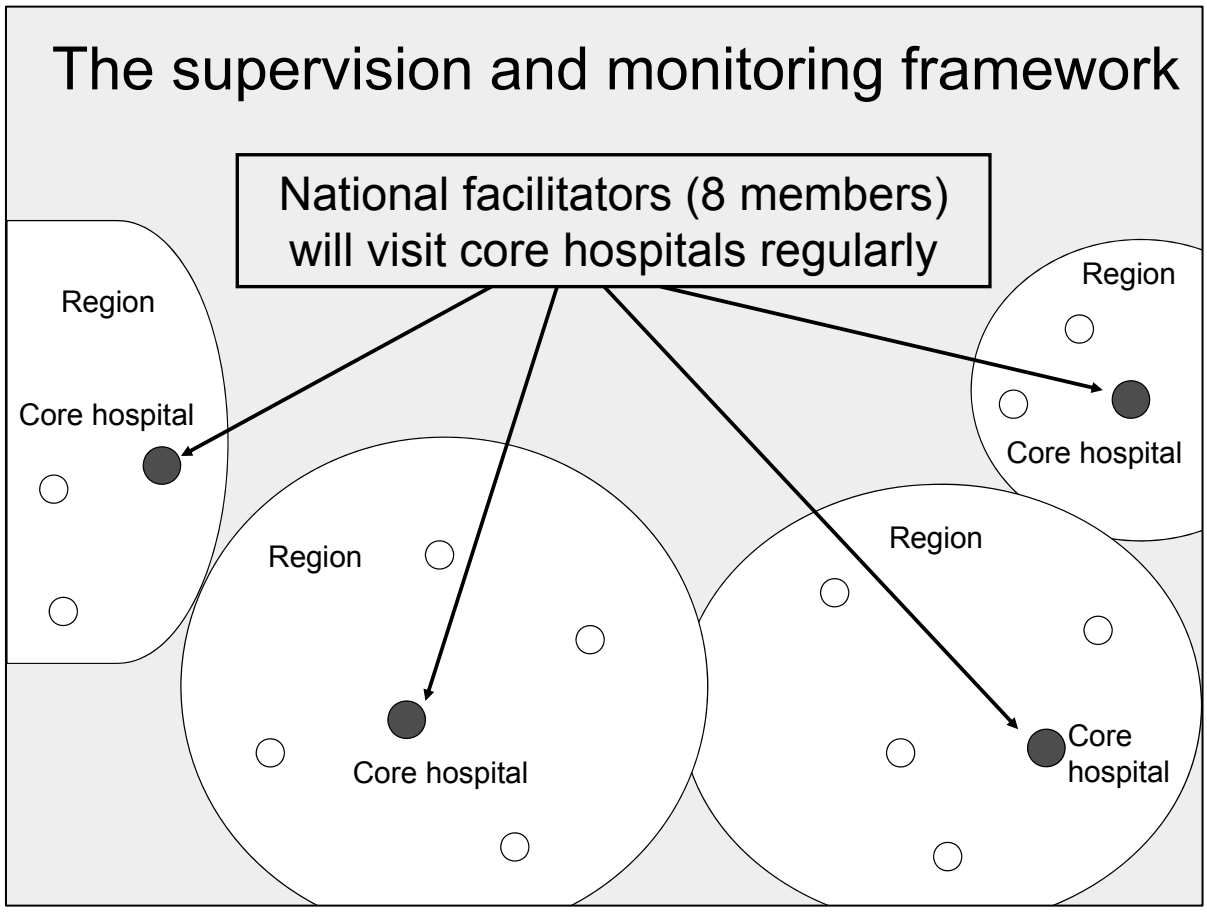
Participants will be 3 staff members from each regions



The expansion process after the 5S-CQI-TQM TOT at Tororo hospital

1. Implementation of 5S-CQI-TQM in the hospitals where the participants attended the TOT at Tororo hospital
2. The hospitals will be considered as the “core hospital” in their regions


After the core hospitals implemented 5S-CQI-TQM
5S committee members in the core hospitals will organize TOT to the hospitals in their regions for initiate the 5S activities
Region
Core hospital
Region
Core hospital
Region
Core hospital
Region
Core hospital


The supervision and monitoring framework
National facilitators (8 members) will visit core hospitals regularly
Region
Core hospital
Region
Core hospital
Region
Core hospital
Region
Core hospital

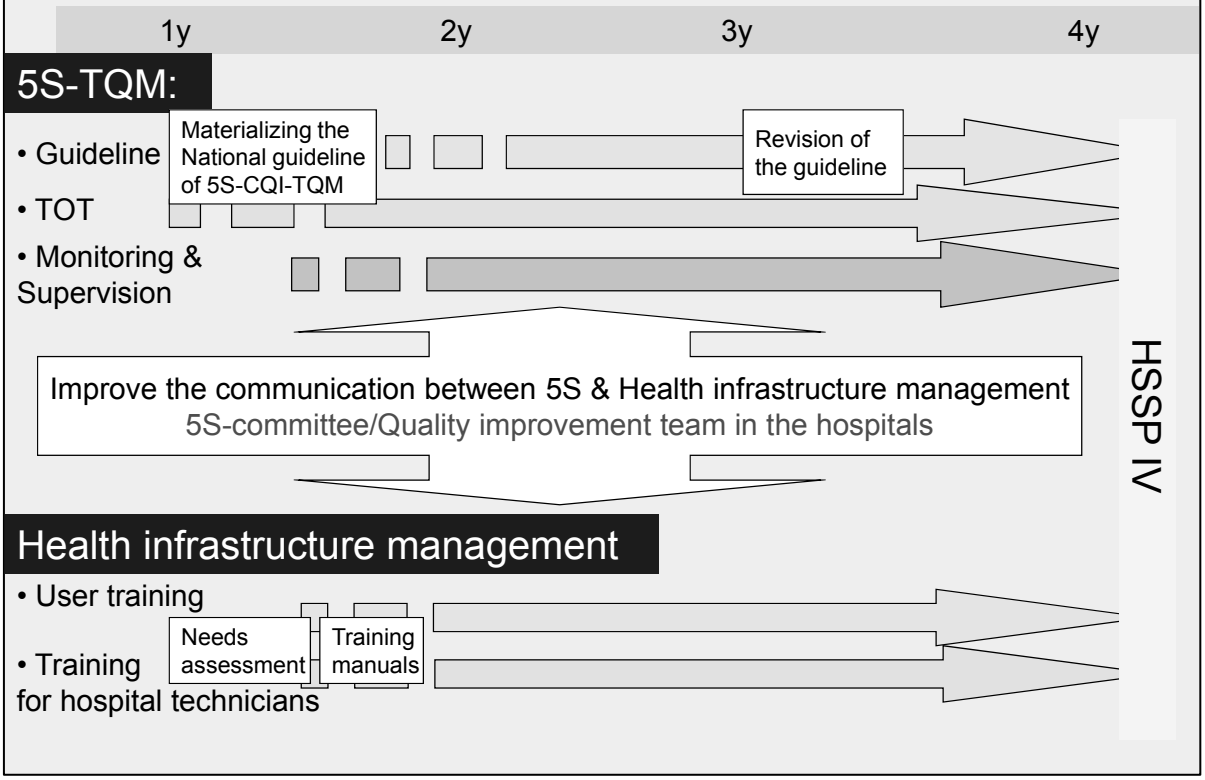
The concept of the cross cutting type of 5S-CQI-TQM TOT

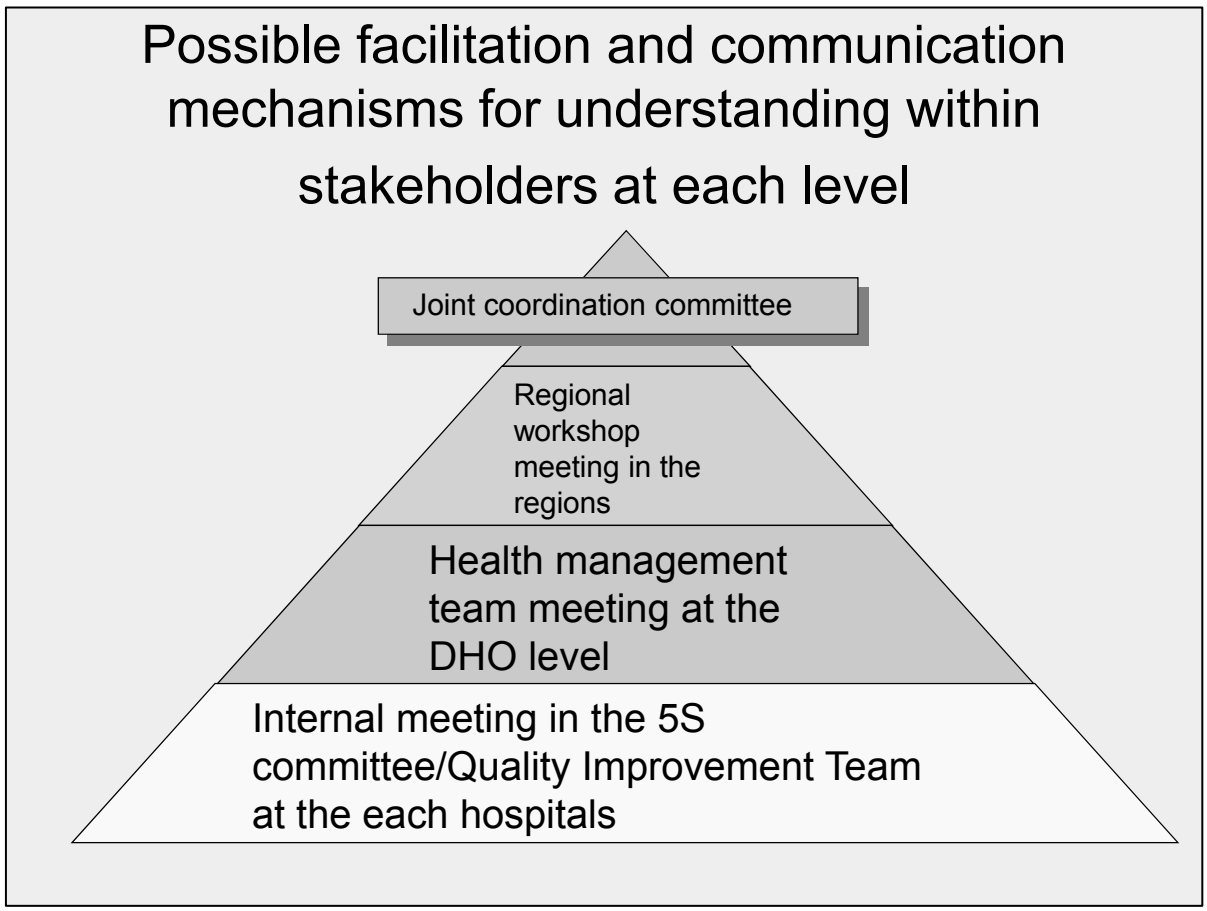
Day:	Morning	Afternoon
1:	5S- TQM	5S- TQM
2:	5S- TQM	5S-Health Infrastructure
3:	5S- TQM	5S- TQM
4:	5S- TQM	5S- TQM

Contents of the 5S-Health infrastructure are basic issues only

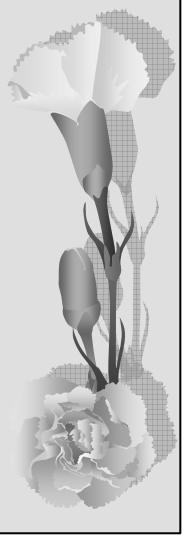
- Effective utilization of medical equipment
- Proper maintenance of medical equipment
- Role of the 6 color coded stickers
- The role of “User Training”
- etc.

Expected progress during the project years



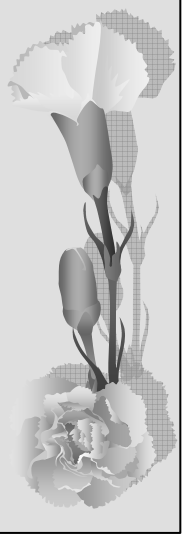

Possible facilitation and communication mechanisms for understanding within stakeholders at each level
Joint coordination committee
Regional workshop meeting in the regions
Health management team meeting at the DHO level
Internal meeting in the 5S committee/Quality Improvement Team at the each hospitals

Incorporate Results of Planning Workshop into PDM

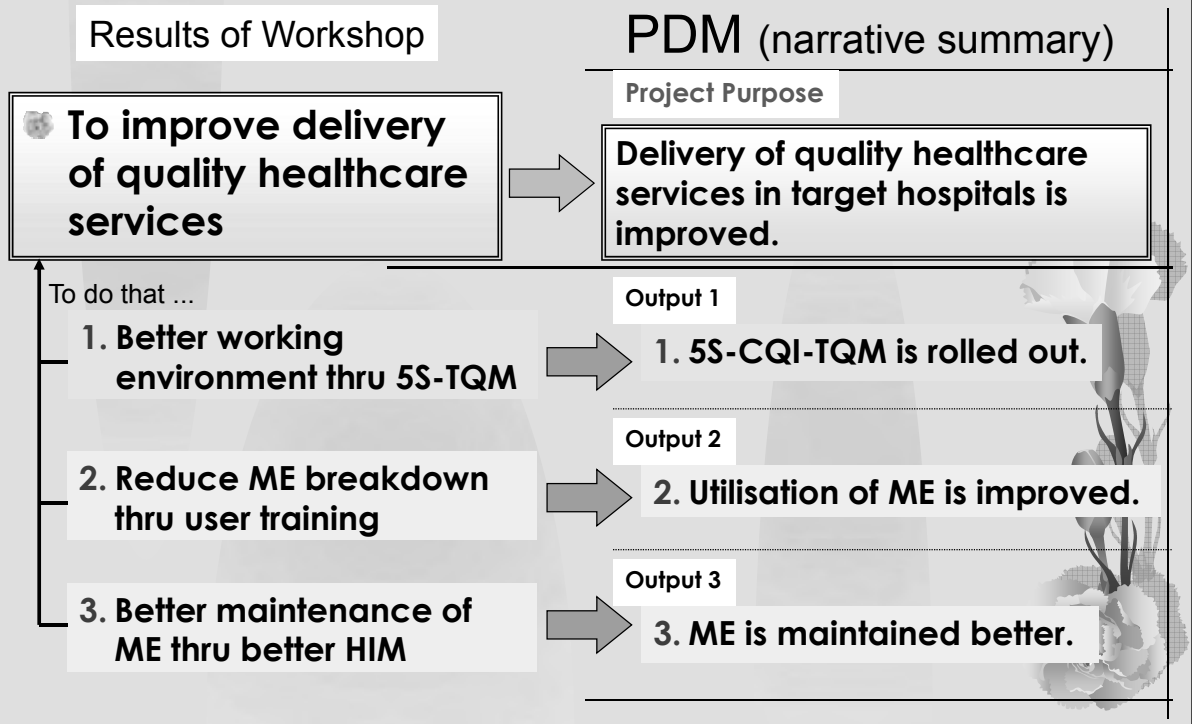


Session 1

What is the outcome of the Project?



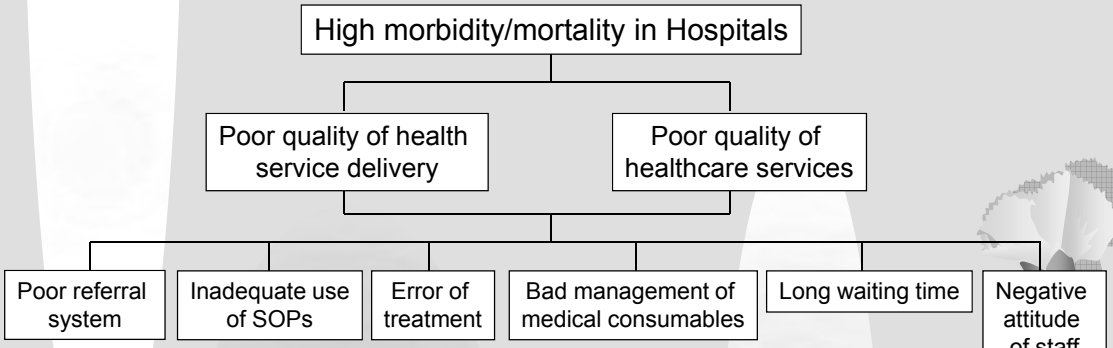
Outcome of the Project is ...



Session 2 (1)

What are problems of quality of services in the absence of 5S-TQM?

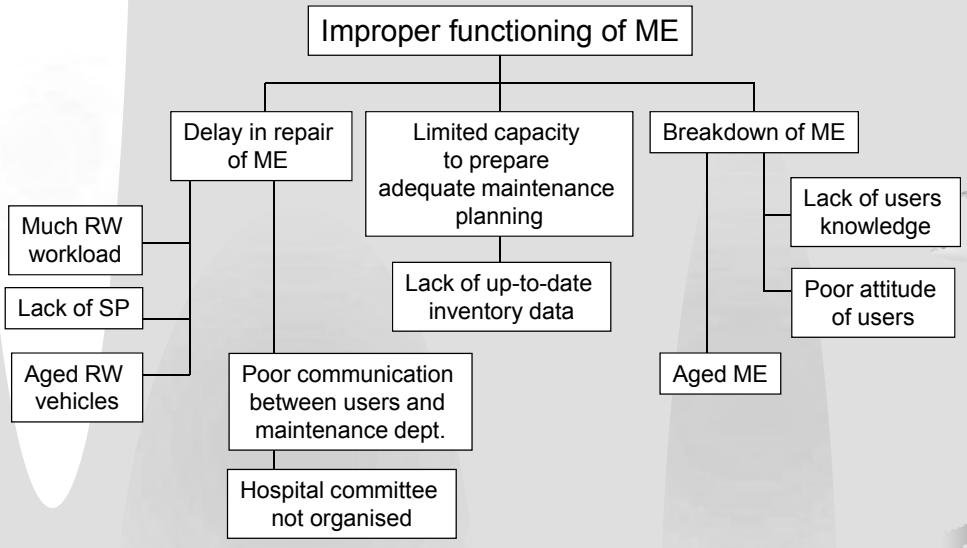
Problem Tree (5S-TQM)



Session 2 (2)

What are problems concerning medical equipment?

Problem Tree (ME)

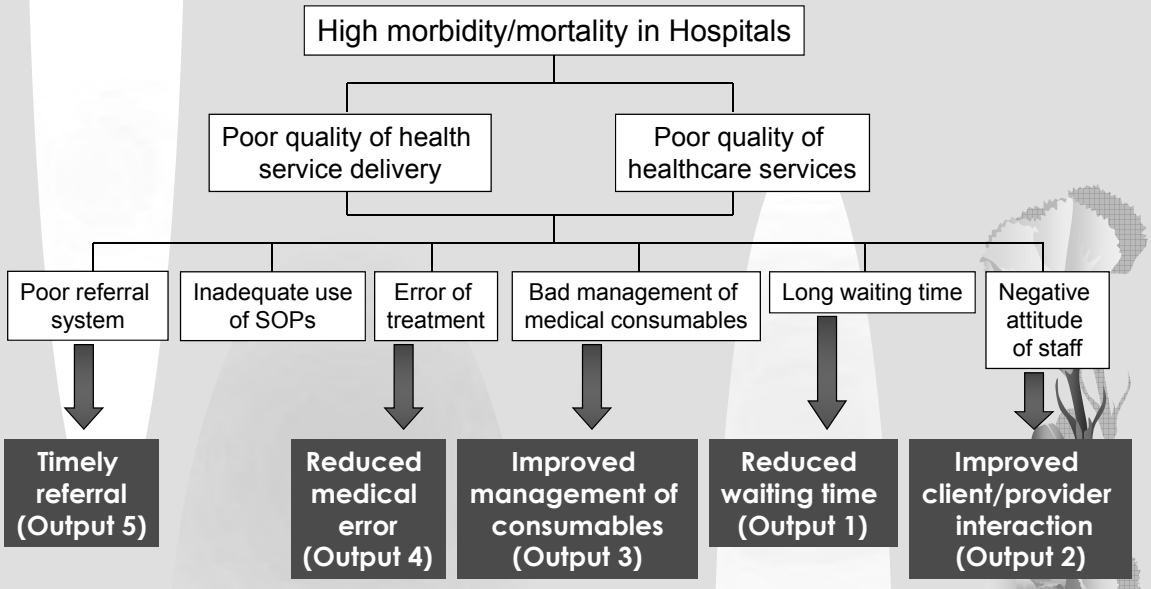


Session 3 (1)

From problem analysis to action plans to overcome:

5S-TQM

From Problem to Action (5S-TQM)



"These problems can be overcome by 5S-TQM in facility level."

Action into PDM: To roll out 5S-TQM nationwide ...

Results of Workshop

Output 6

1. **Establish coordination structure**
2. **Develop national guidelines**
3. **Identify showcase hospitals**
4. **Conduct TOT for trainers**
5. **Sensitise stakeholders**
6. **Develop work plan**
7. **Develop M&E framework**
8. **Develop training manuals**
9. **Implement 5S (<u>with components of Output 1-5</u>)**

PDM (narrative summary)

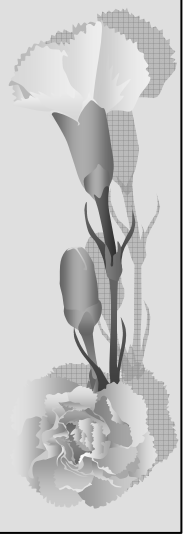
Output 1

1. **5S-CQI-TQM is rolled out.**

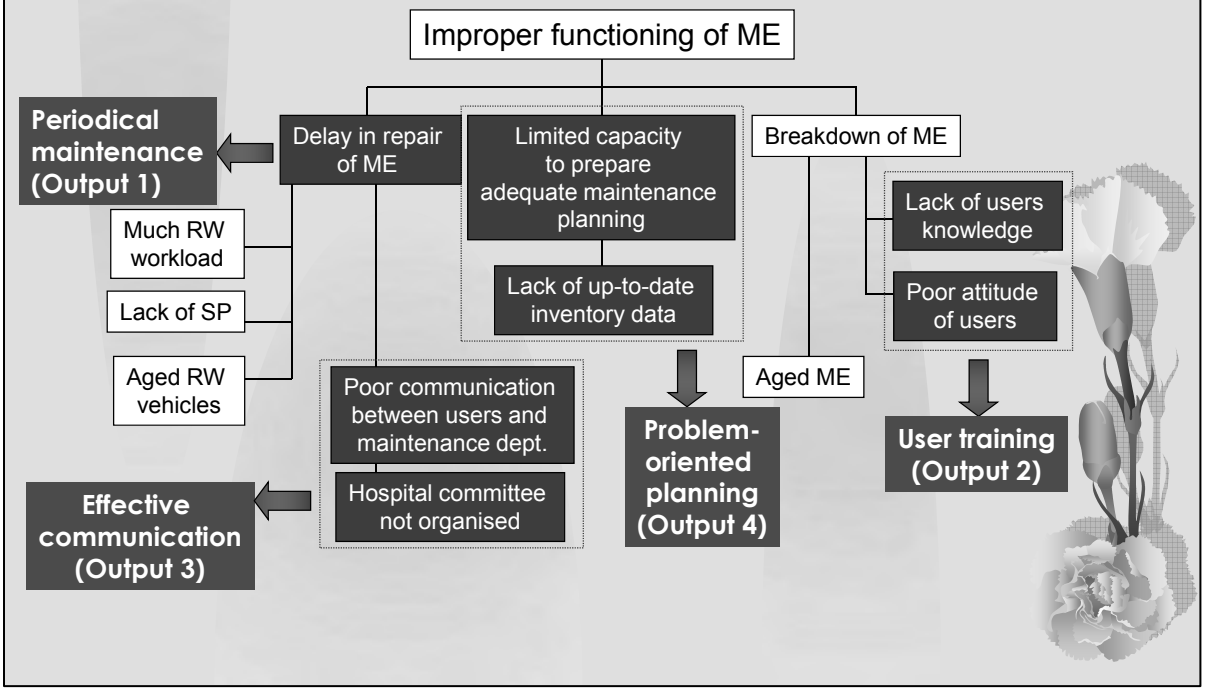
Activities

Session 3 (2)

From problem analysis to action plans to overcome:
Medical equipment



From Problem to Action (ME)



Action into PDM (ME)

PDM (narrative summary)

Proper functioning of ME

Output 2 **2. Utilisation of ME is improved.**

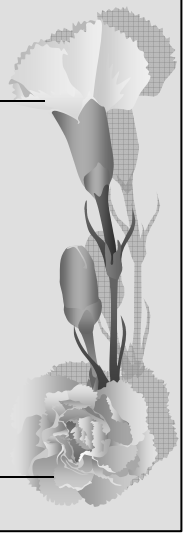
Output 3 **3. ME is maintained better.**

Activities for Output 2

- **User training**

Activities for Output 3

- **Periodical maintenance**
  - **Effective communication**
  - **Problem-oriented planning**



評価グリッド（ウガンダ　保健インフラマネジメントを通じた保健サービス強化プロジェクト）

I. プロジェクトの実施が妥当である条件

1: プロジェクトがウガンダの政策・プログラムと整合している

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) プロジェクトの National Health Policy (NHP II)及び Health Sector Strategic Plan III (HSSP III)における位置づけは？	• NHP II 及び HSSP III における Quality of care 及び Health infrastructure management（HIM）	• Quality of care 及び HIM が NHP II 及び HSSP III に言及されていること • 記載内容	• NHP II • HSSP III	入手済み

2: プロジェクトがウガンダ保健分野のニーズと合致している

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) 関係者の間の、5S 及び HIM の期待は？　5S 及び HIM 向上で何を成し遂げたいのか？	• 5S 及び HIM の活性化で成し遂げたいこと	• プロジェクト目標、上位目標が明確に定義されること • 利用可能・計測可能な指標が定義されること	• インタビュー • 打合せ • 計画策定ワークショップ	• MOH • JICA • 病院及び医療機材維持管理ワークショップ
(2) 成し遂げたいものと現状のギャップ、及びそれをもたらす要因は？	• ウガンダ側が考える問題点	• ウガンダ側に問題構造がしっかりと認識されていること		• MOH • 病院及び医療機材維持管理ワークショップ
(3) ギャップを縮小するために必要な Action は？	• 本プロジェクトの活動	• 関係者により、プロジェクト目標を達成するための活動が適切に計画されること		• MOH • JICA • 病院及び医療機材維持管理ワークショップ
(4) 保健分野、とくに Quality improvement 及び HIM に対する他開発パートナーの支援動向は？	• 他パートナーの計画	• 他パートナーの計画と重複しないこと • 他パートナーの計画との連携が可能となること	• インタビュー	• 他パートナー

3: プロジェクトが日本の援助政策・プログラムと合致している

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) プロジェクトの、日本の援助政策・プログラムとの整合性は？	• 日本の援助政策 • JICA 保健プログラム	• 政策・プログラムに保健分野が位置づけられていること	• ODA 国別データブック • JICA ウガンダ事業展開計画	入手済み
(2) プロジェクトの他スキームとの有効な連携は？	• 無償資金協力及びボランティアとの連携	• 連携が図られていること	• 作成される PDM	• PDM

II. プロジェクトが有効である条件

1: プロジェクト目標及び成果が明確に記述されている

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) プロジェクト目標及び成果の記述は明確か？	• プロジェクト目標 • 成果 • それぞれの指標及び入手手段	• プロジェクト目標及び成果が明確に定義されること • 指標がプロジェクト目標及び成果を適切に表していること • 指標が定期的に入手可能なこと • ベースライン及び目標値が明確なこと	• 作成される PDM	• PDM

2: プロジェクト目標及び成果が期間内に達成可能である

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) プロジェクト目標及び成果の達成見通しは？	• プロジェクト目標 • 成果	• 投入、スケジュール、外部環境を考慮して、達成可能な目標・成果について、ウガンダ側と合意を得ること	• 作成される PDM	• PDM

3: プロジェクト目標←成果←活動のロジックが適切である

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) プロジェクト目標を達成するために十分な成果が定義されているか？	• プロジェクト目標、成果、活動の関係性 • 外部条件	• プロジェクトのロジックについて、打合せ及び計画策定ワークショップを通じて、ウガンダ側と合意を得ること	• 作成される PDM	• PDM
(2) 成果を達成するために十分な活動が計画されているか？				
(3) プロジェクト目標←成果←活動のロジックは適切か？				
(4) 外部条件が適切に定義されているか？				

III. プロジェクトが効率的に実施される条件

1: 成果を達成するために過不足のない投入が計画されている

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) 成果を達成するために過不足のない投入が計画されているか？	• 投入計画 • 活動実施スケジュール	• プロジェクトの投入及びスケジュールについて、ウガンダ側と合意を得ること	• 作成される PDM • 作成される PO	• PDM • PO
(2) 効率的な投入及び活動スケジュールが計画されているか？				

Ⅳ. プロジェクトを実施したインパクトが得られる条件

1: プロジェクトが上位目標の達成に貢献できる

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) 上位目標の記述は明確か？	• 上位目標の記述 • 上位目標の指標及び入手手段 • 外部条件	• プロジェクトのロジックについて、打合せ及び計画策定ワークショップを通じて、ウガンダ側と合意を得ること	• 作成される PDM	• PDM
(2) プロジェクトが上位目標の達成に貢献できる見通しは？				
(3) 指標は上位目標を正確に表しているか？				
(4) 指標は定期的に入手可能か？				
(5) ベースラインを明確にしているか？				
(6) 上位目標達成のための外部条件は？				

2: プロジェクトを実施することで、上位目標以外の正のインパクトもしくは波及効果が期待できる

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) 上位目標以外に期待できる正のインパクトはあるか？	• 期待できる正のインパクト	• 収集資料やインタビューを通じた情報をもとに、考察する	• 各種文献・資料 • インタビュー	• MOH • JICA • 病院及び医療機材維持管理ワークショップ

Ⅴ. 終了後もプロジェクトの効果が持続していく条件

1: プロジェクト終了後も、保健インフラマネジメント（HIM）及び保健サービス強化がウガンダの保健計画に位置づけられる

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) MOH はその保健政策・計画において HIM 及び保健サービス強化を続けるか？	• NHP II、HSSP III における記述 • MOH の方向性	• 強化の方向性が確認できること	• NHP II • HSSP III • インタビュー	• MOH （NHP II と HSSP III は入手済み）

2: プロジェクトで強化された体制を、終了後に自分たちで維持していく体制がウガンダ側にある

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) プロジェクト後に 5S-TQM を推進する体制は？	• 推進する体制	• 体制に関するアイディアがあること	• インタビュー • 資料・情報収集	• MOH
(2) HIM の将来像は？				

3: プロジェクトで強化された体制を、終了後に自分たちで維持していく財政基盤がウガンダ側にある

設問	評価指標	評価基準	指標入手手段	指標入手先
(1) MOH は維持管理予算（機材修理、定期点検、報告業務）を十分に確保できるか？	• 予算の現状 • 将来的な確保の見通し	• 財源が確保される見通しがあること	• インタビュー • 資料・情報収集	• MOH
(2) 県はユーザートレーニング予算を確保できるか？				


ジャイカ
JICA