ウガンダ国
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

プロジェクト事業完了報告書

平成26年12月
（2014年）

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＜添付資料一覧＞

略語集

AHSPR	Annual Health Sector Performance Report	保健セクターの年次報告書
ARV	Antiretrovirals	抗レトロウィルス薬
ASSIST	Applying Science to Strengthen and Improve Systems	
BTC	Belgian Technical Cooperation	ベルギー技術協力機構
BUT	Basic User Trainer	ベーシックユーザートレーナー
CME	Continuing Medical Education	病院スタッフへの院内継続教育
CSO	Civil Society Organisation	市民社会団体
CQI	Continuous Quality Improvement	継続的な質改善
DANIDA	Danish International Development Agency	デンマーク国際開発庁
DHO	District Health Officer	県保健局長
GH	General Hospital	県病院
HC	Health Center	ヘルスセンター
HMIS	Health Maintenance Information System	保健情報システム
HSSIP	Health Sector Strategic and Investment Plan	保健セクター戦略投資計画
JICA	Japan International Cooperation Agency	独立行政法人国際協力機構
JCC	Joint Coordination Committee	合同調整委員会
JOCV	Japan Overseas Cooperation Volunteer	青年海外協力隊
JRM	Joint Review Mission	合同評議会
MCH	Maternal and Child Health	母子保健
ME	Medical Equipment	医療機材
NGO	Non-Governmental Organizations	非政府組織
NHA	National Health Assembly	ナショナルヘルスアセンブリー
NO	Nursing Officer	看護師
PDM	Project Design Matrix	プロジェクトデザインマトリックス
PHA	Principal Hospital Administrator	病院管理部長

QAD	Quality Assurance Department	品質保証部
QIFSP	Quality Improvement Framework and Strategic Plan	質改善枠組みおよび戦略計画
QIP	Quality Improvement Partner	品質管理パートナー
QIT	Quality Improvement Team	品質管理チーム
R/D	Record of Discussion	討議議事録
RRH	Regional Referral Hospital	地域中核病院
SPNO	Senior Principal Nursing Officer	総看護師長
SUO	Standard Unit of Output	標準保健・医療サービス単位
SUT	Senior User Trainer	シニアユーザートレーナー
TOR	Terms of Reference	委任事項
TOT	Training of Trainers	訓練者養成研修
TQM	Total Quality Management	総合的品質管理
URC	University Research Co., LLC	
USAID	United States Agency for International Development	米国国際開発庁
UT	User Trainer/User Training	ユーザートレーナー/ユーザートレーニング
WIT	Work Improvement Team	業務改善チーム
WS	Medical Equipment Maintenance Workshop	医療機材メンテナンス・ワークショップ
5S	Sort-Set-Shine-Standardize-Sustain	整理・整頓・清掃・清潔・躾

１．プロジェクトの概要

１－１　プロジェクトの背景

2009 年、ウガンダ政府は 5S 活動の手法を用いた病院内職場環境の改善、医療機材使用者に対するトレーニング、医療機材維持管理にかかる技術協力プロジェクトの実施を日本政府に要請した。これを受け、2010 年 8 月から 9 月にかけて独立行政法人国際協力機構（以下、JICA）による詳細設計策定調査が実施され､プロジェクトについてウガンダ政府と JICA の協力の方向性が確認された。2011 年 4 月 19 日にウガンダ政府と JICA によって署名された討議議事録(以下、R/D)に基づき、ウガンダ政府は、JICA との協力によって、R/D 添付の基本計画に沿って「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」の実施を決定した。プロジェクトの実施にあたり、JICA はプロジェクトに対する技術協力を行う専門家のチームを選定した。プロジェクトは、第 1 年次（2011 年 8 月～2012 年 9 月)、第 2 年次（2012 年 9 月～2014 年 1 月)、第 3 年次（2014 年 1 月～2015 年 1 月）で実施され、2014 年 11 月に全専門家の現地活動が終了した。

１－２　プロジェクトの目標

本プロジェクトの上位目標、プロジェクト目標、成果は以下のとおりである。

[上位目標]
既存保健インフラの効果的かつ効率的な活用により、保健サービスの供給が改善される。

[プロジェクト目標]
対象医療施設において保健インフラのマネジメントおよび利用が改善する。

[成果]
1. 5S-CQI-TQM 活動が全国の対象医療施設で実施される。
2. 医療機材の利用状況が全国の対象病院で改善する。
3. 全国の医療機材維持管理ワークショップにおける医療機材の維持管理が改善する。

１－３　プロジェクトの活動概要

本プロジェクトは、大きく分けて「5S-CQI-TQM 活動 (成果 1)」､「ユーザートレーニング活動 (成果 2)」､「医療機材維持管理活動 (成果 3)」の 3 活動にくわえ、プロジェクトの成果、目標達成度を評価する効果検証調査から成り立つ。以下にそれぞれの活動の概要を示す。

１－３－１　5S-CQI-TQM 活動

1）5S-CQI-TQM 活動概要

[成果]

1. 5S-CQI-TQM 活動が全国の対象医療施設で実施される。

[活動]

1-1. 5S-CQI-TQM 活動を拡大する（全国レベルの活動）
1-2. 5S-CQI-TQM 活動を拡大する（地域レベルの活動）
1-3. 5S-CQI-TQM 活動を拡大する（病院レベルの活動）

ウガンダ国保健省は、同国医療従事者の経験や技術を最大限に活用し、職場環境を最良のものにするため、「5S」をサービスすべての質改善イニシアティブの基礎とした。整理－整頓－清掃－清潔－躾の「5S」は連続した活動で、職場環境や労働条件を整え、業務を遂行するための準備や業務の標準化を実現し、効率的な業務環境の整備に役立つものである。医療現場においては、これらの活動を導入することにより、医療サービスの質が大きく改善するとが期待される。

・医療サービスと生産性

医療現場において、機材や薬品およびカルテ等の管理は医療従事者に多くの時間を割く要因となるもので、サービスデリバリーのタイムロスを生んでいる。5S 活動によって業務を標準化させ、物品の取り出しや業務を効率的に行うことで、サービスの質の向上につながる。

・医療インフラの運営管理

業務環境をきれいに保つことで、医療従事者自身が機器の不具合等を把握しやすくなり、機器の予防保守管理が可能となる。

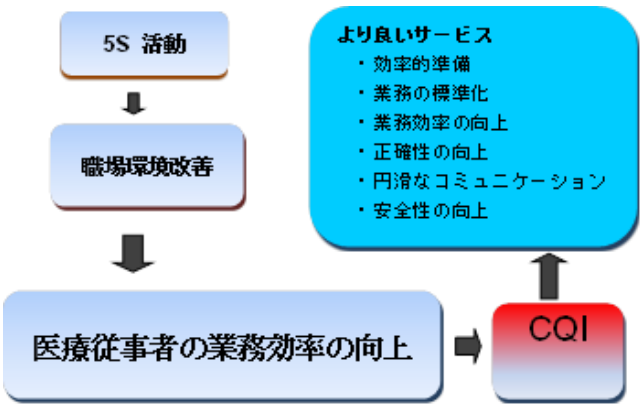


図 1-1：5S-CQI-TQM 概念図

・健康と安全性

5S 活動は患者への医療サービス改善のほか、職場での安全を守ることにも効果がある。また、マーケティングツールとしても有要である。よく整備された病院は、よく管理された職員による良質のサービスを創造できる。

2) 5S-CQI-TQM にかかる課題と、課題解決のために実施した活動

分野	当初の課題	実施した活動
5S-CQI-TQM 活動の全国展開	●全国の医療施設へ 5S-CQI-TQM を展開するメカニズムがない ●5S 専門家が少ない ●保健ディベロップメントパートナーにおける 5S に関する情報が少ない	●5S-CQI-TQM チームの編成 ●ナショナルファシリテーターの育成 ●5S ガイドラインおよび5S ハンドブックの開発 ●ナショナルファシリテーターのタンザニア研修 ●5S 大会の開催（3 回） ●国家品質管理カンファレンス参加 ●改善 TOT の開催 ●ナショナルファシリテーターによる巡回指導の実施
5S-CQI-TQM 活動の地域での展開	●施設内の 5S の認識不足 ●地域内の 5S 指導者の不足 ●RRH と DHO のコミュニケーション不足 ●HDP 活動の情報不足	●ナショナルファシリテーターへの TOT の実施（3 回） ●巡回指導の実施 ●スタディツアーの実施（3 回） ●HDP および DHO への 5S ポスターの作成および配布 ●HDP への研修
5S-CQI-TQM 活動の施設での展開	●職員の医療サービスの質の認識不足 ●QIT 活動の理解不足 ●5S 指導者の不足 ●QI の基礎としての 5S 普及のメカニズムの欠如	●施設内 5S 研修の実施 ●5S 展開のための CME ワークショップ開催（６回） ●5S ハンドブック研修実施 ●巡回指導の実施

１－３－２　医療機材維持管理活動

1) ユーザートレーニング活動概要

[成果]

2. 医療機材の利用状況が全国の対象病院で改善する。

[活動]

2-1. 5S-CQI-TQM のコンセプトを活用したユーザートレーニングを実施する。

2-2. 医療機材ユーザーのトレーニングを実施する。

医学の進歩に伴い、医療機器は年々高度化・多様化している。しかし、ウガンダの医療従事者養成施設では、訓練用の機器が不足しており、実際に機器に触れることなく卒業し、医療現場で業務にあたっている。その結果、不適切な使用により機器を壊してしまう、あるいは破損を恐れるあまり機器を使用せずに放置するといった事例が散見される。

90 年代中頃、ウガンダ保健省は DANIDA の協力を得て、病院内で機器の取り扱いを指導するユーザートレーニングの制度を設立した。全国の看護師の中から、ユーザートレーニングを実施するユーザートレーナーを 20 名強選定し、育成した。

彼らはそれぞれの医療施設で医療機材の適切な使用に係る指導を行っていたが、育成後 20 数年

が経過し、多くのトレーナーが定年で現場を離れため、ユーザートレーニング制度は下火になっていた。

そのような状況下、本プロジェクトが開始され、新規ユーザートレーナーの育成が行われた。各対象施設から計 16 名のトレーナー候補生を選出し、基礎的医療機器、応用電子医療機器、教育指導法などを指導した。その後、候補生自らが対象施設および下位施設で実際にトレーニングを行い、研修スキルを身に付けた。これにより、16 名の候補生は正式なユーザートレーナーとして保健省より正式に認定された。

プロジェクトは、ユーザートレーニングの活動の中心となる組織の設立を提案し、16 名のトレーナーを中心としたユーザートレーナー委員会が設立された。本委員会は各医療施設におけるトレーニングの計画立案と実施、レーニングの質の向上、トレーナーの能力及び地位の向上、後進の育成などを目的とする。

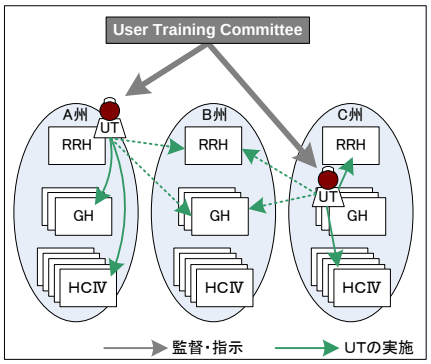


図 1-2：UT 実施概念図

本プロジェクトにおけるユーザートレーニングの主な活動は以下の通りである。これらの活動を全国 8 カ所の地域中核病院、県病院を対象に 3 年 4 か月の間実施した。

1．5S-CQI-TQM のコンセプトを活用したユーザートレーニングを実施する。
- ユーザートレーナーが 5S-CQI-TQM 研修に参加
- ユーザートレーニングのコンポーネントを 5S-CQI-TQM 研修マニュアルに取り込む

2．医療機材ユーザートレーニングを実施する
- ユーザートレーニングのニーズアセスメント実施
- ユーザートレーニングのニーズの高い機材を選定し、研修ガイドラインとマニュアルを作成
- 対象病院からユーザートレーニング受講者を選定
- 対象病院においてユーザートレーニングを実施
- 機材の使用状況について、ユーザートレーナーがモニタリング、スーパービジョンを行う
- ユーザートレーニング実施体制の評価を行う

2) ユーザートレーニング活動の課題と、実施した活動の内容

分野	当初の課題	実施した活動
医療機材ユーザートレーニングを5S-CQI-TQM研修の一部として実施する	●5S-CQI-TQMの普及と研修への参加 ●5S-CQI-TQMマニュアルへの取り込み	●5S大会への参加。 ●5S研修への参加 ●5S院内の5S活動への参加 ●対象施設外での5Sのポイント説明 ●ユーザートレーナーが5S-CQI-TQM研修に参加 ●5S-CQI-TQMマニュアルにUTの該当部分の取り込む
医療機器ユーザートレーニングを実施する	●多くの医療施設では医療機器の使用が適切に行われていない。 ●医療従事者に指導するトレーナーが居ない。 ●医療従事者の多くは医療機器の取り扱いについて正式な教育を受けたことがない。 ●トレーニングマニュアルの改版がなされていない。 UTの活動の中心となる組織が必要。	●トレーニングの対象機器のニーズアセスメント調査　2か月 ●調査結果よりトレーニングの必要性の多い機器の選定と、トレーニング方法の検討。 ●ユーザートレーナーの育成。 ●トレーニングのサポートスーパービジョンの実施。 ●UTマニュアルの改版作成、冊子400冊印刷、関係機関へ配布・普及。 ●UTタスクホースグループの設立支援

- ニーズアセスメントを行い基礎医療機器、応用電子医療機器の合計26アイテムをトレーニング対象機器とした。
- 16名のトレーナー候補生に対して、6回の研修を実施した。
- すべてのトレーナーに対して、修了試験を実施し全員が合格しユーザートレーナー資格証を取得した。
- 16名のトレーナー候補生に対して、7回の所属先、下位施設でのトレーニングの実施を計画しトレーニングを実施した。総合計は56回のトレーニングを実施した。受講者は延べ1200名程度である。
- トレーナーが研修を実施する際、参加者およびシニアユーザートレーナーはそれぞれのトレーナーのファシリテーションスキルを評価し、改善点を明確にしたうえで、それぞれのトレーナーの持つ課題に対して、シニアユーザートレーナーが指導を行った。
- の際に各トレーナーの評価を行いその結果をトレーナーに伝え能力の向上を図った。
- トレーニングマニュアルの改版（作成）を行った。
- ユーザータスクホースグループの設立支援を行った。
- トレーニング補助教材としてフリップチャート及びクイックリファレンスガイドの作成を行った。

１－３－３　医療機材維持管理活動

1）医療機材維持管理活動概要

[成果]

3. 全国の医療機材維持管理ワークショップにおける医療機材の維持管理が改善する。

[活動]

3-1. 医療機材管理計画の改善を行う。

3-2. 医療機材維持管理ワークショップにおける 5S-CQI-TQM 活動を推進する。

3-3. 医療機材維持管理体制の強化を行う。

ウガンダの保健セクター戦略では、医療機材メンテナンスを含む保健サービスの質の改善を重点項目にしている。さらに国家保健政策では、保健インフラマネジメントを保健セクターの優先課題の一つに挙げている。ウガンダ保健省は、医療技術の進歩に対応し医療機材メンテナンス・ワークショップ（Regional Medical Equipment Maintenance Workshop: WS）を設立し、医療機材メンテナンスの体制強化に取り組んでいる。本プロジェクトの医療機材維持管理活動は、WS の技術力および運営力の強化を通じて、医療機材の稼働率を高め、より医療機材が有効活用されることを目指している。

【概要】

カウンターパート：

保健省診療サービス部保健インフラ課（HID/MOH）

対象施設：全国 9 カ所の WS

（カンパラ、ムバレ、ソロチ、リラ、グル、アルア、ホイマ、フォートポータルおよびカバレ）

主な活動：

右概念図の 6 つの活動を通じて以下の向上を図った。

- 医療機材メンテナンス技師の技術と知識
- WS マネージャーの指導力と運営力
- 機材インベントリーの更新と結果の有効活用
- WS 内 5S 活動を通じた施設マネジメント
- WS 業務マニュアルの出版を通じた業務の標準化

サポート・スーパービジョンやマネージャー会議を通じた WS 全体の能力強化

図 1-3：医療機材維持管理活動概念図

2) 医療機材維持管理活動の課題と、実施した活動の内容

分野	当初の課題	実施した活動
インベントリー	●毎年定期更新されていない ●データ整理・分析技術が低い ●分析データが業務計画・予算計画に有効活用されていない	●ベースライン調査：4ヵ月 ●インベントリー更新：2回 ●インベントリー研修：1回 ●カンファレンスや JRM での分析データの発表・広報 ● サポート・スーパービジョン巡回
WS マネージャー会議	●四半期報告書の質と適時提出 ●WS と HID/MOH 間の不十分なコミュニケーション	●WS マネージャー会議開催：9回 ●他の開発パートナー（SUSTAIN, IDI）や若手テクニシャンの会議への参加
WS 内 5S 活動	●メンテナンス工具・機材・スペアパーツが倉庫内で混在している ●低い清潔意識	●全 WS で 5S 活動を展開 ●業務環境の大幅な改善 ●スーパービジョンと参加型リーダーシープを利用した 5S 活動のステップアップ ●5S モニタリング・シート改定
WS 業務マニュアル	●日常メンテナンスが標準化されていない ●標準書やガイドラインがない	●WS 業務マニュアル・メンテナンスガイドラインの開発 ●マニュアル 900 冊の印刷・配布
トレーニング	●医療機材メンテナンスの知識・技術不足	●メンテナンス技術研修：5回 ●Excel 研修：1回 ●日本研修：テクニシャン 4 名参加

１－３－４　効果検証調査

プロジェクトが実施した 5S-CQI-TQM、ユーザートレーニング、医療機材維持管理への介入の効果発現に関し、2012-14 年の 2-5 月にデータ収集、分析、報告書作成を行った。
具体的なテーマは以下の 2 点で、すべて「効果検証調査報告書」に記載された。

- ユーザートレーニングおよび維持管理活動の、医療機材稼働率改善効果
- 5S 活動の、病院スタッフのモチベーション向上、待ち時間短縮、患者満足度向上の効果

分析結果は、ウガンダ国内の 5S 大会（2014 年 8 月）や日本の国際保健医療学会（2013 年 11 月および 2014 年 11 月）で報告された。2014 年 8 月の 5S 大会では、「効果検証調査報告書」が共有された。また「効果検証調査報告書」をもとに 5S 活動の一連の効果に関する論文が作成され、International Journal for Quality in Health Care 誌に投稿された。

1) ユーザートレーニングおよび維持管理活動の、医療機材稼働率改善効果
【概要】ユーザートレーニング実施 8 病院を対象に、プロジェクトを通じて育成されたユーザートレーナー、ユーザートレーニング受講者、医療機材維持管理テクニシャンの知識と医療機材稼働率（可動でかつ使用されている機材の割合）との相関を分析した。また、ユーザートレーニン

グおよび維持管理に関するプロジェクトの介入が、機材稼働率の向上に有意な効果を与えているかどうかについて、重回帰分析を行った。

【結果】

- ユーザートレーナーの知識は、ユーザートレーニング受講者の知識と有意な正の相関があった。また、ユーザートレーニング受講者の知識は、可動でかつ使用されている医療機材の割合と有意な正の相関があった。
- 医療機材テクニシャンの知識は、故障中だが修理可能な機材の割合低下に有意な相関がみられた。
- 重回帰分析の結果、ユーザートレーニング、維持管理いずれの介入も医療機材稼働率向上に有意な効果を与えていたことが明らかになった。

【考察】ユーザートレーニングおよび維持管理に関するプロジェクトの介入は、機材稼働率の向上に効果があった。

2）5S 活動の、病院スタッフのモチベーション向上、待ち時間短縮、患者満足度向上の効果

【概要】地域中核病院 13 カ所と県病院 8 カ所（多くはプロジェクト開始前の 2010 年から 5S 活動を開始）を対象に、2012-14 年の 2-3 月に、病院スタッフのモチベーション、患者待ち時間、患者満足度を計測し、「差の差」理論を応用した重回帰分析を行った。地域中核病院については、2012 年に 5S 活動を開始した 10 病院と未実施 3 病院、県病院についてはプロジェクト介入 2 病院と非介入 6 病院の差の比較を行った。

【結果】

- 地域中核病院（ムバレを除き 5S 活動歴 2 年）：スタッフのモチベーションについては、「現在の病院で働きたい気持ち」について有意な差が見られた。患者待ち時間については、5S 実施 10 病院の薬局で有意な改善が見られた。しかし、患者満足度の差は明らかにならなかった。
- 県病院（5S 活動歴少なくとも 4 年）：5S 活動に対するプロジェクトの介入は、「患者に対するスタッフの態度」、「医薬品があること」等、患者満足度のさまざまな側面で、5S 活動 3 年目には見られなかった有意な差をもたらした。また、外来診療の患者待ち時間を有意に改善した。しかし、2 病院に対する 5S のみの介入は、スタッフのモチベーションを持続させられなかった。

【考察】

- ウガンダでは、病院での 5S 実施が患者満足度のレベルで効果が現れるまでに少なくとも 4 年を要する。これは 「ウガンダ 5S 実施ガイドライン」 で、5S が定着すると期待されるタイミングと一致する。
- しかし、5S 活動への支援のみでスタッフのモチベーションを 4 年も持続させることは困難である。5S が定着し効果が現れる 4 年目は、サービス品質改善のための次のステップである CQI へ移行するタイミングである。

１－４　プロジェクトの対象施設

本プロジェクトの活動対象地域と施設は、次のとおり。7 地域中核病院（以下、RRH）の他、東部のトロロ県病院（以下、GH）を本プロジェクトのナショナルショーケースと位置付ける。また、ヘルスセンター（以下、HC）IV は東部トトロ地区内にあるムクジュ HC IV を対象とする。

表 1-1：対象病院一覧

地域	病院名	地域	病院名
東部	トロロ GH ムバレ RRH ムクジュ HC IV	中央部	マサカ RRH エンテベ GH
南西部	カバレ RRH	西部	ホイマ RRH
北部	リラ RRH	北西部	アルア RRH
北東部	モロト RRH		

一方、本プロジェクトの医療機材維持管理に関連した活動は、首都カンパラに位置するワビガロ中央ワークショップ(以下、中央 WS)および以下に示す 8 カ所の地方ワークショップ（以下、WS）を拠点としている。

表 1-2：対象 WS 一覧

地域	ワークショップ名	地域	ワークショップ名
東部	ソロチ WS ムバレ WS	中央部	ワビガロ中央 WS
南西部	カバレ WS	西部	ホイマ WS フォートポータル WS
北部	リラ WS グル WS	北西部	アルア WS

１－５　プロジェクトの実施体制

本プロジェクトは以下の合同調整委員会（以下、JCC）メンバーおよび日本人専門家により運営された。

表 1-3：JCC メンバー一覧

プロジェクトダイレクター	
Director General of Health Services	Dr. Jane Ruth Aceng
プロジェクトマネージャー	
Director,Clinical and Community Health (Ag) / Commissioner Clinical services,Directorate of Clinical and Community Health	Dr. Amandua Jacinto
JCC メンバー	
Director,Planning and Development	Dr. Ezati Isaac
Commissioner Quality Assurance,Directorate of Planning and Development	Dr. Mwebesa Gatyanga
Assistant Commissioner Department of Nursing	Sr. Mwebaza Enid
Commissioner,Planning Directorate of Planning and Development	Dr. Francis Runumi

Under Secretary	Mr. S.S Kyambadde
Assistant Commissioner,Quality Assurance	Dr. Sarah Byakika
Assistant Commissioner,Integrated Curative Services Division,Department of Clinical Services,Directorate of Clinical and Community Health	Dr. Amone Jackson
Assistant Commissioner,Health Infrastructure Division,Department of Clinical Services,Directorate of Clinical and Community Health	Eng. SSB Wanda
Assistant Commissioner,Budget and Finance,Department of Planning	Mr.Candina Tom Aliti
Assistant Commissioner Accounts,MOH	Mr. Wycliffe Mwambu
Assistant Commissioner,Resource Centre,MOH	Dr. Edward Mukooyo
日本人専門家	
総括/保健システム	阿部一博
5S-CQI-TQM(1)/副総括	田制弘
5S-CQI-TQM(2)	吉川徹
ユーザートレーニング	比留間安弘
医療機材維持管理(1)	三室直樹
医療機材維持管理(2)	東條重孝
評価/研究計画	竹直樹
研修管理/5S-CQI-TQM(補助)	名波晶恵
業務調整/研修管理(補助)	飯島一徳
業務調整/研修管理(補助)	入澤聡子

２．プロジェクトの成果一覧

プロジェクト終了時点でのそれぞれの活動成果と、プロジェクト目標および上位目標の達成状況は以下のとおり。

1）プロジェクト成果および指標

【成果 1】 5S-CQI-TQM 活動が対象病院に拡大する。

指標	達成状況
1a. 5S-CQI-TQM モニタリング評価シートの 1S、2S、3S のスコアが 70%を上回る	モニタリング評価スコア （%）

Unit: %

		Leadership	Sort	Set	Shine	Standardize	Sustain
Arua RRH	Mar. 2012	36	31	22	38	31	32
	Nov. 2014	69	73	62	69	61	53
Kabale RRH	Mar. 2012	36	29	35	35	27	23
	Oct. 2014	72	71	73	70	60	59
Hoima RRH	Mar. 2012	36	20	25	28	22	32
	Oct. 2014	59	71	59	65	57	49
Mbale RRH	Mar. 2012	64	71	64	63	60	60
	Nov. 2014	76	77	76	78	67	69
Lira RRH	Mar. 2012	64	60	53	65	44	56
	Nov. 2014	60	64	65	64	60	48
Masaka RRH	Mar. 2012	56	49	47	48	31	52
	Oct. 2014	58	57	52	56	46	48
Mortro RRH	Mar. 2012	72	51	38	73	44	0
	Nov. 2014	84	86	78	88	75	80
EntebbeGH	Mar. 2012	64	71	65	70	58	60
	Oct. 2014	81	82	80	83	77	75
Tororo RRH	Mar. 2012	96	91	78	92	68	74
	Nov. 2014	56	63	60	64	56	46

	カバレ RRH、ムバレ RRH、モロト RRH、エンテベ GH は 1S～3S の目標を達成した。アルア RRH、ホイマ RRH では 1S のみ目標を達成し、他の施設は目標達成に至らなかった。
1b. 対象医療施設における半数のユニットにおいて WIT が結成され、適切に機能している	対象施設の WIT 数 カバレ RRH、ムバレ RRH、モロト RRH、エンテベ GH、トロロ GH で目標を達成した。

施設名	施設内ユニット数 (A)	目標 WIT 数	WIT 数 2014.11 (B)	% (B/A*100)
アルア RRH	21	11	8	38%
カバレ RRH	20	10	12	50%
ホイマ RRH	19	10	5	26%
ムバレ RRH	23	12	23	100%
リラ RRH	25	13	4	16%
マサカ RRH	26	13	8	30%
モロト RRH	20	10	10	50%
エンテベ GH	20	14	12	60%
トロロ GH	17	8	9	52%

【成果 2】医療機材の利用状況が全国の対象病院で改善する。

指標	達成状況
2a. ユーザートレーナーのポストテストで、全員の正答率が 60%を上回る	ユーザートレーナー育成研修の実施前後でテストを実施し、受講生の習熟度を確認した。 事後テストの結果(%)

UT No.	ポストテスト						個人平均
	第 1 回	第 2 回	第 3 回	第 4 回	第 5 回	第 6 回	
01	78	90	72	83	-	-	80.8
02	75	79	61	75	67	93	75.0
03	83	91	84	66	90	77	81.8
04	75	70	85	50	69	93	73.3
05	80	85	75	58	74	83	75.8
06	83	90	84	75	85	-	83.4
07	85	86	77	91	70	89	83.0
08	78	86	86	75	82	86	82.2
09	70	69	67	83	87	90	77.7
10	78	95	67	79	70	89	79.7
11	77	79	77	83	88	77	80.2
12	82	94	85	70	94	83	84.7
13	84	87	85	66	76	96	82.3
14	82	93	70	70	-	94	81.8
15	78	73	69	66	69	91	74.3
16	80	88	78	91	83	91	85.2
						全体平均	**80.1**

<table>
<tr><td></td><td>全 6 回を通したポストテストの平均は 80.1 であり、目標である 60 をクリアした。</td></tr>
<tr><td>2b. 新規に育成された「有資格」ユーザートレーナーの数が 16 名を上回る</td><td>1)2012 年 8 月にベーシックユーザートレーナー(以下､BUT) の修了試験を、実施し 16 名が BUT の資格を取得した。

2)2013 年 9 月にユーザートレーナ(UT)の修了試験を実施し 16 名が UT の資格を取得した。</td></tr>
<tr><td>2c. ユーザートレーニングを 40 回以上実施する</td><td>第 2 年次までに対象 8 施設でそれぞれ 5 回、計 40 回のトレーニングを実施した。第 3 年次には対象 8 施設において、2 つの下位施設で 2 回ずつトレーニングを実施（計 32 回）した。さらに自立トレーニングを 8 対象施設で実施したため､総トレーニング数は合計 80 回となり、目標は達成されている。</td></tr>
<tr><td>2d. ユーザートレーニング受講者のポストテストで、理解度の平均が 80%を上回る</td><td>巡回指導で受講者に対して実施したトレーニングの実施後のテストの結果の平均

事後テスト結果（%）
<table>
<tr><th>病院名</th><th>第 1 回</th><th>第 2 回</th><th>第 3 回</th><th>第 4 回</th><th>第 5 回</th><th>病院平均</th></tr>
<tr><td>アルア RRH</td><td>94.7</td><td>94.0</td><td>93.8</td><td>87.0</td><td>93.2</td><td>92.5</td></tr>
<tr><td>リラ RRH</td><td>93.7</td><td>86.0</td><td>85.4</td><td>91.1</td><td>99.5</td><td>91.1</td></tr>
<tr><td>ホイマ RRH</td><td>91.8</td><td>88.0</td><td>90.0</td><td>84.0</td><td>95.0</td><td>89.8</td></tr>
<tr><td>ムバレ RRH</td><td>88.0</td><td>86.0</td><td>90.9</td><td>89.6</td><td>86.0</td><td>88.1</td></tr>
<tr><td>マサカ RRH</td><td>95.8</td><td>93.3</td><td>91.5</td><td>-</td><td>92.0</td><td>93.2</td></tr>
<tr><td>カバレ RRH</td><td>92.1</td><td>91.4</td><td>87.5</td><td>86.5</td><td>85.9</td><td>88.7</td></tr>
<tr><td>エンテベ GH</td><td>85.7</td><td>87.1</td><td>80.8</td><td>88.1</td><td>85.2</td><td>85.4</td></tr>
<tr><td>モロト RRH</td><td>87.2</td><td>90.1</td><td>93.5</td><td>94.6</td><td>-</td><td>91.4</td></tr>
<tr><td colspan="5"></td><td>全体平均</td><td>90.0</td></tr>
</table>
上記病院で実施したユーザートレーニングにくわえ、各対象病院が管轄する下部施設でもトレーニングを実施した。以下にポストテストの結果を示す。</td></tr>
</table>

下部施設研修　事後テスト結果（%）

管轄病院	第 1 回	第 2 回	第 3 回	第 4 回	平均
アルア RRH	Oli HCⅣ 90	Maracha GH 92	Koboko HC Ⅳ 96	Kuluba Hospitl 96	93.5
リラ RRH	Ogur HCⅣ 94	Apac GH 86	Amach HCⅣ 100	Dokolo HCⅣ 87	91.8
ホイマ RRH	Kibube HCⅣ 76	Masindi GH 83	Kiboga GH 89	Kigoloobya HCⅣ 100	87.0
ムバレ RRH	Bududa GH 96	Kapchorwa GH 95	Tororo GH 78	Tororo GH 90	89.8
マサカ RRH	Sembabule HCⅣ 94	Rakai GH 92	Kalisizo GH 88	Bukulula HC Ⅳ 87	90.3
カバレ RRH	Kisoro GH 89	Muko HCⅣ 84	Bukinda HC Ⅳ 92	Hamurwa HC Ⅳ 94	89.8
エンテベ GH	Buwambo HCⅣ 88	Ndejje HCⅣ 84	Mukono HC Ⅳ 86	Kasangati HCⅣ 93	97.8
モロト RRH	Abim GH 83	Kotido GH 87	Amudat GH 84	Tokora HCⅣ 93	86.8
				全体平均	**89.6**

対象施設および下部施設におけるトレーニングのポストテスト結果の平均はそれぞれ 90、89.6 であり、目標値の 80 を達成している。

2e. 選定された医療機材の適切な使用にかかるレファレンスシートの作製	2013 年 12 月に完成したユーザートレーニングマニュアルをもとに、下位施設等でよく使用されている機器 19 品目についてレファレンスシートを作成した。

【成果 3】全国の医療機材維持管理ワークショップにおける医療機材の維持管理が改善する。

指標	達成状況
3a. 医療機材インベントリーにおいて、「使用されているか修理が必要」(「C」判定)な機材の割合が 12%を下回る。	

対象施設	2008 年	2012 年 6 月	2014 年 5 月
アルア RRH	7.7%	8.4%	8.2%
エンテベ GH	12.1%	19.5%	7.1%
ホイマ RRH	15.3%	31.3%	21.8%
カバレ RRH	6.7%	8.5%	12.0%
リラ RRH	19.6%	32.4%	30.7%
マサカ RRH	14.7%	13.4%	5.1%
ムバレ RRH	15.6%	20.8%	25.1%
モロト RRH	7.7%	6.1%	14.2%
トロロ GH	16.3%	7.1%	6.3%
ムクジュ HC IV	N/A	3.5%	21.2%
平均	**13.2%**	**17.7%**	**14.3%**

予算の遅延・減額および交換部品が入手できない等の理由によ

<table>
<tr><td></td><td>り、指標の達成には至らなかった。依然として、援助された機材には、交換部品の入手が困難な機材が多い。機材の選定や調達に関連する課題も大きい。</td></tr>
<tr><td>3b. 医療機材インベントリーにおいて、「故障しているが修理可能」（「E」判定）な機材の割合が 10%を下回る。</td><td>
<table>
<tr><th>対象施設</th><th>2008 年</th><th>2012 年 6 月</th><th>2014 年 5 月</th></tr>
<tr><td>アルア RRH</td><td>14.5%</td><td>9.7%</td><td>10.5%</td></tr>
<tr><td>エンテベ GH</td><td>21.4%</td><td>6.9%</td><td>14.2%</td></tr>
<tr><td>ホイマ RRH</td><td>12.2%</td><td>13.5%</td><td>13.6%</td></tr>
<tr><td>カバレ RRH</td><td>12.6%</td><td>13.9%</td><td>10.8%</td></tr>
<tr><td>リラ RRH</td><td>17.9%</td><td>7.2%</td><td>11.3%</td></tr>
<tr><td>マサカ RRH</td><td>11.0%</td><td>11.6%</td><td>11.2%</td></tr>
<tr><td>ムバレ RRH</td><td>16.1%</td><td>2.3%</td><td>0.4%</td></tr>
<tr><td>モロト RRH</td><td>18.3%</td><td>5.3%</td><td>3.2%</td></tr>
<tr><td>トロロ GH</td><td>16.3%</td><td>5.1%</td><td>5.3%</td></tr>
<tr><td>ムクジュ HC IV</td><td>N/A</td><td>8.8%</td><td>0.0%</td></tr>
<tr><td>平均</td><td>15.1%</td><td>9.4%</td><td>9.9%</td></tr>
</table>
いまだに半数の施設では 10%を上回るが、平均値では指標を達成できた。基礎機材の修理促進および 5S 活動を通じた老朽化機材の償却が進められたことが要因と思われる。</td></tr>
<tr><td>3c. 医療機材維持管理ワークショップが四半期報告書を期限内に提出する</td><td>
<table>
<tr><th>時期</th><th>提出数（9 か所中）</th></tr>
<tr><td>2012 年 2 月</td><td>2/9 (22%)</td></tr>
<tr><td>2012 年 11 月</td><td>5/9 (56%)</td></tr>
<tr><td>2013 年 2 月</td><td>8/9 (89%)</td></tr>
<tr><td>2013 年 5 月</td><td>6/9 (67%)</td></tr>
<tr><td>2013 年 9 月</td><td>8/9 (89%)</td></tr>
<tr><td>2013 年 11 月</td><td>8/9 (89%) *1</td></tr>
<tr><td>2014 年 2 月</td><td>9/9 (100%)</td></tr>
<tr><td>2014 年 5 月</td><td>9/9 (100%)</td></tr>
<tr><td>2014 年 11 月</td><td>9/9 (100%)</td></tr>
</table>
WS マネージャー会議の定期開催を通じて、提出率は劇的に良くなり、報告書の質も大幅に改善された。マネージャー会議は、各 WS 予算により今後も継続開催されるため、指標は定着しつつある。</td></tr>
<tr><td>3d. 研修後に知識が向上したスタッフの割合が 80%を上回る</td><td>
<table>
<tr><th>時期</th><th>場所</th><th>知識が向上した
スタッフの割合</th></tr>
<tr><td>2012 年 6 月</td><td>カンパラ</td><td>19/22 (86%)</td></tr>
<tr><td>2012 年 11 月</td><td>カンパラ</td><td>9/16 (56%) *2</td></tr>
<tr><td>2013 年 5 月</td><td>ホイマ</td><td>23/23 (100%)</td></tr>
<tr><td>2013 年 8 月</td><td>ﾌｫｰﾄ･ﾎﾟｰﾀﾙ</td><td>25/25 (100%)</td></tr>
<tr><td>2014 年 6 月</td><td>リラ</td><td>20/21 (95%)</td></tr>
<tr><td>2014 年 11 月</td><td>ムベンデ</td><td>26/26 (100%)</td></tr>
<tr><td>平均（6 回）</td><td></td><td>91.7%</td></tr>
</table>
計 6 回の技術研修を実施し、計 133 名の医療機材メンテナンス</td></tr>
</table>

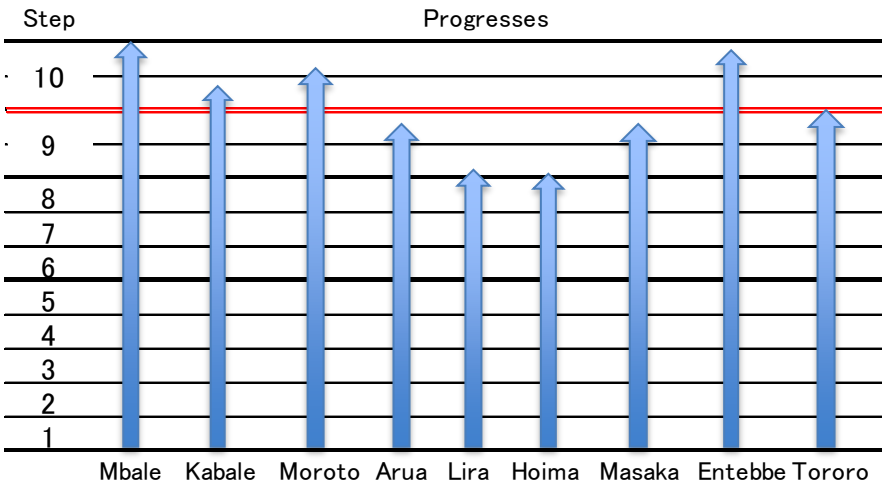
	技師が受講した。第 2 回研修を除く全ての研修で、参加者の大半に学習効果が確認された。 *[2]: 2012 年 11 月のみ、機材メンテナンスの技術研修ではなく、インベントリー更新のための Excel 研修を実施した。データ処理作業に手間取り、回答時間内に分析結果まで出せない参加者が多かったため点数が低くなった。

2) **プロジェクト目標の達成状況**

【成果】対象医療施設において保健インフラのマネジメントおよび利用が改善する。

指標	指標の収集状況と成果の達成状況
1. 医療機材インベントリーにおいて、「使用され、状態も良好」(「A」判定) な医療機材の割合が 60%を上回る	<table><tr><th>対象施設</th><th>2008 年</th><th>2012 年 6 月</th><th>2014 年 5 月</th></tr><tr><td>アルア RRH</td><td>42.6%</td><td>68.2%</td><td>57.3</td></tr><tr><td>エンテベ GH</td><td>37.6%</td><td>51.7%</td><td>67.7</td></tr><tr><td>ホイマ RRH</td><td>42.3%</td><td>39.3%</td><td>54.3</td></tr><tr><td>カバレ RRH</td><td>54.3%</td><td>52.1%</td><td>63.9</td></tr><tr><td>リラ RRH</td><td>35.7%</td><td>30.0%</td><td>46.6</td></tr><tr><td>マサカ RRH</td><td>55.2%</td><td>59.1%</td><td>72.8</td></tr><tr><td>ムバレ RRH</td><td>38.6%</td><td>61.0%</td><td>65.9</td></tr><tr><td>モロト RRH</td><td>31.7%</td><td>41.7%</td><td>51.1</td></tr><tr><td>トロロ GH</td><td>42.9%</td><td>84.7%</td><td>85.3</td></tr><tr><td>ムクジュ HC IV</td><td>N/A</td><td>45.6%</td><td>78.8</td></tr><tr><td>平均</td><td>43.1%</td><td>53.5%</td><td>61.9</td></tr></table> プロジェクト開始前から順調に改善し、プロジェクト目標は達成できた。最大の要因は、5S-UT-ME の 3 活動がうまく連携できたことにある。5S による不要機材の廃棄促進、UT による操作ミスの削減、および ME による修理や部品交換の向上が成果につながった。
2. 75%以上の WIT が 5S ガイドライン記載の 5S 実施レベル 10 (メンテナンス・フェーズ) に達している	5S ガイドラインに示す 5S 実施レベル 1 から 10 は以下のとおりである。 レベル 1　5S-CQI-TQM の意識付け レベル 2　管理者への 5S 研修 レベル 3　品質管理チームの組織化 レベル 4　現状分析 レベル 5　ショーケース部門の設定 レベル 6　ショーケース部門への 5S 研修 レベル 7　5S 活動チーム (WIT) の組織化 レベル 8　整理 - 整頓 - 清潔活動 レベル 9　整理、整頓、清潔の定着、ルール化 レベル 10　全活動、研修の繰り返し

第三年次終了時点の病院別 5S 実施レベルを以下に示す。



ムバレ RRH、カバレ RRH、モロト RRH、エンテベ GH では、WIT 数も順調に増え、ショーケースの 5S 活動も定着している。

3. 医療従事者満足度の上昇

医療従事者満足度は、(1)労働環境満足度、(2)従事施設への献身度、(3)より良いサービスの提供に係る意識で評価した。

(1)労働環境満足度　(スコアレンジ 3-12)

	ベースライン (2012 年 2 月 - 3 月)	**中間評価 (2013 年 2 月 - 3 月)**	**エンドライン (2014 年 2 月-3 月)**
アルア RRH	10.0	9.8	10.5
エンテベ GH	9.0	10.6	9.6
ホイマ RRH	10.2	10.6	8.8
カバレ RRH	10.6	9.8	10.2
リラ RRH	9.5	10.2	10.9
マサカ RRH	8.9	9.6	10.2
ムバレ RRH	10.5	10.4	9.4
モロト RRH	10.1	10.8	11.4
トロロ GH	11.1	10.7	9.9
ムクジュ HC IV	10.3	8.8	10.0
平均	**10.1**	**10.1**	**10.1**

(2)従事施設への献身度　(スコアレンジ 2-8)

	ベースライン (2012 年 2 月 - 3 月)	中間評価 (2013 年 2 月 - 3 月)	エンドライン (2014 年 2 月-3 月)
アルア RRH	6.4	6.0	6.6
エンテベ GH	6.3	7.1	6.1
ホイマ RRH	7.3	7.0	6.3
カバレ RRH	6.0	6.1	6.8
リラ RRH	7.0	6.4	6.6
マサカ RRH	6.1	6.8	6.3
ムバレ RRH	6.5	6.3	6.8
モロト RRH	5.9	6.3	6.1
トロロ GH	6.8	5.8	6.4
ムクジュ HC IV	6.7	5.1	7.0
平均	**6.5**	**6.3**	**6.5**

(3)より良いサービスの提供に係る意識　(スコアレンジ 5-20)

	ベースライン (2012 年 2 月 - 3 月)	中間評価 (2013 年 2 月 - 3 月)	エンドライン (2014 年 2 月-3 月)
アルア RRH	18.8	18.9	18.9
エンテベ GH	18.4	18.7	18.4
ホイマ RRH	18.4	19.3	17.2
カバレ RRH	18.6	18.8	18.6
リラ RRH	18.8	18.7	18.9
マサカ RRH	17.6	18.8	17.5
ムバレ RRH	18.6	18.3	19.8
モロト RRH	19.0	19.1	19.2
トロロ GH	19.6	19.1	19.3
ムクジュ HC IV	19.4	18.1	19.6
平均	**18.7**	**18.8**	**18.9**

3) 上位目標の達成状況

【成果】既存保健インフラの効果的かつ効率的な活用により、保健サービスが改善される

以下、End-line Impact Assessment Report、および 5S 専門家による調査結果から引用

指標	指標の収集状況と成果の達成状況
1. 患者満足度の上昇	RRH の患者満足度は、患者への態度や待ち時間の印象という面でベースライン調査時よりも改善した。しかし、5S 未実施 RRH との比較からは、5S の実施が患者満足度の向上に効果があったとはいえない。 GH においても、患者への態度や全体的な満足度の面でベースライン調査時よりも改善した。また、プロジェクト非介入の 5S 実施 GH との比較から、5S 活動による患者満足度改善の効果が確認された。
2. 患者待ち時間の減少	RRH においては、外来、薬局いずれにおいてもベースライン調査時と比較して改善した。また、薬局の待ち時間において、5S 活動の効果がみられた。 GH の待ち時間は、薬局においてベースライン調査時よりも改善した。また、外来の待ち時間について 5S 活動の効果がみられた。
3. 外来診療科の患者数の増加	外来診療科の患者数は以下のとおり。

	2012	2013	2014
アルア RRH	72,572	166,309	171,639
エンテベ GH	115,276	152,220	164,076
ホイマ RRH	42,352	51,011	203,011
カバレ RRH	109,982	169,430	215,510
リラ RRH	172,745	56,156	98,153
マサカ RRH	96,280	81,995	91,593
ムバレ RRH	44,555	48,939	48,642
モロト RRH	88,648	71,508	71,844
トロロ GH	55,004	61,260	65,223
ムクジュ HC IV	22,104	24,312	27,203
平均	**81,952**	**88,314**	**115,689**

4. 検査室における血液検査数の増加	検査室における血液検査数は以下のとおり。 **2012** / **2013** / **2014** アルア RRH: 8,657 / 15,010 / 11,652 エンテベ GH: 4,843 / 6,450 / 8,043 ホイマ RRH: 7,667 / 7,652 / 8,289 カバレ RRH: 13,358 / 12,793 / 14,861 リラ RRH: 10,756 / 12,901 / 41,453 マサカ RRH: 23,371 / 17,147 / 14,808 ムバレ RRH: 5,220 / 4,060 / 7,347 モロト RRH: 10,201 / 7,583 / 8,271 トロロ GH: 23,867 / 23,518 / 29,094 ムクジュ HC IV: 3,888 / 6,001 / 7,698 **平均**: **11,183** / **11,312** / **15,152**
5. X線検査を受けた患者数の増加	X線検査を受けた患者数は以下のとおり。 **2012** / **2013** / **2014** アルア RRH: 1,300 / 5,096 / 1,307 エンテベ GH: 3,368 / 4,775 / 4,904 ホイマ RRH: 4,206 / 2,298 / 4,305 カバレ RRH: 1,237 / 5,257 / 7,838 リラ RRH: 3,379 / 6,443 / 3,196 マサカ RRH: 2,417 / 4,726 / 3,194 ムバレ RRH: 1,178 / 680 / 1,705 モロト RRH: 2,701 / 2,743 / 0 トロロ GH: 0 / 0 / 0 ムクジュ HC IV: 0 / 0 / 0 **平均**: **1,979** / **3,202** / **2,645**
6. 超音波検査を受けた患者数の増加	超音波検査を受けた患者数は以下のとおり。 **2012** / **2013** / **2014** アルア RRH: 1,660 / 1,915 / 2,724 エンテベ GH: 3,444 / 4,701 / 561 ホイマ RRH: 4,526 / 0 / 0 カバレ RRH: 2,348 / 4,987 / 5,894 リラ RRH: 4,124 / 6,345 / 2,347 マサカ RRH: 2,416 / 4,101 / 5,407 ムバレ RRH: 202 / 458 / 1,601 モロト RRH: 2,691 / 1,507 / 0 トロロ GH: 693 / 1,071 / 1,493 ムクジュ HC IV: 14 / 19 / 28 **平均**: **2,212** / **2,510** / **2,006**

<table>
<tr>
<td>7. 地域5Sファシリテーターによる研修を実施した全国の病院数の増加</td>
<td>・2011年8月：なし

・2013年3月：なし
*該当ファシリテーターの所属する病院以外を対象とした。

・2014年11月：2施設

<table>
<tr><th>場所</th><th>地域ﾌｧｼﾘﾃｰﾀｰ所属先</th><th>概要</th></tr>
<tr><td>マサカRRH</td><td>マサカRRH</td><td>2014年10月
周辺施設より参加者を募り、マサカ RRH で研修を実施</td></tr>
<tr><td>ネビGH</td><td>アルアRRH</td><td>2014年10月
アルア RRH 管轄のネビGHで研修実施</td></tr>
</table>
</td>
</tr>
<tr>
<td>8. 5S 活動を実施している全国の病院数の増加</td>
<td>・2011年8月：15施設
ナショナルショーケース：トロロGH
プロジェクト対象保健施設：ムバレRRH、エンテベGH、ムジュクHCIV
非対称保健施設：ソロチRRH、ブドゥダGH、ブギリGH、ブソルエGH、カプチョルアGH、マサフGH、ゴンベGH、ムランダHCIV、ナゴンゲラHCIV、ブシアHCIV、ムベンデRRH

・2013年3月：22施設(7施設の増加)
プロジェクト対象保健施設：マサカRRH、カバレRRH、ホイマRRH、アルアRRH、リラRRH、モロトRRH、グルRRH

・2014年11月：25施設 (3施設の増加)
非対称保健施設：ジンジャRRH、ムバララRRH、ナグルRRH</td>
</tr>
<tr>
<td>9. CQI 活動*を開始した対象医療施設数の増加

*当 CQI 活動は保健施設の全ての部門で行われているわけではない。</td>
<td>・2011年8月：なし

・2013年3月：2施設
プロジェクト対象保健施設：エンテベGH(母子保健および小児科)
ナショナルショーケース：トロロGH(薬科)

・2014年11月：3施設(1施設増加)
プロジェクト対象保健施設：ムバレRRH(内視鏡科、マサバ棟)</td>
</tr>
</table>

３．活動実施スケジュール

各活動の計画および実績を添付 3-1 に示す。

４．投入実績

４－１　専門家派遣実績

専門家派遣実績は以下のとおり。

表 4-1　専門家派遣実績一覧

氏名/担当	年次	派遣期間			日数	MM	備考	業務概要等
阿部　一博 総括 /保健システム	1	2011/8/9	～	2011/9/12	35	1.17		プロジェクト運営の総括を担当。
		2012/2/8	～	2012/3/8	30	1.00		
		2012/5/4	～	2012/6/16	44	1.47		
		2012/7/15	～	2012/8/19	36	1.20		
				1年次 小計	145	4.83		
	2	2012/10/18	～	2012/11/6	20	0.67		
		2013/2/2	～	2013/3/3	30	1.00		
		2013/4/27	～	2013/5/31	35	1.17		
		2013/10/29	～	2013/11/16	19	0.63		
				2年次 小計	104	3.47		
	3	2014/4/22	～	2014/5/14	23	0.77		
				3年次 小計	23	0.77		
				合計	**272**	**9.07**		
田制　弘 5S-CQI-TQM(1) /副総括	1	2011/10/3	～	2011/11/6	35	1.17		成果 1 5S-CQI-TQM 活動を担当。副総括として総括と共に業務管理を行う。
		2012/1/11	～	2012/5/15	126	4.20		
		2012/6/12	～	2012/8/19	69	2.30		
				1年次 小計	230	7.67		
	2	2012/9/22	～	2012/12/10	80	2.67		
		2013/1/19	～	2013/5/12	114	3.80		
		2013/7/19	～	2013/9/30	74	2.47		
		2013/10/20	～	2013/12/21	63	2.10		
				2年次 小計	331	11.03		
	3	2014/1/25	～	2014/3/29	64	2.13		
		2014/5/3	～	2014/6/21	50	1.67		
		2014/7/20	～	2014/8/19	31	1.03		
		2014/10/13	～	2014/11/29	48	1.60		
				3年次 小計	193	6.43		
				合計	**754**	**25.13**		
吉川　徹 5S-CQI-TQM(2)	1	2011/10/26	～	2011/11/6	12	0.40		成果 1 5S-CQI-TQM 活動を担当。
		2012/4/21	～	2012/5/6	16	0.53		
		2012/7/21	～	2012/8/6	17	0.57		
				1年次 小計	45	1.50		
	2	2013/4/20	～	2013/5/6	17	0.57		
				2年次 小計	17	0.57		
	3	派遣なし			0	0.00		
				3年次 小計	0	0.00		
				合計	**62**	**2.07**		
比留間　安弘 ユーザートレーニング	1	2011/8/9	～	2011/9/22	45	1.50		成果 2 ユーザートレーニング活動を担当。
		2011/11/13	～	2011/12/20	38	1.27		
		2012/2/6	～	2012/3/7	31	1.03		
		2012/4/12	～	2012/7/6	86	2.87		
		2012/7/24	～	2012/8/17	25	0.83		

			1年次 小計	225	7.50		
	2	2012/10/18	～ 2012/12/6	50	1.67		
		2013/1/15	～ 2013/2/27	44	1.47		
		2013/4/26	～ 2013/6/23	59	1.97		
		2013/8/20	～ 2013/10/22	64	2.13		
		2013/11/20	～ 2013/12/24	35	1.17		
			2年次 小計	252	8.40		
	3	2014/2/18	～ 2014/4/2	44	1.47		
		2014/5/18	～ 2014/7/1	45	1.50		
		2014/10/6	～ 2014/11/20	46	1.53		
			3年次 小計	135	4.50		
			合計	**612**	**20.40**		
三室　直樹 医療機材維持管理(1)	1	2012/1/28	～ 2012/3/30	63	2.10		成果3医療機材維持管理活動を担当。
		2012/6/12	～ 2012/8/7	57	1.90		
			1年次 小計	120	4.00		
	2	2013/1/26	～ 2013/3/18	52	1.73		
		2013/7/19	～ 2013/9/16	60	2.00		
		2013/11/1	～ 2013/12/6	36	1.20		
			2年次 小計	148	4.93		
	3	2014/5/3	～ 2014/6/22	51	1.70		
		2014/10/6	～ 2014/11/25	51	1.70		
			3年次 小計	102	3.40		
			合計	**370**	**12.33**		
東條　重孝 医療機材維持管理(2)	1	2011/9/7	～ 2011/11/5	60	2.00		成果3医療機材維持管理活動を担当。
		2012/4/13	～ 2012/7/11	90	3.00		
			1年次 小計	150	5.00		
	2	2012/10/20	～ 2012/12/15	57	1.90		
		2013/4/29	～ 2013/6/14	47	1.57		
			2年次 小計	104	3.47		
	3	2014/2/2	～ 2014/3/6	33	1.10		
			3年次 小計	33	1.10		
			合計	**287**	**9.57**		
竹　直樹 評価/研究計画	1	2011/8/9	～ 2011/9/19	42	1.40		プロジェクト活動の効果測定を担当。
		2011/10/6	～ 2011/11/3	29	0.97		
		2012/1/21	～ 2012/3/29	69	2.30		
			1年次 小計	140	4.67		
	2	2013/2/9	～ 2013/5/24	105	3.50		
		2013/9/14	～ 2013/10/13	30	1.00		
			2年次 小計	135	4.50		
	3	2014/2/22	～ 2014/5/14	82	2.73		
		2014/8/3	～ 2014/9/9	38	1.27		
			3年次 小計	120	4.00		
			合計	**395**	**13.17**		

名波　晶恵 研修管理 /5S-CQI-TQM(補助)	1	2012/1/11 ～ 2012/2/20	41	1.37		各活動の研修企画・実施を担当。成果 1 5S-CQI-TQM 活動を補佐
		2012/6/24 ～ 2012/8/11	49	1.63		
		1 年次 小計	90	3.00		
	2	2013/1/28 ～ 2013/3/3	35	1.17		
		2013/8/4 ～ 2013/9/12	40	1.33		
		2 年次 小計	75	2.50		
	3	2014/2/11 ～ 2014/3/2	20	0.67		
		2014/7/12 ～ 2014/8/11	31	1.03		
		3 年次 小計	51	1.70		
		合計	**216**	**7.20**		
飯島　一徳 業務調整 /研修管理(補助)	1	2011/8/9 ～ 2011/9/12	35	1.17		各活動の研修運営を補佐。調整調整一般。
		2011/10/24 ～ 2011/11/17	25	0.83		
		2012/3/14 ～ 2012/5/12	60	2.00		
		2012/6/22 ～ 2012/7/26	35	1.17	自社 5 日	
		1 年次 小計	155	5.17		
	2	2012/9/22 ～ 2012/10/26	35	1.17		
		2013/1/19 ～ 2013/3/9	50	1.67		
		2013/4/1 ～ 2013/5/15	45	1.50	自社 40 日	
		2 年次 小計	130	4.33		
	3	派遣なし	0	0.00		
		3 年次 小計	0	0.00		
		合計	**285**	**9.50**	自社 45 日	
入澤　聡子 業務調整/ 研修管理(補助)	1	派遣なし	0	0.00		各活動の研修運営を補佐。調整調整一般。
		1 年次 小計	0	0.00		
	2	2013/10/20 ～ 2013/11/21	33	1.10	自社 33 日+渡航 1	
		2 年次 小計	33	1.10		
	3	2014/2/18 ～ 2014/3/20	31	1.03		
		2014/4/19 ～ 2014/5/17	29	0.97		
		3 年次 小計	60	2.00		
		合計	**93**	**3.10**	自社 33+渡航 1	
1 年次 合計 (契約 1295 日 43.17MM)			1300	43.33	自社 5 日	
2 年次 合計 (契約 1256 日 41.87MM)			1329	44.30	自社 73 日+渡航 1	
3 年次 合計 (契約 717 日 23.90MM)			717	23.90		
合計			**3346**	**111.53**	自社 78 日+渡航 1	

４－２　研修員受入実績

プロジェクト期間中に本邦受入研修に参加したカウンターパートは以下のとおり。

表 4-2　研修受入実績

本邦研修

研修員氏名	役職	研修コース名	開始日 終了日	受入機関
Dr. Stuart Musisi	DH, Masaka Local Government	Health Systems Management 保健衛生管理	2011/5/5 2011/7/9	JICA 東京
Dr. Francis Mulwany	Hospital Director, Hoima RRH	Hospital Management (A) 病院経営・財務管理(A)	2011/9/7 2011/11/12	JICA 九州
Mr. Joseph Kisubi	PHA, Kabale RRH	Hospital Management (A) 病院経営・財務管理(A)	2011/9/7 2011/11/12	JICA 九州
Dr. Isaac Kadowa	PMO, QAD, MOH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B) 5S-KAIZEN-TQM による保健医療サービスの質向上(B)	2011/10/16 2011/11/5	JICA 東京

Ms. Dorothy Ajiambo	Senior Clinical Officer, 5S manager, Tororo GH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B) 5S-KAIZEN-TQM による保健医療サービスの質向上(B)	2011/10/16 2011/11/5	JICA 東京
Ms. Beatrice Alupo	PNO, Nursing Department, MOH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B) 5S-KAIZEN-TQM による保健医療サービスの質向上(B)	2011/10/16 2011/11/5	JICA 東京
Ms. Josephine Ejang	NO, Mulago National Referral Hospital	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B) 5S-KAIZEN-TQM による保健医療サービスの質向上(B)	2011/10/16 2011/11/5	JICA 東京
Dr. Ben Ayiko	MS, Entebbe GH	The Specialist in Healthcare Associated Infection Control and Prevention 院内感染管理指導者養成	2011/11/1 2011/11/26	JICA 東京
Dr. Henry Mwebesa	Commissioner QAD, MOH	Health Policy Development 保健衛生政策向上	2012/1/15 2012/1/28	JICA 東京
Dr. Bernard Odu	Hospital Director, Arua RRH	Evidence-Based Public Health:Concepts,Approaches and Tools for Health Policy and Planning エビデンスに基づく公衆衛生学：保健政策と計画立案のための概念・アプローチ・ツール	2012/1/17 2012/2/25	JICA 沖縄
Dr. Mihayo Placid	Hospital Director, Kabale RRH	Health Systems Management 保健衛生管理	2012/5/17 2012/7/21	JICA 東京
Dr. Andema Alex	Hospital Director, Moroto RRH	Hospital Management（A） 病院経営・財務管理（A）	2012/9/10 2012/11/10	JICA 九州
Ms. Drajea Hellen Iraku	NO, Arua RRH	Nursing Management 看護管理	2012/8/29 2012/11/17	JICA 東京
Dr. Osinde Michael Odongo	Hospital Director, Jinja RRH	The Specialist in Healthcare Associated Infection Control and Prevention 院内感染管理指導者養成	2012/11/6 2012/12/1	JICA 東京
Ms. Anguparu Maburuka	Public Health Nurse, Jinja RRH	The Specialist in Healthcare Associated Infection Control and Prevention 院内感染管理指導者養成	2012/11/6 2012/12/1	JICA 東京
Ms. Mwebaza Enid Mbabazi	Acting Commissioner, Nursing, MOH	Health Policy Development 保健衛生政策向上	2013/1/20 2013/2/2	JICA 東京
Mr. ABDALLAH Muhammed	Engineering Technician, Mbale RRH	Medical Equipment Maintenance(A) 医療機材維持管理	2013/6/2 2013/8/15	JICA 東京
Mr. KUSIIMA Noah Mawaggali	Engineering Technician, Hoima RRH	Medical Equipment Maintenance(A) 医療機材維持管理	2013/6/2 2013/8/15	JICA 東京
Ms. KYAZIKE Margaret	NO, Midwife, Mubende RRH	Nursing Management of Maternal and Child Health Nursing for African Countries 母子保健看護管理	2013/6/12 2013/8/10	JICA 東京
Ms. NABULIME Sarah	S.H.A., Bugiri GH	Hospital Management(A) 病院管理	2013/6/16 2013/8/14	JICA 東京
Dr. OUNDO Christopher	MS, DHO, Masafu GH, Busia DLG (Mr.)	Health Systems Management 保健衛生管理	2013/6/20 2013/7/13	JICA 東京
Dr. SSENDYONA Martin	SMO, QAD, MOH (Mr.)	Health Systems Management 保健衛生管理	2013/6/20 2013/7/13	JICA 東京
Ms. NABAWANUKA Doreen Arison	Head Nurse, Infection Prevention and Control, Nursing Dept., Mulago NRH	The Specialist in Healthcare Associated Infection Control and Prevention 院内感染管理指導者養成	2013/7/16 2013/8/10	JICA 東京
Ms. ASIIMWE	Coordinator of	The Specialist in Healthcare Associated	2013/7/16	JICA

Annet	CME/Registered Nurse, Mulago NRH	Infection Control and Prevention 院内感染管理指導者養成	2013/8/10	東京
Sr. TIBIWA Florence	Vice Nursing Director, SNO, 5S Manager, Gombe GH	Nursing Management 看護管理	2013/9/4 2013/11/16	JICA 東京
Ms. OYELLA Josephine	Head of Pharmacy, St. Mary's Hospital Lacor	Hospital Pharmacy - for Hospital Pharmacists - 病院薬局管理	2013/10/2 2013/11/7	JICA 東京
Dr. OPAR Bernard Toliva	PMO, MOH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(A) 5S-KAIZEN-TQM による保健医療サービスの質向上(A)	2013/11/24 2013/12/7	JICA 東京
Ms. ASEGE Jesca Janice	SNO, Mbale RRH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(A) 5S-KAIZEN-TQM による保健医療サービスの質向上(A)	2013/11/24 2013/12/7	JICA 東京
Dr. ACENG Jane Ruth	Director General Health Services, MOH	Health Policy Development 保健衛生政策向上	2014/1/19 2014/2/1	JICA 東京

第三国研修

研修員氏名	役職	研修コース名	研修開始日	受入機関
Ms.Alupo Beatrice	SNO, Nursing Department, MOH	Total Quality Management for Health Care Facilities for Africa	2010/1/9 2010/1/30	JICA エジプト
Dr.Ssendyona Martin	SMO, QAD, MoH	Total Quality Management for Health Care Facilities for Africa	2010/1/9 2010/1/30	JICA エジプト
Ms.Ateng Florence Sophia	PNO, Lira RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Mr.Opete Andrew	MS, Tororo GH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Ms.Kagwa Jaqueline	SNO, Kabale RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Ms.Mutonyi Walimbwa Roselyn	SNO, Entebbe GH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Ms.Aluo Anne Grace	NO, Moroto RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Ms.Auma Winfred	CO, Masaka RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Ms.Busulwa Nakasinde Christine	NO, Hoima RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Ms.Naikesa Florence Idah	NO, Mbale RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Ms,Driwaru Rukia Haruna	NO, Arua RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	JICA エジプト
Mr.Onyanga Geoffrey	NO, Kapchorwa GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2012/5/7 2012/5/11	JICA タンザニア
Ms.Kezaabu Sylivia	SHA, Busolwe GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2012/5/7 2012/5/11	JICA タンザニア
Ms.Kiboko Olobo Petua	SPNO, Lira RRH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2012/5/7 2012/5/11	JICA タンザニア
Dr.Opar Bernard Toliva	PMO, Clinical services Department, MOH	5S-KAIZEN-TQM Observation trip to Tanzania	2012/9/24 2012/9/28	JICA タンザニア

Sr. Draru Jessica	NO, Arua RRH	5S-KAIZEN-TQM Observation trip to Tanzania	2012/9/24 2012/9/28	JICA タンザニア
Dr. SSENDYONA Martin,	SMO, QAD, MOH (Mr.)	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	JICA タンザニア
Ms. ALAYO Mary Hellen,	NO, Tororo GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	JICA タンザニア
Sr. MASETE Metuwa Sarah,	NO, Mbale RRH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	JICA タンザニア
Mr. MUHWEZI Patrik,	Anesthetic Officer, Masafu GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	JICA タンザニア
Dr. MUTANDA Tonny,	MO, Orthopedics, Mulago NRH (Mr)	Integrated Learning Seminar for Medical Techniques and Technology Correlating to Problems in the Sub-Saharan African Countries	2013/8/18 2013/10/17	JICA 北陸
Dr. LUKAKAMWA Daniel,	MO, Specialist, Mulago NRH (Mr.)	Integrated Learning Seminar for Medical Techniques and Technology Correlating to Problems in the Sub-Saharan African Countries	2013/8/18 2013/10/17	JICA 北陸
Mr. ASUTAKU Butti Ben,	Laboratory Technologist, Mulago NRH	Infectious Diseases: Updates in Laboratory Diagnosis (ICCI)	2013/11/17 2013/12/17	JICA エジプト
Mr. OGWOK Patric,	Principal Lanoratory Technologist, Mubende RRH	Infectious Diseases: Updates in Laboratory Diagnosis (ICCI)	2013/11/17 2013/12/17	JICA エジプト
Ms. MIREMBE Violet,	Nursing Officer, Mubende RRH	Women's Health across the Lifespan	2014/1/12 2014/2/20	JICA エジプト
Mr. AHIMBISIBWE Expeditus,	Principal Health Economist, MOH	Health Economics (Economic Evaluation and Health Financing): Principles, Methodologies, Evaluation and Decision Making in Developing Countries	2014/1/12 2014/2/12	JICA エジプト
Ms. IMAET Faith Karakacha,	Nurse, Tororo GH	Total Quality Management for Health Care Facilities for Africa	2014/2/9 2014/2/27	JICA エジプト
Mr. OJWANG James,	Hospital Administrator, Tororo GH	Total Quality Management for Health Care Facilities for Africa	2014/2/9 2014/2/27	JICA エジプト
Ms. AKELLO Christine,	Nursing Officer, Lira RRH	Total Quality Management for Health Care Facilities for Africa	2014/2/9 2014/2/27	JICA エジプト

４－３　供与機材実績

日本円換算で 2 万円以上の供与機材のリストを巻末　添付 4-1 に掲載する。

４－４　在外事業強化費実績

プロジェクト期間中の在外事業強化費は以下のとおり。

表 4-3　在外事業強化費実績

	第一年次 2011 年 7 月 ～2012 年 9 月	第二年次 2012 年 9 月 ～2014 年 1 月	第三年次 2014 年 1 月 ～2015 年 1 月	合計
一般業務費	14,014,000 円	25,389,000 円	16,322,000 円	**55,725,000 円**
供与機材費	5,073,000 円	0 円	0 円	**5,073,000 円**
その他機材費	361,000 円	0 円	0 円	**361,000 円**
現地再委託費	5,480,000 円	6,271,000 円	6,789,000 円	**18,540,000 円**
小計	24,928,000 円	31,660,000 円	23,111,000 円	**79,699,000 円**

５．プロジェクト実施運営上の工夫と教訓

５－１　プロジェクト実施運営上の工夫

1）保健省内の掲示板の利用

プロジェクト事務所がウガンダ保健省内に設営されていなかった 2012 年 6 月､本プロジェクトのプレゼンス向上を目的に、同省内の掲示板 4 カ所を借りてプロジェクト活動紹介を開始した。5S 活動を中心に良好事例などの写真や医療機材インベントリー結果､ユーザートレーニングのポストテスト結果などを公開し、プロジェクトの進捗状況の広報に努めた。

2）無償資金協力事業との連携

2012 年 6 月、本プロジェクトの対象施設の一つであるマサカ RRH およびムベンデ RRH に対し、我が国の無償資金協力事業を用いて新病棟と医療機材の供与がなされた。同案件では医療機材の維持管理に係るソフトコンポーネントが実施された。このソフトコンポーネントの実施日程にあわせ、本プロジェクトのユーザートレーニングをマサカ RRH で実施し、それぞれの研修生が双方の研修に参加するなど､交流を図った｡ムベンデ RRH では無償資金協力による機材の供与を受け、2014 年に新たに WS を設立した。プロジェクトはムベンデ RWS の円滑な運営をめざし、同所において医療機材維持管理研修を実施した。

また、2013 年には、ムベンデ RRH において我が国の無償資金協力で供与した医療機材に関連した事象が発生したことを受け、ムベンデ RRH にくわえ、おなじく過去に無償資金協力によって医療機材が供与されているソロチ RRH の医療従事者に対するユーザートレーニングを実施した。

3）関係者との良好なコミュニケーション

ウガンダ保健省の本省施設内に空室が出なかったため、プロジェクト開始から 1 年 3 ヶ月にわ

たり、同省内にプロジェクト事務所を開設することが出来なかった。これにくわえ、多忙を極める一部のカウンターパートとは直接会って話をすることも難しく、プロジェクト活動にかかる協議は難航を極めた。しかし、メール等を用いて積極的に連絡をとるとともに、現地スタッフを有効に活用することで、十分なコミュニケーションを取るよう留意した。プロジェクト事務所開設後は、各活動レベルのカウンターパートだけでなく、事務次官(Permanent Secretary)や総局長(Director General)といったトップマネジメント層との関係構築に努めた。これらトップマネジメントを巻き込んだことで、その後のプロジェクト運営はより円滑になった。

また、JICA 本部監督職員および同ウガンダ事務所担当職員に対しては、業務管理グループによる毎月の定期活動報告、帰国前後の報告を通じて進捗状況の共有を心がけた。

3) スケジュール管理

保健省カウンターパートによる突然の予定変更など、途上国特有の事情に振り回されたものの、プロジェクト期間を通じて専門家のスケジュール管理に特段の問題はなかった。全年次を通して、専門家が滞在することはなかったが、極力日本人不在期間を減らすように各成果の活動計画の時期を考慮し、各専門家の派遣計画を策定した。

特に、中間レビューや終了時評価の際は、調査団の限られた滞在日程で打合せ、サイト調査、JCC を実施するため、それぞれ半年以上前から準備を進め、円滑な調査の補佐に努めた。

その他、追加業務の発生により、当初計画されていた専門家業務従事日数を変更する必要も発生したが、柔軟に対応することが出来た。

５－２　プロジェクト実施運営上の教訓

1) プロジェクト前提条件

5S 活動のナショナルショーケースとして位置づけていたトロロ GH を中心に全国へ活動を波及する想定であったが、人事異動による、人材の流出等から年次を経るごとに活動が停滞してきた。反面、他の施設が活動のショーケースとしての評価が高まってきている。ウ国においては、人事異動が活動の質を左右することを想定し、ショーケース病院に大きな責務を課すことはリスクがあり、常に活動の基礎固めを考慮しつつ運営する必要があると考える。

ユーザートレーニング活動について、医療機材の取り扱いを対象施設内の看護師などに教えるナショナル・ユーザートレーナーを中心に同活動を進めることが当初の前提であった。しかし活動が開始された直後、現在のナショナル・ユーザートレーナーの多くが 2～3 年以内に定年退職することがわかった。この結果を受け、象施設毎にユーザートレーナー候補者を選出し、育成することをユーザートレーニング活動に追加した。

一方、医療機材維持管理活動では、医療機材インベントリーが稼働していることが活動の前提であったが、対象施設の一部を除いて、2008 年からほぼ稼働していない状況であることが判明した。そこでプロジェクトは、各地方の機材保守ワークショップの現状調査および医療機材インベントリーが稼働していない原因調査を行い、再稼働に向けた計画策定を行った。

このように、プロジェクト活動実施の前提条件が満たされない状況下、カウンターパート、JICAと協議の上で柔軟に活動デザインを修正したことが功を奏したと考える。

６．PDM の変遷

プロジェクト終了時点では、PDM Ver.4 を使用していた。PDM Ver.1 から Ver.4 までの主な変更点を下表に示す。それぞれの PDM を添付資料 6-1 から 6-4 に掲載する。

表 6-1：PDM の変遷

	承認時期	主な変更点
PDM Ver.1	第 1 回 JCC 2011 年 9 月	-
PDM Ver.2	未承認	・ 上位目標、プロジェクト目標、成果の指標とその入手手段を変更
PDM Ver.3	第 3 回 JCC 2012 年 10 月	・ 上位目標、プロジェクト目標、成果の指標とその入手手段を変更 ・ 活動内容を現状にあわせ変更
PDM Ver.4	第 4 回 JCC 2013 年 5 月	・ 対象施設を明確化 ・ プロジェクト目標指標、活動成果指標に数値目標を設定

７．合同調整委員会（JCC）

プロジェクト期間中、全 7 回の JCC を開催した。各回の JCC における主要な議題は下表のとおり。なお、巻末の添付 7-1 から 7-7 に各回の議事録を掲載する。

表 7-1：合同調整委員会(JCC)実施記録

	実施日	主要な議題
第 1 回 JCC	2011 年 9 月	・ インセプションレポート説明 ・ 第 1 年次活動計画説明
第 2 回 JCC	2012 年 3 月	・ 第 1 回 JCC 議事録承認 ・ 第 1 年次活動経過報告 ・ PDM Ver.2（案）の説明
第 3 回 JCC	2012 年 10 月	・ 第 2 回 JCC 議事録承認 ・ 第 1 年次活動経過報告 ・ 第 2 年次活動計画説明 ・ PDM Ver.3 の説明、承認

第 4 回 JCC	2013 年 5 月	・ 第 3 回 JCC 議事録承認 ・ 第 2 年次活動経過報告 ・ 中間レビュー結果報告 / ミニッツ・オブ・メモランダムへの署名 ・ PDM Version 4 の説明、承認
第 5 回 JCC	2013 年 11 月	・ 第 4 回 JCC 議事録承認 ・ 第 2 年次活動経過報告 ・ 第 3 年次活動計画説明
第 6 回 JCC	2014 年 5 月	・ 第 5 回 JCC 議事録承認 ・ 第 3 年次活動経過報告 ・ 終了時評価結果報告 / ミニッツ・オブ・メモランダムへの署名
第 7 回 JCC	2014 年 11 月	・ 第 6 回 JCC 議事録承認 ・ 第 1～3 年次活動結果報告 ・ PDM 成果達成状況報告

以上

添付資料

添付 3-1 活動実施スケジュール
添付 4-1 供与機材リスト
添付 6-1 PDM Ver.1
添付 6-2 PDM Ver.2
添付 6-3 PDM Ver.3
添付 6-4 PDM Ver.4
添付 7-1 第 1 回 JCC 議事録
添付 7-2 第 2 回 JCC 議事録
添付 7-3 第 3 回 JCC 議事録
添付 7-4 第 4 回 JCC 議事録
添付 7-5 第 5 回 JCC 議事録
添付 7-6 第 6 回 JCC 議事録
添付 7-7 第 7 回 JCC 議事録

作　業　計　画

期間	2011年度							2012年度								2013年度											2014年度											
	第1年次															第2年次												第3年次										
	上段＝初年度計画 下段＝活動実績							上段＝初年度変更契約後計画 下段＝活動実績								上段＝2年次従前計画 下段＝活動実績											上段＝2年次変更契約計画 下段＝2年次変更契約活動実績				上段＝3年次活動計画 下段＝3年次活動実績										
作業項目	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
JCCによるモニタリング																																									
年次計画策定・評価(JCCでの協議、論文、提言書)																																									
広報活動																																									
業務実施計画の検討																																									
Ic/R draftの作成																																									
Ic/R の説明・協議、第1回JCC																																									
プロジェクト事務所の開設																																									
効果検証調査																																									
1-1 5S-CQI-TQMの活動の拡大（全国レベル）																																									
1　5S-CQI-TQM活動国内調整委員会の設立																																									
2　トロロ事例紹介による国内有力者啓発																																									
3　他のサービス質改善プログラムとの調和																																									
4　5S-CQI-TQMガイドラインの作成																																									
5　5S-CQI-TQM研修マニュアルの作成																																									
6　モニタリング、スーパービジョン、表彰制度の整備																																									
7　全国ファシリテータ育成研修																																									
8　対象病院のモニタリング、スーパービジョン																																									
9　5S-CQI-TQM活動評価																																									
10　5S-CQI-TQM活動定期会合（優秀病院表彰）																																									
11　活動評価を基にガイドライン、マニュアル改訂																																									
12　HSSIP改訂プロセス参加、5S-CQI-TQM活動成果統合																																									
1-2 5S-CQI-TQM活動の拡大（地域レベル）																																									
1　対象病院（東部HC IV含む）の選定																																									
2　トロロ事例紹介による地域有力者啓発																																									
3　全国ファシリテータによる地域ファシリテータ育成研修																																									
4　5S-CQI-TQM活動の地域内ネットワーク維持																																									
1-3 5S-CQI-TQM活動の拡大（病院レベル）																																									
1　5S-CQI-TQM実施体制（QIチーム）構築																																									
2　5S-CQI-TQM活動の年間計画を作成																																									
3　5S-CQI-TQM活動に必要な資材を調達																																									
4　5S-CQI-TQM活動の実施																																									
5　病院内のモニタリング、スーパービジョンを実施																																									
6　5S-CQI-TQM活動の域内他医療施設への普及																																									
2-1 ユーザートレーニング導入（5S-CQI-TQM研修）																																									
1　ユーザートレーナーが5S-CQI-TQM研修に参加																																									
2　5S-CQI-TQMマニュアルにユーザートレーニング取り込む																																									
3　ユーザートレーナーが5S-CQI-TQMファシリテーターの役割担う																																									
2-2 ユーザートレーニングの実施																																									
1　ユーザートレーニングのニーズアセスメント																																									
2　対象機材選定、研修ガイドライン・マニュアル作成																																									
3　対象病院から受講者を選定																																									
4　対象病院でトレーニング実施																																									
5　ユーザートレーナーによるモニタリング、スーパービジョン																																									
6　ユーザートレーニング実施体制の評価																																									
3-1 医療機材維持管理計画の改善																																									
1　機材インベントリ、報告システムの現状分析																																									
2　トレーニングの実施、改善を促す																																									
3　機材インベントリの更新																																									
4　機材インベントリのデータ分析																																									
5　予算メカニズムに見合うWS活動計画策定																																									
3-2 ユーザーとワークショップのコミュニケーション改善																																									
1　WSマネージャーが5S-CQI-TQM研修に参加する																																									
2　WSで5S-CQI-TQM活動を実施する																																									
3　病院の機材担当をQIチームに加える																																									
4　WSミーティングの機能を強化する																																									
3-3 医療機材維持管理体制の強化																																									
1　維持管理ガイドライン、マニュアルを必要に応じて改訂																																									
2　ガイドライン、マニュアルを対象病院に配布																																									
3　定期点検・維持管理活動の実施																																									
4　ガイドライン、マニュアル使用をモニタリング、スーパービジョン																																									
5　医療機材エンジニアリングの研修を実施																																									

添付 4-1 供与機材リスト

(1 UGX = 0.032 JPY, 1 USD =76.63)

Puechaced Date	Inspection Date	Hand-over date	Equipment	Specifications (Model /Maker)	Price(USD)	Price (UGX)	Price (JPY)	Stored Place	Condition	Note
1-Sep-11	11-Nov-11	2-Jul-12	4WD Veicle	MITSUBISHI PAJERO UG 4008	**59,213**	141,796,631	4,537,492	Project Office	good, in use	Procured by JICA Uganda Office
1-Sep-11	11-Nov-11	2-Jul-12	4WD Veicle	MITSUBISHI PAJERO UG 4009	**59213**	141,796,631	4,537,492	Project Office	good, in use	Procured by JICA Uganda Office
4-Oct-11	11-Nov-11	2-Jul-12	Latop Computer	HP 620 S/N 5CG1131JM7		**2,000,000**	64,000	Project Office	good, in use	Procured by JICA Uganda Office
10-Oct-11	11-Nov-11	2-Jul-12	Copying Machine	KYOCERA Taskalfa 3050 ci S/N N2Q1X04332		**15,940,000**	510,080	Project Office	good, in use	Procured by JICA Uganda Office
10-Oct-11	11-Nov-11	2-Jul-12	Copying Machine	KYOCERA Taskalfa 300 I S/N QZK1917828		**13,040,000**	417,280	Project Office (Wabigalo)	good, in use	Procured by JICA Uganda Office
29-Nov-11	11-Nov-11	2-Jul-12	Latop Computer	DELL P07G S/N 4BL0KP1		**1,725,000**	55,200	Project Office	good, in use	Procured by JICA Uganda Office
27-Mar-12	11-Nov-11	2-Jul-12	Laptop Computer	DELL N5040 S/N 4NNLHR1		**2,175,000**	69,600	Project Office	good, in use	Procured by JICA Uganda Office
27-Mar-12	11-Nov-11	2-Jul-12	Laptop Computer	DELL N5040 S/N 7TNLHR1		**2,175,000**	69,600	Project Office	good, in use	Procured by JICA Uganda Office
27-Mar-12	11-Nov-11	2-Jul-12	Laptop Computer	DELL N5040 S/N B3M7CR1		**2,175,000**	69,600	Project Office	good, in use	Procured by JICA Uganda Office
27-Mar-12	11-Nov-11	2-Jul-12	Laptop Computer	DELL N5040 S/N H2PLHR1		**2,175,000**	69,600	Project Office	good, in use	Procured by JICA Uganda Office
19-Jun-12	19-Jun-12	20-Jun-12	Projector	DELL 1210S S/N 5VH64P1		**1,965,000**	62,880	Moroto RRH	good, in use	
19-Jun-12	19-Jun-12	19-Jun-12	Projector	DELL 1210S S/N CB074P1		**1,965,000**	62,880	Lira RRH	good, in use	
19-Jun-12	19-Jun-12	20-Jun-11	Projector	DELL 1210S S/N HGH64P1		**1,965,000**	62,880	Arua RRH	good, in use	
19-Jun-12	19-Jun-12	20-Jun-12	Projector	DELL 1210S S/N 41J64P1		**1,965,000**	62,880	Kabale RRH	good, in use	
19-Jun-12	19-Jun-12	19-Jun-12	Projector	DELL 1210S S/N D9074P1		**1,965,000**	62,880	Entebbe GH	good, in use	
19-Jun-12	19-Jun-12	19-Jun-12	Projector	DELL 1210S S/N 8MJ64P1		**1,965,000**	62,880	Hoima RRH	good, in use	
19-Jun-12	19-Jun-12	19-Jun-12	Projector	DELL 1210S S/N B8074P1		**1,965,000**	62,880	Masaka RRH	good, in use	
19-Jun-12	19-Jun-12	19-Jun-12	Projector	DELL 1210S S/N J3074P1		**1,965,000**	62,880	Mbale RRH	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Projector	DELL 1210S S/N CC074PI		**1,965,000**	62,880	Wabigaro CWS	good, in use	
2-Jul-12	8-Jul-11	18-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 58J3D2S		**3,165,000**	101,280	Moroto RRH	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Computer	Dell Optiplex 990 S/N HPY1D2S		**3,165,000**	101,280	Lira RRH	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 7BJ3D2S		**3,165,000**	101,280	Arua RRH	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Computer	Dell Optiplex 990 S/N C8J3D2S		**3,165,000**	101,280	Kabale RRH	good, in use	
2-Jul-12	8-Jul-11	13-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 7H35D2S		**3,165,000**	101,280	Entebbe GH	good, in use	
2-Jul-12	8-Jul-11	12-Jul-12	Desktop Computer	Dell Optiplex 990 S/N DT25D2S		**3,165,000**	101,280	Hoima RRH	good, in use	
2-Jul-12	8-Jul-11	20-Jul-12	Desktop Computer	Dell Optiplex 990 S/N GNY1D2S		**3,165,000**	101,280	Masaka RRH	good, in use	
2-Jul-12	8-Jul-11	16-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 7G35D2S		**3,165,000**	101,280	Mbale RRH	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 9BJ3D2S		**3,165,000**	101,280	Wabigaro CWS	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 2T3D2S		**3,165,000**	101,280	Wabigaro CWS	good, in use	
2-Jul-12	8-Jul-11	16-Jul-12	Desktop Computer	Dell Optiplex 990 S/N BJ3D2S		**3,165,000**	101,280	Mbale RWS	**Stolen**	
2-Jul-12	8-Jul-11	11-Jul-12	Desktop Computer	Dell Optiplex 990 S/N GT25D2S		**3,165,000**	101,280	Soroti RWS	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 7735D2S		**3,165,000**	101,280	Kabale RWS	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Computer	Dell Optiplex 990 S/N GPY1D2S		**3,165,000**	101,280	Fort Portal RWS	good, in use	
2-Jul-12	8-Jul-11	12-Jul-12	Desktop Computer	Dell Optiplex 990 S/N GWT3D2S		**3,165,000**	101,280	Hoima RWS	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 4735D2S		**3,165,000**	101,280	Arua RWS	good, in use	
2-Jul-12	8-Jul-11	12-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 4J22D2S		**3,165,000**	101,280	Gulu RWS	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Computer	Dell Optiplex 990 S/N 4G35D2S		**3,165,000**	101,280	Lira RWS	good, in use	
2-Jul-12	8-Jul-11	18-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20312		**1,000,000**	32,000	Moroto RRH	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 19546		**1,000,000**	32,000	Lira RRH	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20308		**1,000,000**	32,000	Arua RRH	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20525		**1,000,000**	32,000	Kabale RRH	good, in use	

Puechaced Date			Equipment	Specifications (Model /Maker)	Price(USD)	Price (UGX)	Price (JPY)	Stored Place	Condition	Reason of "not in use"
2-Jul-12	8-Jul-11	13-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20440		**1,000,000**	32,000	Entebbe GH	good, in use	
2-Jul-12	8-Jul-11	12-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20277		**1,000,000**	32,000	Hoima RRH	good, in use	
2-Jul-12	8-Jul-11	20-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20536		**1,000,000**	32,000	Masaka RRH	good, in use	
2-Jul-12	8-Jul-11	16-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 19781		**1,000,000**	32,000	Mbale RRH	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20218		**1,000,000**	32,000	Wabigaro CWS	good, in use	
2-Jul-12	8-Jul-11	16-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 21909		**1,000,000**	32,000	Mbale RWS	good, in use	
2-Jul-12	8-Jul-11	11-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20526		**1,000,000**	32,000	Soroti RWS	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 19987		**1,000,000**	32,000	Kabale RWS	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20281		**1,000,000**	32,000	Fort Portal RWS	good, in use	
2-Jul-12	8-Jul-11	12-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 19977		**1,000,000**	32,000	Hoima RWS	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20513		**1,000,000**	32,000	Arua RWS	good, in use	
2-Jul-12	8-Jul-11	12-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 20306		**1,000,000**	32,000	Gulu RWS	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Desktop Printer	HP 1102 S/N CNCFD 21900		**1,000,000**	32,000	Lira RWS	good, in use	
2-Jul-12	8-Jul-11	18-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU209430M		**2,650,000**	84,800	Moroto RRH	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU2100LXN		**2,650,000**	84,800	Lira RRH	good, in use	
2-Jul-12	8-Jul-11	9-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU2100M64		**2,650,000**	84,800	Arua RRH	good, in use	
2-Jul-12	8-Jul-11	10-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU1382BIF		**2,650,000**	84,800	Kabale RRH	good, in use	
2-Jul-12	8-Jul-11	13-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU1352TBO		**2,650,000**	84,800	Entebbe GH	good, in use	
2-Jul-12	8-Jul-11	12-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU1352P4B		**2,650,000**	84,800	Hoima RRH	good, in use	
2-Jul-12	8-Jul-11	20-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU21000RRH		**2,650,000**	84,800	Masaka RRH	good, in use	
2-Jul-12	8-Jul-11	16-Jul-12	Laptop Computer	HP Pavilion DM4 S/N CNU210409C		**2,650,000**	84,800	Mbale RRH	good, in use	
9-Jul-12	9-Jul-11		Photoshop CS6	Adobe		2,738,125	**87,620**	Project Office	good, in use	
				Total		440,591,387	14,098,924			

ANNEX VII

Project Design Matrix (PDM)

Project Title: Project on Improvement of Health Service through Health Infrastructure Management
Version 1
Duration: 3 years and 4 months from the date when the first expert(s) is (are) dispatched
Date: February, 2011
Implementing Organization: Ministry of Health (MoH)
Target Area: 7 regions (east, west, central, south-west, north-west, north-east, middle-north) of the country, while Eastern region is identified as the model region.
Target Group: Target hospitals (NRH, RRH, GH) and selected health center (HC) IVs

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
The delivery of health care services is improved through effective and efficient utilization of available health infrastructure.	1. Hospital ranking of Annual Health Sector Performance Report 2. Periodical assessment of: (a) True Positive referral rate. (Number of referrals arriving at receiving facility / number of cases that should have been referred based on agreed protocols/algorithms (b) Correctness of treatment of selected diseases according to national standards (c) Management of medical consumables (d) % of health facilities without any stock outs of six tracer medicines (e) Waiting time of patients 3. Patient Attendance a) Per capita OPD utilisation rate (m/f) b) Average # admission days per client (m/f) c) % pregnant women attending 4 ANC sessions d) % deliveries in health facilities e) % children under one year immunised with 3rd dose Pentavalent vaccine (m/f) f) % pregnant women who have completed IPT 2 g) % pregnant women accessing HCT in ANC h) % eligible persons receiving ARV therapy i) % health facilities submitting the monthly HMIS report timely 4. Level of Client Satisfaction	Annual Health Sector Performance Report Assessment by the Project at the time of commencement of 5S and mid-term review and final evaluation of the Project HMIS reports 4. a) National client satisfaction surveys 4. b) Facility client satisfaction surveys	Centre/NMS provides adequate medical supplies regularly National Surveys carried out as planned Facilities trained to carry out cleint satisfaction surveys
Project Purpose			
Management and utilization of health infrastructure is improved in target health facilities.	1. Number of health facilities implementing 5S-CQI-TQM 2. Scores of 5S-CQI-TQM 3. Scores of Yellow Star Assessment 4. % of health facilities rewarded for good performance 5. Number of Regional Workshops carrying out routine medical equipment maintenance	1 (a) MoH record 1 (b) Project progress reports 2 (a) Health facility reports 2 (b) Project progress reports 3. Yellow Star Assessment Reports 4 (a) Health facility reports 4 (b) Project progress reports 5 (a) RWS reports 5 (b) Project progress reports	If 5S-CQI-TQM is incorporated into HSSP/HSSIP as a tool of quality improvement Districts carry out Yellow Star Assessment regularly MoH revitalizes the system of performance-based management/budgeting to enable it to reward health facilities with quality services.
Outputs			
1. 5S-CQI-TQM activities are implemented in target hospitals.	1. % of health facilities with good working environment	1(a) 5S-CQI-TQM check sheet 1(b) Supervision reports	
2. Utilization of medical equipment is improved in target hospitals.	2 (a) % of "ME in good working condition and in use" 2 (b) % of "ME in good working condition but no in use"	2. (a) Medical equipment inventory 2. (b) Medical equipment inventory	
3. Medical equipment is maintained better by target hospitals and workshops.	3 (a) % of "ME in good working condition and in use", "ME can be repaired" 3 (b) Number of "completed jobs" by workshops	3 (a) Medical equipment inventory 3 (b) Quarterly reports from workshops	

Activities	**Inputs**		**Important Assumptions**
1-1. To promote 5S-CQI-TQM activities at national level.	**<Ugandan Side>**	**<Japanese Side>**	
1-1-1. To establish national coordination committee for 5S-CQI-TQM activities.	Salary and allowances for counterpart staff	1. Dispatch of Experts	
1-1-2. To disseminate 5S-CQI-TQM concept for key stakeholders at national level through introducing model hospital (i.e.Tororo hospital).	Office space for JICA experts/Project	[Long-term Experts]	
1-1-3. To support harmonization and integration with other quality improvement programs.		・Chief Advisor/5S-CQI-TQM	
1-1-4. To develop national guidelines for implementation of 5S-CQI-TQM activities, with consideration for quality improvement framework in Uganda.			
1-1-5. To develop training manuals for 5S-CQI-TQM activities.		・Coordinator/Training Management	
1-1-6. To develop monitoring and supervision framework (including awarding system) for 5S-CQI-TQM activities.			
1-1-7. To conduct training for national facilitators for 5S-CQI-TQM activities.		[Short-term Experts]	
1-1-8. To conduct monitoring and supervision of 5S-CQI-TQM activities at selected hospitals in each target region.		・Other experts on maintenance of ME, user training, health policy planning	
1-1-9. To review and evaluate the results of 5S-CQI-TQM activities based on activity 1.1.8.			
1-1-10. To hold regular meeting for selected hospitals to share their progress for 5S-CQI-TQM activities and for awarding by MOH.		2. Provision of Equipment	
1-1-11. To revise 5S-CQI-TQM guidelines and manuals based on the reviewing activities.		・Vehicle for project operation	
1-1-12. To recommend the results of 5S-CQI-TQM activities for drafting next national health sector program which is currently called as HSSP/HSSIP process.		・Necessary supplies for 5S-CQI-TQM (for the 1st year)	
1-2. To promote 5S-CQI-TQM at regional level.			
1-2-1. To identify selected hospitals in each target region and selected HC IVs in model region.			
1-2-2. To disseminate 5S-CQI-TQM concept for key stakeholders at each target regional level through introducing model hospital (i.e. Tororo hospital).			
1-2-3. To conduct TOT for regional facilitators for 5S-CQI-TQM activities by national facilitators.			
1-2-4. To maintain regional network for 5S-CQI-TQM activities in each target region.			
1-3. To promote 5S-CQI-TQM activities at facility level.		3. Training in Japan and/or third countries	
1-3-1. To establish coordination structure for 5S-CQI-TQM (e.g. 5S committee, QI team) at each selected hospital and at each selected HC IV.			
1-3-2. To develop annual work plan for 5S-CQI-TQM activities at each target region, by necessary coordination with district.			
1-3-3. To procure necessary supplies for 5S-CQI-TQM activities at selected hospitals in each target region.		4. Allocation of operational costs for project activities except mandatory activities of MOH	
1-3-4. To implement 5S-CQI-TQM activities in selected hospitals in each target region and selected HC IVs in model region.			
1-3-5. To conduct monitoring and supervision 5S-CQI-TQM activities within each selected hospital by the coordination structure established in activity 1-3-1.			
1-3-6. To roll out 5S-CQI-TQM activities in other hospitals in each target region by selected hospitals.			
2-1. To incorporate user training into 5S-CQI-TQM training.			
2-1-1. To include national and regional user trainers as participants for 5S-CQI-TQM training.			
2-1-2. To incorporate user training component into training manuals for 5S-CQI-TQM developed in activity 1-1-5.			
2-1-3. To involve national user trainers as facilitators in 5S-CQI-TQM TOT.			
2-2. To implement ME user training.			
2-2-1. To carry out needs assessment for ME user training.			
2-2-2. To review and prepare revised ME user training guidelines and manuals for selected ME.			
2-2-3. To select trainees in selected hospitals and DHO's staff for ME user training.			
2-2-4. To carry out ME user training for equipment users at selected hospitals and DHO's staff.			
2-2-5. To carry out support supervision and monitoring of ME user trainers in the selected hospitals and DHO's offices.			
2-2-6. To review and evaluate the results of ME user training and its implementation mechanism.			
3-1. To improve planning for ME maintenance and management.			**Preconditions**
3-1-1. To assess current ME inventory and reporting mechanism.			Uganda does not go into turmoil as a result of election in February 2011.
3-1-2. To revitalize ME inventory and reporting mechanism including necessary training.			
3-1-3. To collect and update ME inventory.			
3-1-4. To analyze ME inventory data and utilization of ME.			
3-1-5. To support preparation of work plans based on current budget mechanism for CWS and RWSs.			
3-2. To improve communication between ME users and RWSs.			
3-2-1. To conduct TOT training on 5S-CQI-TQM for CWS and RWS managers and selected hospital based technicians.			
3-2-2. To implement 5S-CQI-TQM in CWS and RWSs.			
3-2-3. To incorporate ME in-charge into the coordination structure for 5S-CQI-TQM activities developed in activity 1-3-1.			
3-2-4. To strengthen the functioning of RWS Medical Equipment Maintenance Committees.			
3-3. To strengthen maintenance of ME by RWS.			
3-3-1. To review ME maintenance procedures and develop guidelines/manual for Medical Equipment Maintenance by RWS.			
3-3-2. To disseminate ME maintenance guidelines/manual to stakeholders in selected hospitals and HC IVs.			
3-3-3. To plan and carry out routine ME maintenance.			
3-3-4. To carry out support supervision and monitoring use of the ME maintenance guidelines/manual.			
3-3-5. To train technicians/engineers in biomedical engineering.			

Notes for abbreviations: HMIS (Health Management Information System), WS (workshop), ME (medical equipment), 5S-CQI-TQM(5S (Sort, Set, Shine, Standardise, Sustain, (Seiri, Seiton, Seiso, Seiketsu, Shitsuke (Japanese))-continuous quality improvement-total quality management), HID (Health Infrastructure Division), MoH (Ministry of Health), HC (Health Center), NRH (National Referral Hospital), RRH (Regional Referral Hospital), GH (General Hospital), HSSP (Health Sector Strategic Plan), DHO (District Health Officer), QI (Quality Improvement), TOT (Training of Trainers), CWS (Central Medical Equipment Maintenance Workshop), RWS (Regional Medical Equipment Maintenance Workshop), HSSIP (Health Sector Strategic & Investment Plan)

Project Design Matrix (PDM)

Project Title: Project on Improvement of Health Service through Health Infrastructure Management
Version 2
Duration: From Aug,, 2011 to Dec., 2014
Date: 5th September, 2011
Implementing Organization: Ministry of Health (MoH)
Target Area: 7 regions (east, west, central, south-west, north-west, north-east, middle-north) of the country, while Eastern region is identified as the model region.
Target Group: Target hospitals (NRH, RRH, GH) and selected health center (HC) IVs

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal The delivery of health care services is improved through effective and efficient utilization of available health infrastructure.	1. Hospital ranking of Annual Health Sector Performance Report 2. Periodical assessment of: (a) Correctness of treatment of selected diseases according to national standards (b) Waiting time of patients at clinics, diagnostics (lab, X-ray, etc.), prescription of drugs, etc. (c) Level of client satisfaction 3. Outcome indicators available from Health Management Information System (HMIS), e.g. (a) Per capita OPD utilisation rate (b) Average # admission days per client (c) % pregnant women attending 4 ANC sessions (d) % deliveries in health facilities (e) % children under one year immunised with 3rd dose Pentavalent vaccine (f) % of health facilities without any stock outs of six tracer medicines	Annual Health Sector Performance Report Assessment by the Project at the time of commencement of 5S and mid-term review and final evaluation of the Project HMIS	
Project Purpose Management and utilization of health infrastructure is improved in target health facilities.	Percentage of medical equipment in good working condition and in use	Medical equipment inventory	If 5S-CQI-TQM is incorporated into HSSP/HSSIP as a tool of quality improvement MoH revitalizes the system of performance-based management/budgeting to enable it to reward health facilities with quality services.
Outputs 1. 5S-CQI-TQM activities are implemented in target hospitals.	1 (a) Pre-test/Post-test comparison of trainees of 5S-CQI-TQM 1 (b) Percentage of health facilities that organised Quality Improvement Team (QIT) 1 (c) Percentage of health facilities that the QIT conducted problem analysis in the premises 1 (d) Score of 5S-CQI-TQM check sheet	- Pre-test/post-test to trainees of 5S-CQI-TQM - 5S-CQI-TQM check sheet - 5S-CQI-TQM supervision reports	
2. Utilization of medical equipment is improved in target hospitals.	2. Pre-test/Post-test comparison of trainees of user training	- Pre-test/post-test to trainees of user training of medical equipment	
3. Medical equipment is maintained better by target hospitals and workshops.	3 (a) Percentage of workshops that conducts routine maintenance 3 (b) Number of “completed jobs” by workshops	- Quarterly reports from workshops	

Activities	**Inputs**		**Important Assumptions**
1-1. To promote 5S-CQI-TQM activities at national level.	**<Ugandan Side>**	**<Japanese Side>**	
1-1-1. To establish national coordination committee for 5S-CQI-TQM activities.	Salary and allowances for counterpart staff	1. Dispatch of Experts	
1-1-2. To disseminate 5S-CQI-TQM concept for key stakeholders at national level through introducing model hospital (i.e.Tororo hospital).	Office space for JICA experts/Project	- Chief Advisor/Health Policy Planning - 5S-CQI-TQM	
1-1-3. To support harmonization and integration with other quality improvement programs.		- User Training	
1-1-4. To develop national guidelines for implementation of 5S-CQI-TQM activities, with consideration for quality improvement framework in Uganda.		- Maintenance of Medical Equipment - Impact Assessment	
1-1-5. To develop training manuals for 5S-CQI-TQM activities.		- Training Management	
1-1-6. To develop monitoring and supervision framework (including awarding system) for 5S-CQI-TQM activities.		- Coordinator	
1-1-7. To conduct training for national facilitators for 5S-CQI-TQM activities.			
1-1-8. To conduct monitoring and supervision of 5S-CQI-TQM activities at selected hospitals in each target region.		2. Provision of Equipment	
1-1-9. To review and evaluate the results of 5S-CQI-TQM activities based on activity 1.1.8.		- Vehicle for project operation	
1-1-10. To hold regular meeting for selected hospitals to share their progress for 5S-CQI-TQM activities and for awarding by MOH.		- Necessary supplies for 5S-CQI-TQM (for the 1st year)	
1-1-11. To revise 5S-CQI-TQM guidelines and manuals based on the reviewing activities.			
1-1-12. To recommend the results of 5S-CQI-TQM activities for drafting next national health sector program which is currently called as HSSP/HSSIP process.		3. Training in Japan and/or third countries	
1-2. To promote 5S-CQI-TQM at regional level.			
1-2-1. To identify selected hospitals in each target region and selected HC IVs in model region.		4. Allocation of operational costs for project activities except mandatory activities of MOH	
1-2-2. To disseminate 5S-CQI-TQM concept for key stakeholders at each target regional level through introducing model hospital (i.e. Tororo hospital).			
1-2-3. To conduct TOT for regional facilitators for 5S-CQI-TQM activities by national facilitators.			
1-2-4. To maintain regional network for 5S-CQI-TQM activities in each target region.			
1-3. To promote 5S-CQI-TQM activities at facility level.			
1-3-1. To establish coordination structure for 5S-CQI-TQM (e.g. 5S committee, QI team) at each selected hospital and at each selected HC IV.			
1-3-2. To develop annual work plan for 5S-CQI-TQM activities at each target region, by necessary coordination with district.			
1-3-3. To procure necessary supplies for 5S-CQI-TQM activities at selected hospitals in each target region.			
1-3-4. To implement 5S-CQI-TQM activities in selected hospitals in each target region and selected HC IVs in model region.			
1-3-5. To conduct monitoring and supervision 5S-CQI-TQM activities within each selected hospital by the coordination structure established in activity 1-3-1.			
1-3-6. To roll out 5S-CQI-TQM activities in other hospitals in each target region by selected hospitals.			
2-1. To incorporate user training into 5S-CQI-TQM training.			
2-1-1. To include national and regional user trainers as participants for 5S-CQI-TQM training.			
2-1-2. To incorporate user training component into training manuals for 5S-CQI-TQM developed in activity 1-1-5.			
2-1-3. To involve national user trainers as facilitators in 5S-CQI-TQM TOT.			
2-2. To implement ME user training.			
2-2-1. To carry out needs assessment for ME user training.			
2-2-2. To review and prepare revised ME user training guidelines and manuals for selected ME.			
2-2-3. To select trainees in selected hospitals and DHO's staff for ME user training.			
2-2-4. To carry out ME user training for equipment users at selected hospitals and DHO's staff.			
2-2-5. To carry out support supervision and monitoring of ME user trainers in the selected hospitals and DHO's offices.			
2-2-6. To review and evaluate the results of ME user training and its implementation mechanism.			
3-1. To improve planning for ME maintenance and management.			**Preconditions**
3-1-1. To assess current ME inventory and reporting mechanism.			
3-1-2. To revitalize ME inventory and reporting mechanism including necessary training.			
3-1-3. To collect and update ME inventory.			
3-1-4. To analyze ME inventory data and utilization of ME.			
3-1-5. To support preparation of work plans based on current budget mechanism for CWS and RWSs.			
3-2. To improve communication between ME users and RWSs.			
3-2-1. To conduct TOT training on 5S-CQI-TQM for CWS and RWS managers and selected hospital based technicians.			
3-2-2. To implement 5S-CQI-TQM in CWS and RWSs.			
3-2-3. To incorporate ME in-charge into the coordination structure for 5S-CQI-TQM activities developed in activity 1-3-1.			
3-2-4. To strengthen the functioning of RWS Medical Equipment Maintenance Committees.			
3-3. To strengthen maintenance of ME by RWS.			
3-3-1. To review ME maintenance procedures and develop guidelines/manual for Medical Equipment Maintenance by RWS.			
3-3-2. To disseminate ME maintenance guidelines/manual to stakeholders in selected hospitals and HC IVs.			
3-3-3. To plan and carry out routine ME maintenance.			
3-3-4. To carry out support supervision and monitoring use of the ME maintenance guidelines/manual.			
3-3-5. To train technicians/engineers in biomedical engineering.			

Notes for abbreviations: HMIS (Health Management Information System), WS (workshop), ME (medical equipment), 5S-CQI-TQM(5S (Sort, Set, Shine, Standardise, Sustain, (Seiri, Seiton, Seiso, Seiketsu, Shitsuke (Japanese))-continuous quality improvement-total quality management), HID (Health Infrastructure Division), MoH (Ministry of Health), HC (Health Center), NRH (National Referral Hospital), RRH (Regional Referral Hospital), GH (General Hospital), HSSP (Health Sector Strategic Plan), DHO (District Health Officer), QI (Quality Improvement), TOT (Training of Trainers), CWS (Central Medical Equipment Maintenance Workshop), RWS (Regional Medical Equipment Maintenance Workshop), HSSIP (Health Sector Strategic & Investment Plan)

Project Design Matrix (PDM)

Version 3

Project Title: Project on Improvement of Health Service through Health Infrastructure Management
Date: 24th October, 2012
Duration: From August 2011 to December 2014
Implementing Organization: Ministry of Health (MOH)
Target Area: 7 regions (east, west, central, south-west, north-west, north-east, middle-north) of the country, while east is identified as the model region.
Target Group:
(1) 8 Hospitals: Mbale Regional Referral Hospital (RRH), Masaka RRH, Entebbe General Hospital (GH), Hoima RRH, Kabale RRH, Arua RRH, Lira RRH and Moroto RRH
(2) One Health Center: Mukuju HC-IV
(3) "National Showcase" Hospital: Tororo GH

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal The delivery of health care services is improved through effective and efficient utilization of available health infrastructure.	1. Level of client satisfaction 2. Waiting time of patients for consultation, clinical examination and prescription of drugs 3. Attendance at outpatient department (OPD) 4. Number of blood test done at laboratory 5. Number of patients x-rayed 6. Number of patients scanned 7. Number of hospitals conducted 5S training by Regional Facilitator in the whole country 8. Number of hospitals which implement 5S activities in the whole country 9. Number of target facilities which started CQI activities	1. -6 Health Management Information System (HMIS) or Annual Health Sector Performance Report (AHSPR) 7.,8.,9. Periodical assessment by Regional QI committee	
Project Purpose Management and utilization of health infrastructure is improved in target health facilities.	1. Percentage of medical equipment in good working condition and in use 2. 75% of functioning WITs in a target facilities which reached the level 10 of 5S implementation (Maintenance Phase) which is described in 5S guidelines 3. Level of provider satisfaction	1. Medical equipment inventory 2. - 3. -QIT meeting record -5S Check list -5S-CQI-TQM monitoring and evaluation sheet -Periodical Assessment by National - -Facilitator team	1. 5S-CQI-TQM^2 is incorporated into Health Sector Strategic and Investment Plan (HSSIP) as a tool of quality improvement. 2. MOH revitalizes the system of performance-based management and budgeting to reward health facilities with quality services. 3. Other quality improvement programs are implemented in target hospitals. 4. Target hospitals do not suffer from severe shortage of human resources for health.
Outputs 1. 5S-CQI-TQM activities are implemented in target health facilities	1. Score of 5S-CQI-TQM monitoring and evaluation sheet 2. All units in a target hospital have established WIT that are functioning properly.	1. 5S-CQI-TQM monitoring and evaluation sheet 2. - Periodical Assessment by National Facilitator team - Monthly WIT meeting record (2 times per month)	1. ME is newly provided or replaced. 2. MOH can finance ME maintenance sufficiently.
2. Utilization of medical equipment is improved in target hospitals.	2a. Pre-test/post-test comparison of ME user trainers 2b. Number of "certified" ME user trainers 2c. Number of implemented ME user training 2d. Pre-test/Post-test comparison of trainees of user training 2e. Development of reference sheets for proper utilization of selected ME	2a. Pre-test/post-test to ME user trainers 2b. Project records 2c. Project records 2d. Pre-test/post-test to trainees of ME user training 2e. Reference sheets	
3. Medical equipment is maintained better by ME workshops.	3a. % of ME in use but should be repaired 3b. % of ME in Out of order/Repairable 3c. % of ME workshops that submit quarterly reports timely 3d. % of staff that register improvement in knowledge after training	3a. ME inventory 3b. ME inventory 3c. Quarterly reports of ME workshops 3d. Pre-test/post-test of biomedical engineering training	

Activities	**Inputs**	
1-1. To promote 5S-CQI-TQM activities at national level 1-1-1. To establish the project team for 5S-CQI-TQM activities 1-1-2. To disseminate 5S-CQI-TQM concept for key stakeholders through Tororo GH as a national showcase 1-1-3. To support harmonization and integration with other quality improvement programs 1-1-4. To develop national guidelines for implementation of 5S-CQI-TQM activities with consideration for quality improvement framework in Uganda. 1-1-5. To develop training manuals for 5S-CQI-TQM activities 1-1-6. To conduct training for national facilitators for 5S-CQI-TQM activities 1-1-7. To conduct monitoring and supervision of 5S-CQI-TQM activities in target health facilities 1-1-8. To review and evaluate the results of monitoring and supervision of 5S-CQI-TQM activities 1-1-9. To hold regular meeting for target health facilities to share their progress for 5S-CQI-TQM activities and for awarding by MOH 1-1-10. To revise 5S-CQI-TQM guidelines and manuals based on the reviewing activities 1-1-11. To make use of the recommendations and lessons from 5S-CQI-TQM activities for drafting next HSSIP 1-2. To promote 5S-CQI-TQM activities at regional level 1-2-1. To identify target health facilities in each region 1-2-2. To disseminate 5S-CQI-TQM concept for key stakeholders through Tororo GH as a national showcase 1-2-3. To conduct TOT for regional facilitators for 5S-CQI-TQM activities by national facilitators 1-2-4. To maintain regional network for 5S-CQI-TQM activities in each target region 1-3. To promote 5S-CQI-TQM activities at facility level 1-3-1. To establish Quality Improvement Team (QIT) in target health facilities 1-3-2. To develop annual work plan for 5S-CQI-TQM activities in target health facilities 1-3-3. To procure necessary supplies for 5S-CQI-TQM activities in target hospitals 1-3-4. To implement 5S-CQI-TQM activities in target health facilities 1-3-5. To conduct monitoring and supervision of 5S-CQI-TQM activities within target health facilities 1-3-6. To roll out 5S-CQI-TQM activities in other hospitals in each region by target health facilities	***Ugandan Side*** 1. Salary and allowances for counterparts 2. Office space for the Project ***Japanese Side*** 1. Dispatch of experts (1) Chief advisor/Health policy planning (2) 5S-CQI-TQM (3) User training (4) Maintenance of medical equipment (5) Impact assessment (6) Training management (7) Coordinator 2. Provision of equipment (1) Vehicle for project operation (2) Necessary supplies for 5S-CQI-TQM (for the 1st year) 3. Training in Japan and/or third countries 4. Allocation of operational costs for project activities except mandatory activities of MOH	**Preconditions**
2-1. **To train ME user trainers in 5S-CQI-TQM concept** 2-1-1. To include national and regional user trainers as participants for 5S-CQI-TQM training. 2-1-2. To incorporate user training component into training manuals for 5S-CQI-TQM developed in activity 1-1-5. 2-2. To implement ME user training. 2-2-1. To carry out needs assessment for ME user training. 2-2-2. To review and prepare revised ME user training guidelines and manuals for selected ME. 2-2-3. To train ME user trainers of target hospitals 2-2-4. To carry out ME user training for equipment users in target hospitals 2-2-5. To carry out support supervision and monitoring of ME user trainers in target hospitals 2-2-6. To review and evaluate the results of ME user training and its implementation mechanism.		
3-1. To improve planning for ME maintenance and management 3-1-1. To assess current ME inventory and reporting mechanism 3-1-2. To revitalize ME inventory and reporting mechanism including necessary training 3-1-3. To collect and update ME inventory 3-1-4. To analyze ME inventory data and utilization of ME 3-1-5. To support preparation of work plans based on current budget mechanism for ME workshops 3-1-6. To strengthen the functioning of RWS Medical Equipment Maintenance Management Committees 3-2. To promote 5S-CQI-TQM activities in ME workshops 3-2-1. To conduct TOT training on 5S-CQI-TQM for ME workshops 3-2-2. To implement 5S-CQI-TQM in ME workshops 3-2-3. To incorporate ME in-charge into QIT for 5S-CQI-TQM activities developed in activity 1-3-1. 3-3. To strengthen maintenance of ME by ME workshops 3-3-1. To review ME maintenance procedures and develop guidelines/manual for Medical Equipment Maintenance by ME workshops 3-3-2. To disseminate ME maintenance guidelines/manual to stakeholders 3-3-3. To plan and carry out routine ME maintenance. 3-3-4. To carry out support supervision and monitoring use of the ME maintenance guidelines/manual. 3-3-5. To train technicians/engineers in biomedical engineering		

1. 5S-CQI-TQM is an approach to quality improvement of products and services.
(1) 5S is a set of abbreviations of the Japanese words seiri (sort), seiton (set), seiso (shine), seiketsu (standardise) and shitsuke (sustain). It is an approach to work environment improvement.
(2) CQI: Continuous Quality Improvement
(3) TQM: Total Quality Management

Project Design Matrix (PDM)

Version 4

Date: 9th May, 2013

Project Title: Project on Improvement of Health Service through Health Infrastructure Management
Duration: From August 2011 to December 2014
Implementing Organization: Ministry of Health (MOH)
Target Area: 7 regions (east, west, central, south-west, north-west, north-east, middle-north) of the country, while east is identified as the model region.
Target Group:
(1) 8 Hospitals: Mbale Regional Referral Hospital (RRH), Masaka RRH, Entebbe General Hospital (GH), Hoima RRH, Kabale RRH, Arua RRH, Lira RRH and Moroto RRH
(2) One Health Center: Mukuju HC-IV
(3) "National Showcase" Hospital: Tororo GH

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal The delivery of health care services is improved through effective and efficient utilization of available health infrastructure.	1. Level of client satisfaction 2. Waiting time of patients for consultation, clinical examination and prescription of drugs 3. Attendance at outpatient department (OPD) 4. Number of blood test done at laboratory 5. Number of patients x-rayed 6. Number of patients scanned 7. Number of hospitals conducted 5S training by Regional Facilitator in the whole country 8. Number of hospitals which implement 5S activities in the whole country 9. Number of target facilities which started CQI activities	1. -6 Health Management Information System (HMIS) or Annual Health Sector Performance Report (AHSPR) 7.,8.,9. Periodical assessment by Regional QI committee	
Project Purpose Management and utilization of health infrastructure is improved in target health facilities.	1. More than 60% of medical equipment in good working condition and in use 2. 75% of functioning WITs in a target facilities which reached the level 10 of 5S implementation (Maintenance Phase) which is described in 5S guidelines 3. Level of provider satisfaction	1. Medical equipment inventory 2. - 3. -QIT meeting record -5S Check list -5S-CQI-TQM monitoring and evaluation sheet -Periodical Assessment by National - -Facilitator team	1. 5S-CQI-TQM^2 is incorporated into Health Sector Strategic and Investment Plan (HSSIP) as a tool of quality improvement. 2. MOH revitalizes the system of performance-based management and budgeting to reward health facilities with quality services. 3. Other quality improvement programs are implemented in target hospitals. 4. Target hospitals do not suffer from severe shortage of human resources for health.
Outputs 1. 5S-CQI-TQM activities are implemented in target health facilities	1a. All scores of "Sort","Set","Shine" in 5S-CQI-TQM monitoring and evaluation sheet are higher than 70%. 1b. Half number of the units in a target hospital have established WIT that are functioning properly.	1. 5S-CQI-TQM monitoring and evaluation sheet 2. - Periodical Assessment by National Facilitator team - Monthly WIT meeting record (2 times per month)	1. ME is newly provided or replaced. 2. MOH can finance ME maintenance sufficiently.
2. Utilization of medical equipment is improved in target hospitals.	2a. All ME user trainers score higher than 60% of correct answers of Post test. 2b. More than 16 of newly "certified" Me user trainers. 2c. More than 40 times of implemented ME user training 2d. Average of comprehension rate of trainee is higher than 80% after the user training. 2e. Development of reference sheets for proper utilization of selected ME	2a. Pre-test/post-test to ME user trainers 2b. Project records 2c. Project records 2d. Pre-test/post-test to trainees of ME user training 2e. Reference sheets	
3. Medical equipment is maintained better by ME workshops.	3a. Lower than 12% of ME in use but needs repaired 3b. Lower than 10% of ME in Out of order/Repairable 3c. All of ME workshops that submit quarterly reports timely 3d. Higher than 80% of staff that register improvement in knowledge after training	3a. ME inventory 3b. ME inventory 3c. Quarterly reports of ME workshops 3d. Pre-test/post-test of biomedical engineering training	

Activities	**Inputs**	
1-1. To promote 5S-CQI-TQM activities at national level 1-1-1. To establish the project team for 5S-CQI-TQM activities 1-1-2. To disseminate 5S-CQI-TQM concept for key stakeholders through Tororo GH as a national showcase 1-1-3. To support harmonization and integration with other quality improvement programs 1-1-4. To develop national guidelines for implementation of 5S-CQI-TQM activities with consideration for quality improvement framework in Uganda. 1-1-5. To develop training manuals for 5S-CQI-TQM activities 1-1-6. To conduct training for national facilitators for 5S-CQI-TQM activities 1-1-7. To conduct monitoring and supervision of 5S-CQI-TQM activities in target health facilities 1-1-8. To review and evaluate the results of monitoring and supervision of 5S-CQI-TQM activities 1-1-9. To hold regular meeting for target health facilities to share their progress for 5S-CQI-TQM activities and for awarding by MOH 1-1-10. To revise 5S-CQI-TQM guidelines and manuals based on the reviewing activities 1-1-11. To make use of the recommendations and lessons from 5S-CQI-TQM activities for drafting next HSSIP 1-2. To promote 5S-CQI-TQM activities at regional level 1-2-1. To identify target health facilities in each region 1-2-2. To disseminate 5S-CQI-TQM concept for key stakeholders through Tororo GH as a national showcase 1-2-3. To conduct TOT for regional facilitators for 5S-CQI-TQM activities by national facilitators 1-2-4. To maintain regional network for 5S-CQI-TQM activities in each target region 1-3. To promote 5S-CQI-TQM activities at facility level 1-3-1. To establish Quality Improvement Team (QIT) in target health facilities 1-3-2. To develop annual work plan for 5S-CQI-TQM activities in target health facilities 1-3-3. To procure necessary supplies for 5S-CQI-TQM activities in target hospitals 1-3-4. To implement 5S-CQI-TQM activities in target health facilities 1-3-5. To conduct monitoring and supervision of 5S-CQI-TQM activities within target health facilities 1-3-6. To roll out 5S-CQI-TQM activities in other hospitals in each region by target health facilities	***Ugandan Side*** 1. Salary and allowances for counterparts 2. Office space for the Project ***Japanese Side*** 1. Dispatch of experts (1) Chief advisor/Health policy planning (2) 5S-CQI-TQM (3) User training (4) Maintenance of medical equipment (5) Impact assessment (6) Training management (7) Coordinator 2. Provision of equipment (1) Vehicle for project operation (2) Necessary supplies for 5S-CQI-TQM (for the 1st year) 3. Training in Japan and/or third countries 4. Allocation of operational costs for project activities except mandatory activities of MOH	
2-1. **To train ME user trainers in 5S-CQI-TQM concept** 2-1-1. To include national and regional user trainers as participants for 5S-CQI-TQM training. 2-1-2. To incorporate user training component into training manuals for 5S-CQI-TQM developed in activity 1-1-5. 2-2. To implement ME user training. 2-2-1. To carry out needs assessment for ME user training. 2-2-2. To review and prepare revised ME user training guidelines and manuals for selected ME. 2-2-3. To train ME user trainers of target hospitals 2-2-4. To carry out ME user training for equipment users in target hospitals 2-2-5. To carry out support supervision and monitoring of ME user trainers in target hospitals 2-2-6. To review and evaluate the results of ME user training and its implementation mechanism.		**Preconditions**
3-1. To improve planning for ME maintenance and management 3-1-1. To assess current ME inventory and reporting mechanism 3-1-2. To revitalize ME inventory and reporting mechanism including necessary training 3-1-3. To collect and update ME inventory 3-1-4. To analyze ME inventory data and utilization of ME 3-1-5. To support preparation of work plans based on current budget mechanism for ME workshops 3-1-6. To strengthen the functioning of RWS Medical Equipment Maintenance Management Committees 3-2. To promote 5S-CQI-TQM activities in ME workshops 3-2-1. To conduct TOT training on 5S-CQI-TQM for ME workshops 3-2-2. To implement 5S-CQI-TQM in ME workshops 3-2-3. To incorporate ME in-charge into QIT for 5S-CQI-TQM activities developed in activity 1-3-1. 3-3. To strengthen maintenance of ME by ME workshops 3-3-1. To review ME maintenance procedures and develop guidelines/manual for Medical Equipment Maintenance by ME workshops 3-3-2. To disseminate ME maintenance guidelines/manual to stakeholders 3-3-3. To plan and carry out routine ME maintenance. 3-3-4. To carry out support supervision and monitoring use of the ME maintenance guidelines/manual. 3-3-5. To train technicians/engineers in biomedical engineering		

1. 5S-CQI-TQM is an approach to quality improvement of products and services.
(1) 5S is a set of abbreviations of the Japanese words seiri (sort), seiton (set), seiso (shine), seiketsu (standardise) and shitsuke (sustain). It is an approach to work environment improvement.
(2) CQI: Continuous Quality Improvement
(3) TQM: Total Quality Management

Minutes of the Joint Coordinating Committee meeting held on the September 5th 2011
Record of Discussion

		Made by: Tumukunde Brian Date: 2011/09/07	Confirmed by: Kazuhiro Abe Date:2011/09/07
Date and Time	September 5th 2011 3:00pm-5:00pm		Place: Ministry of Health Headquarters
Attendants and Absentees with apology	**Attendants:** **MINISTRY OF HEALTH:** **Permanent Secretary** Dr. Asuman Lukwago Kawuzi, **Commissioner-Clinical Services** Dr. Amandua Jacinto, **Commissioner-Nursing** Ms. Chota Margaret. **Assistant Commissioner-Integrated Curative Division** Dr. Jackson Amone, **Assistant Commissioner -Health Infrastructure Division** Eng Wanda Sam, **Assistant Commissioner -Human Resource Development** Dr George Bagambisa, **Assistant Commissioner -Accounts Division** Mr. Nyeko Ponziano, **Absent with apologies:** **Director General of Health Services** Dr. Jane Ruth Aceng. **EMBASSY OF JAPAN** **Researcher/Advisor-Economic Cooperation Section** Ms. Kanoko Nishimitsu. **JAPAN INTERNATIONAL COOPERATION AGENCY, UGANDA** **Chief Representative JICA Uganda:** Mr. Seki Tetsuo, **Representative JICA Uganda:**		

	Mr. Takano Shintaro, **In-House Consultant for Health JICA:** Ms. Asiimwe Clare. **JICA Experts** Chief Advisor-Mr. Kazuhiro Abe, Expert on User training-Yasuhiro Hiruma, Expert on Impact assessment-Naoki Take, Expert on Assistant training Manager-Kazunori Iijima, Assistant Coordinator 5S team-Tumukunde Brian.
	I. Opening Remarks by the Permanent Secretary: 1. Dr. Asuman Lukwago Kawuzi gave an opening address stating that it was the first Joint Coordinating Committee meeting (hereinafter referred to as JCC) and welcomed the Japanese International Cooperation Agency (herein after referred to as JICA) experts for the Project on Improvement of the Health Service Through Health Infrastructure Management. 2. He noted that JCC should advice the government on how possible to assess public hospitals and also in future use that as a future model for better health quality. 3. He noted that there should be a disposal program for broken down medical equipments, this being a problem in the health sectors for example the ministry vehicles, some of which electronic devices and therefore in that case should harmonize with all the other committees so that JICA creates a mark. 4. He advised that there should be skilled people to instill all those skills to the rest of the other sectors in the Ministry of Health. Further more on the issue of disposal he pointed out that this should be dealt with the ministry's Biomedical Engineers on how to dispose-off all the unusable medical equipments. 5. He urged the ministry of Health to adopt the thoroughness

	of the Japanese Experts. 6. After the 5 years of the JCC project being introduced in Uganda this should have been picked up by the media already and said that the ministry was willing to support any kind of work that will improve the efficiency of the Health service in Uganda along with the JCC. 7. He stated that the Ministry of Health should lay a foundation for intervention and this should be maintained throughout. 8. He lastly encouraged the JICA team to be ready for the big task ahead of them on this project. **II. Message from the Chief representative JICA Uganda.** 1. Mr. Seki Tetsuo welcomed all the attendants of the meeting and thanked them for their continued support and time. 2. He addressed the objectives of the project on Improvement of Health Service through Health Infrastructure Management giving a brief explanation on the project aims and contents. A. The project consist of three sectors to be covered i) 5S-CQI-TQM ii) User Training iii) Maintenance B. The Project Duration August 2011-Nov 2014 C. JICA experts dispatched to train and help in the implementation of the project. JICA has dispatched a team of JICA Health Experts led by Mr. Abe Kazuhiro and he hoped the Ministry of Health would work closely with them. D. Why the project was brought forth: This was done because of : a) The Poor and Bad working environments b) Lack of User training c) Poor maintenance/Under maintenance of the equipment

	d) Noting that disposal problem as mentioned by the Permanent Secretary needed to be addressed. 3. He pointed out that the 5S-CQI-TQM of 2007 was using Tororo as a pilot hospital so other hospitals in the East have taken up the concept and have already started implementing it in their respective hospitals. Stating that even some Health Center IVs have done the same and are improving their services. 4. He expressed his sincere gratitude and thanks to the ministry for the support that has been shown for all the JICA projects and programs in the previous years. He thanked all the other stake holders of this projects and he hopes that the ministry of health will work and improve the quality of health in Uganda. **III. Dr. Amandua Jacinto.** Suggested the introduction of members present during the meeting and later on requesting Mr. Abe Kazuhiro the Chief Advisor for the Project to continue with the schedule of meeting. **Mr. Abe Kazuhiro.** 1. Introduction. He noted on the objective of the project stressing that the project is meant to improve the health infrastructure and hence improve the building and the equipment of the health sector and then finally the delivery of the better health services. 2. Briefing on the Inception report a) Target areas/regions There will be at least one pilot hospital in East, West, Central, South West, North West, North East, North Central Regions. Asking Mr. Takano to later on give a presentation on the Tororo pilot hospital. He asked the ministry of health and the JICA members to

	work as a team, urging the ministry to take ownership and leadership of the project. b) Policy of activities(refer to 2.2 of the Inception Report) ・ Everyone should work to make better health services in this country not only JICA but also Ministry of Health. ・ For the project to go on well there should be better leadership behind it. ・ There should be collaboration in all aspects regarding the project. ・ Project assessment shall be done in an evidence based manner. 3. During the General meeting held on August 31st 2011 there was issue raised that the JCC member team may need some more members included in it and so Mr. Abe asked for any suggestions from the members present at the JCC meeting for any additions .This was to later on be discussed. 4. About the schedule of the dispatched JICA experts please refer to the schedule handed in the handouts. 5. Activities in the first period. ・ Refer to the inception report section 6.1. The above section's activities of the 5S-CQI-TQM have been scheduled for the 1st year. ・ Refer to Inception Report sec 6.2 In this section the User training has been scheduled for the 2nd year ・ And the rest of 6.3 and 6.4 section of the inception to be finished in the final year. 6. Mr. Abe Kazuhiro thanked Mr. Wanda for providing a good office at the Ministry of Health workshop in Wabigalo. Mr. Abe then asks Mr. Takano Shintaro to present the basic Component for the pilot Hospital. **IV. Mr. Takano Shintaro JICA representative.**

	Handed out the 5S model in the Eastern Uganda documented slides. A. Mr. Takano stated that the 5S project began in Tororo and went to the other regions of Uganda e.g Mbale, Kapchorwa etc (refer to hand out) B. Strategy for the 5S in Eastern Region. i) Sensitization ii) Training iii) Implementation iv) Monitoring supervision C. Tororo being a showcase meant other hospitals should learn from it. D. From 2010 to 2011 there have been a total of 13 consultants who have visited the hospital and learnt the concepts and passed them on to their hospitals. E. There will be need to select a showcase hospitals like Tororo in other Regions F. As everyone knows the quality assurance is writing the formular to get the quality improvement implementations structure. G. Selection of showcase hospital (refer to handout) ・ Different types of facility should be selected to find out the different approach ・ Collaboration with other project by Japan ・ Step by step for sustainability ・ More elaboration for user training and maintenance H. Stressing that leadership is very necessary e.g nurses are the main actors for 5S and also there view point is also needed. The workshop managers are also vital for this project leadership. **V.** Mr. Abe noted on the project design matrix (hereinafter referred to as PDM) that there may be need for a discussion later on for more clarification on it. **VI. Discussions held during the Meeting:**

	a) Ms. Chota Margaret raised the issue of attitude basing on her past experience, and asked if there was anything in the training that will embark on the attitude of the Nurses. b) Dr. Amandua Jacinto agreed on the problem of attitude and also the issue of the leadership, he noted that without leadership at every level there will be a problem with implementation, quoting that leadership without resources is difficult. c) Ms. Chota Margret noted on the issue of Tororo asking whether there have been any kind of drawbacks experienced in the past. Mr. Takano Shintaro responded that there have been drawbacks e.g disposal of equipments due to the distance between the disposal unit and the hospitals, there may have been some draw backs on the communication. d) Dr. Amandua Jacinto asked the JICA representatives and the JICA experts whether the Ministry of health members can have 5S training. The JICA experts agreed that it is true and that it should affect all the whole Ministry not only the hospitals Dr. Amandua Jacinto further added that this kind of 5S project should be adopted even the other Ministries. It was later concluded that the issue of Ministry getting the 5S training was to be discussed in the future. e) Dr. Amandua Jacinto asked if the composition of member of the JCC was final requesting for it to be flexible for future additions of members. He pointed out that the assistant commissioner Human Resources Development should have been included in the JCC member list. f) Ms. Chota Margaret requested if her nursing team could be added in the JCC member list. Mr. Seki Tetsuo replying that only core members that can attend meetings and are active may be considered to be added to the list. g) Eng. Wanda Sam requested for the PDM to be approved asking the quality assurance members to review and approve

	it as soon as possible Mr. Abe Kazuhiro replying that it can be reviewed and approved later not today. Dr. Amandua Jacinto suggesting that the members of the Ministry of Health to review it and then send to Mr. Takano which is to be followed up by Madam Clare Asiimwe JICA office. h) There was a concern about the end of the implementation period of whether it will be 2014 November or 2014 December and the JICA Chief Representative clarified on it saying that it was set to three years basing on the agreements made between JICA and the Ministry of Health suggesting that the end of the implementation period will be reconsidered if the need arises. i) Eng. Wanda Sam asked on how the performance problems should be dealt with in the future. Mr. Takano pointed out that if there were any kind of problems that need to be dealt with he should address them to him (Mr Takano). **VII. Mr. Abe Kazuhiro** A. He gave a briefing on the criteria for pilot hospital selection(refer to annex 5 page 11) B. He would like the Ministry of health to come to agreement on the selected hospitals during the meeting. C. The list of proposed hospitals was decided with the JICA officials. Among all region referral hospital (herein after referred to as RRH) the only one visited is the Mbale RRH. ・ Mr. Takano noted that the RRH is much easier to begin from compared to the General Hospital with Ms. Chota Margret agreeing with the idea of selecting RRH as pilot hospitals. Both JICA team and Ministry of Heath agreed on the list of the selected pilot hospitals proposed by JICA. **Further discussions:**

	j) Eng. Wanda Sam Issue of visited hospitals. If the team can't visit the Arua and Moroto hospitals then on how the implementation could be done. Mr. Takano noting that in the future there will be a security assessment of both areas for easier access for the Japanese internationals. He pointed out that the Ministry of Health can be the fore runner of those areas if need be. k) Eng. Wanda requested for the agreement of the list of the selected pilot hospitals from members present. l) Dr. Amone Jackson asked if the inception report should be inclusive of the whole idea of having a team between the JCC and the project team. m) Dr. George Bagambisa. Noted that meeting once a year as stated in the JCC functions (refer to page 28 of the annex hand out)may be a little bit risky and suggested that we should have quarterly meetings for better follow up and results. Mr. Abe agreed and said no problem with holding a meeting four times a year basing on his experience on the same project in Republic of Burundi 5S project. **VIII. Closing Remarks**. ・ Dr. Amandua Jacinto asked for the JICA experts to draw a substructure of the JCC committee. ・ Eng. Wanda Sam asked for the reviewing of the JCC team and be properly approved. ・ Mr. Abe suggested that the next JCC meeting should be on January 4th 2012 and members present in the meeting agreed on the date set. ・ Eng. Wanda Sam closed the meeting thanking the JICA project making the ministry of health a beneficiary and also hoping that JICA experts and JICA in general may have a good impact on the Ministry at large
Hand outs	i) Agenda

for the Meeting	ii) Inception Report iii) Annexes iv) JICA Experts' Schedule v) Table for Selected Pilot Hospitals vi) 5S Model in Eastern Uganda/Handed by Mr. Takano Shintaro

MINUTES OF THE 2ND JOINT COORDINATING COMMITTEE (JCC) MEETING HELD ON 2ND MARCH, 2012 AT MINISTRY OF HEALTH (MOH)

Date and Time:	March 2nd 2012 9.30a.m-12.00noon	Secretary: Agnes Batuvamu	Place: Ministry of Health Headquarters

Attendance:

JCC MEMBERS PRESENT

-MINISTRY OF HEALTH (MOH):

1. Dr. Amandua Jacinto - Commissioner Clinical Services – Ag. Chairperson
2. Dr. H. Gatyanga Mwebesa - Commissioner Quality Assurance
3. Dr. Jackson Amone - Assistant Commissioner, Integrated Curative Services (ICS)
4. Mr. Francis Ntalazi - Assistant Commissioner, Human Resource Management
5. Eng. Sam SB Wanda - Assistant Commissioner, Health Infrastructure
6. Mr. Ponziano Nyeko - Assistant Commissioner, Accounts
7. Dr. Sarah Byakika - Assistant Commissioner, Quality Assurance

-JAPAN INTERNATIONAL COOPERATION AGENCY (JICA) Uganda Office:

1. Mr. Tetsuo Seki - Chief Representative
2. Mr. Shintaro Takano - Representative
3. Ms. Asiimwe Clare - In-House Consultant for Health

- JICA Experts

1. Mr. Kazuhiro Abe - Chief Advisor
2. Mr. Hiroshi Tasei - Expert on 5S-CQI-TQM
3. Mr. Naoki Take - Expert on Impact Assessment
4. Mr. Naoki Mimuro - Expert on Maintenance of Medical Equipment

JCC MEMBERS ABSENT WITH APOLOGY

Ministry of Health (MOH):

1. Jane Ruth Aceng - Director General of Health Services

JICA Experts:

1. Mr. Yasuhiro Hiruma - Expert on User Training

JCC MEMBERS ABSENT WITHOUT APOLOGY

	Ministry of Health(MOH): 1. (retired before JCC) - Director, Clinical and Community Health 2. Dr. Ezati Isaac - Director, Planning and Development 3. Sr. Margret Chota - Commissioner, Department of Nursing 4. Dr. Francis Runumi - Commissioner, Planning Directorate of Planning and Development 5. Mr. S.S. Kyambadde - Under Secretary, MOH 6. Mr. Enyaku Rogers - Assistant Commissioner, Budget and Finance, Department of Planning **IN-ATTENDANCE** MINISTRY OF HEALTH (MOH): 1. Dr. Ssendyona Martin - Senior Medical Officer (QAD) 2. Sr. Akumu Christine - Principal Nursing Officer (ICS) EMBASSY OF JAPAN: 1. Ms. Kanoko Nishimitsu - Researcher/Advisor – Economic Cooperation section

AGENDA:

1. Opening prayer
2. Communication from the Chair
   -Dr. Jane Ruth Aceng, Director General of Health Services, MOH
   -Mr. Seki Tetsuo, Chief Representative, JICA Uganda Office
3. Introduction of Members from Uganda and Japan
4. Reading of previous Minutes and Matters arising
5. Explanation of overall schedule until November, 2014
6. Confirmation of Project Design Matrix
7. Report of each activity in the 1st Year Schedule
8. Other Relevant Issues
9. Schedule for Next JCC meeting – August, 17, 2012 (prearranged date)
10. Closing Prayer

Minute:	Action Column:
Min.1 : OPENING PRAYER The meeting started at 9.30 a.m. with an opening prayer led by Sr. Akumu Christine.	

Min.2 : COMMUNICATION FROM THE CHAIR Dr. Amandua Jacinto welcomed all members to the 2nd Joint Coordinating Committee (JCC) meeting and informed them that the Director General of Health Services was unable to attend the meeting because she was required in another meeting. She sent her apologies and requested him to chair the meeting. The Chairperson thanked the Chief Representative of JICA Uganda for having accepted to attend the meeting and also thanked the technical team headed by Mr. Kazuhiro Abe for the firm progress of activities carried out in the Health Sector in Uganda. He further mentioned that: I) JCC meetings should be held regularly in order to evaluate what was being done. II) The meeting was to look at strategic issues and time for budgetary implications. The issues should appear in the MOH year planner for next year. III) The MOH on behalf of Uganda government appreciated the government of Japan for the support accorded to the Health Sector in Uganda. IV) The 5S intervention in hospitals had made a bigger impact in Tororo GH and that it was recommendable that the collaboration between JICA and MOH was bringing success. <u>Reaction:</u> One item on the agenda was missing for Reading of minutes of the previous meeting and after adding it, the agenda was adopted for the meeting. **Opening Remarks from the Chief Representative JICA Uganda, Mr. Seki Tetsuo** The Chief Representative welcomed everybody and congratulated all for the work of 5S which was interesting to many. He appealed to the MOH to handle the project well because then they would become 5S advisors when they support it. 5S would help patients to improve their Health. He pointed out about a facility that was going to be opened soon in Mubende RRH, that there was need to introduce a facility visual control method for improvement of Health Services. He thanked the top	*All to note* *All to note* *All to note*

management of MOH for their support since the inception of the project.	
Min.3 : SELF-INTRODUCTION The Chairperson requested members to introduce themselves according to their respective offices. *(Refer to list above for the attendance of members present).*	
Min.4 : READING OF PREVIOUS MINUTES AND MATTERS ARISING **4.1 : Reading, Correction and Approval of Previous Minutes** Minutes were read, corrected and approved as a true record of what transpired in the previous meeting. The following corrections were made:- <u>Corrections:</u> I) Page 4: under No.2 (a) the word to use should *be **core hospital*** not pilot hospital. II) The minutes should have a column for Action III) Page 8: remove the word "*pilot"* use "*core"* IV) Page 8: Arua RRH and Moroto RRH were selected as core hospitals. Only Arua could be visited by Japanese experts and Moroto was still awaiting. **4.2 : Matters arising:** User Training Activity: I) Dr. Amone reported that User Training had already started at Entebbe GH for the Upcoming User Trainers and was headed by Mr. Hiruma the counterpart from JICA. II) Identification of equipment for User Training had been done and two people from each of the eight (8) core hospitals were selected to be trained in User Training of Trainers (TOT). III) Facilitators particularly the Senior User Trainers were identified to train the Upcoming User Trainers, as most of them were soon retiring, therefore there was need to train more User Trainers. IV) Reported further that a 3 days' User Training Workshop and 1 day for 5S training i.e. 28th Feb. to 2nd March, 2012 was conducted at Entebbe GH where Dr. Amone opened the Training which was due to close on 2nd February, 2012. V) Two other User trainings would be conducted in April and June, 2012	*All to note* *All to note*

respectively. VI) There was need to introduce smaller coordinating committees which would work closely with each other in implementation of project activities. VII) The meeting agreed that the different committees with their counterparts explore on it, discuss who should be on the committees and to structure the committees and then report in the next meeting. VIII) Members from MOH were of the view that appointment letters for the JICA activities be given to them, however this matter was discussed and agreed that since they were already operating, there was no need for the appointment.	*MOH Counterparts: Dr. Amone Jackson, Dr. Sarah Byakika, Eng. Sam Wanda & All JICA Experts* *MOH*
Min.5.0 : EXPLANATION OF OVERALL SCHEDULE UNTIL NOVEMBER, 2014 Mr. Abe presented and explained the overall schedule of the three (3) years activities i.e. 1st year, 2nd year and 3rd year. *(Refer to handout on Overall Schedule for details).* I) He explained the colour bars used in the schedule; black was representing assignment for Japanese experts in Uganda, Red was for JCC schedule, and Blue was for Impact assessment. He said that a detailed schedule would be availed before the beginning of implementing activities. II) Informed the meeting that evaluations should be carried out by JICA and MOH members. III) Explained that the Project budget had been allocated about US$ 150,000 which was equivalent to Ug. Shs, 345 million. IV) The budget caters for Allowances, Stationery, Transport, Fuel, Consumables, TOT and equipment. V) The individual activity budget would be communicated later. <u>Issues raised from the presentation:</u>	*All to note* *All to note* *MOH and JICA*

A concern was raised on how members would assess what had been done if a final evaluation of activities was carried out before the end of the project.	
Response:	
I) That Final evaluation was based on how JICA does its project work and according to its own experience; evaluation was done six (6) months before the end of the project.	*All to note*
II) Observed that the Ugandan counterparts could be familiarized to the Japanese approach of carrying out evaluation before the end of the Project period as it seems to be a good approach.	*MOH and JICA*
III) Noted that JCC meetings should be held twice a year.	
IV) The MOH should include the JCC meeting on its year planner.	*MOH*

Min.6.0 : CONFIRMATION OF PDM	
Mr. Abe presented and explained the Project Design Matrix. He mentioned that it was still in a draft form and proposed modifications could be submitted later with reasons for modifying. (Refer to handout on PDM)	*All to note*
<u>Issues raised from the presentation:</u> I) Members were of the view that a reason should be stated for removing Mulago National Referral Hospital from the training. II) MOH expressed a need to be trained in 5S since they were at the headquarters and should be examples to the rest. III) That since the core hospitals were already trained in the 5S activities, they would move to other hospitals and conduct trainings to them. IV) Observed that other members from the non-targeted hospitals like Mulago were invited in the 5S training. V) That those trained should spread out and teach others – an idea of 5S i.e. Sort, Set, Shine, Standardize and Sustain plus "Spread out" would be referred to as "6S". This was being introduced to members as it could be a new term to adopt after those trained spread out VI) Proposed that Mulago being a National Referral Hospital it could be considered for the 5S training for better performance and improvement.	*All to note* *All to note* *All to note* *All to note*
<u>Modification regarding the indicators:</u> Mr. Naoki Take made a presentation on the proposed modifications of the PDM. (*Refer to handout).* He further mentioned that: I) Most of the modifications especially for the project activities for 5S were based on the terminology but without changing the activities. II) Some of the activities were missing and therefore this was one of the reasons for modifying it.	*All to note*
<u>Reaction from the presentation:</u> The PDM should be discussed first after studying it and then a feedback be given in two weeks' time i.e. March, 2nd - 16th,2012	*MOH & JICA*

	(Eng. Sam Wanda, Dr. Sarah Byakika to take lead)
Min. 7.0 : REPORT OF EACH ACTIVITY A presentation of each activity was made by each JICA Expert respectively and a number of issues were raised thereof as below: *(Refer to handout on activities).* **7.1 : 5S Activity presented by Mr. Hiroshi Tasei - Output 1** Reported that there were two activities carried out at the Regional level and Hospital	*All to note*

level.	*All to note*
Issues raised from the presentation of 5S activity:	
I) Observed that the MOH was continuously missing in the 5S training activities.	
II) The involvement of MOH staff in the schedule of activities was lacking.	
III) The MOH staff should be captured in the schedule of activities.	*All to note*
IV) Noted that the MOH should be regarded as a real model in developing the training module for 5S training and therefore they should be involved in the activity. Should involve the Head of Quality Assurance. Dr. Sarah Byakika should liaise with Mr. Tasei to organize the activity.	*JICA Experts* *Dr. Sarah Byakika & JICA Experts*
V) Requested JICA to think of a good strategy on how to support the targeted hospitals.	
VI) Suggested that the PNO Clinical Services could be taken on board for Monitoring and Evaluation of 5S.	*JICA*
Response:	
I) JICA suggested the need to be allocated an office at the MOH headquarters just like in Wabigalo so that a show case should be made as an example to the entire Ministry.	*JICA*
II) JICA should ask the MOH to join them during the visitation on the survey for sensitization of other hospitals.	*MOH*
III) JICA should consider involvement of MOH counterparts in Development of the Training Module.	
IV) The Project Team should review the framework of the 5S activity.	*JICA*
7.2 : User Training (UT) by Mr. Yasuhiro Hiruma – Output 2:	*JICA*
Mr. Abe Kazuhiro made a presentation on User Training activity on behalf of Mr. Hiruma who was away in Entebbe for a User Training workshop. *(Refer to Output 2 Utilization of medical Equipment in handout).*	*JICA*
Mr. Abe emphasized that proper handling of Medical Equipment (ME) was very important for the life span of the equipment.	
Issues raised from the presentation of User Training activity:	
I) Informed the meeting that Entebbe GH was chosen as venue for the User Training because it was near Kampala and had most of the ME for training.	

II) The next User Training workshops would be extended to either Masaka RRH in April or Mubende RRH in case they have the facilities.	
III) Unlike 5S, User Trainers go out to train other hospitals and spread out.	
IV) JICA should capture in the schedule the participation of the counterparts using their names and period.	
V) The Needs Assessment results should be attached to the minutes.	
VI) Observed that Tororo GH was a National showcase of 5S, however, it was not trained in User Training of Medical Equipment (ME).	*All to note*
Response:	*All to note*
I) Suggested if possible to organize a separate User Training of ME for Tororo because it was standing for trainings in the Eastern as Entebbe was standing for Central.	*JICA*
7.3 : Medical Equipment (ME) Maintenance by Mr. Naoki Mimuro	
Mr. Mimuro briefly presented the work schedule of ME workshops to the meeting. He reported that JICA had been allocated an Office at the Central Workshop in Wabigalo. *(Refer to handout – Output 3)*	
Issues raised from the presentation of Medical Equipment activity:	
I) Observed that the counterparts from Uganda should be reflected in the schedule using their names not titles.	
II) Junior staff from the Central Workshop should be included in the implementation of activities for ME.	
III) Engineer Sam Wanda should recommend other staff from Wabigalo Central Workshop to be involved in the implementation of ME activities.	
IV) The roles of ME users, Hospital technicians and Workshop staffs should be clarified.	
V) As for the priority level of these activities, 3-3 of PDM (technical training) was the most important, and then 3-1 (management) was 2nd level. Should consider changing the rank order in PDM.	*JICA*
VI) Observed that the actual ME inventory was not updated periodically, and thus needed to be considered.	*JICA & Eng.Sam Wanda*
VII) Mr. Mimuro would get someone from the Resource Centre at MOH, with a	

form, to know who were involved in the Medical Equipment Training. VIII) Observed that there were missing gaps on the schedule, however, it was explained that it would be indicated in the 2nd Year schedule.	*Eng. Sam Wanda* *Mr. Mimuro* *Eng. Sam Wanda* *Mr. Mimuro*
Min. 8.0 : OTHER RELEVANT ISSUES This item was not handled.	
Min. 9.0 : SCHEDULE FOR NEXT JCC MEETING **Next JCC Meeting:** Was tentatively scheduled for 17th August, 2012 Closing Remarks: Mr. Seki Tetsuo, the Chief Representative JICA, Uganda, gave closing remarks by thanking everybody's participation in implementing of 5S-CQI-TQM activities. Thanked the Ugandan counterparts for being active in the work and also thanked the Japan Team for the work so far done, however, he encouraged them to work harder for greater success.	*All to note* *All to note*
Min. 10.0 : CLOSING PRAYER The meeting ended with a closing prayer at 12.15 p.m.	
Summary of issues discussed: 1. In developing of the guidelines for the training, all counterparts should be involved in doing the work.	

2. Counterparts should be reflected in JICA work schedule for accountability purposes. 3. More junior staff from the Wabigalo Central Workshop should be involved in implementation of ME activities. 4. There was need to know how each activity was funded. 5. JICA Project budget was about US$ 150,000 – catering for; allowances, TOT activities, Fuel, Transportation, Stationery, Consumables and Equipment. 6. The various heads of sections from MOH should also indicate their budgets. 7. The MOH should know what other costs such as taxes that would come from the Japan funded structures.	
Handouts: 1. Agenda 2. Overall Schedule of activities 3. Project Design Matrix – version 3.0 (draft) 4. Modification of indicators – version 2.0 to 3.0 5. 5S Activity (5S) – 1st year schedule for 5S 6. User Training Activity (UT) – 1st year schedule for UT 7. Medical Equipment (ME) – 1st year schedule for ME	

Approved by:

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Dr.Amandua Jacinto Agnes Batuvamu

Ag. CHAIRPERSON SECRETARY

MINUTES OF THE 3RD JOINT COORDINATING COMMITTEE (JCC) MEETING HELD OCTOBER 24TH, 2012 AT MINISTRY OF HEALTH (MOH)

Date and Time:	October 24th 2012 10.47a.m-01.42pm	Minute Secretary: Doreen Mubiru	Place: Ministry of Health Headquarters

Attendance:

JCC MEMBERS PRESENT

-MINISTRY OF HEALTH (MOH):

1. Dr. Jane Ruth Aceng - Director General Health Services - Chairperson
2. Dr. Amandua Jacinto - Commissioner Clinical Services
3. Dr. Ampeire Immaculate - Senior Medical Officer (SMO)
4. Eng. Sam SB Wanda - Assistant Commissioner, Health Infrastructure
5. Dr. Sarah Byakika - Assistant Commissioner, Quality Assurance
6. Dr. Opar Bernard Toliva - Principal Medical Officer, Clinical Services

-JAPAN INTERNATIONAL COOPERATION AGENCY (JICA) Uganda Office:

1. Mr. Hoshi Hirofumi - Chief Representative
2. Mr. Shintaro Takano - Representative
3. Ms. Asiimwe Clare - In-House Consultant for Health

- JICA Experts

1. Mr. Kazuhiro Abe - Chief Advisor
2. Mr. Shigetaka Tojo - Expert on ME Maintenance
2. Mr. Hiroshi Tasei - Expert on 5S-CQI-TQM
3. Mr. Yasuhiro Hiruma - Expert on User Training

JCC MEMBERS ABSENT WITH APOLOGY

Ministry of Health (MOH):

1. Dr. H. Gatyanga Mwebesa - Commissioner Quality Assurance
2. Dr. Jackson Amone - Assistant Commissioner, Integrated Curative Services (ICS)
3. Dr. Lwamafa Dennis - Director Clinical and Community Health
4. Dr. Ezati Isaac - Director, Planning and Development
5. Dr. Francis Runumi - Commissioner, Planning Directorate of Planning and Development
6. Mr. S.S. Kyambadde - Under Secretary, MOH

	Retired – MOH: 1. Dr. Margret Chota - Retired (Commissioner Nursing) IN-ATTENDANCE JICA: 1. Mr. Tumukunde Brian - Assistant Coordinator 2. Ms. Katushabe Brendah - Secretary 3. Ms. Mubiru Doreen - Secretary **JCC MEMBERS ABSENT WITHOUT APOLOGY** Ministry of Health(MOH): 1. Mr. Francis Ntalazi - Assistant Commissioner, Human Resource Management 2. Mr. Enyaku Rogers - Assistant Commissioner, Budget and Finance, Department of Planning 3. Mr. Ponziano Nyeko - Assistant Commissioner, Accounts 4. Dr. Edward Mukooyo - Assistant Commissioner, Resource Centre

AGENDA:

11. Opening prayer
12. Communication from the Chair

    -Dr. Jane Ruth Aceng, Director General of Health Services, MOH

    -Mr. Hoshi Hirofumi, Chief Representative, JICA Uganda Office

13. Introduction of Members from Uganda and Japan
14. Reading of previous Minutes and Matters arising
15. Report of each activity in the 1st year schedule

5S-CQI-TQM:

Dr. Sarah Byakika – Assistant Commissioner, Quality Assurance

User Training:

Dr. Ampeire Immaculate – Senior Medical Officer, Clinical Services

Medical Equipment Maintenance: Eng. Sitra Mulepo - Senior Engineer, Health Infrastructure Management 6. Confirmation of Project Design Matrix 7. Confirmation of the 1st Year progress report (2nd draft) 8. Explanation of pre-arranged schedule for the 2nd and 3rd year Schedule from Japanese experts 9. Other relevant issues 10. Closing prayers	
Minute:	**Action Column:**
Min.1 : OPENING PRAYER The meeting was opened with a word of prayer by Dr. Amandua Jacinto.	
Min.2: COMMUNICATION FROM THE CHAIR ***Director General, MOH:*** The Chairperson welcomed members and apologized for postponing the JCC meeting twice due to other urgent committee meetings due to disease of Marburg outbreak in the country in Kabale District. She acknowledged the efforts of JICA alongside MOH, Uganda, in improving Health Services. She informed the meeting that JICA had helped to harness the three vital components of Health Services i.e. 5S, User Training and Medical Equipment Maintenance (ME); and the Infrastructure as a whole was impressively growing. She expressed the need for continuity of the JICA activities in areas like Moroto RRH and Northern areas where it has not yet reached. ***Chief Representative, JICA Uganda:*** He welcomed members and thanked them for giving him chance to make his remarks on behalf of Japan International Cooperation Agency. He appreciated the effort in the attempt to control the infectious diseases such as Ebola and Marburg.	*MOH & JICA to note*

He mentioned that it was good that he was invited for the JCC meeting because it strengthens team work and decision making. He said that the three components should be harmonized under a strong leadership of MOH in order to make them work hand in hand for sustainability. He said that it was pleasant for MOH staff to be able to work hand in hand with JICA to carry out the Project activities as expected to do, although in most cases the activities were being carried out by JICA experts. He requested that JICA Experts guide MOH and Hospitals on how to achieve the goals and harmonize the 3 components. He appreciated the stakeholders of the Project and the MOH top management for implementing the activities and hoped that the government of Uganda would improve the quality of Health Service in the country. He once again thanked all members for endeavoring to attend the meeting.	*MOH to note* *MOH & JICA*
Min.3 : SELF-INTRODUCTION Members were requested to introduce themselves according to their respective offices. *(Refer to list above for the attendance of members present).*	
Min.4 : READING OF PREVIOUS MINUTES AND MATTERS ARISING **4.1.0 Reading, Correction and Approval of Previous Minutes** Minutes were read, corrected and approved as a true record of what transpired in the previous meeting by Dr. Immaculate Ampeire. The following corrections were made:- 4.1.1 Corrections: I) Page 4, min. 4 (IV): two other user trainings would be conducted in April and June, 2012 not July. **4.2 .0 Matters arising:** *4.2.1 User Training activities*: I. It was mentioned that UT took place in June. II. Eng. Wanda responded that it was slated to take place in July but it took place in June. *4.2.2 5S Training:*	

I. Mr. Takano and Ms. Asiimwe Claire responded that it would be good if 5S helped improvement of the environment. II. Mr. Takano was of the view that the training could be organized after moving into the new building of MOH (page 5, min.6 (II). III. Dr. Amandua commented that a decision should be made to start on a few offices for 5S Training and then spread to the rest of the MOH gradually. IV. There was need to organize and talk about 5S activities to the MOH staff. V. The Director General suggested that 5S should be started with her office to use it as a show case.	*5S Expert*
4.2.3 Allocation of office at MOH for JICA: Page 6, min.7 (i) under responses. I. Dr. Amandua reported that upon inception of the JICA project, it was allocated an office at Wabigalo Central Workshop and another office was yet to be allocated at the MOH Headquarters. II. The exercise for assigning of offices began after the handover of the new building and it was only remaining identification of offices. III. The JICA project would either be in the new office or near the Clinical offices.	*MOH*
4.2.4 Technicians from Wabigalo Central workshop: page 7, 7.3 (III) I. Eng. Wanda informed the meeting that all Technicians had been involved in the inventory exercise collected from 25 Health Facilities by JICA/HID. II. Dr. Amandua expressed need to decide on making a joint report with MOH.	*HID/JICA*
4.2.5 5S activities: I. Dr. Sarah Byakika reported that 5S was new in Uganda and therefore there is a need to work hand in hand with Regional Referral Hospitals to see how it would be incorporated with quality assurance in the Health facilities. II. Dr Immaculate Ampeire suggested that 5S should be introduced in schools. III. Dr. Sarah Byakika responded that it had been taken up in T.Q.I Services and that working together would help to introduce it on the curriculum. The Regional Center was taking it up.	*Dr. Sarah Byakika* *Dr. Sarah Byakika*
Min.5 : REPORT OF EACH ACTIVITY IN THE 1ST YEAR SCHEDULE **5.1.0 Presentation from 5S-CQI-TQM by Dr. Sarah Byakika:**	*Dr. Sarah*

I.	Dr. Sarah Byakika reported and made a presentation on 5S mentioning that MOH in partnership with JICA and the involvement of National Facilitators had helped in turning of the staffs' mind set.	*Byakika and Mr. Hiroshi Tasei*
II.	She mentioned that Tororo should be developed to the level of CQI and staff should be trained after 5S.	*Dr. Sarah Byakika and Mr. Hiroshi Tasei*
III.	Informed that the 5S guideline was in the final stages and that the Training manual would help in improving services in Uganda. A draft was available which would be used to roll out the 5S in Uganda.	
IV.	An example of the 5S Tanzania version was being used but now with developing of a Ugandan version, enrolling of other partners would be embarked on.	
	5.1.1 Challenges*:*	*All to note*
I.	5S was in the initial period of starting in December 2012 to January 2013 the process of transition from Clinical Services to Quality Assurance department hence the slowness.	
II.	The presence of target Hospitals was not felt much. There was lack of involvement of Doctors as far as 5S activity was concerned. It was reported that apart from Mbale RRH, the rest of the Hospitals only nurses were actively involved.	
		Dr. Sarah Byakika and JICA 5S Expert
	5.1.2 Response:	
I.	5S Coordinators had been identified and were working hand in hand with facilitators in RRH to enable them enforce the 5S concept.	*MOH and JICA to note*
II.	Eng. Wanda commented that when quarterly review meetings are held it should be ensured that each component does a report on its activities as it had a very big impact.	
III.	Dr. Amandua said that 5S should be adopted in the Health Sector and it should be the basis in management, monitoring and evaluation. Mentioned that there was need to spearhead the advocacy and it was good that MOH was working hand in hand with JICA partnership.	
IV.	Human Resource: Implementing of all the three components, in future needed to harmonize the work.	*Dr. Sarah Byakika and Mr.*
V.	Mr. Tasei apologized for the delay in finalizing the 5S handbook, however, reported that	

	it was in its final stages.	*Tasei*
VI.	The Director General was wondering as to whether emphasis for the Health Workers about their change of mind set had been addressed during implementation of activities.	
VII.	She stressed that it was that phenomenal that required tackling. That a comment should be made in comparison of areas visited with the GH and RRH, because the GH scored higher than RRH and yet in reality RRH had more capacity. That in her tours she always asked for the names and activities of who does what and would make comparison. She added that apart from Mbale Hospital, the rest were Nurses and Clinical Officer who were mostly involved but not Doctors or Directors.	
	Response to 5.1.2:	
I.	Dr. Sarah Byakika informed the meeting as far as acceptance of 5S activity was concerned MOH adopted it as a fundamental concept. All the District officials and Directors of RRH were looking forward to implementation of 5S.	
II.	Informed that much as the Hospitals were harnessed, each one was on a different level of implementation. Entebbe GH started late but because they embraced it, they excelled.	*Hospital Directors to Note*
III.	It would be put as a baseline for QIT in various Hospitals.	
IV.	There were departments based in Hospitals for quality improvement in RRH.	*Dr. Opar/Mr. Tasei follow up*
V.	In experience, Hospital Directors and Managers had no adequate time to attend fully in the activities.	
VI.	The Directors had been asked to identify ad hoc committees to sit in for them and they would later be briefed as much as possible to be updated.	
VII.	Mr. Tasei reported that there was a challenge of involving Doctors in the 5S activities and this was the reason why Directors were being used.	
VIII.	Dr. Opar and Mr. Tasei were working on the initial stages of involving the Nursing staff and other Health Workers.	
IX.	Observed that Directors were keen at taking the lead but did not have time to implement which made the programme slow down.	
	5.1.3 Comment:	
I.	Eng. Wanda suggested as of the view that an explanation about the issue of Moroto RRH be stated i.e. on page 5 figure 1.	*Mr. Abe to follow*

Further Responses: I. Mr. Tasei said that Moroto RRH could not be visited by JICA staff according to its regulations that govern them, however, reported that the National Facilitator who visited that area, informed that it was just being introduced to the 5S activity. II. The DG thanked JICA for introducing 5S in Soroti RRH and requested that a follow-up should be done in Hoima RRH because the 5S concept had failed. III. Dr. Amandua said that the indicators for quality improvement should be included in the manuals although it was looked at as if they could also be able to work alongside the plan. IV. Dr. Byakika expressed the need to roll out the activities after finishing with the Regional Referral Hospitals as the country was large.	*up with Hoima* *Mr.Tasei to Note* *MOH/JICA*
5.2.0 Presentation from User Training (UT) by Dr. Immaculate Ampeire: Dr. Immaculate Ampeire reported on UT activities and thereof comments were given *(please refer to handout for User Training)* 5.2.1 Response: I. Eng. Wanda commented that standard medical equipment in Uganda were not easy to get however he advised to embrace what was available. II. The Director General informed that with the RRH which had funds to procure on a wider scale, there was need to come up with a standardized manual on procurement of equipment and it should be looked at as an opportunity not as a challenge to enable change of mind set of people since they get trained but fail to use the equipment because of the attitude of referring to it as government property. III. Dr. Byakika said that training was done on principle. There was need to harness User Training with 5S and ME since the three components go hand in hand for sustainability. IV. Dr. Amandua advised that there was need to have a standardized training in the 2nd year and Training manuals should be developed. He further said that there was a	*All to note* *MOH/NACME/ HID* *MOH/JICA to note* “

NACME standard list of equipment which should be considered in the training for ME.	*MOH to note*
V. Vigorous training for the new equipment that had been procured was urgently needed.	
VI. In future if there are supplies of equipment, there should be arrangement of In house training.	*MOH to note*
VII. The DG commented that there was need to know how to handle instruments and how to care for them for the safety of the patients and life span of the instruments.	
VIII. Training had been done on how to handle instruments, disinfect and sterilize and the routine care e.g. in Mbale RRH and Tororo GH and other Hospitals as well.	*User Training Mr. Hiruma*
IX. Dr. Amandua advised that User Training should involve the concept of being economical because Hospital resources were being mishandled. He gave an example of where water was left running on taps, lights and sterilizing machines with tools in them left on.	*MOH to note*
X. Dr. Opar responded that in order to cub the misuse of Hospital resources there was need to go back to 5S training.	
5.3.0 Presentation from Medical Equipment Maintenance by Mr. Shigetaka Tojo Mr. Tojo made a presentation on ME on behalf of his counterpart, Engineer Sitra. *(Please refer to handout of presentation page 61 for ME).* I. The inventory which was presented was for 2008. The inventory for 2012 was already done for the 25 Health facilities and was still being analyzed by Mr. Mimuro, another JICA expert for ME. II. It was reported that there was shortage of budget to procure spare parts hence managers were always complaining and were unable to procure equipment. III. More funding was needed from the government of Uganda. IV. The Government of Uganda should come up with a plan of disposing off the Medical Equipment which was laying all over in RRH and RWS. 5.3.1 <u>Response:</u> I. Eng. Wanda reported that the Health Infrastructure (HI) TWG Working group meeting which was held on 22 October, 2012, Eng. Sitra Mulepo made a presentation on the status of ME in Uganda *(please refer to page 67).* II. A paper would be prepared for HIPAC top Management. III. Mr. Takano suggested that 5S could be applied on the maintenance of ME and improvement of status of equipment. IV. It was observed that there was a big challenge in the percentages about the condition of	*Mr. Tojo /Mr. Mimuro ME experts* *MOH to note* *"* *MOH/HIPAC to follow up*

	ME according to the presentation by Eng. Mulepo.	
V.	Noted that sharing of information on activities between JICA/MOH was very vital and important.	
VI.	It was noted that JICA's commitment on the Volunteers who worked in Hospital facilities like Tororo GH, Masaka RRH, Soroti RRH had helped tremendously in the areas of 5S. *(please refer to page 4).*	
VII.	The DG reported that the Budget issue was at hand but there was need to get Bio-medical Engineers urgently to be trained because most of the ones available were not confident and not well trained.	
VIII.	Eng. Wanda reported that Electrical and Mechanical Engineers were trained to be converted to Bio-medical Engineers. That a lot should be invested in training.	
IX.	The DG said that training should be done from the pool available so as to provide better results.	
X.	Reported that another bigger problem was due to those under retirement, most of the Engineers available were to retire in the next 2-5 years.	*Eng. Wanda to note*
XI.	Dr. Amandua said that looking at the process of integration, components and work on improving the status of A & B condition and maintaining the new ones in use, the delays in disposal of ME was being handled by PPDA as required by the 5S guidelines. He added that some hospitals had no RWS.	
XII.	That in the next budget there should be a slot for construction of workshops for Masaka RRH, Mubende RRH and Mbarara RRH so that Wabigalo was not overburdened and loaded.	*MOH/HID to note*
XIII.	The DG proposed that JICA should concentrate on the areas that needed their attention.	
XIV.	Noted that Training was the first priority to add new Trainers to those in existence.	
XV.	Eng. Wanda highlighted that trainings used to be carried out every after six months at CWS and it was appreciated; therefore he suggested getting funding so as to resume the trainings for at least once a year.	*MOH/HID to note*
XVI.	Eng. Wanda commented on procurement of spares that for the last 3 years nothing had been procured for lack of sufficient budget allocation. He said that there was need for ME spare parts to be procured and had specifications that needed to be adhered to.	*JICA Experts to note*
XVII.	Eng. Wanda requested that contracts should be given to the retiring Engineers to help in training to support the new ones.	
XVIII.	The DG commended JICA for the good job in the area of financial support in the ME training and inventory exercise which was carried out in the 25 health facilities. She added that JICA should encourage the change of mind set whenever they went out on supervision of activities.	
Min. 6 : CONFIRMATION OF PROJECT DESIGN MATRIX		

6.1.0 Presentation of the Project Design matrix version 3 Mr. Kazuhiro Abe presented the Project Design Matrix specification of the project which all members in the meeting had copies. 6.1.1 Response:	*All to note*
I. The DG was in agreement with the PDM document since it captured all that was to be done and that since the rest of the members had got copies to read through. II. Mr. Abe informed that the next surveillance survey would be done between February – April, 2013 and thereafter a report would be made by JICA. III. Noted that compared to the first PDM, there was a change in indicators.	*JICA Experts to note*
6.1.2 Comments:	
I. Eng. Wanda stated that ME maintenance would need to sit down with JICA and iron out the issues at hand in inventory and training areas. II. Dr. Amandua said that equipment that needed to be disposed off should be identified and a quick decision should be made to clear Hospitals and Workshops of such obsolete equipment. III. Reported that there was a big problem in Hoima Hospital which needed a follow-up as it was in a bad state. Mr. Abe was requested to make a follow-up of Hoima RRH by the DG. IV. Eng. Wanda reported that the Inventory for 2012; data was collected, entered and forwarded to Mr. Mimuro in Japan for comparison and this would be depicted in the next Report. V. Eng. Wanda also expressed the concern of damping equipment which was supposed to be disposed off in CWS and thus called upon for a quick solution to be sought on proper disposal.	*JICA ME experts/HID* *MOH/PPDA* *Mr. Abe to make a follow up visit to Hoima* *Mr.Tojo/ Mr. Mimuro ME experts* *MOH PPDA*
Min.7: CONFIRMATION OF THE 1ST YEAR PROGRESS REPORT (2ND DRAFT) **7.1.0 Presentation of the 1st year Progress report.** Mr. Abe presented the 1st year progress report (2nd draft). *(please refer to handout.* 7.1.1 Response:	*All to note*

I. Eng. Wanda – Refer to the report from the HID Item 8, 2nd year schedule (please refer to (hand out). II. Mr. Abe added that in the next JCC meeting JICA team would explain the evaluation of the activities of 2012.	*All to note*
Min.8: EXPLANATION OF PRE-ARRANGED SCHEDULE FOR THE 2ND AND 3RD YEAR SCHEDULE FROM JAPANESE EXPERTS. **8.1.0 <u>5S Activities: (Out put 1)</u>** Mr. Tasei reported that 5S activities would continue from September to October in 3 phases i.e. follow-ups on each target hospital. I. Next year 2013: February – May; July – August with National facilitators from MOH. It was divided into three Regions Eastern, Western and Southern. Regional Facilitators would be assigned to monitor and plan 5S activities. II. Two trainings would be carried out for TOT refreshers and details would be confirmed after visiting all the target areas and then the next 5S Conference would take place towards the end of September. **8.2.0 <u>User Training Activities: Out put 2)</u>** Mr. Hiruma *(please refer to presentation)* I. It would be done four times. II. October 2nd Week - December III. March (1st week) IV. April – June – Mid-Review JICA V. User Training manuals preparation VI. User Trainers should be able to assemble, use and maintain/routine care of Medical equipment. After training each User Trainer should come from each Hospital. VII. General Training will be carried out, then feedback and discussion. **8.3.0 <u>Maintenance Medical Equipment (Out put 3):</u>** Mr. Tojo – *(please refer to work schedule)* I. 2nd Update: - May – April; Inventory Training Excel/Analysis for Workshop Managers and Technicians by JICA II. He mentioned that the 2nd managers meeting were yet to take place so preparations were being made.	*Dr.Sarah /Mr.Tasei* *JICA 5S* *Mr. Hiruma* *UT Expert* “ “

III.	It was also clarified that bio medical training of technicians and staff was yet to take place.	*ME experts JICA/ Eng,Mulepo*
IV.	Data was being collected to make an operational ME manual to be finalized by September 2013.	
V.	Mr. Tojo confirmed that visits to workshops and hospitals would be done.	
8.4.0 <u>Visits for Supervision of Workshops</u>:		*Mr. Tojo ME expert*
I.	Dr. Sarah Byakika commented that the target Hospitals for trainings should be known, identified and number of people to be trained be established.	*WS Managers/Eng. Mulepo/JICA ME experts*
II.	Dr. Opar made a comparison of Mulago Hosptal and Muhimbili Hospital in Tanzania in a presentation form.	
III.	Observed that 5S in Tanzania had already been embraced and it was working well according to the show case areas in Muhimbili Hospital.	*MOH/5S*
IV.	A concern was raised about where Mulago Hospital was falling in implementation because it was in a bad state despite the fact that it was a National Referral Hospital.	
8.5.0 <u>Responses:</u>		
I.	Mr. Takano commented that 5S started in Tororo and when it was embraced and applied there were good results.	
II.	Dr. Opar further said that in Mulago Hospital the concept was introduced and a focal person was identified and trained but did not follow it up, yet Dr. Dumba left in the management was not aware of 5S.	*DG & Dr. Amandua to note*
III.	A Follow-up visit to Mulago was done last year to support them.	*Dr. Opar to note*
IV.	Called upon for a deliberate effort to be done on Mulago Hospital as a separate entity.	
V.	Dr. Opar reported that as one of the people who introduced 5S at Mulago Hospital seemed as if the concept was not taken in and yet 2 Nurses were trained but unfortunately one was transferred to Jinja Hospital. Urged to get the criteria of converted mass to help in that area.	*Dr. Amandua to note*
VI.	The DG advised that a letter from MOH to the Director Mulago Hospital be written for a study tour, and then an implementation to sensitize and train people would begin after identifying potential volunteers.	
VII.	Dr. Opar referred to the presentation done in Tanzania to depict on what was on the ground in Mulago Hospital.	

VIII. The DG commented that during her tour she visited all Nursing Stations and they had districts in all hospitals except Lira and Mbale. IX. The DG advised that staff in Mulago be taken to Tororo GH, Entebbe GH and Lira RRH for showcase comparisons. X. Advised that when Mulago Hospital was visited they should take along the top management officials to talk to the staff for impact and change of mind set.	*Dr. Amadua to note* *DG & Dr. Amandua with Top management*
Min.9: OTHER RELEVANT ISSUES 1. Mulago Hospital 2. Volunteers 3. Pull up stands I. Dr. Amandua requested JICA to provide other volunteers since most of them had left who were in promoting 5S activities. 9.1 <u>Comments:</u> I. The report from Busolwe Hospital about issues with the MS and Management and Hospital, makes it difficult for JICA to appoint a volunteer unless the management was changed it would be difficult to send one. II. Dr. Opar reported that he had visited Busolwe and that there was a group of enthusiastic people who were willing to work but due to others who had stayed there for a long time were influencing them not to deliver, therefore under such conditions it was difficult for 5S activities to be embraced thus a volunteer could not work under such circumstances. III. There was need for redeployment/transfer of old staff and bring new ones in order to implant the 5S concept. IV. Busolwe Hospital had a problem of infrastructure, drainage and water problems. 9.2 <u>Response:</u> I. Mr. Takano said that he could not make a confirmation of sending a Volunteer to Busolwe because next year he would be back to Japan. II. The DG directed that MOH has to find a solution to problems in Busolwe even if it meant	*JICA/MOH To note* *All to note* *MOH to note* *MOH to note* *Mr. Tasei JICA*

to change the whole administration so as to bring good fruits in promoting Health Services in that Hospital. Mr. Tasei presented the 1st draft design for a pull up stand which would be printed after amendments from MOH. It would be put in the target Hospitals, Mulago Hospital and MOH. There being no other issues the DG thanked members who had endeavored to attend the meeting and applauded them upon the fruitful deliberations. She noted that good progress was being made and remarked that politicians should also appreciate that a fundamental change could be made in the Health Service especially Mulago Hospital work which was done as a team with their partners. The meeting ended with a closing prayer by Ms. Asiimwe Claire of JICA at 1:42 p.m.	
Summary of issues discussed: 1. 5S, User training and ME maintenance 2. Training; Technicians/ME, 5S/medical personnel, User training/medical personnel 3. Inventory/ ME up date and analysis 4. Disposal of ME equipment 5. Budget allocation to WS 6. Building of WS in RRH were non exist 7. Retirement of trained staff, rehiring them on contracts. 8. Mulago Hospital overhaul and way forward 9. Follow up visit to Hoima hospital 10. Confirmation of Project Design Matrix 11. JICA cooperation with MOH/Volunteers	
Handouts: *1. Agenda* *2. Project Design Matrix Version 3* *3. 1st Year activity Progress report* *4. 2nd year schedule all activities*	

5. *3rd year schedule-all activities* 6. *Report on 5S activities* 7. *Report on UT activities and Future schedule* 8. *Minutes of 2nd JCC minutes final draft* 9. *Draft Copy of design for the Project pull up stand* 10. *Report on the results of the needs assessment*	

Approved by:

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Dr. Aceng Jane Ruth	Doreen Mubiru
CHAIRPERSON	**MINUTE SECRETARY**

MINUTES OF THE 4TH JOINT COORDINATING COMMITTEE (JCC) MEETING HELD ON 9TH MAY, 2013 AT HOTEL AFRICANA (MINISTRY OF HEALTH AND JICA)

Date and Time:	9th May, 2013 09.45a.m-01.30p.m	Minute Secretary: Agnes Batuvamu	Place: Hotel Africana

Attendance:

JCC MEMBERS PRESENT

-MINISTRY OF HEALTH (MOH):

1. Dr. Lukwago Asuman - Permanent Secretary
2. Dr. Jane Ruth Aceng - Director General Health Services - Chairperson
3. Dr. Amandua Jacinto - Commissioner Clinical Services
4. Dr. H. Gatyanga Mwebesa - Commissioner Quality Assurance
5. Eng. Sitra Mulepo - Senior Principal Engineer, Health Infrastructure Division
6. Mr. Aliti Tom - Principal Finance Officer, B & F
7. Sr. Enid Mwebaza - Assistant Commissioner, Nursing
8. Sr. Beatrice Alupo - SNO, Nursing Division

-EMBASSY OF JAPAN, Uganda:

1. Nishimitsu Kanoko - Researcher/Advisor, Embassy of Japan

-JAPAN INTERNATIONAL AGENCY (JICA), Uganda:

1. Mr. Hoshi Hirofumi - Chief Representative
2. Ms. Takahashi Sonoko - Representative
3. Ms. Asiimwe Clare - In-House Consultant for Health

-JICA Mid-Term Review Team:

1. Ikuo Takizawa - Team Leader
2. Serizawa Akemi - Evaluation Analysis
3. Masumi Okamoto - Cooperation Plan

- JICA Experts 5S Project:

1. Mr. Kazuhiro Abe - Chief Advisor
2. Mr. Shigetaka Tojo - Expert on ME Maintenance
3. Mr. Hiroshi Tasei - Expert on 5S-CQI-TQM
4. Mr. Yasuhiro Hiruma - Expert on User Training
5. Mr. Take Naoki - Expert on Impact Assessment
6. Mr. IjimaKazunori - Project Coordinator

JCC MEMBERS ABSENT WITH APOLOGY

Ministry of Health (MOH):

6. Dr. Jackson Amone	- Assistant Commissioner, Integrated Curative Services (ICS)
7. Dr. Lwamafa Dennis	- Director Clinical and Community Health
8. Dr. Ezati Isaac	- Director, Planning and Development
9. Dr. Francis Runumi	- Commissioner, Planning Directorate of Planning and Development
6. Mr. S.S. Kyambadde	- Under Secretary, MOH
7. Dr. Sarah Byakika	- Assistant Commissioner Quality Assurance
8. Eng. Sam SB Wanda	- Assistant Commissioner, Health Infrastructure
9. Mr. Ponziano Nyeko	- Assistant Commissioner, Accounts with apology
10. Dr. Edward Mukooyo	- Assistant Commissioner, Resource Centre with apology
11. Dr. Isaac Kadowa	- Dr. Isaac Kadowa with apology

IN-ATTENDANCE JICA:

1. Mr. Tumukunde Brian	- Assistant Coordinator
2. Agnes Batuvamu	- Secretary

JCC MEMBERS ABSENT WITHOUT APOLOGY

Ministry of Health(MOH):

5. Mr. Francis Ntalazi	- Assistant Commissioner, Human Resource Management
2. Mr. Enyaku Rogers Department of Planning	- Assistant Commissioner, Budget and Finance,
3. Dr. Opar Bernard Toliva	- Principal Medical Officer, Clinical Services
4. Dr. Ampeire Immaculate	- Senior Medical Officer
5. Dr. Timothy Musila	- Senior Health Planner, Mid-Term Review Team

AGENDA:

1. Opening prayer

2. Welcome Remarks

-Dr. Mwebesa Henry, Commissioner, Health Services (QAD), MOH

3. Communication from the Chair

-Dr. Jane Ruth Aceng, Director General of Health Services, MOH

4. Remarks from JICA Uganda Office

-Mr. Hoshi Hirofumi, Chief Representative, JICA Uganda Office

5. Reading and Confirmation of minutes of the previous JCC meeting and matters arising

-Dr. Mwebesa Henry, Commissioner, Health Services (QAD), MOH

6. Report of each activity in the first half of the 2nd project year

5S-CQI-TQM

- Dr. Mwebesa Henry
- Mr. Hiroshi Tasei, JICA Expert

User Training

- Dr. Amone Jackson, Asst. Commissioner, Integrated Curative Services
- Mr. Yasuhiro Hiruma, JICA Expert

Medical Equipment Maintenance

- Eng. Sitra Mulepo, Senior Principal Engineer, Health Infrastructure Division
- Mr. Shigetaka Tojo, JICA Expert

Impact Assessment

- Mr. Naoki TAKE, JICA Expert

7. Explanation from Mid-Term Review Team

- One Presenter from the Team (TBA)
- Mr. Ikuo Takizawa, Leader

8. Confirmation of Project Design Matrix Version 4.0

- Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

9. Signing of Minutes of Meetings (tentative)

- Dr. Lukwago Asuman, Permanent Secretary, MOH
- Mr. Ikuo Takizawa, Leader

10. Explanation of schedule for the second half of the 2nd Project Year.

- Mr. Kazuhiro Abe, Chief Advisor/JICA Expert

11. Other relevant issues

- Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

12. Schedule for next JCC Meeting – October, 1st 2013 pre-arranged

- Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

13. Closing Prayer

Minute:	**Action Column:**
Min.1 : OPENING PRAYER The meeting was opened with a word of prayer by Dr. Tom Aliti at 9.45 a.m.	
Min.2 : WELCOME REMARKS Dr. Mwebesa Gatyanga led the 1st session and welcomed everybody to the 4th JCC meeting. Dr. Mwebesa informed the meeting that Dr. Amandua Jacinto and other members from MOH had been held up in many other meetings and had sent in their apologies, but Dr. Amandua was to join anytime. He informed the meeting that after the remarks from DG she would briefly go to another meeting but would return and continue with the meeting.	
Min.3: COMMUNICATION FROM THE CHAIR ***Director General, MOH-Dr. Jane Ruth Aceng:***	

The Chairperson appreciated and thanked all members for turning up for the meeting especially the guests from JICA who conducted the Mid-term review exercise that commenced on 22nd April to 11th May, 2013. She said that it was important to review the achievements and failures of the project in order to give room for improvement and assess the impact. She mentioned that the 3 components i.e. 5S, User Training and Maintenance Equipment made most of the Health facilities shine ever since their implementation and that it should be sustained. She expressed gratitude to the government of Japan for its support to Uganda and for the survey team from JICA Headquarters which carried out the Mid-term review that enabled identification of gaps and that the meeting should be able to help cover them. The project scored numerous successes such as the infrastructure development in Masaka and Mubende; and the 5S success in different facilities. She said that use of equipment in most hospitals had improved and was extremely grateful for such achievement, however, stated that there should be a way of sustaining these achievements. After those few remarks she wished everybody good deliberations and apologized for change of venue for the meeting from MOH to Hotel Africana.	*All to note*
Min.4: REMARKS FROM JICA UGANDA OFFICE ***Chief Representative, JICA Uganda:*** The Chief representative Mr. Hirofumi Hoshi welcomed all members and privileged to give remarks at the 4th JCC meeting for the International Technical Cooperation Project on the Improvement of Health Services through Health Infrastructure Management. He said that the project came into consideration after identifying a number of challenges into the Health Sector in the Country. He remarked that after the implementation of 5S and User Training in the core hospitals, fewer breakdowns of equipment and improved working environment had been registered. The medical equipment inventory system had also been restored under the same project though the capacity of the workshops was still weak. He commended having the mid-term review team that was to share its findings as compiled in the 5S project report. He said that JICA would continue supporting the work in the Health sector in Uganda, however, pointed out that for sustainability purposes and better achievements, MOH should be more supportive than before and presume ownership.	*MOH*

He encouraged the Project Team members to work more closely with the co-partners in order to attain the best results.	*counterparts* *JICA* *Counterparts*
Min.5 : READING OF PREVIOUS MINUTES AND MATTERS ARISING Minutes were read, corrected, and approved after discussions were made as follows:- ***5.1: Corrections:*** *I.* Page 4; under challenges No. I the statement should read: *5S was in the initial period of starting in December 2013 the process of transition from DG's office to Clinical Services then to Quality Assurance Department.* *II.* Page 8; min.8: should be written*: Explanation for 2nd and 3rd Year Schedule for the Japanese Experts.* *III. Page 10; delete sentence No.Viii* ***5.2: Matters arising:*** I. Informed that most of the issues raised for each component were to be addressed in the presentations to be made during the meeting that was on going II. Commented that although there was a list of Medical Equipment in Uganda, it was hard to get it. III. The issue of disposing off unnecessary equipment had already been embarked on for	*MOH&JICA* *counterparts*

most workshops; and hospitals were advised on what to discard.	
IV. Noted that insufficient budget allocation for procurement of spare parts was still a problem, as the Central Workshop received very little compared to what it was required on the budget. Advised that lobbying for funding should continue.	*MOH*
V. The problem of ME maintenance for Hoima hospital was solved; the workshop environment was cleared and had improved.	
VI. 5S at Mulago Hospital: JICA sent 15 Nurses to Tanzania for study tour to Muhimbiri in which Dr. Amandua was part of the team.	
VII. JICA 5S project was now housed at MOH headquarters and the experts were working more closely with their counterparts than before.	
VIII. The issue of the 5S Handbook and guideline had been addressed and 5,000 copies were printed and distributed. The Training manual for UT was being developed.	*MOH &JICA counterparts*
IX. Reported that some hospitals like Mbale, Masaka, Mubende had volunteers from Japan, and more Nurses would come in September, 2013 and would be deployed as may be required.	*JICA*
X. The meeting appreciated Mr. Takano the former JICA Representative to Uganda and requested the JICA team to send gratitude to him for his support and input rendered during his stay in Uganda, and wished him more successes.	
XI. It was reported that Ms. Takahashi Sonoko was now the Representative of JICA and was attending JCC for the first time. She was recognized and welcomed to the meeting.	
XII. The problem of Busolwe administration, infrastructure, drainage and water was still standing.	*MOH*
The meeting adopted the minutes as a True record of what transpired however, advised that when taking record of the discussions of the minutes, they should be summarized and should also quote offices instead of personal names.	
Min.6: REPORT OF EACH ACTIVITY IN THE 1ST YEAR SCHEDULE	

6.1: PRESENTATIONS

The second session was led by Dr. Amandua Jacinto who had joined the meeting later and apologized for delaying but it was due to other official commitments.

Presentations for each activity were made as follows:-

6.1.1: 5S-CQI-TQM:

Dr. Mwebesa presented about 5S activities. The presentation depicted the level of performance per each target facility as indicated in the Handout (*please Refer to 5S Handout for details).*

Informed that:-

I. Dr. Kadowa one of the MOH 5S counterparts was away in Mbale and was unable to attend the meeting. Sr. Alupo Beatrice was to join later for the meeting.

II. Mr. Ishijima based in Tanzania, gave much support towards 5S activities when he visited Uganda.

III. More work was required under support supervision as depicted in the presentation depending on the baseline assessment for each target hospital.

Comments:-

I. Implementers of 5S should be role models so as to encourage others to learn from them.

II. CME was pointed out as one of the vital tools to be used for sustainability of 5S in the health facilities.

MOH &JICA 5S Counterparts

6.1.2: MAINTENANCE OF MEDICAL EQUIPMENT (ME):

Presentation on Improving ME maintenance was done by Eng. Sitra Mulepo. *(Please refer to handout on ME for details).*

Informed that:

I. A decision was made that inventory should not only be about the list of equipment but also a list of equipment for maintenance.

II. The challenge of Central Regional workshop was that it was being used as a maintenance workshop as well as a disposal place for equipment from the hospitals.

All to note

6.1.3: IMPACT ASSESSMENT:

The Impact Assessment presentation was made by Mr. Naoki Take, JICA Expert in-charge of that activity. *(Please refer to Handout on Impact Assessment for details).*

Informed that:

I. Staff attitudes towards patients and drug availability were significantly used as a basis to determine the general patients' satisfaction. **Comments:** I. The Expert expressed interest to have an opportunity to present at the coming QI Conference organized by MOH in June 2013 from 17th – 19th to give an introduction about User Training and Maintenance of medical equipment. **6.1.4: USER TRAINING:** The presentation was made by the JICA Expert Mr. Hiruma Yasuhiro in-charge of User Training in the absence of the MOH counterpart, Dr. Amone Jackson. (*Please refer to Handout on User Training for details).* **Informed that:** I. A number of User Training workshops and Follow-up activities had been carried out to assess the Basic User Trainers on the implementation of knowledge and skills acquired. Reported that another training workshop was on-going that commenced 6th – 10th May, 2013 for five (5) days at Masaka Regional Referral Hospital. II. Sixteen (16) Basic User Trainers from eight (8) target hospitals in the country were nominated and were being trained on the commonly used equipment in hospitals.	*MOH*
Min.7: EXPLANATION FROM MID-TERM REVIEW TEAM A Mid-Term Review was carried out to assess the performance of the JICA 5S Project for the period of 1 ½ years of implementation. The Review was carried out by a Team from JICA Headquarters led by Mr. Ikuo Takizawa who remarked that the work was jointly done by Ugandans and Japanese members. He said that the project was uniquely set up to focus on three (3) components i.e. 5S, UT and ME but; also Impact Assessment to measure the change in the Health facilities. He said that although the foreign team (JICA) was giving support to the project, it required much more support from the Ugandan counterparts for stronger successes. Mr. Takizawa invited Ms. Serizawa Akemi one of the team members to give a full presentation of the review report. She highlighted the following:- *(please refer to Mid-Term Review Report for details)* I. The purpose of the review team was to assess activities and achievements of the 5S	

	project.	
II.	A series of discussions with MOH members were done to exchange views on the project.	
III.	The matters raised in the mid-term review report were discussed and agreed upon by both counterparts from MOH and JICA and thereafter a revised PDM into version 4.0 was developed.	
		All counterparts to note

Min.8: CONFIRMATION OF PROJECT DESIGN MATRIX VERSION 4.0 Dr. Amandua Jacinto thanked everybody for their cooperation during the revising of the PDM from version 3 to 4. I. He reported that the various heads of the components had already met and discussed at length about the activities and agreed upon the new PDM version 4 to be adopted for implementation. He further said that there should be feedback on all issues agreed upon during the next JCC meeting. II. He sighted the issue of User training that it should be as a requirement for pre-service training. He mentioned that it would be discussed with the Head of Nursing department so that information about User training starts in training schools. He said that various consultations should be made and a report given about the new suggested proposals.	*MOH & JICA counterparts* *MOH & JICA UT counterparts*
Comments on Impact Assessment: I. A concern was raised as to who was the designated counterpart for Impact Assessment activity on the MOH side and whether he was part of the findings made by the JICA Expert.	
Response: I. Informed the meeting that at the inception of the Project it was Dr. Opar and Dr. Isaac Kadowa designated as counter parts for Impact Assessment. II. MOH needed someone to make a follow-up of the findings got in the presentation on Impact Assessment and because of its significance; it should not be lost for accountability purposes.	*MOH* *MOH & JICA Counterparts*
Comments on ME: I. Wanted to know why updates on inventory were poor as indicated in the presentation made.	*MOH to note*
Response: I. Reported that the Health facilities were meant to do inventory at their level but it was not the case; instead it was the workshops making updates with maintenance of the equipment as well as support supervision for them. II. It was recommended that as a mechanism, the form filled by health facilities should capture the maintenance condition of the equipment and that it should be a requirement or else the facility would be regarded as a failure.	*MOH* *ME counterparts*

III. JICA was requested to come up with a guideline for disposal of unwanted equipment.	*MOH & JICA ME counterparts* *ME JICA Experts*
Min.9: SIGNING OF MINUTES OF THE MID-TERM REVIEW DISCUSSION MEETINGS The Permanent Secretary, MOH Dr. Lukwago Asuman and the JICA Team Leader of the Mid-Term Review Mr. Ikuo Takizawa, officiated the signing of the minutes of discussion for the Mid-Term Review Report for the Project on Improvement of Health Services through Health	

Infrastructure Management. **Informed that:** I. Various discussions had been made as earlier reported about the Mid-Term Review amongst the different concerned parties and mentioned that as a custom they were supposed to be signed at the end. II. Mentioned that the minutes of discussions were believed as a true copy of what transpired and agreed upon to implement the recommendations between now and October before the next JCC meeting. III. The Technical officers would further look at the signed document and make necessary feedback.	*MOH & JICA counterparts*
The Director General, MOH welcomed the Permanent Secretary and thanked him for turning up for the meeting for the function of signing the Minutes of discussion for the Mid-Term Report. She appreciated the leader of the Mid-Term Review, Mr. Takizawa and the entire delegation from JICA for the good work done to assess the Project's activities. She requested the Mid-Term Review Leader to give his remarks and thereafter invited the PS to remark. **Remarks from Mid-Term Review Leader – Mr. Takizawa Ikuo:** He said that as already pointed out in the Mid-Term Review report, sustainability aspect was still low, it should be made better before the end of the project. He quoted one scholar Professor Omaswa in his article – w*ho said that Africa had an attitude of I can't do it,* but with 5S more can be done. He expressed interest to continuously work fruitfully with everybody and was grateful for the assignment entrusted to them and hoped to do the final evaluation at the end of the project period as well. **Remarks from Permanent Secretary – Mr. Lukwago Asuman:** He thanked everybody for participating in the work for Improving of Health Services. He appreciated the team from JICA for carrying out the Mid-Term Review of the project. He further commented that where data was not captured, a lot would be lost and this was due to negligence. He particularly commented on a report on Inventory of the medical equipment, that if it was not done, there would be no evidence, and thus leading to losses of money. He asked the DG to help out on the provider satisfaction in which most hospitals like Arua RRH had deteriorated although some had improved with the aspect of 5S. The causes of deterioration should be identified and addressed. He said that 5S was a key implementing factor in all aspects even if it appeared simple, but low cost effective and thus health workers should be urged to take it seriously. He appreciated that JICA was not only in Uganda but also in East Africa and Worldwide which leads to an improvement in health facilities. He urged to work as a team to attain more	*Commissioner Clinical Services*

successes. JICA should work with MOH to amplify the strength achieved even if the budget on the side of Uganda was not sufficient enough but would give intervention as a priority to the achievements acquired so as to move forward. Thanked the team leader, JICA and said he was available for any support to improve on health services in the country. He said that Mubende was pointed out for consideration and therefore the gaps should be identified and worked upon accordingly. He said that the mechanism to reach Moroto could be worked out, even if the Japanese counterparts were not permitted to go there due to security reasons, but the Ugandan counterparts can work there. He finally thanked Mr. Abe Kazuhiro the Chief Advisor of JICA 5S Project and all the other experts for their hard work. The PS requested the DG to close the meeting, and thereafter it would continue for other relevant issues.	*DG, MOH*
Min. 10: EXPLANATION OF SCHEDULE FOR THE SECOND HALF OF THE 2ND PROJECT YEAR. Mr. Abe Kazuhiro, Chief Advisor JICA 5S project explained the schedule for the experts and their activities as outlined in the Handout on Activities for 2nd Project Year: *(please refer to handout for details).* He briefly stated the following:-	*JICA*
I. 5S - End of August – there will be a 5S conference which will combine other components UT and ME.	*MOH &JICA counterparts*
II. UT – In August – there will be U.T Manual developing.	
III. ME- In September - Carry out 5th training for Managers – operational manual developed – end of the 2nd year	
IV. 5th JCC - to be held 1st October, 2013.	*MOH*
Min. 11: OTHER RELEVANT ISSUES: I. Dr. Amandua informed the meeting that the Bio-medical students – 9 of them from Kyambogo University were due for completion and would be employed to solve on the burden of staff shortage and in addition Students from Makerere were also due for qualification and thus more workers would be deployed to Regional Referral Hospitals. II. Funds of ME**:-** There was a concern raised for lack of other relevant counterpart funding for medical equipment maintenance. III. On the issue of integration of other implementing partners regarding 5S; the document should be availed to areas of quality as an implementing tool. **Response:**	

I. The Senior Principal Engineer- Sitra Mulepo said that with respect to the following Hospitals i.e. Jinja, Masaka, Mubende, Moroto and Naguru, they had not established workshops and this causes suffering of the Central workshop, while the 1 billion that was allocated from Finance, only 100 million was availed to take care of all these hospital facilities for medical equipment maintenance.	*JICA 5S expert* *JICA UT expert*
II. Dr. Amanda agreed that he would take responsibility to present it to the top management of MOH to get extra funding. He would make a detailed strategy paper regarding funding for medical equipment maintenance budget.	*JICA ME expert*
III. He said that the Bio medical staff needed to be clearly designated in the MOH, to embark on the training.	*MOH &JICA*
IV. Agreed that all recommendations made in the Mid-term review should be implemented as suggested.	*MOH*
V. 5S should be done with all the implementing partners as a baseline on other programmes.	
VI. Thanked JICA for the training guideline and handbook developed.	
Min. 12: SCHEDULE FOR NEXT JCC MEETING JCC meeting was scheduled for 1st October, 2013.	
Min. 13: CLOSING PRAYER: The meeting ended at 1.30p.m with a word of prayer led by Sr. Beatrice Alupo.	*MOH &JICA counterparts*
	Commissioner Clinical Services

	MOH &JICA counterparts *MOH &JICA 5S counterparts*
Summary of issues discussed: 1. *Development of Training Manuals* 2. *Deployment of more JOCVs in hospitals* 3. *Presentations:5S, User Training, Maintenance Equipment and Impact Assessment* 4. *Mid-Term Report* 5. *Signing of Minutes of Discussion for Mid Term Review* 6. *Revised PDM version 4.0* 7. *Implementation of all recommendations in the Mid Term Review* 8. *Schedule for next JCC meeting*	
Handouts: 1. *Agenda* 2. *Minutes of Previous Meeting* 3. *Presentations: - 5S, UT, ME, Impact Assessment* 4. *Project Design Matrix Version 4* 5. *Schedule for JICA experts*	

Approved by:

…….. ……

Dr. Aceng Jane Ruth — **CHAIRPERSON**

Agnes Batuvamu — **MINUTE SECRETARY**

MINUTES OF THE 5TH JOINT COORDINATING COMMITTEE (JCC) MEETING HELD ON 15TH NOVEMBER, 2013 AT MINISTRY OF HEALTH

Date and Time:	15th November, 2013 02.00p.m-04.30p.m	Minute Secretary: Agnes Batuvamu	Place: Ministry of Health

Attendance:

JCC MEMBERS PRESENT

-MINISTRY OF HEALTH (MOH):

1.	Dr. Jane Ruth Aceng	- Director General Health Services - Chairperson
3.	Dr. Amandua Jacinto	- Commissioner Clinical Services
4.	Dr. H. Gatyanga Mwebesa	- Commissioner Quality Assurance
5.	Dr. Sarah Byakika	- Assistant Commissioner, Quality Assurance
6.	Eng. Sam Wanda	- Assistant Commissioner, Health Infrastructure Division
7.	Eng. Sitra Mulepo	- Senior Engineer, Health Infrastructure Division
8.	Sr. Tibamwenda Mary	- Senior User Trainer

-EMBASSY OF JAPAN, Uganda:

1.	Ms. Yamasumi Eri	- Researcher/Advisor, Embassy of Japan

-JAPAN INTERNATIONAL AGENCY (JICA), Uganda:

1.	Mr. Hoshi Hirofumi	- Chief Representative
2.	Ms. Takahashi Sonoko	- Representative
3.	Ms. Asiimwe Clare	- In-House Consultant for Health

- JICA Experts 5S Project:

1.	Mr. Kazuhiro Abe	- Chief Advisor
2.	Mr. Hiroshi Tasei	- Expert on 5S-CQI-TQM
3.	Mr. Mimuro Naoki	- Expert on ME Maintenance
4.	Satoko Irisawa	- Coordinator, JICA 5S Project

JCC MEMBERS ABSENT WITH APOLOGY

Ministry of Health (MOH):

1.	Dr. Jackson Amone	- Assistant Commissioner, Integrated Curative Services (ICS)
2.	Mr. Candia Aliti Tom	- Principal Finance Officer, B & F
3.	Mr. S.S. Kyambadde	- Under Secretary, MOH
4.	Dr. Edward Mukooyo	- Assistant Commissioner, Resource Centre with apology

IN-ATTENDANCE JICA:

1.	Ms. Katushabe Brendah	- JICA, Secretary
2.	Agnes Batuvamu	- JICA, Secretary

JCC MEMBERS ABSENT WITHOUT APOLOGY

Ministry of Health(MOH):

1.	Dr. Ezati Isaac	- Director, Planning and Development
2.	Sr. Enid Mwebaza	- Assistant Commissioner, Nursing
3.	Dr. Francis Runumi	- Commissioner, Planning Directorate of Planning and Development
4.	Mr. S.S. Kyambadde	- Under Secretary, MOH
5.	Mr. Wycliffe Mwambu	- Assistant Commissioner, Accounts
6	Dr. Edward Mukooyo	- Assistant Commissioner, Resource Center

AGENDA:

7. Opening prayer

8. Welcome Remarks from Project Manager
   -Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

9. Communication from the Chair
-Dr. Jane Ruth Aceng, Director General of Health Services, MOH

10. Remarks from JICA Uganda Office
-Mr. Hoshi Hirofumi, Chief Representative, JICA Uganda Office

11. Reading and Confirmation of minutes of the previous JCC meeting and matters arising
-Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

12. Report of each activity in the 2nd project year

5S-CQI-TQM and Impact Assessment

- Dr. Sarah Byakika, Assistant Commissioner, Quality Assurance
- Mr. Hiroshi Tasei, JICA Expert

User Training

- Sr. Tibamwenda Mary – Senior User Trainer
- Mr. Yasuhiro Hiruma – JICA Expert

Medical Equipment Maintenance

- Eng. SSB Wanda, Assistant Commissioner, Health Infrastructure Division
- Eng. Sitra Mulepo, Senior Principal Engineer, Health Infrastructure Division
- Mr. Naoki Mimuro, JICA Expert

7. Explanation of schedule for the 3rd Project Year

- Mr. Kazuhiro Abe, Chief Advisor/JICA Project

8. Other relevant issues

- Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

12. Schedule for next JCC Meeting – May 27, 2013 pre-arranged

- Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

13. Closing Prayer

Minute:	**Action Column:**
Min.1 : OPENING PRAYER The meeting began with an opening prayer led by the Director General at 2.10p.m and thereafter self-introduction of members as mentioned above.	
Min.2 : WELCOME REMARKS Dr. Amandua Jacinto, Commissioner, Clinical Service, MOH (Project Manager) welcomed all members to the 5th JCC meeting and thereafter invited the Director General to chair the meeting.	
Min.3: COMMUNICATION FROM THE CHAIR The Director General, MOH-Dr. Jane Ruth Aceng welcomed everybody and thanked JICA for organizing the meeting which was good for monitoring of activities. She communicated as	

follows:- I. Apologized for postponing the JCC meeting but it was due to many other activities. II. The project had done so well even if it was about to wind up. III. Mentioned that there was a great change and quality of services delivery registered in the health facilities because of 5S, User training and ME. IV. She appealed to JICA to extend the project for another phase because there was still need for their services especially to areas of the Northern Uganda which were affected by insurgency in the past. V. Called upon the meeting to give an update of the unfinished issues from the previous 4th JCC meeting. VI. Said that the Minister Primary Health Care was so passionate about the 5S activities and would like to visit one of the health facilities for support. VII. She thanked JICA and all other counterparts for the great work implemented.	*JICA* *All to note*
Min.4: REMARKS FROM JICA UGANDA OFFICE ***Chief Representative, JICA Uganda:*** Mr. Hoshi Hirofumi gave remarks on behalf of JICA mentioning how the 5S Project was instituted to support on improvement of Health Services through Health Infrastructure Management after realizing the challenges in Health Sector in Uganda. Improvement of the hospital working environment and reduced breakdown of medical equipment was registered after intervention of the 5S Project activities. The project managed to develop 5S guidelines and handbooks and in addition the medical equipment inventory system was being revitalized although the capacity of the workshops was still weak. The Chief Representative pledged to continue giving support to the project while closely working with MOH. He further appealed the MOH to take ownership of the program in order to be able to sustain it. He thanked them for the close working relationship with the Project Team enabling them to progress on well.	
Min.5 : READING OF PREVIOUS MINUTES AND MATTERS ARISING Minutes were read, corrected, and approved as a true record of what transpired after making the following correction:- ***5.1: Corrections:*** I. *Page 1: Under - Eng. Sitra Mulepo: delete the word "Principal".* II. *Page 2: Under Agenda, No.6 ME delete the word "Principal"* III. *Page 3: Under Min.1, opening prayer: delete "Dr." replace with "Mr"* IV. *Page 9: UnderMin.11, response: No. I: delete the word "Principal"* ***5.2: Matters arising:*** I. Reported that ME inventory updates was being intensively worked on in the target facilities and by the end of 2014 there should a complete inventory up to HCIVs. However, the challenge was with the limited budget funds to cover more facilities. II. Mentioned that currently the inventory was with the Workshops and were trying to make it electronic for easy accessibility and also share it with the Resource Centre. III. There was still a challenge of facilities having a lot of furniture as well as equipment which needed to be intensively worked on. A strategy of awarding marks for collection of inventory had been put in place as a motivation for workshops to work harder and the framework was available, it just needed to be enforced. IV. Reported that specific guidelines for disposing off obsolete equipment had been formulated and were in a draft form awaiting input from other members for a final copy. 5S brought a great change in the workshops by enabling identification of which equipment to be	*ME & JICA Counterparts* *ME & JICA Counterparts* *ME, MOH* *ME, MOH*

disposed off. V. Noted that an opportunity from JICA to support Busolwe with funds to repair equipment was lost since the timeline was overdue. The cause was due to the delay to work on the equipment because of poor power supply despite purchase of the water pump at the facility which was a challenge to service delivery. UMEME would not make repairs and it was beyond MOH to purchase a new transformer. VI. Technicians (Bio-medical students) who were supposed to be recruited from Kyambogo University, 7 of them were taken up by Sustain thus called upon MOH to make adjustments in the structure before all those trained were lost. VII. There was need to come up with a proper proposal document about the location of the maintenance workshops; the gaps and challenges they had. VIII. The user manual and guidelines for ME were under way to be finalized and would be helpful to the workshops. IX. The issue of JICA going to Moroto was determined by Ministry of Internal Affairs which designates safe areas for them to, however, the Ugandan counterparts were free to travel to the region and work as required.	*MOH* *ME, MOH* *ME & JICA Counterparts* *MOH*
Min.6: REPORT OF EACH ACTIVITY IN THE 2ND YEAR SCHEDULE **6.1: PRESENTATIONS** **Presentations for each activity were made as below:-** **6.1.1: 5S-CQI-TQM:** Dr. Sarah Byakika presented for the 5S activities which depicted the level of performance per each target facility as indicated in the Handout (*please Refer to 5S Handout for details).* **Comments:-** I. MOH Top management i.e. Hon. Minister of State PHC, DGHS, Clinical Services, Quality Assurance and others were highly involved in the 5S Conference that took place at Silver Springs Hotel on 2nd September, 2013. II. Coordination of 5S with other implementers and support from others sources was already adopted and was recognized in the QI, CME framework in the health facilities. **6.1.2: IMPACT ASSESSMENT:** Dr. Sarah Byakika presented on Impact Assessment with a general view of Patients' satisfaction comparing with the waiting time during consultation and receiving drugs. (*please Refer to Impact Assessment Handout for details).* **6.1.4: USER TRAINING:** The presentation was made by one of the Senior User Trainer Sr. Mary Tibamwenda in the absence of the MOH counterpart and the JICA UT Expert. (*Please refer to Handout on User Training for details).* **Comments:** I. There was need to establish proper structures for sustainability of User Training activities in the health facilities just like the 5S component. A team for UT to handle such issues was vital. II. Currently it was the User Trainers from the target hospitals who were in-charge	

of UT activities in their respective health hospitals.	
III. It was proposed that UT should be included in the curriculum / education system of the training Institutions for Nurses for formal structures in place.	*UT & MOH counterparts*
IV. Should establish UT committees in health facilities to take charge of these activities.	
V. Requested that if possible part of the workshop funds could be shared with UT activities.	*Commissioner clinical Services*
VI. Informed that in the guideline for ME, it was indicated that some of the money would be set aside for UT support, however, currently the budget was fixed for ME but hopefully if it improves.	*UT & MOH counterparts*
VII. Mentioned that CME sessions should be utilized for UT enhancement. Suggested that it would be good for the available UTs to be funded to go to HCIVs and Districts to carry out trainings because they have many equipment at their units.	*ME, MOH*
VIII. There should be a mechanism or system in place for continuous user training to maintain the equipment.	
6.1.2: MAINTENANCE OF MEDICAL EQUIPMENT (ME): Presentation on Improving ME maintenance was done by Eng. Sitra Mulepo. *(Please refer to handout on ME for details).*	*MOH*
Comments:	
I. The issue of funding for the specialized equipment for actual maintenance and training was still a problem. There was need to separate funding for each item.	*MOH & UT counterparts*
II. It would be easy to lobby for funding when there was some improvement to be showed. Therefore a top management meeting should be secured to address the matter.	
III. It was mentioned that some facilities were doing well than others because of:-	
a) Support from other funding sources. b) Exemplary leadership, portrayed recently during the ME support supervision in Arua RRH.	*MOH*
c) The Technical competence although it could be supplemented by out-sourcing for example Tororo was doing well because it was under Mbale which had an experienced personnel (technician). d) Proper handling of the equipment and its maintenance.	*ME,MOH*
IV. ME should prepare a write-up indicating achievements, hindrances and gaps to be filled.	
V. Some of the Health facilities were diverting money meant for maintenance of equipment and using it to purchase new equipment.	
VI. Suggested that the Directors should be reminded of the money sent in 2009 for maintenance of equipment and send the guidelines strongly stating what the intent of those funds was for.	
VII. The ME presentation should be presented again in the top management meeting.	

	ME, MOH *ME, MOH*
Min.7: EXPLANATION OF SCHEDULE FOR THE 3RD PROJECT YEAR Mr. Abe Kazuhiro, Chief Advisor JICA 5S project explained the schedule of 3rd year Project as outlined in the Handout. (*please check details in the handout on activities 2014).* **Comments**: I. Mr. Abe Kazuhiro informed the meeting that days of attendance for the Japanese experts in the 3rd year would be less compared to the previous years.	*All to note*
Min. 8: OTHER RELEVANT ISSUES: Noted that: I. It was proposed to have more frequent meetings after every three months before JCC for proper update and follow-up of issues. II. The 5S concept should be taught to MOH staff to know what it meant. III. Informed that there would be a Budget Conference thus Dr. Amandua called upon all other MOH officials to attend the conference and present the issues of funding. He appealed to the DG to consider the maintenance budget of equipment in the health facilities. **Min. 9: SCHEDULE FOR NEXT JCC MEETING** The Next JCC meeting was scheduled for May 8th, 2014. Once again the DG thanked Ms. Sonoko, Mr. Abe, Mr. Tasei and Ms. Cynthia for keeping her updated on the issues of JCC and urged them to keep up that spirit. She encouraged having sub meetings before the actual time for JCC. She emphasized on the document for funding of ME to be worked on. **Min. 10: CLOSING PRAYER** The meeting ended at 4.30p.m with a word of prayer led by Eng. Wanda.	*MOH & JICA counterparts* *5S MOH & JICA Counterparts* *MOH* *DG* *All to note*
Summary of issues discussed: 9. *Extension of JICA 5S Project for the 2nd phase* 10. *Prepare a proper document for ME challenges & gaps to address the funding matter.* 11. *Establish structures for UT activities for sustainability purposes* 12. *Hold sub-meetings before JCC* 13. *Presentations on 5S, UT and ME* 14. *Schedule for Next year 2014 activities and PDM* 15. *Next JCC meeting scheduled on 8th May, 2014*	
Handouts: 6. *Agenda* 7. *Minutes of Previous Meeting* 8. *Presentations: - 5S, UT, ME,* 9. *Schedule for 2014 activities* 10. *Project Design Matrix Version 4*	

Approved by:

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Dr. Aceng Jane Ruth — **CHAIRPERSON**

Agnes Batuvamu — **MINUTE SECRETARY**

MINUTES OF THE 6TH JOINT COORDINATING COMMITTEE (JCC) MEETING HELD ON 12TH MAY, 2014 AT FAIRWAY HOTEL

Date and Time:	12th May, 2014 09:30a.m -02:00p.m	Minute Secretary: Agnes Batuvamu	Place: Fairway Hotel

Attendance:

JCC MEMBERS PRESENT

-MINISTRY OF HEALTH (MOH):

1. Dr. Jane Ruth Aceng - Director General Health Services - Chairperson
2. Dr. Amandua Jacinto - Commissioner Clinical Services
3. Dr. Isaac Kadowa - Director Planning and Development
4. Dr. Jackson Amone -Assistant Commissioner, Integrated Curative Services (ICS)
5. Dr. Sarah Byakika -Assistant Commissioner, Quality Assurance
6. Mr. Ahimbisibwe Expeditus - Principal Health Economist
7. Eng. Sam Wanda -Assistant Commissioner, Health Infrastructure Division
8. Eng. Sitra Mulepo - Senior Engineer, Health Infrastructure Division
9. Mr. Candia Aliti Tom - Principal Finance Officer, B & F

-EMBASSY OF JAPAN, Uganda:

1. Ms. Eri Yamasumi - Researcher/Advisor, Embassy of Japan

-JAPAN INTERNATIONAL AGENCY (JICA), Uganda:

1. Mr. Hoshi Hirofumi - Chief Representative
2. Ms. Takahashi Sonoko - Representative
3. Ms. Asiimwe Clare - In-House Consultant for Health

-JICA Final Evaluation Review Member:

1. Ikuo Takizawa - Director/Team Leader

- JICA Experts 5S Project:

1. Mr. Kazuhiro Abe - Chief Advisor
2. Mr. Hiroshi Tasei - Expert on 5S-CQI-TQM
3. Mr. Mimuro Naoki - Expert on ME Maintenance
4. Mr. Take Naoki - Expert on Impact Assessment
4. Ms. Satoko Irisawa - Coordinator

JCC MEMBERS ABSENT WITH APOLOGY

Ministry of Health (MOH):

1. Dr. H. Gatyanga Mwebesa - Commissioner Quality Assurance
2. Mr. Ponziano Nyeko - Assistant Commissioner, Accounts
3. Dr. Edward Mukooyo - Assistant Commissioner, Resource Centre
4. Dr. Isaac Kadowa -

IN-ATTENDANCE JICA:

1. Mr. Ray Brooks Ampaire - JICA, Assistant Coordinator
2. Ms. Doreen Mubiru - JICA, Secretary
3. M s. Agnes Batuvamu - JICA, Secretary

JCC MEMBERS ABSENT WITHOUT APOLOGY

Ministry of Health(MOH):

1. Dr. Francis Runumi - Commissioner, Planning Directorate of Planning and Development
2. Mr. S.S. Kyambadde - Under Secretary, MOH

	3. Mr. Wycliffe Mwambu 4 Dr. Edward Mukooyo	- Assistant Commissioner, Accounts - Assistant Commissioner, Resource Center

AGENDA:

1. Opening prayer

2. Welcome Remarks from Project Manager

Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

3. Communication from the Chair

-Dr. Jane Ruth Aceng, Director General of Health Services, MOH

4. Remarks from JICA Uganda Office

-Mr. Hoshi Hirofumi, Chief Representative, JICA Uganda Office

5. Reading and Confirmation of minutes of the previous JCC meeting and matters arising

6. Report of each activity in the 1st Half of the 3rd project year

5S-CQI-TQM

- Dr. Sarah Byakika, Assistant Commissioner, Quality Assurance
- Mr. Tasei Hiroshi – JICA Expert

User Training

- Dr. Amone Jackson, Assistant Commissioner, Integrated Curative Services (ICS)

Medical Equipment Maintenance

- Eng. SSB Wanda, Assistant Commissioner, Health Infrastructure Division
- Eng. Sitra Mulepo, Senior Principal Engineer, Health Infrastructure Division
- Mr. Naoki Mimuro, JICA Expert

7. Explanation from the Final Evaluation Team

- Mr. Ikuo Takizawa, Director, Health Division I, Health Group I, Human Development Department, JICA
- Mr. Expeditus Ahimbisibwe, Principal Health Economist, Department of Planning, MOH

8. Q & A

9. Signing of the Minutes of the discussions of the Terminal Review meetings

10. Explanation of the schedule for the second half of the 3rd Project year.

- Mr. Kazuhiro Abe, Chief Advisor/JICA Project

8. Other relevant issues

12. Closing prayer

13. Lunch

Minute:	Action Column:
Min.1 : OPENING PRAYER The meeting started at 9:13 a.m. with an opening prayer and members agreed to adopt the Agenda as it was.	
Min.2 : WELCOME REMARKS Dr. Amandua Jacinto, Commissioner, Clinical Service, MOH (Project Manager) welcomed all members to the 6th JCC meeting and thereafter invited the Director General to chair the meeting.	
Min.3: COMMUNICATION FROM THE CHAIR The Director General, MOH-Dr. Jane Ruth Aceng, welcomed all distinguished guests, from JICA Embassy, the team of JICA Experts and the entire MOH counter parts for the Project in their capacities, to the 6th JCC meeting. She apologized for the irregular changes of dates for JCC meetings and thanked JICA for being flexible. She appreciated the JICA Evaluation Review Team for the work of assessing the project activities and also congratulated the implementing team ever since the project started. She further pointed out the following:- 1. UT and ME had made great improvement at the health facilities visited and through 5S which was a key domain of rolling out. 2. ME component had now clear data inventory of medical equipment at the health facilities and UT was equally doing well in most facilities. 3. There was inadequate budget for ME which UT should be sustained however, this year it had been accommodated under the allocated ME budget. It would be increased as activities progress on. 4. The Clinical Division had a small budget to facilitate the three areas on the basis of training, follow-ups and support supervision to ensure that the progress was maintained. 5. Congratulated and appreciated the evaluation team upon the completion of assessing project activities.	*MOH*
Min.4: REMARKS FROM JICA UGANDA OFFICE ***Chief Representative, JICA Uganda:*** Mr. Hoshi Hirofumi welcomed all members and expressed honor on behalf of JICA to make his remarks at the 6th JCC meeting. He mentioned that the 5S Project which started in August 2011 was in its third year of implementation and would come to an end in December, 2014. He informed the meeting that a team from JICA headquarters together with the co-evaluator from planning department, MOH was sent to conduct a terminal evaluation of the 5S project and the objectives were to assess its achievements and impact on target hospitals, identify challenges faced and way forward. There had been tremendous changes in the target hospitals evidenced by improvement of the good working environment, knowledge on how to use, care for the medical equipment and improved preventive maintenance of medical equipment. The users' manuals and guidelines had been developed and copies were distributed to various health facilities. Furthermore, the inventory system had been revitalized under the same project though capacity of the workshops was still weak. He said that the findings from the terminal evaluation would be discussed on how to sustain	

the outputs and outcomes in order to reach the upper goal of the activities. He urged the MOH to own the programmes and give it financial support. He thanked MOH for the programmes and hoped to continue working together.	*All to note* *MOH*
Min.5 : READING OF PREVIOUS MINUTES AND MATTERS ARISING Minutes were read and approved as a true record of what transpired after making the following corrections:- ***5.1: Corrections:,*** V. *Page 1: Under – JCC Members absent with apology – proper numbering and delete words "with apology" at the end. Also delete names under JCC members without apology for "Dr. Mukooyo and Mr. Kyambadde".* ***5.2: Matters arising:*** X. Reported that there was a copy of guidelines for disposal of obsolete equipment which should be submitted to the top management for approval. Mentioned that in 2009 there were guidelines to ME on the use of funds to improve activities in the health facilities. XI. Proposed that ME guidelines should be revised before the approval of the budget. XII. Informed that orientation of MOH staff for 5S already began whereby three staff attended the TOT workshop held in February 2014. In addition some CQI members were recently sent to Tanzania for 5S Training. XIII. Plans to organize more 5S training were under way in June, 2014 and more MOH staff would be invited to attend.	*ME/MOH* *ME/MOH* *5S & MOH counterpart*
Min.6: REPORT OF EACH ACTIVITY IN THE FIRST HALF OF THE 3RD PROJECT YEAR **6.1: PRESENTATIONS** **6.1.1: 5S-CQI-TQM:** *(please find details in the 5S Handout*) The 5S presentation was by Dr. Sarah Byakika and she outlined the following:- a) Activities of October 2013 to March, 2014; b) Achievements against Project indicators; c) Challenges and Way Forward d) Planned activities November-December 2013. **Comments:-** III. Reported that the 5S implementing partners had been more engaged into the activity. IV. Tororo GH's status as a showcase was worrying, because its performance was deteriorating every year. V. Informed that the Parliament of Uganda expressed interest for 5S to be rolled	*5S & MOH counterparts*

out all over the country.	*5S & MOH*
VI. A concern was raised about the performance of 5S for Mororo RRH compared to other target health facilities, arguing that since the assessment was conducted by only the MOH team without the Japanese experts, the results should not be fully accepted.	*5S & MOH counterparts*
VII. Assessment for all target health facilities should be done concurrently to achieve the same results.	*5S & MOH counterparts*
VIII. Since the situation in Tororo GH was worrying, it was suggested that a new showcase should be identified to replace it and the following facilities were mentioned: *Mbale, Jinja and Entebbe.*	*5S & MOH to note*
IX. Mentioned that Mbale Hospital had also deteriorated according to the last two previous assessments, thus wondering if it would not also fail as Tororo.GH.	
X. The only facility that had sustained 5S was Entebbe GH, the rest were failing to maintain, and therefore there was need for a way forward to ensure sustainability of the activities since even the project was ending in December, 2014.	*5S & MOH counterparts*
Response:	
1. It was true that the evaluation methodology used for some target health facilities was different from that of Moroto RRH, however, the team agreed to standardize it next time.	*5S & MOH counterparts*
2. Reported that evaluators for Moroto RRH had worked with JICA experts giving them a good working experience although some inconsistences might have occurred due to the team being different.	
3. Informed that assessment of 5S activities applied to units where it was being implemented in terms of performance only.	
4. 5S support supervision would be organized in May and June followed by a conference in August to evaluate the activity implementation of the target facilities and the bias of assessing without JICA experts would be covered.	*5S & MOH*
5. Observed that the decline of Tororo GH was due to the continued political leadership problems causing demotivation of staff performance.	
6. MOH was still grappling with the issue of understanding more factors of Tororo GH's decline and would try to handle it systematically.	*5S & MOH*
7. The view to make Entebbe GH a national show case was tricky, because fears were that since it was under renovation; all the efforts of 5S activities might be dismantled.	
8. Agreed that Tororo should not be left but rather try to understand other hindering factors to it and give it more support to rise up.	*5S & MOH*
9. Agreed that there should be two health facilities as show cases alongside Tororo GH so that in case one declines the other one would be left.	
10. Mentioned that some of the factors causing poor performance were:	
a) Transfer of key staffs: The new staffs were not easy to be enrolled into the 5S concept.	

b) Tororo had administrative issues that needed to be addressed.	
11. Informed that the new JICA Volunteer for Tororo GH had been contacted and had started training another member.	
12. Mentioned that Tororo's Pharmacy was a good example of 5S activity and in June Mr. Tasei together with Dr. Sarah Byakika would support it further.	*Sarah/Tasei*
13. Despite the challenges of Tororo GH, it would be supported further; trying to analyze its demotivating factors, poor living conditions of staff and how they should work better.	*5S & MOH*
14. Mbale RRH should be identified as another showcase facility because it was more stable to be uplifted.	
15. Agreed that Tororo GH should remain a national showcase for General Hospitals and Mbale RRH adopted for Regional Show Case.	*MOH*
16. Suggested to convene a high level meeting to analyze Tororo GH's issues and factors causing the decline in performance of health facilities, in order to get a way forward for sustainability.	
17. As a way of motivation and sustainability for 5S activities the following should be considered to be done: a) continuous on-site trainings involving different members of the hospitals; b) identifying champions among the health facilities; c) conducting quality improvement health programmes such as CQI; d) If possible should have various JICA volunteers in the different health facilities.	
18. Informed that having volunteers in all health facilities was still not easy as JICA had a problem with Northern Uganda, however, most of the health facilities had got volunteers who were doing very well like in (Mbale, Hoima, Soroti, Entebbe, Kabale, Mubende). The issue would be discussed at JICA office.	*JICA Offices*
6.1.2: USER TRAINING : UT presentation was made by Dr. Amone Jackson. (*Please refer to Handout on User Training for details).* The presentation outlined the following:- a) The selected 8 target hospitals and the 16 User Trainers. b) UT Manual and flipcharts c) UT Association meeting d) Challenges/Way forward and Recommendations	
Comments: 1. There was need for User Training to be covered in all Health Facilities and thus a need to acquire more User Trainers for Regional Hospitals.	
2. An opinion was raised for the UTs and Technicians in all Health facilities to move together and thus they should get harmonized to benefit all health facilities.	*UT & MOH counterparts*

3. Should come up with a strategy of scaling up more UTs.	
4. MOH should consider the strength to sustain UT activities.	*UT & ME & MOH counterparts*
5. Formulation of UT Association was still questionable, wondering if it would not be better to maintain and harmonize UTs under Regional Workshops since its sustainability requires funds.	*UT &MOH*
6. The Association was a good idea since UTs would be clearly known for training on medical equipment and it would be an opportunity for health facilities to refer to them.	*UT &MOH*
7. Suggested that UT should be introduced right from Nursing Institutions because it was very vital to health facilities.	*UT &MOH*
8. The aspect of UT would strategically be better if it was integrated in the hospital budget. Facilities should consider critically budgeting for the users' training activity.	*MOH*
9. Some facilities had people who were able to train others but lacked attaching importance to them.	*MOH*
10. Training of the medical equipment should be streamlined during programmes such as CMEs.	*UT & MOH counterparts*
11. The standard of Equipment imported should be clearly stated.	*MOH*
Response:	
1. Most of the equipment supplied, MOH emphasized its maintenance to be done by the suppliers as even some facilities might not have the money to facilitate the UTs to train health workers.	
2. It was desired that new user trainers should be trained to reinforce the old ones who were affected by transfers however, a strategy should be put in place.	
3. The issue of transferring UTs had been presented to the Commissioner requesting that they should be retained for two to three years in a health facility.	
4. UT was very vital and therefore the issue of integrating it with ME was crucial because it would keep them together.	
5. Observed that UT would be appreciated better if Health workers were continuously trained on the proper use of medical equipment.	*Comm. Clinical Services.*
6. An Association was to the interest of the people who wanted to come together; however, MOH might not have the money to support it, but it would get back to the UTs on the way forward.	
7. If the budget for Regional workshops was increased, then UT would move forward.	*UT & MOH counterpart*
8. Most health facilities had no set aside funds for conducting trainings, but rather had service contracts as a package with the suppliers of the equipment which was used to train Users.	
9. Emphasis should also be put on training users on receipt of new equipment by the suppliers.	
6.1.3: MAINTENANCE OF MEDICAL EQUIPMENT (ME)	*MOH*
The presentation focused on the overall progress of activities stating the priority	

areas of ME as stated below: - *(Please refer to handout on ME for details). Presented by Eng. Sam Wanda:-* a) Improving the capacity of RWS to maintain ME b) Enhancing ME Inventory Management c) Improving Maintenance Planning and Scheduling d) Improving Reporting by RWS e) Implementation of 5S activities in RWS f) Biomedical Engineering Training for Technician	
Informed that:- a) ME Manual had been printed and distributed to various workshops of health facilities. b) 5S was also being emphasized in the maintenance workshops and it started in the office of Eng. Wanda and made great changes where it was been applied. c) Eng. Wanda desired to have 10 copies of the ME manual so that dissemination of information was done wherever he visited. d) CWS had secured some funding from SUSTAIN and IDI for maintenance of equipment and other related activities.	
Comments:-. 1. It would be appreciative if the ME manual was disseminated to all Users through workshops or meetings. 2. Observed that inventory was limited to only target health facilities, but there was need to implement it to all health facilities in the country, regionally up to the lower units. 3. Observed that some facilities consistently performed better than the others and a concern to understand the factor for failure needed to be well established. 4. Should consider equipment that could not be maintained by technicians especially the electronics which was outside their scope. Sophisticated equipment needed specialized maintenance by technicians.	*ME & MOH counterparts.*
Response:	*ME & MOH*
1. Agreed that the manual would be disseminated to all users and especially workshop Managers who would be guided on how to use it especially on the area of budgeting and planning.	*ME & MOH Counterparts*
2. Informed that it had been planned that dissemination would first be done through RWS Committee and DHOs meetings.	
3. Reported that there was still a big gap left with coverage of inventory and it should be completed by the end of this year, 2014 for the entire health facilities in the country.	*ME & MOH counterparts*
4. Part of the funding from SUSTAIN and IDI would be used to collect more inventory up to HC III.	*ME & MOH counterparts*
5. Inventory for all laboratory equipment would be carried out and in the next three months up-to-date inventory for all HC III should be available.	
6. 25 facilities had been covered so far.	*ME & MOH counterparts*
7. Accepted that performance of some workshops was not good. Data should be analyzed for equipment not in use, to establish whether it was lack of	*ME to note*

knowledge that created failure to use it.	
8. Should work with the UTs to solve the lack of knowledge to use the equipment.	*ME & MOH counterparts*
9. A good report in 2008-2014 was registered to have had more equipment in good working condition. There was need to only refine the assessment to look for factors that affected the quality and safety of the equipment.	
10. Maintenance of Equipment at lower level facilities was still a challenge because of lack proper records.	*M E & MOH counterparts.*
11. A lot of equipment supplied earlier was not using power although some HC IIIs had now new equipment such as HDCs that uses power.	*ME & UT counterparts*
12. More funds should be allocated so that lower facilities are reached using the approach of maintaining equipment whereby the broken equipment should be ferried to the nearest DHO's office or Regional Hospitals for repair by the technician.	*MOH*
13. There was poor management of budgets vis-à-vis what it was allocated for.	*ME & MOH to note*
14. Mubende and Moroto were to get some money for the next financial year for equipment maintenance.	
15. Improvement about the way of procuring spare parts should be revised.	*MOH & ME*
16. CWS budget was too small to cater for items such as; spare parts, per diems, and transport and thus suggested the funds to be separated.	*MOH*
17. PDU and Administration should be advised not to acquire spare parts from any market.	*ME & MOH to note*
18. Suggested to get a framework contract with JMS to procure spares and standardize the procurement process.	
6.1.4: IMPACT ASSESSMENT: It was presented by Mr. Naoki Take. *(Please refer to handout on Impact Assessment for details).* Informed that the activity would end in one month's time. The impact intervention of 5S, User Training and Maintenance was carried on the following aspects:- a) Condition of medical equipment b) Staff motivation, waiting time for OPD/dispensary and patient satisfaction.	*ME & MOH counterparts*
Comments: 1. That the results of the presentation should be interpreted into information understood by all beneficiaries or /should hire an interpreter should be hired 2. Observed that correlation between staff motivation and patient satisfaction had a mismatch, reasoning it that there was no way a patient would be satisfied while a staff was demotivated. 3. Wondered whether there were other countries with 5S experience from which Uganda should learn.	*Impact Assessment*
Response: 1. Assumption of staff motivation being low and patient satisfaction being high was depended on the aspect of time/duration implemented for 5S at the facility and the attempt to measure 5S impact was being done recently using	

different methodologies. 2. 5S was being carried out in 15 countries and it was only Uganda and Tanzania doing vigorous impact assessment. 3. Informed that at first impact assessment might be high and later lower depending on the different aspects used like cleanliness of the facilities. Otherwise the general aspect was the staff attitudes.	
Min.7: EXPLANATION FROM THE FINAL EVALUATION TEAM The Report was presented by Mr. Ikuo Takizawa of JICA assessing the achievements of the JICA 5S project. The evaluation was jointly conducted by Ugandan and Japanese members namely:- (*please check for details in the handout on Terminal Evaluation Report).* 1. Mr. Ikuo Takizawa – Leader, JICA 2. Ms. Masumi Okamoto – Evaluation Analyst, JICA 3. Mr. Ahimbisibwe Expeditus – Principal Health Economist, MOH The following were highlighted:- 1. MOH should consider designating higher performing hospitals in 5S and recommended Mbale RRH to officially be designated as a national showcase. 2. UT was one of the promising components of the project in performance. 3. Mentioned that MOH should have a strong leadership group to improve and implement the 5S-CQI-TQM activities and needed some capacities built to carry out impact assessment. 4. 5S and ME should also be carried out in the in-service training just as UT was suggested. 5. Appreciated the Directors of health facilities where the evaluating team visited i.e. Masaka, Arua, Kabale and Hoima for the good work done for the 5S project activities. **Comments**: 1. Suggested SPNOs to be overall leaders of the 5S activities, it did not necessarily have to be Directors as implementers. 2. It was not easy to get someone to build the capacity on the impact assessment however; the issue had been discussed with the evaluating team.	*MOH* *MOH* *MOH*
Min.9: SIGNING OF THE MINUTES OF MEETINGS OF THE EVALUATION REPORT Minutes of the meetings of the evaluation report were to be signed after the presentation made by Mr. Ikuo Takizawa.	
Min. 8: EXPLANATION OF THE SCHEDULE FOR THE SECOND HALF OF THE 3RD PROJECT YEAR – 2014	

Mr. Kazuhiro Abe, Chief Advisor of the 5S project thanked all members for the implementation of activities ever since the inception of the project in 2011 and informed them that the project was due to end this year in November, 2014. He urged members that even if the project was ending, it had beneficiaries therefore it should be supported to continue with all its activities and that *"where there was a will there was a way.|"* **Response:** The DG appreciated all presentations made and appealed to JICA to extend the project.	*JICA Office, Uganda*
Min.9: OTHER RELEVANT ISSUES There was no specific relevant issues discussed and thus the 1st morning session of the JCC ended at 1:35pm with a closing prayer and thereafter the Director General, MOH welcomed the Hospital Directors who had joined the meeting but were to attend the project conference in the afternoon. She requested the Commissioner, Dr. Amanuda Jacinto to Chair the afternoon session of the Project Conference after lunch.	
Summary of issues discussed: 16. *Presentations: 5S, UT, ME, and Impact Assessment* 17. *Sustainability of Activities* 18. *Final Evaluation Report* 19. *Extension of JICA 5S project*	
Handouts: 11. *Agenda* 12. *Minutes of Previous Meeting* 13. *Presentations: - 5S, UT, ME, Impact Assessment* 14. *Final Evaluation Report*	

Approved by:

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Dr. Aceng Jane Ruth — **CHAIRPERSON**

Agnes Batuvamu — **MINUTE SECRETARY**

AFTERNOON SESSION:

MINUTES OF THE PROJECT CONFERENCE WITH HOSPITAL DIRECTORS HELD ON 12TH MAY 2014 AT FAIRWAY HOTEL

Date and Time:	12th May, 2014 02:30a.m -05:00p.m	Minute Secretary: Agnes Batuvamu	Place:

Attendance:

MEMBERS PRESENT:

- MINISTRY OF HEALTH

1. Dr. Amandua Jacinto - Commissioner Clinical Services - In-Chair
2. Dr. Isaac Kadowa - Director Planning and Development
3. Dr. Jackson Amone -Assistant Commissioner, Integrated Curative Services (ICS)
4. Dr. Sarah Byakika -Assistant Commissioner, Quality Assurance
5. Mr. Ahimbisibwe Expeditus - Principal Health Economist
6. Eng. Sam Wanda -Assistant Commissioner, Health Infrastructure Division
7. Eng. Sitra Mulepo - Senior Engineer, Health Infrastructure Division
8. Mr. Candia Aliti Tom - Principal Finance Officer, B & F

HOSPITAL DIRECTORS PRESENT:

- MINITRY OF HEALTH

1. Dr. Bernard Odu - Arua, Regional Referral Hospital (RRH)
2. Dr. Francis Mulwanyi - Hoima, RRH
3. Dr. Placid Mihayo - Kabale, RRH
4. Dr. Florence Tugumisirize - Masaka, RRH
5. Dr. Alex Andema - Moroto, RRH
6. Dr. William Ocen - Lira, RRH
7. Dr. Thomas Ochar - Tororo, GH
8. Sr. Mutonyi Roselyn - 5S Manager, Entebbe GH

HOSPITAL DIRECTORS ABSENT:

- MINISTRY OF HEALTH

1. Dr. Benon Wanume - Mbale, RRH

	-EMBASSY OF JAPAN, Uganda: 1. Ms. Eri Yamasumi - Researcher/Advisor, Embassy of Japan -JAPAN INTERNATIONAL AGENCY (JICA), Uganda: 1. Ms. Takahashi Sonoko - Representative 2. Ms. Asiimwe Clare - In-House Consultant for Health - JICA Experts 5S Project: 1. Mr. Kazuhiro Abe - Chief Advisor 2. Mr. Hiroshi Tasei - Expert on 5S-CQI-TQM 3. Mr. Mimuro Naoki - Expert on ME Maintenance 4. Mr. Take Naoki - Expert on Impact Assessment 4. Ms. Satoko Irisawa - Coordinator IN-ATTENDANCE JICA: 1. Mr. Ray Brooks Ampaire - JICA, Assistant Coordinator 2. Ms. Doreen Mubiru - JICA, Secretary 3. Ms. Agnes Batuvamu - JICA, Secretary

AGENDA:

1. Opening prayer

2. Opening Remarks from the Project Manager

Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

3. Report of each activity in the 1st half of the 3rd project year

5S-CQI-TQM

- Dr. Sarah Byakika, Assistant Commissioner, Quality Assurance
- Mr. Tasei Hiroshi – JICA Expert

User Training - Dr. Jackson Amone, Assistant Commissioner, Integrated Curative Services (ICS) ***Medical Equipment Maintenance*** - Eng. SSB Wanda, Assistant Commissioner, Health Infrastructure Division - Eng. Sitra Mulepo, Senior Principal Engineer, Health Infrastructure Division - Mr. Naoki Mimuro, JICA Ex pert 4. Explanation of the schedule for the second half of the 3rd project year - Mr. Kazuhiro Abe, Chief Advisor/JICA Expert 5. Closing prayer	
Minute: **Min. 1: OPENING REMARKS**: The Commissioner, Clinical Services Dr. Amandua Jacinto welcomed the Hospital Directors to the conference in the afternoon session and thanked them for turning up. He said that opening remarks and prayers had been done in the morning session during the JCC meeting and suggested to proceed with the next item.	**Action Column:**
Min.2: REPORT OF EACH ACTIVITY IN THE FIRST HALF OF THE 3RD PROJECT YEAR **2.1: PRESENTATIONS** **2.1.1: 5S-CQI-TQM:** *(please find details in the 5S Handout*) The 5S presentation was by Dr. Sarah Byakika and she outlined the following:- a) Activities of October 2013 to March, 2014; b) Achievements against Project indicators;	

c) Challenges and Way Forward d) Planned activities November-December 2013. **Comments:** 1. The challenge observed was that at one time some health facilities were in high gear of implementing 5S but it was not being sustained especially by heads of departments. There was need to work on the staff attitude (example sighted from Masaka RRH). 2. The middle men were disrupting the implementation of 5S activities which was also a challenge. 3. Periodic staff rotations both internally and externally affected proper implementation of 5S causing low moral towards the activity. 4. The attitude of gaining money from 5S activities was another hindrance. 5. Lack of clear structures as to who should spearhead the activity between the SPNO and PNO. 6. A lot should be done in order to change the attitude of workers to embrace the 5S concept. 7. At least Arua Hospital was making a modest improvement in 5S. 8. The leadership issue was very important and major aspect of activity implementation; therefore Hospital Directors ought to own the activities and should create a culture of informing the institution on the way forward. 9. Observed that Nurses were more involved in the 5S activities than Doctors who should be actively involved because they are heads of departments. Suggested that everybody should get involved right from the ground including the Clinical officers. 10. Clarity on the misconception about the incentives/motivation of 5S should be made. **Response:** 1. Suggested that leadership should be built by creating a group of clinicians to carry out the tasks. 2. There was need to have more than one person in charge of 5S, in case one person was away thus a numbers of people should do TOT. 3. CMEs should be a means of sensitizing staff. 4. Directors should be the ones to lead the execution of 5S. 5. Some staff from various health facilities were trained and facilitated for a study tour and another study tour would be organized. 6. The position of 5S Manager was secure enough to be able to meet with WIT members and should give regular updates.	*5S & MOH counterparts* *All Directors & MOH* 5S & MOH counterparts All Directors & MOH 5S, Hospital Directors& MOH All to note

Experiences shared on implementation & progress of 5S:

Entebbe GH:

1. The Medical Superintendent was involved in the training.
2. Regular CMEs were conducted for over 5 weeks.
3. Staff were taken for a study visit to Tororo GH which was the showcase place.
4. JICA organized the study tour to Mbale and more skills were acquired.
5. They made sure the position of 5S Manager was secured.

Hoima RRH:

1. Change of staff attitude was still a problem.
2. Had selected new people eliminating the middle level managers.
3. The activity had been made to be led by the Hospital management.

Lira RRH:

1. All staff leading QIT were promoted and transferred leaving only one person among the team to orient others. The champions were no longer there.
2. The PNO was the only one left to implement 5S and yet had the hospital workload.
3. A lot was required to be taught to the new team.

Kabale RRH:

1. Change of staff attitude and dealing with middlemen level was still experienced.
2. New people were acquired.
3. The Director and the Hospital management were the ones leading.

Masaka RRH:

1. Transfer of staff (WIT) remains a major challenge for implementers of 5S and yet they were key players of 5S.

2.1.2: USER TRAINING: *(please find details in the UT Handout*)

UT presentation was done by Dr. Amone Jackson. (*Please refer to Handout on User*

Training for details). The presentation outlined the following:- a) The selected 8 target hospitals and the 16 User Trainers. b) UT Manual and flipcharts c) UT Association meeting d) Challenges/Way forward and Recommendations **Comments:** 1. A concern was raised from Masaka RRH that a certain category of staff were not getting any training i.e. The Allied medical staff needed training. 2. User training was a very good aspect, however, requested that trainings be done on a quarterly basis other than every month. 3. UTs and technicians should be involved when any new equipment was supplied from MOH to ensure that proper handling of the equipment i.e. completed equipment and training from the supplier should be done. ***Experiences shared on the progress of UT***:- ***Lira RRH*:** 1. User Trainers were very hopeful. 2. Some health workers were not trainable and were stuck with using old equipment thus training them on new equipment was not easy. 3. Communication with UTs was good. 4. Suggested that UT should fall under equipment workshops for budgetary purposes. 5. Number of UTs should be increased so as to expand. 6. Busy schedules were still affecting performance of most people as they had two to three responsibilities. ***Arua RRH:*** 1. User Trainers needed to be organized to draw a plan of activities and should budget accordingly as they communicate with the Hospital Directors. 2. The District Health Officers could facilitate UTs to carry out trainings in their respective areas. 3. Formulation of the Association was a good idea because the UTs would be utilized on teaching of new equipment supplied to the hospitals and would clearly be established and known to health facilities. **Response:**	UT & MOH counterparts

1. A meeting to discuss about UT Association would be convened to highlight further the issues pertaining to its formulation. 2. If the project was extended more UTs would be trained to become seniors in TOT. 3. The issue of other professionals left out for training, i.e. Laboratory Assistants would be addressed administratively; however, currently it was user training being addressed for the commonly used equipment. 4. Recommended that the suggestion for UT to be covered within the available funds under RWS budget could be workable. The technicians should go along with UTs as they go for field trips. 5. Increasing the number of UTs would depend on availability of funds. 6. Suppliers of medical equipment should always train users since the cost of training them was inclusive in the cost of buying. 7. The issue of formulation of the UT Association was still to be discussed further on what modalities to be considered.	UT & MOH counterparts
2.1.3: MAINTENANCE OF MEDICAL EQUIPMENT (ME) The presentation by Eng. Sitra Mulepo focused on the overall progress activities stating the priority areas of ME as follows: - *(Please refer to handout on ME for details).* a) Improving the capacity of RWS to maintain ME b) Enhancing ME Inventory Management c) Improving Maintenance Planning and Scheduling d) Improving Reporting by RWS e) Implementation of 5S activities in RWS f) Biomedical Engineering Training for Technician **Informed that:-** 1. ME Manual had been printed out and distributed to various workshops of health facilities. 2. 5S was also being emphasized in the maintenance workshops and it started in the office of the Assistant Commissioner, Health Infrastructure Eng. Sam Wanda and had made great changes where it had been applied. 3. Eng. Wanda expressed to have 10 copies of the ME manual so that dissemination of information was done wherever he visited. 4. CWS had secured some funding from SUSTAIN and IDI for maintenance of equipment and other related activities. 5. Suggested that there should be funds set aside for disposal of obsolete equipment.	UT & MOH counterparts

6. Required that all inventory for health facilities should be available by the end of this year, 2014. 7. Training for Technicians had been on going. 8. ME was implementing 5S throughout the RWS as a priority area although it was not being assessed and it was appreciated as a vital activity for workshops and they had improved. 9. ME checklists could be used by UTs to compliment the equipment covered in the UT manual. 10. Moroto RRH was an example that used its budget to bring training and CME meetings on board. 11. Hospitals were urged to come up with the initiative of having mobile workshops. **Comments:** 1. A lot of equipment was being dumped in the hospital compounds or workshops. 2. Hospitals should put aside money for the disposal process of obsolete equipment. 3. Should draft guidelines for disposing off equipment. 4. Workshops were clearly budgeting for User training but the money was still little, therefore UTs were advised to carry out targeted trainings i.e. beginning with own health facilities, use CMEs to train staff etc. 5. UTs should identify those who could train others. 6. Clear designation for technician was still outstanding. ***Experiences shared on the progress of ME-*** ***Masaka RRH:*** 1. There was need to get skilled technicians to handle complicated equipment and wondered whether there were right personnel to maintain the sophisticated equipment that was found in health facilities because Artisans were not Engineers, and yet only one would be at the entire facility. ***Arua RRH:*** 1. About inventories: Nurses were claiming that it was their role instead of ME technicians. 2. CJICA 5S/ME team had done a lot to re-organize the regional workshops.	ME & MOH

Kabale RRH: 1. There was need to help technicians to specialize in repair of equipment. 2. UTs and Technicians were cooperating well. 3. The training should cover more of hands on more than introductions to the equipment. ***Lira RRH:*** 1. SUSTAIN was supporting a position of a biomedical technician at the facility however, for sustainability purposes there was need to integrate the position into the structure when the project ends. 2. The discrepancy of inventory reports between Nurses and Technicians was experienced at the facility but needed to be harmonized. **Response:** 1. Regional facilities without Workshops such as Moroto and Mubende were allowed to get them this financial year in order to reach their catchment areas. 2. Hospitals without workshops were advised to initiate and build up one themselves because CWS had a problem of spares and was constrained with the budget. 3. The issue of integrating a Bio-medical technician needed to be streamlined after a discussion and see how the system could work. 4. Suggested that RWS should have a clear structure which recognizes Bio-medicals if possible. 5. There was need for MOH to have room for growth of Civil Engineers, Electricians and Mechanics. 6. The structure of Engineers did not provide for Biomedical technicians, thus the issue was Administrative. 7. It was true that the issue on the professional side of position; i.e. Engineers, Nurse Graduates staying without promotions should be addressed administratively. 8. All departments of the health facilities were supposed to have their own inventory of medical equipment besides the one for the entire facility. Individual inventory was necessary even when handing over. 9. RWS should constitute a team to support the inventory. The team could consist of the clinicians, technicians who would acquire a copy of all inventories of the departments.	CWS & MOH

10. The Registration Board of Engineering should be contacted or be written to about the structure that accommodates positions of Biomedical Engineer, technicians and the like. 11. Started the process of identifying technicians specialized on particular equipment for recommendation of factory training i.e. manufacturer level. 12. Time was not enough to have hands on training of medical equipment and equipment under guarantee were not being covered during training. 13. Technicians had improved on the knowledge of computer skills. 14. RWS should always involve CWS during time for procuring equipment to avoid malpractices of acquiring faulty equipment. 15. NACME should be involved when procuring any new equipment. 16. That the JICA experts should be more regular on the ground and in the next phase, emphasis should be put on more time to be given for the activities. **2.1.4: PRESENTATION ON IMPACT ASSESSMENT:** It was carried out by Mr. Naoki Take on the profiles of 10 Health facilities. . ***(see details in the handout on Impact Assessment).*** 1. The report depicted findings of the facilities comparing the different duration of implementation for each in 5S and concluded that more time should be given to all facilities to be at the same level for better comparisons **Comments:** 2. The aspect for duration of implementation should be considered not 4 years versus 2years was not realistic, thus the project needed more extension of time to have proper impact assessment.	CWS & MOH
The Chairperson thanked everybody for their contributions and tireless effort for implementation of the activities of the Project and the meeting ended with a closing prayer at 5.05 pm by Asiimwe Claire.	

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Dr. Amandua Jacinto Agnes Batuvamu

CHAIRPERSON **MINUTE SECRETARY**

MINUTES OF THE LAST 7TH JOINT COORDINATING COMMITTEE (JCC) MEETING HELD ON 19TH NOVEMBER, 2014 AT FAIRWAY HOTEL

Date and Time:	19th Nov, 2014 09:30a.m -01:00p.m	Minute Secretary: Agnes Batuvamu	Place: Fairway Hotel
Attendance:	**JCC MEMBERS PRESENT** -MINISTRY OF HEALTH (MOH): 5. Dr. Amandua Jacinto - Commissioner Clinical Services 6. Dr. Sarah Byakika - Assistant Commissioner, Quality Assurance 7. Eng. Sam S.B.Wanda - Assistant Commissioner, Health Infrastructure Division -HOSPITAL DIRECTORS AND USER TRAINERS: 1. Dr. Placid Mihayo - Kabale RRH 2. Dr. Alex Andema - Moroto, RRH 3. Mr. Michael Odur - Lira RRH representative of Director (Ag. Principal Hospital Administrator) 4. Alison Byarugaba - User Trainer/Nursing Officer, Kabale RRH 5. Mujalasa Christine - User Trainer/Nursing Officer, Entebbe GH 6. Okwir John Van - User Trainer/Nursing Officer, Lira RRH -JAPAN INTERNATIONAL COOPERATION AGENCY (JICA), Uganda: 1. Mr. Kyosuke Kawazumi - Chief Representative 2. Ms. Sonoko Takahashi - Representative 3. Ms. Asiimwe Clare - In-House Consultant for Health - JICA Experts 5S Project: 1. Mr. Hiroshi Tasei - Expert on 5S-CQI-TQM 2. Mr. Mimuro Naoki - Expert on ME Maintenance 3. Mr. Yasuhiro Hiruma - Expert on User Training **JCC MEMBERS ABSENT WITH APOLOGY** Ministry of Health (MOH): 1. Dr. Asuman Lukwago - Permanent Secretary, MOH 2. Prof. Mbonye Anthony - Director Clinical & Community Health Service 3. Dr. Jane Ruth Aceng - Director General Health Services – Chairperson 4. Dr. H. Gatyanga Mwebesa - Commissioner Quality Assurance		

	5. Dr. Jackson Amone - Assistant Commissioner, Integrated Curative Services (ICS) 6. Eng. Sitra Mulepo - Senior Engineer, Health Infrastructure Division IN-ATTENDANCE JICA: 1. Sr. Apoko Anne Olaro - Senior User Trainer 2. Ms. Doreen Mubiru - JICA, Secretary 3. M s. Agnes Batuvamu - JICA, Secretary **JCC MEMBERS ABSENT WITHOUT APOLOGY** Ministry of Health(MOH): 1. Mr. Candia Aliti Tom - Principal Finance Officer, B & F 2. Mr. S.S. Kyambadde - Under Secretary, MOH 3 . Dr. Edward Mukooyo - Assistant Commissioner, Resource Center

AGENDA:

1. Opening prayer

2. Welcome Remarks from Project Manager

Dr. Amandua Jacinto, Commissioner, Clinical Services, MOH

3. Communication from the Chair

4. Remarks from JICA Uganda Office

-Mr. Kyosuke Kawazumi, Chief Representative, JICA Uganda Office

5. Reading and Confirmation of minutes of the previous JCC meeting and matters arising

6. Report of each activity in the 3rd project year

5S-CQI-TQM

- Dr. Sarah Byakika, Assistant Commissioner, Quality Assurance

User Training

- Sr. Apoko Anne Olaro, Senior User Training

Medical Equipment Maintenance

- Eng. SSB Wanda, Assistant Commissioner, Health Infrastructure Division

7. Remarks from Vice Advisor /JICA 5S Expert

- Mr. Hiroshi Tasei

8. Other relevant issues

9. Closing prayer

10. Lunch

Minute:	**Action Column:**
Min.1 : OPENING PRAYER The meeting started at 9:35 a.m. with an opening prayer and the Agenda was adopted as it was.	
Min.2 : WELCOME REMARKS Dr. Amandua Jacinto, Commissioner, Clinical Service, MOH (Project Manager) welcomed everybody to the 7th JCC meeting and requested for self-introduction of members present.	

Min.3: COMMUNICATION FROM THE CHAIR The Commissioner, Clinical Service, Dr. Amandua Jacinto who presided over the meeting was In-Chair for the Director General (DG), MOH, Dr. Jane Ruth Aceng, who was away on official duties. He extended apologies from both the Permanent Secretary and the DG for not being able to attend the meeting due to their busy schedules. On behalf of the PS, DG and entire MOH, he welcomed all distinguished guests, especially the new Chief representative of JICA Uganda Office Mr.Kyosuke Kawazumi to the last 7th JCC meeting which was his first meeting to attend. He thanked all implementers of the project activities, more so the Government of Japan for remitting funds to run the activities and also for the work of construction of new structures at Hoima RRH and Kabale RRH that was going on well. He said that as the overseer for the Project, a lot had been benefitted from the Project towards the improvement of services in the Health Sector. He further thanked the Senior User Trainer Sr. Apoko Anne Olaro together with the User Trainers who worked so much to train Users of the medical equipment. He thanked all the JICA experts for enduring to work hard in order to improve the health services in the country. He extended gratitude to the Chief Advisor of the Project Mr. Abe Kazuniro who was not present for support rendered and all the key players who have collaborated with MOH. Hospital Directors were appreciated for their cooperation during the three years of implementation for the project. Finally, he thanked Ms. Sonoko Takahashi for her advice all through the time of the project.	
Min.4: REMARKS FROM CHIEF REPRESENTATIVE, JICA UGANDA OFFICE The new Chief representative, JICA, Uganda Office Mr. Kyosuke Kawazumi welcomed all distinguished guests to the final meeting of the project and thanked them for the tremendous work done .during the three years. He mentioned that he was impressed about the commendable changes that had been registered at the targeted health facilities. The 5S Handbooks and manual were developed, as well as the ME and UT manuals. He said that the Proposal for extension of the Project from MOH was received by	

JICA and it was still under discussion and hopefully it would be considered and would probably be resumed next year. He thanked MOH for rendering support to the project and anticipated to continue working together in future.	
Min.5 : READING OF PREVIOUS MINUTES AND MATTERS ARISING Minutes were read and approved as a true record of what transpired after making the following corrections:- ***5.1: Corrections:,*** VI. *Page 1: Under – JCC Members present change the name from Dr. Isaac Kadowa to Dr. Isaac Ezati.* VII. *Page 2: Under – JCC Members absent without apology – delete names Mr. Wycliff Mwambu and Dr. Edward Mukooyo.* VIII. *Page 9: delete the word"the" after the word lacked.* IX. *Page 7: Under Comments No.10 put medical equipment users* ***5.2: Matters arising:*** XIV. Reported that the budget for RWS was doubled and thus some funds should be availed for User Training to move together with the Managers. XV. The guidelines for disposal of obsolete equipment were already drafted and were presented to the top Management meeting for approval. XVI. Reported that more 29 Health workers underwent 5S training organized by MOH and JICA. XVII. Support for Tororo GH was still not fully done but Mr. Tasei visited the facility during the CQI meeting and reported that there were a bit of changes in some areas of the hospital, however there was still need to support them further. The Commissioner Clinical Services and the Assistant Commissioner Quality Assurance would organize a meeting to discuss the matter. XVIII. If security in the restricted areas for JICA staff to go improves, they were willing to send its staff to work there. XIX. Reported that the UT Taskforce group was launched on 7th November, 2014	*Comm. Clinical & Comm. QA*

to carry-on the activities of the User training. XX. The proposed syllabus and curriculum for the training Institutions which was being developed for UT and 5S, should be presented at once to the Commissioner Clinical services for further scrutiny before sending it to Ministry of Education. XXI. Commented that some hospital facilities were considering all service delivery programmes during CMEs. XII. Reported that Technicians were advised to always fully train users on equipment and should liaise with the suppliers of the equipment. XIII. The Assistant Commissioner would remind the RWs Managers to keep joint field work trips with UTs. XIV. The Commissioner Clinical Services would take up the issue to ensure funds for User training was catered for. XV. Mbale RRH was designated as the Showcase and was doing well so far. XVI. The Chief representative, of JICA reported that extension of phase 2 for the Project was still being worked out since the proposal was already submitted to them but it was still discussing its framework and would probably begin next year 2015 around September.	*Asst. Comm. Infrastructure* *Comm. Clinical* *JICA*
Min.6: REPORT OF EACH ACTIVITY IN THE 3RD PROJECT YEAR **6.1: PRESENTATIONS** **6.1.1: 5S-CQI-TQM:** *(please find details in the 5S Handout*) The 5S presentation was by Dr. Sarah Byakika who commented that it was a cumulative report of activities executed for the past three years. The following was outlined:- 19. Many health facilities had benefited from the 5S component including the non-targeted hospitals. 20. It was earlier discussed that 5S should be the foundation for Quality Improvement of Health service for all components.	

21. Each year when 5S conference was held a different theme would be introduced. 22. Progress of 5S implementation for facilities occurred at different levels. 23. The M & E score sheet summarizes performance of the different health facilities. 24. Lira RRH had showed a negative trend in the progress of 5S thus more support and effort was needed. 25. Masaka was still average in 5S performance. 26. The team that assessed Moroto hospital was not the same as for the rest of the target facilities. 27. Tororo GH's performance kept deteriorating every after each year, and need for good leadership to sustain 5S activities was crucial and not only for Tororo but this called for all the implementing facilities to be keen. 28. Most health workers were being motivated because of the 5S activities as it improves their working environment and service delivery.	*5S & MOH counterparts*
6.1.2: USER TRAINNG : UT presentation was made by Sr. Apoko Anne Olaro on behalf of the Assistant Commissioner Dr. Amone Jackson. (*Please refer to Handout on User Training for details).* **Comments:** 12. Advised that a need to support the established UT taskforce group was vital, no matter even if it moved slowly but would attain its goal. 13. Distribution of medical equipment system was still not proper, it should be able to assess what exactly the health facility would require.	*Comm. Clinical Service*
6.1.2.1: The User Trainers' Taskforce Group made a presentation about the Way Forward and Action Plan for the formulated group. The following highlights were made:- 1. They were congratulated upon the newly formulated Taskforce	

group to carry on UT activities.

2. There was need for more collaboration between UT and Workshop Managers which was not good in some hospitals.
3. There should be continuous medical equipment user training to all health workers.
4. UT should be involved in regular annual joint meetings with the engineering department and MOH.
5. UT should have a uniform reporting system.
6. UT should be involved in procurement process and receiving of medical equipment if possible.
7. MOH should provide support supervision and monitoring of medical equipment of User training.
8. MOH/JICA should support user trainers to roll out user training activities.
9. Commented that the term "*User Training"* would better to be called *"Training of Users".*

MOH

6.1.3 MAINTENANCE OF MEDICAL EQUIPMENT (ME)

The presentation was made by conducted by Eng. Sam Wanda *(Please refer to handout on ME for details).*

1. Observed that there was improved Medical Equipment utilization and management in the target hospitals and through 5S as well there was order in the RWs.
2. Improved capacity of Workshop members and maintenance of ME.
3. Enhancing ME inventory data and analyzing.
4. Improving maintenance of ME, planning and budgeting.
5. Training of Technicians had been on- going within the country and abroad.
6. Reporting system for ME had been developed.
7. There was need for continuous inventory management.
8. ME had a good reporting system developed which could be shared to UTs.
9. Regular Quarterly meetings for RWS were introduced and were rotational.
10. The major challenge in Health facilities was with information flow control.

There was a need to learn some basics e.g. power input. 11. Appealed to MOH to organize more training for workshop managers similar to that which was in Tokyo. 12. Commented that it was the responsibility of Hospital Directors to keep reminding the workshop managers to ensure that equipment got for repairs was returned. 13. Mentioned some development partners such as SUSTAIN had supported ME to improve their services. 14. MOH would give more support towards for supervision. 15. Inventory should be done annually to avoid improper mechanism of re-distribution of equipment. 16. Hospital Directors were requested to ensure that some funds for UT was included on their budget to go together in the field. 17. The cause for some inconsistences in performance for some workshops was at times because of lack of spare parts. **Observed that:** 1. The aspect of having showcase facilities was a good motivator and it should be enhanced. ME and UT should also create showcase facilities. 2. The innovation of involving managers for training who were not on the government pay roll was good. 3. MOH should consider critically the quality of equipment supplied since it breaks easily. 4. UTs could combine with the team on the infection control to ensure proper care for medical equipment. 5. The issue of poor collaboration for UT and Workshop managers should be addressed by Hospital Administration in the sense of working together. 6. JICA would continue organizing different programmes and the recommended members would be trained.	*ME*
Min.7: REMARKS ON BEHALF OF THE CHIEF ADVISOR OF THE PROJECT Mr. Hiroshi Tasei gave remarks on behalf of the Chief Advisor Mr. Abe Kazuniro who was away in Japan. He thanked the entire management team of Ministry of Health i.e. the Permanent Secretary, Director General, Commissioners and all counterparts for successfully supporting the project activities for the last three	

years. He appreciated them for knowledge sharing, expertise rendered continuously in order to improve the health services for the facilities. He thanked the JICA office Uganda, the Experts of each component and the local staff for the work well done. He said that the project had successfully implemented its activities for the three years and was to handover to the Ministry to continue implementing and this was most desirable to be effected. He urged Hospital Directors and MOH to offer more support towards these activities for the betterment of the Health Sector in the Country. He officially handed over the Project to Ministry of Health Officials to carry on with all the activities and enforce all recommendations made from the various reports as presented. He once again appreciated everybody for enabling them to work with them even when they had tight schedules but spared time for the project activities.	
Remarks from Ms. Sonoko Takahashi: Ms. Sonoko the JICA representative thanked everybody for their cooperation and commitment to the project and said that nothing would have been done without assistance from counterparts and other key players. She commented ***c***oncerning the extension for the project, that as earlier communicated further discussions were being held and if the budget was found to be big then some items would be removed and concentrates on those most needed. She encouraged members to utilize the available resources. She highlighted that the next phase if approved would start in October, 2015. ***Comment from Mr. Kyosuke Kawazumi*** Mr. Kawazumi further appreciated the efforts put in for all the activities and he was impressed by the performance exhibited in the reports. He said that when discussions about the framework for the project activities are completed, then communication would be given for commencement of the next phase.	

Final Remarks from Commissioner Clinical Services Dr. Amandua Jacinto The Commissioner thanked JICA and all members for turning up and appreciated them on behalf of the Ministry of Health for their efforts to implement the activities of the project. He said that the issues that were raised in the presentations would effectively be handled to ensure good performance especially for the UTs. ***Vote of Thanks*** Dr. Alex Andema gave a vote of thanks to the JICA team for funding the project to the Country, he thanked the health facilities that benefitted from the project and said that the government of Japan shall always be remembered for the support of funds for the Infrastructure in Uganda. He said that his visit to Japan had helped him to improve the hospital status which he leads. He thanked MOH for doing its best for the success of the project. He recognized the Hospital Directors from various facilities and encouraged them to continue with the work even more than before. He thanked the organizers of the meeting which was very necessary. He wished everybody success and the meeting was closed with a word of prayer at 1.00p.m	
Summary of issues discussed: 1. *Presentations: 5S, UT, ME, and User Training Taskforce group presentation* 2. *Extension of phase 2* **3.** *Handover remarks* **Handouts:** *15. Agenda* *16. Minutes of Previous Meeting* *17. Presentations: - 5S, UT, ME, & Taskforce presentations*	

Dr. Amandua Jacinto
CHAIRPERSON

Agnes Batuvamu
MINUTE SECRETARY