THE PROJECT ON IMPROVEMENT OF HEALTH SERVICE THROUGH HEALTH INFRASTRUCTURE MANAGEMENT IN THE REPUBLIC OF UGANDA

PROJECT COMPLETION REPORT

DECEMBER, 2014

JAPAN INTERNATIONAL COOPERATION AGENCY(JICA)

INTERNATIONAL TECHNO CENTER CO., LTD.
KAIHATSU MANAGEMENT CONSULTING, INC.

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ANNEXES

Abbreviations

AHSPR	Annual Health Sector Performance Report
ARV	Antiretrovirals
ASSIST	Applying Science to Strengthen and Improve Systems
BTC	Belgian Technical Cooperation
BUT	Basic User Trainer
CME	Continuing Medical Education
CSO	Civil Society Organisation
CQI	Continuous Quality Improvement
DANIDA	Danish International Development Agency
DHO	District Health Officer
GH	General Hospital
HC	Health Center
HMIS	Health Maintenance Information System
HSSIP	Health Sector Strategic and Investment Plan
JICA	Japan International Cooperation Agency
JCC	Joint Coordination Committee
JOCV	Japan Overseas Cooperation Volunteer
JRM	Joint Review Mission
MCH	Maternal and Child Health
ME	Medical Equipment
NGO	Non-Governmental Organizations
NHA	National Health Assembly
NO	Nursing Officer
PDM	Project Design Matrix
PHA	Principal Hospital Administrator
QAD	Quality Assurance Department
QIFSP	Quality Improvement Framework and Strategic Plan
QIP	Quality Improvement Partner
QIT	Quality Improvement Team
R/D	Record of Discussion
RRH	Regional Referral Hospital
SPNO	Senior Principal Nursing Officer
SUO	Standard Unit of Output
SUT	Senior User Trainer
TOR	Terms of Reference
TOT	Training of Trainers

TQM	Total Quality Management
URC	University Research Co., LLC
USAID	United States Agency for International Development
UT	User Trainer/User Training
WIT	Work Improvement Team
WS	Medical Equipment Maintenance Workshop
5S	Sort-Set-Shine-Standardize-Sustain

1. Outline of the Project

1-1 Introduction

In 2009, the government of Uganda made a request for Japanese technical assistance with the aim of improving hospital work environments through the 5S approach, facilitating user training and the maintenance of medical equipment. In response to this request, the Japan International Cooperation Agency (JICA) dispatched a detailed planning survey team to Uganda from August to September 2010. Following the survey, the team, together with the concerned authorities in the Ugandan government, reached a basic consensus to implement the proposed project. Shortly thereafter, JICA and the Ministry of Health of the Republic of Uganda (MOH) signed the Record of Discussions (R/D) dated April 19, 2011 which contains the details of the discussions between both parties regarding the proposed project. The first project year was completed in August 2011 and the second year was completed in December 2013. The third year started in January 2014. All activities in Uganda for the year will be carried out by November 2014 and this three year project will be completed in January 2015.

1-2 Objectives and Outputs of the Project

Project Overall Goal, Project Purpose and Output are as stated below.

[Overall Goal]
Management and utilization of health infrastructure is improved in target health facilities.

[Project Purpose]
Management and utilization of health infrastructure is improved in target health facilities.

[Outputs]
1. 5S-CQI-TQM activities are implemented in target health facilities
2. Utilization of medical equipment is improved in target hospitals.
3. Medical equipment is maintained better by ME workshops.

1-3 Project Activities

This project consists three major activities namely 5S-CQI TQM, User training, Maintenance of Medical Equipment. A series of impact assessment surveys were conducted to measure the achievement of project's impact and objectives. The outline of each activity will be stated in following sessions.

1-3-1 5S-CQI-TQM

1) Outline of 5S-CQI-TQM

[Output]

1. 5S-CQI-TQM activities are implemented in target health facilities

[Activity]

1-1. To promote 5S-CQI-TQM activities at national level

1-2. To promote 5S-CQI-TQM activities at regional level

1-3. To promote 5S-CQI-TQM activities at facility level

In order to set the best stage for health care personnel to make maximum use of their skills and knowledge, the Ministry of Health of Uganda (MoH) recommends the 5S method as the foundation for all quality improvement initiatives in the country. 5S is a sequence of activities which include: Sort- Set-Shine- Standardize- Sustain to improve the work environment and working conditions and make them as convenient as possible, and thereby improve with regards to preparedness, standardization and timeliness. The activities undertaken in the working environment can only be significantly improved when they have been continued for an adequate amount of time; namely, CQI is the only way to quality health care

・Health care quality and productivity

Health Workers being diverted from service delivery to look for equipment, medicines, and medical records, and it is the most frustrating form of time loss in any health care facility. With 5S, often-needed items are stored in the most accessible location and correct adoption of the standardization approach.

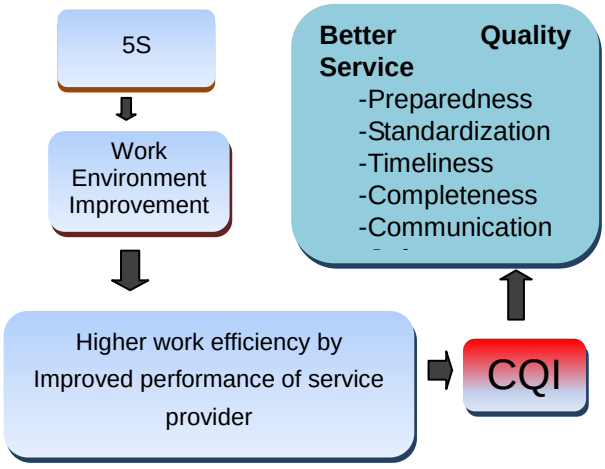


Figure:1-1 5S-CQI-TQM Structure

・Infrastructural maintenance

Health Workers take responsibility for keeping the workplace clean and tidy so that they can take ownership for highlighting potential problems before they have an impact on performance and preventive maintenance of all equipment and instruments.

・Health and safety

5S activities have the concept of continuous improvement in health services for patients and occupational safety and health for health workers. 5S can also be a valuable marketing tool when potential customers visit. A well-organized, clean and tidy facility gives the image of a professional and well-organized service provider.

2) Issues and major activities on 5S-CQI-TQM

Target	Issues	Major Activities and Outputs
To promote 5S-CQI-TQM activities at **national level**	● No mechanism to promote 5S-CQI-TQM to Health facilities ● Lack of skilled person for 5S activities ● Lack of awareness 5S in HDP	● To establish the project team for 5S-CQI-TQM activities ● To conduct training for national facilitators for 5S-CQI-TQM activities ● To develop national guidelines ad 5S Hand book for implementation of 5S-CQI-TQM activities ● To dispatch National Facilitators to Tanzania TOT ● To hold 3 5S Conferences ● To attend National Quality Improvement Conference ● To conduct TOT of CQI ● To conduct support supervision by National facilitators
To promote 5S-CQI-TQM activities at **regional level**	● Not enough awareness 5S in Health Facilities ● Lack of skilled person for 5S in region ● Not enough communication between RRH and DHO ● Not enough information Activities of HDP in region	● To conduct 3 TOT for regional facilitators ● To conduct support supervision and M&E ● To hold 3 “Study tours of RRH” ● To print and distribute “5S poster” to DHO and QI partners ● To support QI training of QI partners
To promote 5S-CQI-TQM activities at **facility level**	● Not enough awareness of health service quality among hospital staff ● Lack of awareness of Quality Improvement Team’s activities in facility ● Lack of skilled person for 5S activities in facility ● Lack of mechanism to promote 5S concept as foundation of Quality Improvement in Health facility	● To conduct 5S training in facility ● To conduct 6 CME workshops on dissemination of 5S ● To conduct 5S Hand book training ● To conduct support supervision and M&E

1-3-2 User Training Activities

1) Outline of User Training Activities

[Output]

2. Utilization of medical equipment is improved in target hospitals.

[Activity]

2-1. To train ME user trainers in 5S-CQI-TQM concept

2-2. To implement ME user training.

In this present-day medical practice can be said to be impossible to carry out without the utilization of Medical Equipment. Therefore, if the medical personnel do not have full knowledge in handling and operation of the medical equipment there is inability of not being able to give the right medical examination, problems with breakage of equipment as a result of lack of knowledge on proper usage which may also cause harm to the patients are likely to arise.

To overcome the above problem the Ministry of Health, Uganda established the system of "user training" with the aim of improving the way in which Medical Equipment were being handled in health facilities with assistance from DANIDA and therefore twenty participants underwent training to become User trainers in mid-90s. Although there were trainings carried out in each medical facilities, after-training about twenty years passed, many trainers left their facilities either due to retirement and official transfers.

The technical cooperation of 5S-UT-ME project funded by JICA was launched. “User training” as one of the activity. However, as already stated, with the majority of the trainers retired it would be a challenge to carry out the training. Therefore, training of new trainers became necessary. This was officially added to the Project Design Matrix as it wasn't originally anticipated before the project launch.

Sixteen participants from the eight target hospitals were selected and trained in both basic and advanced medical equipment along with vital training skills over the project period of 3years.The participants carried out actual practical training both at their own facilities and also at the lower health units. Thereby, 16 participants officially declared User Trainers by the Ministry of Health.

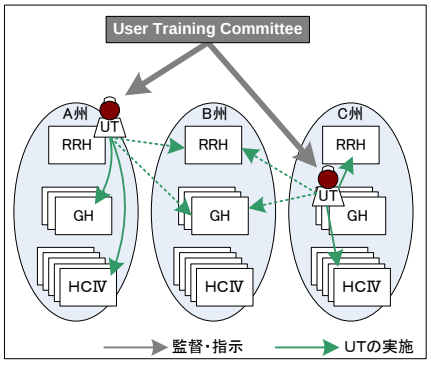


Figure:1-2 UT Structure

However, basing on the past experiences there is a necessity for an organization to manage the user training activity. From the project, establishment of the user trainer task force group was launched. As a result, this committee was constituted mainly of 16 persons' for purposes of easy planning of irregular

trainings, junior trainings etc.

These activities were carried out for three years and four months in eight target hospitals across the country.

The main activities of user training in this project were as follows.

1: To train user trainers in 5S-CQI-TQM concept.

- User trainers as participants for 5S-CQI-TQM training.
- To incorporate user training component into training manuals for 5S-CQI-TQM.

2: To implement user training.

- Needs assessment for user training.
- Review and prepare revised user training guidelines and manuals.
- Train user trainers of target hospitals.
- User training for equipment users in target hospitals.
- Support supervision and monitoring of user trainers in target hospitals.
- Review and evaluate the results of user training and its implementation mechanism

2) Issues and major activities on User Training

Target	Issues	Major Activities and Outputs
To train ME user trainers in 5S-CRQI-TQM concept	● Participation and Spread of 5S-CQI-TQM ● Engagement of 5S-CQI-TQM Manual	● Attend 5S Competition ● Attend 5S Training ● Attend 5S Competition ● Attend 5S activities within Hospital ● Explain 5S point non-target hospitals ● User training attend 5S training ● Engagement of 5S-CQI-TQM Manual by the UT
To implement ME user training	● Improper utilization of Medical Equipment in the Medical facilities ● Insufficient User trainers ● Lack of proper knowledge on the Medical equipment ● No update of Training Manual ● Lack of zeal to carry out User training	● Carried out Needs assessment(2months) ● Assessment of the survey carried out ● Train Upcoming User Trainers ● Carried out Follow up supervision。 ● Compilation of UT Manual(400 copies printed and distributed) ● Launch of UT Task force Group

· Needs assessment was carried out.

· 16 trainees were identified from target hospital.

· All the 16 trainees were train as trainers and completed successfully.

· 16 User trainers carried out training at their respective hospital (8 facilities) .The total amount of trainings carried out being 56.

· During their trainings, each trainer was evaluated and given a feedback for their improvement・

Compilation of User training Manual.

- Launch of the UT Task force group.
- Publication of training materials i.e. Flipcharts and UT Manual.

1-3-3 Maintenance of Medical Equipment

1) Outline of Maintenance of Medical Equipment Activities

[Output]

3. Medical equipment is maintained better by ME workshops.

[Activity]

3-1. To improve planning for ME maintenance and management

3-2. To promote 5S-CQI-TQM activities in ME workshops

3-3. To strengthen maintenance of ME by ME workshops

The current health sector development plan "Health Sector Strategic and Investment Plan 2010/11-2014/15" recognizes quality of health care including medical equipment maintenance as one of the key priorities. Moreover, the "National Health Policy II 2010-2020" indicates that health infrastructure management is one of the key priority issues in the health sector.

In 2009, the Ministry of Health (MOH) Uganda decided to finance medical equipment maintenance through Regional Medical Equipment Maintenance Workshops (WS). However, problems such as inappropriate handling and inadequate knowledge of equipment users to operate the equipment still remained in the health facilities. Under these circumstances, the JICA implemented a technical cooperation aiming at improving management and utilization of health infrastructure through the 5S-CQI-TQM activities (5S component), user training (UT component) and capacity development of medical equipment maintenance WS (ME component).

Figure 1-3: Major Activities on ME

The ME Component aims at improving delivery of health care services through efficient and effective maintenance and management of medical equipment by WSs. This component carried out the following major activities in nine (9) target WSs located in Kampala (Central), Mbale, Soroti, Lira, Gulu, Arua, Hoima, Fort Portal and Kabale. The project activities were coordinated by the Health Infrastructure Division (HID), Clinical Service Department (CS) of MOH.

・Improving the capacity of WSs to maintain medical equipment (ME)
・Enhancing ME inventory management
・Improving maintenance planning, budgeting and reporting
・Implementation of 5S Activities in WSs
・Biomedical engineering training for technicians

2) Issues and major activities on Maintenance of Medical Equipment

Target	Issues	Major Activities and Outputs
Inventory	● Not annually updated. ● Poor data cleaning and analyzing skills. ● Analyzed data is not effectively utilized for planning and budgeting.	● Baseline survey: 4 months ● Inventory update exercise: 2 times ● Training on inventory management: Once ● Dissemination of analyzed inventory data at conferences and JRM. ● Support supervision follow-up.
WS Managers Meeting	● Quality of WS quarterly reports and timeliness of submission. ● Inadequate communication among WSs and HID/MOH.	● Holding WS managers meetings: 9 times ● Other development partners (SUSTAIN, IDI) and some junior technicians attended these meeting.
5S Activities in WSs	● Maintenance tools, equipment and parts were mixed up in store. ● Low attitude of cleanness.	● All the WSs implemented 5S. ● The working environment has dramatically improved. ● Targeted support supervision and participatory leadership was adapted and it helped WSs move to advance stages. ● 5S monitoring sheet was created.
WS Manual	● Routine maintenance works were not standardized. ● No standard manual or guideline.	● Developed a WS Operation Manual and Maintenance Guidelines ● Distributed 900 books
Training	● Low knowledge and skills on medical equipment maintenance	● Biomedical Engineering Training: 5 times ● Excel training : 1 time ● Training in Japan: 4 technicians benefited

1-3-4 Impact Assessment

A series of impact assessment survey was conducted to study the achievement and impact of project interventions namely 5S-CQI-TQM, user training and maintenance of ME. The main themes of the study were to measure:

- Effect of User Training and Maintenance on Condition of Medical Equipment
- Improvement of staff motivation, waiting time and patient satisfaction through 5S practice

The results of the assessment were reported in the Impact Assessment Report. Also the results were presented in 5S Conference (Kampala, Aug. 2014) and Japan Association for International Health (Japan, Nov.2013 / Nov. 2014）. The End-line Assessment Report was shared in the 5S Conference 2014. Also, the research article on the effect of 5S practices was developed based on the End-line Assessment Report, and it was submitted to "International Journal for Quality in Health Care"

1) Effect of User Training and Maintenance on Condition of Medical Equipment

Methods: The Project collected pre-/post-test results of training of user trainers and those of participants in user training in seven Regional Referral Hospitals (Arua, Hoima, Kabale, Lira, Masaka, Mbale and Moroto) and one General Hospital (Entebbe), and of participants in technical training for technicians of maintenance workshops. It also collected data on condition of medical equipment in these eight hospitals from the inventory of Ministry of Health. Following the correlation analysis of the test results of user training and maintenance with condition of medical equipment, multiple regression analysis was conducted to know the magnitude of the impact of the project intervention in the eight hospitals.

Results: As a result of correlation analysis in the eight hospitals, knowledge of user trainers significantly and strongly correlated with that of participants on utilisation of medical equipment, while the knowledge of users significantly correlated with the percentage of medical equipment with "good and in use" condition and that with "out-of-order but repairable" condition. The knowledge of maintenance technicians also significantly correlated. The result of multiple regression analysis showed significant and substantial impact of project intervention to user training and maintenance workshops on the improvement of the percentage of medical equipment with "good and in use" condition in the eight hospitals.

Conclusion: It can be concluded that the project intervention to user training and maintenance workshops was effective to improve the condition of medical equipment and significantly contributed to achievement of a project purpose.

2) Improvement of Staff Motivation, Waiting Time and Patient Satisfaction through 5S Practice

Methods: A project scenario, to improve patient satisfaction as well as waiting time of patients through higher staff motivation as a result of 5S practice, was assessed. Staff motivation, waiting time and patient satisfaction were measured in 13 Regional Referral Hospitals (RRH) and 8 General Hospitals (GH) implementing 5S in February-March 2012 - 2014. 10 RRH implementing 5S were compared with 3 without implementation. As for the 8 GH, 2 GH intervened by the Project were compared with 6 without intervention.

Results: [RRH] "Commitment to work in the current hospital" was significantly higher in 10 RRH implementing 5S practice. Waiting time in the dispensary of 10 RRH implementing 5S was significantly improved. However, significant difference was not identified on patient satisfaction.
[GH] Project intervention of 5S realised significant difference of the patient satisfaction from various aspects. Waiting time was significantly improved more in OPD of 2 GH with the intervention. However, the intervention of only 5S could not sustain the staff motivation in the 2 GH.

Conclusion: The results provided two insights: (1) it takes at least 4 years to improve patient satisfaction through 5S practice in Uganda, (2) the 4th year since commencement of 5S can be a threshold to move forward to CQI to maintain the staff motivation.

1-3 Project Areas and Sites

The Project areas and sites will be as follows.

*TORORO General Hospital, located in the eastern region, will be the National Showcase of the Project.

*Among Health Centre IVs (HC IV), MUKUJU HC IV in Tororo district was selected as the target HC.

Eastern Region	TORORO General Hospital (National Showcase) * MBALE Regional Referral Hospital MUKUJU HC IV*
Central Region	MASAKA Regional Referral Hospital ENTEBBE General Hospital
Southwestern Region	KABALE Regional Referral Hospital
Western Region	HOIMA Regional Referral Hospital
Northern Region	LIRA Regional Referral Hospital
Northwestern Region	ARUA Regional Referral Hospital
Northeastern Region	MOROTO Regional Referral Hospital

The Medical Equipment (ME) maintenance activities and workshop locations are listed below.

Eastern Region	SOROTI Regional Workshop MBALE Regional Workshop
Central Region	WABIGALO Central Workshop
Southwestern Region	KABALE Regional Workshop
Western Region	HOIMA Regional Workshop FORT PORTAL Regional Workshop
Northern Region	LIRA Regional Workshop GULU Regional Workshop
Northwestern Region	ARUA Regional Workshop

1-5 Project Implementation Body

The project was managed by the members of Joint Corrdination Committess (JCC) andJ JICA Experts.

Table1-1：List of JCC members and JICA Experts

Project Director	
Director General of Health Services	Dr. Jane Ruth Aceng
Project Member	
Director,Clinical and Community Health (Ag) / Commissioner Clinical Services,Directorate of Clinical and Community Health	Dr. Amandua Jacinto
JCC Member	
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
JICA Experts	
Chief Advisor/Health System	Kazuhiro Abe
5S-CQI-TQM(1)/Vice Chief Advisor	Hiroshi Tasei
5S-CQI-TQM(2)	Toru Yoshikawa
User Training	Yasuhiro Hiruma
Medical Equipment Maintenance (1)	Naoki Mimuro
Medical Equipment Maintenance (2)	Shigetaka Tojo
Impact Assessment	Naoki Take
Training Coordinator/Assistant 5S-CQI-TQM	Akie Nawa
Coordinator/Assistant Training Coordinator	Kazunori Iijima
Coordinator/Assistant Training Coordinator	Satoko Irisawa

2. Achievement of Objectives and Outputs

At the end of the project, the project purpose and objective achievement status is as stated below.

1）Achievements of Outputs

【Output 1】5S-CQI-TQM activities are implemented in target health facilities

Verifiable Indicators	Achievement Status
1a. All scores of "Sort","Set","Shine " in 5S-CQI-TQM monitoring and evaluation sheet are higher than 70%.	M&E Results (%)

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

Achievement of 1S, 2S and 3S at Kabale RRH, Mbale RRH, Moroto RRH, Entebbe GH. Arua RRH and Hoima RRH only achieved 1S. No achievement recorded for the other Hospitals.

1b. Half number of the units in a target hospital have established WIT that are functioning properly.

Number of WITs in Target hospital

Hospital	Total No. of Unit in facility (A)	Target No. of WIT	WIT in function	Hospital
Arua RRH	21	11	8	38%
Kabale RRH	20	10	12	50%
Hoima RRH	19	10	5	26%
Mbale RRH	23	12	23	100%
Lira RRH	25	13	4	16%
Masaka RRH	26	13	8	30%
Moroto RRH	20	10	10	50%
Entebbe GH	20	14	12	60%
Tororo GH	17	8	9	52%

Achievements recorded at Kabale RRH, Mbale RRH, Moroto RRH, Entebbe GH.

【Output 2】Utilization of medical equipment is improved in target hospitals.

<table>
<tr><th>Verifiable Indicators</th><th>Achievement Status</th></tr>
<tr><td>2a. All ME user trainers score higher than 60% of correct answers of Post test.</td><td>Upbring of User trainer result show total average above 60%, therefore successfully implemented and the index was successfully achieved.

Post test results (%)
<table>
<tr><th rowspan="2">UT No.</th><th colspan="6">Post Test</th><th rowspan="2">Individual Averages</th></tr>
<tr><th>1st</th><th>2nd</th><th>3rd</th><th>4th</th><th>5th</th><th>6th</th></tr>
<tr><td>01</td><td>78</td><td>90</td><td>72</td><td>83</td><td>-</td><td>-</td><td>80.8</td></tr>
<tr><td>02</td><td>75</td><td>79</td><td>61</td><td>75</td><td>67</td><td>93</td><td>75.0</td></tr>
<tr><td>03</td><td>83</td><td>91</td><td>84</td><td>66</td><td>90</td><td>77</td><td>81.8</td></tr>
<tr><td>04</td><td>75</td><td>70</td><td>85</td><td>50</td><td>69</td><td>93</td><td>73.3</td></tr>
<tr><td>05</td><td>80</td><td>85</td><td>75</td><td>58</td><td>74</td><td>83</td><td>75.8</td></tr>
<tr><td>06</td><td>83</td><td>90</td><td>84</td><td>75</td><td>85</td><td>-</td><td>83.4</td></tr>
<tr><td>07</td><td>85</td><td>86</td><td>77</td><td>91</td><td>70</td><td>89</td><td>83.0</td></tr>
<tr><td>08</td><td>78</td><td>86</td><td>86</td><td>75</td><td>82</td><td>86</td><td>82.2</td></tr>
<tr><td>09</td><td>70</td><td>69</td><td>67</td><td>83</td><td>87</td><td>90</td><td>77.7</td></tr>
<tr><td>10</td><td>78</td><td>95</td><td>67</td><td>79</td><td>70</td><td>89</td><td>79.7</td></tr>
<tr><td>11</td><td>77</td><td>79</td><td>77</td><td>83</td><td>88</td><td>77</td><td>80.2</td></tr>
<tr><td>12</td><td>82</td><td>94</td><td>85</td><td>70</td><td>94</td><td>83</td><td>84.7</td></tr>
<tr><td>13</td><td>84</td><td>87</td><td>85</td><td>66</td><td>76</td><td>96</td><td>82.3</td></tr>
<tr><td>14</td><td>82</td><td>93</td><td>70</td><td>70</td><td>-</td><td>94</td><td>81.8</td></tr>
<tr><td>15</td><td>78</td><td>73</td><td>69</td><td>66</td><td>69</td><td>91</td><td>74.3</td></tr>
<tr><td>16</td><td>80</td><td>88</td><td>78</td><td>91</td><td>83</td><td>91</td><td>85.2</td></tr>
<tr><td colspan="7">Total Average</td><td>80.1</td></tr>
</table></td></tr>
<tr><td>2b. More than 16 of newly "certified" Me user trainers.</td><td>1) 16 persons acquired the qualification of the Basic User Trainer after passing final examination in August 2012.

2)Completion examination in Advanced Medical Equipment of the user trainer was carried out in September, 2013, and all the 16 BUT acquired the qualification of UT.</td></tr>
<tr><td>2c. More than 40 times of implemented ME user training</td><td>By the 2nd Project year all the 8 target hospitals had each underwent training 5 times. In the 3rd Project year, all the 8 target hospitals had carried training to two lower health facilities at least twice making it a total of 32trainings.
In addition, to the carried out independent trainings the total number of trainings done are a total of 80, hence the index successfully achieved</td></tr>
</table>

2d. Average of comprehension rate of trainee is higher than 80% after the user training.

Post Test Results (%)

Hospital	1st	2nd	3rd	4th	5th	Hospital Average
Arua RRH	94.7	94.0	93.8	87.0	93.2	92.5
Lira RRH	93.7	86.0	85.4	91.1	99.5	91.1
Hoima RRH	91.8	88.0	90.0	84.0	95.0	89.8
Mbale RRH	88.0	86.0	90.9	89.6	86.0	88.1
Masaka RRH	95.8	93.3	91.5	-	92.0	93.2
Kabale RRH	92.1	91.4	87.5	86.5	85.9	88.7
Entebbe GH	85.7	87.1	80.8	88.1	85.2	85.4
Moroto RRH	87.2	90.1	93.5	94.6	-	91.4
Total Average						**90.0**

Further training was carried out at the lower facilities

Post Test results of trainees at lower facilities (%)

UTrainer's Hospital	1st	2nd	3rd	4th	Average
Arua RRH	Oli HC4 90	Maracha GH 92	Koboko HC4 96	Kuluba Hospitl 96	93.5
Lira RRH	Ogur HC4 94	Apac GH 86	Amach HC4 100	Dokolo HC4 87	91.8
Hoima RRH	Kibube HC4 76	Masindi GH 83	Kiboga GH 89	Kigoloobya HC4 100	87.0
Mbale RRH	Bududa GH 96	Kapchorwa GH 95	Tororo GH 78	Tororo GH 90	89.8
Masaka ;RRH	Sembabule HC4 94	Rakai GH 92	Kalisizo GH 88	Bukulula HC4 87	90.3
Kabale RRH	Kisoro GH 89	Muko HC4 84	Bukinda HC4 92	Hamurwa HC4 94	89.8
Entebbe GH	Buwambo HC4 88	Ndejje HC4 84	Mukono HC4 86	Kasangati HC4 93	97.8
Moroto RRH	Abim GH 83	Kotido GH 87	Amudat GH 84	Tokora HC4 93	86.8
				Total Average	**89.6**

The total average of the trainee's post results in a low rank health facilities shows that the average performance improved by more than 85%, hence the index successfully achieved

2e. Development of reference sheets for proper utilization of selected ME

Publication of User training Medical Equipment Manual containing 19 commonly used Medical equipment's at both the RRH and lower health facilities was complete in December 2013.

【Output 3】Medical equipment is maintained better by ME workshops.

<table>
<tr><th>Verifiable Indicators</th><th>Achievement Status</th></tr>
<tr><td>3a. Lower than 12% of ME in use but needs repaired</td><td>
<table>
<tr><th>Hospital</th><th>2008</th><th>June 2012</th><th>May 2014</th></tr>
<tr><td>Arua RRH</td><td>7.7%</td><td>8.4%</td><td>8.2%</td></tr>
<tr><td>Entebbe GH</td><td>12.1%</td><td>19.5%</td><td>7.1%</td></tr>
<tr><td>Hoima RRH</td><td>15.3%</td><td>31.3%</td><td>21.8%</td></tr>
<tr><td>Kabale RRH</td><td>6.7%</td><td>8.5%</td><td>12.0%</td></tr>
<tr><td>Lira RRH</td><td>19.6%</td><td>32.4%</td><td>30.7%</td></tr>
<tr><td>Masaka RRH</td><td>14.7%</td><td>13.4%</td><td>5.1%</td></tr>
<tr><td>Mbale RRH</td><td>15.6%</td><td>20.8%</td><td>25.1%</td></tr>
<tr><td>Moroto RRH</td><td>7.7%</td><td>6.1%</td><td>14.2%</td></tr>
<tr><td>Tororo GH</td><td>16.3%</td><td>7.1%</td><td>6.3%</td></tr>
<tr><td>Mukuju HC IV</td><td>N/A</td><td>3.5%</td><td>21.2%</td></tr>
<tr><td>Average</td><td>13.2%</td><td>17.7%</td><td>14.3%</td></tr>
</table>

The target was not achieved due to the delayed budget distribution and difficulty of procuring spare parts. It is still a challenge for many of the donated medical equipment to be supplied spare parts. Issues related to selection and procurement of equipment is still need to be tackled.
</td></tr>
<tr><td>3b. Lower than 10% of ME in Out of order/Repairable</td><td>
<table>
<tr><th>Hospital</th><th>2008</th><th>June 2012</th><th>May 2014</th></tr>
<tr><td>Arua RRH</td><td>14.5%</td><td>9.7%</td><td>10.5%</td></tr>
<tr><td>Entebbe GH</td><td>21.4%</td><td>6.9%</td><td>14.2%</td></tr>
<tr><td>Hoima RRH</td><td>12.2%</td><td>13.5%</td><td>13.6%</td></tr>
<tr><td>Kabale RRH</td><td>12.6%</td><td>13.9%</td><td>10.8%</td></tr>
<tr><td>Lira RRH</td><td>17.9%</td><td>7.2%</td><td>11.3%</td></tr>
<tr><td>Masaka RRH</td><td>11.0%</td><td>11.6%</td><td>11.2%</td></tr>
<tr><td>Mbale RRH</td><td>16.1%</td><td>2.3%</td><td>0.4%</td></tr>
<tr><td>Moroto RRH</td><td>18.3%</td><td>5.3%</td><td>3.2%</td></tr>
<tr><td>Tororo GH</td><td>16.3%</td><td>5.1%</td><td>5.3%</td></tr>
<tr><td>Mukuju HC IV</td><td>N/A</td><td>8.8%</td><td>0.0%</td></tr>
<tr><td>Average</td><td>15.1%</td><td>9.4%</td><td>9.9%</td></tr>
</table>

Although about some of the target facilities marked more than 10%, the total average score reached the numerical target. Implementing 5S activities and depreciation of obsolete equipment contributed the achievement.
</td></tr>
</table>

3c. All of ME workshops that submit quarterly reports timely

Period	Number of Submission (9 workshops)
Feb 2012	2/9 (22%)
Nov 2012	5/9 (56%)
Feb 2013	8/9 (89%)
May 2013	6/9 (67%)
Sept 2013	8/9 (89%)
Nov 2013	8/9 (89%) *1
Feb 2014	9/9 (100%)
May 2014	9/9 (100%)
Nov 2014	9/9 (100%)

Through the regular WS Managers Meetings, the submission rate and quality of the quarterly report by each WS manager was dramatically increased. Since the meeting is expected to be held regular basis with each WS's budget, the reporting mechanism was well strengthened.

3d. Higher than 80% of staff that register improvement in knowledge after training

Period	Percentage of the staff knowledge improved
June 2012	19/22 (86%)
Nov 2012	9/16 (56%) *2
May 2013	23/23 (100%)
Aug 2013	25/25 (100%)
June 2014	20/21 (95%)
Average	87%

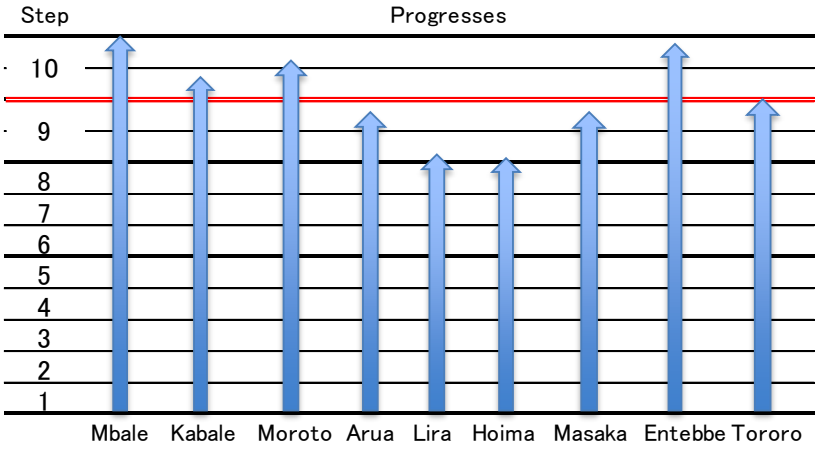
In total 6 technical training were conducted and 133 technicians were trained in the project period. The post-test score shows that the trainings created enough learning effect in most of the trainings.

*2 In the 2nd training, trainees learned how to enter ME inventory data with Microsoft Excel. Due to the shortage of post-test time and technical difficulties, the post-test score was not improved in expected level.

2) Achievements of Project Purpose

【Achievement】

Management and utilization of health infrastructure is improved in target health facilities.

<table>
<tr><th>Verifiable Indicators</th><th>Achievement Status</th></tr>
<tr><td>1. More than 60% of medical equipment in good working condition and in use</td><td>
<table>
<tr><th>Hospital</th><th>2008</th><th>June 2012</th><th>May 2014</th></tr>
<tr><td>Arua RRH</td><td>42.6%</td><td>68.2%</td><td>57.3</td></tr>
<tr><td>Entebbe GH</td><td>37.6%</td><td>51.7%</td><td>67.7</td></tr>
<tr><td>Hoima RRH</td><td>42.3%</td><td>39.3%</td><td>54.3</td></tr>
<tr><td>Kabale RRH</td><td>54.3%</td><td>52.1%</td><td>63.9</td></tr>
<tr><td>Lira RRH</td><td>35.7%</td><td>30.0%</td><td>46.6</td></tr>
<tr><td>Masaka RRH</td><td>55.2%</td><td>59.1%</td><td>72.8</td></tr>
<tr><td>Mbale RRH</td><td>38.6%</td><td>61.0%</td><td>65.9</td></tr>
<tr><td>Moroto RRH</td><td>31.7%</td><td>41.7%</td><td>51.1</td></tr>
<tr><td>Tororo GH</td><td>42.9%</td><td>84.7%</td><td>85.3</td></tr>
<tr><td>Mukuju HC IV</td><td>N/A</td><td>45.6%</td><td>78.8</td></tr>
<tr><td>Average</td><td>43.1%</td><td>53.5%</td><td>61.9</td></tr>
</table>
The indicator has been favorably improved since the project commenced and the numerical target was achieved. A synergistic effect of the outputs of three major activities (5S, UT, ME) contributed the achievement.
</td></tr>
<tr><td>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</td><td>
Definitions of 5S Implementation Level
<table>
<tr><td>Level 1</td><td>Sensitization of 5S-CQI-TQM</td></tr>
<tr><td>Level 2</td><td>S training of Hospital Manager</td></tr>
<tr><td>Level 3</td><td>QIT establishment</td></tr>
<tr><td>Level 4</td><td>Situational analysis</td></tr>
<tr><td>Level 5</td><td>Priority areas identification (showcase)</td></tr>
<tr><td>Level 6</td><td>5S training of staff members in target area</td></tr>
<tr><td>Level 7</td><td>WITs establishment</td></tr>
<tr><td>Level 8</td><td>Sort-Set-Shine</td></tr>
<tr><td>Level 9</td><td>3S implementation, development of standards/regulation</td></tr>
<tr><td>Level 10</td><td>Repeat 5S cycles, education/training for Sustain</td></tr>
</table>
Progress of 5S Implementation at the end of the project.


It was recognized that progress has been made at Mbale, Kabale, Moroto
</td></tr>
</table>

<table>
<tr><td></td><td>and Entebbe. Core member appreciated that 5S is quite effective for improvement of workplace environment.</td></tr>
<tr><td>3. Level of provider satisfaction</td><td>Mean Score of Positive Statements on Providers' Satisfaction (1) Satisfaction with working environment (2) Dedication to work in the current hospital and (3) Willingness to provide better service by target health facilities

(1)Satisfaction with working environment (the range of score:3-12)
<table>
<tr><th></th><th>Baseline (Feb-Mar 2012)</th><th>Mid-term (Feb-Mar 2013)</th><th>End-line (Feb-Mar 2014)</th></tr>
<tr><td>Arua RRH</td><td>10.0</td><td>9.8</td><td>10.5</td></tr>
<tr><td>Entebbe GH</td><td>9.0</td><td>10.6</td><td>9.6</td></tr>
<tr><td>Hoima RRH</td><td>10.2</td><td>10.6</td><td>8.8</td></tr>
<tr><td>Kabale RRH</td><td>10.6</td><td>9.8</td><td>10.2</td></tr>
<tr><td>Lira RRH</td><td>9.5</td><td>10.2</td><td>10.9</td></tr>
<tr><td>Masaka RRH</td><td>8.9</td><td>9.6</td><td>10.2</td></tr>
<tr><td>Mbale RRH</td><td>10.5</td><td>10.4</td><td>9.4</td></tr>
<tr><td>Moroto RRH</td><td>10.1</td><td>10.8</td><td>11.4</td></tr>
<tr><td>Tororo GH</td><td>11.1</td><td>10.7</td><td>9.9</td></tr>
<tr><td>Mukuju HC IV</td><td>10.3</td><td>8.8</td><td>10.0</td></tr>
<tr><td>Average</td><td>10.1</td><td>10.1</td><td>10.1</td></tr>
</table>
(2)Dedication to work in the current hospital(the range of score: 2-8)
<table>
<tr><th></th><th>Baseline (Feb-Mar 2012)</th><th>Mid-term (Feb-Mar 2013)</th><th>End-line (Feb-Mar 2014)</th></tr>
<tr><td>Arua RRH</td><td>6.4</td><td>6.0</td><td>6.6</td></tr>
<tr><td>Entebbe GH</td><td>6.3</td><td>7.1</td><td>6.1</td></tr>
<tr><td>Hoima RRH</td><td>7.3</td><td>7.0</td><td>6.3</td></tr>
<tr><td>Kabale RRH</td><td>6.0</td><td>6.1</td><td>6.8</td></tr>
<tr><td>Lira RRH</td><td>7.0</td><td>6.4</td><td>6.6</td></tr>
<tr><td>Masaka RRH</td><td>6.1</td><td>6.8</td><td>6.3</td></tr>
<tr><td>Mbale RRH</td><td>6.5</td><td>6.3</td><td>6.8</td></tr>
<tr><td>Moroto RRH</td><td>5.9</td><td>6.3</td><td>6.1</td></tr>
<tr><td>Tororo GH</td><td>6.8</td><td>5.8</td><td>6.4</td></tr>
<tr><td>Mukuju HC IV</td><td>6.7</td><td>5.1</td><td>7.0</td></tr>
<tr><td>Average</td><td>6.5</td><td>6.3</td><td>6.5</td></tr>
</table>
(3) Willingness to provide better service (the range of score: 5-20)
<table>
<tr><th></th><th>Baseline (Feb-Mar 2012)</th><th>Mid-term (Feb-Mar 2013)</th><th>End-line (Feb-Mar 2014)</th></tr>
<tr><td>Arua RRH</td><td>18.8</td><td>18.9</td><td>18.9</td></tr>
<tr><td>Entebbe GH</td><td>18.4</td><td>18.7</td><td>18.4</td></tr>
<tr><td>Hoima RRH</td><td>18.4</td><td>19.3</td><td>17.2</td></tr>
<tr><td>Kabale RRH</td><td>18.6</td><td>18.8</td><td>18.6</td></tr>
<tr><td>Lira RRH</td><td>18.8</td><td>18.7</td><td>18.9</td></tr>
<tr><td>Masaka RRH</td><td>17.6</td><td>18.8</td><td>17.5</td></tr>
<tr><td>Mbale RRH</td><td>18.6</td><td>18.3</td><td>19.8</td></tr>
<tr><td>Moroto RRH</td><td>19.0</td><td>19.1</td><td>19.2</td></tr>
<tr><td>Tororo GH</td><td>19.6</td><td>19.1</td><td>19.3</td></tr>
<tr><td>Mukuju HC IV</td><td>19.4</td><td>18.1</td><td>19.6</td></tr>
<tr><td>Average</td><td>18.7</td><td>18.8</td><td>18.9</td></tr>
</table></td></tr>
</table>

3）Achievements of Overall Goal

【Overall Goal】

The delivery of health care services is improved through effective and efficient utilization of available health infrastructure.

Achievements based on the report from the End-line Impact Assessment Report and Survey by the 5S expert.

<table>
<tr><th>Verifiable Indicators</th><th>Achievement Status</th></tr>
<tr><td>1. Level of client satisfaction</td><td>In RRHs, the patient satisfaction I terms of “provider’s attitude towards patient” and “waiting time” was improved from the result of the baseline survey. However, from the comparison of the result between 10 RRH implementing 5Sand 3 RRH as non-implementers, significant difference was not identified on patient satisfaction.
Also in GHs, the patient satisfaction was improved from the result of the baseline survey. And it was identified that the 5S intervention contributed the improvement of the patient satisfaction from the comparison of the result between target group and control group.</td></tr>
<tr><td>2. Waiting time of patients for consultation, clinical examination and prescription of drugs</td><td>In RRHs, waiting time in both the OPD and the dispensary were improved from the result of baseline survey. Especially significant effect of 5S practice was shown in the dispensary of 10 RRH implementing 5S.
In GHs, waiting time in the dispensary was improved from the result of the baseline survey. Also the effect of 5S on the waiting time was identified in the OPD.</td></tr>
<tr><td>3. Attendance at outpatient department</td><td>Attendance at outpatient department as follows
<table>
<tr><th></th><th>2012</th><th>2013</th><th>2014</th></tr>
<tr><td>Arua RRH</td><td>72,572</td><td>166,309</td><td>171,639</td></tr>
<tr><td>Entebbe GH</td><td>115,276</td><td>152,220</td><td>164,076</td></tr>
<tr><td>Hoima RRH</td><td>42,352</td><td>51,011</td><td>203,011</td></tr>
<tr><td>Kabale RRH</td><td>109,982</td><td>169,430</td><td>215,510</td></tr>
<tr><td>Lira RRH</td><td>172,745</td><td>56,156</td><td>98,153</td></tr>
<tr><td>Masaka RRH</td><td>96,280</td><td>81,995</td><td>91,593</td></tr>
<tr><td>Mbale RRH</td><td>44,555</td><td>48,939</td><td>48,642</td></tr>
<tr><td>Moroto RRH</td><td>88,648</td><td>71,508</td><td>71,844</td></tr>
<tr><td>Tororo GH</td><td>55,004</td><td>61,260</td><td>65,223</td></tr>
<tr><td>Mukuju HCIV</td><td>22,104</td><td>24,312</td><td>27,203</td></tr>
<tr><td>Average</td><td>81,952</td><td>88,314</td><td>1,15,689</td></tr>
</table></td></tr>
</table>

4. Number of blood test done at laboratory

Number of blood test done at laboratory are as follows

	2012	2013	2014
Arua RRH	8,657	15,010	11,652
Entebbe GH	4,843	6,450	8,043
Hoima RRH	7,667	7,652	8,289
Kabale RRH	13,358	12,793	14,861
Lira RRH	10,756	12,901	41,453
Masaka RRH	23,371	17,147	14,808
Mbale RRH	5,220	4,060	7,347
Moroto RRH	10,201	7,583	8,271
Tororo GH	23,867	23,518	29,094
Mukuju HC IV	3,888	6,001	7,698
Average	**11,183**	**11,312**	**15,152**

5. Number of patients X-rayed

Number of patients X-rayed are as follows

	2012	2013	2014
Arua RRH	1,300	5,096	1,307
Entebbe GH	3,368	4,775	4,904
Hoima RRH	4,206	2,298	4,305
Kabale RRH	1,237	5,257	7,838
Lira RRH	3,379	6,443	3,196
Masaka RRH	2,417	4,726	3,194
Mbale RRH	1,178	680	1,705
Moroto RRH	2,701	2,743	0
Tororo GH	0	0	0
Mukuju HC IV	0	0	0
Average	**1,979**	**3,202**	**2,645**

6. Number of patients scanned

Number of patients scanned are as follows

	2012	2013	2014
Arua RRH	1,660	1,915	2,724
Entebbe GH	3,444	4,701	561
Hoima RRH	4,526	0	0
Kabale RRH	2,348	4,987	5,894
Lira RRH	4,124	6,345	2,347
Masaka RRH	2,416	4,101	5,407
Mbale RRH	202	458	1,601
Moroto RRH	2,691	1,507	0
Tororo GH	693	1,071	1,493
Mukuju HC IV	14	19	28
Average	**2,212**	**2,510**	**2,006**

<table>
<tr>
<td>7. Number of hospitals conducted 5S training by Regional Facilitator in the whole country</td>
<td>・August 2011：None

・March 2013：None
*Counting only those not the home hospitals of the facilitators

・November 2014：2 facilities
<table>
<tr><th>Hospital</th><th>Facilitator's Hospital</th><th>Outline</th></tr>
<tr><td>Masaka RRH</td><td>Masaka RRH</td><td>October 2014
Participants invited from surrounding facilities and trained.</td></tr>
<tr><td>Nebbi GH</td><td>Arua RRH</td><td>October 2014
Training of Nebbi GH by Arua RRH</td></tr>
</table>
</td>
</tr>
<tr>
<td>8. Number of hospitals in the country which are implementing 5S activities</td>
<td>・August 2011: 15 facilities
National Showcase：Tororo GH
Target Hospital：Mbale RRH、Entebbe HCⅣ
Non-Target hospital：Soroti RRH、Bududah GH、Bugiri GH、Busolwe GH、Kapchorwa GH、Masafu GH、Gombe GH, Mulanda HCⅣ、Nangongera HCⅣ、Busia HC Ⅳ、Mubende RRH

・March 2013: 22 facilities (7 added)
Target Hospital：Masaka RRH、Kabale RRH、Hoima RRH、Arua RRH、Lira RRH、Moroto RRH、Gulu RRH

・November 2014: 25 facilities（3 added）
Non-Target hospital：Jinja RRH、Mbarara RRH、Naguru RRH</td>
</tr>
<tr>
<td>9. Number of target health facilities which started CQI activities *
* These CQI activities are conducted in some units, not whole the health facilities.</td>
<td>・August 2011: None.

・March 2013: 2 Hospital
Target Hospital: Entebbe GH (Maternity and Infant Ward)
National Showcase：Tororo GH

・November 2014：3 hospitals (1 hospital facility added)
Target Hospital：Mbale RRH(Endoscopy、Masaba Ward)</td>
</tr>
</table>

3. Project Implementation Plan and Results

See attached Annex3-1 for the result of implementation plan.

4. Inputs

4-1 Dispatch result of JICA Experts

The following table summarizes the dispatch results of JICA Experts.

Table 4-1：Dispatch Results of JICA Experts.

Name/Designation	Year	Period of Dispatch	Days	MM	Expected Work
Kazuhiro Abe Chief Advisor / Health System	1	2011/8/9 ～ 2011/9/12	35	1.17	Supervise project Management.
		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	
		1st Year	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	
		2nd Year	104	3.47	
	3	2014/4/22 ～ 2014/5/14	23	0.77	
		3rd Year	23	0.77	
		Total	**272**	**9.07**	
Hiroshi tasei 5S-CQI-TQM(1) / Vice Chief Advisor	1	2011/10/3 ～ 2011/11/6	35	1.17	In charge of Output 1: 5S-CQI-TQM. Support Chief Advisor to efficiently manage the project.
		2012/1/11 ～ 2012/5/15	126	4.20	
		2012/6/12 ～ 2012/8/19	69	2.30	
		1st Year	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	
		2nd Year	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	
		3rd Year	193	6.43	
		Total	**754**	**25.13**	
Toru Yoshikawa 5S-CQI-TQM(2)	1	2011/10/26 ～ 2011/11/6	12	0.40	Expert of Output 1: 5S-CQI-TQM.
		2012/4/21 ～ 2012/5/6	16	0.53	
		2012/7/21 ～ 2012/8/6	17	0.57	
		1st Year	45	1.50	
	2	2013/4/20 ～ 2013/5/6	17	0.57	
		2nd Year	17	0.57	
	3	派遣なし	0	0.00	
		3rd Year	0	0.00	
		Total	**62**	**2.07**	
Yasuhiro Hiruma User Training	1	2011/8/9 ～ 2011/9/22	45	1.50	In charge of Output 2: User Training.
		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	
		1st Year	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
				2nd Year	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
				3rd Year	135	4.50
				Total	**612**	**20.40**
Naoki Mimuro Maintenance of ME (1)	1	2012/1/28	～	2012/3/30	63	2.10
		2012/6/12	～	2012/8/7	57	1.90
				1st Year	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
				2nd Year	148	4.93
	3	2014/5/3	～	2014/6/22	51	1.70
		2014/10/6	～	2014/11/25	51	1.70
				3rd year	102	3.40
				Total	**370**	**12.33**
Shigetaka Tojo Maintenance of ME (2)	1	2011/9/7	～	2011/11/5	60	2.00
		2012/4/13	～	2012/7/11	90	3.00
				1st Year	150	5.00
	2	2012/10/20	～	2012/12/15	57	1.90
		2013/4/29	～	2013/6/14	47	1.57
				2nd Year	104	3.47
	3	2014/2/2	～	2014/3/6	33	1.10
				3rd Year	33	1.10
				Total	**287**	**9.57**
Naoki Take Impact Assessment	1	2011/8/9	～	2011/9/19	42	1.40
		2011/10/6	～	2011/11/3	29	0.97
		2012/1/21	～	2012/3/29	69	2.30
				1st Year	140	4.67
	2	2013/2/9	～	2013/5/24	105	3.50
		2013/9/14	～	2013/10/13	30	1.00
				2nd Year	135	4.50
	3	2014/2/22	～	2014/5/14	82	2.73
		2014/8/3	～	2014/9/9	38	1.27
				3rd Year	120	4.00
				Total	**395**	**13.17**
Akie Nawa Training Coordinator /Assistant 5S-CQI-TQM	1	2012/1/11	～	2012/2/20	41	1.37
		2012/6/24	～	2012/8/11	49	1.63
				1st Year	90	3.00
	2	2013/1/28	～	2013/3/3	35	1.17
		2013/8/4	～	2013/9/12	40	1.33
				2nd year	75	2.50
	3	2014/2/11	～	2014/3/2	20	0.67
		2014/7/12	～	2014/8/11	31	1.03
				3rd Year	51	1.70
				Total	**216**	**7.20**
Kazunori Iijima Coordinator / Assistant Training Coordinator	1	2011/8/9	～	2011/9/12	35	1.17
		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
				1st Year	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
				2nd Year	130	4.33
	3	派遣なし			0	0.00
				3rd Year	0	0.00
				Total	**285**	**9.50**

Satoko Irisawa Coordinator / Assistant Training Coordinator	1	派遣なし	0	0.00	Support training coordination. Coordinate project management.
		1st Year	0	0.00	
	2	2013/10/20 ～ 2013/11/21	33	1.10	
		2nd Year	33	1.10	
	3	2014/2/18 ～ 2014/3/20	31	1.03	
		2014/4/19 ～ 2014/5/17	29	0.97	
		3rd Year	60	2.00	
		Total	**93**	**3.10**	
		1st Yea Sub-Total	1300	43.33	
		2nd Year Sub-Total	1329	44.30	
		3rd year Sub-Total	717	23.90	
		Grand Total	**3346**	**111.53**	

4-2 Record of Training in Japan and Third Countries

The following table summarizes the counterparts who attended JICA conducted training in Japan and third countries.

Table4-2: Attendants of Training in Japan and third countries.

Training in Japan

Name	Designation	Course Title	Training Period	Place
Dr.Stuart Musisi	DH, Masaka Local Government	Health Systems Management	2011/5/5 2011/7/9	Tokyo
Dr.Francis Mulwany	Hospital Director, Hoima RRH	Hospital Management（A）	2011/9/7 2011/11/12	Kyusyu
Mr.Joseph Kisubi	PHA, Kabale RRH	Hospital Management（A）	2011/9/7 2011/11/12	Kyusyu
Dr.Isaac Kadowa	PMO, QAD, MOH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B)	2011/10/16 2011/11/5	Tokyo
Ms.Dorothy Ajiambo	Senior Clinical Officer, 5S manager, Tororo GH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B)	2011/10/16 2011/11/5	Tokyo
Ms.Beatrice Alupo	PNO, Nursing Department, MOH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B)	2011/10/16 2011/11/5	Tokyo
Ms.Josephine Ejang	NO, Mulago National Referral Hospital	Quality Improvement of Health Services by 5S-KAIZEN-TQM(B)	2011/10/16 2011/11/5	Tokyo
Dr.Ben Ayiko	MS, Entebbe GH	The Specialist in Healthcare Associated Infection Control and Prevention	2011/11/1 2011/11/26	Tokyo
Dr.Henry Mwebesa	Commissioner QAD, MOH	Health Policy Development	2012/1/15 2012/1/28	Tokyo
Dr.Bernard Odu	Hospital Director, Arua RRH	Evidence-Based Public Health:Concepts,Approaches and Tools for Health Policy and Planning	2012/1/17 2012/2/25	Okinawa
Dr.Mihayo Placid	Hospital Director, Kabale RRH	Health Systems Management	2012/5/17 2012/7/21	Tokyo
Dr.Andema Alex	Hospital Director, Moroto RRH	Hospital Management（A）	2012/9/10 2012/11/10	Kyusyu
Ms.Drajea Hellen Iraku	NO, Arua RRH	Nursing Management	2012/8/29 2012/11/17	Tokyo
Dr.Osinde Michael Odongo	Hospital Director, Jinja RRH	The Specialist in Healthcare Associated Infection Control and Prevention	2012/11/6 2012/12/1	Tokyo
Ms.Anguparu Maburuka	Public Health Nurse, Jinja RRH	The Specialist in Healthcare Associated Infection Control and Prevention	2012/11/6 2012/12/1	Tokyo

Ms.Mwebaza Enid Mbabazi	Acting Commissioner, Nursing, MOH	Health Policy Development	2013/1/20 2013/2/2	Tokyo
Mr. ABDALLAH Muhammed	Engineering Technician, Mbale RRH	Medical Equipment Maintenance(A)	2013/6/2 2013/8/15	Tokyo
Mr. KUSIIMA Noah Mawaggali	Engineering Technician, Hoima RRH	Medical Equipment Maintenance(A)	2013/6/2 2013/8/15	Tokyo
Ms. KYAZIKE Margaret	NO, Midwife, Mubende RRH	Nursing Management of Maternal and Child Health Nursing for African Countries	2013/6/12 2013/8/10	Tokyo
Ms. NABULIME Sarah	S.H.A., Bugiri GH	Hospital Management(A)	2013/6/16 2013/8/14	Tokyo
Dr. OUNDO Christopher	MS, DHO, Masafu GH, Busia DLG (Mr.)	Health Systems Management	2013/6/20 2013/7/13	Tokyo
Dr. SSENDYONA Martin	SMO, QAD, MOH (Mr.)	Health Systems Management	2013/6/20 2013/7/13	Tokyo
Ms. NABAWANUKA Doreen Arison	Head Nurse, Infection Prevention and Control, Nursing Dept., Mulago NRH	The Specialist in Healthcare Associated Infection Control and Prevention	2013/7/16 2013/8/10	Tokyo
Ms. ASIIMWE Annet	Coordinator of CME/Registered Nurse, Mulago NRH	The Specialist in Healthcare Associated Infection Control and Prevention	2013/7/16 2013/8/10	Tokyo
Sr. TIBIWA Florence	Vice Nursing Director, SNO, 5S Manager, Gombe GH	Nursing Management	2013/9/4 2013/11/16	Tokyo
Ms. OYELLA Josephine	Head of Pharmacy, St. Mary's Hospital Lacor	Hospital Pharmacy - for Hospital Pharmacists	2013/10/2 2013/11/7	Tokyo
Dr. OPAR Bernard Toliva	PMO, MOH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(A)	2013/11/24 2013/12/7	Tokyo
Ms. ASEGE Jesca Janice	SNO, Mbale RRH	Quality Improvement of Health Services by 5S-KAIZEN-TQM(A)	2013/11/24 2013/12/7	Tokyo
Dr. ACENG Jane Ruth	Director General Health Services, MOH	Health Policy Development	2014/1/19 2014/2/1	Tokyo

Training in Third Countries

Name	Designation	Course Title	Training Period	Place
Ms.Alupo Beatrice	SNO, Nursing Department, MOH	Total Quality Management for Health Care Facilities for Africa	2010/1/9 2010/1/30	Egypt
Dr.Ssendyona Martin	SMO, QAD, MoH	Total Quality Management for Health Care Facilities for Africa	2010/1/9 2010/1/30	Egypt
Ms.Ateng Florence Sophia	PNO, Lira RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Mr.Opete Andrew	MS, Tororo GH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Ms.Kagwa Jaqueline	SNO, Kabale RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Ms.Mutonyi Walimbwa Roselyn	SNO, Entebbe GH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Ms.Aluo Anne Grace	NO, Moroto RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Ms.Auma Winfred	CO, Masaka RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Ms.Busulwa Nakasinde Christine	NO, Hoima RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Ms.Naikesa Florence Idah	NO, Mbale RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt
Ms,Driwaru Rukia Haruna	NO, Arua RRH	Total Quality Management for Health Care Facilities for Africa	2012/1/8 2012/1/30	Egypt

Mr.Onyanga Geoffrey	NO, Kapchorwa GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2012/5/7 2012/5/11	Tanzania
Ms.Kezaabu Sylivia	SHA, Busolwe GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2012/5/7 2012/5/11	Tanzania
Ms.Kiboko Olobo Petua	SPNO, Lira RRH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2012/5/7 2012/5/11	Tanzania
Dr.Opar Bernard Toliva	PMO, Clinical services Department, MOH	5S-KAIZEN-TQM Observation trip to Tanzania	2012/9/24 2012/9/28	Tanzania
Sr. Draru Jessica	NO, Arua RRH	5S-KAIZEN-TQM Observation trip to Tanzania	2012/9/24 2012/9/28	Tanzania
Dr. SSENDYONA Martin,	SMO, QAD, MOH (Mr.)	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	Tanzania
Ms. ALAYO Mary Hellen,	NO, Tororo GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	Tanzania
Sr. MASETE Metuwa Sarah,	NO, Mbale RRH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	Tanzania
Mr. MUHWEZI Patrik,	Anesthetic Officer, Masafu GH	ToT on Continuous Quality Improvement(CQI)-Kaizen Approach	2013/5/6 2013/5/10	Tanzania
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	Sub-Sahara Africa
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	Sub-Sahara Africa
Mr. ASUTAKU Butti Ben,	Laboratory Technologist, Mulago NRH	Infectious Diseases: Updates in Laboratory Diagnosis (ICCI)	2013/11/17 2013/12/17	Egypt
Mr. OGWOK Patric,	Principal Lanoratory Technologist, Mubende RRH	Infectious Diseases: Updates in Laboratory Diagnosis (ICCI)	2013/11/17 2013/12/17	Egypt
Ms. MIREMBE Violet,	Nursing Officer, Mubende RRH	Women's Health across the Lifespan	2014/1/12 2014/2/20	Egypt
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	Egypt
Ms. IMAET Faith Karakacha,	Nurse, Tororo GH	Total Quality Management for Health Care Facilities for Africa	2014/2/9 2014/2/27	Egypt
Mr. OJWANG James,	Hospital Administrator, Tororo GH	Total Quality Management for Health Care Facilities for Africa	2014/2/9 2014/2/27	Egypt
Ms. AKELLO Christine,	Nursing Officer, Lira RRH	Total Quality Management for Health Care Facilities for Africa	2014/2/9 2014/2/27	Egypt

4-3 Procured Materials

See Attached Annex 4-1 for the detail of the project procured materials.

4-4 Overseas Activities Cost

The table below summarizes the overseas activities cost of the project

Table4-3: Overseas Activities Cost

	1st Project Year Jul. 2011 - Sep. 2012	2nd Project Year Sep. 2012 - Jan. 2014	3rd Project Year Jan. 2014 - Jan 2015	**Total**
Local Activities Cost	JPY 14,014,000	JPY 25,389,000	JPY 16,322,000	**JPY 55,725,000**
Procured Material	JPY 5,073,000	JPY 0	JPY 0	**JPY 5,073,000**
Office Material	JPY 361,000	JPY 0	JPY 0	**JPY 361,000**
Local Consultant	JPY 5,480,000	JPY 6,271,000	JPY 6,789,000	**JPY 18,540,000**
Grand Total	JPY 24,928,000	JPY 31,660,000	JPY 23,111,000	**JPY 79,699,000**

5. Notes of the Project Management

1）PR Activities

The project utilized bulletin boards in MOH Headquarters to publicly open the 5S good practices, the result of ME inventory and the result of UT post-test. It had a certain impact for the project to be known widely to obtain buy-in by the stake holders on the project activities.

2）Collaboration with Grant Aid Project

In June 2012, Japanese Government granted new medical equipment and new ward building to Masaka RRH which is one of the project sites. The project made efforts to strengthen ties with grant aid project to efficiently support the government of Uganda in both hard and soft aspects.

3) Close communication with counterparts

Project office had not been opened in MOH headquarters for fifteen months since the project commenced. Though it was a challenge for the JICA experts to frequently see MOH counterparts, the project team put efforts on close communication with utilizing Email and cell phone. The project hired local coordinator who acted as a mediator between both parties.

4) Scheduling

Schedule was well adjusted in the project period hence coordinating appointment for both parties was a slight challenge. Through the project period, the project team intended to dispatch at least one of the Chief Advisor, the Vice Chief Advisor or Coordinator as possible to efficiently manage the project activities.

5) Modifying Project Implementation Plan

After the project commenced, it was found that some precondition was different from which was reported by detailed planning survey team. To achieve the overall goal and project purpose, the government of Uganda and JICA had close discussion to flexibly adjust the PDM and project implementation plan based on the current situation.

6. Changes in PDM

At the end of the project period, the project team utilizes the PDM Ver. 4. The table below summarizes the major change in PDMs from Ver. 1 to Ver. 4. See attached 6-1 ~ 4 for more information.

Table6-1: Changes in PDM

	Period of Confirmation	Main Changes made
PDM Ver.1	1st JCC Sept 2011	-
PDM Ver.2	Not Approved	Indicators of overall Goal, project purpose and outputs were modified.
PDM Ver.3	3rd JCC October 2012	Indicators of overall Goal, project purpose and outputs were modified. Some activities were modified or deleted concerning the current situation.
PDM Ver.4	4th JCC May 2013	Project sites were stated clearly. Set numerical targets on project purpose andoutputs.

7. Record of Joint Coordination Committee

The project conducted in total seven JCC meetings in the project period. The table below summaries the main topics of each JCC. See attached Annex6-1 ~ 7 for detailed information.

Table6-2: Record of JCC

	Date	Topics
1st JCC	September 2011	● Explain the Inception report ● Discuss the implementation plan of 1st project year
2nd JCC	March 2012	● Reading Previous Minutes and Matters Arising ● Report of the progress of activities in the 1st project year ● Explain Draft PDM Ver.2
3rd JCC	October 2012	● Reading Previous Minutes and Matters Arising ● Report of the progress of activities in the 1st project year

		● Discuss the implementation plan of 2nd project year ● discussion and confirmation of PDM Ver.3
4th JCC	May 2013	● Reading Previous Minutes and Matters Arising ● Report of the progress of activities in the 2nd project year ● Report of the Mid-term Review and minutes signing ceremony ● discussion and confirmation of PDM Ver.4
5th JCC	November 2013	● Reading Previous Minutes and Matters Arising ● Report of the progress of activities in the 2nd project year ● Discuss the implementation plan of 3rd project year
6th JCC	May 2014	● Reading Previous Minutes and Matters Arising ● Report of the progress of activities in the 3rd project year ● Report of the Terminal Evaluation and minutes signing ceremony
7th JCC	November 2014	● Reading Previous Minutes and Matters Arising ● Report of the progress of activities in whole project period ● Report of the achievement of PDM Indicators

ANNEXES

Implementation Schedule

JPY2011 | JPY2012 | JPY2013 | JPY2014

1st Implementation Year | 2nd Implementation Year | 3rd Implementation Year

= Plan
= Actual

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

Annual planning, evaluation

PR Activities

Revise Implementation Plan

Develop Ic/R draft

Explain and discuss Ic/R

Prepare project office

Impact Assessment Survey

1-1 To promote 5S-CQI-TQM activities at national level

1 To establish the project team for 5S-CQI-TQM activities

2 To disseminate 5S-CQI-TQM concept for key stakeholders through Tororo GH as a national showcase

3 To support harmonization and integration with other quality improvement programs

4 To develop national guidelines for implementation of 5S-CQI-TQM activities with consideration for quality improvement framework in Uganda

5 To develop training manuals for 5S-CQI-TQM activities

6 To develop monitoring and supervision framework (including awarding system) for 5S-CQI-TQM activities

7 To conduct training for national facilitators for 5S-CQI-TQM activities

8 To conduct monitoring and supervision of 5S-CQI-TQM activities at selected hospitals in each target region

9 To review and evaluate the results of 5S-CQI-TQM activities based on activity 1.1.8

10 To hold regular meeting for selected hospitals to share their progress for 5S-CQI-TQM activities and for awarding by MOH

11 To revise 5S-CQI-TQM guidelines and manuals based on the reviewing activities

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

1-2 To promote 5S-CQI-TQM at regional level

1 To identify selected hospitals in each target region and selected HC IVs in model region

2 To disseminate 5S-CQI-TQM concept for key stakeholders at each target regional level through introducing model hospital (i.e. Tororo hospital)

3 To conduct TOT for regional facilitators for 5S-CQI-TQM activities by national facilitators

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 To establish coordination structure for 5S-CQI-TQM (e.g. 5S committee, QI team) at each selected hospital and at each selected HC IV

2 To develop annual work plan for 5S-CQI-TQM activities at each target region, by necessary coordination with district

3 To procure necessary supplies for 5S-CQI-TQM activities at selected hospitals in each target region

4 To implement 5S-CQI-TQM activities in selected hospitals in each target region and selected HC IVs in model region

5 To conduct monitoring and supervision 5S-CQI-TQM activities within each selected hospital by the coordination structure established in activity 1-3-1

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

1 To include national and regional user trainers as participants for 5S-CQI-TQM training

2 To incorporate user training component into training manuals for 5S-CQI-TQM developed in activity 1-1-5

3 To involve national user trainers as facilitators in 5S-CQI-TQM TOT

2-2 To implement ME user training

1 To carry out needs assessment for ME user training

2 To review and prepare revised ME user training guidelines and manuals for selected ME

3 To select trainees in selected hospitals and DHO's staff for ME user training

4 To carry out ME user training for equipment users at selected hospitals and DHO's staff

5 To carry out support supervision and monitoring of ME user trainers in the selected hospitals and DHO's offices.

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

1 To assess current ME inventory and reporting mechanism

2 To revitalize ME inventory and reporting mechanism including necessary training

3 To collect and update ME inventory

4 To analyze ME inventory data and utilization of ME

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

1 To conduct TOT training on 5S-CQI-TQM for CWS and RWS managers and selected hospital based technicians

2 To implement 5S-CQI-TQM in CWS and RWSs

3 To incorporate ME in-charge into the coordination structure for 5S-CQI-TQM activities developed in activity 1-3-1

4 To strengthen the functioning of RWS Medical Equipment Maintenance Committees

3-3 To strengthen maintenance of ME by RWS

1 To review ME maintenance procedures and develop guidelines/manual for Medical Equipment Maintenance by RWS

2 To disseminate ME maintenance guidelines/manual to stakeholders in selected hospitals and HC Ivs

3 To plan and carry out routine ME maintenance

4 To carry out support supervision and monitoring use of the ME maintenance guidelines/manual

5 To train technicians/engineers in biomedical engineering

(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 - Maintenance of Medical Equipment - Impact Assessment	
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.		- Training Management - Coordinator	
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.			
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

Date: 24th October, 2012

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. 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		

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(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)
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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**	
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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.	*All to note*
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.	*All to note*
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*

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. 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. III) Noted that JCC meetings should be held twice a year. IV) The MOH should include the JCC meeting on its year planner.	*All to note* *MOH and JICA* *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*
Issues raised from the presentation:	
I) Members were of the view that a reason should be stated for removing Mulago National Referral Hospital from the training.	*All to note*
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.	*All to note*
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	*All to note*
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*
Modification regarding the indicators:	
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*
Reaction from the presentation:	
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:	*JICA*
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.	
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: 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.	*All to note* *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. VI) Observed that the actual ME inventory was not updated periodically, and thus needed to be considered. VII) Mr. Mimuro would get someone from the Resource Centre at MOH, with a	*JICA* *JICA & Eng.Sam Wanda*

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 — Ag. CHAIRPERSON

Agnes Batuvamu — 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).*	*Mr. Tojo /Mr. Mimuro ME experts*
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.	*MOH to note*
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.	*MOH/HIPAC to follow up*
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	

	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:

…….. ……

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:

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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 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	*ME & JICA Counterparts* *ME & JICA Counterparts* *ME, MOH* *ME, MOH*

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. 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. 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. 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. VIII. There should be a mechanism or system in place for continuous user training to maintain the equipment.	*UT & MOH counterparts* *Commissioner clinical Services* *UT & MOH counterparts* *ME, MOH*
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).* **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. 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.	*MOH* *MOH & UT counterparts*

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. 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.	*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.	*ME,MOH*
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	Agnes Batuvamu
CHAIRPERSON	**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.	*ME & 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:	**Action Column:**
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.	
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.	*5S & MOH counterparts* *All Directors & MOH* 5S & MOH counterparts All Directors & MOH
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, 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	UT & MOH counterparts
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. 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. ***Kabale RRH:***	ME & MOH

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. 10. The Registration Board of Engineering should be contacted or be written to about the structure that accommodates positions of Biomedical Engineer, technicians and	CWS & MOH

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
CHAIRPERSON

Agnes Batuvamu
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. XXII. Reported that Technicians were advised to always fully train users on equipment and should liaise with the suppliers of the equipment. XXIII. The Assistant Commissioner would remind the RWs Managers to keep joint field work trips with UTs. XXIV. The Commissioner Clinical Services would take up the issue to ensure funds for User training was catered for. XXV. Mbale RRH was designated as the Showcase and was doing well so far. XXVI. 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".*	
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.	*MOH*

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*	

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Dr. Amandua Jacinto — **CHAIRPERSON**

Agnes Batuvamu — **MINUTE SECRETARY**