Technical Report

独立行政法人国立国際医療研究センター
国際医療協力局

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保健人材開発システム分析モデルと開発途上国における活用

House Model-User's guide

NCGM

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1. はじめに

このテクニカルレポートで紹介するHouse modelは保健人材開発をシステムとしてとらえた場合の包括的な見取り図あるいは全体地図である。NCGM国際医療協力局の著者らがこれまでに関わった、カンボジア、アフガニスタン、コンゴ民主共和国（以下コンゴ民）といったいわゆる「紛争後国家」における国際保健医療協力の経験から生まれた。これらの国は、10 - 20年以上の内戦状態の結果、保健や医療だけではなく教育やインフラなど社会制度そのものが崩壊している。やらなければいけないことは山積みであることは誰もが承知しているが、援助側である我々が、実際にどこから何を支援することが効果的なのか、その判断を何に基づいてすればいいのか、といった疑問から出発した。緊急救援から開発援助に向けては、数多くの国際社会のドナーがその国や地域になだれ込み、援助機関主導で支援が実施されることが多い。受け入れ政府の能力、特に組織体制の弱体な省庁（保健省）や州・郡保健局、育成学校や病院・診療所といったあらゆるレベルにおいて能力のある保健人材の不足により受け入れ側のキャパシティが不足するなかで、受け入れ側の許容範囲を超えた金額が援助として流れていく。「人材が重要」と誰もが思い、研修を実施し、教育を支援する。ドナー調整が行われるとはいっても、往々にして支援は保健人材開発のなかの一部分に集中し、10年単位の視野でことを動かさなければいけないのにもかかわらず、関係者の誰もが全体を見渡すことなく、支援が効果的とはいえないことも多い。保健人材開発全体を見ながら、過不足のある部分を確認しつつバランスよく支援してくことが重要であろう、そのために包括的に全体を見渡し、関係者が共有できるようなものはないか、と考えたところから生まれたものである。

本テクニカルレポートではHouse Modelを具体的な活用例とともに解説した。例えば保健人材開発制度に対するアセスメント調査、5-10年の単位で変化あるいは成熟していく保健人材開発制度の変遷の記録、保健人材に関わる関係者分析への応用、保健人材研修への活用、などである。国際協力に携わる、あるいは関心のある人たちが手にとって利用できるものとなれば幸いである。

2. 保健人材開発とシステムの視点

保健人材は人々の健康を増進することを目的とした活動に関わる人々と定義され、専門教育を受けた専門職（医・歯・薬・看護助産・臨床検査・放射線・理学療法師など）の他に、事務職や保健ボランティアも含まれる[1)]。保健サービスを計画・運営管理し、提供する人材がいなければ、変化する健康課題に対応できる保健システムは機能せず、WHO 保健システムフレームワークで示され 6 つのブロックのひとつとして、保健人材は保健システム強化の文脈の中で重要な役割を果たしている[2)]。

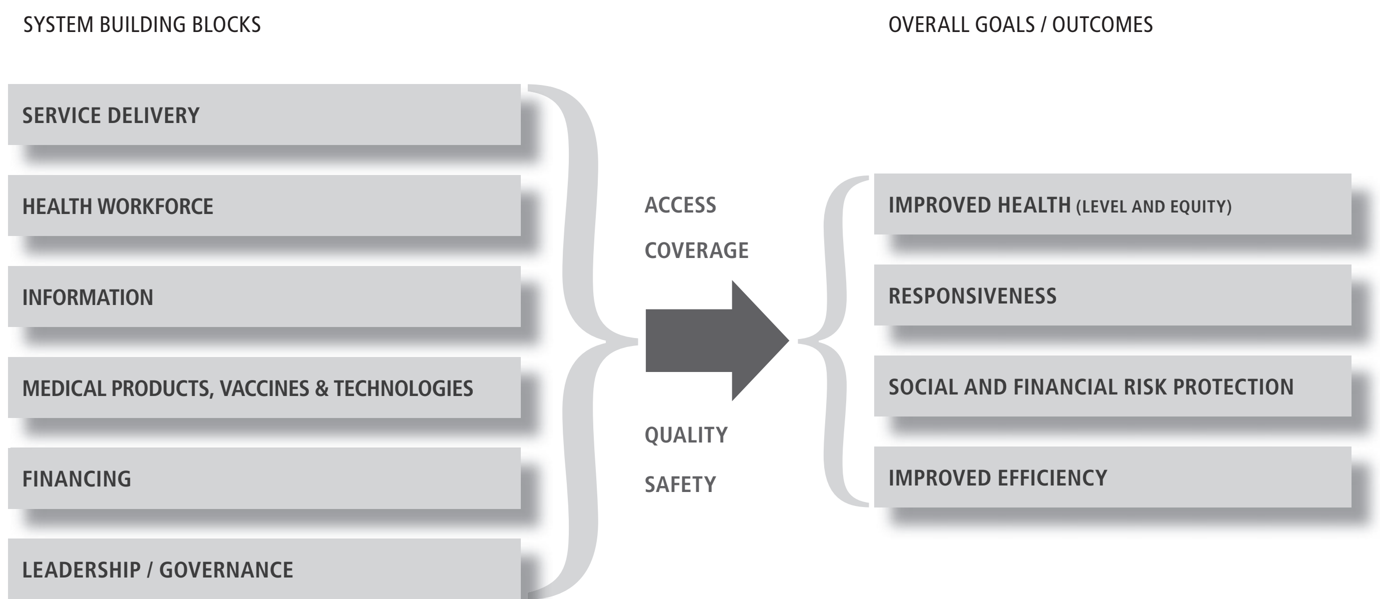


図 1　WHO six building blocks
出典：WHO (2007)Everybody's Business – Strengthening health systems to improve health outcomes. www.who.int/entity/healthsystems/strategy/everybodys_business.pdf

人材開発というと、いかに個人や組織の能力を高めるかといったキャパシティビルディングやエンパワーメントに関心が寄せられることが多い。実際にこれまでの国際協力の現状を見てみると保健人材を養成する学校の教育カリキュラム開発、現場で働く保健スタッフへの研修実施、保健サービス提供をモニターするためのスーパービジョン、学校や病院、保健局の運営組織開発に向けた支援、などが行われてきた。しかしいくら現場に適応可能な教育や実習カリキュラムを作っても卒業した人材の就職先がない、現場で働く保健スタッフの給与や待遇が悪いため研修が収入の一環となり研修に忙しくサービスの提供やその質の向上につながらない、といったことも往々にしておこっていたことである。個人や組織だけではなく、システムとして人材開発を包括的に、全体のバランスを見ることが、国際協力を実施する我々には忘れてはいけない視点と考えられる[3)]。

保健システムのサブシステムとして保健人材開発をどのように考えるかについてはいくつかのフレームワークが存在している。WHO は、保健人材システムの構成要素を時系列から見たステージとしてとらえ、図2のように表現した。すなわち適切な教育を受けた十分な数の人材が、適正に配置され、健康課題に対応できる十分な能力をもち続けサービスを提供できることが保健人材システムの機能している姿であり、それを達成するために、限られた資源をどのように公平に、効率的に活用するかということが取り組むべき対策となる[1)]。

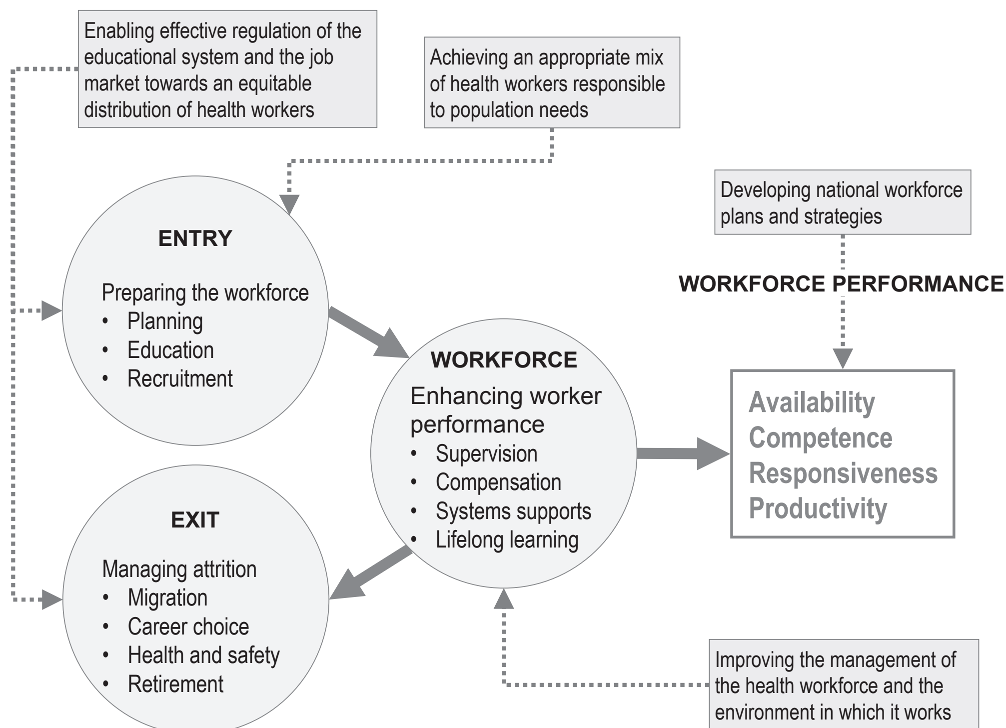


図 2　Stages of health workforce development
出典：WHO (2006). The World Health Report 2006 - Working together for health. http://www.who.int/whr/2006/en/index.html

この発展型として、GHWA、WHO、Capacity Project(USAID)はHRH Action frameworkを提唱している。これは、人材の不足や偏在、技術やコンピテンシー、定着やモチベーション、などといった保健人材に関する課題を明らかにし、政策決定者や組織のマネージャーたちが人材開発の戦略をたて、有効で持続可能な保健人材というゴールを達成するためにツールとして用いる包括的なフレームワークとされている。図3のように6つの分野（人材管理システム、リーダーシップ、パートナーシップ、財政、教育、政策）と4つのフェーズ（現状分析、計画、実施、モニターと評価）からなっていて、WHO西太平洋地域などでは国レベルでの国家人材開発戦略作成に利用されている。

しかし現場で保健省関係者とともに働く我々から見ると、HRH Action Frameworkは保健省関係者自らがツールとして用いるには抽象的であり、保健省の縦割り業務の中で、他者との情報共有の認識が薄い開発途上国では、Actionの基盤となる保健人材に関する現状を関係者が共有し、課題を明らかにすること自体が困難であるという印象であった。これらの分析フレームワークをもとに、保健省関係者自らが利用できるような、具体的でわかりやすいツールとして、筆者らの現場の経験を踏まえて開発したのがHouse Modelである。

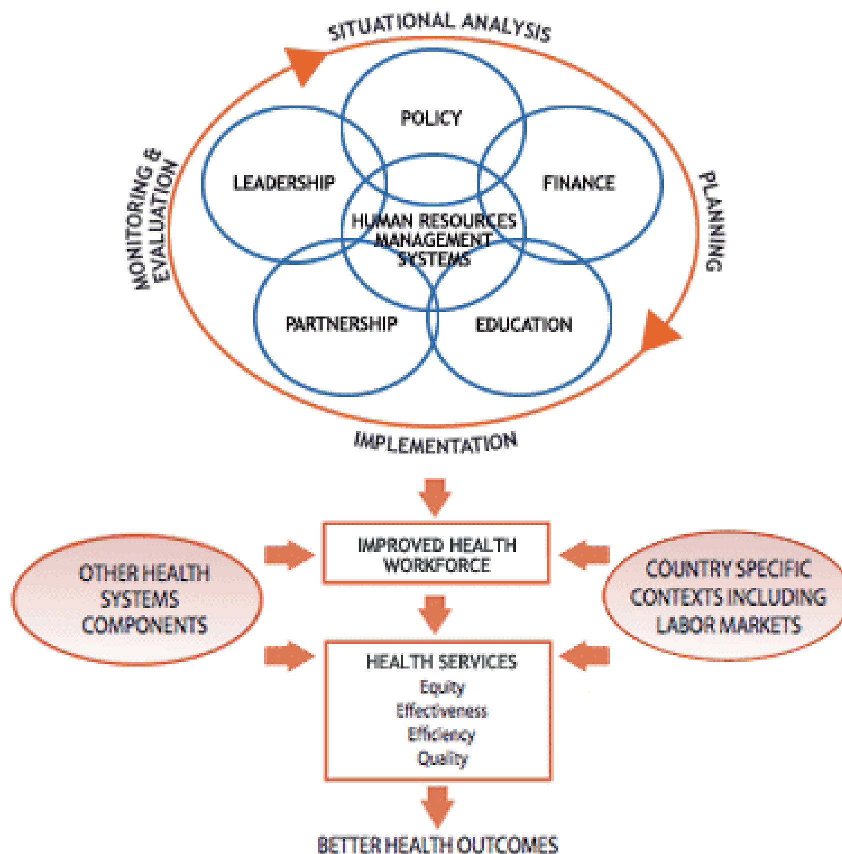


図3 Human Resource for Health Action framework (2009)
http://www.who.int/workforcealliance/knowledge/resources/haf/en/index.html

3. House Model とは

House Model とは保健人材開発システムを包括的にとらえるためのツール、分析の枠組みである。保健人材開発制度を包括的にとらえるために 11 の要素をもち、全体として「家」の形をとっているため、利用者がなじみやすいよう、House Model とニックネームをつけた。

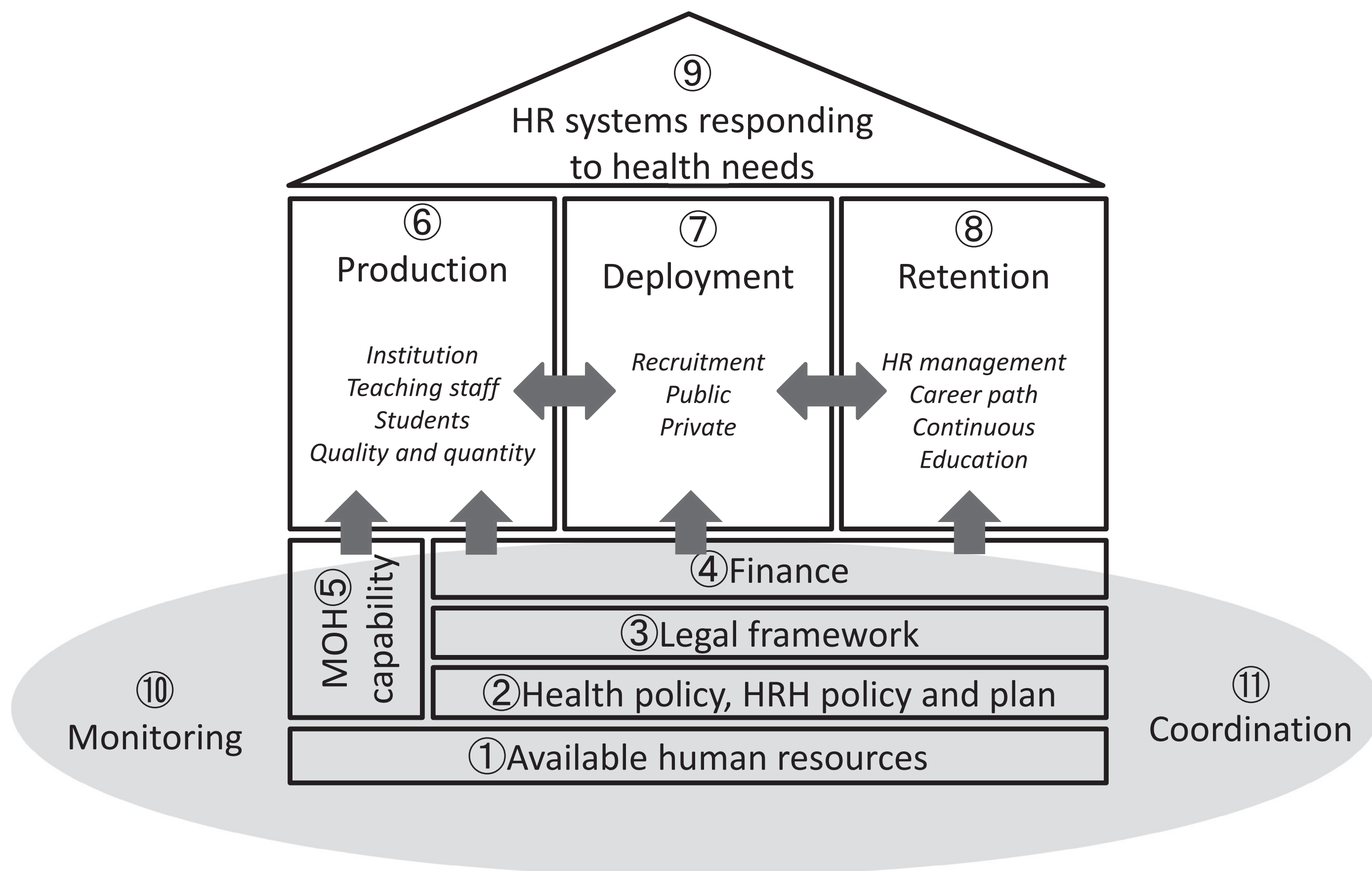


図 4　House Model
出典：Fujita N, Zwi AB, Nagai M, Akashi H (2011) A Comprehensive Framework for Human Resources for Health System Development in Fragile and Post-Conflict States. PLoS Med 8(12): e1001146. doi:10.1371/journal.pmed.1001146

以下、それぞれの構成要素について解説する。

① 保健人材の現状(Available human resources)

国レベルでの保健人材に関する課題は、政治社会文化的な環境、保健システムを構成する組織や資源、などによりさまざまである。分析の出発点は現状把握から始まるが、保健人材開発の場合も同様で、どのような教育を受けた人材がどこで何人、どのような状態で働いているのか、という基本情報の把握から始まる。特に、紛争後国家の場合、国内に残っている施設機材や人材、どの程度の教育や保健サービスが提供されているのかといった保健資源に関する情報は断片的にしかえられないため、復興支援の出来る限り早い段階で全国的に保健資源基礎調査を行うことが、政府や開発パートナーの方針を決定するために重要である。

② 保健政策・保健人材政策・保健人材開発計画(Health policy, HRH policy and plan)

国の保健システムの枠組みや方向性を定めるもの。世銀など開発パートナーの圧力もあり、近年多くの途上国は保健人材関連の重点政策や国家保健人材計画を策定している。

③ 法的な規制枠組み(Legal and regulatory framework)

保健人材に関する法的な枠組みとは、1)保健人材を定義し、その教育方法・登録免許・保健医療行為を規定する法規程が存在すること、そして、2)その法規定を制度(教育機関の認可、保健専門職の登録免許)として実施する仕組みが存在することをいう。保健医療行為は国民の健康を守る一方で、生命を危険にさらすこともありうるため、このような罰則も伴う規制によって保健人材の質を担保する必要がある。日本の場合は、医師法や保健師助産師看護師法に基づいて保健専門職としての免許制度が機能している。日本のように、政府が規制枠組みを作り監督する機能を持つ国がある一方で、プロフェッショナルとして独立性をもつ専門職カウンシルが法律を整備しこの制度を監督する国もある。多くの途上国では保健人材の数の確保が優先課題になっており、人材の質となると教育内容や卒後研修などに目が行きがちで、法的な規制枠組みによる人材の質の担保は忘れられがちである。

④ 財政(Finance)

保健人材に関する財政の主たるものは保健人材に対する給与や諸手当(病院や診療所で働くスタッフ以外にも教育機関や行政職事務職も含む)などの人件費があげられる。しかし、労務環境や待遇改善にかかる必要経費、保健医療施設や教育機関の運営資金なども含めて考える必要がある。

⑤ 保健省の能力(MOH capability)

現状把握(①)を踏まえて、家の土台となるのが②から④までである。これには中央政府の関連省庁(計画省、財務省、公務員省、など)が関わるが、中でも保健人材の Producer, User, Manager, Coordinator である保健省が、その中心的な役割を担う。人材開発制度を構築していくためには、政府内や関連団体との交渉も含めて保健省の能力がカギとなる場合が多い。

⑥ 養成(Production)

ここでは初等中等教育修了後の人材を保健人材として育てるために必要な基礎教育をさす。教育機関や教員・学生の数や質、教育内容カリキュラムなどがここに含まれる。

⑦ 配置(Deployment)

学校を卒業した保健人材が、公的・私的な診療施設や教育施設、そして行政機関などに配属されることをさす。教育年限の長い専門職(医師歯科医師など)になるほど都市部に残りたがる点は途上国だけではなく先進国でも共通で、郡部や

へき地に配置され、保健医療サービスを提供する保健人材の確保が課題となっている。

⑧　**定着（Retention）**

配置された保健人材が継続して働くことをさす。現在、世界の保健人材に関する大きな課題のひとつはへき地診療施設への配置と定着であり、影響を与える因子としては給与やへき地手当、子女教育手当などの福利厚生、施設機材薬剤などの労務環境改善、住宅など生活環境改善、継続教育による技能の維持、キャリアパスや昇進、などが考えられ、様々な対策が取られている。国内(公的セクターからプライベートやNGOへ)・国外（英語圏アフリカから南アフリカや欧米へ）への頭脳流出の課題の大きい国も多い。

⑨　**保健ニーズに応じた保健人材システム（Human resource systems responding health needs）**

保健課題も社会の変化とともに変化する。限られた資源を有効に活用するためには保健の優先課題に応じた保健人材システムを構築していくことを考える必要がある。活用例にも示したが、アフガニスタンやカンボジアでは妊産婦死亡削減に対して助産師に焦点を当てたシステムを作り、これが他の職種や他の課題にも応用可能であることが示された。母子保健の指標が改善し生活習慣病が課題となってくる国もあり、栄養士や理学療法士など新たな職種や予防に関わる新たなサービス提供の形に対応した保健人材のシステムを考慮する必要が出てくるであろう。

⑩　**政策計画の実施モニター（Monitoring）**

現状分析を踏まえて立案された保健人材政策や人材開発計画（Health Workforce Plan）を実施する際は、保健人材に関する情報を定期的に把握し、その推移を分析することが必要となる。これが「政策計画の実施モニター」である。保健の課題に応じて、政策計画の実施・推移の分析を繰り返すことで保健人材開発システムという「家」は形をなし、強固なものとして構築されていく。このためにも保健人材情報システム構築と強化は現在の課題の一つとなっている。

⑪　**関係者の調整（Coordination）**

国家予算以上に多くの予算を開発パートナーに頼らざるを得ない政府保健省関係者にとって、パートナーの投入を調整することは非常に重要な仕事である。保健人材に関する関係者として国際機関やNGOなどの他に忘れてはいけないのは、国内の関係者である。保健省を中心に見れば、政府の関係省庁(教育省、財務省、公務員省、計画省など)、教育機関があり、この他にも、職能団体、労働組合など国内関係者との情報共有や調整が必要となる。

House Modelは“保健人材開発システムという「家」を建てる”イメージである。家を構成する各要素、あるいは積み木のどこかが弱い、あるいは欠けていると家は強固なものにはならない。また積み木のつながりも考慮しないと、少しの揺れで崩れてしまう。特に家の土台となる部分（①—⑤）は基本的には政府、特に保健省の関わる部分であり、この土台の上に養成・配置・定着といった人材開発のステップが柱（⑥—⑧）として乗る。しっかりした土台、土台とそれぞれがつながりをもった柱、最終的なゴールとして保健ニーズに応じた人材システムという屋根（⑨）ができあがる。庭の部分にはこれらのすべての要素を調整し、家の完成具合をモニターしていくという機能（⑩、⑪）がしっかりした家を建てるために必要である。また以下の活用例（アフガニスタン）でも提示するが、往々にして投入や支援の集中する部分(たとえば養成（Production）のみがクローズアップされて、それにつながる人材の配置や定着など、忘れられがちである。

House model は上記 HRH Action Framework（図 3）と同様に包括的な分析フレームワークであり、共通の要素をふくんでいる。HRH Action Framework に比べて House Model に特徴的な点は、

・ 包括的な保健人材開発管理システムの具体的な 11 の要素を提示したこと
・ 各要素の関連やつながりは重要であるが忘れがちであるためこれを強調したこと
・ 法的枠組みのように必要なのに注目されにくい要素を加えたこと
・「家」という象徴的なモデルを使い、複雑な保健人材開発システムの概念を視覚的にもわかりやすく表現していること

である。

以下、House Model の具体的な活用例として、保健人材開発制度アセスメント調査、保健人材開発制度の変遷の記録、保健人材に関わる関係者分析への応用、研修への活用、を紹介する。

4. House Model の活用例

1）保健人材開発制度アセスメントとチェックリスト（資料 1，2）

ある国で保健人材に関する特定の課題（たとえば教育手法やカリキュラム、あるいは卒後研修など）に関わる前に保健人材開発制度全体を分析評価することは、その課題が他の課題と比べてどのような重要性を持っているのか、この課題に取り組むことへの妥当性を確認する意味でも基礎情報として重要である。House Model を用いた保健人材開発制度の包括的アセスメント（システムのスナップショット、即ち、ある時点におけるシステムの全体像を抽出する）の調査概要、チェックリストを紹介する。わかりやすくいえば、家を構成する各要素、あるいは積み木のどこが弱いかあるいは欠けているか、また積み木のつながりがしっかりしているかを調べる際に、この方法が利用できる。

【目的】保健人材開発システムの包括的な現状分析を行う

【手法】文献レビュー、キーインフォーマントインタビュー。分析フレームワークとして House Model を用いた。

【調査手順と留意点】

アセスメントのためのチェックリストは添付資料1に示したが、これは A guide to rapid assessment of human resources for health (WHO 2004)[4] を改変し、House Model に基づいて項目を整理しなおしたものである。House Model の要素ごとに網羅されている分、質問は相当数に上り、政策レベルから現場レベルまで質問の範囲も広く、質問の中には事実を確認するもの、インタビュー相手の認識を確認するもの、が含まれている。このチェックリストはインタビューの際の質問票ではなく、制度全体を見渡すために必要な情報のチェック項目のリストである。

手順として、まずは政策文書や報告書など入手可能な基本的な資料を入手し内容を確認し、インタビュー相手を確認する。チェックリストのすべての項目に答えられる人はいないため、インタビュー相手により入手できそうな情報を絞り、質問することが必要である。たとえば保健省中央の保健人材関連担当部署から始めて、教育機関関係者、開発パートナーなどキーインフォーマントの範囲を広げながら、関連資料をさらに入手できれば確認し、質問項目の情報を埋めていく。調査には時間的な制約もあるので、目的に応じてどのチェック項目が重要か優先順位をつけながら情報収集していくが、最終的にすべての項目をカバーできるとは限らない。限られた時間と可能な範囲で得られる情報ではあるが、全体を見渡したうえで House Model のどの要素が発達し、どの要素に強化が必要なのか、といった最終的な整理をして、スナップショットとする。例として別添資料 2 に 2009 年にカンボジアで実施した看護助産分野の保健人材開発制度調査報告書を添付した。実施当時の House Model は改良前のものであり、本テクニカルレポート執筆時のものとその構成要素や形は異なる。

2）アフガニスタンへの支援

アフガニスタンでは、20 年以上続いた内戦の後、国際社会の支援を得て、2001 年末より戦後復興に向けた取り組みが始まった。2002 年の全国保健資源調査で明らかになったのは、保健人材の絶対的な不足と、期間も内容も統一されない保健人材としての教育の質であった。特に世界的な妊産婦死亡の高さ（2000 年 MMR1900（出生 100,000 あたり））と女性医療スタッフ特に助産人材の不足（人口 50,000 人あたり助産師 1 名）が優先課題となり、2003 年から保健省とドナーの総力を挙げて、助産師教育標準カリキュラムの作成、教員研修、助産師教育の再開に取り組んだ。しかし保健省およびドナー関係者が教育だけに集中した開始当初は、都市部出身の卒業生は必要とされるへき地の保健センターへは就職したがらず、その結果、卒業生の就職率は 50%以下であった。この反省から卒業後の就職や定着を考慮し、へき地出身の学生のリクルートと奨学金、卒業後の出身地での就職先の契約制度を導入し、2008 年には育成された助産師数は 3 倍に増え、就職率も 74%と増加した。助産師教育すなわち人材の***＜養成＞***だけではなく、育成された人材の***＜配置＞***から***＜定着＞***へとつなげて包括的に人材開発を見る（House Model の育成配置定着の 3 つの柱をつなげる）ことで、支援が有効なものに変化した例である [3]。

3）カンボジアの人材開発制度の変遷

カンボジアでは内戦時代に保健人材を含む知識人の虐殺という特異な歴史（1975 ― 79 年）をもち、全国でほぼゼロに近くまで減少した保健人材の数の増加に取り組んだ。80 年代からは教育年数の少ない初級看護師助産師（1 年）、准医師（4 年）を育成し、郡部の病院保健センターへの配置が進められた。90 年代は国際社会の支援のもとに、保健セクターリフォームなどの様々な取組みの一環として保健人材の数の改善から質の改善への転換を行ってきた。しかし保健セクターリフォームによる保健施設数の増加、80 年代初めの新規大量採用者の定年退職により、質への転換とうまく合致せず、2000 年初頭には保健人材の中でも特に助産師の不足が課題となっていた。再度、助産師教育コースを増やすなどして数の増加を試みていたものの、2005 年には乳幼児死亡率に比べて妊産婦死亡率の停滞が課題として挙げられ、MDG 達成に向け妊産婦死亡削減が保健省優先課題***＜保健ニーズ＞＜政策計画＞***となった[7)8)]。助産師の数不足については、助産師教育コースの増加による新卒者増加***＜養成＞***だけではなく、様々な政策が次々と実施されていった。それは、へき地出身の学生のリクルートと奨学金・卒後へき地保健センターへの就職契約制度***＜配置＞***、公務員制度改革（公務員削減）にもかかわらず保健省は助産師のポストと給与を確保し***＜配置＞***、配置された新人助産師の技術的な支援なども合わせて実施し***＜定着＞***、2009 年には全国すべて

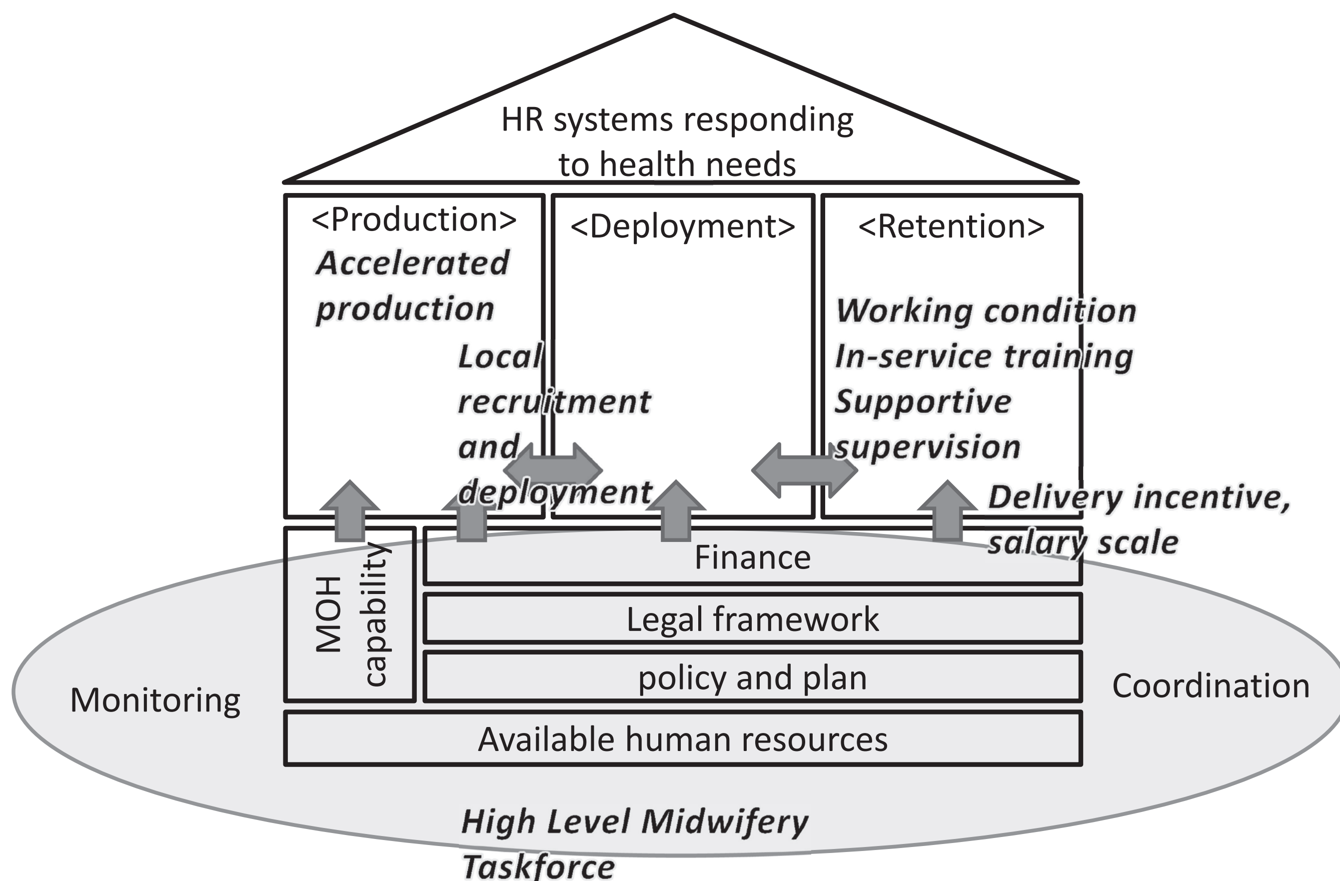


図 5　助産師関連の政策介入と House Model（カンボジア）

の保健センターに最低1人の助産師を配置し 24 時間サービスを実現させた***<モニター>***。保健センターを改修、機材薬剤を確保し***<定着>***、政府予算で病院保健センターに分娩報奨金（出産1人あたり 10-15ドル）の給付を開始、施設出産数増加が低給与のへき地勤務の助産師たちの収入増加につながった***<財政><定着>***。対象を助産師に集中し、House Model のすべての要素を考慮し、限られた資源を集中させた包括的な対策が次々と実施されていった（図 5)。これは保健省の強いリーダーシップのもと、財務省・公務員省などの関連政府機関とドナーを巻き込んだ High Level Midwifery Taskforce を通じて実現したものである***<保健省の能力><関係者の調整><モニター>***（図 6)。へき地保健センターでの 24 時間助産サービスの担保とともに、外的な要因として治安安定・経済発展・就学率の増加など社会的な要因もプラスに働き、技能職による出産介助へのアクセスは増加し、妊産婦死亡の改善につながったと評価されている（図 7）[9]。

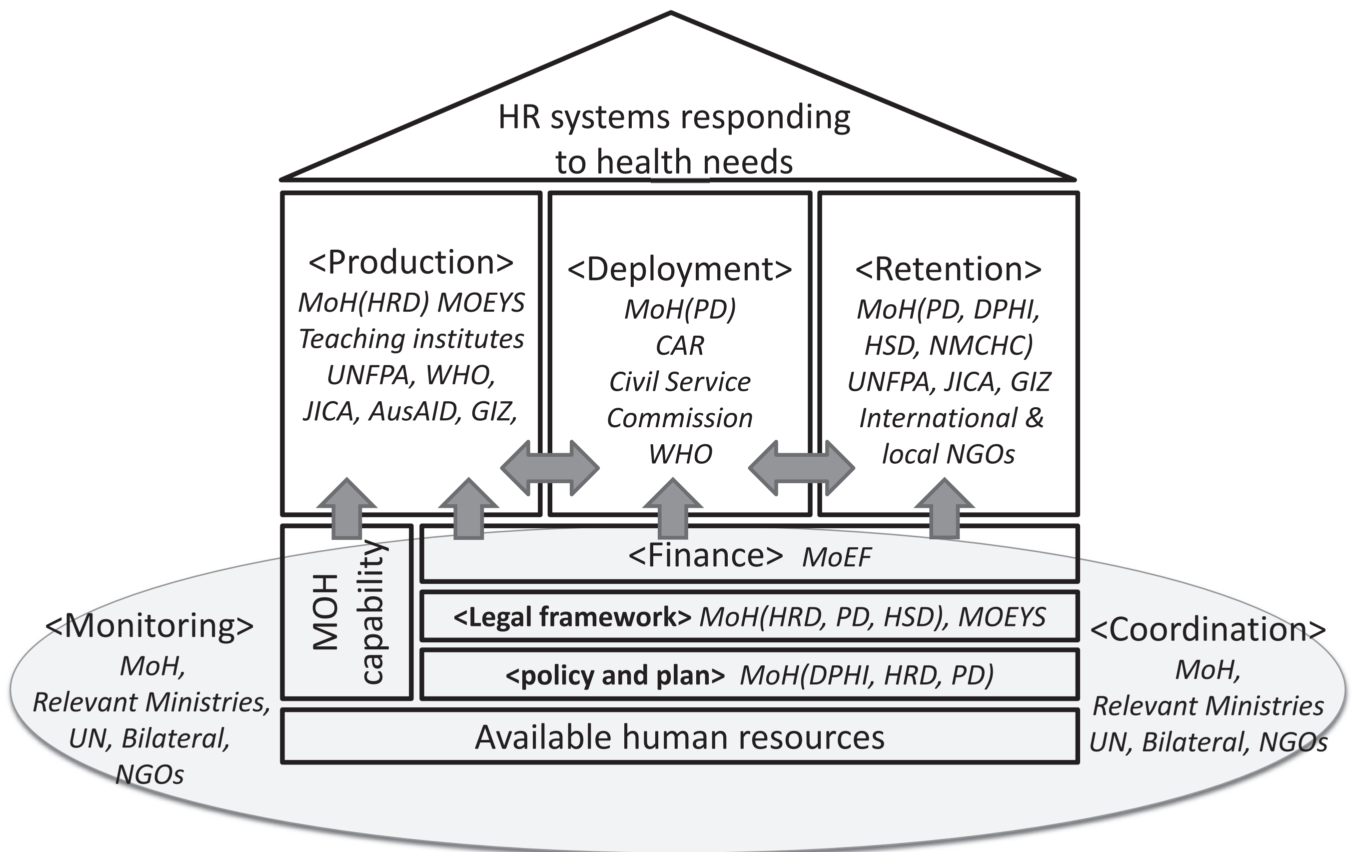
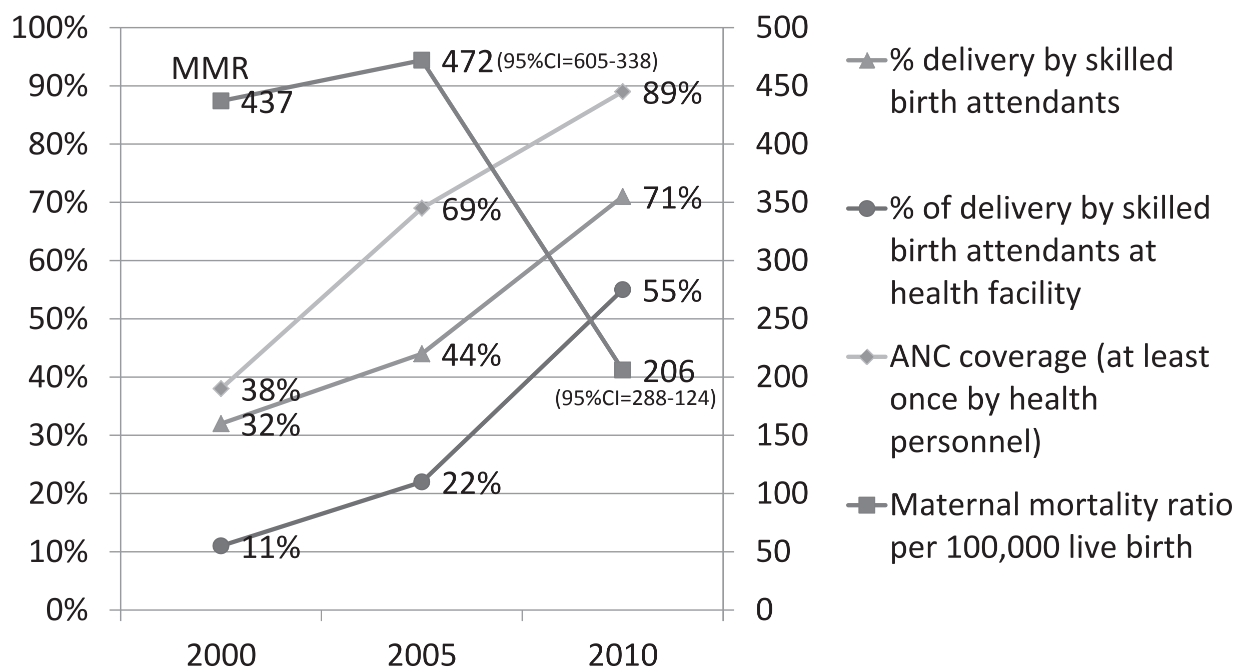


図 6 助産師関連の関係者マッピング（カンボジア）



Data source: Cambodia Demographic and Health Survey 2000, 2005, 2010

図 7　サービスへのアクセスと妊産婦死亡の推移（カンボジア）

一方で保健人材の質を担保するための規制の枠組みとその基本となる保健人材の定義・教育・免許・業務を記した法規程類の整備が 2000 年代後半にいたるまで取り残されていた***＜法的な規制枠組み＞***。2013 年現在、ASEAN 相互認証協定（MRA）による 2015 年からの域内の保健人材の移動の自由を目指してカンボジアでは国家試験と免許登録制度の整備が始まっており、JICA プロジェクトを通じて、NCGM はそのための基盤となる法規程制度整備支援に関わっている。2000 年初めまで公立校と公立病院診療所が中心だったカンボジアにおいては、House Model の土台の中の Legal Framework の部分は人材開発政策の中でも優先順位は高くなく、顧みる必要もあまりなかったと考えられる。2000 年以降の社会の変化で教育・保健サービスともにプライベートセクターが急速に発展し、プライベートの保健医療人材育成学校や医療施設数が増加したことで、教育やサービスの質をいかに担保するかが政府にとっての優先課題となってきたこと、そして相互認証協定という外的要因の影響のため、Legal Framework に注目し、強化する必要性が生じてきたという説明が可能かもしれない [9]。

4）コンゴ民共和国の関係者分析調査（資料 3）

コンゴ民においては House Model をフレームワークとして用いて保健人材に関する関係者分析調査を実施した。コンゴ民の場合、まずは関係者の全体像の把握が必要であったため、保健省、関連省庁、カウンシルや労働組合、開発パートナーや NGO、教育関係者、など広く対象に House Model の構成要素の中の活動分野、関心のある分野を同定し関係者マッピングを行った。関係者マッピングから明らかになったことは、

- コンゴ民保健省が 4 つの柱とみなしている基礎教育、継続教育、定着、キャリア管理のなかでは、継続教育への関心および関わりが他に比較して高い。
- ハウスモデルの各要素への関係者の関わりを見ると、協調（72%）、保健省の組織能力強化（69%）、継続教育（69%）に関わっている割合が高かった。キャリア管理（21%）、財政（39%）に関わっている関係者は比較的少なかった。

また、関係者の中でも特に人材開発システムの中核と考えられるキーインフォーマントたちに対しては、横断的な現状分析とともに Retrospective および Prospective な時間軸の視点も加えて、制度の変遷、将来の課題、さらに深く意識調査を行った。ここからわかったことは、

- Retrospective な視点からは、質の高い保健人材の配置は不十分で、保健人材の養成も計画的ではなかったが、国家保健計画、国家保健人材開発計画の策定、保健に関する法整備が実施されてきた。
- 保健セクターの様々なリフォームが実施された。
- 保健省と高等教育省の連携および開発パートナー間の連携が開始された。
- Prospective な視点からは、保健省および保健人材の能力強化、保健人材データベース、評価・モニタリングが必要である。
- 保健セクターの予算、保健人材への十分な給与、政府の保健分野へのコミットメントが必要である。

以上の点を、多くの関係者が共通して認識していることが判明した。

この調査は保健省人材管理関連部局の担当者自らがチームを組みインタビューを行った。面接者の選択は、「保健省人材局の考える」関係者を選んでいるため、プライベートセクターが少なくなっている。本来であれば、snow ball technique でインタビューを増やしていくのだが、時間的制約もあり、予め選んだ関係者のみのインタビューとなっている。また、政府関係者が聞くため利害関係者からの情報収集に関してはバイアスも考えられる。一方で、インタビュー実施、結果の分析などを保健省人材関連局が実施しているため、関係者分析を実施しながら、能力強化も同時に実施している。また、関係者分析を通して人材開発分野全体を俯瞰する考えも身に付きつつある。今後、分析結果の公表や関係者との共有など調査結果を活用する予定である。

5）研修への応用－ JICA 仏語圏中西アフリカ保健人材管理研修

House Model を用いた研修の概要を以下に紹介する。

【対象】仏語圏アフリカ諸国中央政府における保健人材管理担当局および州政府における保健人材管理担当局の局長級および課長級

【期間】約 3 週間（2012 年 12 月実施）

【人数】16 名

【研修目標】仏語圏アフリカ諸国の保健人材開発政策の改善により、保健人材管理が強化され、最終的には同地域の人々の健康改善に寄与する。

【研修目的】研修員が、仏語圏アフリカの関連政策の現状と問題点を把握するとともに、保健人材管理の重要な要素についての議論を深め、自国への適用策・改善策を計画できるようになる。

ここでは、House Modelの中でも保健人材の＜定着＞に主眼をおいて研修を構成した例を紹介するが、研修目的に応じ研修テーマを自由に選択する事が可能である。House Model の構成要素のどの課題をえらぶ場合も、「House Model の構成要素を包括的にとらえる事」、「House Model の構成要素の一つを独立した課題としてとらえるのではなく、相互に関連している事」を強調することが重要と考えられる。

【研修コンセプト（研修のねらい）】

（1） 本研修参加者は各国保健行政官であるため保健システム全体を見据える役割を期待されており、保健人材管理に関しては保健行政上の主な課題を包括的にとらえる事を 1 つ目の研修のねらいとする。House Model を用い、保健人材開発をその構成要素（養成、配置、定着、保健省の能力、財政、法的な枠組み、保健政策・保健人材開発計画、国内にいる保健人材、モニター、調整）から概観し、各要素が互いに密な関係性のなかにある事を理解し、共有する。

（2） 本研修は、保健人材管理の重要な要素である「保健人材の定着」に焦点をあて研修課題を設定する。これに伴い、仏語圏アフリカ諸国における保健人材の定着とは、1. 国内への定着、2. 僻地への定着、3. 公的機関への定着である事を共有するのが、2 つ目の研修のねらいである。

（3） 保健人材の定着に関する講義や質疑等を通じ、自国への適応策や改善策を計画できるようになることを研修目的としているが、この際、保健人材の定着は独立した課題ではなく、他の関連要素と共にこの課題を捉える事が重要である事を共有するのが、3 つ目の研修のねらいである。具体的には、養成・配置・定着が一貫した保健政策・計画の中で実施されることを理解することである。当然の事ながら、養成・配置・定着を考慮するうえで、他の要素も関連している事を説明する必要がある。

【研修構成例】

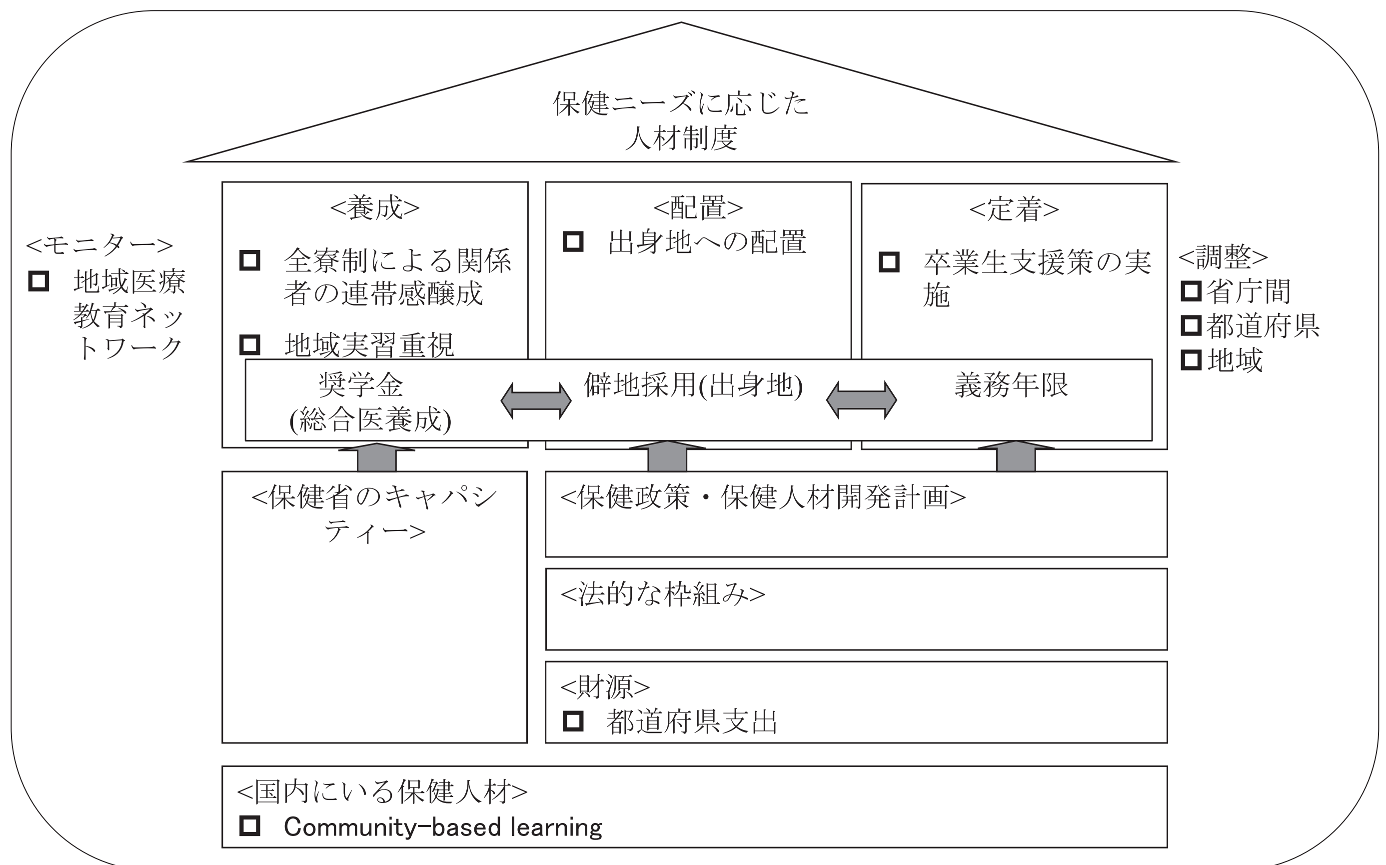
この研修コンセプト（3 つの研修のねらい）を基に、講義、視察、協議等で本研修を構成した。

単元	内容	形態
保健人材開発の枠組み	1. 保健人材開発分析フレームワーク「House Model」を紹介する 2. 保健人材開発分析フレームワークを使いながら、参加国の例を各自分析・紹介する	講義・討論
定着に関する計画や政策	1. 課題の整理①国内への定着②へき地への定着③公的機関への定着 2. 国、都道府県、大学、保健医療施設における保健人材の定着に向けた日本の計画や政策を紹介する 3. 保健人材の定着に向けた参加国の計画や政策を紹介する 4. 財政的・非財政的インセンティブ等の対策を紹介する[10)11)12)]	講義・討論・視察
定着を促進する保健人材の養成と配置	1. 国や都道府県等における対策 2. 大学や保健人材養成教育機関等の取り組みの紹介	講義・討論・視察
参加国の保健人材開発の現状を共有と課題分析・活動計画案の作成	1. 参加国の定着に関する現状共有 2. 単元毎の学びを整理する 3. 課題を分析し、解決に向けて実施されている、効果のあった対策を共有する 4. 保健人材管理に関する問題点解決のための活動計画案を作成する講義・討論	グループワーク 発表

【研修実施上の留意点】

各講義や視察開始時には、House Model の構成要素のどの部分に関する講義や視察なのかを研修員に明確に提示する工夫が必要である。また、研修期間中に複数回の振り返りのセッションを設け、受講した講義内容や視察が研修コンセプトにどのように関連しているのかを提示する。同時に、House Model の構成要素全体をバランスよく概観する事が必要である。以下に、研修中に実施した振り返りの例を紹介する。

振り返り:○月○日　△△大学「日本の地域医療と△△大学（医師を中心とする養成配置定着システム）」



この図を用いながら講義内容をレビューし、構成要素の関連を視覚化する事で、研修員の理解を深めることができる。House Model を用いることで、その構成要素を包括的にとらえたり、構成要素の一つを独立した課題としてとらえるのではなく相互に関連している点を理解するには有効と考えられた。

【研修員の意見】

研修対象が保健行政官であることから、土台部分である「保健省の能力」を玄関ととらえ、保健人材開発の入口は研修員自身（保健行政官）であると認識した、という意見が聞かれた。

5. House Model の活用と限界

これまでの活用経験から、House Model をツールとして使い、保健人材開発システムを包括的に分析すること、システムが構築されていく過程を記述すること、構成要素の一つが独立した課題ではなく相互に関連している、すなわちつながりの重要性を理解すること、には有効と考えられた。また崩壊した社会のシステムを立て直さなければいけない立場の政府保健省行政官、あるいは現場で一緒に働く筆者らにとって「家」を建てるというイメージは、シンプルであるが、自らのものとして理解しやすく、受け入れやすいようである。

House Model はあくまで全体を包括的に見ていくための見取り図であり、これですべてを説明できるわけではない。たとえば人材開発システムの変遷や構築の過程での保健人材の質や質の変化について説明できるわけではない。また研修実施を通じて、House Model に足りない要素も見えてきた。その一つは High-level Political Commitment である。House Model の中では言及していないが、保健人材開発を包括的に概観し、効果的に実践していく上で、High-level Political Commitment が欠かせない。従って、House Model の土台部分にある保健省のキャパシティで説明するか、構成要素全体をオリエンテーションする機能として High-level Political Commitment を盛り込んでもいいかもしれない。

この「家」は完成品ではなく、国や地域の状況を見ながら使ってみて、他にも必要な要素と思われるものがあれば加えればいいし、不要であれば外せばいい、常に改築中である。たとえばコンゴ民では柱は養成・配置・定着の 3 つではなく、基礎教育・継続教育・キャリア管理・定着の 4 つとなって使われている。重要なことは、保健人材開発を考えていく際には、現在起こっていることや自分たちが行っている活動や支援が全体のどこに位置しているか、常に全体を意識しながら包括的にみていくこと、そして、個々の要素だけではなく関連する他の要素とのつながりも注意を払うこと、であろう。

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資料

1. 保健人材開発システムアセスメント チェックリスト

Rapid assessment checklist of HRH system development

Dimension		*"Questions with under line" represent Quantity aspects of Human Resource for Health ** "Questions of iltalic letter" represent Quality aspects of Human Resource for Health	備考
A.General information			
Health system	1	How is the structure of the health system? ヘルスシステムの構造はどうなっているか。	例えば、保健医療行政、リファラルシステム、民間セクターの有無、関連文書を入手し、確認する
	2	What are the share of the government health expenditure in the total health expenditure? 全保健医療支出に占める政府の支出はどれくらいの割合か。	関連文書を入手、確認する
	3	How is the system of health financing? (user fees or health insurance, etc.) 保健財政システムはどうなっているか（ユーザーフィーや医療保険制度など）。	同上
External partners' support	4	What is the mechanism of partner support? Common fund? Program approach? 開発パートナーによる支援メカニズムは何か。コモンファンド？　プログラムアプローチ？	同上
B. Policy and Planning			
Policy	1	Is there a national health policy? Briefly describe it, including the building process, content, last update and other relevant issues. 国家保健医療政策はあるか。策定過程、内容、最終改定日、他の関連課題を含めて簡単に述べてください。	国家保健医療開発政策戦略文書を入手、確認する
	2	Does the country have an HRH policy? Is it written down? 国家保健人材開発政策はあるか。記述されているか。	国家保健人材開発政策文書を入手、確認する
	3	Is HRH acknowledged in broader development policies (PRSP, MTEF)? 保健医療人材は保健セクターより上位の開発政策(PRSP,MTEF)において承認されているか。	関連文書を入手、確認する
	4	Are there HRH policies at each level (national to local, decentralized)? 保健医療人材政策は各レベルにあるか（国レベルから州県レベルまで）。	地方分権に伴い、州や県レベルで保健人材政策や計画を持っている国があるので、確認する
Planning	5	Does the country have a strategy for HRH or a health wokrforce plan ? Is it periodically updated? 国には保健医療人材戦略や保健医療従事者計画があるか。それは定期的に改定されているか。	国家保健人材戦略、計画文書を入手、確認する
	6	Who are involved in formulating HRH strategies and planning? 保健医療人材戦略や計画の策定に誰が関わったか。	開発パートナーのコンサルタントが短期で調査を行い、報告書として戦略文書を置いていった場合も多く、必要ならば策定過程や期間、保健省担当部署の関わりを確認する。
	*7	Does the plan include staffing targets ? Which target is used, target staffing per population, per health facility, or others? その計画は、人材配置目標を含んでいるか。どの目標が使用されているか、対人口か、対保健医療施設か、あるいはその他か。	国家保健人材開発計画を入手、確認する
C. Legal framework			
Definition of HRH	1	Do you have any legal document for defining HRH (i.e. physician, nurse, midwife, etc)? 保健医療人材を定義した法規があるか（例えば、医師、看護師、助産師など）。	法規があれば入手、内容を確認する

Regulations	2	What are the main regulatory bodies in the area of HRH? 保健医療人材の法的な規制枠組みを実施する組織はどこか。	保健省(担当部局)か、カウンシルか。
	3	What is the process from graduating school to starting practice as professional? 養成校卒業から専門職として働き始めるまでのプロセスは何か。	学校卒業、国家試験、免許登録の流れについて確認する
	4	Besides the national regulations, are there specific regulations at local level? 国家規定のほかに、地方レベルでの何か特別な規定があるか。	保健人材の資格、免許登録を州レベルで管轄する場合、国とは別に地方レベルでの規定があるか？
	**5	*What categories of HRH (i.e. physicians, nurse, midwife, etc.) are required to be registered in order to practice?* *どの保健医療人材が実務のための登録が必要か(医師、看護師、助産師など)。*	保健専門職として実務を行うための登録制度が存在しない国もある。
	**6	*What licensing requirements and procedures of HRH now exist? Are they adhered to?* *保健医療人材の免許交付資格や手続きは何か。それは遵守されているか。*	保健専門職の免許制度はなく、認可された学校を卒業し、カウンシルあるいは保健省に登録すれば実務可能な国もある
	**7	*What authorization is required for private and traditional facilities? What authorization is required for private and traditional providers to practice?* *民間診療施設と伝統医療施設開設の認可制度はあるか。民間診療施設や伝統的保健医療施設において保健医療サービス提供者が実践するための認可制度はあるか。*	民間診療所・伝統医療施設の開設基準や開設許可制度があるか？公的セクターと民間セクターでの実務に関する免許や登録制度があるか？
Job description	8	Are there detailed job descriptions for the main categories of personnel at each level of the health care delivery system? ヘルスケアを提供するシステムの各レベルにおいて、職員の主な職種の詳細な定まった業務内容はあるか。	関連文書があれば入手、確認する
D. Financing for HRH management			
	1	Who are the main actors involved in funding HRH policies and plans? 保健医療人材政策や計画実施への財源はどこか。	政府予算か。ドナー援助の場合は、財源は主にどこか。
	2	Do HRH plan implementation correspond to the available resources? If not, has the gap been measured? 保健医療人材計画実施は利用可能な資源とつりあっているか。もしも調和していない場合、そのギャップは測定されているか。	国家保健人材開発計画を入手、詳細を確認する
E. MOH capability			
Responsible unit for HRH	1	Does the country have an unit within the MOH responsible for HRH planning and monitoring, production, deployment, retention, legal framework, finance, and coordination ? 保健医療人材計画、モニタリング、育成、配置、維持、法的枠組み、財政、調整における責任部署が保健省の中にあるか。	例えば、人材育成局など。ただし、ひつの部署が全ての責任を担っているとは限らない。どの役割がどの部署にあるか、部署のTORに照らして確認する。(計画は人材育成局だが、予算は財政局、法的枠組みは治療局など)
	2	Does the country have an unit at subnational level responsible for HRH planning and monitoring, production, deployment, retention, legal framework, finance, and coordination ? 保健医療人材計画、モニタリング、育成、配置、維持、法的枠組み、財政、調整におけるサブナショナルレベル(州や県など)に責任部署があるか。	同上

	3	Do the above units have enough personnel with adequate skills? 上記部署は、適切な技術をもった十分な数の人員を兼ね備えているか。	責任部署の人数と人材の背景（年齢、経験、教育背景）、など
F. Production			
Educatinal institutions	1	Is there a national HRH education strategy? 保健医療人材養成に関する国家戦略があるか。	国家保健人材政策の中で、養成に関する記述があるか、
	2	Is there a standard of educational institute for main HRH cadres? 主な保健医療人材の教育機関の基準はあるか。	関連文書があれば入手、確認する
	3	Does any mechanism exist to link supply of professionals to demand (quantitative and qualitative) of the health sector? 専門職の供給と保健セクターの需要（質と量）の関連づけるメカニズムがあるか。	国家保健人材開発計画、保健人材情報報告、保健人材情報に関する報告書など関連文書があれば、確認する
	*4	Does the country have education and training institutions for the main HRH cadres? How many? Where are they? (private and public)? 主な保健医療人材の教育研修施設はあるか。その数、どこか（公的と民間）。	教育研修機関に関する情報や報告書などがあれば入手、確認する
	**5	*What is the accreditation system for health schools? (criteria, audit or inspection)* *保健医療人材の教育施設認可制度の内容は（認可基準、監査や立ち入り検査）。*	関連文書があれば入手、確認する。認可制度の監督機関(部署）はどこか？
	**6	*Do you have a standardized curriculum for main HRH cadres?* *主な保健医療人材のスタンダードカリキュラムはあるか。*	関連文書があれば入手、確認する。
Educational staff	7	Is there an educational system for teachers? 教員養成システムはあるか。	ある場合、どのような仕組みか、確認する
	8	Are there measures for deployment and retention of teachers? 教員配置や定着のための方策をとっているか。	ある場合、どのような仕組みか、確認するどのような方策か確認する
	9	Is the migration of HRH teachers a problem ? In what sense? 教員流出の問題はあるか。どのような意味で問題か。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	*10	Are there enough full-time-equivalent teachers for the main HRH categories? 常勤職員（フルタイム勤務）の教員は十分か。	正規雇用の教員（フルタイム勤務）/学生数などの基準があればそれを満たしているか、確認する
	**11	*Is there a system for evaluating teachers' performance?* *教員の仕事を評価するシステムはあるか。*	関連文書があれば入手、確認する
Students	12	What is the policy for admission to health professions school? 教育機関の入学資格は何か。	関連文書があれば入手、確認する
	*13	Does current number of yearly graduates cover the needs for the main categories of HRH? 現在の年次卒業生数は主な保健医療人材のニーズをカバーしているか。	卒業生の就職先に関する情報を把握しているか？指標があるか？
	*14	Are data for total entrants and graduates available for recent years? Can these data be disaggregated by sex, age, and citizenship? 最近の入学者数と卒業生数のデータはあるか。これらのデータは性別、年齢、資格別にも分けられるか。	可能であればデータを入手、確認する

	*15	Do you have a data on the proportion of entrants who have successfully graduates, in recent years? What proportion? 最近の入学者数と実際の卒業生数の割合に関するデータはあるか。どれくらいの割合か。	同上
	**16	*Is there a standardized final exam to ensure the qulaity of education?* *教育の質の確保のために最終試験（卒業試験）の基準があるか。*	関連文書があれば入手、確認する
G. Deployment			
Recruitment in the public sector	1	Is there a specific recruitment policy ? 採用に関して特別な戦略があるか。	関連文書があれば入手、確認する
	2	What level (national, subnational) is in charge of recruitment of HRH? 採用に関する責任はどのレベル（国レベル、サブナショナルレベル）か。	同上
	3	What is the rule and procedures for recruitement and deployment? 採用や雇用に関するルールや手順はどのようなものか。	同上
Deployment in the public sector	4	Is there a national staff deployment strategy? 国家公務員の配置戦略はあるか。	関連文書があれば入手、確認する
	5	Do you have a registration system for main categories of HRH? 主な保健医療人材の登録システムはあるか。	同上
	*6	Do you have a data for the number and workplace of health personnel (which category, where, how many, age, sex?) 保健医療人材の勤務先や数に関するデータはあるか。（カテゴリー、場所、人数、年齢、性別）	可能であればデータを入手、確認する
	*7	Do you have a data of what share of graduates is recruited each year? 毎年の新卒採用者率のデータはあるか。	同上
Imbalance /equity	8	Does deployment strategy fit with the needs of poor/vulnerable settings and people? 僻地や弱者のニーズに合う配置戦略があるか。	国家保健人材開発計画、保健人材情報報告、保健人材情報に関する報告書など関連文書があれば、確認する
	9	Do you have a problem of mal-distribution of professionals in the country? 専門職配置の国内格差があるか。	同上
	10	Are there major segments of the population that are seriously underserved? 保健医療サービスが危機的に行き届いていない場所があるか。	同上
	*11	Are human resources distributed appropriately among the different types and levels of health services (hospital, ambulatory, home, preventive, etc)? 人材は異なるタイプやヘルスサービスのレベルに応じて適切に配置されているか。	同上
	*12	Do you have any measures for the deployment in rural and remote area? 僻地への配置に関する何らかの対策があるか。	同上
	13	Do you have a registration systm for private hospitals and clinics? プライベートクリニックや病院における登録システムがあるか。	関連文書があれば入手、確認する

Private sector	14	Do you have a functional inspection system for private sector? プライベートセクターにおける実際的な監査があるか。	関連文書、報告書などあれば確認する
	15	Is dual practice common in your country? 副業はよくあることか。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	16	What are the main reasons for leaving the public sector for the private or non-health sector? 公的保健セクターを離れ、プライベートあるいは、保健以外のセクターに移る主な理由は何か。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	*17	Do you have an idea of the number of health personnel working in the private sector? プライベートセクターで働く保健人材の数は把握しているか。	保健人材情報報告書など関連文書があれば確認する
H. Retention			
Wages / salaries	1	What is the monthly salary of each category of HRH (from the government, include hardship or family allowance, etc.) ? Or What is your monthly salary? 保健医療人材の各カテゴリーの月給はいくらか（手当等も含めて政府から）。 あなたの月給はいくらですか。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	2	Do other forms of income exist for HRH? (Do you have any other income besides government salary?) 保健医療人材の収入には、（政府からの給与の他に）何か他の形態があるか。 （あなたは政府からの給与の他に他に収入があるか。）	同上
	3	Did staff (you) experience delayed payment in the last 12 months? あなたも含めた職員は、過去12ヶ月間に給与支払いが遅れた経験がありますか。	同上
	4	How much is average monthly expense in your family? 家庭の支出は、月平均いくらくらいですか。	同上
Working condition	5	Is the living condition and transport of health workers adequate to work? 保健ワーカーの住居や交通手段は働くために充分な状況か。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	6	Does health staff (Do you) have a problem of security in the workplace? あなたも含めて職員は、職場のセキュリティーの問題はありますか。	同上
	7	Does work place have a problem of water, electricity, building; drug and materials, equipment? 職場に、水や電気、建物、薬、物品や機材の問題があるか。	同上
	8	What is the official and actual working hours? 公の労働時間と実際の労働時間は何時ですか。	同上
	9	Did workers go on strike in the last 12 months? 労働者は過去12ヶ月間にストライキをおこしたか。	同上
Motivation / incentives	10	Does health staff (Do you) receive monetary incentive? 職員は金銭的なインセンティブを受け取っているか。	同上
	11	Does health staff (Do you) receive non-monetary incentive (in kind, promotion, etc.)? 職員は金銭以外のインセンティブを受け取っているか（物品や昇進など）。	同上

Supervision / leadership	12	Do you have a system of supervision? スーパービジョンシステムがあるか。	実際にどのようなスーパービジョンを行っているか？あるいは自分自身が受けたか？
	13	What is the system of supervision? (by whom, to whom, how often, standard tool for supervision, etc) どのようなスーパービジョンシステムか。（誰が誰に、どれくらいの頻度で実施されるのか。スーパービジョンのスタンダードツールはあるか。）	スーパービジョンの計画と実施の責任はどこか。
	14	How are these mechanisms used to improve performance? (ex. performance based incentive, non-pay incentive,) パフォーマンスに応じた金銭的インセンティブ、非金銭的なインセンティブどのようにパフォーマンスを向上させているのか。	金銭的・非金銭的なインセンティブが実施されているか？パフォーマンスの向上につながっているかどうか確認されているか？
	15	Are supervisors or managers themselves trained in leadership? スーパーバイザーやマネージャー自身は、リーダーシップの研修を受けているか。	研修の機会がどのような形や頻度であるか？
Career path / Continuous education	16	Did health staff (Did you) have an opportunity for in-service training last 12 months? If yes, which topic? あなたの部下の保健スタッフ（あるいはあなたは）は過去12ヶ月間に継続教育の機会があったか。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	**17*	*Is there a system of career path for major categories of HRH?* *保健医療人材の主な職種においてキャリアパスシステムはあるか。*	可能であれば、主な職種のキャリアパスについて詳細を確認する
Migration	18	Is international migration perceived as a major problem in the country? （保健医療人材の）越境移動は国内の大きな問題ですか。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	19	Do you have a data for the health professional (physician, nurse, etc.) who migrate overseas each year? 毎年、越境する保健専門職（医師や看護師など）のデータはあるか。	情報が入手可能であれば確認する
	20	For the total health workforce in the country, do you have a data on what share of the main HRH categories are not nationals? 主な保健医療人材のカテゴリーのうち外国人の割合に関するデータがあるか。	同上
	21	To what extent does international migration of staff create distributional imbalance on HRH? 越境する保健医療人材が、どの程度、保健医療人材格差を生み出しているか。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	22	What are the main factors causing international migration? 越境が起こる主な要因は何か。	同上
I. Monitoring and evaluation			
HRH Information	1	Do you have available HRH information/data? 入手可能な保健医療人材情報やデータはあるか。	報告書などがあれば確認する

management	2	What are included in HRH information system? (category of HRH, levles of qualificaiton, workplace, gender, age, etc.) 保健医療人材情報システムには何が含まれているか。（保健医療人材の分類、資格、職場、性別、年齢など）	報告書や人材情報フォーマットなどがあれば確認する
	3	How is HRH information collected? 保健医療人材情報をどのように収集するか。	保健医療人材情報の流れ、頻度、保健情報システムとの関連はあるか？報告書などがあれば確認する
	4	Is there information at subnational level? If yes, specify at what level (province, district,) 保健医療人材情報はサブナショナルレベルにもあるか。あれば具体的にどのレベルか。（州、県など）	報告書などがあれば確認する
	5	Does HRH information cover the private sector? 保健医療人材情報は民間セクターも含んでいるか。	同上
	6	Does the country have population census or labour force surveys? Do these sources make it possibel to analyse HRH information? 国勢調査や労働調査を実施しているか。この情報源で保健医療人材情報を分析することは可能か。	同上
	7	Does MOH conduct HRHsurveys or health census? If yes, when was the last one? 保健省は保健医療人材サーベイや保健センサスは実施しますか。ある場合、最終はいつか。	同上
	8	Are these available administrative records for HRH? 保健医療人材の行政記録はあるか。	例えば公務員の場合、公務員番号や雇用の記録、など
	*9	What are core indicators to monitor and evaluate HRH? 保健医療人材の評価やモニターするための主な指標は何か。	関連文書があれば入手、確認する
	*10	Does the country have staffing norms per facility type according to the levels of care? 国には、保健システムの中でケアレベルに応じた施設タイプごとの職員配置基準はあるか。	同上
	*11	Is there a problem of shortage or oversupply of HRH? 保健医療人材の不足や過剰の問題があるか。	面接者に対する一般的な質問。
J. Stakeholders and coordination			
Stakeholders and external partners	4	Who are the national and external stakeholders in HRH? ((MOH, other ministries, professional associations, universities, etc) 保健医療人材に関して、国内ならびに国外の団体の関係者は誰か（保健省、他省庁、専門職団体、大学など）。	調査前に作ったリストをもとに、面接者に他に関係者がいるか聞く（雪だるま方式）を繰り返すと主要な関係者は網羅される。
	5	What professional association exists? What are the criteria for membership? *What is the structure, staffing, and activities ?* *職能団体はあるか。その会員となる基準は何か。その構造は職員、活動は何か。*	関連文書があれば入手、確認する
	6	What professional council exists? What are the criteria for membership? What is the structure, staffing, and activities? 職能カウンシルはあるか。その会員となる基準は何か。その構造は職員、活動は何か。	同上

	No.	Question	Notes
	7	What categories of HRH have their own unions? 労働組合をもつ職種はどれか。	同上
	8	Is there coordination mechanism of stakeholders? Who are the members? 関係者の調整メカニズムはあるか。　誰がメンバーか。	この場合の、調整メカニズムとは保健医療人材に関わる国内国外の関係者が会合をもち情報共有などを行うことをさす。
	9	To what extent are stakeholders involved in formulating and implementing national policies for HRH development? 保健医療人材開発における国家戦略の策的や実施に、どの程度、開発パートナーが関わっているか。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	10	On what basis to external partners support HRH activities? 開発パートナーは、何に基づいて保健医療人材に関する活動を支援しているか。	たとえば、保健人材開発戦略や計画、あるいは開発パートナー独自の支援戦略など。関連文書があれば入手、確認する
	11	Does a Country Cooperation strategies or partner cooridnation mechanism exist? If yes, does it include HRH issues? 国の援助戦略やパートナーの調整メカニズムはあるか。ある場合保健医療人材の課題は含まれているか。	保健分野あるいは保健省レベルのみならず、マルチセクターにおける政府開発援助調整会合なども含む。これらの援助調整会合で保健医療人材が課題としてとりあげられているか？
K. Others			
	1	Do you have any problem(s) about absenteeism? 欠勤に関する問題があるか。	面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る
	2	Is there any problem relating "Ghost workers" (which means staff receiving salary are not working)？ （給料は受け取っているが働いていない）　幽霊労働者に関する問題があるか。	同上
	3	Is there any example(s) of "Task-shifting"? タスクシフティングの事例があるか。	同上
	4	Is there any positive/negative impacts due to the "prioritized Health Program(s)"? 優先的保健プログラムに起因するポジティブ/ネガティブなインパクトがあるか。	疾病対策プログラムなどドナーの資金を選択的に受けている保健プログラムが保健人材に関する影響をどのように与えているか？面接者に対する一般的な質問。調査目的によっては、質問方法を検討することも可能だが、詳細は別に譲る

2. 保健人材開発システムに関する調査報告書 (カンボジア)

人材開発システムに関する調査報告書

（一部改編）

2009 年 6 月

JICA 地域における母子保健サービス向上プロジェクト

短期専門家　　藤田則子

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略語表

ADM	Associated Degree of Midwife
ADN	Associated Degree of Nursing
HRD	Human Resource Department
HSP	Health Sector Strategic Plan
HC	Health Center
IMCI	Integrated Management of Childhood Illness
MDG	Millennium Development Goal
MOH	Ministry of Health
NMCHC	National Maternal and Child Health Center
OD	Operational District
PHD	Provincial Health Department
PNS	Primary Nurse
RH	Referral hospital
PMW	Primary Midwife
RTC	Regional Training Center
SNS	Secondary Nurse
SMW	Secondary Midwife
TSMC	Technical School of Medical Care

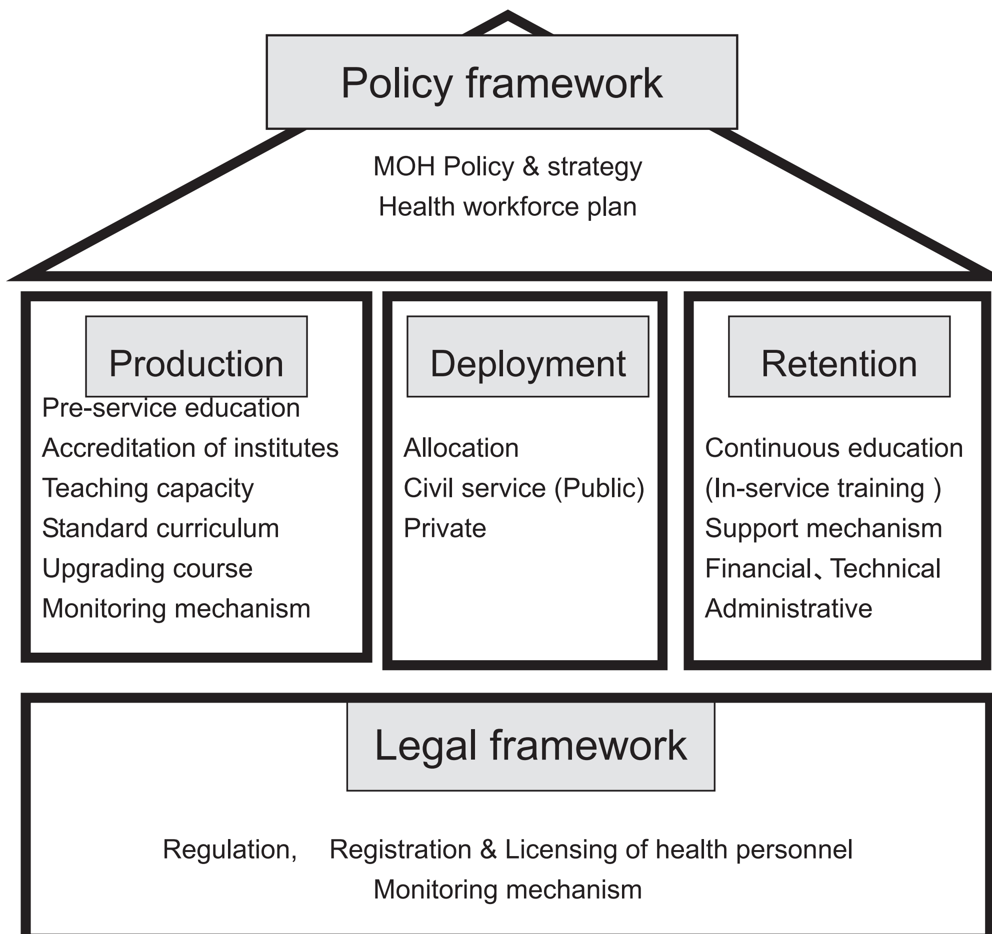
Ⅰ）　調査目的

カンボジア看護助産分野の人材開発システムの現状分析を行い、優位点と改善点を明らかにする

Ⅱ）調査方法

調査期間 2009 年 5 月 25 日―6 月 12 日
カンボジアにおける保健人材（看護助産）分野の保健省担当部署、開発パートナー、教育機関関係者、他 27 名の Stakeholder に対し、別添チェックリストの質問項目を用いた半構造面接、関連資料収集、既存の文献レビューを行った（収集資料文献リスト）。結果は人材開発システムの中の各要素 (Policy Framework, Legal Framework, Production, Deployment, Retention)（図1　調査のフレーム）から優位点と改善点に関して分析を行った。

図1．調査のフレーム



Ⅲ) 調査結果

1. カンボジア保健人材開発の現状

Policy Framework

1)　保健政策と人材開発の位置づけ

現在の保健政策は Health Strategic Plan 2008-15 (HSP 2) としてまとめられている。HSP 2 では人材開発は保健プログラムの3つの分野（RMNCH、CDC、non CDC）に横断的に関わる 5 つの保健システムコンポーネント (Service delivery, Health financing, Human Resource for Health, Health information system, and Health System Governance) のひとつとして位置づけられている。現在の人材開発戦略としては、

- 保健人材の技能の向上、
- ライセンス制度や職能団体強化を通じた専門職の確立、
- 配置定着の促進 (助産師が優先)、
- 人事院による公務員制度改革（Civil Administrative Reform：CAR）やユーザーフィや種々のインセンティブを通じた公務員給与の改善、

が柱になっている。

2)　人材開発計画

人材育成部（HRD）により 1995 年に始めて人材開発計画が策定され、引き続き Health Strategic Plan　2003-2007 (HSP 1) に基づいて Health Workforce Development Plan (2006-2015) が策定された。結果的に現在の HSP 2と整合性をもつものとなっている。カンボジアは 1997 年より National Health Coverage Plan にもとづいて施設整備計画が進められ、州・保健行政区（OD）以下の施設（レファラル病院、ヘルスセンター）における人材配置基準（最大・最小）が決められている（レファラル病院の基準は CPA（Comprehensive Package of Activities)、ヘルスセンターの基準（MPA(Minimum Package of Activities) とよばれる）。国立病院・国立センターには人材配置基準がないが、現状のスタッフ数と CPA・MPA 基準をもとに HRD は各職種の Workforce plan を作成している。保健人材数は表 1 のように増えてはいるが、例えば、2007 年の CPA/MPA 職員（看護助産分野）の人材と数をみると助産師不足が問題であり、表 2 のように国立病院を除く CPA と MPA 施設の人材基準と比べると、最小基準を満たすには 498 人、最大基準を満たすには 712 人不足である。一方で都市部偏在も大きく、2004 年には国内 963 のヘルスセンターのうち 229 が助産師不在であった。

表1：　1996 年から 2008 年までの保健人材の推移

	1996	1998	2000	2004	2006	2007	2008
MD	1,247	1,711	1,878	2,177	2,120	2,162	
MA					1,282	1,267	
SNS	3,979	4,384	4,268	4,521	4,758		5,186
PNS	4,430	3,993	3,892	3,563	3,327	3,464	3,534
SMW	1,706	1,830	1,771	1,813	1,822		1,844
PMW	1,515	1,482	1,257	1,113	1,113	1,339	1,478

(National Health statistics 2006, 2007, 2008, 資料29を改変)

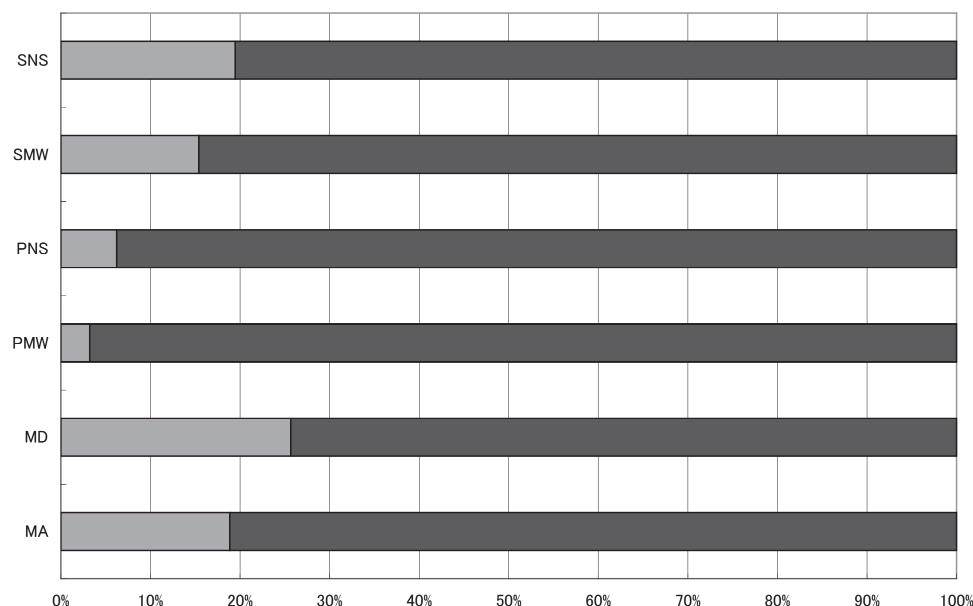
表2：　プノンペン・州での保健人材数

	MA	MD	PMW	PNS	SMW	SNS	PMW+SMW（助産師）	PNS+SNS（看護師）
Phnom Penh Municipality	123	105	32	105	99	168	131	273
Province	1282	2120	1113	3327	1822	4758	2935	8085
合計	1405	2225	1145	3432	1921	4926	3066	8358

MPA+CPA 人材最小基準	1952	960	1920	2604	4656	3564	6576
MPA+CPA 人材最大基準	2353	1920	1920	2858	5683	4778	7603

MPA+CPA 人材最小・最大基準は MPA、CPA の施設数から施設ごとに配置される人材基準をもとに算出。
MD(Medical doctor), MA(Medical assistant)

図2.プノンペンと州の人材配置



人材開発計画の実施にあたり保健省人材養成部（HRD）は「助産師数の増加」、「偏在解消と僻地のヘルスセンターへのスタッフの充足」を問題として認識しており、人事部と共に後述の配置を踏まえた学生リクルートや助産師再配置を進めていて 2008 年には国内の助産師不在ヘルスセンターは 79 に減少している。カンボジアの場合歴史的な事情から公務員の年齢分布が特殊であり、州ごとに違いはあるが職員の 20 ― 30% が 50 歳台であり、今後 5 ― 10 年で定年を迎える。現在の Workforce plan はこの特殊性を踏まえた作り方になっていない。過去数年は助産師教育がさまざまに変化していたため学生数は一定しなかったが、今年度の国内の助産師学生総数は PMW 約 200 名、SMW 約 600 名、しかし定年退職者を差し引くと助産師数の増加は限定的である。実際全体の助産師数は 2000 年と比べてほとんど増えていない。また現在のヘルスセンター数は計画にはまだ届かず、建物のない HC に職員が勤務している場合も多く見られる。このように人事部のもつ職員数と HRD のもつ学生数との比較、計画保健情報部による施設数（建設予定数）などをつき合わせた定期的な調整もいない。また、防衛省管轄の Military School と Military hospital があり、またプライベート病院診療所が増加しているが、これらのスタッフ数を保健省は把握していないため、人材開発計画は保健省公的セクターのみが対象となっている。

3） 保健予算・保健財政（Health financing）

政府予算は人件費（公務員給与）と Central Medical Store(CMS) の薬剤調達と配布に当てられ、保健サービス提供に関わる行政・施設の運営費はほとんどがドナーからの外部予算によるものである。WHO country profile（2005）によれば保健予算は政府予算の 12.0%であり、保健全体の予算の中で外部支援が 25.7%を占める。一人当たりの総保健支出は US ＄29 だが、うち公的支出は＄7.0 と少なく残りは out-of-pocket（79%）である。公的施設ではユーザーフィーが導入されており、支援しているドナーや NGO が地域割りで貧困者対策のための基金（Equity Fund）や Community Health Insurance を導入しているが、ドナー毎にばらばらであり統一されたものはない。

人件費に関して、基本給はここ数年間毎年 10% 程度増えているが、それでも月 30 ドル程度であり生活費とは程遠い状況のため、公務員制度改革（Civil Administration Reform）が進行中である。そのひとつとして今年から MBPI（Merit Based Performance Incentive）が準備されている。これは保健省や国立センター、PHD などの中核のポストに対して資格と役職に応じた報酬が追加される（保健省局長クラスで月 US$ 450）。後述の SOA の一環として 7 つの州保健局や管轄施設でも開始予定である。

4） 保健システム・保健医療サービス

National Health Coverage Plan により保健行政・診療システムは全国 24 州を OD と呼ばれる 76 の保健行政区に分けられている。別添2のように人口に応じた公的保健施設設置基準がある。レファラル病院は病院診療機能が高いほうから CPA3，2，1 と分けられサービス・施設・人材・機材の基準が規定されている。ヘルスセンターも同様に基準 MPA が存在する。しかし現実は、例えば帝王切開ができる病院は CPA3 レベルのみしかない、CPA1 の病院の現在の機能はヘルスセンターと変わらない上にヘルスセンターよりも患者数が少ないこともある。また建物のないヘルスセンターは Non-MPA ヘルスセンターとよばれ、看護助産師が勤務している。これらの原因は人材（数・質）不足、そして施設機材の不備とされている。また首都プノンペンには7つの国立病院、9つの国立センターがあるが、これらの施設基準・人材配置基準はない。

プライベート病院・診療所は保健省への届出制度があり、その施設長は公務員でないことになって

いる。実際のサービス提供の数や質、勤務している人材の種類や数は保健省も把握できていない。公務員である保健人材は給与が低いこともあり、同時にプライベート診療所（定年退職者や非公務員が長として届出）で勤務し生活費を稼ぐDual Practiceが一般的である。

5） 保健人材の数と種類

保健省計画保健情報部は公務員保健人材の種類と数を保健統計年次報告で出している。これまでの推移は表1で、人口当たりの医師・看護・助産師数と看護職対医師の比は別添3に示す。

6） 主要ドナーの支援（セクターワイドマネージメントと人材開発分野のドナーの投入）

Health Sector Strategic Plan 2003-2007 では HSSP (Health Sector Support Project)1 として Sector Wide Management(SWiM) が実施され、ADB/WB ($50M)、DFID ($10M)、UNFPA ($18M) が参加した。このSWiM内において、Contracting というサブシステムが 11OD において実施された(ADB/WB 予算)。NGO が保健予算を得て、保健行政区と共に保健行政を運営し、保健省人材が保健サービスを提供する形態であった。NGO と保健行政区がサービスの量質を評価し、それに基づくPerformance Incentive が保健スタッフには支払われたのが特徴であった。UNFPA は、18OD に対して、保健年次計画（AoP Annual Operational Plan）の母子保健コンポーネントに対して予算をつけた。平行して 2007 年から GAVI ― HSS が 10OD で Performance Incentive を含む Internal Contract を開始した。BTC が 7 つの OD で BTC 型の Contracting を実施している。複数のスキームにより、援助方法を試す状態となった中で、2007 年には Contracting の評価が行われた。総体的には、ドナーごとにやり方が異なるものの、国家予算と違って計画額と執行・OD へ到着する額に大きな差がなく（国から州 OD へ到達する段階での職員による抜き取りも原因のひとつとされる）、援助資金が末端の OD 単位に届いていること、OD のマネージメントが向上し、Performance Incentive により職員の収入が増え、サービス提供量が増えていることが上げられている。保健省はセクターワイド・マネジメント（SwiM）の継続を決定し、SwiM に参加する援助団体も、HSSP1 の際の 4 団体から、HSSP 2の 7 団体に増加している。かつ、支援スキームを標準化する方向である。この形式として、SOA（Special Operating Agency）が 2009 年 5 月から実施予定とされている。SOA は、NGO ではなく OD が contractor となる。実力がない OD においては、Technical Advisor（TA）を雇うことが出来ることとなっている。HSSP2 では7ドナーが JPIG(Joint Partnership Arrangement Development Partners Interface) としてプールファンドを結成し、SOA への資金援助を行うことになった。これまでの Contracting では、資金が直接 OD に流れたことから州保健局の責任と役割が不明瞭となることが懸念された。一方、SOA では PHD は commissioner として、OD の監督者としての役割を持つ予定である。またこれまでの Contracting では、モニターは NGO に任されたため、外部監査的にある一定のモニタリング機能を NGO 側が担ってきた。 Performance Based Incentive においては、サービスの質のモニターが肝要である。インセンティブとして OD や施設スタッフで分けられただけでサービスの質の向上にはつながらない事例も他国で報告されている。今後、SOA において、OD レベルでの TA 以外、OD,PHD レベルでのモニタリングの外部実施者が不明瞭であり、SOA において誰がどのように、州・保健局以下のレベルをモニターするのか、中央保健省の役割をどうするか、という点は今後の課題として関係者の聞き取りで挙げられた。プールファンドに参加するドナーはセクターワイド以外にも個別に事業を予定（Discrete Fund）しているが、この7ドナーの内訳と現在コミットしている総金額は以下の通りである。

Amount	Note	
AfD	Euro 7,000,000	2008-2013
AusAID	Au$ 37,150,000	2009-2011
BTC	Euro 3,000,000	2009-2013
DFID	GBP 35,000,000	2009-2013
UNFPA	US$ 8,867,000	2009-2010
UNICEF	US$ 4,000,000	2009-2010
WB (IDA Credit)	SDR 18,500,000	2009-2013

JPIG（プールファンド）以外の看護助産人材開発分野に関わるドナーの投入は別添4の通りである。助産教育のカリキュラム作り、卒後の継続教育実施、さまざまなスキームのインセンティブによる助産師活動支援にドナーが集中している。一方で看護助産教育の実施支援やモニター・教員育成・人材配置・人材制度整備に関わろうとしているドナーは少ない。また現在の懸念事項として、USAID の新たな資金の流入が挙げられる。USAID は今後 5 年間3つの NGO に対しそれぞれ年間約＄6M の支援を約束した。（2008 年の保健分野 AoP の外部援助団体からの予算は $56M で、うち母子保健分野は＄5.9M である。つまり、これと同額を得る母子保健分野 NGO が3つ存在することとなる）。USAID パートナーの 3 つの NGO の支援は、金額は大きいが、対象地域は、全国ではなく、10 州、43OD に限定される。さらに、これらの対象州では、ほかの援助スキームと重なる地域もあり、対象地域は HSSP2 などと調整されているわけでなない。この 3 つの NGO は技術支援が中心となるが、一部、貧困者基金や Performance Based incentive に使われる予定でもある。しかし、その資金の用途はまだ最終決定されていないためインセンティブとしてばら撒かれる可能性もある。

また、2005 年ごろから助産師関連が政策の優先課題となり、保健省のみならず副首相、人口開発国家委員会（National Committee for Population and Development）や公務員改革評議会 (Council of Administrative Reform)、主要パートナーを巻き込んだ政策対話の場（High level midwifery Task Force や Midwifery Forum）ができていて、後述するようなさまざまな対策が比較的すばやく実施されていることは特記すべき事項である。

Legal Framework（法制度基盤）

1） 保健人材に関する規定

日本の医師法や保健師助産師看護師法（保助看法）にあたる専門職種の規定は省令のレベルでも存在しない。一方で、看護課（病院サービス部の下にある）が 2003 年に作成した看護師の業務分掌（省令）があるが、病院での看護ケアが中心でヘルスセンターでの看護師の役割は記載されておらず、医師やそのほかの職種との関係も不明瞭である。医師、助産師、他の職種に関する業務分掌はない。2000 年以降に策定された MPA や CPA ガイドラインでは提供されるサービスの内容は記載されているが、誰 (どの職種) がそのサービスを提供するのかは記載されていない。しかし Abortion Law など

サービス個別の法律や開業法など、別の法的文書においては、職種ごとの規定がある。（例えば、中絶に関する処置ができるのは Secondary Midwife か医師に限る、助産師はプライベート診療では産前産後健診を提供できるが分娩は提供できない、等と記載されている。） 省内のさまざまな公式文書の中に断片的に業務内容が記載されているだけで、統合された職種の規定は見当たらなかった。また、専門職種の規定を作る責任部署について、保健省関係者 (Secretary of State) の中でも認識はさまざまで、Medical Council　や Nursing or Midwifery Council、あるいは保健省 HRD との見解であった。日本の場合保健医療に関する法律は厚生労働省により策定され、民法・社会法として憲法をもとに立つものであるが、カンボジアは現在憲法を基に刑法・民法の策定中であり法律分野の JICA 技術協力プロジェクトがこれを支援している。

2)　保健人材教育施設に関する規定

2007 年 3 月保健職種 (医歯薬・コメディカル) と学校認可に関する規則が SubDecree21（首相、関連省庁大臣の承認による、クメール語で Anukret）として制定された。学位・コース名、学生の入学資格、学校認可制度を確立されること、国家試験を行うことなどが規定されている。Council Minister の元に Accreditation Committee of Cambodia (ACC) が設立され、教育の質を担保する制度として増加する私立学校の認可制度が開始された。現在保健従事者育成校として ACC から認可されているのは

- University of Health Science (UHS)：保健省下の独立法人（Autonomous Body）
- Technical School of Medical Care (TSMC)：国立
- Regional Training Center (RTC): コンポンチャム、バッタンバン、カンポット、ストントレンの4つ：国立
- 他に私立校 2 校（International University、Life University）

保健省では学校設置基準・教育基準がすべてのコースに関して作られており、学校施設 (教室他の設備や機材、教員と学生数の比率、教員の資格、学生の入学資格、卒業試験の基準) が記載されている。公立校（TSMC、RTC）はこの基準に従い、保健省 HRD の指導のもと教育を実施しているが、私立校の教育の状況は学生数が把握されているだけで、保健省 HRD がそれ以上の情報を得るのは難しいとのことであった。

3)　資格認定試験・免許登録制度

2003 年から土日だけの授業で医学教育を行う私立大学が参入し、教育の質を担保するため、2004 年に Council Minister のもとに委員会が結成されカリキュラムの標準化と共通入学試験制度が進められた（SubDecree21 として法的に名文化されたのは 2007 年）。保健科学大学（University of Health Science）の医歯薬学部と私立大学で 2008 年から共通入学試験が導入され、2012 年には医歯薬学部共通卒業試験が計画されており、実質上の国家試験に当たる資格試験が開始されることが期待される。看護助産分野ではまだ共通試験の計画はなく、入学は保健省内の選考委員会でバカロレアの成績を元に決まり、卒業試験すなわち資格取得となっている。しかし卒業試験も共通問題から各学校が出題するなど標準化が図られている。免許・登録制度はない。

Production(養成)

1)　教育制度

保健人材全般の育成校・コース名、入学卒業の仕組みは別添5の通りである。看護助産教育は現在 5 つの公立校 (首都の Technical School of Medical Care: TSMC, 4 つ の Regional Training Center: RTC)、2 つの私立校で実施されている。5 つの公立校はカバーする州からの学生を受け入れ

ている。高卒後 3 年教育の Associated Degree of Nurse (以前の Secondary Nurse : ADN), Associated Degree of Midwife (以前の Secondary Midwife: ADM、Direct entry) の他に、特に僻地のヘルスセンターでの勤務を想定した Primary Nurse（PNS）, Primary Midwife（PMW）（高卒後 1 年の教育）が地方 4 つの公立校で実施中である。また TSMC では 4 年の Bachelor of Nursing のコースが始まった。またこれまでの助産師教育の変遷を経て、助産師を増やすための臨時措置として始まった ANS3 年＋助産師教育 1 年（Diploma of Nurse Midwife（DNM)。通称3＋1コース）も継続中だが、HRD によればこのコースの位置づけは今後検討（廃止あるいは Bachelor へ）とのことであった。現在の助産師学生数は別添6の通りである。

2） 学校運営

4つの RTC は政府予算（人件費・運営経費）と HSSP2 のプールファンドからの予算（教員研修・調整会議・実習病院へのモニター費用など）により運営されていて、施設や教育機材はドナー供与や政府予算から支出されている。学費は無料。TSMC は Autonomous となり運営は政府予算（公務員給与）と学費収入（一人年間 800ドル）により運営されていて、校舎や機材は日本の無償資金協力で建設された。面接を行った2つの RTC 校長によれば以前に比べて政府予算が増え RTC の運営はやりやすくなったとのことであった。

3） 標準カリキュラムとツール

看護助産分野では現在 3 年の助産師コース（ADM）の 2，3 年目を除いたすべてのコースの標準カリキュラムが策定され、シラバスがある。2000 年ころからこの活動が始まったが現在のカリキュラムは外国人のアドバイザーが参加して作ることがほとんどであり、英語で作られクメール語に訳され、各 RTC に配布されている。

4） 教員の資格・待遇

教育基準によれば看護助産教員の資格は、医師看護助産などの有資格者かつ 3 年以上の臨床経験であり、教員になるための育成コースはない。（実態としては、3 年以上の臨床経験のない教員も少なくない。）近年の ADM 新カリキュラム導入で、主に助産師研修を担当している RTC 教員に対して、2008 年後半—2009 年前半にかけて、もともと保健省 HRD がもっている、カリキュラムをどう使うか、などといった、既存の TOT 研修（3週間）が、WHO や ACCESS などの予算支援で実施された。4 つの RTC のコアトレーナーグループが育成され、彼らが全国 RTC の教員や実習教員を指導、各 RTC で現在実施されていている。その他に NGO やドナーが持ちこむ断片的な TOT 研修に参加する程度で、教員にとっての研修の機会は系統だったものはない。教員は政府給与（月約 30ドル）のほか小額の講師料 (現在一時間 0.5ドル) をもらうだけで、HRD や校長たちによれば給与の低さがやる気の低さにもつながり、優秀な教員は休職制度を利用して NGO に移動するため定着しないとのことであった。現在 HRD は講師料基準を見直しており財務省に通ればプールファンドからの支出が可能とのこと (一時間 2ドル程度)。どの学校も教員の確保は課題であり、特に助産師コースはコース数が増え、学生数が増えているが担当の RTC 常勤助産師職員はどこも数名程度と不足は深刻で、学生教員比の基準を満たせなくなることになる。TSMC の場合は学費収入からの教員へのインセンティブがあり、政府給与の他に月 120ドル程度の報酬（通称 School fee）が常勤教員の収入となる。TSMC、RTC（カンポット、コンポンチャム）の現状は、看護助産教員は科目により医師・看護師・助産師、他のコメディカルが担当している。

5） 教育の現状に関するモニター制度

教育の標準化にあたり、保健省 HRD と学校や州

保健局による定期会議などで標準カリキュラムの実施徹底や現場の問題の解決が図られているが、実際の講義や実習の状況に関しては各 RTC や教員任せとなっており、教育の質に関するモニター制度は確立されてはいない。

Deployment（配置）

MPA 基準はあるものの現実には都市部以外のヘルスセンターは看護師（男性）が施設長と EPI や小児診療（IMCI）と結核やマラリア、助産師（女性）が母と新生児保健を見る形が一般的である。都市部への保健人材偏在解消のために設けられた PNS、PMW コースの学生は入学時に州保健局と RTC に対して卒後僻地のヘルスセンターへの就職の契約を結ぶ制度がストントレン RTC で 2003 年に始まった。その結果人材定着につながったことから 2006 年から他3つの RTC でも始まり、この制度は現実に機能していた。ADN と ADM は空席のポストに新卒業者が応募する形をとるが、助産師の場合ほぼ全員就職可能、看護師の場合は成績により就職できないこともある。応募には年齢制限があり助産師は 30 歳以下、看護師は 28 歳以下。また助産師の公務員給与の等級を看護師より 2 段階格上げるなど助産師確保の努力が継続されている。医師の場合、卒業後公務員とならず、プライベートセクターで勤務する学生もいる。看護助産とも、いずれの学校、保健省 HRD、人事部も卒業後の就職率や学生の就職先のデータをもっていない。

2008 年 9 月新大臣就任後、MDG 達成に向けて母子保健、特に妊産婦死亡削減が優先課題として挙げられ、Fast Track Intervention が施政方針として上げられた。それによれば

(1) すべてのヘルスセンターに最低1名の助産師を配置する (2009 年 9 月までに)、
(2) リプロダクティブ母子新生児小児保健件の継続ケアを改善する
(3) 安全な出産へのアクセスを上げる（適切なレファラルシステムや出産待機所、助産師インセンティブの実施、貧困者支援）
(4) レファラル病院の機能強化

(1)）により助産師育成配置に関してさらに注目度があがった。当地では、通称“Re-allocatkon”といわれている。具体的には保健次官 (H.E. Dr Te Kuy Seang) のもと人材養成部・人事部・州保健局長による委員会が設置され、助産師の配置転換やローテーション勤務（RH から HC へ、あるいは HC 間で)、新卒採用枠の中で MW 増加と HC への配置が始められた。今年は新卒 800 人採用のうち ADM69 名、PMW234 名で州保健局の状況に応じてヘルスセンターに配属、来年は新卒 850 名のうち 300 名以上は助産師（PMW あるいは DNM）の予定である。既存の助産師の配置転換を進めていることから、新規助産師育成を待たずに、今年 9 月に目標達成は可能としている。しかし当座の数合わせはできても、Fast Track は MW の定着や、配置された MW の能力やパフォーマンスまで言及しているわけではない。

Retention（定着）

1)　配置された保健スタッフの支援メカニズム

経済的支援（インセンティブ）：　現在、実施されている多様な援助スキームには、サービスの数 (例えば妊婦検診) に応じてドナー毎に異なるさまざまな仕組みのパフォーマンスインセンティブが組み込まれている。　ガイドラインもなく、標準化もされておらず、収集がつかない状況となっている (別添8)。また施設分娩推進のために 2007 年より政府より分娩インセンティブの支払いが開始された（一分娩あたりレファラル病院で 10 ドル、ヘルスセンターで 15 ドル）。これは導入に当たり保健省から僻地勤務の助産師に対する僻地手当ての導入として財務省に

交渉したところ、議論の中で施設分娩インセンティブにすりかえられてしまったという経緯がある (原因は不明)。現行 JICA 地域における母子保健サービス向上プロジェクトの調査によればこのインセンティブは施設内のスタッフで分配され、スタッフの収入向上に役立ち、サービスの数の向上にはつながっているようである。しかしインセンティブを獲得するために実際に助産師以外の職員が助産師が行うべきサービスを行っていることも多く観察され、サービスの質に関する問題は取り残されたままである（別添9）。また同プロジェクトの調査によると Contracting や NGO 支援のない地域では国家予算からヘルスセンターに至る過程で予算は目減りし、ヘルスセンターに到着する運営経費はゼロに等しい。現在のカンボジア保健省は、国家予算の流れをあるべき形にしようとするのではなく、外部資金をインセンティブとして使い人件費の上乗せを続けている状態である。僻地手当ては現在経済財務省と交渉中とのことであった。

技術支援： 現行 JICA 母子保健サービス向上プロジェクトによれば配置された新卒 PMW が「妊婦検診や安全な出産介助、新生児ケア」ができるようになるために NMCHC で 2 ヶ月の追加実習が必要であった。通常の助産師は 1 ヶ月の研修で十分であるところ、最低限の技能レベルに達するまでに 2 ヶ月を要したことより、新卒 PMW が卒前研修で習得している技能レベルが低いことが明らかとなった。これを踏まえて、同プロジェクトで実施中の PHD/OD レベル母子保健行政官と RH 助産師によるヘルスセンター助産師の支援制度モデル作りが進んでいて、その成果も見られている。他にも技術支援が可能な NGO はヘルスセンター助産師のスーパービジョンを行っているが、保健省（HRD）レベルではまだ助産師の配置までしか考えられていない。NMCHC（国家リプロダクティブヘルスプログラム）は自分たちの役割として配置された人材の提供するサービスの質を確保するためにいかに支援していくかは今後の検討課題と認識している。

2） 継続教育としての卒後研修

助産師は現在の話題の中心であることもあり、妊娠・出産・産後・新生児・乳幼児・家族計画など In-service training は、5 つの国家プログラムと、NGO やドナーがそれぞれに研修を実施している（別添 4）。助産師対象の包括的な 2 種類の In-service training コース（NMCHC 1 ヶ月コース、RACHA LSS コース）については、国家リプロダクティブヘルスプログラムは標準化を試みてはいるが困難な状況である。Comprehensive Midwifery Review によれば技能に焦点を当てた比較的長期の卒後研修 2 種類（NMCHC1 ヶ月コース、RACHA LSS コース）のみについては研修直後だけではなくその後も技能は定着し効果があることが示されている。しかし、研修で学んだ内容が実際に実施されるためには、薬剤機材があること、施設や部門の長が新しく学んだ知識や技術を使うことを認めることが必要であるが、これらに焦点をあてたフォロアップはほとんど行われていない。これらの卒後研修がどこまでサービスの改善につながっているか十分には検証されていないのが現状である。

3） 看護職のキャリアパス

現在保健省 HRD は PNS、PMW が SNS、SMW になるコース（Bridging program）を計画中である。現在の基礎教育以外には高等教育（修士・博士）のコースはまだなく、計画段階にもない。

2. 人材開発に関わる保健省担当部署や職能団体の役割とキャパシティ

1）　人材育成部（Department of Human Resource）

人材育成部（HRD）の組織図と人材配置は別添10の通り。部長、副部長2名、卒前・卒後・資格登録の3部門に分かれている。スタッフは15名、うち2名が国外長期留学中。実質の活動は、看護助産を中心とした卒前教育制度の確立と教育の実施に多くの時間と人材が割かれている。

卒前教育部門は看護・助産・臨床検査・放射線・理学療法のコースをカバーし、教育機関（TSMCと4つのRTC）を指導監督する役割を持っている。実際、看護助産カリキュラムの内容やチェックリストなどのツール、から試験監督までHRDが参加し、教育の標準化をHRD主導で実施している。2000年以降標準カリキュラム以外にも学校設置基準や入学卒業規定など教育制度の確立が進んだ。HRD担当者自身「コースカリキュラムの見直しは学校の役割との認識はあるものの現在は自分たちHRD側が進めていかないと進まない、将来はRTCに任せるべきである」と認識している。また一年の看護助産コース（PNSやPMW）は僻地への人材配置のための短期的な戦略で長期的には3年コース（ANDやADM）、そして4年のBachelorに発展すべきであるという長期的な視点を持っている。教育のモニターツールは作成したものの、スタッフが2名しかおらずHRDが直接教育の現場を訪れる形でのモニターは実施できていない。2002年から開始されたRTCやTSMCによる四半期会合で相互の連絡は改善しており、この会合はモニターの機能も果たしている。HRDとして今後は卒前教育（公立・私立）のモニター機能を強化すべきと考えているが、実施方法は検討すべきであろう。

卒後教育部門は予算を確保しHRDが実施することになった研修をアドホックに実施し、国外の研修の窓口が主な活動である。多くの卒後研修が国家プログラムにより実施されている中でこの部門の役割が明確ではない。資格登録部門は人材データベースの入力（GTZにより2000年に導入、全国保健人材登録と受講した研修が記録されている）以外の仕事はほとんどなく、データベースが利用されたことは、ほぼない。HRD全体としては卒後部門の4人、資格登録部門の6人、卒前部門の2名は出勤しているものの建設的な仕事をしている様子はあまり見られない。対外交渉も含めてHRDの仕事のほとんどは部長と2名の副部長で実施している状況である。

HRDはサウスウェールズ大学（オーストラリア）から技術支援を受けて2006年に人材育成計画を策定した。Workforce planは保健情報計画部（Department of Planning & Health information）や人事部（Department of Personnel）と調整し、実際の配置（スタッフ数）を見ながら中長期的に学生数を見直す必要があるとHRDは認識している（が実施されていない）。またPMW/PNSの配置を見越した学生受け入れが始まったころから人事部との情報共有が進むようになった。育成コース（特に助産師）の変遷を見ると、助産師育成の方向性の方針決定が人材開発計画、Workforce plan、現状の職員数や学校のキャパシティなどの現状分析、将来の展望に基づいて決められていたとは考えにくいほど場当たり的である。実際現在の助産師3年コース（ADM）は政治家の鶴の一声で開始が決まり大慌てで開始した、退職助産師の契約職員としての雇用継続がほとんど議論のないままに助産師フォーラムの結論として決まった、などという経緯がある。

人材制度の法的な制度整備（保健人材の規定・免許・登録、など）はほとんど進んでいないが、保健省がどこまで管轄するのか、省内のどの部署が担当するのか、どこまでがHRDの役割か明確ではないことも影響しているようである。

2） 人事部（Department of Personnel）

部長以下スタッフ 30 名。TOR は、データベースによる保健省スタッフの登録管理、給与・転勤などの管理、公務員新人オリエンテーション、など。年に一度、新卒就職後に状況を確認するために 2 － 3 名で州保健局を巡回する。HRD のデータベースと人事部のデータベースは連携しておらず、入力が主で、データを利用する、HRD と連携して育成と配置をつなげて考えるところまではいかないようである。現在 WHO とGTZ が 2 箇所のデータベースをつなげ、データの利用についてアドバイスを始めたところである。

3） 病院サービス部看護課（Department of Nursing）

病院サービス部の下にあり、課長とスタッフ 2 名。96 年から WHO が、その後 French Cooperation が支援、そのときに看護師の業務分掌を作った。現在アドバイザーはいない。主な活動は病院の看護サービスを巡回指導する、Regional Nursing Committee(全国6つ、病院看護部長会議を指導) が中心。昨年から HSSP の支援で予算がつくようになったが、スタッフがいないので 3 ヶ月に一度程度、州病院を巡回し、病院の記録を確認、衛生状況を見ている。現在は分娩インセンティブの実施状況モニターの指示があり、施設内の分配方法や記録類をチェックしている。課の人数が少ないこと、TOR と活動が病院レベルのみに限られていて、看護助産職全体を見渡す活動は難しいようである。

4） 職能団体

Cambodia Midwifery Association（CMA 助産師協会）, Midwifery Council は存在し、役員も決まっている。役員は病院勤務の助産師たちが主体で、専属職員はおらず、実質的な活動はあまり行われていない。最近の助産師に対する注目が大きくなったことから、助産師協会は資金を得て、助産師デーなどの催しものを実施しているが、この 2 団体の役割の違いを関係者は認識できておらず、アドボカシーの面でも技術面でも弱体である。Medical Council、Nursing Association, Nursing Council についての情報は時間の制約上入手できなかった。 助産師に関連して、UNFPA の技術アドバイザーの考えとしては、Midwifery Council は、助産師業務のスタンダードの定義、ライセンスや Accreditation について責任があり、CMA は、卒後研修、他の職能団体との連携、他国の助産師協会との連携、助産師の職能の向上に責任があると考えている。一方、保健省上層部を含め、保健省関係者すべて、これらの団体の役割や活動の方向性については明瞭ではなかった。

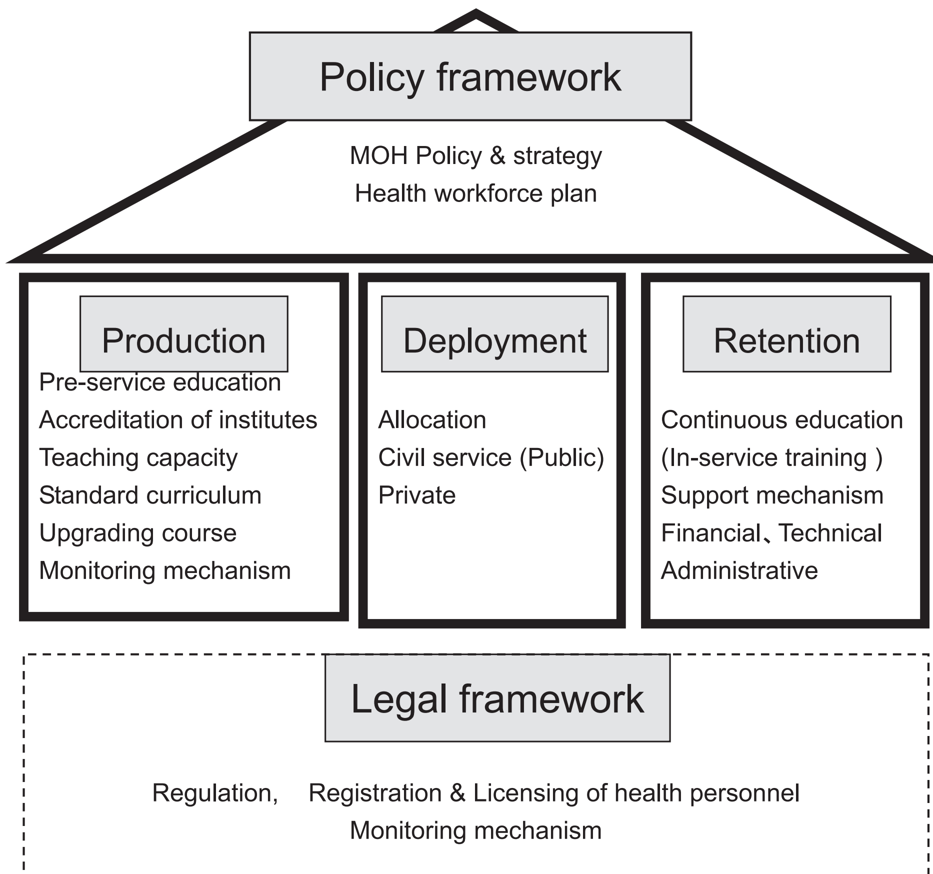
3. カンボジア人材開発システムの優位点と改善点

	優位点	改善点
政策・保健システム	人材開発が保健政策の中でプログラムを横断する優先課題として位置づけられている 人材開発計画が存在し、優先課題 (助産師、人材の偏在) と対策が明確である 公務員制度改革が進行中である 人材に関するアドボカシーの機会がある （助産師フォーラム、など）	人材開発計画の実施にあたり Workforce plan 修正と実施のために人事部・計画情報部との連携が強化される必要がある プライベートセクターや内務省（military）の保健人材に関する情報が少ない 3次施設（国立病院・センター）の人材配置基準がない 人材データベースが計画策定や政策決定に利用されていない
法制度	保健人材教育施設基準と認可制度がある	保健人材に関する規定、資格･免許登録制度がない 統合された職種の業務分掌がない
育成	標準カリキュラムが作られ、それに沿った教育が実施されている HRD と RTC のネットワークが強化された	(長期の) 教員育成コースがない 教員・実習教員の能力が不十分 実習体制が未整備 教員の待遇が悪い 教育実施に関するモニター制度が未整備
配置	卒後の僻地への配置を考慮した学生との契約制度がある 助産師の再配置・雇用の増加・基本給増加などで助産師のいないヘルスセンターが減少している	人材が都市部に偏在 (助産師のいないヘルスセンターがある) 低給与や教員ポスト数が少ないため教員の配置が難しい
定着	インセンティブにより僻地スタッフの収入が増え、サービスの増加につながっている NGO や国家プログラムにより卒後研修（国内外）の機会がある 支援メカニズムとしての新スーパービジョンがモデルとして実施されている（JICA プロジェクト）	基本給が低い さまざまなインセンティブのスキームが混在 インセンティブ取得のため、専門職以外のスタッフがサービスを提供している 卒後研修が標準化されていない 再配置された助産師の提供するサービスの質がモニターできていない 職能団体が弱体である
保健省人材養成部	組織図と TOR がある RTC・TSMC との報告連絡体制が確立した HRD と人事部の情報共有が進み人材配置と学生リクルートがつなげられるようになった	やる気と能力のあるスタッフが少ない 卒前教育の実施に HRD の多くの活動が裂かれている。 人材政策・法制度面での仕事が進んでいない
ドナーの投入	助産教育のカリキュラム作り、卒後の継続教育実施、さまざまなスキームのインセンティブによる助産師活動をドナーが集中して支援している。	看護助産教育の実施支援やモニター・教員育成・人材配置・人材制度整備に関わろうとしているドナーは少ない。

Ⅳ）まとめ

カンボジアにおいて保健人材は保健政策の中で常に中核に位置づけられ、助産師の不足と保健人材の偏在という課題を解決するために国家人材開発計画も存在する。特に2002年以降、看護助産を中心としたコメディカルの育成制度が確立し、実施するTSMC/RTCと監督するHRDとの連絡調整が改善した。また人事部との連携がよくなり、人材育成と配置が同時に検討され、配置につながる人材育成が進んだ。特に分娩インセンティブやさまざまなパフォーマンスインセンティブなどの支援制度がスタッフの定着を促進した。それに比べて保健人材の法制度面での整備（人材の規定、免許・資格・登録）が遅れている。また教員も同様に育成配置定着が必要であるが、その対策は卒業しサービスを提供する助産師に比べてほとんどなされていない。

これらを調査のフレームまとめると、Policy Framework は改善点を抱えてはいるものの形を作りつつあり、Production-Deployment-Retention は政策としての優先性からここ数年保健省を超えて政府内、公務員制度改革委員会による決断が下りさまざまな取り組みが実施されていて、成果を上げつつある。しかしそれに比べて人材制度の基盤となる保健人材の規定、資格認定・免許登録制度といった、国民へ保健医療サービスを提供する保健人材の質を確保するための制度が存在しない点が今後カンボジアの人材制度構築に向け改善すべき点と考えられる。



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カンボジアの社会保健指標とその推移

	2000	2005	2007	2008
乳児死亡率（出産 1000 対）	95	66		
5 歳未満死亡率（出産 1000 対）	124	88		
妊産婦死亡率（出生 100,000 対）	437	472		
合計特殊出生率	4.0	3.4		
妊婦検診カバー率（最低 1 回）	37.7%	69.3%	68%	81%
施設分娩率	11%	21%	25.5%	39%
SBA がカバーする出産率	32%	44%	46%	58%
DPT3 カバー率	43%	76%		
DPT3-HepB カバー率			87%	90%
IMCI を実施しているヘルスセンターの割合			58%	69%
低体重児（－2SD）の割合	39.5%	28.4%		
安全な水へのアクセス（都市部 / 郡部）		67%/54%		
一人当たり国民総生産（US$）＊	300	460	550	
HIV 有病率（15-49 歳 ）＊	1.6	1.0	0.8	
初等教育完了率　＊	47	85		
人口 (Census 2008)				13,388,910
都市部人口 (Census 2008)				19.5%
面積				181,035 Km^2

Data source：
Demographic Health Survey (2000, 2005);
Progress report HSP taskforce program area 1 RMNCH (2007, 2008)
＊ World Development Indicators database
＊＊ General Population Census of Cambodia 2008

National Health Coverage Plan

Operational District: OD(保健行政区) の標準サービスと施設数（2009 年 5 月現在）

診療施設	主なサービス	カバー人口	施設数
Referral hospital	CPA3（CPA2 ＋血液銀行、眼科耳鼻科） CPA2（CPA1+ 外科・手術室） CPA1（内科小児科産婦人科、救急外来、臨床検査放射線、薬局）	60,000 ― 200,000	CPA3（21） CPA2 (39) CPA1 (16)
Health center	MPA（妊婦検診、出産、新生児、乳児、EPI、結核、マラリア、健康教育など）	8,000 ― 12,000	960（＊）

（＊）建物のある MPA ヘルスセンター、建物がないがスタッフがいる non-MPA ヘルスセンターを含む

公的セクターの保健人材数 (人口あたりの医師・看護・助産師数、看護助産職・医師の比率)

	2007	2008	総数	人口 1000 人当たり	看護助産 / 医師
Medical Doctor	2,162		医師 3,429	0.25	3.22
Medical Assistant	1,267				
Secondary Nurse or ADN		5,186	看護師 8,720	0.65	
Primary Nurse		3,534			
Secondary Midwife or ADM, DMN		1,844	助産師 2,322	0.17	
Primary Midwife		1,478			

（National Health Statistics 2007 & 2008）

Total population ＝ 13,388,910 （Census　2008）を総人口として用いた

ドナー投入表

看護助産関連の人材育成へのドナーの投入状況

	Policy framework	Legal framework	Production	Deployment	Retention	その他
WHO	データベースを元に Workforce plan 詳細の支援（アドバイザー長期 2009 年 4 月から 2 年）、HLMWTF・TWGH などメンバー	MW Council 設立支援、Regulation、Registration 支援は可能 (投入は未決定だが)	助産師教育カリキュラム作成支援、WHO 技術ガイドラインの配布など	HRD と Personnel にあるデータベースの活用支援、Personnel の MBPI、SOA 準備支援（アドバイザー長期 2009 年 4 月から 2 年）	WHO 技術ガイドラインの配布など	
UNFPA	HLMWTF・TWGH などメンバー	MW Council、MW Association 支援？	助産師教育カリキュラム・ツール作成印刷支援、RTC/TSMC に教育機材 (モデルなど計＄200,000）供与 (供与先は未決定)、HRD によるRTC モニター支援、TOT など HRD からのリクエストに応じ研修費用支援、RTC 教員に対するインセンティブ (講師料（一時間 2ドル程度）の支援、財務省の許可が下りればプールファンドからの支出が可能）	学生リクルートのための TV やラジオ広報、公務員へのオリエンテーションの費用を支援 (実施は Personnel)	PHD/OD からの AOP の中の RMNCHコンポーネント (研修、スーパービジョンなど）への資金支援（24OD)	現在のカントリープログラムは 2010 年まで RMNCH、人材育成、HSSP の 3 分野。2011 ー 15 年を現在作成中だが大きな変更はないだろうとのこと。HSP2 の実質リーダー的存在
GTZ/EPOS	HLMWTF・TWGH などメンバー		看護プレセプター研修カリキュラム作成支援、チャム・カンポット・バッタンバン RTC 対象に研修実施。3つの RTC への機材供与など。 DED(JOCV にあたる) による OJT(チャム・カンポット・バッタンバン州病院に配属され実習教員の指導。	HRD データベースに関する技術支援	HC、RH の MW 対象の研修 (カンポット、コンポントム 2 州）に対し RACHA 委託して LSS を実施。研修後は州の MCH チームによるフォロアップ支援、同時に HC に必要な機材供 .	
Aus AID			TSMC 助産教員と実習教員強化、実習体制整備のための技術アドバイザー (2009 年後半より 2 年）2 名			プールファンド、UNFPA・GAVAI への拠出

RACHA/USAID	TWGMCH メンバー		助産師教育カリキュラム・ツール作成支援、RTC 教員・実習教員の育成、RTC の改修や機材、実習先（RH や HC の開拓と実習体制づくり）		対象州 OD の RH・HC に対する LSS 研修、PHD/OD によるスーパービジョン（資金）支援、RH/HC スタッフへのパフォーマンスインセンティブ、	
URC/USAID	HLMWTF・TWGH などメンバー				象州・OD の運営強化（HIS 含む）、RH/HC の質管理とスタッフへのパフォーマンスインセンティブ、Equity fnud、	Access/JPHIEGO との連携が検討中
RHAC/USAID	HLMWTF・TWGH などメンバー				対象州・OD スタッフへのパフォーマンスインセンティブ	対象州およびプノンペンにある RHAC クリニックによる RMNCH サービス提供、家族計画のディマンド増加のためのコミュニティ動員活動
French Cooperation	TWGH などメンバー		TSMC 助産コースに AV 機材供与（＄20,000）			
ACCESS/UNICEF	HLMWTF メンバー				対象州・OD の HC や RH の新生児ケアトレーニング実施。	他国で導入した「産後出血予防のための地域 TBA による Misoprostol 使用」を提案したが MOH 倫理委員会で却下された。

USAID はこの3つの NGO に、5 年間で各々約＄30M の資金支援。6. 対象地域は 10 州、43OD（プルサット、バッタンバン、バンテミンチェイ、シエムリアップの全州、コンポンチャム、プレイベン、ココン、シアヌークビル、コンポンスプー、プノンペンの一部の OD）。これらは USAID 州（OD）となり、RACHA、RHAC がヘルスセンターとコミュニティをつなぎ、MNCH 分野で活動。
黄色部分は、支援がないことが確認できた部分である。

保健人材全般の育成校・コース名、入学卒業制度
保健従事者の教育システム（As of June 2009）

1. 育成コース、資格

Higher Education（Bachelor を取得）

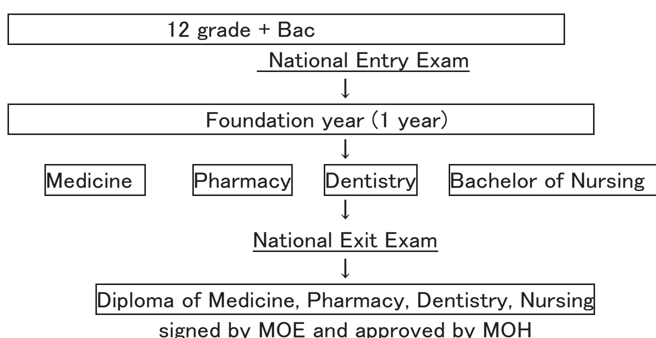
	Public university	Private university
Medical Doctor Dentist Pharmacist	University of Health Science (UHS)	International University (IU): Phnom Penh
Bachelor of Nursing	University of Health Science (UHS): TSMC	International University (IU): Phnom Penh Life University: Sianouk Ville

Secondary Education（Diploma 他を取得）

Qualification	Duration	TSMC	RTC Kg, Cham	RTC Kampot	RTC Batambang	RTC Stung Treng
Secondary NS（Associated Degree of Nursing）	3 years	○	○	○	○	○
Primary NS	1 year		○	○	○	○
Secondary MW（Associated Degree of MW）	3 years	○	○	○	○	○
Primary MW	1 year		○	○	○	○
Diploma NS/MW	4 years (NS 3 + MW1)	○	○	○	○	
Laboratory technician	3 years	○				
X-ray technologist	3 years	○				
Physiotherapist	3 years	○				
Bachelor of Nursing	4 years	○				

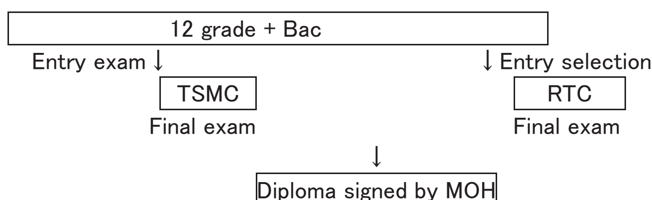
2. 入学・卒業

1）Medical Doctor, Pharmacist, Dentist, BcNS



National Entry Exam（国家入学共通試験）は2008年より開始、National Exit Exam（資格取得のための国家試験に相当）は2012年実施を目指している。Council Minister（Sok An 副首相）が長となりNational Examination Committeeが試験を準備運営している。メンバーはCouncil Minister, Secretary of State（MoH and MoE）, representatives of ACC, professional board（Medicine, Pharmacy）, Dean of UHS and IU, とHRD/MoH。

2）Nurse, Midwife, & other comedicals



・ RTCの入学試験

高卒・バカロレア受験後、学生はRTCの各コースに応募、MOHにあるNational Committee（HE Dr. Tey Kyu Sien、HRD, RTC）により学生が選抜される。基準は年齢、住所、バカロレアの点数（生物、数学、化学）で、選抜後各学校に配置される。

SMWとSNSの学生数は州人口により決められ各RTCに割り振られる（Quota system）。PMWとPNSは僻地HCでの職員でありPHDからの不足人員の報告を元に割り振るが、入学時にPHD/RTCと卒業後の就職先に関する契約を結ぶ。学生は自分の住所の属するRTC以外のRTCには入学できない。

	カバー州
TSMC	Phnom Penh, Kandal, Kg Chhnang, Kg Speu
RTC Kg Cham	Kg Cham, Kg Thom, Svay Rieng, Prey Veng
RTC Battambang	Battambang, Siem Reap, Pursat, paillin, Bantemeanchey, Odymeanchey,
RTC Kampot	Kampot, Takev, Koh Kong, Sianouk Ville, Kep
RTC Stung Treng	Stung Treng, Kuratie, Preah Viher, Mondolkiri, Ratanakiri,

以前に比べてTSMCやRTCは人気が高くなり、Bacのスコアにより選抜で落ちる学生もでてきた。TSMCはPNS/PMWコースを実施していないので、PNS/PMWと希望するKandalの学生はRTC Kg Chamに、Kg Speuの学生はRTC Kampot、Kg ChhnangはRTC Batambangに入学する。

Diploma NS/MW（4 year）は助産師不足解消を目的として2003より開始。SNSの有資格者に対し1年の助産師教育を提供し助産師となる。しかし看護師と助産師の給与スケールが同じだったため希望者が少なかった。最近の助産師優遇政策で助産師の給与スケールが看護師に比べて上がったため希望者も前よりは増えているとのこと。HRDは今後このコースをどう整理するか今後検討するとのこと（廃止、BcMWとする、など）

・ RTCの卒業試験

HRD/MOHとRTC/TSMCは卒業試験標準問題集を作成、毎年各RTCはこの中から問題を選び卒業試験とする。臨床実習も標準評価用紙（チェックリスト）を作成、教員がこれに基づき学生の技能を

評価する。卒業試験の正解率はRTCにより40%－80%と差があるが、卒業＝資格取得であり、国家試験はまだ予定されていない。

・ TSMCの入学卒業試験
　TSMC は Autonomous（2006 年より）となったため、入学卒業試験は上記標準問題集とチェックリストを使いTSMCが独自に実施している。学生の約25%が学費免除の学生、残り75%が年間800ドルの学費を払う。

3. Study Report on Stakeholder Analysis in the Development of HRH in the Democratic Republic of the Congo

THE DEMOCRATIC REPUBLIC OF THE CONGO

MINISTRY OF PUBLIC HEALTH

SECRETARIAT-GENERAL

GENERAL SERVICES AND HUMAN RESOURCES DEPARTMENT

STUDY REPORT

ANALYSIS OF STAKEHOLDERS IN THE DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH IN DRC

Study financed by the Japanese International Cooperation Agency (JICA) and the National Center for Global Health and Medicine (NCGM)

By ZANDIBENI KAKU Jacques
Consultant.

October 2012

This report was originally written in French and translated in English

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THANKS

The content of this report is the product of input from multiple persons: the officials and managers of the Ministry of Public Health, namely those of Central departments responsible for human resources, the officials and managers of other Ministries visited, key informants and focal points of stakeholders and partners of the Ministry of Health with an interest in the question of human resources for health in the DRC.

Convinced of this work, they gave up their time, dedication, availability, ideas and experiences; namely, their best to ensure its realization.

We trust that in reading these words, they will also understand our expression of gratitude to all of them.

Dr. Jacques ZANDIBENI KAKU

ABBREVIATIONS AND ACRONYMS

MA	Managerial administrator
AHAM	Association of Health structure Managerial administrators
NANC	National Association of Nurses of the Congo
AMPS/GHWA	Global Health Workforce Alliance
ADB	African Development Bank
DOMW	Diocesan Office for Medical Works
WB	World Bank
DPSD	Department of Population Sciences and Development.
Monkole/CSTS	Monkole Center of Studies and Training Support
NMC	National Medical Council
BTC	Belgian Technical Cooperation
UCK	University Clinics of Kinshasa
HD	Head of Division
HO	Head of Office
TCC	Technical Coordination Committee
DSP	Department of Studies and Planning
OM	Office of Migration
KHD	Kimbanguist Health Department
PDIH/Kinshasa	Provincial division/inspection of Health of Kinshasa
CCC/SANRU	Church of Christ in the Congo/Sant? en Milieu rural (Rural Healthcare)
ESP/UNIKIN	School of Public Health of Kinshasa University
AFDRC	Armed Forces of DRC
EDF	European Development Funds
GAVI-Alliance	Global Alliance for Vaccines and Immunization
IHSDG	International Health Sector Donors’ Group
IMS	Institute of Medical Studies
NIS	National Institute of Statistics
HIPCI	Heavily Indebted Poor Countries Initiative
Monkole/HIN	Monkole/Higher Institute of Nursing
HITMS	Higher Institute of Technical Medical Studies
JICA	Japan International Cooperation Agency
KOICA	Korea International Cooperation Agency
MIHUE	Ministry of Higher Education and University
MICS	Multiple Indicator Cluster Survey
PMI	Provincial Medical Inspector
LDHZ	Lead Doctors in Health Zone
MPA	Ministry of Public Administration

MPH	Ministry of Public Health
MPH/D12	Office in Charge of MPH Partnership (12th Office)
MEWSW	"Ministry of Employment, Work and Social Welfare"
NCGM	National Center for Global Health and Medicine
NTCI	New Technology of Communication and Information
OCM	Observatory of Congolese Media
WHO	World Health Organization
NEO	National Employment Office
NGOD AFRO BENELUX	"No-Governmental Organization of the Congolese Diaspora of Belgium, Netherlands and Luxembourg."
NHWO	National Health Workforce Observatory
GSP	Governance Support Project
NPHD	National Plan of Health Development
HHRNDP	Human resources for health National Development Plan
UNDP	United Nations Development Programme
SH	Stakeholder
PRGC	Project to Reinforce Governance Capacities
HRH	Human Resources for Health
CNRT	Congolese National Radio & Television
SG	Secretariat-General
MGS	Minimum Guaranteed Salary
NSHI	National System of Health Information
NUD	National Union of Doctors
NUDS	National Union of Dental Surgeons
NUPC	National Union of Pharmacists of the Congo
NUEAESS	"National Union of Executives, Agents and Employees of Service Sectors"
HSRS	Health Sector Reinforcement Strategy
PHC	Primary Health Care
UNIKIN	University of Kinshasa
UCL	"Catholic University of Louvain, Belgium"
FUB	Free University of Brussels
USAID	United States Agency for International Development

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SUMMARY

People are the core at the center of the operation of any organization; considered as a form of capital which adds value to all other resources by allowing them to become socially useful products.

In its 2006 World Health Report, the World Health Organization condemns a crisis of human resources for health which has beset the world for some years; no continent immune to the problem. However, this crisis is particularly acute in African nations. This report highlights in particular how Human resources for health (HRH) are one of the bottlenecks which prevent international aid from materializing into improved health outcomes in developing countries.

The DRC, like most developing countries, faces multiple problems concerning human resources for health (HRH). These include: inappropriate production not taking any planning into account, unfair distribution among provinces, inappropriate retention measures, lack of coordination among national and international actors and the lack of a reliable system of information on HRH, including production of substandard health workers.

Since 1998, the country has been implementing a HRH development system. In 2006, with the accession of the Health System Reinforcement Strategy (HSRS), the process was accelerated, finishing in 2010 with the creation of the National HRH Development Plan (HHRNDP, 2011-2015) which, in turn, is an integral component of the National Plan of Health Development (NPHD) to obtain the Millennium Development Goals.

To facilitate the implementation of the HHRNDP, a project to support the development of HRH (PS-DHHR) was initiated by the Management in charge of HR at the Ministry of health (D1) supported by the Japanese International Cooperation Agency (JICA). The flagship activities of the project, namely clarifying the content of actions of national and international partners in the HRH area and sharing information among stakeholders in the National HRH Observatory were cited as priorities.

It was necessary to analyze stakeholders via a survey to map out the latter as a key tool for the organizing authority to coordinate the interventions of all actors implementing the HRH development.

The overall objective of this analysis is to establish a Status Report of stakeholders in HRH development in the DRC.

In specific terms, 6 objectives were chosen:

1. Analyze stakeholders monitoring their missions and respective priority areas in HRH in the DRC.
2. Analyze stakeholders according to their HRH activities and their areas of engagement in the HRH development process.
3. Compare stakeholders according to their areas of interest in this process.
4. Map out details of all stakeholders in the development process of Human resources for health.
5. Analyze the HRH development system of the DRC via the key informants.
6. Formulate recommendations.

From a methodological perspective, it involves a cross-sectional study with descriptive intention. It

was initiated primarily utilizing qualitative methods for collecting data, namely interviews centering on focal points of stakeholders and semi-structured interviews with the key informants. In total, 31 stakeholder structures were visited and 10 key informants interviewed.

Main study results:

- The areas of interest and engagement for stakeholders concerning the National Development Plan of Human resources for health were identified. In fact, the study points out that the 4 sectors of HHRNDP, namely career management, basic training, continuous training and retention, are of interest to all stakeholders. However, their interest seems stronger in the area of continuous training compared to other sectors.
- As for areas of engagement in the HRH development process, according to "the house model", apart from consultation, which is of interest to almost all parties (72%), continuous training (69%) and reinforcement of institutional capacities (69%) headed the field in terms of interest of stakeholders; while there was much less commitment to career management (21%) and funding (39%) of HRH. Nevertheless, there are specific features of interest or commitment according to the categories of stakeholders.
- The lack of commitment among stakeholders to fund the agenda of the HHRNDP was cited. In fact, this analysis shows that only around 13% of stakeholders offered funding to MPH as opposed to 81% which were ready to offer it expertise.
- In qualitative terms, the study results corroborate the situational analysis of the HRH performed in 2010; which shows that the implementation of the HHRNDP is still lagging behind.
- Other partners, previously unknown in terms of their interest in the HRH issue, were discovered, and can be capitalized with a number of opportunities.
- Finally, other considerations not mentioned in the HHRNDP such as strategies to sustain the current gains of countries in terms of HRH development were discussed with the key informants.
- In sum, the analysis allowed mapping of the required data for the HRH National Observatory and facilitated the coordination of stakeholders in HRH development by the Management responsible for HR within the MPH.

1. INTRODUCTION

1.1. Context and justification

In all nations in the world, Human Resources represent the key element of any organization, since over and above their economic impact, it is they which add value to other resources by allowing them to become socially useful products. (1, 2).

In its 2006 World Health Report, the World Health Organization condemns a crisis of human resources for health which has beset the world for some years; no continent immune to the problem. However, this crisis is particularly acute in African nations. In fact, according to this report, 57 countries are affected worldwide, 36 of which in Sub-Saharan Africa, with a cumulative lack of 4.3 million health workers and 1 million in the African continent alone (3). As regards the glaring inequalities observed in quantitative and qualitative terms, firstly between developed and developing countries, and secondly between rural and urban areas, especially in Africa, this Report clearly shows that Human resources for health (HRH) are one of the major bottlenecks preventing international aid from materializing into improved health outcomes in developing countries. (3, 4).

Developing human resources is thus the mainstay of efforts to ensure the adequate operation of a health system. In fact, “Human resources, alongside material resources and infrastructure, constitute the factors for establishing care in a health system” (Kashala[1], 2008). “Given their importance in the organization and especially in the implementation of healthcare to benefit the community, it is crucial for countries to strive for a sustainable development perspective of these human resources for health” (Youssouf Ould Limam)[2].

HRH development transcends the administrative management function of health professionals; rather, it is a more strategic approach of assessment and recognition of the latter as compelling and irreplaceable human capital for the provision of quality healthcare, the sole guarantee of attaining the Millennium Development Goals in the health field. This makes it the benchmark and the catalyst for the adequate operation of a health system. (5).

The DRC, like most developing countries, faces multiple problems in terms of human resources for health (HRH). These most commonly involve: inappropriate production not taking any planning into account, unfair distribution among provinces, inappropriate retention measures, lack of coordination among national and international actors and the lack of a reliable system of information on HRH, including production of substandard health workers.(6,7).

In 1998, initial discussions on HRH development in the DRC were held during the country’s participation in the HR development strategy for the WHO region formulated in Lome, Togo. Regarding this strategy, the DRC set out its first document on HR development policies, but no implementation followed. In fact, the country suffered from a lethargy due to armed conflicts up until 2006, the year prescribed by the WHO to health workers.

[1]Kashala : First Professeur Noir of human resource management lessons, at the School of Public Health of the University of Kinshasa/DRC. In “course module on human resource management, Academic Year 2008-2009”.

[2]Youssouf Ould Limam provided the preface for the Development Plan of the RHS of the Islamic Republic of Mauritania ; he is in charge of the Computer-aided HR Management Office at the Ministry of Health and Social Affairs in this country.

The participation of countries in international forums on human resources, particularly in Douala (with the preparation of the Douala plan in 2008) and in Kampala (notification of the Declaration of Kampala), allowed the DRC to identify the major weaknesses which assailed its human resources for health system, namely the lack of a reliable information system on HRH(1, 2). Instead, without available data on human resources, workers will be raised without planning and coordination, and with no guarantee of the quality of training. (8).

This situation prompted the country, via a multisectoral committee, called “Commission of human resources for health”, in collaboration with development partners, GAVI and cooperation agencies namely JICA, to set up a National Development Plan of Human resources for health, HHRNDP for short, since November 2010. This plan fits into the general framework of the Health System Reinforcement Strategy and the National Plan of Health Development of the country, which retained HRH development as one of the strategic priorities to support the development of ZS. In fact, the development of human resources is one of the key aspects of the health system reinforcement strategy (5,7).

Moreover, the HHRNDP-DRC, for its part, retained the reinforcement of the intra- and inter-sector partnership in the HRH sector as a strategic priority. It commences, among other things, with the creation of a framework for dialog with all stakeholders (MESU, users, unions, orders and professional associations...) (1,6).

In view of the implementation of Planning, a Project of the Ministry of Health initiated by the Management responsible for Human Resources (D1) partnering the Japanese International Cooperation Agency (JICA) entitled: “Project to Support the Development of Human resources for health (PSDHHR)” was established. The main activities of the project, including clarifying the content of activities performed by national and international partners intervening in human resources for health and sharing information between stakeholders were retained as priorities (9).

To ensure feasibility, a process to set up the National Observatory of Human resources for health (NHWO) was launched within the Ministry of Public Health thanks to technical support provided by the WHO. This set up should proceed in stages, the most important of which consists of the identification, analysis and involvement of all stakeholders involved in the HRH issue. The first sector of this stage was completed since August 2011, with the adoption of job description by the NHWO, involving preparation of the list of stakeholders committed and allocation of roles for each of them to play in this process.

This should lead to the second sector, which consists of analyzing stakeholders to clarify the content of their respective activities related to the development of human resources for health with a view to improved involvement. Therefore, it proved necessary to embark on a study, in the form of a survey, initiated among all stakeholders to facilitate analysis and preparation of efforts to map stakeholders. This is the context to the present study report.

1.2. Conceptual framework

The analysis of stakeholders for the development of Human resources for health in the DRC, was conducted with regard to the elements of the Human resources for health development system such as illustrated in the conceptual model below: (House Model)

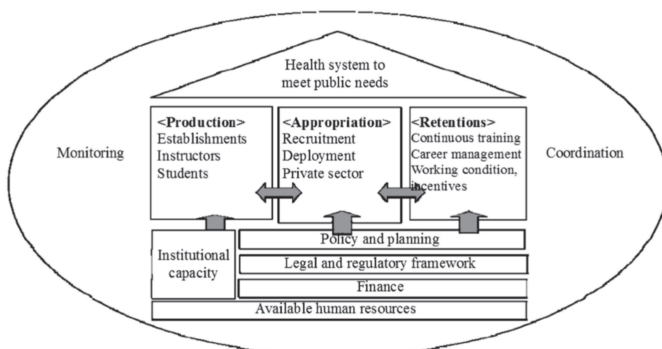


Figure 1: Conceptual model of HRH development "House Model" (10).

The conceptual framework above shows a health system which responds adequately to the needs of the population like the framework of an organization which must be constructed on a cornerstone of available human resources, of high quality and in sufficient quantity.

To achieve this, the HRH development must itself be built on its three main pillars, namely production, deployment and retention. Those, in turn, must be founded on an effective policy and planning, a consistent and well-adapted judicial and regulatory framework, a reliable and concrete system of funding and institutions with reinforced capacities. All architecture constructed in this manner should be supported by a coherent and functional coordination and dialog mechanism involving all stakeholders.

1.3. Objectives

The objectives pursued in this study are given below:

a) General objective:

   Establish an inventory of stakeholders involved in the development of human resources for health in the DRC.

b) Specific objectives:

   1. Analyze stakeholders, monitoring their mandates/missions and their respective priority areas in HRH in the DRC.
   2. Analyze the stakeholders according to their activities in HRH and their areas of engagement in the HRH development process.
   3. Compare stakeholders according to their areas of interest in this process.
   4. Map out details of all stakeholders in the Health Human Resource development process.
   5. Analyze the HRH development system of the DRC via the key informants.
   6. Formulate recommendations.

2. STUDY METHODOLOGY

The methodology followed in this analysis is the same as that used for qualitative studies. In fact, it comes into its own when used for an analysis of stakeholders as a tool to identify the needs, issues and/or interests of the various parties concerned by what is often too wide a question, based on the model of the development of human resources for health. The goal here is to improve understanding of the areas of interest and mutual perceptions for the development (11, 12). Nevertheless, before proceeding with the qualitative analysis, some qualitative data were also collected with the intention of measuring simple indicators.

The SD 21000 standard (Sustainable development for the 21st century) defines the "***relevant parties or stakeholders***" as "*any individual or group which may affect or be affected by, directly or indirectly, in the short- or long-term, by strategies, actions, messages (and their consequences), that the organization implements to attain its objectives*". More recently, the ISO 26000 standard on societal responsibility invites companies to identify their "stakeholders": "*The stakeholders are the organizations or individuals which have one or more interest/s in a decision and any activities performed by an organization*". *They may also provide genuine development opportunities for the organization*(13).

2.1. Type of study

It is a cross-sectional study with descriptive intention primarily based on qualitative methods.

2.2. Site of study

The study concerns all three levels of the health pyramid of the DRC. However, this report centers on collected data mostly in Kinshasa, provincial city and capital of the DRC. In fact, this first section of the analysis of stakeholders focused initially on Kinshasa; based on the idea that starting with Kinshasa, which is at the center of the health system and which encompasses almost all head offices of official institutions active in the country, this would allow information on most stakeholders operating in the country to be obtained. Lessons learnt from the survey in Kinshasa could allow the scope of the analysis to be extended to other provinces subsequently.

2.3. Population of study

The population of this study constitutes all stakeholders involved in the area of human resources for health.

At a central level, the study targeted the Ministry of Public Health (MPH), namely the Secretariat-General, as the administrative authority and two other central divisions, namely that responsible for studies and planning (D7) and that responsible for partnership (D12). The three Management arms of MPH directly involved in HRH, namely the Management of General Services and Human Resources (D1), the Management of the Teaching of Health Sciences (D6), and the Management of Continuous Education (D11), as integral components of the research and/or analysis team, were not targeted by the analysis.

The other Ministries involved in HRH were also targeted, namely, the Ministry of Higher and University Education (MIHUE), Ministry of the Civil Service, Ministry of Labour, Employment and Social Benefits, Ministry of Planning, Ministry of Finance and Ministry of the Budget.

Furthermore, the other stakeholders, particularly the training institutions, the private and religious sector, the orders, unions and associations of health professionals, development partners, and some NGOs were also involved in this analysis.

2.4. Variables, indicators and expected results

In the course of this study, some variables of interest were analyzed, including:

- Categories of stakeholders involved in HRH development in the DRC.
- Levels and priority areas of stakeholders in the health system.
- Areas of interests of stakeholders in the HRH development process;
- Nature of available resources for stakeholders to support the HRH development process.
- Level of interest of stakeholders in the HRH development process.

Indicators:

The analysis allowed us to measure certain indicators; such as:

- Number of stakeholders involved in the HRH Development process.
- Proportion of stakeholders by level of intervention in the health pyramid.
- Proportion of stakeholders by areas of intervention.
- Nature of information on HRH available from stakeholders.
- List of main actions of stakeholders by level of intervention.
- Existence of mapping of stakeholders implementing the HRH Development.

Main study results:

- Mapping of information on HRH linked to the prepared NHWO.
- Mapping of stakeholders: localization, seniority and areas of interest in the HRH, available.
- Qualitative analysis of the HRH development system implemented.

2.5. Sampling

a. Sampling technique:

Based on a previously drawn-up list of stakeholders having participated in the preparatory workshop of the National Health Workforce Observatory (NHWO), the research team members used brainstorming to complete the list, while ensuring all categories of stakeholders involved in the issue of human resources for health were represented. In fact, given the multisectoral nature of the structures involved in human resources for health, it was a matter of ensuring all sectors could at least be represented in the sample analyzed, namely, the public sector, private sector, religious, civil so-

ciety as well as development partners.

The ideal was to list up the stakeholders visited using the snowball sampling technique but constraints of time, namely just two weeks in which to collect data, did not allow sorting to proceed. In other words, the sampling was performed out of convenience, made up according to professional networks.

b. Choice of key informants.

In the course of the workshop for adoption of job discription of NHWO, each stakeholder structure designated a focal point, which would represent it within this forum. The latter was officially identified as a target to respond to a questionnaire concerning its holding structure.
For stakeholders not having participated in this workshop, the contact person was the manager of the targeted structure or similar around the same, who guided the investigator on the ground.

As regards key informants for the qualitative analysis of the HRH development system, this was chosen based on a profile: their knowledge, experience and responsibility in the research, training and/or management of human resources for health. A shortlist of 14 informants was compiled, 10 of which were found and 4 were unavailable.

c. Size of the sample

In total, the scope of this analysis included meeting with 41 stakeholders, 31 of whom responded to the questionnaire survey targeting their structures as stakeholders and 10 key informants who were interviewed in depth about the HRH development system of the country.
Among these stakeholders, two were portrayed using two types of tools via two different respondents, namely, one focal point having responded to the questionnaire survey as a structure stakeholder, and a key informant who was passed on to the interview guide. (see diagram of stakeholders grouped according to the tool used to collect the data, lower, in the results section). From here, a difference is seen in the addition, namely 39 stakeholders, in the mapping of annexed data.

2.6. Data collection techniques

As already detailed above, the data used for this analysis were collected by two main techniques, namely, documentary review and questionnaire interviews and by an interview guide based on target informants.

The documentary review allowed a summary of the background to the evolution of the development process of human resources for health in the DRC as well as the major challenges it faces at this time. To do so, a certain number of normative and other documents were reviewed and the information within was summarized and used in the introductory section of this report.

The directed interviews, meanwhile, were conducted using a pre-established questionnaire sur-

vey, intended for the structural analysis of stakeholders for the observatory of HRH. This tool is set out in the annex of this report.

The conversations or semi-structured interviews with key informants were conducted using an interview guide. (See tool in annex).

To guarantee the quality of the collected data by interviews, interviewers were briefed for two days on the methodology of how to conduct interviews (qualitative method) and on the data collection tools; this briefing also allowed supervisors to ensure that all interviewers had the same understanding of the importance weighted on different questions based on role-playing games in the classroom with feedback. Finally, the tools were pretested with the intention of perfecting their formulation.

Aiming to maximize the potential information provided by the key informant, each interview was conducted by three interviewers, namely one main interviewer and two note-takers. The study did not use recordings to avoid any misunderstanding on how such recorded information would be used on the part of the interviewees.

In total, the data collection lasted two weeks and was performed by a team comprising 12 interviewers divided into 4 groups of 3 interviewers by work team. The 3 initial teams were tasked with collecting data from stakeholders with the questionnaire survey, while the fourth team was earmarked to conduct the semi-structured interviews with the key informants. The interviewers were accompanied on the ground by a team of supervisors, including two Central managers of MPH and a JICA consultant.

2.7. Data processing and analysis

After having collected data on the ground, the interviewers should consult at the end of the day to compile the notes for the interviews completed and/or duly complete the questionnaire survey. These field notes should be entered before being passed on to supervisors, who should validate them before passing them onto the consultant for compilation.

Once all the entered questionnaires have been collected, all data of the structural analysis were centralized in a summary matrix, bringing together the main questions and their responses for each stakeholder. This file, which was created in Excel, was debugged to reduce typing and transcription errors as far as possible and then used as the base document for analyses performed on the collected data. Moreover, the quantifiable information was summarized using the cited statistical methods: frequency, percentage, etc. to calculate the relevant indicators.

The data collected via semi-structured interviews with key informants, meanwhile, was subject to manual qualitative analysis.

In fact, an analysis team comprising 7 persons was assembled, including interviewers having collected the specific data in question (namely, the 3 interviewers of group 4), D1, and three public health experts, of which 1 short-term Japanese consultant, the head of the PSDHHR project and 1

Congolese consultant.

Following a careful reading through all the interview notes, the team proceeded to the identification of concepts, and labeling, coding and grouping the same before the analysis in real terms got underway.

The information thus compiled allowed the main tendencies of the points made by informants to be aired, also by category, from which useful lessons could be learnt. Nevertheless, attempts were also made to respect the terms, points and key words or verbatim responses used by respondents to preserve the original flavor of the same.

Moreover, to create schematic representations of the qualitative analysis results, the Mindjet Mind-Manager 9 software package was used.

In absolute terms, all the information analyzed allowed the results of this analysis to be presented in the form of a narrative report, summary tables, graphics, and finally mapping of stakeholders in relation to the conceptual framework of the study.

2.8. Timetable of activities

The activities performed as part of this study were initiated from August 2011, with the assembling of the research team and the preparation of the draft list of stakeholders to visit.

This is followed by the recruitment of a consultant who should support the team already assembled by members of the Ministry of Health and those of JICA, to prepare the study protocol, the data collection tools as well as a combined timetable of activities. This preparatory period lasted nearly 3 months; from September to November 2011. The activities summarized in the timetable are those included with effect from the finalization of the protocol and the data collection tools until the submission of the final study report. (see timetable of activities below).

TIMETABLE OF ACTIVITIES

No.	ACTIVITIES	IN CHARGE	PERIOD BY WEEKS																		Observation
			Dec. 11		January 12				February 12				March 12				April 12				May 12, to be determined
			S3	S4	S1	S2	S3	S4	S1	S2	S3	S4	S1	S2	S3	S4	S1	S2	S3	S4	
1	Finalization protocol and tools and manual	Research team																			
2	Obtaining of authorizations	D1																			
3	Briefing of supervisors and interviewers	D1 and Consultant																			
4	Collection of the data	Supervisors and interviewers																			
5	Entry of the data	Interviewers																			
6	Compilation of the data	Consultant																			
7	Processing and analysis of the data	Research team																			
8	Editing of provisional report	Consultant																			
9	Sharing and feedback of the team	Consultant																			
10	Submission of provisional report	Consultant																			
11	Validation workshop with pp	D1 and JICA																			
12	Submission of the final report	Consultant																			

2.9. Ethical considerations

Given that this analysis started with the collection of data from human subjects, primarily by interviews, ethical considerations were taken into account, in this case, those concerning the 3 fundamental principles of respect for the individual, respect for benefaction and for justice.

In fact, reflecting our respect for human rights, we obtained the verbal and voluntary consent of interviewees to respond to the study questions. Their right of refusal to respond to our interview was respected. Furthermore, they were assured of confidentiality of the information provided to us as follows: "the names of interviewees will never be associated with their contacts and will not be included in any report of this analysis". Moreover, to provided even more reassurance of confidentiality, it was decided to avoid using recorders when collecting information for this study since the results of the analysis will not be used for reasons other than those cited in the context, namely, those facilitating coordination of the actions of stakeholders harmoniously in terms of alignment, efficacy and efficiency of interventions made as part of National Development Planning of human resources for health.

The principle of justice was respected for selecting all the categories of stakeholders and administering them all with the same questionnaire.

In addition to taking into account these three fundamental ethical principles, interviewees were reminded that the study did not involve any significant ethical risk. Furthermore, the stakeholders would be the prime beneficiaries of adjustment measures resulting from this analysis.

3. STUDY RESULTS

The study results in "analysis of stakeholders in HRH development in the DRC" are collected in two sections based on the tool used to obtain them. The first section known as the "structural analysis of stakeholders" summarizes the results of structures analyzed via the questionnaire survey. The second section presents the results of the qualitative analysis of the HRH development system, scanned using in-depth interviews with key informants.

In the first section below, apart from the characteristics of the sample, the study results are presented in three sections, namely general information, the characteristics of stakeholders concerning the HRH and finally their interest in the HRH development process in the DRC.

3.1. STRUCTURAL ANALYSIS OF STAKEHOLDERS

3.1.1. CHARACTERISTICS OF THE SAMPLE

The stakeholders visited are presented in table 1 below, which shows their spread by category. Based on the group to which they belonged, the stakeholders were divided into seven categories namely:

- The Ministries/Central ministry departments;
- Specialized state services;
- Training institutions;
- Medical departments of religious orders;
- Orders, unions and Professional associations;
- Partners, Donors, NGOs and others.

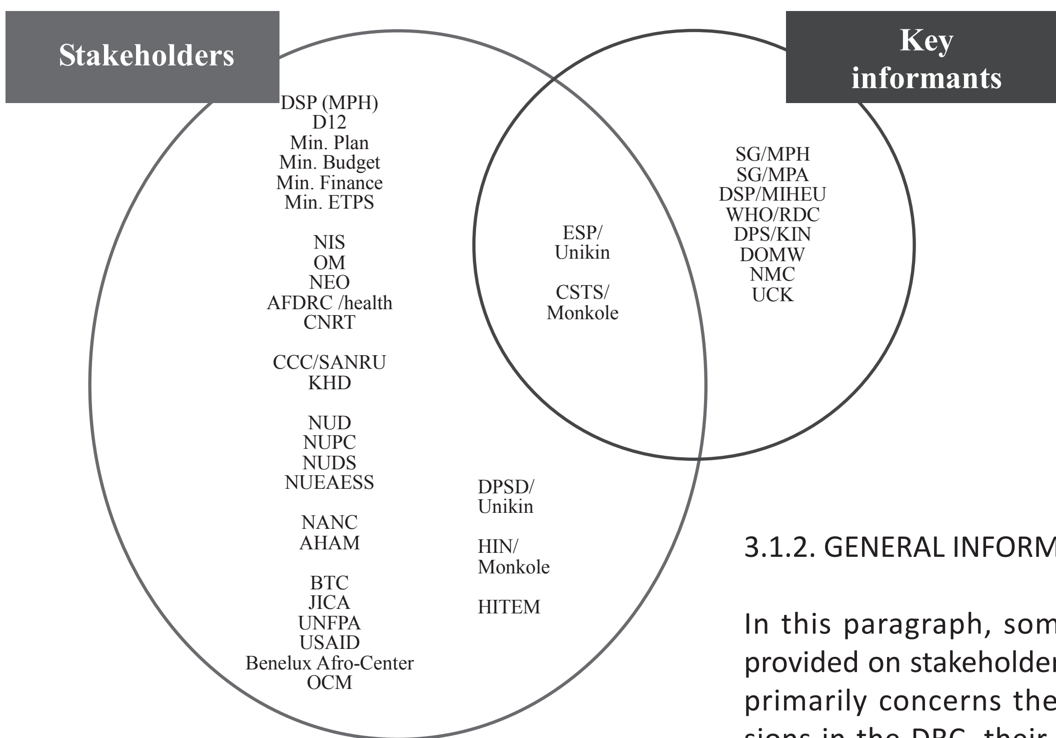
A.Table 1: Number of stakeholders surveyed by category

No.	Categories of stakeholders	Number	Percentage
1	Ministries/Central departments of Ministries.	10	25.60%
2	Specialized state services	5	12.80%
3	Training institutions	6	15.40%
4	Medical departments of religious orders	3	7.70%
5	Orders/unions and Professional associations	7	18.00%
6	Partners, Cooperations, Donors and NGOs	6	15.40%
7	Others	2	5.10%
	Total	**39**	**100%**

The table shows that the those responding to the study came from 7 structural categories of stakeholders. These are Ministries, their General secretariats and/or Central departments (25.6%), Specialized state services (12.8%), Training institutions (15.4%), Medical departments of religious orders (7.7%), Orders and Health professional associations (18%), development partners, donors and NGOs (15.4%), and others (5.1%).

B. The distribution of stakeholders based on the tool used for collecting the data

Figure 2: Stakeholders and key informants interviewed



The above diagram illustrates the spread of respondents according to the tool used to collect the data. In total, 31 entities were surveyed via a questionnaire targeted at their structures, and 10 were questioned with an interview guide in the capacity of key informants. Moreover, the diagram shows 2 stakeholders who were targeted with two types of tools simultaneously. These are two training institutions: the School of Public Health of the University of Kinshasa (ESP/UNIKIN), and the Training Support Center of Monkole (CEFA-Monkole).

3.1.2. GENERAL INFORMATION ON STAKEHOLDERS

In this paragraph, some general information is provided on stakeholders visited. This information primarily concerns their mandates and/or missions in the DRC, their priority areas or those of interest in general as well as the spread of their service scope nationwide.

3.1.2.1. Areas of intervention and interest of stakeholders by category

Before specifying the activities performed by stakeholders directly linked to HRH, there was a need to explore their areas of priority or of general interest in the DRC. Table Nos. 2, 3, 4, 5, 6 and 7 give a description of the main areas of priority and interest by categories of stakeholders, such as received from interviewees on the ground.

Table 2: Description of missions and priority areas of Ministries and Central departments visited

No.	Stakeholder	Missions DRC	Areas of intervention or general interest
1	DSP/ MPH(D7)	1.Prepare a macroeconomic diagnosis of the health sector; 2.Prepare, monitor and evaluate macroeconomic and sectoral policies, strategies and plans, projects and health programmes 3. Prepare and/or update legislation on procedures to prepare the framework law and the Hospital Act...; 4. Promote the partnership for the mobilization of resources.	· Planning · Studies · Reform · Mobilization of resources.
2	Management of Partnership/MPH (D12)	1. Manage partners administratively and technically.	· External partnership (cooperation agencies and international NGOs; · Internal partnership/national NGOs; · Intersectoral collaboration
3	Ministry of the ESU/ Secretariat-General	The Ministry of the ESU has a triple role: 1. Teaching, 2. Research (fundamental, operational, applied) and 3. Service for the community (which includes professional support for young graduates).	· Higher and university education · Research · Services to the community
4	Ministry of Planning	1. Planning of socioeconomic development of the DRC (the main mission); 2. Technical coordination of all interministerial committees working in the development sector; 3. Monitoring and evaluation of all development projects.	· Intersectoral coordination · Investments and development projects/programmes. · Monitoring/evaluation
5	Ministry of the Budget	1. Preparing the State budget 2. Preparing and monitoring the budget.	· Identification of number of executives and state officials; · Preparation of budget envelopes.
6	Ministry of Finance	1. Management of public State finances in various forms: mobilization of receipts, exchange rate, currency monitoring, framework for expenditure, etc."	· Finances.
7	Ministry of the Labour, Employment and Social Benefits	1.The Ministry deals with national policy for employment and benefits or social security.	· Employment · Social security

NB: The official duties of all Ministries of the DRC are stipulated in Ordinance No. 08/074 of 24 December, 2008. (see Official journal of the DRC).

Table 3: Description of missions and priority areas of Specialized state services visited

No.	Stakeholders	Missions in the DRC	Areas of intervention or general interest
01	National Institute of Statistics (NIS)	1. Produce and distribute encrypted data (statistics) in the DRC 2. Train personnel in statistics.	・Production of statistics
02	National Employment Office(NEO)	1. Produce statistics on workers (as an adviser to the State). 2.Manage databases concerning jobseekers, employee needs or employment markets and possible resulting job placements." 3.Dealing with unemployed (jobless): Receiving offers of employment; Intervention in social security (health and education); recommendation from Employers as required) 4. Certifying contracts from employers.	・Employment
03	Department of Migration (OM)	1. Management of national frontiers (main mission); 2. Control of stays of foreigners/expatriates; Issuing visas to foreigners; 3.Management of repatriated refugees (in tandem with the High Commission for Refugees); 4.Collaboration with Interpol or International Police (as a member).	・Safety ・Education, training ・Health
04	Health Services Branch/AFDRC	1. Help improve health and food safety of servicemen by reducing morbidity and mortality and physically and mentally boosting troops, particularly during military operations. 2. Facilitating reconciliation between army and public by relief actions for the population in the event of catastrophes.	・Basic training of A2 nurses and combat stretcher-bearers. ・Readying troops for combat. ・Relief for the population.
05	Congolese National Radio and Television (RNTC)	1. Inform, train, educate and entertain the Congolese public	・Audiovisual press ・Communication broadcast and television

Table 4: Description of missions and priority areas of training institutions visited

No.	Stakeholders	Missions in the DRC	Areas of intervention or general interest
01	Department of Population Sciences and Development (DPSD)/UNIKIN	1. Teaching of population sciences (Demography) and of development (Economics, etc.): a. Methods of collecting, monitoring and evaluating projects and programmes, analyses of sociodemographic data; b. Analysis of sociocultural, environmental and economic factors affecting the population and analysis of influences of the various demographic components on development; 2. Research: a. Fundamental research covering varied themes and b. Applied research targeting the service to the community (Preparing policies in the area of population, Evaluation of programmes and projects, Consultations, sub-contracting, etc.).	・University teaching; ・Research in all areas linked to the population.
02	School of Public Health of the University of Kinshasa (ESP/UNIKIN)	1. Training of health workers of the DRC and elsewhere 2. Research into health; 3. Assistance to the community (reinforcing the capacities of the MPH in areas combating HIV, monitoring avian flu and Monkey-Pox; etc.).	・Training; ・Research; ・Social intervention.
03	Kinshasa University Hospitals (BTC)	1. Provision of tertiary care, 2. Basic training and training courses for students studying medicine and at the ISTM; 3. Training during employment.	
04	Higher Institute for Nursing Services (ISSI)	1. Train quality nursing staff (multi-skilled nurses and midwives); 2. Contribute to the ongoing training of nurses.	・Training of HRH in the care sector.
05	Higher Institute of Medical Technical Teaching (HITMS)	1. The training of nurses at secondary level (A2), higher level (A1) and laboratory technicians.	・Training and follow-up of pupils and students in hospitals.
06	Center de Formation and Support Sanitaire (CEFA) Monkole	1. Ensure ongoing training of health professionals based at the Monkole Hospital Center; 2. Ensure post-university training of nurses, lab technicians, etc.	・Coordination of medical training activities; ・Fight against sickle cell; ・Practical laboratory work.

Table 5: Description of missions and priority areas of medical departments of religious orders visited

No.	Stakeholder	Missions in the DRC	Areas of intervention or general interest
01	Diocesan Office of Catholic Medical Work (DOMW).	1. Coordinate health services in line with national and pastoral policy of the Catholic church. 2. Promote access to healthcare to the poorest sector of the population in Kinshasa and its surrounding area	
02	Church of Christ in the Congo/Project Health Rural (CCC/ SANRU)	1. Restore the health of the Congolese public	・Health of the population by PHC with three main areas: malaria, HIV and vaccination.
03	Kimbaguist Department of Health "KHD"	1. Participate in the State health campaign	・Basic training (ITM and medical faculty); Setting up hospitals and health centers.

Table 6: Description of missions and priority areas of orders and associations of health professionals visited

No.	Stakeholder	Missions in the DRC	Areas of intervention or general interest
01	National Union of Doctors (NUD)	1. Defend the interests of all member doctors; 2. Protect the medical profession against charlatans; 3. Organize cultural activities for doctors.	・Socioprofessional aspects of doctors (remuneration, working conditions).
02	Order of doctors/ National council of the Order of doctors (NMC	1. Including doctors in the order before engaging in profession (requirement of the Law); 2. Ensuring compliance with medical deontology; the order has the power to sanction doctors either by apportioning blame, temporary suspension, suspension or striking them off.	
03	National Union of Pharmacists of the Congo (NUPC)	1. Defend the interests of the pharmaceutical profession/ professional union.	・Constitution of the union in federations according to institutional affiliation ・Continuous training ・Partnership for ongoing training

04	National Union of Dental Surgeons (NUDS)	1. Defend the social benefits of members; 2. Monitor changes in membership numbers; 3. Check diploma qualifications (authentication of academic titles).	・Ongoing work training for members; ・Verification of academic title before posting by the Ministry.
05	National Association of Nurses of the Congo (NANC)	1. Gather together nurses in their capacity as professionals and ensure their awareness of professional, deontological and ethnic issues; 2. Offer training during employment, seminars and studies; 3. Establish partnerships with national and international organizations. 4. The main mission involves protection of the nurse's job.	・Sectors of care in pediatric, surgery and obstetric care etc.; ・Interventions for HIV/AIDS, and other infectious diseases (malaria, TBC..) in collaboration with partners; ・Interventions in the zoonosis in collaboration with FIS (Federation In Health).
06	National Union of Executives, Agents and Employees of Service Sectors (NUEAESS)	1. Defend its affiliates, collectively and individually; 2. Protect their employment and promote their socioprofessional and moral interests aiming to constantly improve their working conditions and standing in life.	・Working and social conditions in view of the retention of unionized employees.
07	Association des Association of Health structure Managerial administrators (AHAM).	1. Contribute and help facilitate intellectual and social promotion of members. 2. Lead members; 3. Defend the interests of members.	・Actions on members who are Management Administrators of health institutions.

Table 7: Description of missions and priority areas of partners, Donors and NGOs visited

No.	Stakeholder	Missions in the DRC	Areas of intervention or general interest
01	World Health Organization/DRC-Kinshasa (WHO)	Institution of the United Nations, having a support mandate at the Ministry of Health: "We are so to speak, an adviser of the MPH, and provide it with logistical support".	

02	Belgian Technical Cooperation (BTC)	The BTC is an agency for funding bilateral cooperation in the form of projects in various sectors not for profit.	・The BTC intervenes in areas of health, agriculture, roads, bridges, ferries, teaching and good governance projects.
03	Japanese International Cooperation Agency (JICA)	1. Cooperation: bilateral, 2. Technical cooperation: non-refundable financial aid, construction of infrastructure; training courses in Japan for Congolese in multiple areas, and other modalities of funding or refundable loans.	・Public health (HRH and health establishments) ・Professional training ・Road infrastructures (urban roads), ・Urban water supply, ・Safety: support for training of police and judiciary; ・Environment.
04	United Nations Population Funds (UNFPA)	1. Promote the rights of each woman, man and child to live with good health and enjoy equal opportunities; 2. Assist countries which use data relating to population to devise policies and programmes for efforts to reduce poverty and help ensure that each pregnancy is wanted, each childbirth is safe, young people do not contract HIV/AIDS, each girl and woman is treated with dignity and respect.	・Universal access to health in the area of reproduction, including family planning and sexual hygiene; ・Support for population and development strategies; ・Promotion of awareness of problems of population and development; ・Advocating the mobilization of resources and Political will to succeed in this area.
05	United States Agency for International Development (USAID)	1. Promotion of peace and stability in the DRC; 2. Contribution to establish viable democratic institutions in the DRC; 3. Macroeconomic growth and stability ; 4. Intervention in social security (basic social services: health and education); 5. Intervention in humanitarian crises (epidemics, volcanoes...); 6. Diplomatic field; etc.	・Training ・Research; ・Intervention to benefit the population; ・Peace and security (social stability); ・Health (70% of the budget); ・Economic growth; ・Social protection (vulnerable groups) ・Education (primary and secondary).

06	Benelux Afro-Center	1. Ensure support for the reform of the HRH management with the expertise of the Congolese diaspora; 2. Ensure support for computerization of the health sector; 3. Ensure institutional reinforcement of health NGOs; 4. Ensure reinforcement of the role of civil society organizations in the health sector; 5. Ensure efforts to combat the digital divide in the social sector.	・Health; ・Social area (efforts to combat the digital divide).

Table 8: Description of missions and priority areas of other stakeholders visited

No.	Stakeholder	Missions in the DRC	Areas of intervention or general interest
01	Observatory of Congolese Media (OCM)	1. Self-regulation of media with the role of: 2. Helping enrich the public with educational programmes 3. Helping journalists do their jobs professionally; 4. Policing the media (while ensuring compliance with the code de deontology of Congolese journalists).	・Media: Pedagogical role of journalists.
02	Provincial division of health/Kinshasa	1. Intermediary level of the health system, responsible for technical and logistical support… on a peripheral level (ZS) in the provincial city of Kinshasa.	

To depict the actual scope of the field on which this analysis is based via the structures visited, figure 3 below shows the distribution of frequency of stakeholders according to the spread of their service scope nationwide.

3.1.2.2. The service scope of stakeholders visited throughout the provinces.

The study focused on specifying the scope of services offered by stakeholders visited in Kinshasa, aiming to obtain a relatively precise overview of the scope of data collected by reports nationwide. Therefore, the question was raised to determine, as of the day of the survey, in which national provinces the services of the stakeholder structure were offered? Table 9 below summarizes the information.

Table 9. Frequency of the scope of services offered throughout the provinces

Spread of the offer via the national provinces	Frequency	Percentage
All provinces	22	71
Some provinces	9	29
Total	31	100

The table above shows that of the 31 stakeholders visited, 22 (71%) offered their services in all

national provinces including the provincial city of Kinshasa, against 9 (29%) of whom, who only offered services in some provinces as well as Kinshasa. The details on the provinces covered by each of the stakeholders are listed in the annexed summary table of mapping.

3.1.3. CHARACTERISTICS CONCERNING HRH

As regards human resources for health (HRH), the survey explored multiple elements of stakeholders.

Among other things, areas covered included the types of information at their disposal concerning HRH, the activities each of them performed and their seniority in the work for human resources for health .

The analysis also sought to specify the current level of intervention and/or the activity of stakeholders in the health system of the country; whether they encompassed provincial branches capable of offering equivalent services to their central offices/services in Kinshasa and finally, the services they offered for the Ministry of Public Health concerning the ongoing reform of human resources within this Ministry.

The results corresponding to all this information are listed in tables 10, 11, 12, and 13 below.

3.1.3.1. Information available from stakeholders on HRH

Table 10: Types of information offered by stakeholders on HRH

Types of information offered	Frequency	Percentage (n=31)
On training	26	83.9
On use	17	54.8
Others	16	51.6
None	2	6.4

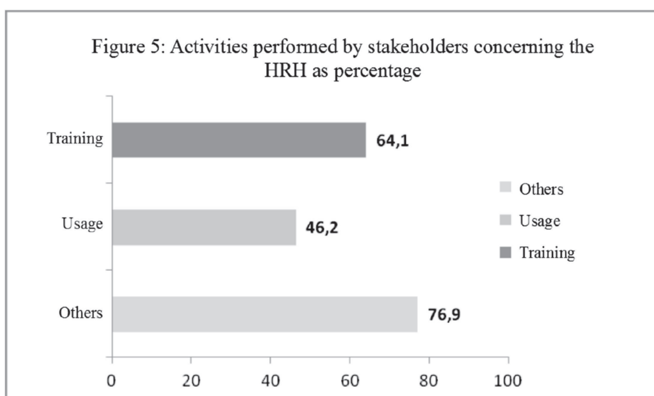
The table above shows that the stakeholders visited had more information on HRH training itself (83.9%) rather than its actual use (54.8%). This also reflects the far greater interest in training compared to that for its use. However two stakeholders visited (6.5%) declared that they did not have any information concerning the HRH, namely the OCM and the Min. of the Budget. In fact, the observatory of Congolese media as well as the Ministry of the Budget did not engage in any activity directly targeting HRH.

Apart from these two types of information, more than half (51.6%) of the structures visited indicated that they also had other information, details of which are listed in the summary tables of information concerning the NHWO in annex. Nevertheless, for information, here is a summary of some other information available from stakeholders:

- ▶Information on staff numbers in various categories of HRH and the different promotions of degree-qualified health workers since 1984 (USAID, ESP)
- ▶Information on unmet needs for qualified

personnel in Bandundu (DPSD);
- ▶Statistics on the categories and movements of nurses (ISSI);
- ▶Bank of data concerning human resources applying for employment in all categories combined (NEO);
- ▶Migratory movements of HRH (OM);
- ▶Information on active and deceased pharmacists (NUPC)
- ▶Information on the job profile to facilitate the selection of civil service officials (BTC);
- ▶A databank on HRH of the Congolese Diaspora (BENELUX AFRO CENTER) etc.

3.1.3.2. HRH activities performed by stakeholders



The graphic above shows that in terms of HRH, the stakeholders visited engaged in more activities concerning training (64.1%) than those concerning usage (46.2%). It also transpired that apart from the activities concerning training and usage, other types of activities were performed by nearly 77% of stakeholders, summarized in the paragraphs below:

1° Activities concerning the control of staff: inventories of active personnel (SG/MPH and WHO), HRH staff active in the catholic religious network (DOMW), the registration of doctors in the table of the order (NMC), number of unionized employees among health service executives and officials (NUEAESS), etc.
2° Activities concerning the viability of HRH training establishments and programmes: Survey of viability of secondary and superior level training establishments performed with the JICA support (SG/MIHUE), project to support the training programme of the midwife branch with the UNFPA and USAID (DSP/MIHUE).

3° Activities concerning the reinforcement of HRH capacities by specialization, recycling, and refresher training courses and/or the awarding of grants for doctorate (USAID, UNFPA, ESP/Unikin, BTC) and training of ZS executives and community liaisons in PHC (CCC/Sanru, KHD).

4° The partnership for HRH development: cooperation contract with MPH/Human resources department for collaboration with HRH of the diaspora (Benelux Afro-Center), partnership for the training of executives (General Health Service Management of AFDRC) and partnership for ongoing training of pharmacists (NUPC).

5° Other specific activities of certain stakeholders, particularly the recording movements in of HRH (OM), recording of jobseekers and applicants placed among HRH(NEO), etc.

3.1.3.3. Mapping of stakeholders according to their seniority involved in HRH work

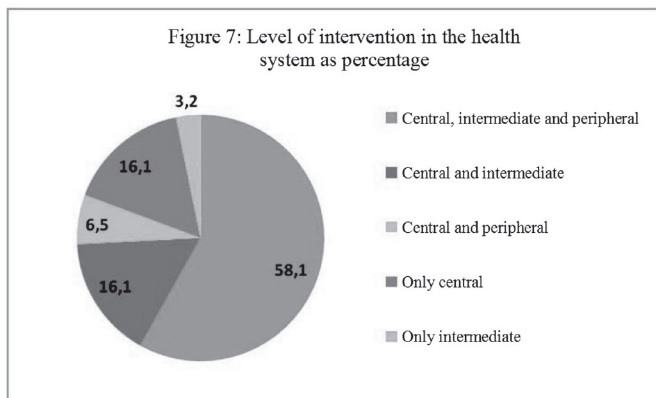
Table 11: Seniority of stakeholders visited by age ranges

Age range/number of years	Frequency	Relative frequency
0 to 9	9	29
10 to 19	8	26
20 to 29	6	19.5
30 to 39	4	13
40 to 49	1	3
50 and more	2	6.5
ND*[3]	1	3
Total	31	100

The table shows that of the 31 stakeholders visited, only 9 (29%) had less than 10 years of seniority, while 1 (3%) did not specify seniority. In contrast, all others (21) had seniority of more than 10 years in their work for human resources for health, among which, 2 for more than 50 years.

The data received shows significant variation in the seniority of stakeholders involved in HRH work. The average age is 19.2 years, peaking at 52 years and with a minimum of 0.7 year (namely 8 months). It was seen that among MPH partners, the USAID (external partner) and religious orders (internal partners) already have a history of more than 30 years spent involved in HRH work in the DRC.

The response to the question posed to determine the level at which the stakeholders visited actually intervened in the health system of the country in terms of HRH is shown in figure 7 below.



The figure shows that most stakeholders visited intervened at all 3 levels of the health system at a time (58%), others intervened in at least 2 levels, including the central level (nearly 39%); only 3% (one single stakeholder) who only intervened at an intermediary level.

3.1.3.4. Stakeholders with offices throughout the provinces

Table 12. Existence of provincial branches among the stakeholders visited

Stakeholders	Staff	Percentage
With provincial branches	20	64.5
Without provincial branches	11	35.5
Total	31	100

The table above shows that of the 31 structures visited, 20 declared that they had provincial branches capable of providing services equivalent to others at a central level, namely nearly 65%, compared to 11(35%) who did not. Related details are listed in table 12 below, bringing together by category the stakeholders with and without provincial branches.

[3] ND* : not done= pas des données.

Table 13. Spread of stakeholders according to the number of provincial branches owned

Categories of stakeholders	With provincial branch	Without provincial branch
Ministries/Central Divisions	D12, PLAN, BUDGET, MEWSW	DSP/health, MIHUE, Finance
Specialized state services	NIS, NEO, OM, AFDRC/Health	CNRT
Training institutions	ISSI/Monkole, CEFA, HITMS	DPSD/UNIKIN, ESP/UNIKIN
Medical/religious services	CCC/SANRU, KHD	
Orders and Professional associations	NUD, NUDS, NUPC, NUEAESS, NANC, AHAM.	
External partners, Donors and NGOs	UNFPA	USAID, BTC, JICA, BENELUX- AFRO
Others		OCM

The table above reveals that all Medical departments of religious orders as well as Orders and Health professional associations, have provincial branches which can perform work equivalent to their central divisions in Kinshasa. Furthermore, apart from the UNFPA, the main development partners and donors with an interest in the HRH issue, along the lines of USAID, JICA, BTC…, currently lack provincial representations capable of completing tasks equivalent to their Central departments in Kinshasa.

3.1.3.5. Types of services to be provided at the Ministry of Public Health

Table 14. Distribution of frequencies of services to be provided by types

Types of services to be provided	Frequency of responses	Percentage (n=31)
Expertise	25	80.6
Finance	4	13
Material support	5	16.1
Others	18	58.1

The table above shows that most of the stakeholders visited provide expertise to MPH (80.6%); but are lacking in terms of material support (16.1%) and funding (13 %) for HRH development. The graphic below better illustrates this result.

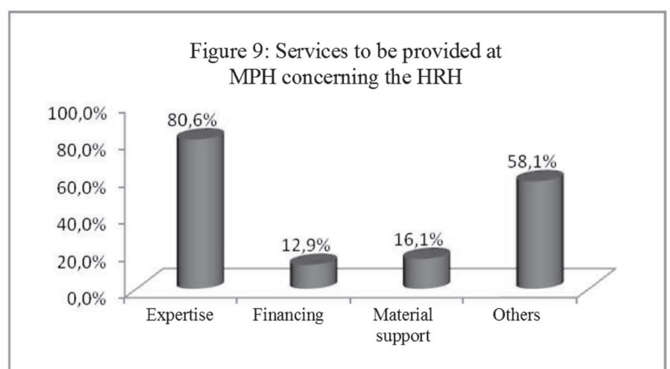


Figure 9: Services to be provided at MPH concerning the HRH

However, apart from the three types of services detailed above, other services on offer were cited by stakeholders (58%), including:

- ▶Contribution to planning and studies (DSP/MIHUE),
- ▶Preparation of a plan of advocation by part-

ners (Min. Plan)

- ▶Contribution to reflections on reform, research and in-depth analyses of HRH (ESP and DPSD/Unikin);
- ▶Contribution to enhance the visibility of research work by publication via their web site (CEFA/Monkole).
- ▶Provide various information on HRH in the form of data banks or databases (MEWSW, OM, NEO, NIS, CEFA and ISSI Monkole, HITMS, etc.);
- ▶Contribution to basic training and ongoing lessons of HRH (UNFPA, ESP/Unikin, CEFA/Monkole, KHD, etc.).
- ▶Assistance from MPH to control staff (NUE-AESS), to assess each profession and improve retention (NUPC), to promote the available quality of HRH in the DRC (AHAM);
- ▶Reinforcement of the capacities of the MPH through technical cooperation and construction of the IMS as part of the HHRNDP(JICA).

3.1.4.Interest of stakeholders in the HRH development process

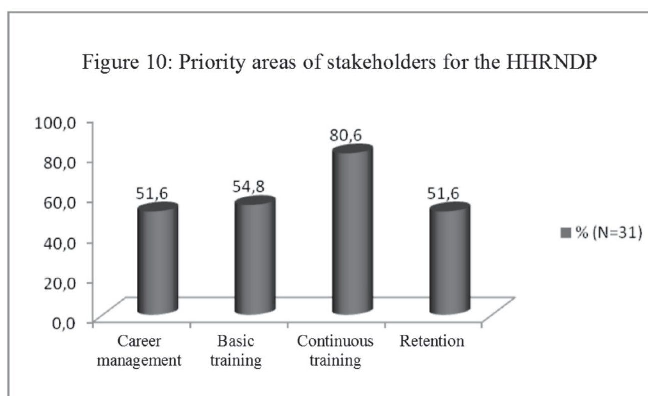
As stated above, the analysis of stakeholders primarily aims to map and give a perspective of their activities and particularly their areas of interest in HRH development. Following are the results concerning the interest expressed by stakeholders in the 4 sectors of the National Development Plan for Human resources for health (HHRNDP 2011-2015), the functions attributed to the National HRH Observatory and the HRH development process in general such as illustrated in “the organizational model” stated above.

3.1.4.1. Priority areas of stakeholders compared to HHRNDP

Table 15. Spread of stakeholders according to their interest expressed in the 4 sectors of HHRNDP

Priority areas	Frequency of responses	Percentage (n=31)
Continuous education	25	80.6
Basic education	17	54.8
Career management	16	51.6
Retention	16	51.6

The table above points out that all 4 sectors of the HHRNDP involve the stakeholders since the data on responses in each of the 4 sectors exceeds 50%; although the key interest is in continuous education (80.6%).
The figure below better illustrates this result.

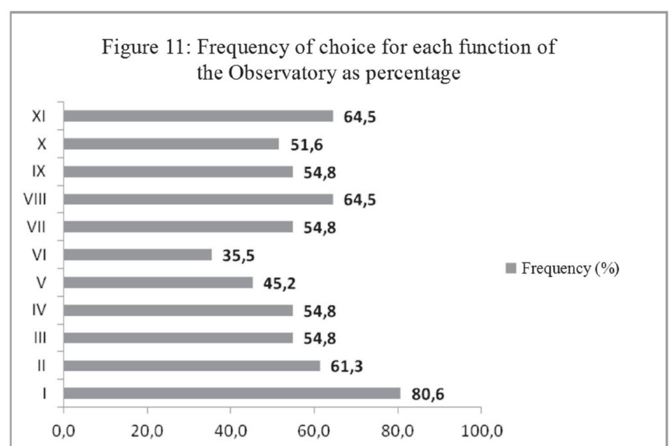


3.1.4.2. Key functions for the HRH National Observatory

Faced with the crisis involving health workers, which is a global problem and particularly acute in African nations, the World Health Organization has recommended that all countries establish National HRH Observatories. The DRC, as one of the signatories to the Declaration of Ouagadougou, on Primary Healthcare and health systems, made the commitment, along with all other African countries, to meet this recommendation. Therefore since June 2010 up to the present, the country has been in the process of setting up the NHWO.
In addition, in August 2011, the Ministry of Public Health organized a meeting with the stakeholders to adopt the terms of reference of this forum. In the course of this workshop, 11 main functions were attributed to the NHWO. Including:

1. Sharing of experiences and information on planning for HRH development;
2. Analysis of tendencies of the HRH situation in the DRC;
3. Support for research/study activities to facilitate evidence-based decision-making;
4. Redynamization of the information system by improving the quality and coverage of the data on HRH;
5. Improvement of the quality of tools and data collection mechanisms;
6. Support for management of networks of expertise in the HRH area to reinforce national capacities;
7. Reinforcement of national capacities for monitoring and evaluating HRH;
8. Availability of reliable information for national HRH development;
9. Development of collaborative links for the collection and storage of data as well as sharing;
10. Contribution to the mobilization of resources for the HRH agenda;
11. Sharing of available strategies on the retention and equitable distribution in HRH.

In the course of this analysis, it was a matter of the stakeholders confirming their interest in identifying the functions which particularly interested them and in which they could be involved as part of the effective implementation of the Observatory. The figure below shows us the frequency of choice of stakeholders for the 11 functions.



This figure shows that all functions attributed to the NHWO are significant for the stakeholders but to differing extents. The most significant is the first function, which comprised nearly 81% of votes, followed by the XI and VIII functions (64.5%); while the least popular choice was the VI function (35.5%). Given the importance of managing networks of expertise in the HRH area, this function must be scrutinized more closely by the organizing

authority.

Moreover, to further refine the choice of functions of interest by stakeholders, they were asked to identify the most specific function based on their mandate. The straw graphic and table 10 below respectively represent the frequency of choice of the most specific function and the details of stakeholders based on the chosen specific function.

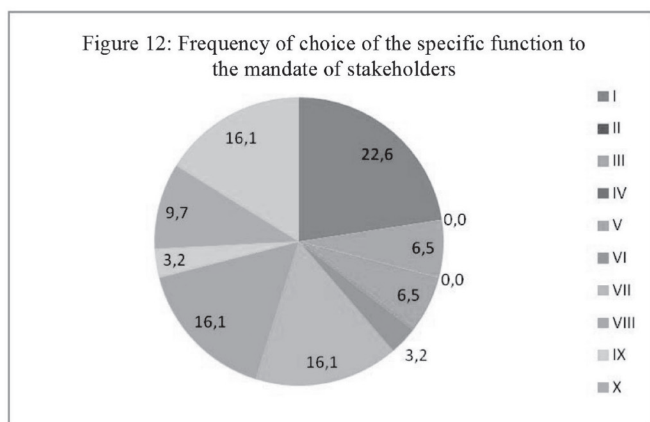


Figure 12: Frequency of choice of the specific function to the mandate of stakeholders

According to the choice made by interviewees to go for one specific function or the other, it emerges that two functions of the NHWO seem non-specific to any stakeholder visited; namely functions II and IV.

Table 16 below shows the spread of stakeholders based on their choice of one NHWO function, identifying them as the ones which were most specific to their mandate or the mission of their organization.

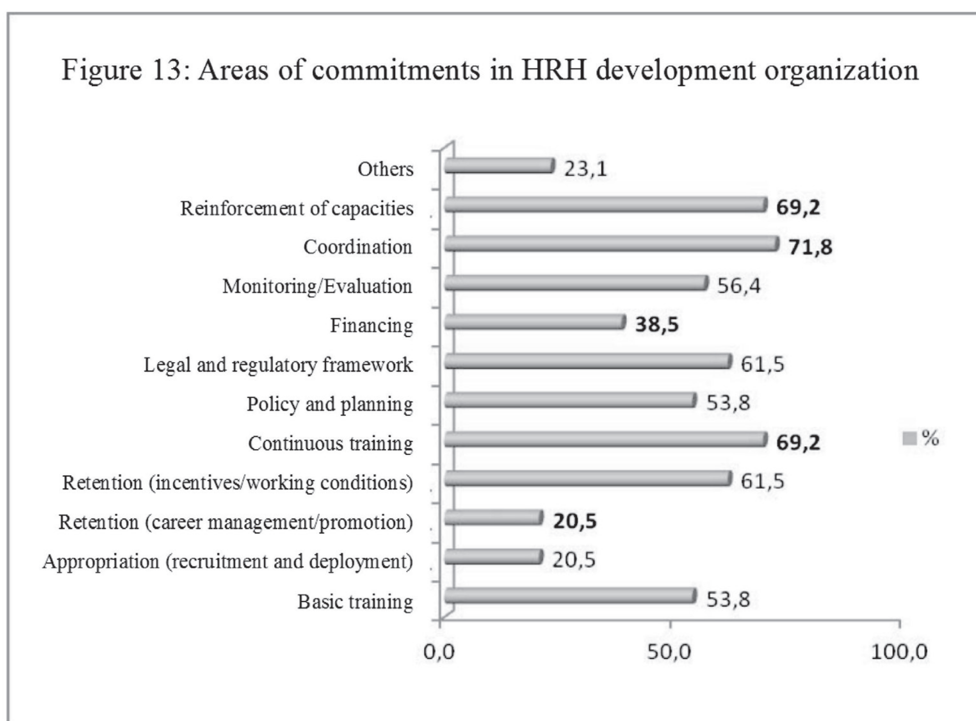
Table 16: Spread of stakeholders according to the specific NHWO function in their mandates

No.	Most specific function chosen	Stakeholders	Comments
I	Sharing of experiences and information on planning for HRH development?	DSP/MPH, SG/MIHUE, HITMS, AFDRC/health, CNRT, BTC, UNFPA, OCM	Includes all categories of stakeholders, except orders, unions and religious orders
II	Analysis of tendencies of the HRH situation in the DRC		Function not identified as specific in the mandate by any stakeholder
III	Support for research/study activities to facilitate evidence-based decision-making	ESP/UNIKIN, CEFA/ Monkole,	Significant function, primarily for training and research institutions, higher level
IV	Redynamization of the information system by improving the quality and coverage of the data on HRH?		Function not identified as specific in the mandate by any stakeholder

V	Improvement of the quality of tools and data collection mechanisms	DPSD/UNIKIN, NIS	Function conforming to the mandates of these 2 institutions
VI	Support for management of networks of expertise in the HRH area to reinforce national capacities	D12	Of specific interest for the management of partnership
VII	Reinforcement of national capacities for monitoring and evaluating HRH	JICA AHAM, NUD, OM	A more specific function for partners with technical expertise in monitoring/evaluation of HRH
VIII	Availability of reliable information for national HRH development	Min. of Planning, Min. of the Labour, Employment and Social Benefits, ISSI/Monk, KHD, NANC,	Almost all categories of stakeholders included, except external partners
IX	Development of collaborative links for collection, storage and sharing of data	NEO	Function not very specific to the mandates of stakeholders involved
X	Contribution to the mobilization of resources for the HRH agenda	Min. Budget, Min. Finance, USAID	Relevant function of the specific responsibility of the State and partners
XI	Sharing of available strategies on the retention and equitable distribution in HRH	NUPC, NUDS, NUEAESS, CCC/SANRU, Benelux Afro-Center	More significant function for the unions, religious orders and NGOs

This table shows us that based on their respective mandates, no stakeholder visited could identify functions II and IV of the NHWO as specific to their institutional mandate. It is thus incumbent on the organizing authority to take all responsibilities for organizing activities which may help implement these actions within the NHWO.

3.1.4.3. Spread of stakeholders according to the areas of engagement in HRH development organization.



The graphic shows that the stakeholders are clearly committed to all stages of the HRH development process. Nevertheless, as for the 4 sectors of the HHRNDP, apart from consultation, which is of interest to almost all parties (nearly 72%), continuous education (69%) and reinforcing institutional capacities (69%) still hold the record in terms of stakeholder commitment; while little commitment is shown by the same for career management (21%) and funding (39%) of HRH.

These results are best shown by reporting them within "the Congolese house" of HRH development reconstructed in figure 14 below.

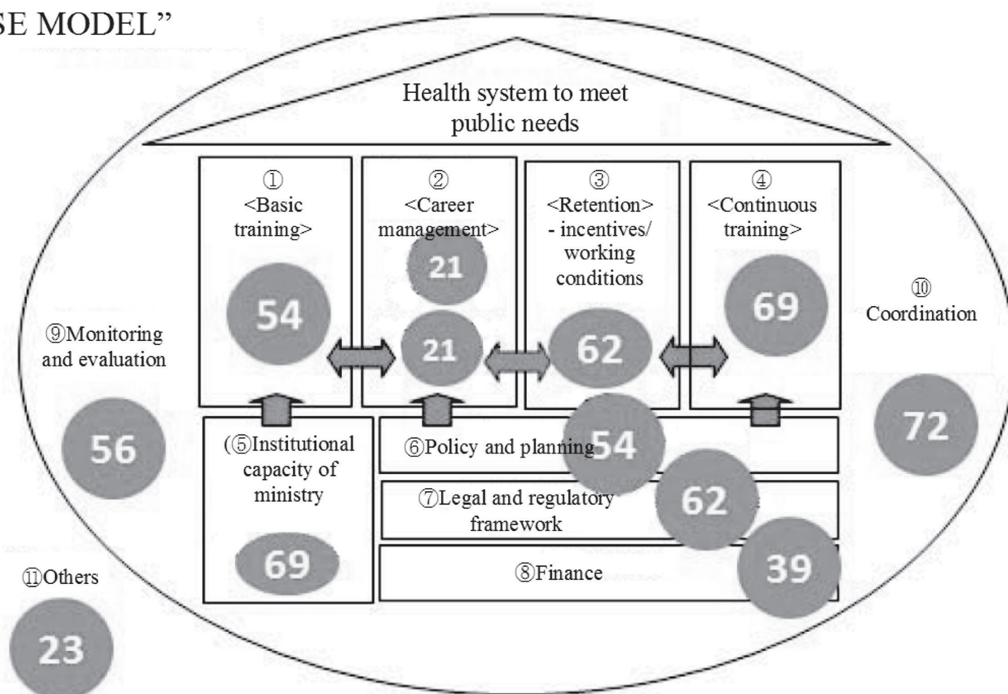


Figure14: HRH development system; Congolese organizational model.

NB: In questions corresponding to the conceptual organizational model, for career management, two components came to light: the posting (recruitment and deployment) and promotion (progress in grades). In each case, the percentage of commitment of stakeholders was 21%. Moreover, as well as the components summarized in the model, other areas of engagement were highlighted (23%) such as coordination, supervision, technical assistance, conflict management, follow-up of internal and external HRH movements and monitoring of the implementation of NHWO.

In addition to this overall tendency in the results, also revealed are specific tendencies within categories of stakeholders, as can be seen in the two graphics below, which respectively illustrate the areas of engagement of orders, unions and professional associations and those of development partners.

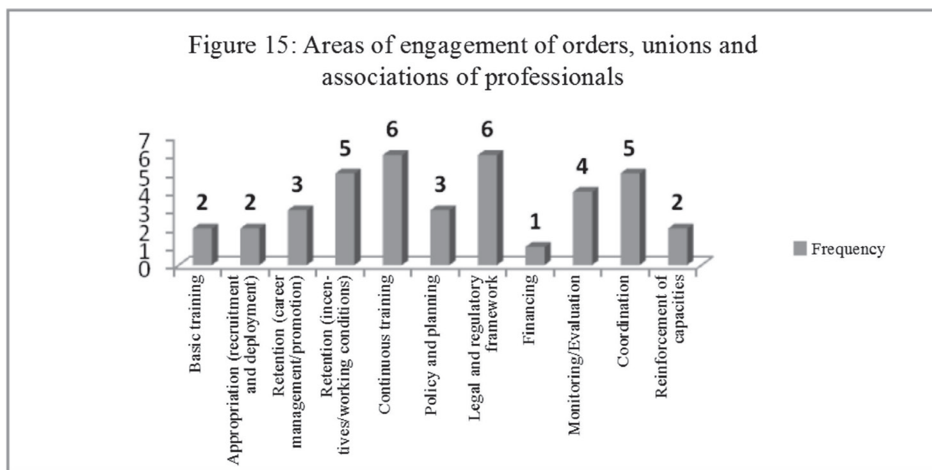


Figure 15: Areas of engagement of orders, unions and associations of professionals

The graphic shows that the main areas of engagements for the orders, unions and associations of health professionals appear to be the legal and regulatory framework, continuous education, consultation then the monitoring/evaluation of HRH.

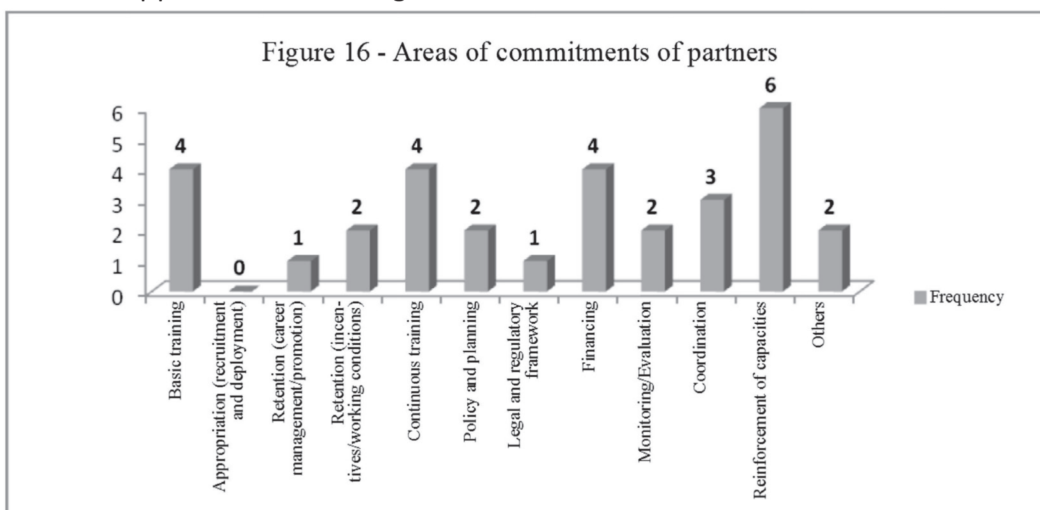


Figure 16 - Areas of commitments of partners

The areas of engagement of development partners appear to be mainly reinforcing institutional capacities followed by support for basic education, continuus education and finance.

All other specific features of these points can be explored in the mapping of the data which will be annexed to this report.

Since the main results of the mapping of stakeholders have been presented, the purpose of the following section is to indicate outlines of the results of the qualitative analysis of the HRH development system performed thanks to in-depth interviews with key informants pre-identified among the stakeholders.

3.2. RESULTS OF QUALITATIVE ANALYSIS

The in-depth interviews completed with key informants generally targeted a comprehensive analysis of the HRH development system of the country through specific questions focusing on the past and future. From here, we distinguish the two sectors in terms of the results presented in this section.

3.2.1. RETROSPECTIVE VIEW OF SYSTEM

Six fundamental questions allowed analysis of the HRH development system in terms of the retrospective plan; namely:

- what major changes were observed in the last 5 to 10 years?
- what events influenced these changes?
- what were the main contributory factors?
- who were the key players involved in these changes?
- what main partners contributed to it? and
- what results were obtained thanks to these changes?

The responses obtained to these questions are summarized in the paragraphs below.

A.MAJOR CHANGES IN TERMS OF THE HRH.

In response to the question of determining the major changes which have marked the DRC over the last 5 to 10 years, in terms of HRH development, three major trends emerged in the responses from respondents; a minority thought that there was no significant change: “not much change; nothing at all in qualitative terms”. but the vast majority acknowledged that major changes had indeed effectively taken place. The latter were observed in four main areas: policies, governance, training and service delivery.

In terms of policies, the following positive changes were noted:

- The political will which enabled effective collaboration between the Ministry of Public Health and that of Higher and University education;
- The key place earmarked for Nursing as national policy.

Nevertheless negative change was also noted: “unregulated exploitation of human resources for health”, with disorderly appropriation not always taking account of needs.

In terms of governance, numerous positive changes were noted; primarily including:

- The reform of Human resources deployed within the MPH
- The determination and monitoring of an MGS for the remuneration of health professionals;
- The special status of doctors prescribed by Ordinance law
- The risk premium of doctors;
- Completing inventories of the health sector
- Management autonomy accorded to public hospitals; and
- The special status of other health professionals.

As for negative changes in terms of governance, key informants deplored the following:

- The catastrophic management of HRH,
- Appropriations not taking into account basic needs expressed;
- Substandard conditions of living "and working", not appealing for health workers in rural areas;
- Many executives trained in public health working outside the health system;
- The hospitals and ZS served are managed by young doctors without experience.

In terms of training, the positive changes signaled were:

- The training of health professionals by stakeholders involved with national strategies or standards;
- The change in qualification of nurses from A3 to A2 level, by reinforcing their capacities using a short-term training programme;
- The reform of Higher and University Education with the uniformization of medical faculty programmes; and the introduction of a degree course in Nursing Sciences.
- The training of the 3rd cycle of central level executives in Public Health ensured by the School of Public Health of the University of Kinshasa.

Nevertheless, in terms of training, some negative changes were also noted:

- The disorderly production of HRH, both quantitatively and qualitatively;
- Lack of specialists in health structures: "too many generalists, very few specialists".
- Not enough pharmacists
- Many executives trained in Public Health working outside the national health system.

In terms of service delivery finally, a single positive change was cited, namely the introduction of the community sector in all health-related activities.

B.WHAT MAJOR EVENTS INFLUENCED CHANGES?

In response to this question, the informants briefed the research team by citing certain events sorted into two main sectors: health and socio-economic-political. The cited events included those which could be classed both positively and negatively.

In the health sector, tables 17 and 18 below summarize events cited by key informants:

Table 17: Sectoral events having influenced the changes in HRH

No.	Positive events	No.	Negative events
01	The accession of the NPHD and HHRNDP	01	The poor HRH management
02	The setup of technical committees within the MPH	02	Lack of planning for HRH management
03	The reform of health sector funding	03	Many agents in health institutions at all levels

No.	Positive events	No.	Negative events
04	"The Health report card of the country established based on surveys/studies (EDS, Inventories, reports etc.)"	04	The underqualification of personnel
05	The support and accompaniment of JICA for the MIHUE and MPH collaboration	05	The lack of description of jobs and tasks
06	The support of development partners		
07	The onset of Global Funds		
08	The orientations of the WHO: MDG and HRH development pillars		

In socioeconomic and political sectors, the cited events are listed in the following table:

Table 18: Socioeconomic events having influenced the changes in HRH

No.	Positive events	No.	Negative events
01	The dialog between the State and Professional associations	01	Political instability
02	The political will of the Government to create the School of Public Health	02	"The events in the EAST of the country (war, humanitarian catastrophes…), and shift of partners of Kinshasa toward the EAST"
03	Internationalization and globalization	03	The national and global economic crisis
04	Striking by doctors in an attempt to gain a specific status	04	The social discontent

C.FAVORABLE FACTORS:

In posing the question of determining the factors which encouraged the changes observed in relation to the HRH, multiple responses were received. Analysis allowed them to be categorized and grouped, as shown in table 12 below:

Table 19: Factors having favored the HRH changes observed

Factors	Positive	Negative
Internal institutions	Political will of the government	Situation of political, social, economic and financial crises of the country
	Awareness within the MPH	Problem of good governance
	Transition of foreign teachers by nationals to the ESP (adequate transfer of competences)	Abuse noted in HRH management: career poorly defined (MPH)
	Openness to other public and private institutions	Substandard working conditions
	Based on young teachers	

External institutions	Reinforcement of procedures of the Global Funds	
	The IHSDG (Inter-Donor Group of the Health Sector)	
	Contribution of development partners	
People/ individuals	Engagement of Actors	
	Availability of interested experts	
	Capacity to take initiatives	
	Surge in demand for medical candidates	
Social factors	Pressure of professional associations	Demographic growth with insufficient infrastructure
	Increased demand for healthcare	Cost of living
	Dynamism of Congolese people (willingness to study)	
Scientific factor	Development of Science	
Technology factor	Technological development	

D.KEY PLAYERS AND PARTNERS.

As for the question of determining who were the key players involved in the changes respectively and which main partners supported these developments, the informants identified the main actors involved and the partners.

In terms of the main actors involved, these include:

1) The Government.
The Congolese government, via the Ministries directly concerned by the HRH issue, namely the MPH, MIHUE and MPA, were identified as key players in the development inventory of human resources for health.
Moreover, within the Government, some individual entities were cited for their personal involvement in these developments; namely the Minister of Public Health, the Secretary-General for health, and some Central Directors of MPH; Governors of provinces and head doctors of the Health Zone.

2) The community or civil society
Civil society includes all active social structures in the community which are involved one way or the other in the production, use or consumption of services involving human resources for health (beneficiaries of health services); including: churches, schools, companies, unions and associations of professionals, non-governmental organizations and private profit-making bodies.

3) The development partners

The results of interviews clearly show that the country benefits from the support of multiple partners in sectors implementing HRH development, which include an impressive number of external partners and some local partners.

All, in general terms, are involved in the activities respecting the HRH development process building on support in the process of planning, basic training and during employment, including reinforcing institutional capacities (logistical, technical and financial support) up to retention.

The list of partners collected according to their affiliation is shown in the table 20.

Table 20: List of partners having contributed to changes observed(No-exhaustive)

United Nations System	Bilateral and multilateral partners	Banthat Fund	NGO, External universities	Local partners and stakeholders
WHO, UNICEF UNFPA	USAID, BTC, UE, JICA, DFID, CORDAID	WB	CBM (German NGO), CARITAS Spain, MISEREOR (Spanish NGO)...	Government/DRC (completion point PPTE initiative)
UNDP/GSP project	Chinese cooperation Indian cooperation French cooperation, Spanish cooperation, Italian cooperation. Swedish cooperation Canadian cooperation	FM GAVI Bill Gates	Handicap International CICR (Red Cross International) CEMUBAC	Catholic and protestant churches Unions
	SAR (South African Republic).		World Medical Association	
			UCL FUB	

E.MAIN RESULTS OBTAINED.

In posing the question of determining the main results which were obtained thanks to changes mentioned above, most respondents oriented their responses in three ways in which, according to them, despite some tangible results; a minority believe that to date, there has been no notable result yet.

1) Results in institutional terms.

- Reform underway within the MPH, which according to a respondent, should be interpreted “more as an indicator than a result, given its sectoral character”;

- The HHRNDP is available within the MPH;
- Retaining directions of HRH and Teaching of Health Sciences despite the reform within the MPH;
- The effective collaboration between the MIHUE and MPH
- The effort to clean up the Health Education Establishments within the MIHUE
- The restructuring of public hospitals with "collaboration and complementarity" of doctors-nurses
- The Kinshasa University Hospitals equipped with the latest materials and equipment thanks to the support of partners (Japanese Cooperation, Indian cooperation, Belgian universities etc.);
- Reinforcement of capacities of health workers
- The significant boosting of remuneration of State doctors.
- The return of certain doctors toward structures of State.

2)Results in terms of training

- Post-university training of health workers (ESP/BTC);
- More than 1000 health executives trained for the 3rd cycle by the Kinshasa ESP;
- Relaunch of the IMS as a Pilot training school with JICA support;
- Existence of ITM for nursing training of A2 quality level, managed by private religious partners, like DOMW.

NB: Concerning the 3rd cycle training of health executives at the ESP, this institution reveals a negative result, based on the fact that the primary objective set, namely to train 5 executives to operational level by ZS (LDHZ, MA, Pharmacist, Sanitation engineer and nurse supervisor) remains a distant goal. In addition, numerous trained executives remain outside the health system.

3)Results in terms of the delivery of care

- Construction of more than 50 CS and 1 HGR by the DOMW in Kinshasa to provide localized care according to the national policy of primary healthcare.

F.CONSTRAINTS AND DIFFICULTIES ENCOUNTERED.

The entire development process has always been confronted with constraints or difficulties; this certainly also applied to the experience of establishing the current gains in the area of HRH development in the DRC.

As for determining the nature of the main constraints or difficulties encountered in establishing the current gains on HRH, the respondents blamed the following elements:

D.ifficulties linked to governance:

- Lack of clear vision of the government on HRH management
- Lack of specific orientations on HRH reform
- Quality of HR in the management responsible for HRH at MPH poses problems;
- No HR management specialists in the DRC
- No estimated management mechanism of HRH (planning,…);

- Correct management constraint of resources (difficulty in managing correctly);
- Inappropriate and/or disorderly frequency of appropriations
- Inadequate work tools (materials, equipment, conditions, infrastructure,…);
- No-compliance with contractual clauses agreed with the State;
- Enormous needs (in the sector);
- Lack (or weak) engagement of local authorities;
- Threats faced of the hierarchy (by the lower level);
- Failure indicated by the retirement of personnel in the other ministries;
- Aging of personnel: replacement, learning and innovation become difficult.
- Lack of capacity of directors.

Financial difficulties or constraints:

- Low State budget for health
- (Many) budgetary constraints
- Limited duration of support from partners
- Strike of health workers following poor working conditions;
- Self-funding of hospitals due to a lack of subsidies from the State;
- No leave taken by personnel, due to a lack of holiday pay.

Constraints linked to HRH production:

- Function of ITM left to be tackled by parents
- Nursing training having become a commercial matter
- Reduction in the quality of the basic training: ITM, ISTM, Medical faculty…).
- Limited number of entrants to ESP/year (limited number of grants).

Social constraints:

- Low socioeconomic level of the population.

3.2.2. PROSPECTIVE VIEW OF SYSTEM

As for the retrospective sector above, the prospective sector of the analysis of the HRH development system of the DRC covered specific questions, the results of which are presented in paragraphs, tables and illustrations below.

A.THE MAIN PRIORITIES.

As for determining the main priorities for HRH development in the DRC in the next 5 to 10 years according to the opinion of interviewees, the latter indicated multiple priorities, which were grouped into four categories below:

1)Priorities for HRH development:

- Implement the HHRNDP
- Ensure strong management of HRH within the MPH
- Modernize the HRH
- Control numbers of health workers
- Establish an inventory of personnel by service
- Identify personnel eligible for retirement and retire them
- Identify deceased officials
- Prepare the job description for personnel

- Appropriate HRH logically according to needs and competences
- Covering personnel
- Sense of responsibility and transparent management of personnel at MPH
- Accountability
- Computerization of HRH management
- Fitting-out BTC with adequate infrastructure and equipment
- Ensuring good health and good working conditions for agents
- Define a good salary scale.
- Regularly evaluate the assigned objectives.

2)Priorities for training

- Identify personnel training needs
- Improve the quality of basic training
- Create reference ITM and ISTM
- Promote the training of specialists
- Promote the training of (quality) nurses
- Promote moral education and correct training of personnel.

3)Priorities for service delivery

- Improve the tools of work, namely working conditions (for personnel)
- Provide ease of access to healthcare
- Reduce maternal mortality.

4)Priorities for social issues:

- Develop social and psychological assistance resources
- Develop social security.

B.INSTITUTIONAL COMMITMENTS.

Regarding the cited priorities, key informants were asked to determine the areas in which their respective institutions could commit or continue to be committed with fulfillment of these priorities in mind. The following table summarizes the main areas of commitment of each institution concerned.

Table 21: Areas of institutional commitments of key informants

Institutions	Areas of priority commitments	Comments
MPH	・Re-evaluate HD and HO to the first direction ・Transparency in HRH management ・Accountability at all levels ・Sense of responsibility	Via these 4 priorities, the MPH commits itself to good governance
MPA	・Take into account the assets of HRH reform of the MPH (remuneration, promotion, and progress).	The FP has a significant role in the reform of HRH
MIHUE	・Continuous training, in dialog with MPH, to evaluate the real need; ・Initial training responding to quality criteria; ・Creating reference establishments with the accompaniment of partners	

WHO-DRC	・Controlling numbers of personnel ・Setting up the HRH Observatory ・Encouragement for performance ・Contractualization with HRH	As adviser of the MPH, the WHO is deployed to do what the latter asks
ESP/UNIKIN	・Training of health workers and ・Identification of overall needs, by research activities	
BTC	・Planning first; then, ・Basic and continuous training	
CEFA/Monkole	・Provide ongoing training in nursing, medicine and ethics	
DOMW	・Basic and continuous training ・Institutional development: supervision, monitoring…	
Order of doctors	・Ensure the quality of the training of health service providers (doctors).	
DPS/Kinshasa	・Retirement of eligible official s ・Ensuring a reliable HRH database	The solution would be to apply decentralization

aced with development priorities of human resources for health in the DRC, multiple opportunities can be taken according to key informants; this is covered in the following paragraph.

C.KEY OPPORTUNITIES TO SUPPORT HRH DEVELOPMENT.

Two main groups of opportunities were identified: those originating from Government and key Ministries (actually, the forces) and those offered by the presence of external and local partners of the MPH. They are summarized in table 22 below.

Table 22: List of opportunities and/or forces cited (No-exhaustive)

Government and key Ministries (forces)	External and local partners	External conditions
Political will of the Government	Presence of multiple partners of the MPH	Social peace
Political will of the government to introduce NTCI	Presence and support of WHO: definition of HRH pillars	Introduction of the NTCI (on an international level)
Reform of the judicial framework/ general status of State personnel	Intervention of JICA for HRH	
Attaining the completion point of the PPTE initiative	Bilateral cooperation from South Korea (KOICA)	
The existence of the NPHD and the implementation of the HHRNDP	Bilateral Indian cooperation	

The presence of experts in the 2 key ministries: MPH and MIHUE	AMPS/GWHA	
Result-based funding and Barem de Mbudi[4]	Global Funds	
The existence of the School of Public Health for training and research; Academic personnel available	Presence of pressure groups: unions and corporations of health professionals	
Need for HRH renewal (perceived at a local level)		

As regards results-based funding, this strategy has not yet been applied in the public state-managed institutions. However, according to a high-level official of the Ministry of Health, the successful track record of this strategy elsewhere means it should be imported for use within the MPH.

As for the implementation of the HHRNDP, one informant thought that this would be an opportunity provided that "this implementation was compliant and correct, respecting all other legislative and regulatory material drawn up"; this is the only way in which, he added, "things will run smoothly".

To demonstrate the importance of compliance with judicial legislation, another informant insistently stated that: "the reform of the judicial framework or the general status of personnel of the administration of State officials and civil servants, remains the obligatory path for any reform, and as long as this framework is ignored, reform will be blocked".

D.THE SUSTAINABILITY OF RESULTS.

The objectives of the dialog with informants included asking them about the strategies needing to be implemented to ensure the sustainability of the current gains of the country in the area of HRH development. The responses obtained to this issue are listed in the form of actions to implement, with the level of responsibility shared between the key players: the government and its partners (stakeholders in general).

The responsibilities of the government:

- Acknowledge its role as the organizing authority;
- Increase the budget allocated for health;
- Pay good salaries to health professionals;
- Apply positive and negative sanctions;
- Promote general reform of the civil service;
- Ensure compliance with regulation and standards;

[4] **The Mbudi accord**, or **Mbudi social contract**, is an accord signed on 12 February, 2004 in Mbudi, a suburb to the west of the capital Kinshasa, between the transitional Government of the DRC, represented by the former Vice-président Z'Ahidi Ngoma responsible for social and cultural matters and the trade unionists of the public administration which provided for the payment of 208 USD to bailiffs and 2080 USD to the Secretary-general, by applying a salary scale going from 1 to 10. The Mbudi scale should be applied progressively in three tiers, over a period of eight years. To date, eight years on, this scale has still not been applied.

- Ensure the continuity of NPHD and HHRNDP activities;
- Ensure effective planning of HRH deployment and the setting-up of bodies;
- Implement (make functional) the framework for consultation;
- Maintain active collaboration between MIHUE and MPH;
- Assign a key place to training of nursing personnel in the reform;
- Ensure the stability of personnel involved in the reform and the implementation* of the same.

As regards the stability of personnel involved in the reform, and the retirement of eligible officials, one informant declared: "*we have to save personnel involved in the reform of HR; no disorderly forced retirement as in 2009, 2010*"; while another, discussing the HHRNDP continued as follows: «***… because, its success depends on the mobilization of funds and the stability of personnel involved in its implementation***". A latter went even further in declaring: "a permanent minister would perpetuate reform".

The shared responsibilities of the Government (MPH) and its partners:

- Advocate to support gains
- Administer the HHRNDP budget
- Exercise good management of resources
- Ensure compliance with mutual commitments
- Develop a reference system for successful experiences
- Promote sharing of knowledge and transfer of competences.
- Create good working conditions, by improving the working tool, ensuring a good atmosphere and innovation in the employment field.

Responsibilities of Partners:

- Demand competences from promoters of training schools, to ensure the quality of basic training.

NB. It is also necessary to underline the fact that, according to an informant, there is a need to initially develop gains before considering how to sustain them, since according to him, to date, there had not been "any clear gains yet in HRH development in the DRC".

4. DISCUSSION OF RESULTS

Given that it involves an initial analysis concerning the stakeholders involved in the issue of human resources in the DRC, the discussion of the results of this analysis will focus mainly around the three following points: the lessons learnt from the study results, the proofreading of the conceptual “House model” in the HRH development process in the DRC with regard to HHRNDP and finally, the study constraints.

4.1. Lessons learned

The analysis of the results of this study allowed us to make discoveries from which we could learn some lessons.

4.1.2. The discoveries

The results of the structural analysis of stakeholders and those of the qualitative analysis of the HRH development system in the DRC allowed some discoveries to be made.

a) Identification of the areas of interest of partners concerning the HHRNDP.

It is noted at this point that all four pillars of HRH development are of interest to stakeholders, including basic education, career management, continuous training as well as retention. The same applies to areas of engagement, as specified in the conceptual organizational model. In fact, the stakeholders all showed real commitment with an acceptable balance in all areas, which is evidence of the ample interest of stakeholders in all aspects of human resources within the Ministry of Health. Nevertheless, some differences came to light in terms of the sector of interest chosen by stakeholders, some details of which are listed in the following point.

b) The tendencies of interest of key players for continuous education.

In fact, the results show that overall, the stakeholders show more interest in continuous education (80 %) than all other sectors of the HHRNDP, with average interest around 53%. This reality is not a one-off, since it is also reflected with reference to activities performed by partners favoring HRH, namely that training on the job has always been given preferential treatment in budgetary terms compared to other aspects of HRH development.

In its Global Health Report, the WHO speaks of the rocketing training on the job (WHO 2006). Over and above the real needs to reinforce the capacities of health professionals faced with ever-growing innovations due to the evolution of health science, a system of motivation for personnel by performance premiums and a per diem system during training activities is at the heart of this epidemic. This explains the multiple distortions observed within the health system of the country (multiple absences due to training, fees for service, contradicting the overall approach advocated by national health policy of Primary Health Care, a shift toward activities financed by performance, etc.)(14).

Moreover, in terms of activities of stakeholders concerning HRH, the results show that they engage in more activities concerning training in gen-

eral (64.1%) than those concerning usage (46.2%), the scope of which includes activities of recruitment, appropriation, career management and retention.

In fact, apart from the weaknesses linked to the sampling effect which could be used to explain such a result in quantitative terms, the reality emerging from qualitative analysis is that “the training of health professionals has become a commercial matter in the DRC”, explaining the proliferation of training establishments and the increasing decline in training quality, since it often takes place without any prior planning (7). This could be easily explained from one perspective, namely the fact that stakeholders have more information on training of health professionals than their usage. Set against the background of a lack of resources, usage being more constraining, in terms of the duties and responsibilities of the employer, whether public or private, HRH production seems more significant for stakeholders.

This clearly reflects what has been observed for some decades, namely the fact that the DRC produces human resources for health, but has no idea how to use them; or even less retain them. In fact, multiple health professionals, especially in the teaching profession, tend to emigrate to neighboring countries and the north, hoping to find employment, and a better situation in socioeconomic and safety terms and improved working conditions. This situation is likely to have significantly contributed to impairing the quality of care and the tertiary training in the country (15). While the country itself lacks sufficient qualified human resources for health especially in remote areas (5, 7). In addition to the economic losses linked to the costs of training such qualified professionals, the country experiences an outflow of its human capital, which it needs to provide healthcare to its population. This phenomenon of an exodus of skills: “brain drain”, although a global problem, is especially acute on the African continent (16, 17).

Furthermore, while considering the areas of commitment in the HRH development process and monitoring the organizational model, the same tendencies can also be seen. In fact, putting aside the specific interest in consultation noted (72 %) and in reinforcing institutional capacities (69%), continuous education still holds more interest (69%) comparatively than other areas.

Accordingly, there is a need to indicate that the authors of the conceptual framework model proposed in response to the global issues concerning HRH, that reflections on the development of the system must be made within a more global and holistic framework going beyond solely traditional considerations, where the initial training is emphasized, during employment, to cover the management of training and personnel (10).

Fuijita and her colleagues believe that the HRH development system in post-conflict countries like the DRC, require all other components of the organizational model to be taken into account, up to sociocultural aspects and that the collaborative links between them must be guaranteed, giving all those involved the opportunity to work together and harmoniously in a well-coordinated system (10). The interest shown by stakeholders in consultation suggests their tendency to favor a frame-

work for proposed consultation within the MPH.

In contrast to what is recommended, however, it is noteworthy that stakeholders, the Government and development partners in general, focus more on certain components of the system, such as reinforcing the institutional capacities; while the teaching institutions converge their efforts on training, while neglecting other aspects, like the judicial, policy and planning framework etc. (18).

c) Weak commitment of stakeholders to fund the agenda of the HHRNDP

Regarding the results concerning the services to be provided at MPH and the areas of engagement of stakeholders, there is undeniably a lack of commitment of partners and interventionists in general in funding of the HHRNDP.

In fact, while two years have already passed since the MPH gained the HHRNDP 2011-2015, it is clear that the implementation is still making no headway. Moreover, this analysis shows that only around 13% of stakeholders offered funding to MPH against 81% which were ready to offer expertise; Moreover, in areas of engagement for HRH development, less than 40% (38.5%) made financial commitments. Furthermore, as with the category of development partners, cooperations, Donors and NGOs visited, funding commitments were only made by 4 of the 6 parties.

This situation is at odds with the recommendation of the WHO which, in its 2006 World Health Report, namely recommends development partners to adopt a "50:50 approach" whereby 50% of external aid is dedicated to reinforcing the health system, half of which for human resource development strategies" and to orient their financial and institutional support toward supporting the health system and implementing policies. However, the scope of this analysis did not extend to analyzing the budget allocated to the HRH development system, but to assess the willingness of partners to fund the activities of the HHRNDP.

A look at literature shows that some decades ago, Development Partners and Donors hardly funded HRH. For example, while most projects funded by the World Bank include activities linked to HRH, they would only have equated to 10% of budgets allocated between 1970 and 2002 and mainly focused on specific training activities rather than overall plans to reinforce HRH (19). However, there are signs that despite the change of course since 2007 with its new strategy for Health, Nutrition and Population centering on Reinforcement of health systems, "human resources will only be one of many points"(20, 21).

Faced with a lack of commitment of stakeholders to fund HHRNDP, there is a need to plan more activities to advocate the mobilization of resources, local as well as external, for the implementation of this Plan. In fact, regionally as well as globally, the lack of financial resources dedicated to health remains a major cause of the shortage of HRH (3, 20).

d) Specific commitment of technical and financial partners to reinforce institutional capacities.

Despite the reduced number of development

partners visited, it was nevertheless clear from the results that all are engaged in reinforcing institutional capacities. This engagement should be capitalized on as far as possible to further reinforce the central level, where the weaknesses still present in the management body overseeing HRH are still all too obvious. In fact, reinforcing institutional governance and the leadership of bodies in charge of HRH development, is one of the major strategic objectives of the HHRNDP.

Furthermore, there are very few development partners engaged in working to retain and monitor/evaluate HRH. Only the BTC commits to funding the retirement of eligible personnel, while this is a key priority for the Government. Moreover, it is involved in ongoing reform within Public Administration in the sense of rationalizing human resources; it also accompanies bodies compared to the selection of profiles responding to position (job description) as part of its institutional support. As for the WHO, it commits to the implementation of the NHWO.

e) The availability of stakeholders to support the NHWO

The majority of stakeholders visited expressed their full support for the process of setting up and operating NHWO in the DRC. In fact, the results show that a significant proportion (nearly 81%) of stakeholders are interested in the first function attributed to this forum, namely that of sharing experiences and information on planning for HRH development. Nevertheless, a significant function attributed to this forum does not seem to take sufficient account of the interest of stakeholders, namely the support for management of networks of expertise in the HRH area to reinforce national capacities (35.5%). It is noteworthy, nonetheless, that this function seems to be specific to the mandate of the Central Management of the MPH responsible for partnership (D12).

f) Availability of information needed for the coordination of partners.

Important information has been made available thanks to this analysis: the stakeholders involved in the HRH issue and their respective activities are identified; the information and other resources on HRH which they have are detailed; the services which they could potentially provide at MPH are identified; the localization and spread of activities performed by these latter in the health system of the DRC are clarified, etc. All this information have allowed mapping of the latter variables to a certain extent, which is a key tool provided to the organizing authority to coordinate the interventions.

For the qualitative portion of the analysis, as well as what was discovered, lessons were also learnt.

g) Comparison of study results for the situational analysis of HRH of 2010.

One key question was raised in the course of analyzing the results of this analysis. Namely “What link can be made between the study and sectoral diagnosis made in 2010? Since according to the questioner, the problems identified in this study are the same as those cited in 2010, which prompted the establishment of the HHRNDP.

The discussion of the points around this question led to the finding that this study, despite having differing goal and objectives from those involved in analyzing the situation preceding the process of drawing up the HHRNDP, can be considered an evaluation of the process in some ways and could allow for some adaptation of the actions to be implemented based on actual events.

In fact, the study results corroborate the sectoral diagnosis used to draw up the HHRNDP and are perfectly aligned with the same. This provides reassurance that despite the fact that the situational analysis of 2010 was not implemented in the form of a study, it still managed to target real problems and it is on this basis that strategic priorities were developed in the HHRNDP 2011-2015. This correlation is in addition to the common vision between the MPH and other stakeholders on questions of HRH. Moreover, it also shows that the implementation of HHRNDP is still taking time. In fact, two years after the validation of the HHRNDP by the Government and its partners, the picture of HRH remains almost unchanged even now.

h) Compliance with MPH policy by certain local partners

One of the key discoveries made in the course of this analysis was that of the application and approval of the national policy for Primary Healthcare by certain local religious partners and their involvement in training of health workers in the management of PHC.

i) Identification of constraints which could hinder the implementation of the HHRNDP

The retrospective sector of analyzing the HRH development system allowed identification of some constraints which would have to be taken into account when implementing HHRNDP to avoid potential hindrances. These would primarily include poor governance, budget shortfalls for health, a lack of control over production and decline in the quality of health professionals trained and finally, the general poverty of the population.

j) Identification of some strategies for sustainability of gains

The prospective sector of qualitative analysis allowed key informants to determine some tried and tested strategies to ensure the sustainability of the current gains of the HRH development process in the DRC.

In fact, sustainability is only possible given effective and responsible involvement by the State and its partners. Using the proposed strategies, the leadership of the State is again highlighted in the sense of awareness of its role as an organizing authority and to increase the budget to be allocated to health. Moreover, the State must also ensure it channels the reform of the MPH in the shape of a general reform of public administration. Moreover, in terms of the choice of strategies and actions, it is easier to promote experiences which have already proven successful instead of reinventing the wheel, which underlines the need for a framework for dialog and to promote the sharing of experiences and information through the NHWO.

k) Discovery of other partners with an interest in the HRH issue

Studying its qualitative aspect allowed us to identify some key partners for which the nature of interventions for HRH development were not well-known. These subsequently became potential partners to support the implementation of the HHRNDP.

l) Some points to be clarified.

Among the points made by informants, some require further clarification.

- Among the major changes cited concerning HRH, apart from the special status of doctors among the public services of the State, the special status of other health professionals was underlined. However, it should be noted that at this time, the special status of other health professionals remains an ongoing project within the MPH.

- It was also signaled that the reform of HR at MPH would represent a jump start to trigger reform in all other Ministries of Public Administration. Considering the scope and speed of health reform, it is quite easy to understand although expressed by the informant in these terms. However, the reality is that the reform of Public Administration came before that of the MPH. In fact, the South African Republic, which championed support for reforming the public administration, preceded partners which support health; hence health reform is more a consequence of the reform triggered within public administration.

- Certain informants, discussing opportunities to be taken concerning the National Plan of HRH development indicated between the Government of the DRC. It is clear that the government, which is the internal and main player of the action cannot simultaneously be an opportunity in the form of external factors which can be exploited to reinforce the system. It is therefore more a strength and not an opportunity.

4.2. Congolese House of Development for HRH

The National Plan of HRH development in the DRC describes 4 sectors in this process, the development of which was based on 4 cornerstones. These are career management, basic education, continuous education and retention. However, the conceptual framework of HRH development according to the organizational model referred to in this analysis, represents 3 pillars on which the process should be constructed, namely production, as the equivalent of basic education, posting which could correspond to the management career (recruitment, distribution, promotion…) and retention which includes continuous education, working conditions and incentives.

The organizational model, as its authors state, "offers a symbolic opportunity to reconstruct key elements in the health system, while underlining the overall functions required to respond effectively to the needs of the community and highlighting the manner in which the components supporting

the model must slot in and reinforce each other, if a durable structure is to be established"(10).

Therefore to better measure the progress from the perspective of activities outlined in the 4 sub–plans of the HHRNDP, it was crucial to reconstruct the HRH development organization while monitoring the Congolese model; the latter of which includes 4 pillars instead of 3 listed in the Japanese organizational model.

With this result, in this analysis, all components of the conceptual framework were taken in isolation in the areas of commitment of stakeholders involved in the HRH development process.

4.3. Study limitations

The results of this study do not reflect the fact that the situation observed for some stakeholders showed a less than representative selection. In fact, as well as the study being limited to Kinshasa, and the limited number of observations, the sample observed did not list all categories of stakeholders, since there is a key lack of international and national NGOs. Moreover, the profit-making private sector was not cited, especially among HRH users.

Another limit was exposed in the choice of respondents. In fact, apart from the qualitative portion, for which key informants were selected considering well-established criteria by those seeking, the respondents for the quantitative portion were not chosen taking into account carefully chosen selection criteria. In fact, as indicated above, this concerned focal points delegated by their bodies for the National HRH Observatory. With this in mind, we cannot be sure that they are those best-placed to give us the precise answers to all the questions posed.

In all cases, the tendencies revealed by the results of this analysis are worthy and likely to inform decision-makers when coordinating stakeholders in HRH development.

Furthermore, the huge field of human resources for health and the limited resources available to conduct this study limited what could be achieved in this initial phase. Moreover, since the process of analyzing stakeholders happens dynamically over time, extending the scope of this analysis should be envisaged to sectors not yet covered as well as facilitating periodic updates.

5. CONCLUSION AND RECOMMENDATIONS

Based on what precedes, the following conclusions are drawn from the analysis:

- The HRH issue is of interest to multiple stakeholders in the DRC, but none have yet become involved in the HHRNDP process.

- The clarification, thanks to this analysis involving mapping of stakeholders in terms of their missions, activities and areas of engagement for the HRH in the DRC, is obtained for the existing coordination bodies within the MPH for the effective organization and coordination of interventions on HRH in the sense of the HHRNDP.

- The persistent nature of problems linked to HRH highlighted in this study and resembling those described in the situational analysis of 2010 underlines the urgency of the implementation of the HHRNDP. This also highlights the need to proceed with reinforced advocation and marketing among stakeholders to accelerate the implementation.

To achieve the advocated development in the HRH area in the DRC, and with regard to the results presented and discussed above, some recommendations should be formulated. They are all expressed in the form of proposals for optimal use of the results of this analysis.

- There have been persistent problems concerning the HRH illustrated from 2010 to date, and a lack of commitment of stakeholders to fund the HHRNDP, It is imperative that the MPH reinforce advocation activities; starting with the publicity of the study results via all possible channels and in the short term, organizing a restoration at the major TCC forum.

- The MPH must also organize a round table meeting of stakeholders to discuss the implementation of the HHRNDP (PAO 2012) and provide specific orientations using constraints clarified in this analysis.

- The Management responsible for HRH within the MPH must use the results of this analysis to reinforce the coordination mechanisms of stakeholders via
  - The HRH commission and reinforcement of its capacities (CNPSS).

- Accelerate the process of setting up a framework for dialog between the key ministries and the NHWO for all stakeholders.

- The need to engage in interventions to accelerate the training of specialists in the area of health in general, and those in HRH management in particular within the MPH.

- Briefly, with all stakeholders, collaborate to transform all the negative points cited in this report into positive situations or objectives to be achieved with the intention of approach the desired level of development; which would achieve quality HRH for the DRC, with sufficient manpower, sufficiently motived and equally distributed targeting theMillennium Development Goals.

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ANNEXES:

Annex 1: Questionnaire survey from stakeholders

DEMOCRATIC REPUBLIC OF CONGO/MINISTRY OF PUBLIC HEALTH/SECRETARIAT GENERAL/HEAD OF HUMAN RESOURCES

ANALYSIS OF STAKEHOLDERS IN THE DEVELOPMENT OF HEALTH HUMAN RESOURCES IN DRC QUESTIONNAIRE SURVEY

0. WORK TEAM

1. Number of the questionnaire:……………………………………………
2. Date of the interview:……………………………………………………
3. Interview start time:……………H…………MIN……………
4. Province/district/town/city: …………………………………………………
5. Work team:

Members	Surname and given name	Date	Signature	Code
Interviewer		___/____/2012		
Note-taker		___/____/2012		
Supervisor		___/____/2012		
Data inputter		___/____/2012		

I. IDENTIFICATION OF THE STAKEHOLDER

No.	Questions	Responses	Code
Q1	Denomination of the stakeholder		
Q2	Localization of the office	1. Street:.. 2. No.:.. 3. Commune:............................... 4. City:....................................... 5. Province:.................................	
Q3	Identification of the respondent/focal point?	1. Name:.. 2. Sex: 1. M 2. F 3. Telephone No.:............................. 4. E-mail:....................................... 5. Function:..................................... 6. Seniority:..................................	
Q4	Address/contact details		

II. GENERAL INFORMATION:

No.	QUESTIONS	RESPONSES	CODE
Q5	What is the mandate/ mission of your institution/structure?	....	
Q6	What are your areas of interventions or of interest in the DRC?	....	
Q7	For how long has your your institution/body existed in the DRC?	....	

Q8	Currently, in which national provinces are your services offered?	....	
Q9	When exercizing your mission, do you think you have a role to play in the development of human resources for health?	1. Yes 2. No **If Q9= 1, ask Q10.** **If Q9=2, proceed directly to Q11.**	
Q10	If yes, at what level of the health system of the DRC do you currently intervene?	1. Central level 2. Intermediate level (province/district) 3. Peripheral level (ZS)	

III. INFORMATION ON HUMAN RESOURCES FOR HEALTH

No.	QUESTIONS	RESPONSES	CODE
Q11	What type of information do you have on human resources for health?	1. Information on training 2. Information on usage 3. Other information (please specify)	
Q12	What are the main activities performed by your institution concerning human resources for health? **Interviewer: Only suggest the answers opposite if required.**	1. Training 2. Usage 3. Other (please specify)	
Q13	Have you already been approached by the Ministry of Health to help resolve problems of human resources for health? **Instruction: interviewer, do not ask this question if the stakeholder is par t of the MPH.**	1. Yes 2. No 3. If yes, how did you proceed?	

Q14	Do you have an office, service or cell capable of providing information on or resolving a problem linked to human resources for health?	1. Yes 2. No 3. If yes, which?	
Q15	Do you have provincial branches which can accomplish the same tasks as those in Kinshasa?	1. Yes 2. No 3. **If yes, specify which provinces (and in the province: town or city)?**	
Q16	For how long have you been working for HRH development?	....	

IV. <u>INTEREST IN THE PROCESS OF DEVELOPMENT OF HRH.</u>

No.	QUESTIONS	RESPONSES	CODE
Q17	The Ministry of Health wishes to involve you (more) in the development process of Human Resources, which service(s) can you offer? **Multiple responses possibles. Do not suggest responses.**	a) Expertise ☐ b) Finance ☐ c) Material support ☐ d) Other to be specified ☐	
Q18	In the development of human resources for health, there are 4 main sectors. Which of these sectors interest your service?	a) Career management ☐ b) Basic training ☐ c) Continuous training ☐ d) Retention ☐ **Instruction: check the box corresponding to the response.**	

Q19	In August 2011, the Ministry of Health organized a workshop on the observatory of human resources for health. 11 functions were retained as part of this observatory - which are of interest to you? ***(Instruction: suggest functions to the interviewer; multiple responses possibles).*** ***Circle the number(s) corresponding to the chosen function.***	1. Sharing of experiences and information on planning for HRH development 2. Analysis of tendencies of the HRH situation in the DRC 3. Support for research/study activities to facilitate evidence-based decision-making 4. Redynamization of the information system by improving the quality and coverage of the data on HRH 5. Improvement of the quality of tools and data collection mechanisms 6. Support for management of networks of expertise in the HRH area to reinforce national capacities 7. Reinforcement of national capacities for monitoring and evaluating HRH 8. Availability of reliable information for national HRH development 9. Development of collaborative links for collection, storage and sharing of data 10. Contribution to the mobilization of resources for the HRH agenda 11. Sharing of available strategies on the retention and equitable distribution in HRH			
Q20	Among the functions cited above, which is the most specific compared to your mission?	....			
Q21	Please help us identify the activities performed by your institution concerning HRH more specifically by assessing them in the areas of engagement listed below. **Please identify them in increasing order of priority and estimate the percentage of time that you spend on this activity during a working week.**				
No.	**Area of engagement**		**Check the activity**	**Order of priority**	**%**
01	Basic training				
02	Appropriation (recruitment and deployment)				
03	Retention (career management/ promotion)				
04	Retention (incentives/working conditions)				

05	Continuous training			
06	Policies and planning			
07	Legal and regulatory framework			
08	Finance			
09	Monitoring/evaluation			
10	Concertation			
11	Reinforcement of institutional capacities			
12	Other (please specify)..........................			

Interview end time: ……..H………minutes.

THANK YOU FOR YOUR CONTRIBUTION.

Annex 2: Interview guide from key informants

DEMOCRATIC REPUBLIC OF CONGO/MINISTRY OF PUBLIC HEALTH/SECRETARIAT GENERAL/HEAD OF HUMAN RESOURCES

ANALYSIS OF STAKEHOLDERS IN THE DEVELOPMENT OF

HEALTH HUMAN RESOURCES IN DRC
In collaboration with the Japanese International Cooperation Agency (JICA).

INTERVIEW GUIDE

0. WORK TEAM

1. Number of questionnaire:………………………………………………
2. Date of the interview:……………………………………………………….
3. Interview start time:……………H…………MIN……………
4. Province/district/town/city: …………………………………………………
5. Work team:

Members	Surname and given name	Date	Signature	Code
Interviewer		___/____/2012		
Note-taker		___/____/2012		
Supervisor		___/____/2012		
Data inputter		___/____/2012		

I. INTRODUCTION:

Nous sommes entrain d'essayer de comprendre le development of human resources for health in the DRC and to identify the main problems and the priorities for son development futur.

Il would be bon, for nous, de commencer by recevoir des explications on your mission in the DRC and particularly your engagement in the area of human resources for health. Nous allons for cela, we entretenir with vous en vous posant some questions.
Notre interview comprend two parties principales; la first section includes des questions on the past (partie retrospective) and the deuxième, des questions concerning the future (partie prospective) of the development process of human resources for health in the DRC.

Following avoir collected all information utiles, we allons rediger un report qui rendra available the results of this survey.

Notre conversation with vous pourra prendre around 45 minutes.

SVP, Mr...; pouvons- nous commencer maintenant?

No.	Questions	Responses	Code
1°	Identity of the respondent		
2°	Capacity of the respondent?		
3°	Current function		
4°	Denomination of his/her associated institution		

III. INTERVIEW TOPICS:

Q1. Could you tell us more about the main activities performed by your institution related to human resources for health?

Q2. Please help us identify the activities performed by your institution concerning HRH more specifically by assessing them in the conceptual framework of our analysis **(HRH development organizational body). Please identify them in increasing order of priority and estimate the percentage of time that you spend on this activity during a working week.**

No.	Activities deployed	Check the activity	Order of priority	%
01	Basic training			
02	Appropriation (recruitment and deployment)			
03	Retention (career management/promotion)			
04	Retention (incentives/working conditions)			
05	Continuous training			
06	Policies and planning			
07	Legal and regulatory framework			
08	Finance			
09	Monitoring/evaluation			
10	Concertation			
11	Reinforcement of institutional capacities			
12	Other (please specify)...........................			

Q3. In your opinion, which major changes have marked our country over the last 5 to 10 years, concerning HRH development?

Q4. What are the major events which have influenced these changes?
Q5. Who were the key players behind these changes?
Q6. What were the key factors having encouraged these developments?
Q7. Who are the main partners having supported these developments?
Q8. What have been the main results obtained thanks to these changes?
Q9. Which constraints or major difficulties have been encountered? ....
Q10. In your opinion, which are the key priorities for HRH development in the DRC in the next 5 to 10 years?
Q11. Among the main priorities of HRH development you have just cited, in which areas does your institution continue to be engaged or still intends to engage? Please explain and give details of the scope of your engagement.
Q12. In your opinion, what are the key opportunities which could encourage HRH development in the DRC?
Q13. At this time, who are your main partners in HRH activities?
Q14. In your opinion, what are the specific features of the health system of the DRC in general and its human resource system in particular compared to other pays with which you are famliar? Please make a parallel comparison, indicating the differences and common areas?
Q15. Considering all the gains made in the area of developing human resources for health in the DRC, how do you think we can make them sustainable?
Q16. Is there anything else concerning your experience on HRH in our country which you would like to share with us?
Q17. As regards the the HRH issue, do you know anyone else whom you could suggest to us as an interview candidate?

THANK YOU VERY MUCH FOR YOUR CONTRIBUTION.

Interview end time:.............H...........min.

SUMMARY TABLE OF MAPPING. (See below).

Categories	No.	Stakeholders	Since when existing in the DRC?	To what extent is it localized into the health system?	Since when has this body worked in DHHR?	Sectors of interest in DHHR/HHRNDP	Areas of engagement in the DHHR/organizational model
MINISTRIES/CENTRAL DEPARTMENTS OF MINISTRIES.	1	MPH (SG)		The MPH is present in all provinces: DPS	Since its creation	a) Career management b) Basic training c) Continuous training d) Retention	6) Policy and planning; 7) Legal and regulatory framework; 8) Finance; 9) Monitoring/evaluation; 10) Conciliation; 11) Reinforcement of institutional capacities.
	2	MPH (DSP/D7)	Since 5 September 2001. (but the DSP existed as the Studies Office since 1982).	All provinces (the DSP is nationwide)	Since 1999.	d) Retention	4) Retention (incentives/working conditions) 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 8) Finance 9) Monitoring/evaluation 10) Conciliation 11) Reinforcement of institutional capacities 12) Other: Coordination
	3	MPH(D12)	Since 1999, but functional in 2005	In all 11 provinces	Since 2004, namely, since I have taken charge.	c) Continuous training	5) Continuous training; 7) Legal and regulatory framework; 9) Monitoring/evaluation; 10) Conciliation; 11) Reinforcement of institutional capacities
	4	DSP/MIHUE				b) Basic training c) Continuous training d) Retention	1) Basic training; 7) Legal and regulatory framework; 6) Policy and planning; 3) Retention (incentive/working conditions); 11) Reinforcement of institutional capacities; 10) Dialog and 12) Inventories.
	5	MESU(SG)	Since independence	The MIHUE is national, with no provincial bodies. These establishments are found at a provincial level.	Since 1978.	b) Basic training c) Continuous training d) Retention	1) Basic training, 4) Retention (incentives/working conditions) 6) Policies and planning, 7) Legal and regulatory framework, 10) Conciliation, 11) Reinforcement of institutional capacities;

	6	Plan	In 1979, with the creation of the Commissioner of Plan.	In all provinces. There is a provincial (regional) division of planning.	Since 1985.	a) Career management b) Basic training c) Continuous training d) Retention	4) Retention (incentives/working conditions); 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 8) Finance; 9) Monitoring/evaluation 10) Conciliation; 11) Reinforcement of institutional capacities
	7	Budget	Since 1987.	In all provinces of the DRC	Since 1987.	d) Retention	1) Basic training 10) Conciliation 11) Reinforcement of institutional capacities
	8	Finance	Since the accession of the country to independence.	In all provinces, they are provincial divisions of Finance and in Kinshasa, the central Finance management division.	Since the accession of the country to independence.	a) Career management b) Basic training c) Continuous training d) Retention	7) Legal and regulatory framework 8) Finance; 10) Conciliation 11) Reinforcement of institutional capacities
	9	Civil Service		All provinces		a) Career management.	6) Policy and planning 7) Legal and regulatory framework 10) Conciliation; 11) Reinforcement of institutional capacities
	10	Ministry ET/PS	Since 1960 (with Mr. Charles Kisolekele as Minister).	All provinces	Since the existence of the ministry; in 1960.	a) Career management c) Continuous training d) Retention	2) Appropriation (recruitment and deployment) 4) Retention (incentives/working conditions); 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 8) Finance 9) Monitoring/evaluation 10) Conciliation 11) Reinforcement of institutional capacities.
TRAINING INSTITUTIONS	11	Department of Population Sciences and Development (DPSD)/UNIKIN	Since 1973	a) Volet Teaching: in virtually all universities (Bas-Congo, Equateur, Kinshasa) b) Volet research: nationwide	This sector was properly taken into account from 2001.	a) Career management; b) Basic training c) Continuous training d) Retention	1) Basic training 4) Retention (incentives/working conditions; 5) Continuous training 9) Monitoring/evaluation; 10) Conciliation 11) Reinforcement of institutional capacities.

	12	The School of Public Health (ESP/UNIKIN)	Since 1984	Nationwide (including externally)	Since 1988	b) Basic training c) Continuous training	1) Basic training 5) Continuous training 6) Policies and planning 9) Monitoring/evaluation 11) Reinforcement of institutional capacities
	13	Kinshasa University Hospitals (BTC)				a) Career management b) Basic training c) Continuous training d) Retention	1) Basic training, 6) Policy and planning; 7) Legal and regulatory framework 2) Appropriation (recruitment and deployment),3) Retention (career management/promotion), 4) Retention (incitation/working conditions), 11) Reinforcement of institutional capacity 6) Continuous training, 8) Finance; 9) monitoring and evaluation; 10) Dialog .
	14	ISSI MONKOLE	For 15 years	In Kinshasa and Au Katanga, where a cell is focused on continuous training.	For 12 years	a) Career management b) Basic training c) Continuous training	1) Basic training 4) Retention (incentives/working conditions); 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 8) Finance; 9) Monitoring/evaluation 10) Conciliation; 11) Reinforcement of institutional capacities
	15	HITMS	Since 1992.	Our services are offered in the provincial city of Kinshasa and Kasaï-Occidental, more specifically in Luiza.	Since 1998	b) Basic training	1) Basic training
	16	CEFA/MONKOLE	For 10 years (2002)	In Katanga, Kasaï-Oriental, Bas-Congo and Kinshasa	For 10 years (2002)	b) Basic training c) Continuous training	1) Basic training 5) Continuous training 11) Reinforcement of institutional capacities

SERVICES SPECIALISES DE The ETAT	17	NIS (Institut national des statistics)	The 3 october 1978, la loi de 1978 consacre the NIS like company publique à caractère scientifique. la reform des companies publiques de 2009, consacre the NIS like establishment public.	In les national provinces à the exception des provinces of the Maniema and Nord-Kivu.	Since sa creation in 1978.	b) Basic training c) Continuous training	1) Basic training 4) Retention (incentives/working conditions); 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 9) Monitoring/evaluation; 10) Conciliation 11) Reinforcement of institutional capacities 12) Others: assistance technique
	18	NEO(Office National d the Employment)	Since 2003	Katanga, Bandundu, Nord and Sud-Kivu, Province Orientale and Bas-Congo. Kasaï Occidental will soon be involved.	Since 2008	a) Career management.	4) Retention (incentives/working conditions) 7) Legal and regulatory framework 10) Conciliation 11) Reinforcement of institutional capacities
	19	OM (Ministry of the Interior and Decentralization)	Since the Colonial period	In all provinces	Since la creation of the organization; and since 2002 (we have our own Center of health).	c) Continuous training d) Retention	2) Appropriation (recruitment and deployment); 3) Retention (career management/promotion) 4) Retention (incentives/working conditions); 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 8) Finance; 9) Monitoring/evaluation 10) Conciliation; 11) Reinforcement of institutional capacities.
	20	Health Services Branch/AFDRC	Since 17 April, 1964	At a central level (Kinshasa) and intermediate level in all military regions	Since the end of 2007: establishing the general management of health services within the Ministry of Defense.	a) Career management b) Basic training c) Continuous training d) Retention	1) Basic training; 2) posting (recruitment and deployment); 3) Retention (management carrière); 4) Retention (incentives..) 5) Continuous training 6) Policies and planning; 7) Legal and regulatory framework 9) Monitoring/evaluation; 10) Conciliation; 12) others: Etats de needs en HRH en cas humanitaire.
	21	CNRT	Since the signature of the Presidential ordinance in 1981	Throughout the country, with a station (branch) in each province and a sub-station in some districts.	For 1 year (2011)	a) Career management c) Continuous training	5) Continuous training 9) Monitoring/evaluation; 10) Conciliation.

MEDICAL, PRIVATE AND RELIGIOUS SECTOR.	22	DOMW				a) Career management b) Basic training c) Continuous training d) Retention	1) Basic training; 2) Appropriation ; 3) Retention (career management); 4) Retention (incentives); 5) Continuous training; 6) Policy and planning; 7) Legal and regulatory framework; 8) Finance; 9) Monitoring/evaluation; 10) Dialog;11) Reinforcement of institutional capacities; 12) Others: supervision.
	23	CCC medical	Since 1963	In all provinces of the national territory. Palu: coverage in 11 provinces (119 ZS), HIV: coverage in 5 provinces (BC, BDD, 2 KASAI, KATANGA)	Since its creation in 1963	b) Basic training c) Continuous training d) Retention	1) Basic training 4) Retention (incentives/working conditions); 5) Continuous training 9) Monitoring/evaluation; 10) Conciliation 11) Reinforcement of institutional capacities
	24	KHD	Created in around 1960	In all provinces of the national territory	Since 1974 for HRH production of secondary level and in 1995 for university level	a) Career management b) Basic training c) Continuous training d) Retention	1) Basic training 4) Retention (incentives/working conditions), 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 8) Finance; 9) Monitoring/evaluation 10) Conciliation; 11) Reinforcement of institutional capacities
ORDERS/UNIONS AND PROFESSIONAL ASSOCIATIONS	25	Order of doctors				a) Career management	1) Basic training;7) Legal and regulatory framework; 9) Monitoring/evaluation; 11) Reinforcement of institutional capacities. 12) Registration in Doctors' Register
	26	NUD	Since le 07. 11.1990	In all provinces and in all districts	Since 1987	a) Career management	2) posting (recruitment and deployment); 4) Retention (incentives and working conditions); 6) Policies and planning; 7) Legal and regulatory framework 9) Monitoring/evaluation; 10) Conciliation;

	27	NUDS	Since 1987	The organization operates in 11 national provinces	Since 1987	d) Retention	2) Appropriation (recruitment and deployment); 3) Retention (career management/promotion) 4) Retention (incentives/working conditions); 5) Continuous training 7) Legal and regulatory framework 10) Conciliation
	28	NUPC	Since 1992. (one year after the creation of the Order of pharmacists, in 1991).	Practically in all areas where the Provincial Council of the Order of Pharmacists exists, the union is alongside.	Since 1992. (a year after the creation of the Order of pharmacists, in 1991).	a) Career management c) Continuous training	5) Continuous training; 7) Legal and regulatory framework 9) Monitoring/evaluation; 10) Conciliation.
	29	Union health professionals (NUEAESS)	Created on 18 April 1991, and recorded by the Ministry of Work and that of the civil service in 1992.	In all provinces of the national territory	Since its creation in 1991.	a) Career management c) Continuous training d) Retention	3) Retention (career management/promotion); 4) Retention (incentives/working conditions) 5) Continuous training 7) Legal and regulatory framework 10) Conciliation
	30	NANC	Since 1965, initially known as AIZA (Association of nurses of the Congo Zaïre) from 1965 to 1971. Then, from 1971 to the present, NANC.	We offer our services throughout all national provinces	Since engaging in the process of reform and HRH workshops; namely, since 2008.	a) Career management b) Basic training c) Continuous training	1) Basic training; 4) Retention (incentives/working conditions) 5) Continuous training 6) Policies and planning 7) Legal and regulatory framework 8) Finance; 9) Monitoring/evaluation 10) Conciliation; 11) Reinforcement of institutional capacities
	31	AHAM	Since 1964	Our services are offered in all provinces	We have been working on HRH development for 8 months.	a) Career management b) Basic training c) Continuous training d) Retention	3) Retention (career management and promotion); 4) Retention (incentives/working conditions); 5) Continuous training; 6) Policy and planning.
PARTNERS, COOPERATIONS AND DONORS	32	WHO				a) Career management d) Retention	1) Basic training, 7) Legal and regulatory framework; 9) monitoring/evaluation (monitorage of HRH), evaluation of the Assurance quality); 10) Conciliation; 11) Reinforcement of institutional capacities;

	33	BTC	For 11 years	Our services are offered in all provinces	For 11 years	a) Career management d) Retention	All tasks concerning BTC; especially funding and HRH training (secondary level teaching).
	34	JICA	JICA office open in the DRC since July 2007. However, there has been diplomatic cooperation (embassy) since 1970.	At a central level (in Kinshasa only up to 2013). but from 2014, expanding into provinces.	Since December 2008.	a) Career management b) Basic training c) Continuous training d) Retention	1) Basic training, 6) Policies and planning 8) Finance; 11) Reinforcement of institutional capacities; 12) others: bilateral cooperation with UNICEF for vaccination and healthy village project.
	35	UNFPA	For 31 years (namely in 1981)	Since 2011: Restructuring to improve efficacy in 3 decentralized offices: Katanga (for Katanga); Nord Kivu (for NK, SK, Maniema and Uturi) and Kinshasa (for Kinshasa, BDD, and BC). In 8 provinces in total.	Since it established itself in the DRC, in 2002.	b) Basic training c) Continuous training	1) Basic training 5) Continuous training 6) Policies and planning 8) Finance 10) Conciliation 11) Reinforcement of institutional capacities
	36	USAID	Since the 1980s. Subsequently closed following looting in 1991, then re-opened in 1998.	Nationwide. As for health, in 4 provinces (the Kasaï, Katanga and Sud-Kivu).	Since the 1980s. (with major projects: SANRU, PSND, PEV etc.).	b) Basic training c) Continuous training	1) Basic training 4) Retention (incentives/working conditions); 5) Continuous training 8) Finance; 9) Monitoring/evaluation 10) Conciliation; 11) Reinforcement of institutional capacities
	37	Benelux Afro-center	Since 2007 (namely for around 5 years).	The first programme developed initially (from 2007 to 2009) was a centralized approach. Actually (from 2010 to 2012), this approach was changed to favor decentralization, with 4 provinces involved up to that point: Bas-Congo, Bandundu, Nord-KiGiven and Maniema.	Since 2010 (around 2 years ago).	c) Continuous training d) Retention	1) Basic training; 4) Retention/incentives and working conditions; 5) Continuous training. 11) Reinforcement of institutional capacities

OTHERS	38	OCM (Observatory of media)	Since 2005	In each province, there is a provincial branch which operates if there is funding of partners. but in Kinshasa, it works at a central level.	The OCM has never worked for HRH development.	c) Continuous training	12) Sharing of experiences.
	39	Provincial division of health/Kinshasa.				b) Basic training c) Continuous training d) Retention.	1) Basic training; 4) Retention (incitation/working conditions); 5) Continuous training; 6) Policy and planning; 12) Others: Conflict management in hospitals; and notification of personnel on the approval committees.

No.	**Functions of the NHWO significant for development partners and donors and others**	BTC	JICA	UNFPA	USAID	Benelux Afro	Autre (OCM)
I	Sharing of experiences and information on planning for HRH development	x		x	x	x	x
II	Analysis of tendencies of the HRH situation in the DRC			x	x		x
III	Support for research/study activities to facilitate evidence-based decision-making			x	x		
IV	Redynamization of the information system by improving the quality and coverage of the data on HRH			x			
V	Improvement of the quality of tools and data collection mechanisms						
VI	Support for management of networks of expertise in the HRH area to reinforce national capacities			x	x		
VII	Reinforcement of national capacities for monitoring and evaluating HRH		x				
VIII	Availability of reliable information for national HRH development			x	x	x	
IX	Development of collaborative links for collection, storage and sharing of data		x	x	x	x	
X	Contribution to the mobilization of resources for the HRH agenda		x	x	x		
XI	Sharing of available strategies on the retention and equitable distribution in HRH	x	x		x	x	

No.	**Functions of the NHWO significant for Ministries and Special State Services visited**	DSP health	D12 MPH	SG MIHUE	Min. plan	Min. Budget	Min. Finance	Min. ETPS	NIS	NEO	OM	AFDRC	CNRT
I	Sharing of experiences and information on planning for HRH development	x	x	x	x	x	x		x	x	x	x	x
II	Analysis of tendencies of the HRH situation in the DRC	x		x	x		x	X	x	x	x		
III	Support for research/study activities to facilitate evidence-based decision-making	x	x	x	x		x		x				
IV	Redynamization of the information system by improving the quality and coverage of the data on HRH	x	x	x	x			X	x	x	x	x	x
V	Improvement of the quality of tools and data collection mechanisms	x		x	x			X	x	x	x	x	
VI	Support for management of networks of expertise in the HRH area to reinforce national capacities		x		x				x				
VII	Reinforcement of national capacities for monitoring and evaluating HRH	x			x		x	X	x	x	x	x	
VIII	Availability of reliable information for national HRH development	x		x	x			X	x	x	x	x	

IX	Development of collaborative links for collection, storage and sharing of data	x		x	x		x	X	x	x	x		
X	Contribution to the mobilization of resources for the HRH agenda	x	x		x	x	x	X			x		
XI	Sharing of available strategies on the retention and equitable distribution in HRH	x	x	x	x			X			x	x	x

No.	Functions of the NHWO significant for Training institutions visited	DPSD/ UNIKIN	ESP/ UNIKIN	ISSI/ MONKOLE	HITMS	CEFA/ MONKOLE
I	Sharing of experiences and information on planning for HRH development	x	x	x	x	x
II	Analysis of tendencies of the HRH situation in the DRC	x		x	x	x
III	Support for research/study activities to facilitate evidence-based decision-making	x	x	x		x
IV	Redynamization of the information system by improving the quality and coverage of the data on HRH		x			x
V	Improvement of the quality of tools and data collection mechanisms	x	x			
VI	Support for management of networks of expertise in the HRH area to reinforce national capacities					x
VII	Reinforcement of national capacities for monitoring and evaluating HRH	x	x	x		x
VIII	Availability of reliable information for national HRH development			x	x	x
IX	Development of collaborative links for collection, storage and sharing of data		x	x		
X	Contribution to the mobilization of resources for the HRH agenda		x	x	x	
XI	Sharing of available strategies on the retention and equitable distribution in HRH			x		

No.	**Functions of the NHWO significant for religious medical departments, unions and associations of health professionals**	CCC/ SANRU	KHD	NUD	NUPC	NUDS	NUEAESS	NANC	AHAM
I	Sharing of experiences and information on planning for HRH development				x	x		x	x
II	Analysis of tendencies of the HRH situation in the DRC					x	X	x	x
III	Support for research/study activities to facilitate evidence-based decision-making	X	x			x		x	x
IV	Redynamization of the information system by improving the quality and coverage of the data on HRH	X			x		X		x
V	Improvement of the quality of tools and data collection mechanisms	X					X	x	x
VI	Support for management of networks of expertise in the HRH area to reinforce national capacities			x	x	x	X	x	
VII	Reinforcement of national capacities for monitoring and evaluating HRH	X		x				x	x
VIII	Availability of reliable information for national HRH development		x	x		x	X	x	x
IX	Development of collaborative links for collection, storage and sharing of data		x			x		x	
X	Contribution to the mobilization of resources for the HRH agenda						X	x	x
XI	Sharing of available strategies on the retention and equitable distribution in HRH	X		x	x	x	X	x	x

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4. Glossary

Glossary by World Bank

http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:20190578~menuPK:438351~pagePK:148956~piPK:216618~theSitePK:376793~isCURL:Y,00.html (Accessed 26Februayl 2013)

[Balanced distribution]

Refers to appropriate allocation of health personnel, geographically and among levels of care and types of services, to ensure equitable provision of quality health services to all.

[Brain drain]

Outflow of health professionals to other countries, or from the public to the private sector within a country, or out of the health sector, usually in search of more employment opportunities, and better working and living conditions.

[Capacity building]

Continuing process of strengthening existing capacities and introducing more efficient technologies and systems in order to address a problem in a more effective manner. UNDP defines capacity building as "the process by which individuals, groups, organizations, institutions and societies increase their ability to (1) Perform core functions, solve problems, define and achieve objectives and (2) Understand and deal with their development needs in a broad context and in a sustainable manner."

UNDP, Capacity Development, Technical Advisory Paper II. In: Capacity Development Resource Book. Management Development and Governance Division. UNDP, 1997.

[Career]

The movement of individuals from one job or position to another job or position which has different (usually higher) levels of authority, income and or skills/requirements.

[Career structure]

Planned set of differentiated steps, posts or jobs through which one can progress professionally within a specific position or across positions along time to ensure the continued effectiveness of an organization.

[Career management]

Process of setting goals, identifying specific skills, capabilities, interests, and implementing a career plan. Providing career management assistance is one of the strategies employed to retain health professionals (see Retention of staff)

World Health Organization, Public Services International (PSI) Terms of Employment and Working Conditions in Health Sector Reforms: Points for discussion, 2001. In: Workshop on Global Health Workforce Strategy. Annecy, France, 9-12 December 2000. Retrieved 03/18/02.

[Competences]

Knowledge, skills and attitudes which an individual possesses. Competencies are accumulated and developed through education and training and experience.

[Continuing professional development]

Process of systematic learning that allows health professionals to continue to meet the needs of the population being served by updating and enhancing their skills, whilst addressing health professionals' career and educational aspirations.

[Coping strategies]

Approaches employed by health personnel to overcome unsatisfactory remuneration or working conditions in order to fulfill professional and material expectations. Examples of coping strategies

are: (1) undertaking extra duties to supplement income (see fragmentation of work), (2) migrating to private practice or out of the health sector (see brain drain) and (3) being in a payroll without providing services (see ghost worker).
Ferrinho P, Van Lerberghe W, Providing health care under adverse conditions: Health personnel performance & individual coping strategies, Studies in Health Services Organisation & Policy, 16, 2000.

[Deployment]
Refers to the process of allocating personnel among types and levels of services and among regions and sub-regions of a country. (Dussault G,1999)

[Discipline]
A generic term covering the process and methods in an organization through which the conduct/behavior of the workforce is managed.

[Education; basic, specialization, continuing]
Education – development of competencies, or the process by which the appropriate number of each category of providers is produced and equipped with the knowledge, skills and attitudes needed to produce the kind of performance necessary to achieve health services objectives.
Basic - acquisition of fundamental professional competencies by new personnel. Provision of basic education is usually under the responsibility of professional schools and universities.
Specialization – process of acquiring specific competencies in addition to basic education.
Continuing education – all educational experiences, activities and resources engaged by a health professional after completion of professional training.

[Employment status: full-time, part-time, temporary, permanent]
Full-time (whole-time) – employment for or working for the amount of time considered customary or standard.
Part-time – employment for or working for less than the amount of time considered customary or standard. The trend towards part-time or temporary employment with lower salaries is attributed to attempts by employers to develop more flexible employment practices, but can also be used positively as a way of retaining workers who wish to work reduced hours.
Permanent – Employment contracted for an indeterminate period.
Fixed term – employment contract for a fixed period of time
Temporary – short-term contracts or "casual" work, either for a definite period or for a specific activity.

[Feminization] –
Process by which number of female workers proportionately increases in specific occupations.

[Flexibility]
"Flexibility in the use of labor can be of two types: time-based, to match staffing to workload (use of different shift patterns, working hours etc.); or contract-based, for organizational flexibility (use of temporary staff and fixed-term contract staff, and even contracting-out whole sections of the service)." (Martineau, Martinez, 1997). Flexibility can also cover pay flexibility and skill flexibility as well as other aspects.

[Fragmentation of work, multi-employment] [Roenen et all 1997]
Process by which health personnel seek alternative ways to increase income by undertaking other forms of paid employment either after or during official working hours. (Machado, 1997)

[Gender]
Socially defined aspects of being male or female. Gender roles refer to those activities considered by a given culture to be appropriate to a woman or a man. When applied to human resources in health, gender refers to an understanding of the significance of gender in (1) employing people in the health sector workforce, (2) recognizing how gender affects occupational choices, career patterns and working practices and (3) considering the non-institutional care of the sick, usually carried out by female family members (see Gender Imbalance). (Dussault, 1999)
World Health Organization, "Public Services International (PSI) Terms of Employment and Working Conditions in Health Sector Reforms: Points for discussion", 2001 In Workshop on Global Health Workforce Strategy. Annecy, France, 9-12 December 2000. Retrieved 03/18/02.
http://www.who.int/health-services-delivery/human/workforce/papers/PSI.pdf
Moser C, Tornqvist A, Bronkhorst B, Mainstream gender and development in the World Bank: progress and recommendations, World Bank Report, Washington, DC, 1998
[Ghost Worker]
Personnel formally on payroll but providing no service (See coping strategies)
[Grievance]
A generic term covering the processes and methods through which members of the workforce may express disagreement with the conditions of employment.
[Human capital]
The stock of accumulated skills, experiences and personnel that make workers more productive.
Or
Human skills and capabilities generated by investments in education and health. (WHO)
[Human resources development]
Human resource development (HRD) refers to functions involved in planning, managing and supporting the professional development of the health workforce within a health system, both at the strategic and policy levels (Martineau,Martinez, 1997). HRD aims at getting 'the right people with the right skills and motivation in the right place at the right time'. (Hornby, 1980)
Hornby P, Ray D, Shipp P, Hall T, Guidelines for health manpower planning: a course book. World Health Organization, Geneva: 1980.
Or
Systematic effort, within the limits of what a country is prepared to spend, to maximize the effective utilization of the workforce in the health sector (Dussault, 1999)
[Human resources management]
Process of creating an adequate organizational environment and ensuring that the personnel perform adequately using strategies to identify and achieve the optimal number, mix and distribution of personnel in a cost-effective manner (Martineau, Martinez, 1997)
[Human resources planning]
Process of estimating potential requirements for human resources in health and of designing ways of fulfilling those requirements (see Workforce planning).
[Human Resource Policies] Guidelines and directions that regulate the utilization of workforce both within the health sector and within the wider context (socio/political/economic)
Martineau and Martinez, 1997.
[Imbalances: regional, service, occupational, gen-

der] An imbalance occurs when there is shortage or surplus of health personnel as a result of a disequilibria between demand and supply for labor. In the health sector, imbalances can be of the following types: (1) Profession/specialty imbalances, related to a disparity in various health professions, such as doctors or nurses, as well within professions, for example, a shortage of one type of specialist, (2) Geographic imbalances, which refers to urban-rural and poor-rich regions disparities of health personnel, (3) Institutional and services imbalances, related to differences between health care facilities, as well as between services, (4) Public/private imbalances, associated with differences in human resources allocation between the public and private health care system, and (5) Gender imbalances, which refers to disparities in the female/male representation in the health workforce.

Zurn P, Dal Poz M, Stilwell B, Adams O, Imbalances in the health workforce: Briefing paper, World Health Organization, Geneva, 2002.

[Industrial action]

Collective activities of workers to pressure management into agreeing to some demands. It can include strikes, demonstrations and other forms of expression of discontent.

[Job analysis]

Process of identifying the requirements and defining roles of specific tasks.

[Job equivalence]

The weighted values of the skills requirements and work conditions of a particular job that allow comparison to other jobs in an organization, most normally used to determine career development and pay.

[Labor legislation]

Policies and guidelines regulating the labor market. Laws and regulations that govern the functioning of the labor market.

[Labor markets]

Institutions and processes through which employment and wages are determined, affecting the supply and demand for labor. Labor markets can be divided into regional, occupational or skills segments. Health labor market is the segment concerned with human resources in the health sector. Factors affecting health labor market are imbalances, mobility, and migration.

Mehmet O, The emerging global labor market: some implications for international health, report prepared for WHO Consultation on Imbalances in the Health Workforce in Ottawa on 10-12 March 200. WHO, Geneva.

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[Labor relations, bargaining, conflicts]
Labor relations – relations between management and employees in relation to collective bargaining and maintenance of contract.
Bargaining – negotiation over the terms and conditions of an agreement or contract.
Conflicts – opposition or disagreement between parties that calls for an agreement or a contract.

[Lay-off, downsizing, redundancies]
Staff reductions resulting from organizational changes or budget cuts; form of termination of employment without negative evaluation of performance.

[Management of change, change management]
The concept of change management encompasses three basic definitions: (1) the task of managing change, referring to (a) making changes in an organization in a planned and systematic way, or (b) "responding to changes over which the organization exercises little or no control", such as legislation, social and political upheaval, changing economic situations, etc; (2) "an area of professional practice," referring to experts or firms engaged in planning and managing change for their clients; (3) a body of knowledge, consisting of " models, methods and techniques, tools, skills and other forms of knowledge that go into making up any practice." (Nickols,2002) http://home.att.net/~nickols/change.htm

[Migration]
Process of movement of people from one country, region or place to settle in another. In the health sector, when related to movement of health workers, this process is also referred to as brain drain.

[Mismatches]
A bad match, a discrepancy, or a lack of correspondence between the competencies of a person and the requirements of a job, or an imbalance between required numbers/skills of staff and staff available.

[Mobility]
The capacity or facility of movement of personnel between positions, organizations and regions. Mobility of health care personnel is an important issues in the allocation of personnel within a health care system (see deployment and brain drain).

[Motivation, satisfaction]
Motivation – individuals' degree of willingness to sustain efforts towards achieving certain goals. (See System of Incentives)
Satisfaction - Contented state of mind that affects or motivates behavior. (See Systems of Incentives)

[Outsourcing, Outcontracting]
To obtain goods or services (sometimes already provided by the staff of the organization, thus implying a process of transfer) by contract from a source outside an organization or are.

[Payment mechanisms]
Methods and systems through which health care service providers are reimbursed. Examples of payment mechanisms are fee-for-service, capitation, bonus payment and case payment.
Hicks V, Adams O, Pay and non-pay incentives, performance and motivation, prepared for the Global Health Workforce Strategy Group. World Health Organization, Geneva, December 2001.

Performance management, evaluation]
Performance Management – Process of optimizing productivity and quality of work of the workforce. This includes designing or adapting performance management and performance appraisal systems. Martineau and Martinez, 1997)
Evaluation - assessment process that provides feedback to workers on their performance and ensures the quality and effectiveness of services provided.
[Personnel information system]
National and/ or local information system that provides, analyses, evaluates and distributes information needed to support decision-making and health personnel management and practices.
[Productivity]
Refers to outputs extracted from given inputs, such as patients seen per doctor, number of procedure per provider, and so on.
[Psychological contract]
Describes a reciprocal relationship which may be defined as the mutual expectations of the individual and the organization with each other. The psychological contract is often unwritten and unspoken, but nevertheless represents each party's expectations for the relationship's continued existence . Adams, O., Hicks, V.:Pay and Non-Pay Incentives, Performance and Motivation, Prepared for WHO's December 2000 Global Health Workforce Strategy Group, Geneva.
[Recruitment]
Process of searching for personnel to enter a particular job or position.
To strengthen or increase the supply of personnel to perform services.
[Regulation of practice: certification, licensing, accreditation, professional discipline monitoring and dealing with professional errors)]
Regulation of Practice – Formal recognition granted by a representative body (usually at national level) to an individual or group to verify that certain predetermined educational requirements and/or professional standards have been met. Such mechanisms are implemented to ensure maintenance of standards and the quality of health care services provided. In some systems there will be a requirement to re-certify or re-accredit at specified time intervals.
Accreditation – approval of an educational program or an institution by a governmental or voluntary body.
Certification – process by which a non-governmental agency grants recognition to an individual who has met certain qualifications.
Licensing – (of health personnel): governmental authorization of a person to engage in a health profession occupation.
Registration - (of official recording of the names of persons who have certain qualifications to health personnel); practice a profession or occupation.
World Health Organization. HUMAN RESOURCES FOR HEALTH: A Toolkit for Planning, Training and Management, WHO, Geneva, 2001
[Remuneration]
Payment of an equivalent to a person for a service or expense.
[Retention of staff]
Maintenance of health personnel by offering adequate opportunities for re-training and career management assistance (see career management).
[Skills mix]
Refers to the mix of posts in the organization, the mix of employees in a post, the combination of

skills available at a specific time, or it may also refer to the combinations of activities that comprise each role, rather than the combination of different job titles. Skill mix is a strategy used to ensure the most cost-effective combination of roles and staff.
Buchan J, Ball J, O'May F, Skill mix in the health workforce: Determining skill mix in the health workforce: guidelines for managers and health professionals, WHO working paper no.

[Staffing]
Process of recruiting, allocating and retaining staff or personnel, in terms of mix and number of personnel (the right combination of categories of personnel and adequate numbers per category), and its deployment, of its distribution by region (including internal migration pattern), by level of care, by type of establishments, by gender, in order to meet the service objectives.
(Martinez and Martineau, 1997)

[Stock]
Quantity of accumulated productive assets. In workforce planning, "stock" refers to the current composition of the workforce. In budgetary terms it can refer to mobile clinics as well as fixed assets are part of the capital stock of the health care system.

[Stress : occupational stress]
An individual may perceive stress related to their occupation or job because of the interaction between personal factors and workplace characteristics; especially specific job role demands. Occupational or job-related stress adversely impacts productivity, absenteeism, worker turnover, and employee health and well-being (Reissman, D.; Orris, P.; Lacey, R.; Hartman, D.: Downsizing, Role Demands, and Job Stress. Journal of Occupational & Environmental Medicine. Volume 41(4) April 1999 pp 289-293)

[Substitution]
Process of delegating tasks to less qualified personnel with the goal of improving cost-effectiveness.

[Systems of incentives]
Sets of rewards and sanctions to improve staff performance and motivation by providing financial and non-financial benefits such as flexible working schedule and training, education and career development opportunities.

[Teamwork]
Work done by a group formed by associates with different skills and backgrounds, with each doing a part but all subordinating personal prominence to the efficiency of the whole (see Skills Mix)

[Training: in-service]
Training – maintenance and adaptation of the competencies of existing personnel within the context of their current position.

[Unemployment, underemployment]
Unemployment – The condition in which personnel available for work in a labor market are not employed.
Underemployment - The condition in which personnel available for full-time work in a labor market is (1) employed at less than full-time or regular jobs or (2) in jobs where their full skills are not utilised, or are inadequate for economic needs.

[Trade unions, Unions]
Representative bodies of personnel that act to protect and defend the legal rights and interests of their members. Unions influence the contents and the pace of implementation of reforms agendas, especially in issues involving conditions of pay, terms of employment or job specifications.

[Work organization]

Process of defining arrangements of work in an organization, coordinating tasks and assigning responsibilities. Coordination of clinical departments in hospitals, which brings together professionals from different disciplines, is one example of work organization. (see Teamwork)

[Workforce dynamics]

The way the stock changes through movement into (entry of newly trained individuals, immigration, re-entry) and out (retirement, death, emigration, exit of the occupation) of the workforce.

[Workload]

The amount of work expected or assigned to a specific position or to one person (can also be a technical term related to "measures" of activity by individuals or teams.).

[Workforce planning: needs, supply and demand, surpluses, shortages]

Comprehensive process to provide a framework for staffing decision-making based on an organization's mission, strategic plan, budgetary resources, and a set of desired workforce competencies. It incorporates an analysis of present workforce to identify competencies needed in the future and possible gaps and surpluses, preparation of plans for building workforce (See Capacity building), and evaluation process to assure objectives are being met. (See Performance Management and Human Resource Planning)

[Working conditions, terms of employment, benefits]

Working conditions - Characteristics of the environment in which a person is expected to work. Includes terms of employment, benefits, physical and social climate.

Terms of employment - Conditions that regulate and define employment contracts (See Job Analysis)

Benefits - Advantages that a person is entitled to such as maternity leave and health insurance (See System of Incentives)

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Technical Report

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