MAPPING AND ANALYSIS OF CAPACITY BUILDING INITIATIVES ON HUMAN RESOURCES FOR HEALTH LEADERSHIP

Human Resources for Health Observer Series No. 23
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The development of this report was coordinated by Giorgio Cometto and James Campbell (World Health Organization – Health Workforce Department).

Abbreviations and acronyms

CC    collaborating centre
ECTS  European Credit Transfer and Accumulation System
GSHRH Global Strategy on Human Resources for Health
HQ    WHO headquarters
HR    human resources
HRD   human resources development
HRH   human resources for health
ICT   information and communication technology
LMICs low- and middle-income countries
MOOCs massive open online courses
ToR   terms of reference
UHC   universal health coverage
WHO   World Health Organization
Executive summary

Introduction

The performance of health-care systems depends ultimately on the knowledge, skills and motivation of persons responsible for delivering services. Hence, the WHO Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH), adopted by the 69th World Health Assembly in May 2016, identifies as one of its four strategic objectives, “to build the capacity, stewardship, leadership and governance of actions on human resources for health (HRH)”. Among the responsibilities envisaged for WHO, the GSHRH includes the “development of an internationally recognized, postgraduate professional programme on HRH policy and planning, with international mentoring and a professional network to support the implementation of workforce science”.

Objectives

The objective of this survey was to identify and analyse human resources development (HRD) courses and training materials globally, in order to inform the development of a WHO strategic and sustainable approach to build countries’ and stakeholders’ capacity in HRH governance, policy and planning, management, metrics and evaluation, in alignment with the priorities and vision of the WHO GSHRH, contributing to developing a more harmonized and visible platform of courses for general and specialized topics in the field of HRD improvement.

Data collection strategies

The data collection strategy involved key informants, internet searches and two types of questionnaires/data extraction tools.

Key findings

We have identified and analysed a total of 107 training programmes from 67 institutions in 28 countries. Of these programmes, 14 had been discontinued; further, we identified plans for 26 new programmes.

With five exceptions, all institutions participating in the study were higher education institutions, mostly from the public sector.

The HRD training initiatives identified were predominantly policy/strategy focused in emphasis, and rather neglected issues related to metrics and evaluation (from all responses on the focus of the content of training, 20% related to human resources policy and strategies; 6% on health metrics for human resources management and 10% on evaluation); they had a significant academic focus (about one third leading to a master’s or PhD degree; and about 12% were modules embedded within larger courses); and limited interest in massive open online courses (MOOCs), emphasizing face-to-face classroom teaching and few innovative teaching methods. The predominant language of teaching was English but there was a substantial number of courses offered in both Spanish and Portuguese.

Association with internationally recognized credit systems was acknowledged for 34 training programmes, predominantly the European Credit Transfer and Accumulation System (ECTS).
Regarding the 14 training programmes in Africa, 28% were delivered via face-to-face classroom methods (in Namibia and Senegal). Blended learning and computer-mediated activities were the delivery modalities in 72% of the programmes in the other African countries.

Offering training as part of a network was considered a good practice. The training was offered as part of a network in 35 programmes: 46% as part of an international network (involving countries such as Argentina, Brazil, Nigeria, Senegal and from European countries – Belgium, Hungary, Portugal, Spain, Sweden, United Kingdom); and 26% of a national one (six from Europe, two from Brazil and one from Honduras). A network of both national and international elements is mentioned by 29% of the programmes (involving countries such as Botswana, Brazil, Canada, Chile, Ethiopia, Hungary, Mozambique, Nigeria, Peru, Portugal, Rwanda, Senegal, South Africa, United States of America).

Other examples of good practice included the development of HRD toolkits, courses demanding interdisciplinary professional collaborations, strong institutional involvement in international collaborations, focusing the training on specific HRD problem-solving issues, training the trainers, and supporting them through adequate supervisory/mentoring/coaching mechanisms.

Lastly, lack of sustainability led to the termination of 14 programmes during the period covered by this study (2005–2016). Lack of sustainability was attributed to: insufficient funding or end of external funding; lack of partnerships to sustain the training capacity; and lack of interest and emphasis of the country’s health and educational policies. Frequent challenges mentioned by respondents included, dispersion of students across the national territory, difficulty in using information and communication technology (ICT), and pedagogical aspects related to limited teaching capacity.

Limitations

There are some limitations to the methodological approach that we undertook, largely related to the relatively short timeframe, to the global approach adopted for data collection and to the low response rates. The results focus mostly on the African, American and European regions of WHO, with little data on the Western Pacific, South-East Asia and Eastern Mediterranean regions.

Recommendations

From a methodological point of view, key informants’ surveys have a relatively low efficiency when compared with internet searches, but cover niches of information not easily accessible from the internet (future courses and terminated courses).

The following recommendations should be considered in the conceptualization and organization of training and capacity-building initiatives focused on HRH and HRD:

• Develop new programmes for the Western Pacific, South-East Asia and Eastern Mediterranean regions and partner up with existing ones in Africa, Europe and the Americas.

• Focus on developing flexible syllabuses that can be either included on a modular basis in longer programmes (public health or health sector management course), and focus on issues such as health workforce metrics or evaluation; or a generic core syllabus that could be adopted for short HRH courses directed at operational institutional leaders (hospitals or health centres) or expanded into a one-year course entirely dedicated to HRH from a health systems policy perspective.

• Develop financial incentives to aid the integration of modular packages into well established public health/health sector management training programmes.
• Build an accredited tertiary education sector supportive of HRD capacity building.

• Encourage the adoption of a shared credit system – ECTS seems to be the most widely used system.

• Link programme accreditation and adoption of ECTS or other credit system to a system of incentives, including financial incentives.

• Encourage the adoption of relevant pedagogic approaches addressing problem-solving and providing cases relevant to students’ professional contexts.

• Make better use of ICT-based teaching and learning models to improve access and to support new models of education.

• Also make use of ICT to disseminate information about accredited professional development training opportunities ensuring strategies to give visibility to training courses from countries less endowed with ICT resources.

• Build stable partnerships and collaborations:
  
  o Where relevant, encourage multifocal international collaborations with student and staff mobility and with strong institutional commitment (including possible twinning arrangements).

  o Ensure interdisciplinary professional collaborations.

• Address sustainability issues from the beginning.

• Address skills needed/lacking in the health labour market.

• Support the development of a capable teaching workforce.

• Mobilize financial resources and develop mechanisms to target promising sustainable programmes. Direct financial incentives at subsidizing student fees, supporting institutional pedagogic capacity, encouraging adoption of ICT-based teaching, marketing, engaging in accreditation procedures, or network building.

• Encourage programmes to develop tools and instruments as part of the training and make them available to human resources managers in the health system.

• Ensure health system support for health workforce development. As most initiatives identified are in the educational sector, some key informants identified the need to build bridges between the two sectors (education and health) to ensure relevance, to support demand and access, and to mobilize resources (financial and pedagogic).

• Explore the relevance and feasibility of adopting the WHO health labour market and the health workforce accounts frameworks as the guiding structure for the development of a harmonized and visible platform of courses for general and specialized topics in the field of HRD improvement.
1 Introduction

Effective human resources development (HRD) is a key priority for countries at all levels of socioeconomic development. Health systems cannot function without health workers (WHO, 2016). It is a universal truth that there is no health without a workforce and there is recognition of the centrality of the health workforce in translating the vision of universal health coverage (UHC) into improved health care on the ground (WHO, 2014). The performance of health-care systems depends ultimately on the knowledge, skills and motivation of persons responsible for delivering services (WHO, 2000).

2 Objectives

With the objective of conducting a mapping and analysis of training programmes focused on HRD capacity building, this study’s focus is on identifying, scoping and analysing HRD courses and training materials globally, collating information and consulting with key informants from HRH WHO collaborating centres (CC) and training institutions that currently offer such courses.

This is acknowledged in the WHO Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH), adopted by the 69th World Health Assembly in May 2016, which identifies as one of its four strategic objectives, “to build the capacity, stewardship, leadership and governance of actions on human resources for health (HRH)”. Among the responsibilities envisaged for WHO, the GSHRH includes the “development of an internationally recognized, postgraduate professional programme on HRH policy and planning, with international mentoring and a professional network to support the implementation of workforce science” (WHO, 2016).

1 Education and training is one of the key supports of HRD capacity building (WHO, 2015a). HRD is “a concept that integrates workforce analysis and planning, human resources management and capability development, to strengthen organization success by aligning the workforce to both current and future service demands” (Staron, 2008, cited by Bourgeault et al, 2009). At least 10 models of workforce development were described in the international literature (Bourgeault et al, 2008). It is partly a technical process, requiring expertise in HRH planning, education and management, and the capacity to root this in the long-term vision for the health system as a whole; but it is also a political one, requiring the will and the capacity to coordinate efforts by different sectors and constituencies in society, and different levels of government (WHO, 2015a).

2 There is a general consensus in the literature that capacity building is a difficult concept to define. Capacity building is an approach to strengthening organizations that is common to a variety of different sectors, including business and health programme management. It is a term that has been used with such frequency and variety of interpretation that its true meaning has become obscured. Commonalities among definitions of capacity building include that these efforts are generally linked in some way to better performance with a commitment to improvement in the health and other sectors in order to prolong and multiply health gains many times over. Capacity building usually involves some form of education and training (Hawe et al, 2005; Goldberg and Bryant, 2012).
The work’s focus was on identifying, scoping and analysing HRD courses and training materials globally, collating information and consulting with key informants from HRH WHO CC and training institutions that currently offer such courses. The methodology followed is summarized in Figure 1.

Figure 1. Methodological framework

Objective
To conduct a mapping and critical analysis of relevant initiatives and post-graduate training programmes focused on HDR capacity building

Descriptive study of mixed approach

Sources of data
Key informants

Digital sources
Search of internet sources

Data search
Snowballing

Searches extracted using a specialized browser plug-in around groups of keywords

Data collection instruments
Online mixed questions questionnaire

Short questionnaire

Data analysis
Descriptive statistics

Content analysis methodology

Deliverable
First draft report

Final report

We understand the use of the word “courses” as being teaching blocks leading to a certificate or diploma at any level of education. Thus, our search included doctoral and master’s degrees, postgraduate courses, technical courses or independent modules or curricular units integrated into larger training programmes.
3.1 Study design
This was a descriptive study with a mixed methods approach. A descriptive study detects patterns or tendencies in a situation, but not causal associations. Data are collected to identify the features of a situation (a population or a phenomenon) being studied. Such studies focus on the “what” question (what are the characteristics of HRD courses?). They do not answer questions about how/when/why the characteristics occurred.

3.2 Sources of data and sampling
Data were collect from key informants and from digital internet sources.

Key informants
Key informants were individuals considered to have knowledge of training courses on HRD – institutional leaders, course administrators, teachers, members of WHO CCs, WHO staff and others.

An initial pool of key informants was provided by WHO headquarters (HQ), regional offices, WHO HRD CCs and academic centres known to offer or to have been associated with initiatives relevant to the scope of the current study. The initial pool of key informants was expanded from additional contacts they suggested and from internet sources.

In the initial contact, key informants from WHO HRH CCs and regional offices (HRH focal points) were contacted by email and asked about agencies and academic institutions that currently offer or have offered such courses and a contact person for each situation. This initial contact was done by the WHO HQ focal point.

The initial contact was followed by a mail from the Lisbon-based focal point. After one week, if no answer was received, a reminder was sent. If again there was no reply within a week, a second reminder was sent. A lack of response after this process was considered a non-response.

Next, the agencies and academic institutions (their leaders, course administrators, teachers) and other key informants identified by the WHO HRH CCs and HRH focal points in regional offices, were asked to answer an online questionnaire. They were also asked to collaborate with the study by providing a list of other key informants from training initiatives focused on the study topic who would be able to answer an online questionnaire. These contacts could be sent to the Lisbon focal point or sent the questionnaire link directly. After one week, if no answer had been received, a new email was sent. If again there was no reply within a week, a second reminder was sent. A lack of response after this process was considered as non-response.

The process was conducted from Lisbon in English, Portuguese, Spanish and French.

Search of internet sources
Identification of HRD postgraduate training initiatives was done using a search strategy around groups of keywords (and their equivalents in Portuguese, French and Spanish):

- “human resources for health” or equivalents, such as “health workforce”, “health workers”, “doctors”, “nurses”, “physicians”, “health managers”
- “human resources development”
- “capacity building”
- “postgraduate training program”
- “postgraduate course”.

The keywords were linked with Boolean operators:

- «AND» to limit the breadth of the search and ensure that all concepts were included;
- «OR» to extend the reach of the search to the entirety of words with similar meaning.

Lastly, where relevant, truncation was applied to include plural and singular results.

The first 200 search results from each search engine for each group of keywords, were extracted for further review; this was a pragmatic approach, assuming that results after the first 200 will either be irrelevant or repetitive.

These results, exported with SEOQuake (https://addons.mozilla.org/en-US/firefox/addon/seoqueake-seo-extension/), were hand-searched one by one, and a selection of courses and programmes for further data collection was done if the inclusion criteria noted in Box 1 were satisfied.

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2 A descriptive study detects patterns or tendencies in a situation, but not causal associations. Data are collected to identify the features of a situation (a population or a phenomenon) being studied. Such studies focus on the “what” question (what are the characteristics of HRD courses?). They do not answer questions about how/when/why the characteristics occurred.

3 Mixed methods research “focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone”. Data collection involves gathering both numeric as well as text data so that from the final database both quantitative and qualitative information can be extracted (Creswell and Plano Clark, 2011).
Box 1. Inclusion criteria to send long questionnaire to key informants

Postgraduate training programmes on HRD capacity building were eligible if they took place between January 2005 to November 2016 (the study period); had a HRD perspective; primarily targeted health professionals, and focused on human resources governance, policy and planning, management and/or evaluation.

3.3 Data collection and/or extraction tools

Data for analysis were collected using a long questionnaire (Annex 1) completed by key informants. To obtain data from programmes not addressed by key informants, a short data extraction sheet/questionnaire (Annex 2) was completed by the Lisbon-based research staff, directly from the internet sites. Both the long questionnaire and short data extraction sheet were Survey Monkey-based (https://www.surveymonkey.com/), allowing automation of descriptive outputs.

Long questionnaire

Data were collected for the following variables, using an online long questionnaire:

- country
- name of institution
- nature of training
- contents of training
- delivery modalities
- pedagogic approaches
- association with recognized credit system
- target audiences
- demand for courses and outcomes of training
- financing and sustainability considerations
- collaborating networks
- alumni networks
- prospects for future programmes.

The questionnaire was available in English, French, Spanish and Portuguese. It contained mostly closed-answer questions, but also some open-ended ones.

Data for the long questionnaire were obtained from supplementary key informants suggested via the initial key informants (n = 14), and others identified by the Lisbon-based research team from internet sources (n = 30)\(^4\) and key informants contacted directly by other key informants without the direct intermediation of the research team (n = 5) (total 49).

Short data extraction sheet/questionnaire

To obtain information about programmes identified in the internet search, but not addressed by key informants through the long questionnaire, a short data extraction sheet/questionnaire was filled by the Lisbon-based research staff from internet sites for postgraduate training programmes focusing exclusively on HRD capacity building.

The short data extraction sheet was applied to collect data on the following variables, if available, from the internet site of the course:

- country
- name of training institution
- nature of training
- contents of training
- delivery modalities
- target audiences
- collaborative networks
- association with recognized credit system.

3.4 Data analysis

The Survey Monkey outputs were analysed using descriptive statistics for the quantitative questions and content analysis methodology (Bardin, 2008) for the qualitative ones.

As the range of data collected varied for the long and short questionnaires, they were analysed separately. Variables shared among the two tools were also analysed together in a separate section of the results.

3.5 Timeframe

The data collection and analysis were conducted between October and November 2016, and the development and finalization of the report between December 2016 and August 2017.

\(^4\) From the search of internet sources, we extracted 8000 outputs and selected a total of 493 entities/667 training programmes for analysis. From these, only 29 institutions out of 493 (6\%) answered the long questionnaire, providing information on 40 of the 667 (6\%) identified training programmes.
4 Results

The report firstly briefly characterizes the respondents and institutions, quantifies the programmes analysed and then presents the results of their geographic distribution. After, other results are presented from the responses to both the long questionnaire and the short data extraction sheet, followed by a synthesis of the two. Because of the possibility of choosing more than one option for some of the questions, the totals may exceed the number of respondents.

4.1 Respondents

As previously mentioned, long questionnaire data were obtained from supplementary key informants suggested by the initial pool of key informants (n = 14), those identified by the Lisbon-based research team from internet sources (n = 30), and key informants contacted directly by key informants without the direct intermediation of the research team (n = 5) (total 49).

Some 53% (26/49) of the respondents were professors or teachers in training programmes, 47% (23/49) were directors/coordinators of courses/programmes, 16% (8/49) were directors of institutions where the training programmes were taught and 24% (12/49) fell into other categories.

4.2 Institutions

We obtained data on programmes from 67 institutions (49 by the online questionnaire and 18 by the short data extraction sheet/questionnaire).

With five exceptions, all institutions participating in the study were higher education institutions. The exceptions were two private firms (in Australia and Botswana), the WHO office in Nigeria, the Ministerio de Salud de la Nación - Observatorio Federal de RHUS in Argentina, and a centre for continuing professional development in a Brazilian hospital. Of the higher education institutions, 38 (61%) were in the public sector.

4.3 Programmes analysed

The 49 respondents provided information on 86 programmes. Of these, 17 focused exclusively on HRD capacity building. From the internet search, using the short data extraction sheet/questionnaire, the Lisbon-based team identified a further 21 postgraduate training programmes, focusing exclusively on HRD capacity building. In total, 107 programmes were analysed; 38 of them focused exclusively on HRD capacity building.

4.4 Geographic distribution

Figure 2 and Table 1 present the geographic distribution of responses by country and WHO region.

![Figure 2. Institutions and training programmes that responded to the questionnaire by WHO region](chart)
<table>
<thead>
<tr>
<th>WHO REGION</th>
<th>Country</th>
<th>RESPONSES FROM LONG QUESTIONNAIRE</th>
<th>RESPONSES FROM SHORT QUESTIONNAIRE</th>
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<td></td>
<td>Total</td>
<td>49</td>
<td>86</td>
<td>18</td>
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4.5 Responses from long questionnaire

In this report, the responses on training courses/programmes on HRH capacity building have been divided into three categories for analysis:

• Training courses/programmes available between January 2005 to November 2016.
• Training courses/programmes in existence from January 2005 but since discontinued (a sub-set of the previous category);¹
• Training courses/programmes envisaged for the near future.

4.5.1 Training courses/programmes available between January 2005 to November 2016

Quantitative data²

The training identified showed a clear predominance of policy/strategic content (Figure 3); an important academic focus (30% were conducive to a master’s or PhD degree) (Figure 4); modest use of innovative teaching methods (Figure 5); an emerging interest in distance or blended learning (28%) (although most required the presence of the student in the class room) (Figure 6); and targeted equally all professional groups (Figure 7).

¹ These results are also presented as part of the collective results from the previous section on training courses/programmes available between January 2005 to November 2016.

² To the questions “focus of the contents of training”, “nature of the training”, “pedagogic approaches”, “delivery modalities”, “target audience”, “training funding” and “language of teaching” the respondents could select more than one answer option. The denominator for the percentages presented is the total of number of answers to the question and not the number of answered questionnaires or training programmes (the Y axis in the graphs presented refers to the percentage of questions answered). Hence, the percentages should total 100%. This explanation is valid for all the sections of the report.
Only one of the programmes was exclusively directed to physicians and four were directed exclusively to nurses and midwives (Figure 7). Health managers and administrators were the exclusive target of 11 programmes.

Although about half had some level of self-financing, only 21 were wholly self-financed (Figure 8) and 14 were free to the participants.

It is difficult to make general statements about the costs of studying, but from the limited data available, private institutions appear to be more expensive than public ones (e.g. Master en Gestión Sanitaria y Hospitaria – IFFE Business School [private institution, Spain], US$ 10 000 vs. faculty development programme/MiniMBA master’s programme in health programme – Faculty of Medicine, Chulalongkorn University [public institution in Thailand], US$ 1200). If we consider annual student tuition fees, master’s programmes are the most expensive (e.g. community-based nursing leader training course – Gunma University, Japan, master’s degree, US$ 5500 or MBA con especialización en salud – Instituto Salud Pública Universidad Andrés Bello, Chile, master’s degree, US$ 5000).

Trying to characterize the demand, we have analysed the last three editions of the training programmes, regarding the number of candidates, number of admissions, percentage of female admissions and number of graduate students. As we can see in Tables 2 and 3, classes vary in size. The proportion of females admitted to courses seems to be increasing in the most recent editions (Table 4). The number of graduates seems low for the reported number of admissions (Table 5).
Figure 8. Training funding (n = 109)

Table 2. Number of candidates/programme

<table>
<thead>
<tr>
<th>EDITION OF THE PROGRAMME</th>
<th>0–10</th>
<th>10–20</th>
<th>20–50</th>
<th>&gt;50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent</td>
<td>9</td>
<td>26</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Last but one</td>
<td>6</td>
<td>16</td>
<td>22</td>
<td>15</td>
</tr>
<tr>
<td>Previous</td>
<td>3</td>
<td>15</td>
<td>21</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 3. Number of admissions/programme

<table>
<thead>
<tr>
<th>EDITION OF THE PROGRAMME</th>
<th>0–10</th>
<th>10–20</th>
<th>20–50</th>
<th>&gt;50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent</td>
<td>11</td>
<td>26</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>Last but one</td>
<td>8</td>
<td>16</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>Previous</td>
<td>7</td>
<td>14</td>
<td>23</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 4. Percentage of females admitted/programme

<table>
<thead>
<tr>
<th>EDITION OF THE PROGRAMME</th>
<th>&lt;30%</th>
<th>30–50%</th>
<th>50–70%</th>
<th>&gt;70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent</td>
<td>11</td>
<td>26</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Last but one</td>
<td>11</td>
<td>24</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Previous</td>
<td>11</td>
<td>22</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 5. Number of graduating students/programme

<table>
<thead>
<tr>
<th>EDITION OF THE PROGRAMME</th>
<th>0–10</th>
<th>10–20</th>
<th>20–50</th>
<th>&gt;50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent</td>
<td>7</td>
<td>16</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Last but one</td>
<td>7</td>
<td>16</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Previous</td>
<td>4</td>
<td>16</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

The reported language of training reflects the geographical distribution of the respondents (Figure 9).

Figure 9. Language of teaching (n = 78)
Qualitative data
The major strengths, successful approaches and valued added aspects of the programmes studied were identified as:

For the schools:
• Going through accreditation procedures.
• Building national and international networks and partnerships.
• Promoting multidisciplinarity and interdisciplinarity.
• Improving research outputs.
• Increasing access by distance learning.
• Acknowledgment of teaching cases, case studies, real-life problems, problem-based learning and workplace-oriented learning as pedagogical strategies that bring advantages to programmes.
• Enhancing technical quality of teaching staff.

For the students:
• Contributing to enhancing students’ academic and professional levels and maturity.
• Developing the research capacity of students.
• Recognition that using case studies helps participants to contextualize HRH problems and encourages them to adopt more innovative solutions.
• Recognition that studying online allows students to remain at work full time.
• Benefiting from global and regional tutors with distance learning or from partnerships/networks.
• Facilitating career progress as many of those completing the programmes have access to leadership positions.
• Increasing possibility of working in health institutions in training and research areas.
• Contributing to salary improvement.
• Equipping nurse leaders for involvement in policy development; leadership development among nurses and midwives.

For the health system:
• Keeping the programme in Africa adapts it to the African environment.
• Underlining HRH as essential elements in service delivery.
• Training programmes promote availability of continuously updated learning materials for continuing education.
• Contributing to competence building of leading positions in the countries health systems.

More negatively, the main bottlenecks and challenges associated with the programmes studied included:

Funding issues:
• Funding was frequently deemed insufficient.
• Students had difficulty paying fees.
• Medium-term sustainability dependant on external financing.
• Difficulty in obtaining financing for:
  - internships abroad
  - fieldwork
  - invitations to external teachers, participation at congresses, payment of publication in periodicals.

Obtaining accreditation was difficult, leading to degree qualifications that were not recognized.

Pedagogical aspects:
• Shortage of competent training of trainers and supervisors.
• Limited institutional teaching capacity.
• Shortage of workplace-based mentors.
• Limited capacity to promote e-learning.
• Changing mindsets so that prospective students embrace online learning.

• Difficulty in the management of learning materials in foreign languages.

**Contextual aspects:**

• Students come from many different backgrounds with variable knowledge of human resources, policy, planning and management.

• Variable proficiency in the use of new technologies.

• Variability of internet availability with connectivity problems in some regions.

• Lack of unified software in all areas involving management technology.

• Little follow-up of graduates, often because of the size of the territory.

• Geographical access, including difficulties in transportation for people from other provinces.

• Displacement and accommodation for foreign students.

• Difficulty in finding internships for students.

• Low student knowledge about research methodologies.

• Insufficient dissemination of the product of thesis.

• Low terminal efficiency (number of graduates).

• Weak marketing of the courses.

• Lack of relevant partnerships.

• Lack of interest in and emphasis on the country’s health and educational policies.

• Health institutions not yet aware of the importance of HRH management.

### 4.5.2 Training courses/programmes in existence from January 2005 but since discontinued

From a total of 86 training programmes analysed, 14 were discontinued – five from Hungary, three from Honduras, three from Portugal, two from Argentina and one from South Africa. Of these, six were exclusively focused on HRH capacity building.

**Quantitative data**

The courses discontinued had a higher relative weight of operational dimensions than the courses described in the previous section (Figure 10). They tended to be more frequently “technical training oriented for specific job competencies” or “modules within larger courses” (Figure 11), to follow “standard instructional approaches” (Figure 12) and use face-to-face classroom methods (Table 6), targeting mostly health managers and administrators (Table 7).

---

**Figure 10. Focus of the contents of training**

(n = 25)

<table>
<thead>
<tr>
<th>Focus of Contents</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human resources policy and strategies</td>
<td>17</td>
</tr>
<tr>
<td>Human resources leadership and change management</td>
<td>4</td>
</tr>
<tr>
<td>Human Resources Governance</td>
<td>4</td>
</tr>
<tr>
<td>Human resources management and supervision</td>
<td>17</td>
</tr>
<tr>
<td>Human Resources Evaluation</td>
<td>17</td>
</tr>
<tr>
<td>Health metrics for Human Resources management</td>
<td>13</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
</tr>
</tbody>
</table>

---

Series No. 23 17
Table 6. Delivery modalities

<table>
<thead>
<tr>
<th>Delivery Modality</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-face classroom methods</td>
<td>67%</td>
<td>6</td>
</tr>
<tr>
<td>Distance learning</td>
<td>22%</td>
<td>2</td>
</tr>
<tr>
<td>Blended learning</td>
<td>11%</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 7. Target audiences

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health managers and administrators</td>
<td>53%</td>
<td>8</td>
</tr>
<tr>
<td>Doctors</td>
<td>20%</td>
<td>3</td>
</tr>
<tr>
<td>Nurses and midwives</td>
<td>7%</td>
<td>1</td>
</tr>
<tr>
<td>Other health professionals</td>
<td>20%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>

Regarding the 14 discontinued programmes, seven provided information about how the training was financed: two were exclusively and another two were partially self-financed (all in Hungary). Regarding the other three, two were co-funded by the health sector budget (in Latin America) and one by a donor (in Nigeria).

Qualitative data

The main reasons for discontinuation were:

- Related to funding.
- Associated with project cycles.
- Lack of internal capacity to sustain the training.
- Connected with discontinued partnerships.

For the discontinued programmes, the main bottlenecks were associated with funding issues, specifically to insufficient funding, end of external funding and lack of partnerships to sustain the training capacity. The lack of interest and emphasis of the country’s health and educational policies is also referred to as a bottleneck.
Frequent challenges mentioned by respondents included dispersion of students in the national territory, difficulty in using ICT and pedagogical aspects related to limited teaching capacity.

The major perceived advantages of the discontinued programmes were their promotion of multidisciplinarity and interdisciplinarity, the partnerships and networking opportunities, and the adaptation of the training to the students’ environment. Benefiting from global and regional tutors and the availability of updated learning materials were also referred to as advantages.

4.5.3 Training courses/programmes envisaged for the near future

Some 26 training programmes envisaged for the near future were identified. Their geographic distribution is reflected in Table 8 (Figure 13) – most are concentrated in the Region of the Americas.

<table>
<thead>
<tr>
<th>WHO REGION</th>
<th>COUNTRY</th>
<th>NUMBER EXPECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Region</td>
<td>Namibia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nigeria</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Uganda</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sub-total</td>
<td>4</td>
</tr>
<tr>
<td>European Region</td>
<td>Hungary</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Portugal</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Spain</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>United Kingdom</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sub-total</td>
<td>9</td>
</tr>
<tr>
<td>Region of the Americas</td>
<td>Argentina</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Brazil</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Chile</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Colombia</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>El Salvador</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Honduras</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sub-total</td>
<td>13</td>
</tr>
</tbody>
</table>

Again, the planned future training identified has a clear policy/strategic emphasis (Figure 14), an important academic focus (39% will be conducive to a master’s or PhD degree) (Figure 15), emphasizes innovative teaching methods (Figure 16), with some interest in distance or blended learning (36%) (most will require the presence of the student in the classroom) (Figure 17), targeting equally key professional groups (Figure 18). The predominant language of teaching will be English (52%) (Figure 19).
**Figure 14. Focus of the contents of training (n = 73)**

- Human resources policy and strategies: 22%
- Human resources leadership and change management: 15%
- Human resource workforce planning: 20%
- Human Resources Governance: 7%
- Human resources management and supervision: 12%
- Human Resources Evaluation: 8%
- Health metrics for Human Resources management: 10%
- Human resources management and supervision: 15%
- Health metrics for Human Resources management: 7%
- Others: 5%

**Figure 15. Nature of the training on HRH development capacity building (n = 36)**

- Postgraduate diploma: 19%
- Masters degree: 25%
- Postgraduate certificate: 14%
- Technical training oriented for specific job competencies: 14%
- Doctoral degree: 6%
- Module within larger course: 0%
- Massive Open Online Course: 3%
- Other: 19%

**Figure 16. Pedagogic approaches (n = 71)**

- Problem-based learning: 27%
- Teaching Cases: 28%
- Work Based project: 17%
- Standard Instructional Model: 14%
- Learning Sets: 9%
- Others - specify: 4%

**Figure 17. Delivery modalities (n = 34)**

- Face-to-face classroom methods: 56%
- Distance learning: 18%
- Blended learning: 18%
- Other: 9%
4.5.4 Examples of good practice

Respondents to the long questionnaire were asked to identify examples of good practices that they would like to recommend as widely relevant. These included:

- Toolkit on health workforce planning and forecasting (http://hwftoolkit.semmelweis.hu).
- Multifocal international collaborations with student and staff mobility and distance learning.
- Interdisciplinary professional collaborations with other professional teams (on topics such as patient safety, health policy, e-health).
- North-South collaborations with local institutes in developing countries to address HRH challenges.
- Focusing training on specific issues according to identified needs, such as:
  - Monitoring and evaluation
  - Advanced nurse practice role
  - Finance for nurse managers
  - Systems management
  - Government policies on HRH
  - Training trainers for HRD
  - Development of supportive supervision.
4.6 Results from short online data extraction sheet

The HRD training identified had a clear policy/strategic emphasis (Figure 21), a major academic focus (32% will be conducive to a master’s degree) and strong emphasis on MOOCS (Figure 22), emphasizing innovative blended teaching methods (Figure 23) and targeting equally key professional groups (although the target audience is not specified for most programmes) (Figure 24). The predominant language of teaching was English (68%) (Figure 25).

Figure 21. Focus of the contents of training (n = 40)

<table>
<thead>
<tr>
<th>Focus of the Contents of Training</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human resources policy and strategies</td>
<td>30%</td>
</tr>
<tr>
<td>Human resources leadership and change management</td>
<td>1%</td>
</tr>
<tr>
<td>Human resources workforce planning</td>
<td>0%</td>
</tr>
<tr>
<td>Human Resources Governance</td>
<td>0%</td>
</tr>
<tr>
<td>Human resource management and supervision</td>
<td>3%</td>
</tr>
<tr>
<td>Human Resources Evaluation</td>
<td>3%</td>
</tr>
<tr>
<td>Health metrics for Human Resources management</td>
<td>0%</td>
</tr>
<tr>
<td>Others</td>
<td>0%</td>
</tr>
</tbody>
</table>

Policy/strategic dimension | Operational dimension | Mixed strategic/operational
---|---|---
20% | 30% | 30%

Figure 22. Nature of the training on HRH development capacity building (n = 28)

<table>
<thead>
<tr>
<th>Nature of the Training</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postgraduate diploma</td>
<td>7</td>
</tr>
<tr>
<td>Masters degree</td>
<td>32</td>
</tr>
<tr>
<td>Postgraduate certificate</td>
<td>0</td>
</tr>
<tr>
<td>Technical training oriented for specific job competencies</td>
<td>0</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>11</td>
</tr>
<tr>
<td>Module within larger course</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
</tr>
<tr>
<td>Massive Open Online Course</td>
<td>0%</td>
</tr>
</tbody>
</table>

Figure 23. Delivery modalities (n = 21)

- Face-to-face classroom methods: 5%
- Distance learning: 24%
- Blended learning: 5%
- Other: 67%
The duration of the programmes analysed ranged from three weeks (module in a major course) to four years (postdoctoral programme).

The price ranged from US$ 349 (module in a major course) to US$ 25 000 (postdoctoral programme).

Only two of the 21 programmes had information about financing (Spain and Canada). Both were funded by a patron/benefactor and one also had funding from the health sector budget (the postdoctoral programme).

Only 33% of the programmes had information about the pedagogic approaches employed (Figure 26).
4.7 Synthesis of responses to long questionnaire and short data extraction sheet

The HRD training identified had a clear policy/strategic emphasis, neglecting issues related to metrics and evaluation (Figure 27); a significant academic focus (about one third are conducive to a master’s or PhD degree); limited interest in MOOCS (Figure 28); emphasizing face-to-face classroom teaching; with some interest in innovative teaching methods (Figure 29). There is a slight predominance of English language teaching (Figure 30).

Figure 27. Focus of the contents of training (n = 344)

<table>
<thead>
<tr>
<th>Human Resources Policy and Strategies</th>
<th>Human Resources Leadership and Change Management</th>
<th>Human Resources Governance</th>
<th>Human Resources Management and Supervision</th>
<th>Human Resources Evaluation</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>20</td>
<td>17</td>
<td>15</td>
<td>6</td>
<td>10</td>
</tr>
</tbody>
</table>

Policy/strategic dimension

Operational dimension

Mixed strategic/operational

Figure 28. Nature of the training on HRH development capacity building (n = 162)

<table>
<thead>
<tr>
<th>Postgraduate Diploma</th>
<th>Masters Degree</th>
<th>Postgraduate Certificate</th>
<th>Technical Training Oriented for Specific Job Competencies</th>
<th>Doctoral Degree</th>
<th>Module within Larger Course</th>
<th>Other</th>
<th>Mass Open Online Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>20</td>
<td>16</td>
<td>11</td>
<td>10</td>
<td>11</td>
<td>10</td>
<td>4</td>
</tr>
</tbody>
</table>

Figure 29. Delivery modalities (n = 145)

- Face-to-face classroom methods: 9%
- Distance learning: 53%
- Blended learning: 12%
- Other: 26%
Association with a recognized credit system was acknowledged for 34 of the training programmes, 20 (59%) of which were international with the rest being either a national credit system or not specified. Those that had an internationally recognized credit system were administered in Europe (18 using the ECTS), United States of America and Pakistan (networking with the United Kingdom). Some of the national credit systems make 1 credit equivalent to 15 or 17 hours of study/lectures or 34 hours of practical classes (Brazil), 17 hours (Peru) or 10 teaching hours (South Africa).

The training was offered as part of a network in 35 programmes: 46% as part of an international network (involving countries such as Argentina, Brazil, Nigeria, Senegal and from European countries – Belgium, Hungary, Portugal, Spain, Sweden, United Kingdom) and 26% a national one (six from Europe, two from Brazil and one from Honduras). A network of national and international elements is mentioned by 29% of the programmes (involving countries such as Botswana, Brazil, Canada, Chile, Ethiopia, Hungary, Mozambique, Nigeria, Peru, Portugal, Rwanda, Senegal, South Africa, United States of America).

Regarding the 14 training programmes in Africa, 28% were delivered through face-to-face classroom methods, in Namibia and Senegal. Blended learning and computer-mediated activities were the delivery modalities in 72% of the programmes in other African countries.

Figure 30. Language of teaching (n = 100)

- Portuguese: 39%
- English: 29%
- Spanish: 23%
- French: 9%
5 Discussion and conclusions

5.1 Limitations

There are some limitations to the methodological approach that we undertook, largely related to the relatively short timeframe, to the global approach adopted for data collection and to the low response rates.

The timeframe prevented us from pretesting the variables to be collected with a panel of experts, and from piloting the methodology and the data collection tools.

The response rate from some of the WHO regions was particularly low, namely, from South-East Asia, and the Eastern Mediterranean and Western Pacific Regions.

We sacrificed depth in favour of breadth, adopting a searching strategy of the internet concomitant and supported by a process of identifying additional key informants through a snowballing approach. Data collection was done through these key informants and by the Lisbon-based team directly from the internet.

Hence the data obtained by the Lisbon-based team has a more limited scope (limited to the information available on the internet sites).

The response rates from key informants were low and even the ones who responded had variable response rates for the different variables in the questionnaire. Some of the questions with negligible response rates included those on costs of training, course completion rates and on the existence of alumni networks. For example, one of the online questionnaire questions was, “Has the programme undergone an internal or external assessment or evaluation? If so, please attach.” We did not receive any answers to this question, so it is not possible to examine the existing evaluations and analyses of these courses.

Lastly, the closed answer options for the questions on course content do not allow the presentation of the content of training against the health labour market (Sousa, Scheffler et al, 2013) and the national health workforce accounts frameworks (WHO, 2015b).

5.2 Complementarity of data collection strategies

The data collection strategy ensured that with the results of the supplementary key informants we captured information on 10 courses not detected with the internet search. Of the courses focusing exclusively on HRD capacity building, 21 were captured by the short data extraction sheet questionnaire and 17 by the long questionnaire (of these, 10 by supplementary key informants). Most of the data on discontinued (10 out of 14) and future courses were obtained from the supplementary key informants.

Despite the limitations and considering the results achieved with the research approach adopted, this study still provides a range of leads useful for the “development of an internationally recognized, postgraduate professional programme on HRH policy and planning, with international mentoring and a professional network” to support the development of a WHO strategic and sustainable approach to build countries’ and stakeholders’ capacity in HRH governance, policy and planning, management, metrics and evaluation.

5.3 Overview of data availability

The manual search of our internet outputs suggested that human resources programmes were abundant, but not so for HRH. As an example, in the Spanish language there was a site (emagister) with 76 human resources management training programmes, none of which was about HRH. The development of skills in strategic management, where human resources was one of the themes, also appeared frequently – not specifying health.
Topics such as leadership of health-care organizations, health-care management, health-care administration and public health dominated the supply of training programmes with a HRH component. In these, HRH appeared as a module or subtopic – hence the links appeared in our internet search process. Interestingly, the topic of leadership was apparently the most prevalent, followed by health-care management, health-care administration and training in public health. In the Spanish sites, health administration was usually found as a theme of public administration and HRH management as a theme of health administration.

Our findings indicated a wide offer of online training. There were also training opportunities in which students could choose to take courses online or through blended learning. Little appeared in the internet search referring to programmes with only classroom teaching. This was particularly true in Western Europe and the United States of America. Classroom teaching only emerged particularly in key informants’ replies to the long questionnaire.

We could also verify that a significant proportion of the training confers postgraduate diplomas or a master’s degree. Few PhD programmes had a focus relevant to the scope of this survey.

In the Brazilian and French courses identified there were many references to training in (clinical) teamwork, sometimes referring to it as a human resources management issue. These courses were not selected for analysis.

Lastly, it is interesting to note that the Brazilian training offer on the internet was vast but unclear in terms of costs, methods of teaching and the academic qualifications conferred. Visiting the sites of the institutions (and not just the programmes) it was verified that much of the training offered was not accredited, a quite different situation from the courses offered in English, French and Spanish.

5.4 Key findings

Notwithstanding the limitations, we have analysed a total of 107 training programmes from 67 institutions in 28 countries. Of these programmes, 14 had been discontinued and we identified plans for 26 new programmes. The overwhelming majority of responses were from the tertiary education sector.

The HRD training identified was predominantly policy/strategic in emphasis; neglected of issues related to metrics and evaluation; had a significant academic focus (about one third are conducive to a master's or PhD degree and 12% were modules embedded within larger courses); and showed limited interest in MOOCs, emphasizing face-to-face classroom teaching and exhibiting few innovative teaching methods. The predominant language of teaching was English but there were significant offers in both Spanish and Portuguese. The training programmes’ association with internationally recognized credit systems was acknowledged for 34 – predominantly the ECTS.

Regarding the 14 training programmes in Africa, blended learning and computer-mediated activities were very important delivery modalities.

Offering training as part of a network was common and considered good practice.

Other examples of good practice included development of HRD toolkits, courses demanding interdisciplinary professional collaborations, strong institutional involvement in international collaborations, focusing the training on specific HRD problem-solving issues, training the trainers, and supporting them through adequate supervisory/mentoring/coaching mechanisms.

As for undergraduate training of health workers (Sousa et al, 2013), the evidence suggests that funding by patrons/benefactors represents a small percentage of the income sources financing postgraduate HRD training.

Lastly, lack of sustainability led to the termination of 14 programmes during the study period (2006–2015). Lack of sustainability was attributed to: insufficient funding, end of external funding, lack of partnerships to sustain the training capacity, and lack of interest and emphasis of the country’s health and educational policies.

Frequent challenges mentioned by respondents included dispersion of students across national territories, difficulty in using ICT and pedagogical aspects related to limited teaching capacity. ICT may be an important consideration for visibility, access and sustainability of training programmes. The potential for acquiring and sharing new knowledge through new models of transformative education by use of distance and blended learning using internet-based ICT is high (Bollinger et al, 2013).

The adoption of ICT can contribute to scaling up health worker training and improve its quality: e-learning tools can support curriculum development and course scheduling and management.
in ways that are conducive to blended learning approaches and that
take advantage of multiple learning environments (Global Health
Workforce Alliance, 2008).

Training methods based on videoconferencing, webcasting,
recording, localization and playback of training can enable global
access to the very best educators, and may represent an important
complementary approach to enhance standard face-to-face
educational programmes (WHO, 2015a).

It is encouraging to note that the appetite for ICT-based teaching
among the programmes studied, although not as high as could
be expected from references in the literature, it is nevertheless an
important part of the training supply. This seems particularly so in
African programmes, which is surprising considering that in most
developing countries, there is a reported dearth of fundamental
e-learning components such as computers, electricity and related
skills (Safie and Aljunid, 2013). This shortage may explain why, on
the internet search, the outputs from Africa, Asia and Latin America
do not appear in the first links of a global search.

5.5 Main messages

From a methodological point of view, key informant surveys have a
relatively low efficiency when compared with internet searches, but
cover niches of information not easily accessible from the internet
(future courses and terminated courses).

Based on the available survey data, some of the approaches and
implementation modalities to develop an accredited postgraduate
capacity-building initiative WHO HQ should consider include:

- Develop new programmes for Western Pacific, South-East Asia
  and Eastern Mediterranean Regions and partner up with existing
  ones in Africa, Europe and the Americas.

- Focus on developing flexible syllabus that can either: be included
  on a modular basis in longer programmes (public health or
  health sector management course) focusing on issues such as
  health workforce metrics or evaluation; or form a generic core
  syllabus that could be adopted for short HRH courses directed at
  operational institutional leaders (hospitals or health centres) or
  expanded into a one-year course entirely dedicated to HRH from
  a health systems policy perspective.

- Associate this with a financial incentives package for including
  the modular packages into well established public health/health
  sector management training programmes.

- Build an accredited tertiary education sector supportive of HRD
  capacity building.

- Encourage the adoption of a shared credit system – ECTS seems
to be the system most widely used.

- Link programme accreditation and adoption of ECTS or other
  credit system to a system of incentives, including financial
  incentives.

- Encourage the adoption of relevant pedagogic approaches
  addressing problem-solving and relevant cases for the students’
  professional context.

- Make better use of ICT-based teaching and learning models to
  improve access and to support new models of education.

- Also make use of ICT to disseminate information about
  accredited professional development training opportunities
  ensuring strategies to give visibility to training courses from
countries less endowed with ICT resources.

- Build stable partnerships and collaborations:
  o Where relevant, encourage multifocal international
    collaborations with student and staff mobility and with
    strong institutional commitment (possibly including twinning
    arrangements).

- Address skills needed/lacking in the health labour market.

- Support the development of a capable teaching workforce.

- Mobilize financial resources and develop mechanism to target
  them to promising sustainable programmes. These resources
  should be used as incentives directed at subsidizing student
  fees, supporting institutional pedagogic capacity, encouraging
adoption of ICT-based teaching and/or marketing, engaging in accreditation procedures or in network building.

- Encourage programmes to develop tools and instruments as part of their training and to make them available to human resources managers in the health system.

- Ensure health system support for health workforce development – as most initiatives identified are in the educational sector some key informants identified the need to build bridges between the two sectors (education and health) to ensure relevance, to support demand and access and to mobilize resources (financial and pedagogic).

- Explore the relevance and feasibility of adopting the WHO health labour market and the health workforce accounts frameworks as the guiding structure for the development of a harmonized and visible platform of courses for general and specialized topics in the field of HRD improvement.
Bardin L. Análise de Conteúdo. 5a ed. Edições 70, LDA; 2008.


