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# Examination of the Benefits of the Global Health Workforce Programme on the Health Systems and Health Workforce in Ghana, Kenya and Nigeria

## Introduction

The Global Health Workforce Programme (GHWP), funded by the UK Department of Health and Social Care (DHSC) and managed by Global Health Partnerships (GHP, formerly THET), supports Health Partnerships (HPs) between health institutions in Ghana, Kenya, Nigeria and the UK. HPs are long-term, institution-to-institution collaborations that aim to strengthen national health workforces and health systems. Phase 1 of GHWP (February 2024–January 2025, with extensions to August 2025 for some grants) funded 41 HPs. The programme focused on:

▶ improving pre- and in-service education and training

▶ strengthening workforce leadership, management, wellbeing and retention

▶ supporting more equitable, resilient service delivery in pursuit of Universal Health Coverage (UHC).

This study synthesises evidence from 11 HPs to understand how the HP model contributed to health system strengthening (HSS) and health workforce development (HWD) in Ghana, Kenya and Nigeria, and what this implies for future investment.

# Methodology

The study was based on documentary analysis only; no new primary data were collected. Sources included proposals, monitoring and evaluation reports, learning event summaries, final reports and learning papers for the 11 selected HPs, as well as relevant literature. The 11 HPs were purposively selected to reflect:

- a spread of countries (Ghana, Kenya, Nigeria)

- different grant sizes (large and small) and durations (12–20 months)

- variation in themes (leadership, several cadres, digital education, primary care, early childhood development, obstetric care, retention and equity)

- differing levels of engagement with national policy and regulatory bodies.

A light-touch Critical Realist[1] lens was used to move beyond activity counts and explore how and why change occurred, linking context, mechanisms and outcomes. An adapted version of Edwards et al.'s (2015) typology[2] was applied to assess sustainability potential, distinguishing between:

- the level of intended impact (individual, organisational, system)

- the type of skills (highly specialist vs more generic and transferable)

- the capacity-building strategy (one-off training vs "application-through-action" such as supervised practice, mentoring or quality improvement).

The study is subject to limitations: the short programme timeframe (12–20 months), reliance on self-reported project documentation, and lack of post-project follow-up mean that long-term outcomes, especially sustainability, cannot yet be verified empirically. Findings should therefore be read as "emerging evidence" rather than final verdicts.

1 Pawson, R; Tilley, N (1997) Realist Evaluation. Sage Publications, London, 2 Pawson, R; Tilley, N (2004) 'Realistic Evaluation' in S Matthieson (ed) Encyclopaedia of Evaluation, Newbury Park: Sage
2 Edwards, N. et al. (2015) 'Towards a simple typology of international health partnerships', Globalization and Health, 11(1), p. 49.

# Findings: Impact and Achievements

## 1. From training to changing practice and leadership:

Across the 11 HPs there was a marked shift away from one-off workshops towards strengthening leadership, management and day-to-day practice.

- In Kenya, the Florence Nightingale Foundation (UK) and Nursing Council of Kenya combined leadership courses, coaching and workplace quality-improvement (QI) projects for nursing leaders. Around 50 QI projects were reported, many targeting maternal and child health.

- In Ghana, Nottingham University Hospitals NHS Trust (UK) and The King's Village (Ghana) focused on district-level leadership and management, working with municipal assemblies to solve practical problems such as internet connectivity for facilities.

- A multi-country partnership led by the NHS Consortium for Global Health (UK) used action learning sets with senior leaders from Ministries of Health and Public Service Commissions, supporting work on workforce policy, labour relations and migration, and contributing to Kenya's first Health Workforce Policy and Strategic Plan.

**So what?** These examples show HPs not just delivering training, but changing how teams lead, problem-solve and manage services – a core requirement for sustainable HWD and HSS.

## 2. Tackling workforce gaps and maldistribution:

HPs helped address shortages, skills gaps and maldistribution by expanding roles and bringing specialist functions closer to communities.

- ▸ In Nigeria, the Royal College of Paediatrics and Child Health (RCPCH) (UK) and Obafemi Awolowo University Teaching Hospitals Complex (OAU) trained around 300 staff across primary, secondary and tertiary levels to use the Malawi Development Assessment Tool[3]. Over 11,400 children were screened in 19 primary health centres, three secondary hospitals and one tertiary centre, bringing developmental assessment into routine primary care.

- ▸ In Kenya, the Nursing Council of Kenya and Nursing and Midwifery Council of Ghana advanced the introduction of Advanced Practice Nurses (APNs) in primary care. The partnership worked with regulators, professional bodies, the Public Service Commission, the Commission for University Education and the Ministry of Health to agree APN registers, schemes of service and salary scales.

- ▸ Also in Kenya, the Kenyan Nurses and Midwives Association (UK) and Matakiri Tumaini Centre (Kenya) developed a mobile-first learning platform for Community Health Promoters, optimised for basic smartphones, offline use and hosted on county servers, improving access to standardised training aligned with Kenya's primary health care agenda.

**So what?** HPs used practical task-shifting, new cadres and digital tools to extend quality care into underserved areas, while working with regulators so that new roles can be recognised and funded.

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3 Reference: https://mdat.org.uk/

## 3. Strengthening education systems and digital infrastructure:

Several HPs focused upstream on educators and institutions, recognising that lecturer capacity and educational infrastructure are critical for long-term workforce supply.

▶ In Nigeria, the Nana Girls and Women Empowerment Initiative (Nigeria) and Medical Aid Films (UK) trained over 500 lecturers in digital pedagogy, developed practical guides for digital content, and installed solar-powered servers and recording studios in nursing colleges, shifting nurse education towards blended learning that can withstand power cuts and staff turnover.

**So what?** Investing in educator skills and robust infrastructure multiplies impact – each trained lecturer reaches large cohorts of students, and resilient digital systems protect learning from disruption.



Nana Girls and Women Empowerment Initiative

## 4. Bridging policy and practice through regulatory influence:

The most influential HPs deliberately connected service innovations to ministries, councils and professional bodies, helping to "lock in" change.

▸ The APN partnership in Kenya worked across regulation, university accreditation, pay scales and job descriptions so that APNs can be trained, employed, paid fairly and regulated.

▸ In Nigeria, Liverpool School of Tropical Medicine (LSTM) (UK) and Wellbeing Foundation Africa supported the National Postgraduate Medical College of Nigeria to adopt the Advanced Obstetric Surgical Skills course into the national curriculum, making it mandatory for all pre-Part 1 resident doctors and embedding respectful maternity care and informed consent into practice.

▸ In Osun State, Nigeria, the early childhood development (ECD) HP between the RCPCH & OAU combined a functioning Child Development Centre with a state ECD strategy, now being used to advocate for national adoption and inclusion of developmental checks in the national child immunisation card.

▸ In Ghana, the Nursing and Midwifery Council of Ghana and Ghana Nurses Association UK turned an existing memorandum of understanding into a structured remote teaching faculty, reaching more than 900 nurses and midwives with online training in stroke, sepsis and diabetes.

**So what?** HPs acted as bridges between practice and policy, making sure that innovations in training and service delivery are reflected in curricula, regulations, salary structures and national strategies.

## 5. Context-sensitive and equity-oriented design:

HPs showed strong sensitivity to local context, gender and social inclusion, often addressing structural barriers that undermine retention and access.

▸ In Ghana, LSTM (UK) and the University of Ghana worked with Chiefs and community leaders to renovate staff housing in remote districts using community labour and contributions. They also helped facilities improve health insurance claims, increasing Internally Generated Funds by 68%, which are now used for retention incentives such as accommodation repairs.

▸ In Kenya, IntraHealth International (Kenya) and Primary Care International (UK) redesigned antenatal outreach in Garissa County using geo-mapping and "nomadic social mapping", taking services to where pastoralist communities actually move.

▸ In Nigeria, the Nana Girls and Women Empowerment Initiative and Medical Aid Films combined childcare and accommodation for women attending residential training with work through the Nursing and Midwifery Council of Nigeria on a national Gender Equality and Social Inclusion policy for nursing and midwifery colleges.

**So what?** By tackling practical barriers – housing, safety, childcare, geography – HPs turned efforts to address equity into a concrete workforce strategy, improving both retention and service reach.

# Sustainability Analysis

Because projects were short and there was no post-grant follow-up, sustainability was assessed through design features using the adapted Edwards et al. framework.

Three broad patterns emerged:

| Sustainability Potential | Results |
|---|---|
| **Lower sustainability potential**<br>Where HPs focus mainly on highly specialist skills for individuals. Benefits are likely to "travel with the individual" and depend on continued external support. | 3 HPs fell in this category. These were focussed on skills development for individual clinicians or single digital platforms without strong institutional anchoring. |
| **Moderate sustainability potential**<br>HPs that combined individual capacity building with:<br><br>▶ generic, transferable skills (leadership, supervision, teaching), and/or<br><br>▶ specialist skills embedded in organisational structures (curricula, protocols, committees, learning systems). | 6 HPs fell in this category. Those that focussed on leadership, APN, digital education and ECD partnerships. The focus of these programmes indicated increasing likelihood that gains will persist even as staff move on. |
| **Higher sustainability potential**<br>HPs that aimed at organisational or system-level change, prioritised generic capacities and used "application-through-action". | 2 HPs fell in this category. Examples include district leadership and management strengthening in Ghana and the multi-country HRH leadership work across Ghana, Kenya, and Nigeria. |

## Across the portfolio, sustainability was deliberately supported through:

- ▶ transferring curricula and intellectual property to councils and universities

- ▶ securing continuing professional development (CPD) accreditation

- ▶ embedding innovations in national policies and strategies

- ▶ creating local revenue streams (e.g. improved insurance claims)

- ▶ investing in permanent physical and digital infrastructure (e.g. solar servers, county-hosted platforms).

However, without longer-term follow-up, these are indicators of potential sustainability rather than proof of sustained impact.

# Recommendations

For stakeholders considering future HP investments:

## Support HPs that sit between policy and practice:

Prioritise HPs that explicitly connect front-line innovation to Ministries and regulatory bodies. Require clear plans for policy engagement and regulatory anchoring from the outset.

## Invest in institutions, not just individuals:

Favour designs that strengthen education institutions, councils, and management teams through curriculum transfer and governance support. Treat educator capacity and leadership development as high-leverage investments.

## Embed "application-through-action" in funding criteria:

Ask HPs to demonstrate how training will be followed by QI projects, mentoring, or peer learning. Allow budgets to include facilitation of action learning, not just initial training.

## Support HPs that address structural barriers to retention and equity:

Encourage proposals that tackle gender equality and social inclusion barriers, such as housing, safety, childcare, and geographic barriers. Make gender and social inclusion a core performance issue linked to retention and coverage.

## Allow longer timeframes and light-touch follow-up:

Where possible, extend funding beyond 12 months or add a follow-up phase to test if new roles and systems are sustained. Use this to refine sustainability frameworks.

# Conclusion

GHWP demonstrates that the HP model is a credible method for strengthening health systems in partner country settings. The 11 HPs studied improved leadership, expanded frontline service quality, strengthened education infrastructure, and shaped national workforce policies. The strongest partnerships bridged policy and practice, embedding change in national structures and addressing retention barriers. While long-term sustainability is not yet proven, institutional anchoring and application-through-action make a strong case for HPs as a strategic instrument for health system reform, supporting stronger institutions and more equitable services in Ghana, Kenya, and Nigeria.

## Image credits

*Nana Girls and Women Empowerment Initiative / Medical Aid Films*

## Acknowledgements

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