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SOLUTIONS

Strengthening the health workforce through partnerships:

Synthesis paper on learnings from the Global Health Workforce Programme

Contents

Executive summary 3
Introduction 4
Purpose and scope 5
Analytical framing: synthesis questions 6
Methods 7
Findings by GHWP objective 8
1) Workforce capability: Delivery models, evidence, and conditions that matter. 8
2) Leadership, governance, and management: mechanisms and institutionalisation 10
3) Retention and wellbeing: constraints, mechanisms, and measurement. 12
4) Sustainability and scale: What is likely to sustained, and what minimum conditions recur 14
5) Mutual learning: adaptation is common; reciprocal learning needs clearer articulation 16
Cross-cutting synthesis 18
6.1 Gender Equality and Social Inclusion (GESI) and equity 19
6.2 Implementation enablers and constraints 20
6.3 Political commitment 22
Conclusions and implications 23
Acknowledgements 24

Executive summary

This paper synthesises learning from 18 Learning Papers (LPs) produced under the Global Health Workforce Programme (GHWP) to identify cross-cutting patterns, mechanisms, enabling conditions, and evidence gaps across Health Partnership (HPs) interventions. Using a structured thematic approach aligned to GHWP objectives, the synthesis examines how partnerships have contributed to workforce capability, leadership and governance, retention and wellbeing, sustainability and scale, and mutual learning. The intention is not to assess impact in a summative sense, but to draw programme-level learning that can inform future delivery and policy-relevant decision-making.

The findings show that workforce capability strengthening is the most consistently evidenced domain, with most partnerships using practical or clinical training models (17/18) alongside blended or virtual learning approaches (14/18). Evidence typically combines objective and subjective measures, although short follow-up periods, small samples, and limited comparators constrain stronger causal claims. Leadership interventions commonly combine structured development, mentorship, and governance routines; however, evidence of sustained institutional performance change is uneven, with stronger examples embedding individual development within organisational systems. Retention and wellbeing are widely recognised but less directly measured, with most papers documenting constraints and workload pressures rather than reporting concrete retention outcomes. Sustainability narratives are most credible where institutionalisation pathways are explicit, such as curriculum embedding or formal governance arrangements, and where scale-up is supported by defined delivery platforms and realistic resourcing. Mutual learning is evident across the cohort, particularly through adaptation to local context and South–South exchange, though it is often described as an activity rather than analysed as a mechanism contributing to implementation quality or system strengthening.

Overall, the portfolio demonstrates strong implementation experience and partnership working, but is comparatively weaker on analytical explanation. While most Learning Papers clearly describe activities and outputs, many would benefit from clearer articulation of mechanisms, more consistent methodological reporting, and stronger linkage between interventions and outcomes. Strengthening these areas would enhance the programme's ability to communicate its contribution to health workforce strengthening and to support evidence-informed policy and practice.

Introduction

Health Partnerships (HP) are a long-term collaboration model used to strengthen health systems through the exchange of knowledge and skills, capacity building, and co-development of context-appropriate interventions between institutions in high-income and low- and middle-income countries.[1] This partnership model is particularly relevant given persistent health workforce deficits in many low-resource settings. The WHO Global Strategy on Human Resources for Health: Workforce 2030 highlighted the scale of the workforce challenge, with early projections suggesting a large global shortfall by 2030, especially affecting low- and lower-middle-income countries, with direct implications for service coverage, quality and equity[2].

Within this wider context, the Global Health Workforce Programme (GHWP), funded by the UK Department of Health and Social Care (DHSC), supported HPs between institutions in Ghana, Kenya, Nigeria and the UK to develop the health workforce and strengthen health systems for post-pandemic recovery and progress towards Universal Health Coverage. The programme was delivered through HPs between institutions in the UK and partner countries, with Global Health Partnerships (GHP, formerly THET) and Ducit Blue Solutions (Local Grant Manager in Nigeria for GHWP) supporting projects designed to strengthen health workforce

1 Turner RR, Hart J, Carr N, Bull E, Fraser J, Byrne-Davis L. Interview study exploring how global health partnership principles are enacted and recommendations for practice. BMJ Open. 2024 Jun 11;14(6):e076475. doi: 10.1136/bmjopen-2023-076475. PMID: 38862224; PMCID: PMC11168132.

2 Global Strategy on Human Resources for Health: Workforce 2030, 2008, World Health Organization.

skills, training, capacity and retention, aligned with national and sub-national priorities and plans. As a portfolio, GHWP enables the testing and adaptation of different workforce and system-strengthening models across settings and cadres, generating actionable learning on what is feasible, acceptable, and implementable under real-world conditions.

Learning Papers (LPs) were commissioned as a learning-focused programme output, distinct from formal evaluation to document what was implemented, what changed, and the mechanisms and enabling conditions shaping results. They support GHWP's aim to co-develop and share practical learning on health workforce interventions with policymakers and practitioners. This synthesis brings that evidence together across the LP cohort for programme and policy audiences, drawing out strong examples, contextual variation, and priority evidence gaps to inform future workforce investment and partnership practice.

Purpose and scope

This thematic synthesis draws on 18 Learning Papers produced by HPs under GHWP. It synthesises evidence against the four programmatic outcomes: (1) strengthened health workforce leadership capacity aligned with national health workforce strategies, with contribution to reducing gender inequalities; (2) alignment with and contribution towards retention and wellbeing strategies; (3) improved number and quality of training opportunities for health workers; and (4) co-developed and documented learning on health workforce interventions shared with key national and international stakeholders.

Beyond summarising individual LPs, the synthesis identifies cross-cutting patterns, plausible mechanisms, and enabling conditions that appear to shape implementation and results across settings and cadres, and surfaces strong examples, contextual variation, and recurring evidence gaps to support programme learning and decision-making.

To support cross-paper comparison, the synthesis additionally uses a set of analytic lenses that reflect how HPs are expected to deliver change in practice, focusing on workforce capability (training and competence), leadership/governance/management, retention and wellbeing, and sustainability and scale. Mutual learning is included as an analytic lens

because it underpins the HP approach, although it is not a standalone DHSC programme outcome.

This is a learning synthesis, not an impact evaluation. It draws on evidence presented in the LPs to inform programme and policy audiences about what appears feasible and transferable, but it does not attempt causal attribution or make definitive claims about programme-wide impact beyond the scope of the LP evidence base.

Analytical framing: synthesis questions

These research questions (RQ) are used as organising lenses for a learning-focused synthesis. Rather than testing hypotheses, they structure how evidence is extracted and compared across the LPs to identify cross-cutting patterns, plausible mechanisms, and enabling conditions, as well as variation by context and gaps in the evidence base. Cross-cutting lenses are applied across all questions to interpret findings consistently, rather than treated as standalone themes.

- **RQ1 Workforce capability**: What approaches show the clearest evidence of improved knowledge, skills, or practice. And under what implementation conditions?
- **RQ2 Leadership**: What leadership and governance mechanisms are used, and what evidence suggests they shift decisions, behaviours, or institutional performance?
- **RQ3 Retention/wellbeing**: What interventions plausibly influence wellbeing and retention outcomes and drivers, and what contextual factors enable or constrain effects?
- **RQ4 Sustainability/scale**: What is most likely to be sustained beyond the project period, and what minimum conditions enable replication and expansion?
- **RQ5 Mutual learning**: What evidence exists of reciprocal learning (UK–Partner Countries and South–South), and how do partnership arrangements shape implementation quality, adaptation, and ownership?

Cross-cutting lenses used throughout:

- Gender equality and social inclusion (GESI)/Equity (explicit operationalisation, disaggregation, targeted actions)
- Implementation conditions (enablers and barriers)
- Political commitment (MoUs, formal strategy adoption, endorsement vs engagement only)

Methods

A pragmatic thematic synthesis was conducted using a primarily deductive coding framework aligned to the programme outcomes and the synthesis questions (RQ1–RQ5), while allowing inductive sub-themes to emerge within each domain. The corpus comprises 18 LPs produced by HPs; these papers vary in focus, setting, cadres, and are intended as learning-focused outputs rather than standardised evaluation reports.

Coding was undertaken in ATLAS.ti using a shared deductive codebook mapped to RQ1–RQ5. Consistency was supported through clear code definitions and an auditable record of coding decisions (e.g., notes/memos on interpretation) maintained throughout.

The synthesis draws on coded quotations (frequency and spread across LPs) alongside qualitative interpretation to identify recurring patterns, plausible mechanisms, and enabling or constraining conditions, as well as cross-paper variation and evidence gaps. A key methodological caveat is that coded frequency does not equal effectiveness: counts help identify what is common and where evidence clusters, but do not, on their own, demonstrate impact.

Findings by GHWP objective

1) Workforce capability: Delivery models, evidence, and conditions that matter.

Workforce capability is central to GHWP, reflecting the programme's emphasis on strengthening health worker knowledge, skills and practice as a foundation for service quality and health system performance. This section synthesises how HPs approached capability-building across the cohort, what evidence was reported, and which implementation conditions appear to shape feasibility, effectiveness, and sustainability.

Across the cohort, workforce capability-building is delivered through a relatively consistent set of training and learning models. Practical and clinical training approaches are near-universal and are frequently combined with blended or virtual delivery to extend reach and support continuity of learning. Many LPs additionally report deliberate adaptation to local context alongside quality assurance mechanisms such as standardised materials, curriculum alignment, and structured supervision.

While both objective and subjective outcome indicators are commonly reported, methodological clarity and follow-up are often limited. These limitations constrain cross-paper comparison and reduce confidence in attributing observed changes to specific interventions.

Common delivery models:

- **Practical/clinical training**: hands-on skills strengthening through workshops, simulation-based approaches and structured learning activities embedded within service settings.
- **Blended/virtual delivery**: online modules, webinars, mixed synchronous and asynchronous learning, and hybrid mentorship models used to increase reach and continuity.
- **Cascade/Training of Trainers (ToT) models**: trainer development and step-down training approaches designed to scale delivery while reducing reliance on external facilitators.

- **Adaptation, co-creation and quality assurance**: papers frequently report tailoring training content to local context (cadres, facility level, language, workflows), often through collaboration with local counterparts, alongside standardisation or fidelity mechanisms such as curriculum alignment, standard operating procedures, and structured materials.

Evidence is widely reported across the cohort, but often without full methodological clarity:

- Frequent reporting of knowledge and competence gains. For example, pre/post-tests, Objective Structured Clinical Examination (OSCE) assessments used as objective indicators.
- Widespread use of subjective measures including participant-reported confidence, satisfaction and perceived practice changes.
- Recurring evidence gaps included limited denominators, small sample sizes, low response rates, short evaluation windows, and limited linkage to service-level outcomes.

Across the cohort, learning is clearest when papers make the "results chain" explicit: linking the intervention to a plausible mechanism, observed outcomes, and the evidence base (including limitations). Where this chain is less explicit, cross-paper comparison of lessons and transferability is more constrained.

Illustrative examples include:

- **LG01**: (To improve the quality of chemical pathology training and service provision in Ghana, Kenya, and Nigeria): A hybrid point-of-care testing (POCT) model combining virtual and in-person delivery, with accredited Continuing professional development (CPD) and hybrid mentorship. The LP provides strong implementation learning but reports limited objective outcome data; sustainability appears contingent on regulatory approvals, adequate resourcing and infrastructure and time protections.
- **LG24**: (Developing medical simulation programs in low-resources settings, Kenya): Simulation-based education scaled through Training of Trainers (ToT), local champions and professional networks. The LP

reports strong competence and confidence gains but sustainability depends on addressing the ongoing time and staffing constraints and facilitator retention.

- **LG130**: (Strengthening the capacity of the National Postgraduate Medical College of Nigeria to deliver Advanced Obstetrics Surgical Skills): Institutionalisation through curriculum and exam integration and establishment of Centres of Excellence; with reported objective of knowledge and (or) skills gains and evidence of practice change.

2) Leadership, governance, and management: mechanisms and institutionalisation

Leadership, governance, and management are cross-cutting enablers within GHWP, shaping whether investments in workforce capability, retention and wellbeing, and sustainability translate into system-level change. Across the cohort, leadership is repeatedly cited as the factor that unlocks protected time, legitimises new practices, enables institutionalisation, and supports scale-up decisions.

This section synthesises how leadership-focused interventions were designed and implemented, what evidence of change is reported, and which conditions appear to support institutionalisation and sustained performance.

Leadership strengthening is commonly delivered through formal leadership development programmes and mentorship. It is often accompanied by governance routines such as committees, boards, and task teams, alongside guideline or protocol development intended to embed new ways of working within organisational structures.

Many LPs provide plausible evidence of improved leadership confidence and self-reported behaviours, but fewer demonstrate sustained institutional performance change beyond participant perceptions. A small subset of papers attempts to evidence organisational change through documented quality improvement (QI) outputs or service-related indicators, adoption of protocols/guidelines, strengthened supervision and accountability routines, or performance of system platforms (e.g., management information systems and revalidation processes). Even where such measures are included, findings can be mixed or difficult to interpret due to short implementation windows and uneven routine data availability.

A key cohort insight is that leadership is most convincing when it is evidenced as organisational change, not only individual development. The strongest papers combine leadership training/mentorship with routines and structures that embed new ways of working, such as supervision cycles, accountability meetings, data-use practices, and protocol implementation. Where evidence of institutionalisation is limited, this is usually because papers report improvements in confidence or skills but provide limited evidence that routines persisted over time or translated into measurable changes in service performance or adherence to standards persisting beyond the intervention window.

Illustrative LP examples

- **LG22**: (Strengthening Nursing & Midwifery Leadership in Kenya): Mixed-mode leadership development combined with mentorship and QI activities. It is illustrative of leadership linked to measurable service/QI improvements, alongside common constraints (workload, limited protected time, funding gaps).
- **LG12**: (Strengthening the Nursing and Midwifery Council of Ghana's licensing regulation): Governance-anchored digital reform integrating a management information system and revalidation framework, illustrative of governance reform with system performance measures, slowed by contracting, procurement and change-management constraints.
- **LG83**: (Strengthening undergraduate nursing and midwifery education through lecturer capacity building in multimedia teaching and CPD integration in Nigeria): Management training combined with infrastructure investments enabling digital teaching and GESI action planning at scale, illustrative of leadership linked to institutional capacity-building and scale, rather than standalone training.
- **LG130**: (Strengthening the capacity of the National Postgraduate Medical College of Nigeria to deliver Advanced Obstetrics Surgical Skills): Practice and process change embedded through formal routines (e.g., standardised processes and role clarity), illustrative of institutionalisation via organisational routines, even where longer-term performance effects are not yet observable.

3) Retention and wellbeing: constraints, mechanisms, and measurement.

Retention and wellbeing are central to GHWP because workforce stability is a prerequisite for sustaining gains in capability, leadership, and service quality over time. Across the cohort, this theme is widely recognised, but it remains the least directly evidenced objective in terms of measurable retention outcomes. Many LPs describe plausible pathways, for example: improved training, stronger supervision, better infrastructure, peer support, and more supportive organisational culture, yet retention is rarely measured using indicators such as turnover, vacancy duration, absenteeism, or intent-to-stay. Where influence is discussed, it is more often captured through proxy measures such as morale, perceived support, or job satisfaction (for example, LPs including LG02 (Build capacity for subspecialty psychiatry training in Ghana) and LG09 (Building capacity for the provision of children's palliative care in Ghana) frame wellbeing and retention influence through staff experience, perceived support, and intention-related narratives rather than workforce-flow measures), which limits generalisable claims about impact and attribution.

What is more consistently evidenced across the cohort is the retention risk environment: the system conditions that shape whether investments in capability and leadership can realistically be sustained.

Constraints affecting retention (16/18): structural and system factors recur across settings, including posting/transfer policies, staffing ceilings, industrial action, governance delays, and wider labour market dynamics. These constraints are reported across multiple contexts rather than being confined to a single country or project type, suggesting they represent transferable implementation realities for HPs.

Workload and burnout pressures (13/18): high workloads repeatedly constrain participation in training and mentorship, reduce time available for supervision, and undermine wellbeing. It is also described across settings, reinforcing its relevance as a cross-cutting constraint.

Taken together, these patterns position retention less as a stand-alone intervention domain within the cohort and more as a cross-cutting consequence of broader health system constraints.

Where retention-relevant strategies are described, they cluster into three groups:

Non-financial strategies (8/18): recognition, career pathways, supportive management practices, mentorship/peer support, and access to development opportunities.

Work environment improvements (5/18): accommodation, facility conditions, equipment, and practical enablers that make day-to-day work more feasible.

Financial measures (3/18): stipends/allowances or other direct incentives, less commonly reported than non-financial approaches.

Across the cohort, these strategy clusters are more often described as plausibly supportive of retention and job quality than linked to measured retention outcomes; where outcomes are reported, they tend to rely on proxy indicators (e.g., satisfaction or perceived support) rather than turnover- or vacancy-type measures.

Direct measurement remains limited. Across the coded set, turnover/vacancy-type indicators appear in only 1/18 LPs, while satisfaction-type indicators appear in 3/18. Where wellbeing is measured, some LPs report improvements in satisfaction or facility recommendation, but this does not consistently translate into evidence of willingness to remain. Where workforce-flow outcomes are reported, results are context-sensitive rather than consistently directional, reinforcing both the importance of context and the difficulty of attributing retention shifts to single interventions, particularly over short time horizons. Recurring limitations include weak Human resources for Health (HRH) information systems; external confounders such as political shifts, industrial actions, facility openings and staffing reallocations; and short follow-up windows that are not well suited to detecting retention effects.

The most defensible cross-paper conclusion is therefore not “retention impact,” but: (i) which constraints and job-quality mechanisms recur most consistently, and (ii) which minimal measurement approaches (intent-to-stay, absenteeism, vacancy duration, turnover, time-to-fill) would strengthen future HP reporting and learning on retention outcomes.

Illustrative LP example:

- **LG07**: (Improving retention of health workers in three deprived districts in Ghana) As a retention-focused project rather than a training-led project with secondary retention intent, LG07 provides the clearest evidence under this theme. The LP reports statistically significant gains in job satisfaction and improvements in selected retention indicators, while also demonstrating variation by district and sensitivity to wider systemic and political factors.

4) Sustainability and scale: What is likely to sustained, and what minimum conditions recur

Sustainability and scale are central to GHWP because the programme aims to translate time-bound partnership investments into durable system change, so that improvements in capability, leadership, and service delivery can persist beyond the project period and, where appropriate, be extended to new settings. At the same time, scale-out is particularly challenging in the GHWP context: it depends on delivery platforms (trainers, supervision and governance), infrastructure readiness, predictable resourcing, and political commitment, and is highly sensitive to workforce constraints.

Sustainability is the most consistently emphasised objective across the cohort; however, it is also the area where claims are most at risk of becoming aspirational. Across the papers, “sustainability” is used in multiple ways, including continuation of activities after project end, institutionalisation through system routines, and replication or scale-out. The dominant framing is scale-out: nearly all LPs describe sustainability in terms of extending interventions to new regions, facilities, cadres, or institutions.

Across LPs, the dominant sustainability framing is replication/scale-out (18/18), rolling interventions out to new regions, facilities, cadres, or institutions. The most consistently cited enabling conditions for sustainability are:

Recurring sustainability conditions

- Human resource continuity (17/18): local faculty, trainers, supervisors able to continue delivery.
- Local leadership/champions (15/18): legitimate actors with authority to sustain routines and motivate uptake.

- Infrastructure readiness (13/18): equipment and digital tools, plus mitigation for connectivity/power constraints
- Co-creation/local ownership (13/18): shared decision-making and adaptation that builds commitment and feasibility.
- Financing strategies (9/18): plans for resource mobilisation or budget integration, unevenly developed
- Dependency risks acknowledged (5/18): explicit recognition that external inputs may be hard to replace
- Policy integration (4/18): comparatively less common as an explicit sustainability pathway in the cohort's coded narratives

Illustrative LP examples

- **LG130**: (Strengthening the capacity of the National Postgraduate Medical College of Nigeria to deliver Advanced Obstetrics Surgical Skills): Institutionalisation through national curriculum and exam integration and establishment of Centres of Excellence, illustrative of sustainability via formal system embedding.
- **LG83**: (Strengthening undergraduate nursing and midwifery education through lecturer capacity building in multimedia teaching and CPD integration in Nigeria): Use of formal MoU and engagement with national bodies combined with ToT approaches and infrastructure investments, illustrative of sustainability via governance anchoring and reduced reliance on external facilitators.
- **LG06**: (Remote Consultation for Primary Health Care REaCH Project in Nigeria and Ghana): Large-scale multi-cadre training with CPD accreditation and institutional commitments, illustrative of sustainability via accreditation-based anchoring, while showing how implementation delays and resourcing constraints can weaken scale-out feasibility.

The most credible sustainability claims are those anchored in demonstrable institutionalisation. For example curriculum embedding, accreditation/revalidation platforms, mandated supervision/accountability routines, or formal governance arrangements, paired with operational feasibility (staff time, workload realism, and infrastructure constraints).

Across the cohort, what appears most likely to persist is therefore not scale-out "intention," but institutionalised components that become part of routine systems. The synthesis also highlights the importance of distinguishing between aspirational scale-out (intent to expand) and demonstrable institutionalisation (evidence that routines, roles, and platforms have been embedded and can persist beyond the project window).

5) Mutual learning: adaptation is common; reciprocal learning needs clearer articulation

Mutual learning underpins the HP model and is a core principle of how GHWP expects partnerships to work, through reciprocal exchange, co-development, and shared problem-solving across institutions. In this synthesis, mutual learning is treated as a mechanism that can strengthen implementation quality, adaptation, ownership, and ultimately sustainability, rather than simply a description of collaboration. This section therefore examines what evidence the LPs provide on how mutual learning operated in practice across the cohort, what forms it took, and where it is under-specified or difficult to evidence.

Mutual learning is a visible thread across the cohort; however, it is more consistently reported as process than as mechanism and outcome. Most LPs describe collaboration and exchange, yet fewer specify what was learned, by whom, how learning shaped implementation decisions, or what improved as a result. This limits the extent to which mutual learning can be treated as an evidence-backed contributor to effectiveness and sustainability.

Across the cohort, mutual learning most often manifests through practical implementation dynamics and shared outputs:

- Adaptation to local context (14/18): projects evolve based on feedback from local partners, often improving relevance and feasibility and demonstrating responsiveness to context.
- South–South learning (11/18): learning exchanges across African partners represent a notable strength, supporting regional collaboration and transfer of practice.
- Knowledge products and shared outputs (11/18): co-authored products, learning resources, and dissemination activities reflect tangible outputs of collaboration.

- Co-design dynamics (8/18): shared decision-making during design helps integrate local insight and strengthens ownership.
- Transferable lessons (8/18): a subset of LPs articulate lessons intended for wider use, supporting cross-programme learning.
- Reverse/UK learning (5/18): explicit documentation of learning by UK partners is less common, creating an imbalance in how mutual learning is evidenced.

LPs are strongest when mutual learning is presented as a driver of implementation quality rather than solely as a partnership characteristic. The most convincing narratives explicitly link learning and exchange to concrete improvements, for example:

- adaptation decisions that increase uptake (for example, reaching more participants or improving engagement),
- changes that improve fidelity and feasibility (such as better alignment with workload, infrastructure, or workflow realities),
- refinements that strengthen equity or GESI (including improved targeting, inclusion, disaggregation, responsiveness to marginalised groups),
- modifications that support sustainability (for example, local ownership, institutional anchoring, local trainer capacity).

Illustrative LP examples

- **LG116**: (Development and Evaluation of a Breast Cancer Resource for Inter-Specialty Training and Education BRITE in Sub-Saharan Africa) Mutual learning was operationalised through iterative adaptation with local partners, culminating in a locally tailored MDT toolkit that supports implementation, standardisation, and future scale-up.
- **LG130**: (Strengthening the capacity of the National Postgraduate Medical College of Nigeria to deliver Advanced Obstetrics Surgical Skills) Mutual learning was operationalised through structured co-design with stakeholders and iterative refinement of the training approach based on implementation experience. This included cross-country inputs (including South–South exchange) that informed delivery choices, alongside the production and dissemination of shared

learning outputs (e.g., evaluation/dissemination materials) to support broader uptake.

- **LG135**: (Piloting an Early Childhood Development Strategy for Osu State in Nigeria) Mutual learning was operationalised through a global collaboration model that enabled iterative adaptation of content and delivery to local constraints (including feasibility issues such as connectivity). Learning was translated into practical, shareable outputs such as information/training packages that supported standardisation of delivery and facilitated replication beyond the initial implementation setting.

Across the cohort, mutual learning appears to contribute most strongly to implementation quality and sustainability when it is explicitly structured through co-creation processes, joint problem-solving, shared governance arrangements, and iterative adaptation informed by local feedback. Where partnerships document how learning influenced design decisions, ownership, or institutional embedding, mutual learning functions as a visible mechanism rather than a background process. However, evidence of reciprocal learning, particularly learning and practice change on the UK side, remains limited and inconsistently articulated.

Cross-cutting synthesis

This cross-cutting synthesis brings together three lenses that consistently shape feasibility, quality, and sustainability across the LP cohort: (i) GESI and equity, (ii) implementation conditions (enablers and constraints), and (iii) political commitment. Across all three lenses, a consistent pattern emerges: while many LPs reference the relevant concepts, stronger learning depends on more explicit operationalisation and clearer evidence of what was done, under what conditions, and with what level of formal commitment. These lenses cut across all GHWP outcomes and objectives, influencing design choices, implementation quality, and the likelihood that gains are sustained or scaled. They are therefore applied throughout this synthesis (rather than treated as standalone themes) to interpret patterns consistently across the cohort.

6.1 Gender Equality and Social Inclusion (GESI) and equity

GESI is referenced across the cohort, but explicit operationalisation and disaggregated reporting remain uneven. Across the reviewed LPs, explicit GESI operationalisation is evident in 7/18 papers, disaggregation is reported in 5/18, and targeted actions for marginalised groups appear in 6/18. This suggests growing recognition of equity as a programme priority, but inconsistent translation into mechanisms and measurement that would enable robust synthesis and cross-paper comparison.

Variation by theme is visible. Leadership, governance, and management-focused LPs more often describe equity-related roles, routines, safeguarding structures, or action plans that could plausibly influence decision-making and institutional practice. By contrast, training-focused interventions more commonly reference equity as intent without consistently specifying *how* participation, content, delivery or follow-up was adapted to reach underserved groups or what was measured to assess differential participation and outcomes.

Where GESI is clearly articulated, it is typically operationalised through a limited set of recurring approaches:

- Dedicated GESI training and/or action plans, often linked to leadership or governance programming aimed at influencing attitudes, behaviours, and decision-making practices.
- Safeguarding and inclusion structures such as committees, champions, and formal inclusion mechanisms designed to embed equity responsibilities and accountability.
- Accessibility improvements, including efforts to strengthen access for persons with disabilities (PWD) and other marginalised groups.

A consistent cross-paper gap is that equity is often referenced as principle or intent without sufficient operational detail to assess: who benefits, who is missed, and whether interventions reduce or reproduce inequities. Even when LPs describe inclusive intent, they do not consistently report disaggregated participation/outcomes (e.g., by gender, disability, cadre, geography), nor do they specify equity-targeted mechanisms in enough detail to assess implementation quality and effectiveness. As a result, the cohort's GESI evidence base is constrained less by lack of commitment

and more by limited disaggregation, limited mechanism clarity, and uneven outcome tracking.

Across the cross-cutting lenses, stronger learning is generated when intent is paired with explicit operationalisation and evidence, i.e., what was done, for whom, under what conditions, and with what level of accountability and commitment, so that lessons can inform future programme design and policy dialogue.

6.2 Implementation enablers and constraints

Implementation conditions function as core explanatory variables across GHWP objectives, shaping feasibility, quality of delivery, and the likelihood that gains can be sustained or scaled across different contexts. Across the cohort, LPs converge on a relatively consistent set of high-frequency enablers and constraints, and the clearest learning emerges when papers describe how constraints were mitigated rather than listing them as background context. Common patterns across the cohort include:

Key enablers

- Leadership commitment (at national, sub-national, or facility management level) enabling legitimacy, participation, and system integration.
- Trainer and mentor platforms (such as ToT networks) supporting local delivery capacity and reducing dependence on external facilitators.
- Digital platforms and tools where connectivity and electricity constraints are mitigated enabling reach, continuity, and access to learning resources.
- Protected time for training, explicitly stated in a subset of LPs but repeatedly implied as a prerequisite for participation and completion.

It is important to note that enablers frequently co-occur in practice. Leadership commitment is often the upstream condition that helps unlock protected time, authorises participation, and legitimises integration into routines; similarly, trainer platforms and digital tools tend to reinforce each other by expanding reach while maintaining continuity through local facilitation.

Key constraints

- Connectivity and electricity limitations affecting access to online learning and digital tools.
- High workload and limited protected time constraining participation, supervision time, and learning uptake.
- Financing barriers, limiting continuity, scale-up, and maintenance of platforms and resources.
- Equipment and infrastructure gaps undermining practical training and service-level uptake.
- Governance delays, industrial actions and administrative disruption affecting continuity and timing.

How do these enablers play out in practice (implementation conditions)? Across the cohort, enabling conditions repeatedly take a concrete "implementation design" form:

- Stakeholder engagement early in delivery: involvement of county leaders and policymakers can increase institutional legitimacy and make sustainability pathways more plausible by embedding interventions within routine structures.
- Flexible learning to fit local needs: use of a Learning Management System (LMS) and blended modalities allows participants to engage around workload constraints and reduces reliance on synchronous participation.
- Capacity building for future scale-up: training local trainers and mentors supports cascading and continuity beyond external partner inputs.
- Ongoing monitoring and evaluation: structured MEL approaches help track whether leadership/capability gains translate into practice and system functioning over time.

These conditions matter because they shape whether interventions are delivered as intended, whether learning translates into practice, and whether sustainability claims are plausible. LPs are analytically stronger and more transferable when they document explicit mitigation strategies.

- **LG59**: (To strengthen the capacity of the Nigerian health workforce to deliver high-quality gynaecological care to women and girls), for example, explicitly points to senior/facility leadership engagement

as an enabling condition, including working with facility managers to secure release time for participants. This is a strong example of leadership commitment translating into a practical implementation condition that makes participation feasible.

Additionally, LG02 (Build capacity for subspecialty psychiatry training in Ghana) provides a clear example of adaptation in response to constraints: it notes technical difficulties such as unreliable internet and responds through delivery adaptations (e.g., using pre-recorded lectures shared with trainees), alongside operational fixes (e.g., appointing a local on-ground coordinator).

6.3 Political commitment

Political commitment is frequently referenced across the cohort, but it varies in strength, ranging from stakeholder engagement through to formal adoption and/or endorsement. For sustainability and scale, the most credible claims are grounded in demonstrable commitments (for example, MoUs, strategy adoption, policy or regulatory endorsement, or mandated changes to routines and responsibilities), rather than engagement alone. This is illustrated in a small number of LPs that document formal commitment beyond consultation. LG130 (Strengthening the capacity of the National Postgraduate Medical College of Nigeria to deliver Advanced Obstetrics Surgical Skills) , for instance, evidences adoption through integration into national curriculum and examination structures, while LG83 (Strengthening undergraduate nursing and midwifery education through lecturer capacity building in multimedia teaching and CPD integration in Nigeria) describes formalised commitment through MoUs and structured engagement with national bodies.

A consistent cross-paper pattern, however, is that many LPs report "engagement" (such as meetings, consultations, involvement of officials), while fewer provide documentary evidence of formal commitments that would institutionalise interventions (including endorsed strategies, adopted guidance, accredited curricula, formalised supervision requirements, budget integration). For programme learning, it is therefore essential to distinguish engagement from adoption or endorsement, as scale and sustainability are far more plausible when they rest on formalised commitments rather than participation in meetings or consultations alone.

Conclusions and implications

Across the GHWP cohort, the Learning Papers function as a practical programme learning asset: they document how HPs operationalise workforce strengthening under real-world constraints, and what appears to enable or limit change across settings. Collectively, the LPs suggest that HPs contribute to GHWP aims through a distinctive implementation and institutionalisation role, not only delivering training and support, but translating these inputs into practice through co-development, adaptation, mentoring relationships, and the embedding of routines within local systems.

HP contributions are strongest where interventions connect to existing institutional platforms, for example training systems, professional regulation, and established supervision or governance routines. And where sustainability is pursued through explicit anchoring like curriculum integration, revalidation mechanisms or policy adoption. Capability strengthening is the most consistently evidenced contribution, typically delivered through practical training models, blended delivery, mentorship, and locally facilitated cascade approaches that extend reach while maintaining applied learning. Leadership, governance and management contributions are most convincing when individual development is paired with organisational routines (e.g., supervision cycles, data use, committees, protocol adoption), supporting institutionalisation in some settings.

By contrast, contributions to retention and wellbeing are more often indirect, via job quality factors such as supervision, workload management practices, and work environment, because direct retention outcomes are rarely measured, are difficult to shift within short timeframes, and are often constrained by weak routine HRH data systems. Mutual learning is present across the cohort, but is more consistently described as a partnership process than evidenced as a mechanism improving implementation; UK-side learning and practice change are less frequently articulated, representing an important area for strengthening reciprocity and the wider UK leadership narrative within GHWP.

Taken together, the LPs portray a portfolio characterised by blended delivery, strong partnership working, and frequent use of mentorship and cascade models to support continuity. To strengthen programme learning and comparability across future cohorts, the evidence suggests four priority improvements:

1. Standardise a light-touch outcomes package across LPs: core capability indicators; minimum leadership/governance routine markers (e.g., supervision cadence, protocol adoption, data-use practices); and a small set of feasible retention and equity measures where relevant (e.g., intent-to-stay, absenteeism, vacancy duration; participation disaggregation).
2. Make mechanisms explicit by consistently articulating the results chain (intervention → mechanism → outcome), including what was adapted, why, and what improved as a result.
3. Strengthen follow-up and denominators where feasible, prioritising a small number of outcomes tracked beyond training events and linking participant-level change to practice or service markers when routine data allow.
4. Document political and institutional enabling conditions more explicitly, distinguishing stakeholder engagement from formal adoption/endorsement (MoUs, accredited curricula, mandated routines, budget integration), as sustainability and scale claims are substantially more credible when grounded in formal commitments.

Overall, the LPs reinforce the value of partnerships as a learning-oriented approach to workforce strengthening, and indicate that durable gains are most achievable when programmes invest in institutional anchoring, address workforce constraints, and consistently capture the mechanisms and conditions that translate activity into sustained practice change.

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