Advancing African health workforce capacity through a consortium model

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Despite carrying a quarter of the global disease burden, Africa faces a shortfall of approximately six million health workers by 2030,[1] with only 34.6% of its needed doctors, nurses, and midwives.[2] The dominant policy response has been to scale up numbers of medical schools and graduates. In 2023, there were roughly 444 medical schools across the continent, a 168% growth in public and 338.6% in private medical schools since 2010.[3] Furthermore, the annual output of health professionals grew by nearly 70% between 2018 and 2022 across over 4000 health-related training institutions.[4]

While expanding enrollment contributes to closing the 65.4% gap in doctors, nurses, and midwives numerically, it doesn't adequately tackle the underlying structural issues and is not sufficient to bridge the projected health worker gap by 2030. An effective workforce strategy to bridge this gap must rather address the structural factors shaping educational quality, graduate competencies, and retention mechanisms. Corroborating this, a survey across new medical schools in Africa argued that new schools may not be able to accommodate increased intakes, citing common challenges, including financial (87%), faculty retention (65%), and developing faculty/staff to meet a rapidly evolving educational landscape.[5] Alongside the significant growth in output, another study across 39 African countries found that 21% did not have any accreditation mechanism, posing a significant risk to quality assurance.[3]

The deficit, therefore, is systemic, reflecting a landscape where Africa's 444 medical schools, across over 4000 health training institutions, operate largely in isolation from one another, sharing neither faculty, nor accreditation standards, nor a unified political voice. Generally, institutions and countries negotiate independently with governments, donors, and accreditors. Alongside approximately one in five countries lacking accreditation frameworks, existing regional accreditation frameworks are not fully recognized or implemented, even though health workforce challenges are inherently transboundary.[3] One study in Sub-Saharan Africa found that while accreditation bodies have increased by around 300% since 2008, there were still only 48% of the surveyed countries having accreditation bodies, with regional bodies just starting to emerge.[6]

The *2024 Africa Health Professions Education (HPE) Dialogue* called for stronger collaboration among stakeholders: "governments, academic institutions, professional bodies, and international organizations must work together to address the health workforce challenges in a coordinated and sustainable manner."[4] The 2022 Sub-Saharan African Medical Schools Study found that only 22.4% of the 146 surveyed medical schools reported having collaborations with other African countries.[7] Each re-engineers its own curricula, faculty development, and clinical placements that a neighboring school already built, producing systemic redundancy. African countries already face the unique challenge of dually needing to build workforce capacity while also working within their existing constraints, a burden which is exacerbated without leveraging partnerships.

Global HPE literature consistently documents the limits of the school-by-school model, with fragmented systems producing fragmented workforces and faculty shortages, worsening when institutions compete rather than collaborate.[8] Harmonizing curriculum, standards, regulation, and accreditation promotes a workforce that is more "fit-for-purpose" to meet the health system's needs.[2] Harmonized recognition standards also promote south-to-south collaboration, physician retention and mobility, and joint degree recognition.[9]

Consortia models offer a response to bridge this gap, operating as the vehicle for medical schools to achieve shared governance structures with pooled resources, harmonized standards, and collective accountability.[6] Evidence across Africa demonstrates that consortia better engage in workforce planning issues with a unified voice, building infrastructure that outlasts any individual initiative or grant. The Medical Education Partnership Initiative, for example, led to a paradigm shift, promoting a healthy, collaborative culture, rather than competitive siloes.[10]

The recent establishment of the Consortium of Medical Schools–Africa, uniting over 200 medical schools across 37 countries, demonstrates this at

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continental scale, representing a deliberate shift to African-owned partnership that centers shared decision making, distributed leadership, and locally owned agendas. While its long-term success depends on stakeholder commitment and its ability to unite diverse and complex settings, early evidence suggests that schools acting collectively are better positioned to influence national health workforce policy, attract sustained investment, and produce more "fit-for-purpose" graduates.

Achieving the WHO African Region's health workforce targets requires more than establishing new schools. We are calling for a different kind of institution building, one that invests in the connective tissue between schools rather than the schools themselves. This means resourcing consortium infrastructure as a priority, with international partners channeling support through African-led consortia, and with accreditation bodies and governments developing frameworks that recognize and reward such collaboration. No single medical school can solve a systems problem alone, and the architecture of health professions education must match the scale of the challenge.

Contributors
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Declaration of interests
We declare no competing interests.

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