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Learning Governance under Constraint: A Critical Case Study of Medical Education Accreditation in Ghana and its Implications for Global Quality Assurance

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Abstract

The governance of medical education accreditation in low- and middle-income countries (LMICs) represents a critical global challenge, balancing the urgent imperative to scale up the physician workforce with the non-negotiable duty to safeguard quality. This qualitative study employs Ghana as a critical case to theorise the dynamics of "Learning Governance", the integrated rules,

processes, and power relations that steer an educational system. Through reflexive thematic analysis of interviews with Deans, Clinical Directors, and Medical Interns, the research maps a governance subsystem under strain. Key findings reveal a foundational yet contested system where the legitimacy derived from standardisation is undermined by a pervasive perception of asymmetric regulation between public and private institutions, a significant deficit in robust assessment mechanisms, and the strategic use of accreditation to enforce social accountability. Compared with Ghana's experience, Sub-Saharan Africa (SSA) illuminates a central tension: the equity-legitimacy nexus, in which accreditors must be both gatekeepers and growth facilitators. The study identifies an assessment chasm, symptomatic of systemic resource constraints, and highlights how accreditation can actively steer the social contract in LMICs. The contested transition from affiliation to chartering exemplifies the lifecycle of governance tools in evolving systems. We argue that strengthening medical education globally, particularly in LMICs, requires moving beyond compliance checklists to foster governance that is equitable, evidence-based, socially accountable, and adaptively intelligent. Ghana's case offers transferable lessons on navigating the political economy of quality assurance during rapid expansion.

Keywords: Accreditation; Medical Education; Governance; Sub-Saharan Africa; Social Accountability; Ghana

Introduction

The pursuit of quality in higher education, and in medical education in particular, has become a global imperative. It is inextricably connected to the underlying goal of producing competent, ethical physicians capable of meeting the health needs of the populations they serve. In this enterprise, accreditation has emerged as the principal external quality assurance (EQA) mechanism, a structured process through which an authorised body assesses and formally recognises an educational institution or programme as meeting pre-determined standards (Frank et al., 2020). For over half a century, accreditation systems have evolved from rudimentary inspections to sophisticated frameworks emphasising outcomes, continuous improvement, and institutional capacity building (Blouin & Tekian, 2018). This evolution mirrors a broader paradigm shift in higher education governance, moving from state-centric control to models that blend regulation, market forces, and institutional autonomy, often characterised as 'steering at a distance' (Wilkins & Mifsud, 2024).

In industrialised countries, accreditation is typically embedded in mature regulatory regimes characterised by well-resourced institutions, stable policy environments, and a long-standing culture of professional self-regulation. The discourse in these contexts frequently centres on enhancing reliability, reducing unintended consequences, and integrating accreditation with competency-based medical education (CBME) outcomes (Boyd et al., 2018). The challenges, while significant, are often those of refinement and alignment within systems of relative abundance.

Sub-Saharan Africa (SSA), and Ghana in particular, presents a fundamentally different landscape. The region confronts a profound physician workforce crisis, accounting for an

estimated 25% of the global shortfall of 18 million health workers (Boniol et al., 2022). High burdens of communicable and emerging non-communicable diseases, fragile health systems, and persistent inequities in access to care compound this challenge (Adeyeye et al., 2023). In such an environment, the pressure to rapidly scale up the production of doctors is both immense and politically urgent. This urgency has fuelled diversification among educational providers with a significant rise in private medical schools alongside established public universities, creating a pluralistic and potentially fragmented educational landscape (Kiguli-Malwadde et al., 2020).

Within this pressured and complex scenario, accreditation assumes heightened significance. It acts simultaneously as a gatekeeper, safeguarding minimum standards and professional integrity, and as a catalyst for responsible expansion to meet workforce targets. This dual mandate places considerable strain on governance capacity. In Ghana, governance of medical education is structurally shared between two statutory entities: the Medical and Dental Council (MDC), the professional regulator established under Act 857, and the Ghana Tertiary Education Commission (GTEC), the overarching higher education authority. This co-regulation model, while designed to ensure both professional and academic rigour, can also lead to overlapping jurisdictions, bureaucratic complexity, and potential conflicts over standards and priorities.

Despite the critical importance of accreditation in SSA, the scholarly literature remains disproportionately focused on models and experiences from high-income countries. There is a paucity of nuanced, context-rich analyses that explore how accreditation is enacted, perceived, and contested on the ground in African settings. Existing studies frequently adopt a technocratic lens, evaluating compliance with standards or documenting processes while paying insufficient attention to the political economy of regulation, the lived experiences of stakeholders, and the unique systemic tensions that define accreditation in resource-constrained, rapidly evolving systems (Darley & Luethge, 2018).

This study addresses this gap by moving beyond a descriptive account of Ghana's accreditation system to offer a deep, qualitative analysis framed by the concept of systems governance. We contend that accreditation in this context is best understood not as a discrete event or a simple compliance exercise but as a dynamic, interactive governance subsystem within the larger health and education ecosystems – a mechanism through which power is exercised, resources are allocated, legitimacy is negotiated, and institutional behaviours are shaped. The central research question guiding this study is: What role does Ghana's accreditation system play in governance, and what key tensions, implementation gaps, and stakeholder perceptions shape its effectiveness in ensuring quality and social accountability in medical education?

By interrogating the perspectives of three key stakeholder groups – deans (academic stewards), executive health directors (clinical training hosts), and medical interns (the ultimate 'products' of the system) – this research uncovers the often-hidden fissures between policy intent and practical reality. It exposes how governance is mediated by power differentials between the public and private sectors, undermined by weaknesses in assessment mechanisms, and challenged by legacy policies such as institutional affiliation. In doing so, the findings contribute a critical, grounded perspective to regional and global debates on accreditation, with

particular relevance for low- and middle-income countries navigating the complex terrain between scaling up health professions education and protecting its quality.

Navigating Global Paradigms and Local Realities in Accreditation Governance

The pursuit of quality assurance in medical education through accreditation is a global endeavour, yet its implementation is profoundly local. This review traces the evolution of accreditation paradigms, examines the distinct challenges of applying these models in low- and middle-income contexts, and presents a conceptual framework for analysing the complex, contested nature of systems governance. The literature reviewed was identified through systematic searches of electronic databases (including PubMed, ERIC, Scopus, and Google Scholar) using terms such as 'medical education accreditation,' 'quality assurance Sub-Saharan Africa,' 'higher education governance,' and 'competency-based medical education.' Priority was given to peer-reviewed empirical studies, theoretical contributions, and policy documents published since 2000, supplemented by seminal earlier works. Studies from SSA and LMICs were specifically sought to ensure contextual relevance.

From inputs to systems: the evolution of global accreditation paradigms

Globally, the philosophy of accreditation has undergone a significant transformation, reflecting broader shifts in educational theory and public accountability. The early twentieth-century model was predominantly prescriptive and input-focused, emphasising quantifiable resources such as faculty-to-student ratios, library holdings, and laboratory space (Kayyali, 2024). This approach prioritised standardisation and offered a veneer of objectivity but was widely criticised for fostering a culture of minimal compliance over pedagogical innovation and for its tenuous correlation with actual educational outcomes (Ahn, 2020).

A paradigm shift gained momentum towards the end of the twentieth century, moving decisively towards outcomes-based accreditation. Pioneered by bodies such as the Accreditation Council for Graduate Medical Education (ACGME) in the United States, this model refocused attention on what graduates can demonstrably do (Joyce, 2010). This evolution is inextricably linked to the global rise of CBME, which organises training around the attainment of defined skills essential for practice (Frank et al., 2020). The focus thus shifted from counting resources to measuring competencies, requiring institutions to develop robust internal assessment systems to demonstrate graduate readiness.

The most contemporary paradigm extends beyond outcomes to embrace continuous quality improvement (CQI) and a systems-based approach. Frameworks advanced by global standard-setters such as the World Federation of Medical Education (WFME) emphasise institutional culture, critical self-study, and an embedded cycle of planning, implementation, evaluation, and enhancement (Karle, 2006). In this view, exemplified by bodies such as the

Liaison Committee on Medical Education (LCME, 2024), accreditation is reconceptualised from a punitive inspection to a formative partnership, with the ultimate goal of building an institution's intrinsic capacity for self-regulation and sustained improvement.

Accreditation in context: the distinct challenges of low- and middle-income settings

The translation of these advanced, resource-intensive paradigms to LMIC settings, particularly in SSA, is fraught with context-specific challenges that reveal a persistent tension between global benchmarks and local realities. Literature consistently highlights several interconnected themes.

First, severe resource constraints create a fundamental disconnect. Standards developed in high-income contexts that assume access to high-fidelity simulation, extensive digital libraries, or large cadres of sub-specialist faculty may be unattainable for many institutions in SSA. These risks penalise schools that may nevertheless produce competent, contextually adept physicians, raising critical ethical questions about the relevance and equity of externally derived benchmarks (Mullan et al., 2011).

Second, the constrained capacity of accreditation bodies themselves poses a systemic challenge. Effective accreditation requires trained surveyors, reliable data systems, and administrative rigour. Nascent or underfunded regulatory agencies may struggle with irregular site visits, superficial evaluations, and an inability to enforce compliance, undermining the entire assurance mechanism (Dudley et al., 2015).

Third, the rapid rise of private medical education introduces a complex public-private dichotomy. Driven by market demand and the state's limited capacity to expand public provision, private schools have proliferated across SSA. This growth presents acute governance challenges, including concerns that profit motives may compromise educational integrity, significant disparities in resource availability between sectors, and the political difficulty of regulating well-connected private entities (Girma et al., 2016; Kiguli-Malwadde et al., 2020).

Finally, the imperative for social accountability is especially urgent in regions with high disease burdens and underserved populations. Here, scholars argue that accreditation must move beyond ensuring minimum standards to actively promote alignment between a school's mission and the community's priority health needs (Boelen & Heck, 1995). This entails integrating criteria for community-engaged curriculum design, equitable student selection, and graduate tracking into the standards themselves, thereby making responsiveness a core component of quality (Utomo et al., 2022).

Conceptual framework: accreditation as a system of governance

To analyse the complex interplay of these global paradigms and local challenges, this study adopts a systems governance perspective. This framework moves beyond a technocratic view of accreditation as a mere compliance exercise. Instead, it conceptualises accreditation as a dynamic socio-political subsystem within the larger health and education ecosystems, a mechanism through which power is exercised, resources are allocated, legitimacy is negotiated,

and institutional behaviours are shaped (Jaradat, 2015). This lens is particularly apt for SSA contexts, where accreditation bodies operate under immense pressure to simultaneously safeguard quality and facilitate rapid workforce expansion, a dual mandate laden with political and economic stakes (Wilkins & Mifsud, 2024).

The framework structures inquiry around five analytical elements: (1) Nodes of power and authority: mapping the key actors and their formal mandates, informal influence, and resource dependencies; (2) Formal and informal rules: examining both codified regulations and the unwritten norms that collectively define the 'rules of the game;' (3) Steering mechanisms: focusing on governance tools including standard-setting, monitoring, assessment, and sanctioning; (4) Legitimacy and contestation: exploring how legitimacy is granted or contested when mechanisms are deemed ineffective or rules applied inconsistently; and (5) Feedback loops and system adaptation: assessing whether and how systems incorporate stakeholder feedback and outcome data to evolve policy. Ghana's planned transition from affiliation to chartering exemplifies this last dimension: an attempted systemic adaptation in response to sustained friction.

By employing this framework, the analysis seeks to explain not only the characteristics of Ghana's accreditation system but also why it functions as it does, and what implications this has for educational quality, equity, and the broader goal of producing a socially accountable physician workforce. The framework provides a robust lens for understanding how global models are enacted, resisted, and adapted in specific local terrains, yielding insights relevant to similar contexts worldwide.

Methods: A Reflexive Thematic Analysis of Learning Governance

Research design and qualitative approach

This study employed a qualitative, exploratory design to capture the complex, contextualised experiences and perceptions of stakeholders within Ghana's medical education accreditation system. A qualitative methodology was selected as epistemologically appropriate for investigating the nuanced social phenomena of governance, power, and legitimacy, which cannot be readily reduced to quantitative metrics (Cleland, 2017).

The research was guided by a critical realist perspective, acknowledging an objective social reality, the accreditation system, while recognising that our knowledge of it is always mediated through language, culture, and subjective experience (Bhaskar, 2013). Critical realism holds that social structures exist independently of our knowledge of them, but that they are only knowable through the interpretive accounts of those who inhabit and enact them. This stance enabled serious engagement with participants' accounts as evidence of lived reality, while situating those accounts within broader structural contexts, including historical legacies of colonial educational governance and contemporary political-economic pressures to expand workforce capacity (Creswell & Clark, 2017; Yin, 2015). The sub-heading 'A Reflexive Thematic Analysis' signals the primary analytic method, which is well-aligned with a critical realist

epistemology in that it attends to both the structural conditions that shape experience and the active, interpretive role of the researcher in generating understanding. Where phenomenological attention to the quality of lived experience informs the depth of interviewing and early phases of analysis, the overarching philosophical framework is critical realist: we are interested in explaining, not merely describing, the mechanisms that generate the patterns of stakeholder experience we observe.

Reflexivity and researcher positionality

Reflexivity is central to the integrity of qualitative inquiry, and particularly to reflexive thematic analysis, in which the researcher is explicitly positioned as an active co-constructor of meaning rather than a neutral instrument of data collection (Braun & Clarke, 2022). In keeping with this commitment, we offer a transparent account of our positionalities and how these shaped the research process.

The lead researcher is a Ghanaian medical educator with direct professional experience in the institutions under study, having navigated accreditation processes both as a faculty member and in administrative roles. This insider positioning was a significant analytical resource: it enabled rapid rapport with participants, facilitated access to professional networks, and provided contextual sensitivity that an outsider researcher might have lacked. Participants spoke with candour, reflecting a shared professional vocabulary and a mutual recognition of the stakes involved. At the same time, this proximity required deliberate management. There was an ever-present risk of assuming shared understanding where interpretation was in fact needed, of overlooking taken-for-granted practices as 'normal,' and of unconsciously affirming narratives that aligned with the researcher's own institutional experiences. For instance, given the researcher's prior experience in private medical education, particular vigilance was required when analysing data on regulatory equity between public and private institutions to ensure that participant accounts were not read through the lens of personal grievance or advocacy.

To manage these risks, a reflexive journal was maintained throughout the study, documenting analytical decisions, emotional responses to data, and moments of interpretive tension. Entries were written immediately following each interview and at key decision points in the analysis. This journal served as both an audit trail and a space for disciplined self-interrogation. Preliminary themes and interpretations were also subjected to peer debriefing with academic colleagues who had no stake in the Ghanaian medical education system, providing an important external check on the internal coherence and plausibility of the emerging analysis.

The research team also carried assumptions shaped by sustained engagement with global accreditation literature, predominantly produced in high-income country settings. A conscious effort was made to resist the uncritical mapping of Ghanaian experiences onto these frameworks, treating apparent 'deficits' as simply failures to meet northern standards rather than as adaptive responses to distinct structural conditions. This required treating the data as potentially theory-generative, not merely theory-confirming, and remaining open to the possibility that Ghanaian governance practice might offer lessons to the global field, rather than merely receive them.

Participant recruitment and data collection

A purposive sampling strategy was used to recruit information-rich participants from three key stakeholder groups (Fusch & Ness, 2015). Sampling continued until informational sufficiency was achieved, characterised by the repetition of themes and the absence of new conceptual insights across successive interviews. This criterion has greater methodological transparency than the contested concept of 'data saturation' and is better suited to the interpretive logic of reflexive thematic analysis (Braun & Clarke, 2022). The final sample comprised 21 participants:

- Deans of medical schools (n=7): Academic leaders responsible for institutional compliance and curriculum governance.
- Executive directors of major teaching hospitals (n=7): Clinical training site leaders who host accredited rotations and internships.
- Medical interns (n=7): The immediate graduates experiencing the outcomes of the training system as its primary beneficiaries.

To ensure diversity of perspective, recruitment spanned public and private institutions across Ghana's regions. Initial contacts were made through formal professional channels, specifically official correspondence to the offices of medical school deans, hospital Executive Directors, and the coordinating body for medical interns, supplemented by snowball sampling, in which early participants referred professional colleagues who met the inclusion criteria (Campbell et al., 2020). The use of official entry channels was important for ethical transparency and to avoid the perception that participation was covert. Where a gatekeeper facilitated introductions, this was noted in the reflexive journal, and the potential influence on participant candour was considered during analysis.

Data collection consisted of semi-structured interviews conducted in English, either in-person or via Microsoft Teams, lasting between 45 and 110 minutes. An interview guide was developed from the literature and validated by three senior academics with expertise in health professions education research, ensuring both conceptual coherence and practical relevance. The semi-structured format preserved flexibility to follow emergent lines of inquiry without sacrificing comparability across participants. All interviews were audio-recorded with informed consent, transcribed verbatim, and anonymised using alphanumeric codes (e.g., D-1, ED-2, I-3), with deans designated 'D,' executive directors 'ED,' and interns 'I.'

Data analysis: a reflexive and iterative thematic process

The data were analysed using reflexive thematic analysis as outlined by Braun and Clarke (2006, 2022). This method was chosen for its theoretical flexibility, suitability for exploring complex social phenomena, and explicit recognition of the researcher's active interpretive role in theme development. The analysis was recursive and interpretive rather than linear and mechanical, comprising six adapted phases.

First, familiarisation and deep immersion involved repeated, active reading of all transcripts, accompanied by listening to audio recordings to capture nuances of tone and emphasis. Initial analytic notes were documented in the margins of printed transcripts, marking observations and early interpretive ideas. Second, the entire dataset was systematically coded manually using coloured pens and paper. This approach was deliberately chosen over software-assisted coding to foster a more intimate, reflective engagement with the text: an approach that preserves contextual meaning in interpretive analysis (Maher et al., 2018). Codes were concise labels capturing a relevant feature of the data in relation to the research question, such as 'perception of bias,' logbook as ritual,' and 'community curriculum.'

Third, initial themes were generated by collating and grouping codes on large thematic maps using sticky notes. This physical, spatial arrangement enabled visualisation of connections and patterns across the dataset. Fourth, themes were reviewed and refined in a two-stage process: first, against the coded extracts to ensure strong grounding in the data; then, across the full dataset to assess coherence and ensure that contradictory cases were not overlooked.

Through this process, some candidate themes were merged, others subdivided, and some discarded for insufficient evidence. It was during this stage that the overarching organising concept of 'Learning Governance' was solidified, emerging not as a theme found directly in the data but as a higher-order analytical framework generated through the researcher's interpretation of the interconnected sub-themes as parts of a coherent governance subsystem. Fifth, each final theme was clearly defined and named to capture its analytical contribution. Sixth, the production of the final report wove the thematic narrative together with carefully selected data extracts, linking findings back to the research question and the conceptual framework for systems governance.

Ensuring trustworthiness and ethical rigour

Several strategies were employed to ensure the study's credibility and dependability (Bryman, 2016). Triangulation was achieved by drawing data from three distinct stakeholder groups, providing multiple perspectives on the same governance system. Reflexivity was maintained through the research journal described above. Peer debriefing, in which preliminary themes and interpretations were discussed with academic colleagues external to the Ghanaian context, challenged assumptions and enhanced analytical clarity. Member checking involved sharing summaries of key interpretations with a subset of participants to confirm the accuracy and resonance of the findings. An audit trail was maintained as a detailed record of all methodological and analytical decisions.

Ethical approval was granted by Griffith University (2022/047) and the Ghana Health Service Ethical Review Committee (GHS-ERC: 006/04/22). All participants provided written informed consent prior to participation. Data are stored securely and anonymised to protect confidentiality.

Results: Learning Governance in Ghana – Comparative Tensions and Transferable Lessons

The analysis reveals Ghana's medical education accreditation system as a dynamic subsystem of 'Learning Governance:' an integrated set of rules, processes, and power dynamics that steer medical education, yet which is contested and unevenly enacted. Five themes were generated from the data, each illuminating a distinct dimension of this governance landscape. Together, they reveal a system that has established foundational legitimacy while grappling with deep structural fault lines around equity, assessment, social purpose, and institutional transition.

Theme 1: Standardisation as foundational legitimacy - a universal principle with contextual nuance

Across all three participant groups, accreditation was understood as the system's essential 'guardrail', a mechanism that provides structure, accountability, and protection against the collapse of educational standards. This foundational function was articulated with conviction by deans who had navigated the accreditation process from the outset of their institutions' existence:

> "Well, accreditation is essential because the regulatory bodies must ensure we are doing the right things." D-1

This sentiment was not merely procedural. Several participants expressed a deeper appreciation of accreditation as a socially necessary governance function, one that shapes not just institutions, but the professional culture of medicine itself. One dean offered a vivid local idiom to capture the importance of external oversight:

> "I think if it [accreditation] is done properly, it has a huge role because, like the proverbial saying: 'One who is cutting the path does not know it is crooked.'" D-3

This metaphor speaks directly to a theme that recurred across participant groups: the indispensability of an external vantage point. Institutions embedded in their own routines and assumptions are not best placed to evaluate their own quality. Accreditation provides the corrective, external line of sight.

The procedural architecture of this oversight was described in consistent terms across deans and Executive Directors. The dual-regulator model, in which both the MDC and GTEC exercise oversight, was understood as a structural strength, ensuring that both professional competence and academic viability are assessed:

> "Accreditation of medical schools ensures that we adhere to the minimum requirements or standards imposed by the Medical and Dental Council. An Act of Parliament

> established the NAB, and as a result, all institutions are mandated to comply with the Board's role and responsibilities." ED-1

> "Medical schools are required to report to both MDC and NAB to maintain accreditation status and to undergo reaccreditation." D-3

However, a critical finding was a significant 'governance gap' in the understanding of accreditation across stakeholder groups. Whereas deans and executive directors demonstrated detailed procedural knowledge of how accreditation processes operate, medical interns, the direct beneficiaries of the system, possessed only an abstract awareness of its existence and significance:

> "Yes, they do. They are the ones who validate and ensure the school is following the curriculum. They have a role to play." I-3

While this intern acknowledged the regulatory role of accrediting bodies, the account remained overly general and lacked the procedural specificity demonstrated by institutional leaders. This differential understanding is significant: if the people whose training accreditation is designed to ensure have minimal insight into how the system works or what it demands, the feedback loops through which governance legitimacy is sustained are weakened. Legitimacy requires not only robust standards but their transparent communication with all stakeholders, including those whose careers and competencies are shaped by them (Bandiera et al., 2020).

Theme 2: the fracture of regulatory equity - a defining SSA dilemma

Perhaps the most politically charged finding to emerge from the data was the pervasive perception among participants, particularly from private institutions, that accreditation standards are not applied with consistent rigour across the public-private divide. Multiple deans described a system in which private institutions face exacting scrutiny while public universities are effectively shielded from equivalent enforcement pressure:

> "That is a difficult question. In the past, they had not been able to insist that public institutions conform to the same standards they required of private institutions. Fortunately, we have been able to at least push them out of the way a little, so they are now coming hard on public institutions. Moreover, it is easy for them to insist that we, as private parties, have certain facilities, but it is more difficult for them to insist that public institutions do so." D-2

> "Yes, public institutions not conforming to the way private institutions are supposed to is very unfair. It is very unfair to the private institutions." D-2

A second dean, from a different private institution, offered a strikingly similar account, suggesting that this perception is not idiosyncratic but reflects a structural pattern:

> "Historically, GTEC and MDC could not enforce the same standards for public institutions that they required from private ones. Fortunately, we have managed to advocate for a shift, and now they are taking a tougher stance on public institutions. Additionally, while it is straightforward for them to demand that we, as private institutions, maintain certain minimum facilities, it is much more challenging for them to hold public institutions to the same expectations." D-4

Notably, both participants acknowledge a recent shift, a degree of advocacy that has begun to move the needle. This suggests that the governance system is not static and that stakeholder pressure can function as a feedback mechanism. Nevertheless, the persistence and intensity of the equity grievance across private-sector participants signal a legitimacy deficit that remains unresolved. Procedural justice, the perception that rules are applied consistently and fairly, is a precondition of regulatory authority (Murphy, 2017). Where that perception is absent, compliance may be experienced as coercion rather than commitment, undermining the collaborative, self-improvement orientation that contemporary accreditation theory seeks to foster.

Theme 3: The assessment gap - a universal challenge with acute LMIC manifestations

A third major theme concerns the inadequacy of assessment mechanisms as instruments for verifying governance. Across participant groups, significant weaknesses were identified in both workplace-based assessment and the architecture of final examinations, weaknesses that collectively constitute what we term the 'assessment gap' in Ghana's governance chain.

<u>The Hollow Logbook</u>

The internship logbook, intended as a formative tool for tracking clinical skill development, was described by deans, executive directors, and interns alike as a bureaucratic ritual stripped of meaningful educational purpose. The logbook's function had, in effect, been reduced to the collection of signatures:

> "What level of pass is he getting from the signature?" D-4

> "Because the house job (internship) is supposed to train us, there should be some assessment to see whether your training was adequate." ED-2

Medical interns confirmed this account from their own perspective:

> "We only sign and present this to the Council, but we are not sure for what purpose." I-5

This ritualisation of assessment, the substitution of procedural compliance for substantive evaluation, is a widely documented problem in workplace-based assessment globally (Norcini et al., 2018). However, participants were clear that the absence of meaningful feedback

is particularly acute in Ghana's clinical environment, where overwhelming service demands on supervisors and limited training in formative assessment compound the tool's structural weaknesses. One dean, however, offered a more positive assessment of the broader examination architecture, noting the role of external examiners in maintaining institutional accountability:

> "I remember during my exam and my 'seniors' exam, the way external lecturers, examiners kept coming in... I think the fact that they hold that authority or that power over medical school, it puts medical schools on their toes to do their best to train the medical students the best they can." I-4

This account introduces important nuance: while the logbook is experienced as hollow, the presence of external examiners in university assessments is perceived as a genuinely effective accountability lever. The governance problem, then, is not assessment as such, but the failure to extend the same scrutiny and rigour to workplace-based assessment that is applied at the formal examination stage.

The Missing National Benchmark

A related and more structural assessment gap concerned the absence of a national licensing examination in Ghana. Several participants noted that without a standardised exit assessment, the system lacks a definitive mechanism to verify that graduates from different accredited schools have attained equivalent core competencies. An executive director made the case directly:

> "The Medical and Dental Council should ensure that all schools... require their students to take the same exam." ED-1

The call for a national examination reflects the desire for a final, transparent quality checkpoint; one that can command both professional and public trust by providing objective, comparable evidence of graduate readiness. One dean, drawing on the system's historical continuity, expressed confidence in the existing framework while acknowledging room for enhancement:

> "Yes, I believe it is very effective. The training program (curriculum) and its assessment have been in place since 1969, when the first batch of doctors graduated, and have continued to this day. So, it produced quality doctors, so I do not doubt that it is effective." D-2

This is a significant counterpoint: the absence of a national standardised examination does not necessarily mean that individual school assessments are inadequate. Nonetheless, the systemic inability to make cross-institutional comparisons remains a governance gap, limiting the accreditation system's capacity to function as a guarantor of equivalence across the increasingly diverse landscape of Ghanaian medical schools.

Theme 4: Curriculum for social accountability - from global principle to SSA imperative

A fourth theme concerns the role of accreditation in actively steering institutional curricula towards social accountability, that is, aligning medical education with the priority health needs of the communities schools serve. In Ghana, this function is explicitly embedded in the standards applied by the MDC, which frames curriculum adequacy in terms of fitness for the Ghanaian context:

> "Alright! So, you may want to know what the minimum curriculum you need to fulfil is for our environment and how much exposure they should have to it. So, there are various curricula that the universities may develop. However, the Medical and Dental Council needs to accredit them and ensure that the things you are coming to do, we think, satisfy what will go into management of the average Ghanaian patient." ED-1

This framing is significant. The reference to the 'average Ghanaian patient' is not rhetorical; it reflects a governing philosophy in which accreditation is explicitly used as a lever to align curriculum design with the specific epidemiological and social context in which graduates will practise. Several schools described actively designing programmes in response to this mandate, incorporating community health exposure, rural posting requirements, and locally relevant clinical scenarios.

Executive directors and deans converged on the view that this orientation is both appropriate and enforceable through the accreditation mechanism:

> "One, ensure they have the requisite training, knowledge and skills. This is assessed during the accreditation process." ED-4

This operationalisation is a potentially distinctive strength of accreditation in LMICs. While HICs like Canada also emphasise social accountability and distributed training, the imperative is arguably less immediate than in SSA nations with acute workforce maldistribution and high disease burdens (Strasser et al., 2016). In South Africa, the accreditation process explicitly links the curriculum to transformative equity and redress, helping to decolonise it (Nel et al., 2022). In contrast, in Sudan, the lack of such steering has been linked to a mismatch between graduate skills and community needs (Badr, 2023). Ghana's experience demonstrates that accreditation can be a powerful tool to align education with national health priorities, offering a transferable model for other LMICs seeking to enforce the medical 'social contract.'

Theme 5: affiliation as a contested lever - transitional governance in evolution

The fifth and final theme concerns the mandatory affiliation policy, which requires private medical schools to affiliate with established public universities as a condition of operation pending the achievement of chartered status. This policy was a focal point of significant frustration for private-sector participants:

> "We are not yet a chartered private institution. We have applied to become a chartered institution, and the meeting was held in Koforidua. They gave us a questionnaire with about 150 questions. We had to fill them out and submit them to the GTEC for review; if they are accepted, the GTEC will then send them to the Ministry of Education for final recommendation. Since we are not yet chartered, we are affiliated with the University of Ghana, and this affiliation is expensive and time-consuming." D-1

The bureaucratic burden described here, a 150-item questionnaire, ministerial sign-off, and protracted timelines, was experienced by participants not merely as inconvenient, but as symbolically inequitable: a further instance of the regulatory system placing disproportionate demands on private institutions. The affiliation model was understood as a pragmatic governance solution for an earlier era, a mechanism for extending quality assurance to new providers by anchoring them to established institutions, but one that had outlived its utility and was generating friction without equivalent benefit.

The ongoing transition to direct chartering under Act 2020 was therefore broadly welcomed, though also viewed with cautious concern. The risk identified by several participants was that abolishing affiliation without simultaneously building the direct regulatory capacity of the MDC and GTEC to assume those oversight functions would create a dangerous governance vacuum. The transition, in other words, is not self-implementing: it requires active capacity investment to succeed.

Discussion: Ghana in the Continental and Global Frame - Theorising Learning Governance

The findings of this study, viewed through a systems governance lens, offer more than a national account of accreditation in Ghana. They provide the empirical foundation for the theorisation of 'Learning Governance' under constraint: a concept that captures how accreditation systems in resource-constrained, rapidly expanding contexts operate as adaptive, contested, and politically charged subsystems of governance. In what follows, we situate each major finding within the broader scholarly literature, drawing out the implications for theory, policy, and comparative understanding.

The equity-legitimacy nexus: A structural dilemma in SSA accreditation

The pervasive perception of asymmetric regulation, in which private institutions face stricter enforcement than their public counterparts, is the most politically significant finding of this study and has deep structural roots that extend beyond Ghana. As Ansah et al. (2017) have documented, this pattern of asymmetric regulation strikes at the heart of procedural justice, the principle that regulatory authority depends on the consistent and transparent application of rules across comparable actors. Murphy (2017) has similarly argued that voluntary compliance, the disposition that underpins effective self-regulatory governance, is fundamentally dependent on

the perceived fairness of the regulatory process. Where that perception is absent, institutions comply with external pressure rather than internalise quality as an institutional value.

The Ghanaian case illustrates why this equity–legitimacy nexus is a particularly acute dilemma in SSA. As Wilkins and Mifsud (2024) observe, contemporary higher education governance in many developing contexts is characterised by the tension between state-centric regulatory traditions and the rapid emergence of market-driven private providers. In Ghana, this tension is compounded by a post-colonial legacy in which public universities have historically enjoyed not merely resource advantages, but political proximity to the regulatory apparatus itself, a proximity that private institutions, however well-resourced, do not share. The emergence of private medical schools as necessary responses to state capacity deficits (Kiguli-Malwadde et al., 2020) does not automatically confer on them equal regulatory standing.

Similar dynamics have been documented in Kenya and Uganda, where private sector expansion has outpaced regulatory adaptation (Kiguli-Malwadde et al., 2020), and in Ethiopia, where the establishment of new medical schools in resource-limited settings has generated ongoing tension between expansion targets and quality standards (Girma et al., 2016). In contrast, in high-income systems such as Australia and the United Kingdom, while inequalities between established and newer institutions exist, both public and private medical schools (typically not-for-profit) are regulated by frameworks perceived to apply equivalent standards irrespective of institutional type. The Australian Medical Council's and the UK General Medical Council's standard-setting processes are designed and generally perceived to operate at arm's length from political pressures.

The lesson for Ghana's regulatory bodies, and for SSA accreditors more broadly, is not simply to enforce standards more stringently across the board but to make the enforcement process visibly equitable. This might include joint inspection regimes involving teams from both MDC and GTEC, published compliance scorecards enabling cross-institutional comparison, and a transparent sanctions framework applicable to public and private institutions alike. Such mechanisms would not merely improve regulatory consistency; they would signal a systemic commitment to procedural justice, which is the precondition of regulatory legitimacy (Murphy, 2017).

The assessment gap: symptomatic of systemic resource and priority deficits

The 'hollow logbook' and the absence of a national licensing examination are not, on their own terms, unique to Ghana. The ritualisation of workplace-based assessment is a documented global challenge in health professions education; Norcini et al.'s (2018) consensus framework for good assessment identifies meaningful feedback, developmental purpose, and alignment between assessment and learning as universal requirements that are difficult to achieve. What distinguishes the Ghanaian context, and many comparable LMIC settings, is that the gap between assessment ideal and assessment reality is substantially wider, and the structural conditions for closing it are considerably more constrained.

In high-income settings, the transformation of logbooks into tools for genuine formative assessment has been pursued through sustained national investment in CBME frameworks, clinical supervisor training programmes, and IT infrastructure for competency tracking (Frank et

al., 2020). Canada's Royal College of Physicians and Surgeons and the UK's General Medical Council have both committed to assessments that constitute 'entrustment decisions', judgements that a trainee is ready for independent practice, rather than mere signature collection. These reforms have taken decades and considerable investment to achieve and remain contested even in their countries of origin (Boyd et al., 2018).

Participants' call for a national licensing examination reflects a pragmatic governance insight: in contexts where internal institutional assessment is variable and difficult to standardise, a national exit examination provides an external, objective benchmark that creates accountability at the system level rather than at the institutional level alone. Nigeria's MDCN examination, South Africa's HPCSA-moderated assessments, and the national examinations of Australia (AMC) and the UK (UKMLA) all serve this function (Aderinto et al., 2025). The absence of an equivalent mechanism in Ghana means that accreditation's capacity to guarantee graduate equivalence across schools is structurally limited. Investing in this assessment infrastructure is therefore not merely an educational priority; it is a fundamental governance imperative, the mechanism through which accreditation processes are connected to verifiable graduate outcomes.

At the same time, the finding that interns perceive external university examinations as effective accountability levers, putting schools 'on their toes', suggests that the problem is not assessment as such, but its uneven application across the learning continuum. A coherent governance approach would seek to extend the rigour of formal examinations to workplace-based assessment throughout the internship, investing in supervisor training and explicit competency frameworks that make the logbook a tool of substantive governance rather than bureaucratic performance.

Social accountability as governance advantage: a lesson for the global field

One of the most distinctive and generative findings of this study is the degree to which social accountability functions in Ghana not as a philosophical aspiration, but as an operationalised governance criterion embedded in accreditation standards. The MDC's explicit orientation towards the 'average Ghanaian patient' as the reference point for curriculum adequacy represents a form of regulatory steering that directly connects educational governance to health system outcomes. This is consistent with the theoretical framework advanced by Boelen and Heck (1995), who argued that medical education's 'social contract' with society requires active institutional commitment to community health priorities. This commitment should be enforceable through accreditation.

The comparative significance of this finding becomes clear when viewed against the global literature. In high-income systems, social accountability has frequently remained at the level of institutional aspiration, expressed in mission statements but only weakly operationalised in accreditation standards or site visit processes (Strasser et al., 2016). The entrenched traditions of specialist-focused, hospital-based training in many high-income systems have proved resistant to reorientation, despite decades of rhetoric about community-responsive education. In contrast, South Africa's explicit use of accreditation to promote transformative equity and the decolonisation of medical curricula (Nel et al., 2022) demonstrates how regulatory levers can advance systemic educational change, a model with direct resonance for other SSA systems.

Ghana's experience suggests that LMIC accreditation systems may, paradoxically, be better positioned than their high-income counterparts to enforce social accountability as a governance function, precisely because the urgency of the health workforce crisis makes such alignment non-negotiable. Freed from the inertia of well-resourced specialist traditions and driven by the acute salience of population health needs, regulators in Ghana and comparable contexts are operationalising the 'social contract' of medicine in ways that the global accreditation community has long endorsed in theory but has struggled to achieve in practice. This represents not a deficit to be remedied, but a potential model to be recognised and learned from.

The lifecycle of governance tools: policy fluidity and the affiliation transition

The contested transition from affiliation to direct chartering illustrates a dimension of governance in evolving systems that receives insufficient attention in the mainstream accreditation literature: the lifecycle of regulatory mechanisms. Governance tools are not permanent features of a regulatory landscape; they are pragmatic responses to particular historical conditions that may outlive their usefulness and require managed retirement. The affiliation model was a sensible governance innovation for its era, a mechanism for extending oversight to new private providers by anchoring them to established institutional benchmarks during a period when the MDC and GTEC lacked the capacity to conduct fully independent oversight of all entrants. Its contemporary contestation reflects a system that is learning, adapting, and outgrowing its original infrastructure, precisely as Jaradat's (2015) systems governance framework anticipates for resilient, adaptive systems.

The risk that participants identified that abolishing affiliation without simultaneously building direct regulatory capacity creates a governance vacuum is a critical warning for comparable transitions elsewhere in SSA. As Wilkins and Mifsud (2024) observe, policy reform in higher education governance rarely proceeds in neat, sequential phases; the dismantling of existing mechanisms frequently outpaces the development of replacement capacity, with quality assurance consequences that are difficult to reverse. Ghana's ongoing transition, therefore, offers a real-time case study in managing the sunsetting of a transitional governance mechanism, with lessons applicable to any nation expanding private higher education provision in contexts of limited regulatory infrastructure.

The contrast with mature systems such as the UK, where new medical school approval involves a detailed, direct process with the GMC underpinned by decades of regulatory experience and extensive institutional support infrastructure, is instructive not as a target to be emulated wholesale, but as an illustration of what direct oversight eventually requires. Ghana's transition is not a failure of foresight; it is a predictable challenge in a system that has been asked to do too much too quickly with too little. Acknowledging this structural reality, rather than treating governance challenges as the product of individual institutional shortcomings, is an important analytical contribution to this study.

Challenging global assumptions: what the Ghanaian case contributes to the field

Taken together, the findings of this study challenge several assumptions that have, implicitly or explicitly, structured the global accreditation literature. First, they challenge the assumption that the primary direction of knowledge transfer in accreditation is from high-income to low-income settings. While Ghana's system faces genuine challenges, it also demonstrates capacities, particularly in social accountability governance, that high-income systems have struggled to develop. The field would benefit from a more genuinely bidirectional exchange of learning.

Second, the findings challenge the technocratic framing of accreditation as a process of standards compliance and procedural audit. In Ghana, accreditation is experienced and enacted as a profoundly political process, one in which questions of legitimacy, equity, institutional identity, and national health workforce strategy are continuously at stake. This political character is not an anomaly to be corrected; it is an inherent feature of any governance system operating at the intersection of professional authority, market dynamics, and public health imperative.

Third, and most broadly, the concept of 'Learning Governance' that emerges from this study offers a theoretical contribution to the literature on higher education governance in LMICs. Learning Governance captures the idea that accreditation systems in evolving contexts are not simply administering standards; they are themselves learning entities, adapting their tools, their rules, and their relationships in response to changing conditions, stakeholder pressure, and accumulated experience. Recognising this adaptive character is essential to understanding why governance looks different across contexts and why difference does not necessarily mean a deficit.

Limitations

This study has several limitations that should be acknowledged. First, the study is situated in a single national context. While Ghana has been theorised as a critical case with broader relevance for SSA and LMIC contexts, findings should be transferred to other settings with contextual sensitivity. The structural conditions that shape Ghana's accreditation governance, including its specific co-regulation model, the pace of private sector expansion, and the particularities of its post-colonial institutional history, may not map directly onto other national contexts, even within SSA.

Second, the sample, while purposively constructed to represent three key stakeholder groups, does not include accreditation officials from the MDC or GTEC. The perspectives of regulatory actors would have provided an important additional vantage point on the equity perceptions documented in Themes 1 and 2, and on the rationale for governance decisions that participants experienced as problematic. Future research would benefit from including regulatory agency perspectives.

Third, as noted in the reflexivity section, the lead researcher's insider positioning in the Ghanaian medical education system, while analytically advantageous in many respects, carries the risk of blind spots, despite the mitigation strategies employed. Readers should weigh the findings with this positionality in mind.

Fourth, the study is cross-sectional, capturing stakeholder perspectives at a particular point in time within a rapidly evolving system. Ghana's accreditation governance is actively transitioning from affiliation to chartering and potentially towards new assessment frameworks; longitudinal research would be valuable in tracking how these governance reforms play out in practice over time.

Conclusion: Towards Strengthened Learning Governance - Lessons from Ghana for Sub-Saharan Africa and Beyond

This study has employed a systems governance lens to interrogate the medical education accreditation regime in Ghana, framing it as a critical case of 'Learning Governance' within Sub-Saharan Africa. Through a qualitative exploration of stakeholder perspectives, analysed using a reflexive thematic approach and situated within a critical realist framework, the research has illuminated how accreditation functions not as a neutral, technocratic exercise, but as a profoundly political and adaptive governance subsystem. It is a mechanism through which power is negotiated, resources are allocated, and the social contract of the medical profession is steered amidst the pressing demands of health workforce expansion.

The findings reveal a system that has successfully established a foundational framework for quality assurance, one in which the legitimacy of the accreditation function is broadly affirmed across stakeholder groups, yet whose effectiveness is contested along predictable and critical fault lines: the equity of enforcement between public and private sectors; the robustness of outcome verification; the management of legacy governance mechanisms; and the differential distribution of governance knowledge across the stakeholder community.

The comparative analysis situates Ghana's tensions within a broader continental and global conversation. The pervasive perception of a two-tiered regulatory system underscores the equity–legitimacy nexus as a defining dilemma in SSA accreditation; one rooted in post-colonial institutional histories and the structural dynamics of rapid private-sector expansion. The assessment chasm connects micro-level practice (the signed logbook) to macro-level policy (the absence of a national licensing examination), revealing a governance system struggling to verify its own outcomes. The affiliation-to-chartering transition exemplifies the lifecycle of governance tools in evolving systems, with lessons for all nations navigating the sunsetting of transitional regulatory mechanisms.

Conversely, Ghana's operationalisation of social accountability as an active accreditation criterion offers a model that the global field, including high-income systems that have long endorsed social accountability in principle while struggling to enforce it in practice, would do well to study. The claim that we make here is not that Ghana's system is without problems. It is that those problems are structural and systemic, not simply technical; and that addressing them and recognising the genuine governance innovations embedded in Ghana's experience require the kind of critical, contextually sensitive analysis that this study has sought to provide.

The pathway forward for Ghana, and for many SSA nations navigating similar terrain, lies in strengthening the quality of governance itself: ensuring that accreditation is equitable in perception and practice, evidence-based in its judgments, socially accountable in its orientation,

and adaptively intelligent in its policy evolution. A strengthened system of Learning Governance is not merely an educational aspiration; it is a public health imperative, essential to ensuring that the expansion of medical education yields not simply more physicians, but a competent, equitable, and socially responsive health workforce capable of meeting Africa's pressing health challenges and, through that example, contributing to the global renewal of medical education governance.

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