

Original Research Article

Faculty development for interprofessional education in resource-constrained West Africa: priorities, institutional gaps and implementation pathways

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ABSTRACT

Background: Interprofessional education (IPE) is a recognised strategy for addressing healthcare workforce challenges in sub-Saharan Africa, but evidence on faculty preparation in resource-constrained settings is limited.

Methods: Between September and November 2024, we conducted a cross-sectional needs assessment of all eligible faculty (n=28; 100% response) at a West African regional medical education and research institute. A validated, pilot-tested semi-structured questionnaire (content validity index 0.89; Cronbach's $\alpha=0.82$) assessed demographics, professional development priorities, institutional support, and programme-design preferences. Quantitative data were summarised using frequencies, percentages, weighted priority scores, and five-point Likert means; open-ended items underwent thematic analysis.

Results: Most participants held master's degrees (67.9%, n=19); 60.7% were female, 50.0% held lecturer rank, and 78.6% had under ten years' teaching experience. Research methodology (85.7%) and data analysis (89.3%) were the top development priorities. Enhanced mentorship was the highest improvement priority (92.9%; mean 4.3/5), yet only 28.6% currently accessed formal mentorship programmes. Institutional support ratings were modest (grand mean 3.1/5), with professional development rated lowest (mean 2.8/5). Key programme characteristics identified were institutional leadership support (89.3%), research-practice integration (85.7%), resource allocation (82.1%), collaborative learning (78.6%), flexible delivery (75.0%), and comprehensive assessment (71.4%). Faculty preferred quarterly delivery (50.0%) in blended formats (75.0%), and 89.3% reported readiness to participate.

Conclusions: A pronounced gap exists between faculty demand for mentorship and existing institutional provision. Research-integrated, blended faculty development anchored in formal mentorship is a feasible, contextually appropriate approach to strengthen IPE capacity at this institution; broader generalisability requires multisite investigation.

Keywords: Faculty development, Health workforce, Interprofessional education, Mentoring, Needs assessment, Resource-constrained settings, Sub-Saharan Africa

INTRODUCTION

Healthcare systems across sub-Saharan Africa face a persistent workforce crisis: physician density averages 0.3 per 1,000 population against the WHO recommended minimum of 1.0 per 1,000, with allied health workforces similarly depleted; despite incremental regional gains over the past decade, workforce density remains well below target thresholds.¹⁻³ These shortages intensify the need for educational strategies that maximise collaborative potential across available health professional groups. Interprofessional education (IPE), defined by the WHO as learning that occurs when students from two or more professions learn about, from, and with each other, has gained international traction as the evidence base for its effect on collaborative practice, patient safety, and educational outcomes continues to grow.⁴⁻⁶

Realising this potential depends on faculty who can design, deliver, and role-model collaborative practice, yet faculty development itself remains an inconsistently defined and unevenly implemented field. A recent scoping review of 418 studies found wide variation in how faculty development is conceptualised and practised across health professions education. It spans everything from single workshops to longitudinal programmes and mentoring or coaching relationships, and its central finding was that outcomes depend as much on institutional context as on curriculum content.⁷ Where faculty development has been rigorously evaluated in medical education more broadly, the pattern is consistent: longitudinal, programme-based interventions outperform single workshops in producing durable change in teaching practice. Programme design and sustained institutional support, not participation alone, appear to be what determines impact.⁸

This evidence base has, however, been generated predominantly in high-income settings. Medical and health professions schools across sub-Saharan Africa face compounding constraints, including faculty shortages, limited protected academic time, and constrained infrastructure, that shape whether and how faculty development can be delivered.² Meeting local population health needs, in turn, requires training and capacity-building models calibrated to these realities rather than transplanted unchanged from elsewhere.⁹ Effective IPE implementation requires faculty who are both competent in IPE facilitation and supported by institutional structures that sustain their development.^{8,10} Despite growing global IPE interest, published evidence on faculty development needs and institutional readiness in West African or broadly sub-Saharan African settings remains sparse, limiting the ability of regional institutions to design contextually appropriate capacity-building programmes.¹¹

This study addresses that gap. The objective of this study was to characterise faculty development priorities, institutional support levels, and programme-design preferences among faculty at a regional medical education and research institute in West Africa, to provide an evidence-informed framework for contextually appropriate IPE faculty development planning.

METHODS

Study design and setting

This cross-sectional needs assessment examined faculty development requirements for IPE implementation between September and November 2024. The study was conducted at a regional medical education and research institute serving multiple West African countries.

Participants

This study employed total population sampling (a census-based approach) rather than probability sampling: all eligible faculty meeting the inclusion criteria were invited to participate, and all consented (n=28; 100% response rate). Because the entire eligible faculty population, rather than a subsample drawn from it, was surveyed, no a priori sample size calculation was performed; the achieved sample represents the full population of faculty meeting inclusion criteria at the institution at the time of data collection, and 28 is accordingly reported as the population size rather than an estimated or targeted sample size. Inclusion criteria comprised current faculty appointment, a minimum of two years' teaching experience in health professions education, active curriculum involvement, and willingness to participate in IPE initiatives. Faculty with less than one year's institutional affiliation or unavailable during data collection were excluded.

Data collection

A semi-structured questionnaire was developed based on established faculty development assessment frameworks with contextual adaptations for West African healthcare education. Content validity was assessed through expert panel review comprising three medical education specialists, two IPE practitioners, and one psychometrician, achieving a content validity index of 0.89 across all domains. Cognitive interviewing with four faculty members assessed comprehension and cultural appropriateness. A pilot test with eight additional faculty members established internal consistency for scaled items (Cronbach's alpha=0.82 for the development priorities section). The survey comprised four sections: (1) demographic and professional information; (2) faculty development needs assessment; (3) institutional support systems evaluation; and (4) programme design preferences and recommendations. Data were collected through structured personal interviews.

Data analysis

All analyses were performed in IBM SPSS Statistics version 27.0 (IBM Corp., Armonk, NY, USA). Categorical variables are reported as frequencies and percentages. Continuous variables are reported as means and standard deviations. Five-point Likert-scale items are summarised as means for descriptive comparison only; no parametric inferential tests were applied to individual scale items, consistent with best practice for small-sample survey studies.¹² Cross-tabulation with Pearson's chi-square or Fisher's exact test (for cells with expected frequency <5) examined associations between demographic subgroups and priority rankings; effect sizes are reported as Cramér's V. Priority rankings used weighted scoring (rank 1=5 points through rank 5=1 point) to identify critical development needs and preferred programme characteristics. Open-ended responses were analysed thematically following the Braun and Clarke six-phase framework: familiarisation, initial coding, theme generation, theme review, theme definition, and reporting. No missing data were encountered; all 28 participants completed all questionnaire sections.

Ethical considerations

The study received institutional review board approval prior to data collection (approval reference: AAMIR/IEC/2024/FD-IPE/09). All participants provided written informed consent, with clear explanations of study purposes, voluntary participation, and confidentiality protections. Participant anonymity was maintained throughout; findings are reported in aggregate only.

RESULTS

Participant demographics and professional development engagement

Twenty-eight faculty members participated. The demographic profile showed predominantly female faculty (60.7%, n=17); most participants (71.4%) were under 40 years of age. Educational qualifications were high, with 89.3% holding advanced degrees, predominantly master's degrees (67.9%, n=19). Faculty composition was characterised by junior positions, with half (50.0%, n=14) at lecturer rank and 78.6% having fewer than ten years' teaching experience. Most participants (75.0%, n=21) were affiliated with public institutions. Professional development engagement showed considerable variation: subject-specific workshops recorded the highest participation (57.1%, n=16), while research methodology training was attended by 42.9%. Notably, 21.4% of respondents reported no formal programme participation in the preceding year, and 78.6% reported annual or more frequent pedagogical reviews.

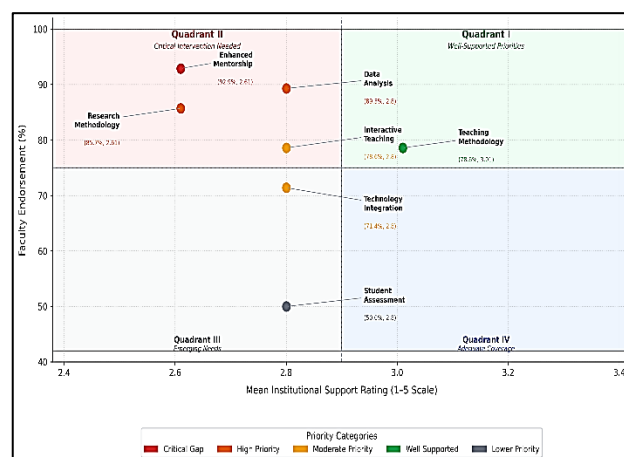


Figure 1: Faculty development priority matrix: institutional support versus faculty endorsement.

Priority matrix plotting faculty endorsement (%) on the y-axis versus mean institutional support rating (1-5 scale) on the x-axis. The quadrant boundary is set at 75% endorsement and 2.9/5 mean support. Quadrant II (high endorsement, low support) indicates critical intervention areas. Data points are colour-coded by priority category: red = Critical Gap; orange = High Priority; yellow-orange = Moderate Priority; green = Well Supported; grey = Lower Priority. Each point is labelled with the corresponding development area and its coordinates.

Faculty development priorities and skill enhancement needs

Faculty development priorities reflected a strong research orientation: research methodology ranked highest overall (85.7%), followed by teaching methodology updates (78.6%) and technology integration (71.4%). Within specific skill domains, data analysis (89.3%), publication strategies (82.1%), and research design (75.0%) were most prioritised; among pedagogical skills, interactive teaching methods (78.6%) and student assessment strategies (71.4%) ranked highest; and among technology needs, online teaching platforms (71.4%) and digital assessment tools (64.3%) were most sought. Figure 1 (priority matrix) maps faculty endorsement against mean institutional support ratings, visually identifying enhanced mentorship, data analysis, research methodology, and interactive teaching as quadrant II priorities (high faculty demand, low institutional provision), with enhanced mentorship (the sole critical gap item) representing the single most critical area for intervention.

Academic support systems assessment

On a five-point scale, teaching resources received the strongest rating (mean 3.4); administrative support followed (mean 3.3); research support and technology infrastructure both rated 3.1; and professional development support ranked lowest (mean 2.8). The grand mean across all five support domains was 3.1/5, indicating an adequate foundation for teaching activity but limited institutional investment in structured faculty capacity-building (Table 1).

Table 1: Academic support systems evaluation (n=28).

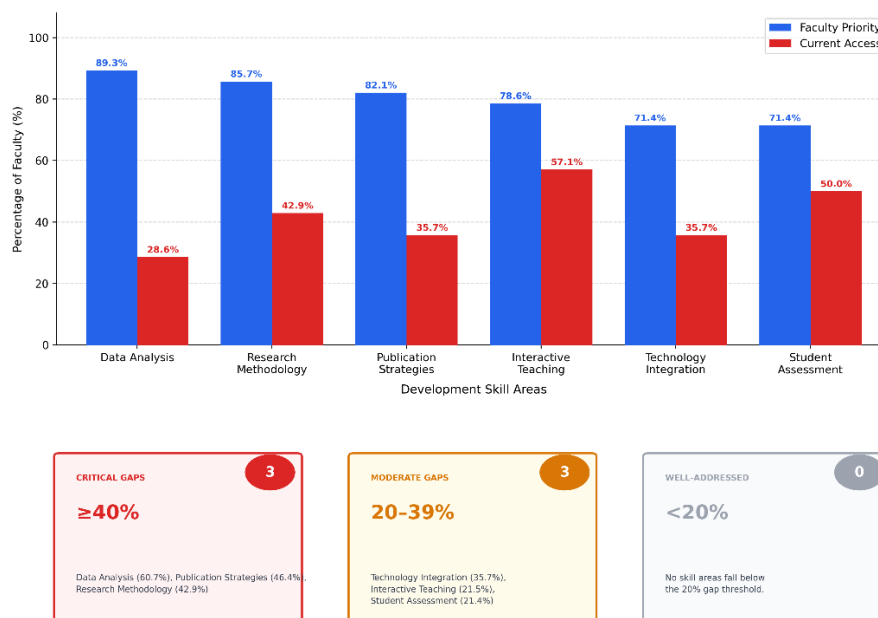
Support domains	Excellent (%)	Good (%)	Average (%)	Poor (%)	Very poor (%)	Mean*
Teaching resources	5 (17.9)	8 (28.6)	9 (32.1)	4 (14.3)	2 (7.1)	3.4
Research support	3 (10.7)	7 (25.0)	10 (35.7)	6 (21.4)	2 (7.1)	3.1
Administrative support	4 (14.3)	9 (32.1)	8 (28.6)	5 (17.9)	2 (7.1)	3.3
Technology infrastructure	2 (7.1)	8 (28.6)	10 (35.7)	6 (21.4)	2 (7.1)	3.1
Professional development support	2 (7.1)	6 (21.4)	8 (28.6)	8 (28.6)	4 (14.3)	2.8

*Mean rating on a 5-point scale (1 = very poor, 5 = excellent), computed as the frequency-weighted average of the category responses shown in each row. Grand mean across all five domains = 3.1.

Table 2: Faculty development programme design preferences (n=28).

Programme component	Items (N; %)	Mean score*
Enhancement strategy priorities	Enhanced mentorship programmes (n=26, 92.9%); Increased funding allocation (n=24, 85.7%); Regular workshops/seminars (n=22, 78.6%); Technology integration support (n=20, 71.4%); Improved research facilities (n=18, 64.3%); Curriculum development support (n=16, 57.1%); Administrative training programmes (n=14, 50.0%)	Range 3.1-4.3
Programme frequency	Quarterly (n=14, 50.0%); Biannual (n=7, 25.0%); Monthly (n=4, 14.3%); Annual (n=3, 10.7%)	--
Programme duration	Multi-day workshops, 2-3 days (n=12, 42.9%); One-day intensive sessions (n=8, 28.6%); Half-day sessions (n=6, 21.4%); Extended programmes, 1+ weeks (n=2, 7.1%)	--
Delivery method	Blended approaches (n=21, 75.0%); Face-to-face workshops (n=18, 64.3%); Online/hybrid formats (n=15, 53.6%); Self-directed learning (n=8, 28.6%)	--
Administrative support	Leadership endorsement: Essential (n=25, 89.3%); Resource allocation: Essential (n=23, 82.1%); Policy integration: Essential (n=21, 75.0%); Administrative training: Necessary (n=25, 89.3%)	--

*Mean score on a 5-point scale (1 = Not Important, 5 = Very Important), applicable to Enhancement Strategy Priorities only. Delivery Method responses are not mutually exclusive; respondents could select all applicable options (column percentages sum to >100%).

Figure 2. Faculty Development Skills: Priority versus Access Gap Analysis**Figure 2: Faculty development skills: priority versus access gap analysis.**

Grouped bar chart comparing faculty priority ratings (%) (blue) versus current institutional access (%) (red) across six development skill areas. Critical gaps (40 or more percentage points) are identified for data analysis (60.7%), publication strategies (46.4%), and research methodology (42.9%). Moderate gaps (20-39%) are identified for technology integration (35.7%), interactive teaching (21.5%), and student assessment (21.4%). No skill area falls below the 20% gap threshold. Summary classification boxes at the bottom of the figure categorise skill areas by gap severity.

Programme design preferences

Enhanced mentorship received the highest priority among improvement strategies (mean 4.3/5; 92.9% endorsement), followed by increased funding allocation (mean 4.1; 85.7%) and regular workshops or seminars (mean 3.9; 78.6%). Frequency preferences strongly favoured quarterly delivery (50.0%), with multi-day workshops of two to three days as the preferred duration (42.9%). Delivery preferences strongly favoured blended approaches (75.0%) combining face-to-face and online components, followed by face-to-face workshops alone (64.3%). Interactive teaching received the strongest endorsement as a learning format (78.6%), followed by peer-to-peer learning (71.4%) and case-based learning (67.9%). Administrative support requirements showed strong alignment: leadership endorsement was considered essential by 89.3%, and resource allocation commitment by 82.1% (Table 2). Figure 2 illustrates the priority-access gap across six skill domains; disparities of 40 or more percentage points were observed for data analysis

(60.7%), publication strategies (46.4%), and research methodology (42.9%), identifying these as the most urgent targets for institutional investment.

Programme effectiveness measurement and success characteristics

Respondents endorsed multiple evaluation modalities: student feedback (85.7%), peer review (78.6%), and research output tracking (71.4%) ranked highest (Table 3). Six characteristics were identified as essential for programme success: institutional leadership support (89.3%), research-practice integration (85.7%), resource allocation (82.1%), collaborative learning environment (78.6%), flexible delivery (75.0%), and comprehensive assessment (71.4%) (Figure 3). Implementation readiness was high, with 53.6% indicating readiness to participate immediately and a further 35.7% requiring only minor preparation (89.3% combined); exchange programme perceptions were similarly positive, with 78.6% rating them effective or very effective (Table 3).

Figure 3. Multi-panel Visualisation of Programme Design Preferences

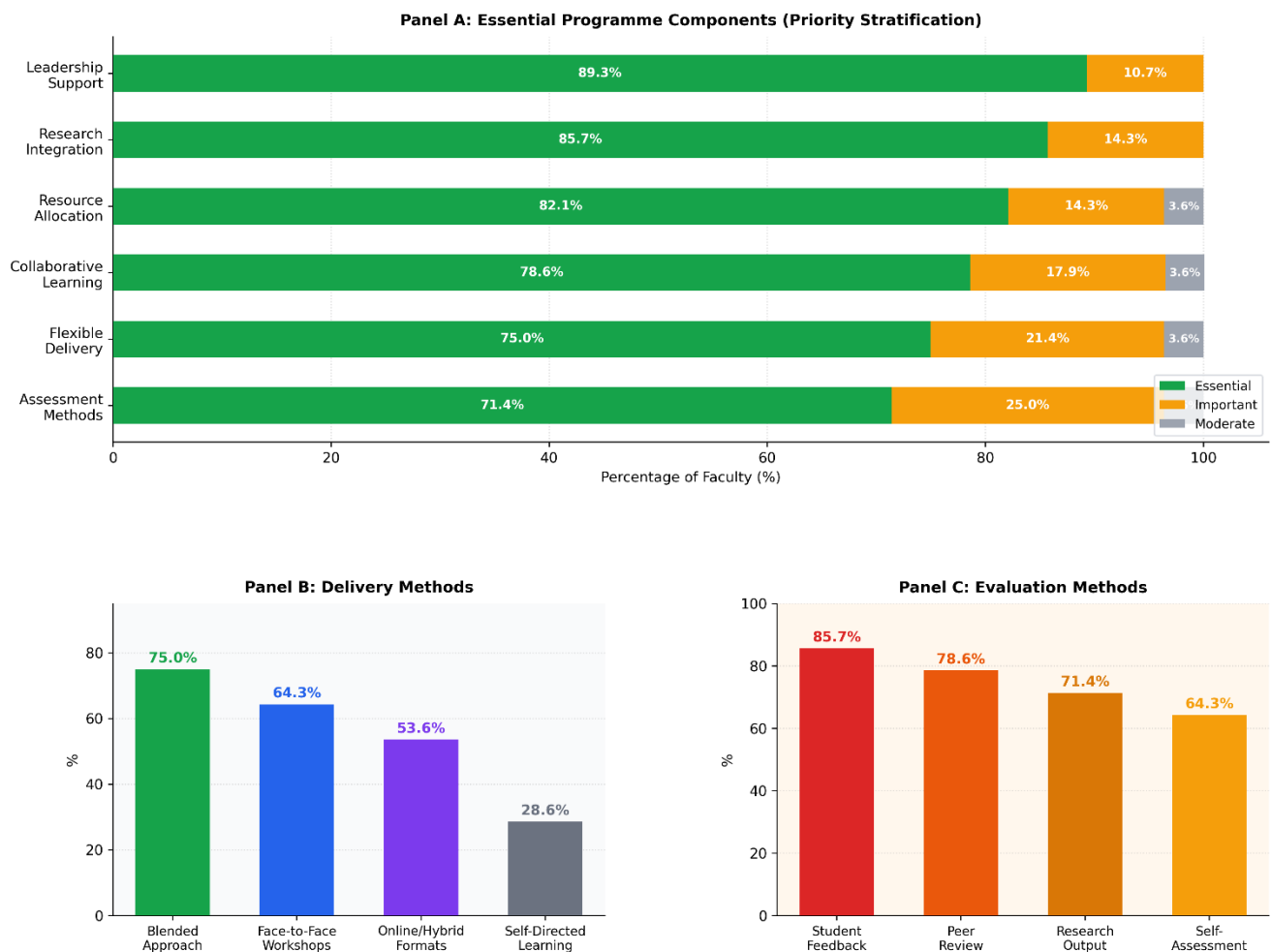


Figure 3: Essential programme components: priority stratification.

Stacked horizontal bar chart showing the six components most consistently rated essential for programme success, ranked by proportion of faculty rating each as essential (green), important (orange), or moderate (grey).

Table 3: Programme effectiveness measurement framework and implementation readiness (n=28).

Assessment components	Item	N	%	Mean*
Programme effectiveness measures	Student feedback evaluation	24	85.7	4.2
	Peer review/observation	22	78.6	3.9
	Research output tracking	20	71.4	3.7
	Self-assessment tools	18	64.3	3.5
	Teaching portfolio development	16	57.1	3.4
	360-degree feedback	14	50.0	3.2
Exchange programme effectiveness	Very effective	12	42.9	--
	Effective	10	35.7	--
	Moderately effective	4	14.3	--
	Slightly effective	2	7.1	--
Implementation readiness	Ready to participate immediately	15	53.6	--
	Ready with minor preparation	10	35.7	--
	Need significant preparation	3	10.7	--

*Mean rating on a 5-point scale (1 = not effective, 5 = very effective), applicable to programme effectiveness measures only.

DISCUSSION

This needs assessment describes well-qualified yet predominantly early-career faculty, a profile presenting clear capacity-building opportunities alongside structural gaps in institutional mentoring support. The predominance of lecturers with fewer than ten years' experience (78.6%) is consistent with reports from similar sub-Saharan African institutions, where faculty pipelines are dominated by junior staff due to attrition and brain drain at senior levels.^{2,11} The high proportion of female faculty (60.7%) is noteworthy; while gender parity in health professions education is improving across sub-Saharan Africa, women remain underrepresented in senior academic ranks, suggesting an equity dimension to faculty development planning that warrants monitoring.¹³ This profile underlines the importance of planned, sustained faculty development over one-off workshops: the landmark BEME systematic review by Steinert et al identified longitudinal, programme-based interventions as consistently more effective than workshops alone in translating motivation into durable practice change, a finding directly applicable to this setting.^{8,14}

The pronounced research orientation of participants (85.7% prioritising research methodology) offers strategic advantage. The WHO framework for interprofessional education and collaborative practice explicitly calls for context-specific evidence generation as a driver of IPE scale-up: faculty who are active researchers are precisely the people who can build that local evidence base and strengthen institutional knowledge production in the process.⁴ When faculty development links pedagogical skill-building with scholarship opportunities, engagement and sustainability improve because activities align with career incentives and local academic culture.^{8,15} Findings from FAIMER's international faculty development fellowship, which similarly serves educators from resource-constrained settings worldwide, indicate that engagement in educational scholarship is strongly contingent on protected time and institutional recognition, mirroring the resource allocation concerns identified

here.¹¹ Integrating teaching development into research practice helps anchor capacity locally, reducing reliance on external technical assistance, a structural limitation widely documented in sub-Saharan health workforce programmes.^{2,11}

The mentorship gap is the most clinically and operationally significant finding: fewer than one-third of faculty accessed formal mentorship programmes, yet 92.9% identified enhanced mentorship as their top institutional priority. Mentorship is a well-documented mechanism for converting knowledge into applied teaching skill and for improving career satisfaction, research productivity, and retention in academic medicine, though causal inference is not possible from the present cross-sectional data.^{16,17} Evidence from African medical schools tells a similar story: faculty welcome mentorship and structured pedagogical training, but institutional arrangements, workload, and funding commonly undermine sustained relationships.¹⁶ Comparable patterns have been reported elsewhere in the region: faculty at a Ugandan medical school valued mentorship and expressed willingness to engage in it, yet described limited structured knowledge and practice of mentoring, pointing to institutional and policy-level gaps rather than individual unwillingness.¹⁶ Pragmatic solutions include peer mentoring circles, short mentor training modules, and mentorship tied to small-scale research or teaching deliverables.¹⁶⁻¹⁸

Faculty overwhelmingly preferred quarterly, multi-day blended programmes combining face-to-face and online components (75.0%), with interactive and case-based learning formats. This fits with what Mezirow's transformative learning theory would predict: adult learners engage most deeply when content is tied to real professional challenges rather than delivered as abstract instruction.¹⁹ Blended, modular approaches produce better retention and practice transfer among busy clinicians and educators than isolated sessions, a finding corroborated by the updated BEME guide number 40.^{8,20} The emphasis on peer-to-peer learning (71.4%) and case-

based methods (67.9%) further aligns with IPE-specific pedagogical principles that prioritise collaborative, role-clarifying learning experiences.⁵

Professional development support received the lowest mean institutional rating (2.8/5), indicating that structural barriers, rather than motivational deficits, are the primary impediment to faculty growth. Faculty development in resource-constrained settings must acknowledge and mitigate competing clinical and administrative demands.^{16,21} This is consistent with continuing professional development research from other low- and middle-income countries showing that well-designed training programmes fail to generate lasting behaviour change when faculty return to unsupportive institutional environments.²¹

Translating these findings into action at this institution does not require building an entirely new infrastructure. Formalising mentorship agreements and appointing a faculty development coordinator are achievable within the first three months and would address the most immediate gap identified here. Over the following months, up to about a year, structured mentorship cohorts and quarterly blended modules linking pedagogical skill-building to applied research could build on the strong research orientation already evident among faculty. The harder work is longer-term and institutional: workload models need to protect dedicated faculty development time, in the region of 10 to 15% of appointments, IPE competencies should be reflected in promotion criteria, and funding for educational innovation needs its own line rather than being absorbed into general budgets.^{4,10} The high implementation readiness reported here (89.3% willing to participate immediately or with minor preparation) is a favourable enabling condition; comparable studies in similar settings have noted motivational barriers as a more common challenge, though direct comparison across single-institution studies should be made cautiously.^{11,22}

Limitations

Single-institution focus limits generalisability across different West African contexts. The cross-sectional design captures conditions at one time point and cannot assess change over time.²³ The relatively small sample (n=28), while appropriate for an institutional needs assessment, may limit statistical power for subgroup analyses.²⁴ Self-reported data carry recognised social desirability bias.¹² Despite these limitations, the principal findings (a critical mentorship gap, demand for research-integrated faculty development, and preference for blended delivery) are consistent with those documented across comparable settings.

CONCLUSION

This needs assessment identifies a structural gap between faculty demand for mentorship and current institutional

provision at a resource-constrained West African medical education institute. Despite strong qualifications, research orientation, and high readiness to engage in IPE, fewer than one-third of faculty access formal mentorship, revealing a persistent disconnect between individual motivation and institutional support. Faculty development initiatives integrating pedagogical training with research scholarship, delivered through blended quarterly formats and anchored by formalised mentorship structures, are most likely to generate durable practice change. At this institution, IPE faculty development should be conceptualised as a sustained institutional strategy rather than a series of isolated workshops; explicit workload recognition, administrative alignment, and dedicated funding are enabling conditions consistent with established WHO and HPAC policy frameworks. Whether these findings generalise to other West African or sub-Saharan settings requires confirmation through multisite, longitudinal research that evaluates effects on faculty competency, collaborative practice behaviours, and patient outcomes.

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Declaration

No generative AI tools were used in the design, data collection, analysis, interpretation, or original drafting of this manuscript. Language-editing assistance was provided by an AI writing tool solely for grammar, clarity, and conciseness of the final text; all intellectual content, interpretation, and conclusions are solely the work of the authors.

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REFERENCES

1. Anyangwe SCE, Mtonga C. Inequities in the global health workforce: the greatest impediment to health in sub-Saharan Africa. *Int J Environ Res Public Health*. 2007;4(2):93-100.
2. Mullan F, Frehywot S, Omaswa F, Buch E, Chen C, Greysen SR, et al. Medical schools in sub-Saharan Africa. *Lancet*. 2011;377(9771):1113-21.
3. Asamani JA, Bediakon KSB, Boniol M, Munga'tu JK, Christmalls CD, Okoroafor SC, et al. State of the health workforce in the WHO African Region: decade review of progress and opportunities for policy reforms and investments. *BMJ Glob Health*. 2024;7(Suppl 1):e015952.

4. World Health Organization. Framework for action on interprofessional education and collaborative practice. Geneva: WHO Press; 2010. Available at: <https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice>. Accessed on 7 November 2025.
5. Reeves S, Perrier L, Goldman J, Freeth D, Zwarenstein M. Interprofessional education: effects on professional practice and healthcare outcomes (update). *Cochrane Database Syst Rev*. 2013;(3):CD002213.
6. Shuyi AT, Zikki LYT, Mei Qi A, Koh Siew Lin S. Effectiveness of interprofessional education for medical and nursing professionals and students on interprofessional educational outcomes: a systematic review. *Nurse Educ Pract*. 2024;74:103864.
7. Van Schalkwyk S, Amaral E, Anakin M, Chen R, Dolmans D, Findyartini A, et al. Disentangling faculty development: a scoping review towards a rich description of the concept and its practice. *Med Teach*. 2025;47(8):1304-25.
8. Steinert Y, Mann K, Centeno A, Dolmans DH, Spencer J, Gelula M, et al. A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8. *Med Teach*. 2006;28(6):497-526.
9. Celletti F, Reynolds TA, Wright A, Stoertz A, Dayrit M. Educating a new generation of doctors to improve the health of populations in low- and middle-income countries. *PLoS Med*. 2011;8(10):e1001108.
10. Health Professions Accreditors Collaborative. Guidance on developing quality interprofessional education for the health professions. Chicago: HPAC; 2019. Available from: <https://healthprofessionsaccreditors.org/wp-content/uploads/2019/02/HPACGuidance02-01-19.pdf>. Accessed on 7 November 2025.
11. Burdick WP, Diserens D, Friedman SR, Morahan PS, Kalishman S, Eklund MA, et al. Measuring the effects of an international health professions faculty development fellowship: the FAIMER Institute. *Med Teach*. 2010;32(5):414-21.
12. Dillman DA, Smyth JD, Christian LM. Internet, phone, mail, and mixed-mode surveys: the tailored design method. 4th ed. Hoboken: John Wiley and Sons; 2014.
13. Liani ML, Nyamongo IK, Pulford J, Tolhurst R. Institutional-level drivers of gender-inequitable scientific career progression in sub-Saharan Africa. *Health Res Policy Syst*. 2021;19(1):117.
14. McLeod PJ, Steinert Y. The evolution of faculty development in Canada since the 1980s: coming of age or time for a change? *Med Teach*. 2010;32(1):e31-5.
15. Steinert Y, Naismith L, Mann K. Faculty development initiatives designed to promote leadership in medical education: a BEME systematic review: BEME Guide No. 19. *Med Teach*. 2012;34(6):483-503.
16. Mubuuke AG, Mbalinda SN, Munabi IG, Kateete D, Opoka RB, Kiguli S. Knowledge, attitudes and practices of faculty on mentorship: an exploratory interpretivist study at a sub-Saharan African medical school. *BMC Med Educ*. 2020;20:192.
17. Sambunjak D, Straus SE, Marusic A. Mentoring in academic medicine: a systematic review. *JAMA*. 2006;296(9):1103-15.
18. Kashiwagi DT, Varkey P, Cook DA. Mentoring programs for physicians in academic medicine: a systematic review. *Acad Med*. 2013;88(7):1029-37.
19. Mezirow J. Transformative learning: theory to practice. *New Dir Adult Contin Educ*. 1997;74:5-12.
20. Steinert Y, Mann K, Anderson B, Barnett BM, Centeno A, Naismith L, et al. A systematic review of faculty development initiatives designed to enhance teaching effectiveness: a 10-year update: BEME Guide No. 40. *Med Teach*. 2016;38(8):769-86.
21. Merry L, Castiglione SA, Rouleau G, Letourneau D, Larue C, Deschenes M-F, et al. Continuing professional development (CPD) system development, implementation, evaluation and sustainability for healthcare professionals in low- and lower-middle-income countries: a rapid scoping review. *BMC Med Educ*. 2023;23(1):498.
22. Olasoji HO, Mu'azu AB, Garba MH. A study of clinical teachers' attitude to teaching and perceived learning needs in a medical college in Nigeria. *Adv Med Educ Pract*. 2019;10:605-17.
23. Levin KA. Study design III: cross-sectional studies. *Evid Based Dent*. 2006;7(1):24-5.
24. Lall P, Rees R, Law GCY, Dunleavy G, Cotic Z, Car J. Influences on the implementation of mobile learning for medical and nursing education: qualitative systematic review by the digital health education collaboration. *J Med Internet Res*. 2019;21(2):e12895.

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