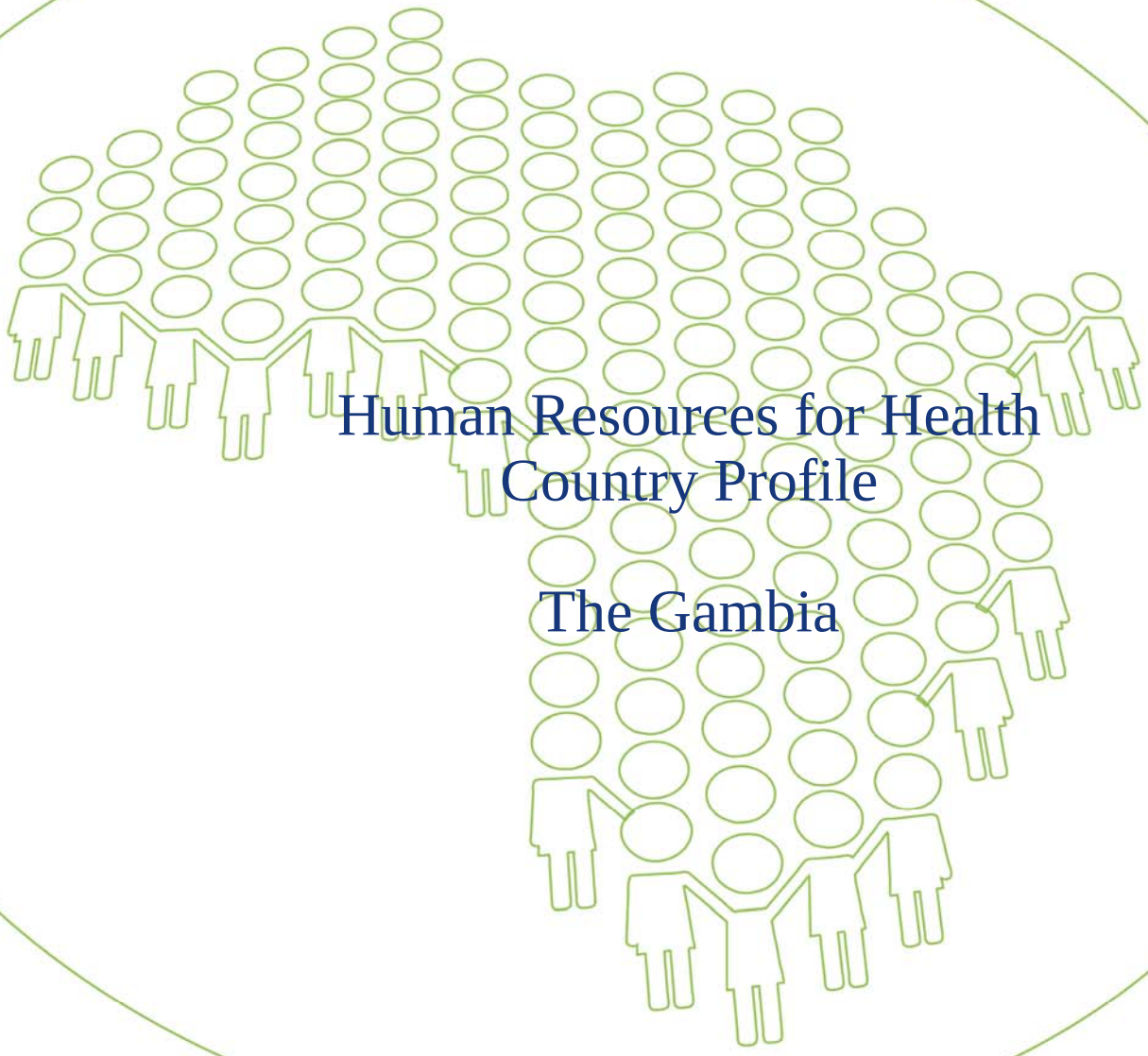

Human Resources for Health Country Profile

The Gambia

AHWO

AFRICA HEALTH WORKFORCE OBSERVATORY

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March 2009

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Content

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APRC	Alliance for Patriotic Reorientation and Construction
ARI	Acute Respiratory Infection
BHS	Basic Health Services
BSc	Bachelor of Science
CEO	Chief Executive Officer
CHN	Community Health Nurse
CMS	Central Medical Stores
CNA	Community Nurse Attendant
CNO	Chief Nursing Officer
CPD	Continuing Professional Development
DoSE	Department of State for Education
DoSFEA	Department of State for Finance and Economics
DoSH&SW	Department of State for Health & Social Welfare
DoSLG&L	Department of State for Local Government and ??
DPHN	Divisional Public Health Nurse
DPI	Department of Planning and Information
EC	European Commission
EPI	Expanded Programme on Immunization
ESU	Epidemiology and Statistics Unit
GAPHO	Gambia Association of Public Health Officers
HIS	Health Information Services
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HND	Higher National Diploma
HRH	Human Resources for Health
HRIS	Human Resources Information System
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ISTU	In-Service Training Unit
LGSC	Local Government Services Commission
MDC	Medical and Dental Council
MDGs	Millennium Development Goals
MTEF	Medium Term Expenditure Framework
MMR	Maternal Mortality Rate
MRC	Medical Research Council
NADD	National Alliance for Democracy and Development
NGO	Nongovernmental Organization
NMC	Nurses and Midwives' Council
NRP	National Reconciliation Party
OIC	Officer-in-Charge
OPD	Outpatient Department
PER	Public Expenditure Review
PHC	Primary Health Care
PHOs	Public Health Officers

PMO	Personnel Management Office
PNO	Principal Nursing Officer
PRSP	Poverty Reduction Strategic Plan
PSC	Public Services Commission
RHT	Regional Health Team
RHO	Regional Health Officer
RPHO	Regional Public Health Officer
RPHN	Regional Public Health Nurse
SEN	State Enrolled Nurse
SRN	State Registered Nurse
SRNM	State Registered Nurse Midwife
SWAp	Sector Wide Approach
TA	Technical Assistant
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UDP	United Democratic Party
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHS	Village Health Services
VHWs	Village Health Workers
WHO	World Health Organization

Tables

Figures

Executive Summary

The Gambia has a population of about 1.3 million. About 60% of the population lives in the rural areas; while the remaining 40% live in the urban areas. It is located in the southern part of the West African sub-region completely surrounded by the Republic of Senegal.

The Gambia is a former British colony and like many African countries has gone through health reforms in order to efficiently deliver health services to its population. The Gambia has predominantly a very youthful population with 64% of the population aged 24 or below. Average life expectancy at birth is 64 years and 51% of the population is female.

Health systems

The Gambia has a three-tier system comprising the Primary, Secondary and the Tertiary levels. The Primary level includes the Village Health Services and Community clinics; the Secondary includes Minor and Major Health centres while the Tertiary level is made up of hospitals and a Teaching Hospital. The Health sector is managed at two levels, the Central and Regional levels. The central level is organized into three directorates of Health Services, Planning and Information and Social Welfare.

The country is divided into six health regions each with a Regional Health Team (RHT) headed by a Regional Health Officer (RHO). The RHTs have overall responsibility for the Primary and Secondary health care facilities and their staff within their respective regions. The tertiary level, which comprises the hospitals and teaching hospital on the other hand, have semi autonomous boards and are headed by Chief Executive Officers and a Chief Medical Director respectively.

Data on health workforce

The Gambia Health sector has 4945 staff that includes 1150 community health workers (CHWs). The public sector employs 84% of staff while the remaining 16% are in the private sector. However, the Government does not recruit salaried CHWs but is responsible for their training and supervision. Out of the 3795 salaried staff 79% are employed in the public sector. The Public sector has 47% of professional staff and 53% support staff.

The Gambia has 162 Registered Nurses and 22 of them work in the private sector. Only nine of the 95 Physician Generalists work in the private sector. However there are 35 specialists working in the private sector compared to 45 in the Public sector. Pharmacists are predominantly found in the private sector.

The Gambia just like most developing countries still has challenges in the consistent collection of reliable human resource data. The data used in this profile was mainly from the situational analysis, the private sector study and a new database created by the DOSH&SW (using quarterly returns). There is an urgent need for the DOSH & SW to develop or purchase a reliable human resource information system that will provide regular staff information by age, gender, region and facility.

Distribution of health workforce

The Gambia also has an HR profile with majority of the professional health staff located in urban (66%) than rural areas. In addition, there are also regional variations in the distribution of health workers. Most of the health workers both public and private are within the Greater Banjul Area

(GBA) that is Kanifing and Banjul City Councils. In fact GBA has the highest percentages of all cadres. More than half of Physician Specialists, Dentists, Pharmacists and Laboratory Workers are found in the GBA. Sector HR statistics also show that majority (79%) of salaried professional health workers are employed in the public sector. It is however interesting to note that The Gambian health sector has no Faith Based Organizations (FBOs).

In order to fully outline the HR profile and distribution of the Gambia, there is definite need to carryout a survey to estimate the country's immigration and emigration. This could also cover the attrition profile of all health workers in Gambia.

Health workforce production

The Gambian government currently has the sole responsibility for health workforce production. The private sector has not yet been engaged in the training of health workers. There are six Health Training Institutions in the country. Three of these institutions, School of Nursing and Midwifery, School of Public Health and the School of Medicine (opened in 1999) are under the Department of State for Education while the Regional Ophthalmic Training is semi-autonomous and is sub-vented by Government. The Schools for Enrolled Nurses and Community Health Nurses are the only two institutions directly under the Department of State for Health.

The health training institutions in the Gambia currently do not have adequate capacity to meet the demands of the health service delivery. The lack of tutors and limited educational infrastructure are among the major impediments of these health training institutions. In addition, there are still some major health cadres such as pharmacy and laboratory staff that are not produced locally. In order to meet the service delivery demands the DOSH & SW have introduced a policy to double intakes of all locally produced health workers.

Health workforce utilization

The Gambia health sector has not been spared from the challenges of health workforce utilization. The high vacancy rate ranging between 35-45% in the public sector leaves a workforce that is over burdened especially in the rural areas. The most affected cadres are the Medical Doctor and Nurse cadres. The current low public sector salaries compared to the private even make the work environment more demotivating. It is these higher salaries in the private sector that make health workers to be better utilized in the private sector.

The Personnel Management Office (PMO) is responsible for recruitment, deployment, promotion, retention and management of the National Civil Service. It is through this unit that a number of HRH policy decisions have been implemented to improve the motivation and retention of health workers especially in the rural areas. The DOSH & SW have introduced a number of hardship, on-call and responsibility allowances in order to motivate public sector employees. In addition to the supervision mechanisms, the DoSH & SW is in the process of introducing a performance management package for the health sector. The PMO representative works with health professional associations to negotiate improvements in personnel matters and conditions of service.

Governance of HRH

The Department of State for Health (DoSH) recognizes the challenges it is faced with owing to the increasing demand for equitable and quality health services in the country. This recognition is exemplified by the clear National Health Policy, "Health is Wealth" (2007), the Public Expenditure

Review (2001), PRSP, HRH situational analysis (2003) and HRH policy (2005) including other sector policies and strategies.

The HRH Policy (2005–2009) was developed within the context of the National Health Policy of The Gambia. The main purpose of the HRH Policy is to elaborate further, the HRH component of the National Health Policy Framework – "Changing for Good" (2001), which states: Ensure appropriate and adequate human resource for the health Sector, with a view to addressing the HRH issues in a more comprehensive manner. It is also expected to serve as a guide to policy-makers, planners and implementers including private and public sector, as well as development partners, with regards to the planning, education/training and management including the appropriate utilization of HRH.

The HR Unit which is currently operating under the Directorate of Planning and Information (DPI) has the sole responsibility for HRH policy development, planning and management. There are plans to turn the HRH Unit into an independent Directorate. However it does not currently have the necessary HR capacities to be a directorate. The HRH Policy recommends the creation of a HRH Directorate but as of now it is operating as a small unit with few staff. At the regional level the Administrative Officer is designated as HRH focal person charged with the responsibility of HRH issues in the region.

Introduction

Human resources (HR) is a very crucial component in any country's health care system. However, it should also be noted that HR is a very delicate and mobile resource. The high attrition rate, acute staff shortages, staff motivation and retention issues reported in the National Health Policy – NHP (2001–2005), the Public Expenditure Review – PER (2001) and the Human Resources for Health (HRH) Situational Analysis Report – HRHSAR (2003), are clear examples of the complexity and challenges associated with HR. The need to establish and adequately support a system for the effective and efficient planning, development and management of HR in the health sector cannot therefore be over-emphasized.

Over the years, the DoSH has not adequately addressed HRH issues in a comprehensive and holistic manner. HR needs in terms of quantity and quality for both the public and private sector have not been appropriately projected and planned for. Also, the roles, linkages and relationship between the public and private health sectors have not been clearly defined.

Therefore, there is a need to develop a HRH country profile so as to show a clear picture of the HRH situation in the country. The purpose of the HRH country profile is to serve as a tool for:

- providing a comprehensive picture of the health workforce situation in the country;
- systematically presenting the HRH policies and management situation in a comparable way and to help monitoring of HRH stock and trends in the country;
- communicating with and between policy-makers and stakeholders in the country;
- strengthening the HR information system in the country by establishing evidence for baselines and trends;
- facilitating information sharing and cross-country comparisons;
- contributing towards producing regional HRH profiles.

Different sources of data were used to compile the HRH Country profile. However the mostly widely used source of data was the one compiled by the HR Unit using an excel spreadsheet to facilitate easy and regular updates. The spreadsheet does not capture the ages and gender of personnel. The public sector staff profile data on the spreadsheet was collected through HRH quarterly returns submitted by various regional heads and hospitals The private sector staff profile data was quoted from the Private Sector Study conducted in 2008 by the Directorate of Planning and Information.

Another possible source of HRH data is the National Treasury payroll but this has its shortfalls as some personnel such as the Cuban doctors and other expatriate staff who are not paid directly through this payroll are not captured.

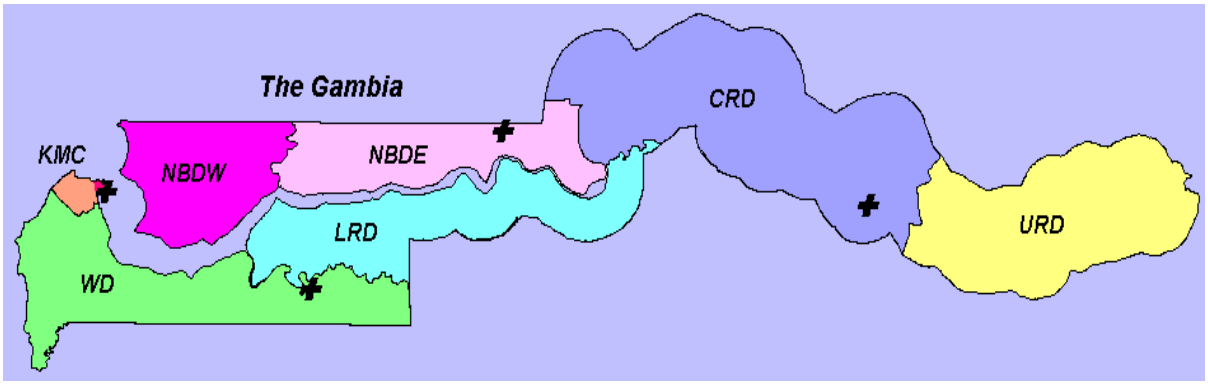
The health personnel training information was collected from the schools as they maintain individual school databases. The HRH office used such information for this exercise. The databases mainly contained information on students' annual inputs and outputs.

1. Country Context

1.1 Geography and demography

The Gambia forms a narrow stretch of land from the coast to about 400 kilometres inland, varying in width from about 50 kilometres near the coast to less than 35 kilometres inland. The Gambia has a land area of ten thousand, six hundred and eighty nine (10 689) Square kilometres and a population density of 127 persons per square kilometre. It is bordered on the east, north and south by the Republic of Senegal and on the west by the Atlantic Ocean (740 km length border with Senegal and 80 km coastline). It lies between latitudes 13.03 and 13.49 north and longitudes 13.47 and 16.48 west. The land is generally low lying with the highest point less than fifty meters above sea level. It has a tropical semi-arid or Sahelian climate characterized by two seasons (five months wet seasons from mid June to mid October, with a rainfall highest in August and seven months dry season the rest of the year). Drought conditions were experienced in the 1980s, but the rainfall pattern had shown improvement in recent years.

Figure 1 A map of The Gambia showing the regions/divisions



According to the National Census 2003, The Gambia has a population of about 1.3 million. About 60% of the population lives in the rural areas; while the remaining 40% live in the urban areas. It has a population growth rate of 2.7%, a high fertility rate as well as a heavy burden of disease with high maternal, child and infant mortality rates. The crude birth rate is 46 per 1000 population while the total fertility rate is 5.1 births per woman. The high fertility level has resulted in a very youthful population structure. According to the 2003 Census, nearly 45% of the population is below 15 years and 19% between the ages 15 to 24. Average life expectancy at birth is 64 years overall, with 63 and 65 for male and female respectively. About 51% of the population is female. Illiteracy rate especially among women is also very high. The 2003 Integrated Household Survey shows that, about 58% of the population lives below the poverty line i.e. US$ 1 per day.

Table 1.1 Per cent population distribution by age group and year

Age Group	2003	2004	2005	2006	2007	2008
0–14 years	42%	42%	42%	42%	42%	42%
15–59 years	52%	52%	52%	52%	52%	52%
60+ years	6%	6%	6%	6%	6%	6%
Total	100.0%	100.0%		100.0%	100.0%	100.0%
Total population	1 360 681	1 397 419	1 435 150	1 473 899	1 513 694	1 554 564

Source: 2003 Census.

Table 1.2 Population distribution by sex

Year	Total	Male	Female	Male/Female (%)	Growth rate (%)
2003	1 360 681	670 841	689 840	97.25	2.74
2005	1 435 150	707 556	727 594	97.25	2.74
2007	1 513 694	746 279	767 415	97.25	2.74
2008	1 554 564	766 429	788 135	97.25	2.74

Source: 2003 Census (estimates based on the 2.74% growth rate projected forward from 2003).

1.2 Economic context

The Gambia belongs to the less developed Country (LDC) category with per capita Gross Domestic Product (GDP) of around US$ 300. The Gambia is ranked 155 out of 171 in the HDI[1] with an estimated 62% of the population living below the poverty line with great disparity between rural and urban areas. The unemployment rate is currently estimated at 62.4% (2003) an improvement from 66.5% in 1993. The Agriculture sector employees the largest labour workforce with 75% of the population depending on agriculture as a source of income. Agriculture contributes 20% of the country's GDP. The main export cash crop for the country are groundnuts.

Currently domestic revenue is mainly from international trade tax and continues to be the major source of funding the national budget. In addition bilateral and multilateral grants and loans are also an important funding source for the national budget. However, fiscal deficit has been kept low at around 5% in the past two years, while inflation rate has ranged between 2.0% to 5.0%. The Gambia recently qualified for the HIPC completion point with substantial debt relief. The gains are expected be used to fund programmes in health and education sectors.

The Estimates and expenditure of the DoSH & SW for 2003, 2004 and 2005 show considerable fluctuations in government spending within the health sector. During the period 2003 to 2005, the total Government budget for the health sector ranged between 11% and 13% with 11% in 2005. However, in 2006 it dropped to 5.34% compared to Education's 7.3% and Agriculture's 2.9% of the same year (PRER 2006). The Department of State for Finance and Economic Affairs (DoSFEA) and the PMO through their "call circular of 2007" however, noted zero growth on the recruitment of personnel for the public sector in 2006. This was however, seen as a general routine circular for the whole public sector and was not expected to have any effect on the recruitment of health personnel in view of the gross shortages that the sector is encountering and graduates coming from the health training institutions who were accommodated in the budget estimates. The current health expenditure per capita per annum is US$ 10. It is expected to increase by 4.6%, taking into consideration the economic growth rate.

[1] UNDP Human Development Report 2006.

Table 1.3 Economic indicators

Indicators	2006	2007	2008	Source and year
GDP	$300	$300	$653	DoSFEA
National debt	-	-	$628.8m	DoSFEA
Economic aid	-	-	-	
Proportion of budget spent on health	5.3	7.5	7.98	DoSFEA
Annual income per capita	-	-	-	
Proportion of population living below poverty line		69 (1998)	58	2003 (HIS)
Proportion of > 5 population with malnutrition	17.1 (MICS III (2000)	-	19	MICS III 2005
Unemployment rate	62.4 (2003)	62.4 (2003)	62.4 (2003)	2003 census
Inflation rate	-	-	2.3%	

1.3 Political context

The Gambia is a democratic State and holds elections for the President and National Assembly members every five (5) years. There are forty-eight (48) National Assembly seats countrywide, which are contested for every election by an average of four Political Parties (APRC, UDP, NRP and NADD).

Health is among the main priority agendas for all the political parties in the country. The ruling APRC has three main areas of concentration and health is one of them. The president has the powers to appoint Secretaries of State who are the political leaders of government departments. At the National Assembly there are sub-parliamentary committees for different sectors and health has a subcommittee comprising of 10–15 national assembly members. This committee is responsible of health activities and can mount an investigation into health matters when it is necessary especially at the level of the National Assembly.

The Gambia is divided into seven local government administrations: two municipalities (Banjul and Kanifing) headed by mayors, and five regions headed by governors. In every municipality or region, there is an area council headed by a chairperson who is elected by the people during the local government elections. The mayors and councillors are elected by the people, but the Governors are appointed normally from the public servants by the Head of State. Governors serve as the representative of the Head of State in their respective areas. They also preside over the local development and coordinating committees and co-ordinate work of representative of line departments and public agencies within the Division.

The regions are subdivided into districts headed by district chiefs. There are 39 chieftaincy districts in the country. The Alkalos are the village heads who assist the Chief and Governors in the administration of the Division.

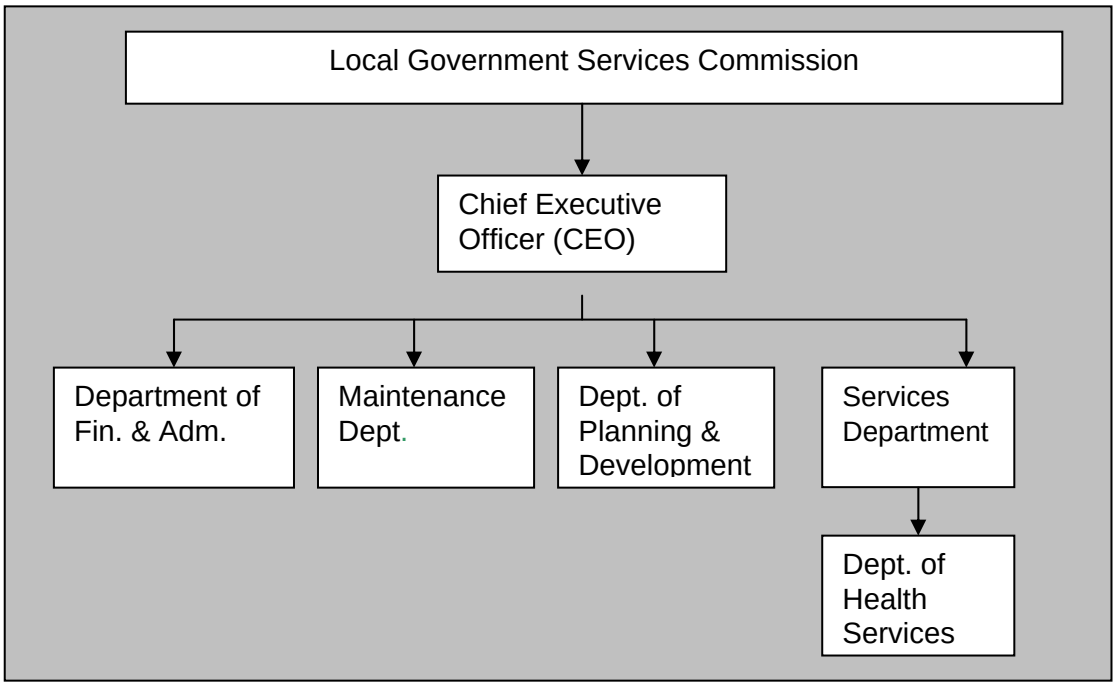
The Local Government Decentralization Policy and Act (April 2002) is expected to have important implications for the health workforce. The Local Government Act (April 2002) gives potential great autonomy to Local Area Councils and Local Services Commissions that form part of the Public Service. The present RHTs will be transformed into Divisional Health departments, the heads of which will report to the Chief Executive Officer (CEO) of the Council. Devolution of responsibilities from the Departments of State to the Councils will however be a gradual process that should take the capacities of the Councils into account.

According to the Decentralization Policy and Act (2002), the planning and management of Human Resource for Health will also be devolved to Local Government. The transfer of HRH from central to Local Government will be implemented by an intersectoral mechanism involving the Local Government, PMO, DOSH&SW and finance department. The proposed Local Government organizational structure below shows where the health teams and its subordinates will fall within the decentralized system.

The highest organizational and management body per each council will be the Local Government Services Commission (LGSC). There will be the Council Executive Officer (CEO) under this commission, heading departments including: finance and administration (DFA); planning and development (DPD); services (DS) including health etc; maintenance (DM). When the decentralization is fully effected, the salaries of health workers will be determined and paid by the councils. But as at now the salaries of all health workers are paid by the Department of State for Health (Government). Those working in the hospitals are paid by the hospital boards and the hospitals receive subvention from government.

Technical and auxiliary staff will fall under each of the above departments accordingly.

Figure 1.2 Local Government organization structure



It is worth noting that the Local Government Decentralization Act has not yet been effected.

1.4 Health status

The Gambia 2003 Census estimates the population at 1.36 million (2003), projected to reach 1.79 million by 2011, with an annual growth rate of 2.74%[2] representing a decline from 4.2% in 1993. Average life expectancy at birth is 64 years while crude birth rate is 46 per 1000 population. The total fertility rate is 5.4 births per woman. A high fertility and mortality rates combine to give

[2] The Gambia 2003 Census

The Gambia – a youthful population with nearly 44% of the population below 15 years and 19% between the ages 15 to 24. About 60% of the population live in the rural area; and women constitute 51% of the total population.

The Gambia's Infant Mortality Rate is estimated at 93/1000 live births and under five mortality rate at 131 per 1000 live births (MICS III, 2005 – 2006), attributable mainly to malaria, diarrhoeal diseases and acute respiratory tract infections. The Maternal Mortality Ratio is estimated at 556/100 000 live births, the majority of which are due to sepsis, haemorrhage and eclampsia (Fistula Study 2007) and is considered high.

Communicable diseases such as malaria, tuberculosis and HIV are the main causes of morbidity and mortality in adult population. Forty per cent (40%) of total outpatient consultation in 1999 was due to malaria, while diarrhoeal diseases and acute respiratory tract infections constitute about 25%. The proportion of smear positive tuberculosis cases identified increased from 56% in 2004 to 66.7% in 2005. Despite the low HIV prevalence rate of 2.8% (sentinel surveillance 2006), there is still the need for vigorous intervention to control the spread.

Noncommunicable diseases such as hypertension, diabetes, cancer and asthma are on the increase due to changing lifestyles and are becoming a serious burden on the public health services. Diabetes mellitus is estimated to affect about 1% of the population while a study found that about 16% of urban women are obese compared to only 1% of rural women. Malnutrition remains a major public health problem with 19% stunting, 6.8% wasting and 17% underweight.[3] Road traffic accidents are also becoming major public health issues in the country.

Considerable progress has been made in EPI coverage, with increases in national coverage for fully immunized children to 79.6 % for under one year olds and 84.9% for the under two year olds.[4] The Government has also invested in the expansion of health facilities and the recruitment of trained health personnel.

Table 1.4 Health indicators

Indicators	Both sex	Male	Female	Source and year
Life expectancy	64 yrs	63 yrs	65 yrs	2003 Census
Crude mortality rate	7.55/1000	-	-	2003 Census
Under-5 mortality rate	99/1000	-	-	2003 Census
Maternal mortality ratio	-	-	556/100 000	Fistulae Study (2007)
HIV/AIDS prevalence rate	2.8%	-	-	Sentinel Report (2006)
% safe water access	84%	-	-	MICS III (2006)

[3] MICS 2006.
[4] 2004 EPI Cluster Survey.

2. Country Health System

The Gambia has a three tier system comprising the primary, secondary and the tertiary levels. The primary level includes the Village Health Services and community clinics; the secondary includes minor and major health centres while the tertiary level is made up of hospitals and a teaching hospital.

Health care policy-making and most financial decisions, as well as logistical support and negotiations with funding agencies are provided from the "Central Level". This means that the management of personnel still falls within the Department of State for Health and Social Welfare (still sometimes referred to as the Department of State for Health or simply as DoSH or DoSH&SW).

Despite discussions about decentralization of the DoSH&SW, many decisions and important activities that routinely affect health care delivery are still controlled from Banjul. Examples of this include decisions on resource allocations (drug supply and other medical supplies, vehicles and fuel) and the central level control of hiring, firing and discipline of personnel who work in various provinces.

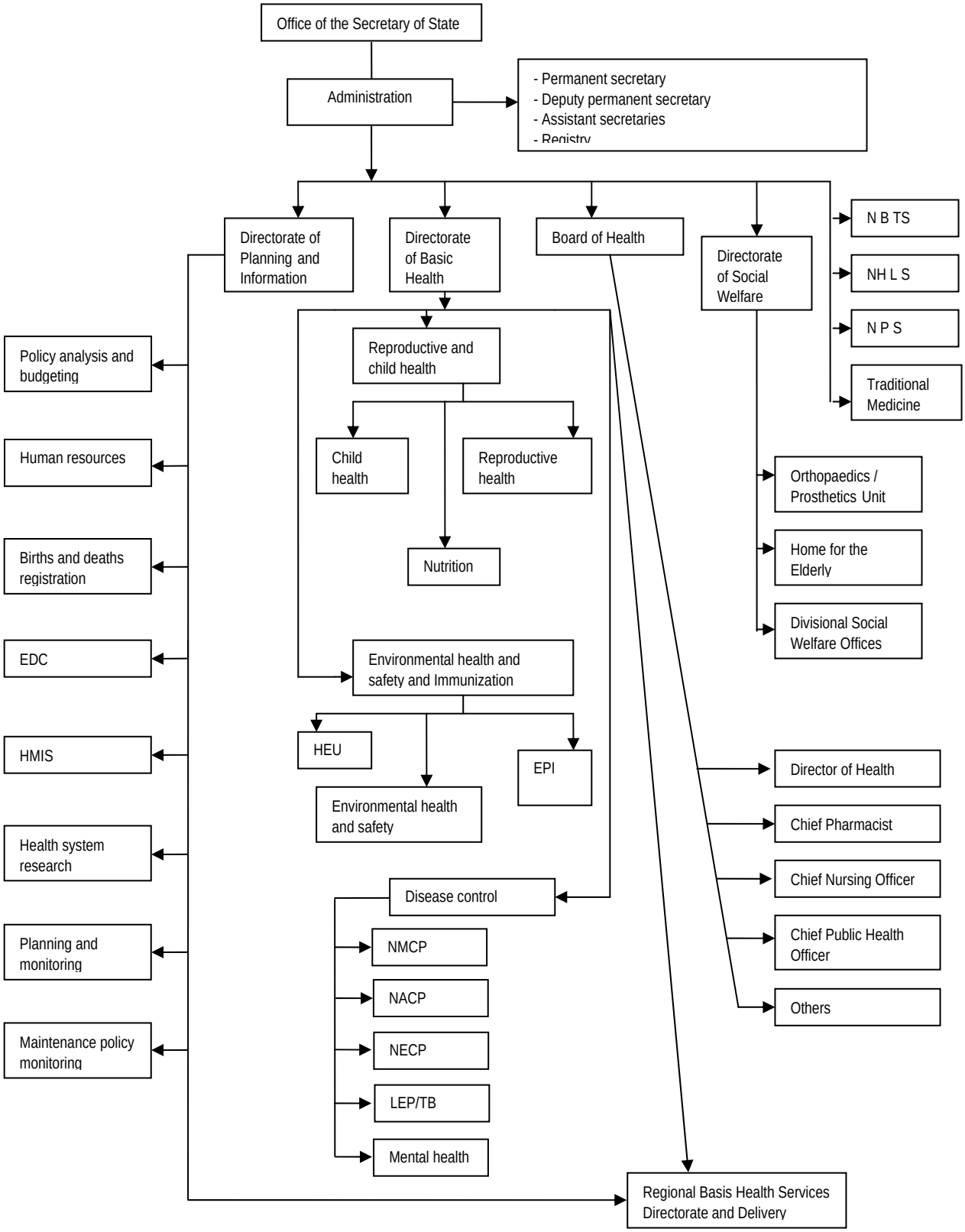
2.1 Governance

The Department of State for Health and Social Welfare (DOSH & SW) is the main government agency responsible for the health care delivery in the Gambia .The health sector is managed at two levels, the central and regional levels. At the central level, the Secretary of State and the Permanent Secretary are the Government’s appointees responsible for the whole health sector. To support the latter in the management of the health sector, the central level is organized into three directorates of Health Services, Planning and Information and Social Welfare. Public servants (directors) head these directorates. The central level is the decision-making point for the health sector’s internal issues.

The three directorates plan, direct, manage and coordinate all Government health care activities countrywide through specialized units. The relationship between these directorates is neither vertical nor horizontal but iterative.

The country is divided into six health regions each with a regional health team (RHT) headed by a Regional Health Officer (RHO). The RHTs are responsible for the day-to-day administration, management and supervision of health services in their respective regions. They have overall responsibility for the primary and secondary health care facilities and their staff within their respective regions. The RHOs are assisted by the Regional Public Health Officer, Regional Public Health Nurse, Senior Administrative Officer and other support staff. The tertiary level, which comprises the hospitals and teaching hospital on the other hand, have semi autonomous boards and are headed by chief executive officers and a Chief Medical Director respectively.

Figure 3.1 Organigram of the Department of State for Health & Social Welfare



The Department of State for Health (DoSH) recognizes the challenges it is faced with owing to the increasing demand for equitable and quality health services in the country. The development of a National Health Policy, "Health is Wealth" (2007), the Public Expenditure Review (2001), NHA (2007), PRSP, other sector policies and strategies are examples of the efforts being undertaken towards meeting such demand. The HRH situational analysis (2003) and HRH policy (2005) are part of such initiatives.

The HRH policy is within the context of the National Health Policy of The Gambia. In fact all other programme policies should be derived from the National Health Policy. The main purpose of the HRH Policy is to elaborate further, the HRH component of the National Health Policy Framework – Health is wealth (2007), which states: ensure appropriate and adequate human resource for the health sector**,** with a view to addressing the HRH issues in a more comprehensive manner. It is also expected to serve as a guide to policy makers, planners and implementers including private and public sector, as well as development partners, with regards to the planning, education/training and management including the appropriate utilization of HRH.

It is further developed to be consistent with other relevant policies and developments in the country, in particular the Poverty Reduction Strategic Plan (PRSP) and the Local Government Decentralization Act of April 2002. It takes into account previous studies and builds on a HRH situational analysis conducted between November 2002 and January 2003. The policy environment supports PHC and poverty reduction, and emphasizes: Increased Access to PHC services, Reduction of Infant and Child Mortality Rates and Reduction of Maternal Mortality Rate.

Preferably all health systems development processes should be integrated and overseen at policy level by one Steering Advisory Committee that is then further subdivided to form theme related subcommittees optionally with additional coopted members such as demanded by the character of the theme of the subcommittee.

2.2 Service provision

Health care services are provided by 4 hospitals at the tertiary level; 7 major health centres and 38 minor health centres at the secondary level; 38 village clinics and 492 health posts at the primary level. There is also one hospital under construction. The public health system is complemented by over 60 other special private, NGO and community managed health facilities. Formal health services in The Gambia are delivered mostly in health facilities funded by the Government of The Gambia. These facilities are also supported by a number of donors and NGOs. NGOs and private practitioners also provide services though most of them are located in the Greater Banjul Area. In addition, there are a large number of private pharmacies, drug sellers, and traditional healers that deliver health services of some kind.

Activities within the private sector of the health care delivery service are regulated and monitored by the Directorate of Health Services, a function that the regulatory bodies should be involved. The relationship between DoSH and the private sector health facilities is cordial.

The Government is the main provider of health services in the country. Health care services are funded by the Government through its annual budgetary allocation to the health sector. Donor partners such as UNICEF, WHO, UNDP, UNFPA, etc. also give maximum support to the health sector through programmes and projects' support.

2.2.1 Referral hospitals

There are currently four (4) major referral hospitals. These are: Royal Victoria Teaching Hospital in Banjul (serving the western third of the country and for special services unavailable elsewhere), Bansang Hospital in Bansang, Central River Division (serving the eastern half of the country) and a third hospital in Farafenni in the North Bank Division. This serves the central third of the country, particularly the North Bank, and is expected to reduce the patient load on the other two hospitals. A fourth hospital has just opened in Bwiam, Western Division, but still functions as a major health centre, and another one (Serrekunda hospital)is under construction in Kanifing.

The referral hospitals provide tertiary care for patients whose conditions cannot be handled at the basic health facilities. This would include major trauma requiring extensive surgery, complicated deliveries and cerebral malaria, among others. They have semi-autonomous status, with hospital management boards, and are not generally supplied or supervised by the RHTs. They do, however, have some important responsibilities to the RHTs, including reporting diseases incidences, maternal deaths, and providing feedback on patients referred to them by the VHS and basic health facilities. Communication between the hospitals and the RHTs is often poor.

The administration at the hospitals generally consists of the Chief Executive (often a physician) and several administrative support staff (administrator, accountant, procurement officer). The medical staff comprise of physicians (both consultants and medical officers) in medical, surgical, paediatric, ophthalmic, dental and obstetric/gynaecology specialities. These are sometimes Gambian, but are usually Cuban, Egyptian or Nigerian technical assistants. The Principal Nursing Officer (PNO) oversees a staff of SRNs (state registered nurse), SENs (state enrolled nurse), midwives (SRN/M and SEN/M) and nurse Attendants. X-ray, pharmacy, laboratory, medical record staff and orderlies complete the staffing profile.

2.2.2 Basic health service (BHS)

Functioning in parallel with the VHS are the basic health facilities. In the past only the health centres usually had physicians. In 1999 a large number of Cuban physicians arrived, providing all levels of basic health facilities with physicians.

Major health centres which admit patients (10 to20) should do some surgery if they have the staff to do so. SRNs and SENs are assigned to the inpatient wards and OPD clinics with the assistance of Community Nurse Attendants (CNAs). Nurse midwives are on staff establishment to run the labour and delivery ward. There are also positions for a pharmacy assistant and a laboratory assistant. Additional support staff include orderlies and ambulance drivers. There are six major health centres in the country.

Minor Health Centres admit patients but do not do surgery (except eye surgery, which is handled by the National Eye Care Programme-trained staff). The other staff positions include SRNs, SENs, CNAs and nurse midwives. There are 38 minor health centres.

The Assistant Public Health Officers (APHOs) are in charge of the immunization programme (Expanded Programme on Immunization or EPI) and are posted at each facility. Their other duties include disease surveillance, health education and environmental sanitation activities.

These BHS facilities provide the core outpatient (OPD) clinics and the Reproductive and Child Health (RCH) services. OPD clinics usually are held daily and treat children age five and above and all non-pregnant adults, as well as children less than five years and pregnant women. RCH clinics provide most of the health care to children under the age of five (Infant Welfare Clinic, IWC) and antenatal care for pregnant women. RCH base clinics are held at the facility one or two days per week. The rest of the week a trekking team visits a set schedule of outreach clinics in each health facility's catchments area. These trekking stations will be visited one to four times a month, depending on the number of people in the area.

The RCH team usually consists of a nurse midwife (the officer-in-charge, OIC), facility-based CHNs or CHN/midwives (with the addition of the VHS/CHN at some of the clinics), Community Nurse Attendant(s) (CNAs), an APHO for EPI activities and a Drug Revolving Fund (DRF) collector. The numbers of staff will vary with the size and importance of the facility and the catchment area which is always understaffed.

Gambian patients pay D5 for each OPD visit, while antenatal mothers and children under five years (RCH) do not pay for services. Non-Gambians pay for the same services. A single payment (non-Gambians) for the ANC service covers a woman throughout her pregnancy; non-Gambian infant registration covers a child up to the age of five.

Growth monitoring of children under five, antenatal care, immunisations and family planning services are all provided through these RCH base and trekking clinics. Supervision of the RCH team is carried out by the basic health facility and, ultimately, by the RHT.

Health centres and clinics run by NGOs supplement the government-run facilities and are supervised by the RHT in whose jurisdiction they operate. The Medical Research Council (MRC) is a British research organization which has some clinical services in Fajara, Keneba, Farafenni and Basse.

A few dozen private health clinics and many pharmacies also diagnose and prescribe treatment, particularly in the urban area. These are not integrated into the government system, and provide services for fees paid by the patients.

2.2.3 Village health service (VHS)

Primary health care villages have generally been selected from those with a population over 400 or occasionally from ones located in relatively isolated areas. In these villages, village health workers (VHWs) and traditional birth attendants (TBAs) are selected by the Village Development Committee (VDC). They are given 6 to 8 weeks of formal training in a centralized course with a standardized curriculum. All VHWs and TBAs have been trained through the Department of State for Health, but some of these trainings have been funded by Action Aid and the Italian Government in recent years. These workers are issued a start-up supply of drugs and equipment (minimal) at Government expense. A fee of D 0.75 is charged for each patient seen. This money is paid to the VDC treasurer to be used for the purchase of additional drugs and supplies as needed. The VDC and other village authorities are supposed to see that the community assists the VHWs with food contributions, farm work, etc. to enable them to take time to attend to the community's health needs. However, this does not always happen.

The VHW function as primary health care providers for minor illnesses and injuries, serving males and females of all ages. In addition, the VHW is supposed to function as a community-

based health educator and adviser. The TBA, as their name implies, have been part of the culture long before the formal health care system was introduced. They function as trained birth attendants, as antenatal and postnatal advisers, family planning distributors and health educators. Both TBA and VHW are expected to refer serious cases to the local health facility.

The VHWs and TBAs are supervised and given continuing education by VHS/Community Health Nurses (VHS/CHN) who oversee circuits of 4 to 10 PHC villages. This VHS/CHNs in turn report through their nearest BHS facility and is supervised by the OIC of that facility and by the Divisional Health Team. There are 492 PHC villages organized into 69 circuits. The CHNs are supposed to have motorbikes to travel their circuits.

The VHS/CHNs are essential for the successful functioning of primary health care in The Gambia. If they cannot, or do not, rigorously supervise and educate the VHWs and TBAs, then access to community-based medical treatment and health education could be seriously compromised.

2.3 Health care financing

Health financing system in The Gambia is organized through Government tax revenue, allocated by the Department of State for Finance and Economic Affairs to various financing agents, e.g. departments of Health, Education, Defence, Interior and Foreign Affairs. The contribution from direct out-of-pocket payments (OOPs) for health goods and services do not go through any resource pooling and risk-sharing mechanism. Some private sector operators (banks and NGOs) do provide medical cover for their employees, either through self-operated health clinics (e.g. Gambia Ports Authority (GPA) Clinic) or by paying premiums into private health insurance schemes. However, there is no social health insurance in the Gambia. Other innovation has been for the private sector to adopt hospital wards in health facilities for funding.

Health budget is classified as recurrent and development. Most of the funds are allocated to recurrent, as it is term as poverty spending. Before budget preparations, regions and programme units are sensitized to come up with their costed development programme for possible funding. Based on this, funds are allocated to regions and programme areas taking into consideration the priorities of the health sector. In implementing the budget, requests are made by the regions and programme areas monthly based on what is approved in the budget. Funds are then disbursed to them to implement activities.

Currently the funding from international donors (e.g. bilateral and multilateral agencies, Global Fund for AIDS, Tuberculosis and Malaria, GAVI) is channelled directly to the intervention programmes through the Department of State for Health. To a lesser extent the local government authorities also contribute to health financing in the area of environmental sanitation and the employment of auxiliary health workers.

User charges for services are being made as part of cost recovery programme introduced in 1988 to supplement the high Government expenditure in health. This was part of the Economic Recovery Programme/Structural Adjustment Programme of the eighties. Maternal and Child Health Services including family planning are offered free of charge

Formal community health insurance schemes do not exist in The Gambia. However, as part of community contribution to the health sector, some communities do construct health facilities or donate ambulances indicating opportunities to harness community resources to fund the health sector.

Government allocations to the health sector as a percentage of the total national budget continue to improve, ranging from 7% to 10% in the past five years.[5] This is still below the Abuja Declaration of 15% budgetary allocation to the health sector.

In 2007, the first National Health Accounts (NHA) for The Gambia was constructed covering the fiscal years 2002–2004. The results revealed marginal increase in total health expenditure (THE), moving from approximately D 1 185 223 103 in 2002; and D 1 395 958 522 in 2003; to D 1 682 323 673 in 2004. As a percentage of GDP, the THE was 16.1% in 2002, 13.9% in 2003 and 14.9% in 2004. Per capita health expenditure was D 895 in 2002, D 1026 in 2003 and D 1203 in 2004. This ranges between US$ 33 and US$ 40, almost matching the WHO Commission for Macroeconomics and Health (CMH) recommendation of US$ 34 per capita expenditure for a package of essential health services. It is instructive that the bulk of these funding came from donors as over 66% of the total health funding came from international health development partners.

Access to health services has greatly improved in the Gambia. Four new minor health centres have been constructed and are fully operational. The construction of Serekunda hospital has also been completed. The four new health centres have been commissioned but Serekunda Hospital is yet to open. In addition the upgrading of two major health centres (Kuntaur and Basse) into district hospitals is in progress. Thirteen dispensaries have been upgraded to minor health centres. There are about 38 village clinics in the country and are being run by Cuban personnel and Gambian nurses.

This increased geographical access has reduced the distance to the nearest basic health facility. This is in line with the National Health Policy, which recommends that all communities should be within 5km to the nearest health facility. However, the required functions of these facilities are limited due to lack of trained, skilled and motivated personnel.

2.4 Health information system

The Health Management Information System was formed in 2001 from the Epidemiology and Statistics Unit. It has six components in which HRH is one.

The Unit is managed by a manager who is a trained demographer and is supported by a statistician, a senior health information systems officer, IT technicians and data entry clerks. At the Regional level, there is a Health Information System focal person and every RHT has a data entry clerk. In addition the majority of the public health facilities also employ data entry clerks. All staff in the HMIS Unit are provided with computers.

The Unit receives data on quarterly basis from the RHT who receive data monthly from the health facilities. Data from the health facilities are verified at the RHT before being entered in a template by the data entry clerk. The RHT will then send the data on quarterly basis to the HMIS Unit who will also verify the data. So at each level data verification is done.

In 2007 the Unit harmonized all data collection tools in the health system so as to make collection easier and more accurate. It was during this time that a HRH quarterly return was developed and is filled by each health facility every quarter.

[5] Budget estimates for the period 2002–2007.

3. Health workers situation

There are about 4945 total staff in the health sector including CHWs (TBAs and VHWs). The public sector employs 84% of staff while the remaining 16% are in the private sector. CHWs comprise 1150 of the total staff. However, it should be noted that the Government does not officially recruit salaried CHWs. Nevertheless, the Government staff, including RHTs' members, are responsible for their CHWs' training and supervision. The total number of officially employed staff (i.e. salaried personnel), in the public and private health sector is 3795. The public sector employs 79% of the salaried employees. The public sector has 47% professional staff and 53% support staff.

3.1 Health workers stock and trends

There are 162 registered nurses in the country and only 22 work in the private sector. Of the 95 physician generalists only 9 work in the private but there are as many as 35 specialists working in the private sector compared to 45 in the public sector. However pharmacists are found more in the private sector than the public.

It is important to note that none of the cadres has reached the minimum health worker population ratio of 1:1000. The best so far are the nurses cadres, i.e. RNs 0.1/1000, ENs 0.13/1000 and enrolled midwives 0.14/1000 population. However, auxiliary nurses (who are untrained) have a population ratio of 0.36/1000 and CHW has 0.74/1000 population. Physicians both generalists and specialists are at 0.06 and 0.05/1000 population respectively. This is very alarming especially when you consider that about 60% of physicians in the public sector are expatriates.

So far there has been an increase in absolute numbers of health workers over the years.

Table 3.1 Health worker population ratios at national level
(See definition of each occupational category in annex)

Health occupational categories/cadres	2007		2008	
	Number	HW/1000 Population	Number	HW/1000 Population
Physicians (generalists)	89	0.06	95	0.06
Physicians (specialists)	70	0.05	80	0.05
Professional/registered nurses	103	0.07	162	0.10
Enrolled nurses	161	0.10	195	0.13
Auxiliary nurses	548	0.35	558	0.36
Registered midwives	92	0.06	115	0.07
Enrolled midwives (SEN & CHN)	160	0.10	223	0.14
Dentists	11	0.01	12	0.01
Dental technician	11	0.01	11	0.01
Dental assistant	24	0.02	24	0.02
Pharmacists	13	0.01	13	0.01
Pharmacy technician	5	0.00	6	0.00
Pharmacy assistant	39	0.03	56	0.04
Lab scientist	13	0.01	15	0.01
Laboratory technician	15	0.01	24	0.02
Laboratory assistant	52	0.03	60	0.04
Radiographer technicians	15	0.01	15	0.01
Physiotherapist	4	0.00	6	0.00
Community health nurses	169	0.11	132	0.08
Ophthalmic nurses	30	0.02	26	0.02
Environment & public health workers	59	0.04	79	0.05
Health management workers/skilled administrative staff	285	0.18	284	0.18
Other health support staff	1587	1.02	1604	1.03
Community health workers (VHWs & TBAs)	1156	0.74	1150	0.74
TOTAL	4711	3.03	4945	3.18

Source: HRH Unit 2008.

Table 3.2 Distribution of health workers for five past years

Health Occupational categories / cadres	2004*	2005*	2006*	2007	2008
Physicians generalists	95	98	113	89	95
Physicians specialists	71	68	62	70	80
Nurses	460	476	485	480	491
Midwives	235	256	268	269	338
Dentists	-	10	10	11	12
Pharmacists	15	11	11	13	13
Laboratory workers	40	57	62	80	99
Environment and public health workers	44	46	48	59	79
Health management and support workers	205	204	210	285	284
Other health workers	-	-	-	3355	3454
TOTAL	1165	1226	1269	4711	4945

Source: HRH Unit 2008
* Public sector only.

3.2 Distribution of health workers by category/cadre

3.2.1 Gender distribution by health occupation/cadre

The cadre that has the highest percentage of women is the nursing cadre especially the SRNs and SENs. Female nurses constitute about 52% of the total SRNs in the country. Fifty two per cent (52%) of the CHN and EN Midwives are women as well. This gender distribution among nurses is as a result of the priority given to women in the enrolment for SRNs and SENs.

However, in the public health cadre men form about 77% which shows that women are grossly under represented in this cadre.

Table 3.3 Gender distribution by health occupation/cadre
(See definition of each occupational category in annex)

Health Occupational categories/cadres	Total	Female	% Female
Physicians (generalists)	95	34	36
Physicians (specialists)	80	15	19
Professional/registered nurses	162	85	52
Enrolled nurses	195	95	49
Auxiliary nurses	558	302	54
Registered midwives	115	56	49
Enrolled midwives (CHN & SEN)	223	115	52
Dentists	12	2	17
Dental technician	11	3	27
Dental assistant	24	9	38
Pharmacists	13	2	15
Pharmacy technician	6	0	0
Pharmacy assistant	56	18	32
Lab scientist	15	2	13
Laboratory technician	24	4	17
Laboratory assistant	60	18	30
Radiographer technicians	15	2	13
Physiotherapist	6	1	17
Medical assistants/assistants medical officer	-	-	-
Community health nurses	132	53	40
Ophthalmic nurses	26	5	19
Environment and public health workers	79	18	23
Health management workers/skilled administrative staff	284	22	8
Other health support staff	1604	706	44
Community health workers (TBAs & VHWs)	1150	710	62
TOTAL	4945	2277	46

Source: HRH Unit 2008.

3.2.2 Age distribution by occupation/cadre

The Gambian health work force is very young. Most health workers are below 50 years and in some cases even below 30 years especially general nurses, dispensing assistants, laboratory assistants and public health workers. Most midwives are above 30 years as they are required to have some years' experience in the field before doing the midwifery programme. However, it is common among ward in-charges at the RVTH and health management and support workers to be above 50 years of age. The retirement age in The Gambia is 60 years. About 95% of health facility staff are below 50 years.

3.2.3 Region/province/district distribution by occupation/cadre

There are regional variations in the distribution of health workers. Most of the health workers both public and private are within the Greater Banjul Area (GBA) that is Kanifing and Banjul City Councils. Health staff such as dentist and pharmacists are rarely found in the rural areas and are 83% and 85% respectively in the GBA. In fact GBA has the highest percentages of all cadres. More than half of Physician Specialists, Dentists, Pharmacists and Laboratory Workers are found in the GBA.

Table 3.4 Regional/district/province distribution of workers

Health occupational categories	Total number	% GBA	% WR	% LRR	% NBW	% NBE	% CRR	% URR
Physicians generalists	95	46	18	5	5	8	13	4
Physicians specialists	80	81	9	1	1	3	4	1
Nurses	491	44	17	3	7	7	11	11
Midwives	338	49	18	5	6	6	9	7
Dentists	12	83	8	0	0	0	8	0
Pharmacists	13	85	8	0	0	0	8	0
Laboratory workers	99	60	13	1	2	13	8	3
Environment & public health workers	79	34	22	6	5	10	13	10
Health management and support workers	284	77	5	2	2	5	5	2

Source: HRH Unit 2008.
Note: See definition of each occupational category in annex.

3.2.4 Geographical distribution by occupation/cadre

There are imbalances in the distribution of health workers between urban and rural. Except for Community Health Nurses (CHNs) and Environmental/Public Health Officers (PHOs), all other cadres are more represented in the urban areas. However, about 77% of CHNs and 58% of PHOs are found in the rural areas.

Table 3.5 Urban/rural distribution of workers
(See definition of each occupational category in annex)

Health occupational categories	Total number	% urban	% rural	HW/1000 pop in urban	HW/1000 pop in rural
Physicians (generalists)	95	57	43	0.09	0.04
Physicians (specialists)	80	81	19	0.10	0.02
Professional/registered nurses	162	60	40	0.16	0.07
Enrolled nurses	195	66	34	0.21	0.07
Auxiliary nurses	558	57	43	0.51	0.26
Registered midwives	115	62	38	0.11	0.05
Enrolled midwives	223	78	22	0.28	0.05
Dentists	12	83	17	0.02	0.00
Dental technician	11	73	27	0.01	0.00
Dental assistant	24	58	42	0.02	0.01
Pharmacists	13	100	0	0.02	0.00
Pharmacy technician	6	67	33	0.01	0.00
Pharmacy assistant	56	55	45	0.05	0.03
Lab scientist	15	73	27	0.02	0.00
Laboratory technician	24	67	33	0.03	0.01
Laboratory assistant	60	52	48	0.05	0.03
Radiographer technicians	15	60	40	0.01	0.01
Physiotherapist	6	100	0	0.01	0.00
Community health nurses	132	23	77	0.05	0.11
Other technicians and health cadres*	26	54	46	0.02	0.01
Environment & public health workers	79	42	58	0.05	0.05
Health management workers/ skilled administrative staff	284	80	20	0.37	0.06
Other health support staff	1604	62	38	1.60	0.65
Community health workers (TBA & VHW)	1150	3	97	0.06	1.20

Source: HRH Unit 2008

3.2.5 Sector distribution by occupation/cadre

There are more health workers working in the public than the private sector. About 91% of Physician Generalists and 56% of Specialist are working in the public sector. Eighty six percent (86%) of Registered Nurses, 74% of Registered Midwives and 81% of Enrolled Midwives are employed by the public sector. However in the pharmacist cadre only 38% are employed in the public sector. There are also more Pharmacy Technicians in the private sector (83%) than the public sector (17%). Faith Based Organizations (FBOs) do not operate in the Gambia.

Table 3.6 Public/private for profit/faith based organization/private not for profit distribution of health workers

(See definition of each occupational category in annex)

Health occupational categories	Total number	% public sector	% private sector	% faith based organization
Physicians (generalists)	95	91	9	0
Physicians (specialists)	80	56	44	0
Professional/registered nurses	162	86	14	0
Enrolled nurses	195	78	22	0
Auxiliary nurses	558	95	5	0
Registered midwives	115	74	26	0
Enrolled midwives	223	81	19	0
Dentists	12	58	42	0
Dental technician	11	45	55	0
Dental assistant	24	75	25	0
Pharmacists	13	38	62	0
Pharmacy technician	6	17	83	0
Pharmacy assistant	56	82	18	0
Lab scientist	15	60	40	0
Laboratory technician	24	58	42	0
Laboratory assistant	60	83	17	0
Radiographer technicians	15	47	53	0
Physiotherapist	6	33	67	0
Community health nurses	132	91	9	0
Ophthalmic nurses	26	88	12	0
Environment & public health workers	79	100	0	0
Health management workers/ skilled administrative staff	284	88	12	0
Other health support staff	1604	72	28	0

Source: HRH Unit 2008.

*Please itemize on separate sheet of the names of cadre.

4. HRH Production

4.1 Pre-service education of health workforce

Pre-service training of health workers in The Gambia is the sole responsibility of the Government. The private sector has not yet been engaged in the training of health workers. There are about six health training institutions in the country, i.e. School of Nursing and Midwifery, School for Enrolled Nurses, School for Community Health Nurses, School of Public Health, School of Medicine of the University of The Gambia and the Regional Ophthalmic Training Centre. Three of these institutions (School of Nursing and Midwifery, School of Public Health and the School of Medicine are under the Department of State for Education while the Regional Ophthalmic Training is semi-autonomous and is sub-vented by Government. There are only two institutions directly under the Department of State for Health, i.e. schools for enrolled nurses and community health nurses which the ministry is mandated to run and has direct responsibility.

The relationship between the Ministries of Health and Education is very cordial. The Ministry sometimes uses fellowships at its disposal to train lecturers at the institutions under the education ministry and also support the schools at times in terms of logistics. Under the HRH policy it is stated that mechanisms will be put in place for closer collaboration between DOSH&SW and DOSE to allow cross transfer of teaching staff between training institutes run under the two departments and to reduce tutor shortage. The coordination of the quality and quantity of training is normally the responsibility of the ministries and the professional councils.

There are three separate nursing schools in The Gambia. The Gambia College School of Nursing in Banjul trains the SRNs who in addition to patient care have management and supervision roles in the facilities. SRNs begin as hospital-based nursing staff who can eventually progress to Ward-in-Charge, Officer-in-Charge, PNO or DPHN. This School of Nursing also conducts 18-month advanced midwifery and ophthalmic training programmes. A BSc nursing programme has been initiated by the University of The Gambia. Most SRNs in the civil service are based at hospitals.

The School of Enrolled Nursing in Bansang trains the next level of facility-based nurses, the SEN whose training is not as rigorous as that of the SRNs and whose role in the facilities is more general patient care. The majority of facility nurses are SENs.

The Community Health Nursing School, located in Mansakonko, trains nurses with a very different orientation, that is, the village-based community health nurses (CHN). These nurses live and work for the most part in primary health care villages, supervising the community health workers, doing health education and being the liaison between the health system and the community. Some of the CHNs are posted to the MCH teams.

The School of Public Health of The Gambia College, now located in Brikama, trains the Assistant Public Health Officers (APHO) in an HND awarding course, and a BSc programme has been initiated by the University. Advanced public health training is also obtained at various institutions outside The Gambia. This school is under the management of the Department of Education.

There is now a medical school under The Gambia University, which admitted its first class in October 1999. The programme, including basic science training and basic medicine, will take six years. It is estimated that with the current class intake, it would take many years to replace the expatriate physicians providing medical care in the country.

There are no training facilities for the pharmacists and pharmacy technicians. Currently, local on-the job training of dispensary assistants is provided by way of an 18-month structured programme of instruction undertaken at the RVTH leading to a DoSH Dispensary Assistant certificate. Some of these personnel trained on the job also leave the system after a few years. All other professional training of pharmacy personnel has to be undertaken out of the country.

Laboratory staff also do not have local training facilities. At present local training of laboratory assistants is provided by way of an 18 months structured program of instruction undertaken by employees within the health service and leading to a DoSH Certificate in Laboratory.

There are some bonding agreements signed between the Personnel Management Office and the trainees who are sponsored by the Government. The arrangements involve the number of years the individual should work for the DoSH after graduation, which normally depends on the duration of the program. But this bonding agreement is not adhered to and it is common to see bonded graduates getting employed to in the private sector just after graduating.

Table 4.1 Number of health Training Institutions by ownership in the country

Type of training institution	Type of ownership			Total
	Public	Private not for profit, FBOs	Private for profit	
Medical schools	1	0	0	1
Schools of dentistry	0	0	0	0
Schools of pharmacy	0	0	0	0
Nursing & midwifery schools	3	0	0	3
Health sciences training schools	-	-	-	-
Regional Ophthalmic Training Centre	1	0	0	1
Environnent & public health	1	0	0	1
TOTAL	6	0	0	6

Health Training Institutions were in the past years enrolling an average of 20 students per annum. Due to the inadequate number of qualified health personnel, the Department of State for Health and Social Welfare has embarked on accelerated training of health workers. Now intakes at all the training institutions have been doubled as a measure to minimize the shortage of trained health workers. The school of medicine enrols 20 or less annually mainly due to lack of space as the school is still using the school of Nursing and Midwifery premises.

Table 4.2 Training inputs in the health training institutions from 2005 to 2008

Cadre being trained	Actual annual inputs				Total input
	2005	2006	2007	2008	
Physicians	15	18	20	18	71
Nurses	145	130	123	80	478
Midwives	20	27	29	83	159
Laboratory workers	15	-	21	-	36
Environment & public health workers	40	40	38	37	155
TOTAL	235	215	231	218	899

It is important to note that all the schools lack capacity in terms of space, logistics and tutors. Therefore, the annual output is controlled by the capacity of these schools and not the market

demand. However, the Department of State for Health has been supporting especially by providing funds to the Gambia College for the accelerated training of SRNs. The rate of production of health workers does not match the required or needed health staff.

Table 4.3 Training outputs in the health training institutions from 2005 to 2008

Cadre being trained	Actual annual outputs				Total output
	2005	2006	2007	2008	
Physicians	-	-	11	12	23
Nurses	91	90	98	103	382
Midwives	20	22	29	89	160
Laboratory workers	-	14	-	20	34
Environment & public health workers	34	32	32	39	137
Total	145	158	170	263	736

4.2 Post-service and continuing education

Even though an In-service Training Coordinator has been appointed, there are still no guidelines and plans for in-service training and continuing education. A proposal is on the way to develop the first In-service Training Policy and Plan. What happens is that the various programmes/units provide in-service training for health staff in a vertical and uncoordinated way, bypassing the HRH Unit and interfering with the work schedules of the RHTs. In-service training is planned to be fully integrated into the Human Resource Development Unit. The Unit will be effectively strengthened and empowered to coordinate, plan and supervise implementation of in-service training in the context of performance management. This will be done in close consultation with programme units and RHTs, while encouraging development of capacity of RHTs to take on this responsibility.

Post-service training is regularly provided for health workers. After some years of experience in the health service delivery, nurses are trained to become midwives, perioperative nurses, nurse anaesthetists and ophthalmic nurses. Nurses and public health officers can also opt to enrol in the BSc programme at the University of The Gambia after some years of work experience in the service delivery system. Other post-service training opportunities are supported by the World Health Organization (WHO) and other UN agencies, the Commonwealth as well as the Government training vote under the Personnel Management Office.

4.3 Health workforce requirements

Table 4.4 Projections for health workforce requirements for the next five years

Cadre	2009	2010	2011	2012	2013
Medical doctors	357	367	377	387	397
Registered nurses	782	828	863	898	933
Enrolled nurses	442	470	510	550	590
Community health nurses	412	440	496	552	608
Environmental health officers	20	20	20	20	20
Pharmacists	16	19	22	25	28
Pharmacy technician	12	18	26	32	38
Pharmacy assistant	70		94-		118
Lab scientist	15	17	19	21	23
Lab technician	24	26	-	31	36
Lab assistant	74	88	102	116	130

Source: 15-year HRH Projection & Comprehensive Training Plan 2005.

5. HRH utilization

The Personnel Management Office (PMO) is responsible for personnel recruitment management functions of the entire National Civil Service. A liaison officer (Principal Assistant Secretary) from the PMO is working in the office of the Permanent Secretary of the DOSH&SW, expected to be working closely with the health profession representatives in the Health Services Department and the Planning and Information Department on matters of recruitment, transfers, promotions and other personnel matters including fellowships. Other stakeholder in the recruitment and management of personnel include the Public Services Commission.

In the health sector the vacancy rate ranges between 35–45%. It is more prominent in the rural areas than the urban areas. The most affected cadres are the medical doctor and nurse cadres.

There are many school leavers seeking to train as nurses in The Gambia and who are not employed. However, there are difficulties in recruiting more than 40 entrants to the three-year and two-year general health training programmes due to shortage of training staff, lack of space and inadequate logistics in the training institutions.

One of the major components of human resource management is motivation. It has been realised that this aspect has not been given the attention it deserves. The result is a large majority of human resources who are demotivated and not performing their work at the required standard. Up to 50% of the skilled human resources have avoided the demotivating circumstances by abandoning public health service jobs. This has resulted in a very high staff attrition rate in The Gambia health sector and a direct negative impact on quality of services, the health status and socioeconomic development of the nation.

Supervision of HRH is decentralized and RHTs normally supervise health workers in their respective regions. There is also quarterly supervision by the Central Level but this is not regular due mainly to lack of funds.

5.1 Recruitment

The health workforce is recruited by the Public Service Commission assisted by the Personnel Management Office. All graduates from the health training institutions are recruited into the health system unless the graduates opt otherwise. Few exceptions exist where other departments such as Interior, Defence, etc. send their staff to train in these institutions. There has been no reported case of an unemployed health professional other than those who have retired. All health professionals are employed, either in the public or private sector.

5.2 Deployment and distribution mechanisms

There is a Posting, Transfers and Promotion Review Committee (PTPRC). This Committee is responsible for the deployment and distribution of health staff. It consists of the Director of Health Services as Chair, Head of Cadres, and HRH focal person as Secretary. Job descriptions for most cadres are available but need to be reviewed.

After serving for two years in a particular area, a health worker can apply for redeployment to the PTPRC. The committee will review applications and act accordingly or otherwise depending on the situation.

5.3 The work environment

The Department of State for Health in a bid to motivate workers especially those in the rural areas, has created special staff allowances which were approved by the Department of State for Finance. These allowances include: risk allowances for all workers at the health centres, hardship allowances for trained staff in the rural areas, on-call-duty allowances for staff who are always on-call especially the midwives and responsibility allowances for officers-in-charge of health facilities.

There is high attrition within the health sector especially skilled staff such as nurses, doctors, public health officers and midwives both internally and externally. A study conducted in November 2002 on the attrition of health personnel by a consultant and Directorate of Planning and Information estimated the attrition to be between 30% and 50%. Majority were said to be nurses with public health officers ranking second. It is stated that at least 50% of the public health cadre who graduated within the last 10 years left the service. About 100 nurses, mostly SRNs and senior SENs in grades 6, 7 and 8, left Royal Victoria Teaching Hospital between 2001 and 2004.

During the HRH situational analysis in 2003, the analysis on the causes of staff attrition cited the following:

1. Very low salaries compared to cost of living.
2. Unfriendly and unconducive working environment.
3. Inadequate and poorly maintained staff houses.
4. Perceived favouritism in the selection for continuing education, up-grading and fellowships.
5. Lack of recognition and reward for excellence.

5.4 Employment of health workers in the private sector

Salaries of health workers are set out by the General Public Service based on the salary scales and grade steps for every established post throughout the public sector. Staff salaries and other emoluments accounted for 35% of total health budget in 2004 and declined to 33% in 2005. The Department of Finance is determined to maintain this zero growth in future regarding the proportion of DoSH budgets allocated to personnel costs in any one year. However, monthly salaries of health workers in the public sector are very low compared to those in the private sector. A nurse working for part-time in the private sector earns twice more than his monthly salary at the public sector.

Table 5.1 Showing salary information for health workers (excluding allowances)

Cadre	Minimum salary (monthly) in US$	Maximum salary (monthly) in US$
Medical doctors	178	274
RN midwives	130	150
En midwives	87	107
Enrolled nurses	54	67
Environmental health officers	108	128
Pharmacists	130	233
Pharmacy technician	68	86
Pharmacy assistant	46	54
Lab scientist	130	233
Lab technician	68	86
Lab assistant	46	86

Source: Government integrated pay scale 2008.

5.6 Supervision systems and mechanisms

There is no performance management system in place but there is the intention to develop one to guide supervisors. However some RHTs do give annual incentives for the best health worker in each cadre in their respective regions. This is done during their supervision visits to the facilities. Here they look at a host of things such how the individual is executing his/her duties, how patients are treated etc, and also interview some service users on the performance of the individual staff.

6. Governance for HRH

The Department of State for Health (DoSH) recognizes the challenges it is faced with owing to the increasing demand for equitable and quality health services in the country.

The development of a National Health Policy, "Health is Wealth" (2007), the Public Expenditure Review (2001), PRSP, other sector policies and strategies are examples of the efforts being undertaken towards meeting such demand. The HRH situational analysis (2003) and HRH policy (2005) are part of such initiatives.

6.1 HRH policies and plans

The HRH Policy (2005– \2009) was developed within the context of the National Health Policy of The Gambia. The main purpose of the HRH Policy is to elaborate further, the HRH component of the National Health Policy Framework – "Changing for Good" (2001), which states: "ensure appropriate and adequate human resource for the health sector, with a view to addressing the HRH issues in a more comprehensive manner". It is also expected to serve as a guide to policy-makers, planners and implementers including private and public sector, as well as development partners, with regards to the planning, education/training and management including the appropriate utilization of HRH.

6.2 Policy development, planning and managing for HRH

The HR Unit which is currently operating under the Directorate of Planning and Information (DPI) has the sole responsibility for HRH policy development, planning and management. There are plans to turn the HRH Unit into an independent Directorate. However, it does not currently have the necessary HR capacities to be a directorate. It has a total staff complement of four; three are graduates in Public Health (BSc) from the University of The Gambia, while the remaining one is currently pursuing the BSc Programme at the University of The Gambia but has a wealth of experience in the health sector. The HRH Policy recommends the creation of a HRH Directorate but as of now it is operating as a small unit with few staff. Below is the staffing profile of the HRH unit.

Table 6.1 The HR Unit staff establishment

Health Occupational categories / cadres	Establishment
Principal human resource officer	1
Principal HRD officer (education & training)	1
Senior HRM officer	1
Human resource planner	1
In-service training officer	1
Typist	1

At the regional level the Administrative Officer is designated as HRH focal person charged with the responsibility of HRH issues in the Region.

During the most recent policy development and planning exercise the HR Unit was supported by some committees which included:

1. The HRD team composed of the Principal Assistant Secretary (DoSH), the Head of HRD Unit of DPI, Head of ISTU and the Technical Officer Human Resources (HRD Specialist, WHO).

2. HRH Technical Working Group: Members included the Deputy PS, DoSH Directors, HRD Directors of DoSE and PMO, Local Government representatives (decentralization programme), Finance (PRSP Coordinator), registrars and principals of schools, the HRD team, RHT representative and appropriate representation from the private sector.

3. HRH Steering & Advisory Committee: is a multidisciplinary body at policy level with high level representation including the Chair of the HRH TWG, permanent secretaries for DoSH, DoSE, Local Government, Finance, PMO, the Vice Chancellor of the Gambia University College, the private and NGO sectors, a high level representative of the civil society and the WHO Representative (WR). The Director of Planning and the HRD Team serve as the committees' secretariat.

However, it is pertinent to note that none of the last two committees are functioning as expected.

The Local Government Decentralisation Policy and Act (April 2002) is expected to have important implications for the health workforce. The Local Government Act (April 2002) gives potential great autonomy to local area councils and local services commissions that form part of the Public Service. The present RHTs will be transformed into Regional health departments, the heads of which will report to the Chief Executive Officer (CEO) of the Council. Devolution of responsibilities from the Department of State to the councils will, however, be a gradual process that should take the capacities of the councils into account.

According to the decentralization policy and act (2002), the planning and management of Human Resource for Health will also be devolved to Local Government. The transfer of HRH from central to Local Government will be implemented by an intersectoral mechanism involving the Local Government, PMO, DOSH&SW and Finance Department.

6.3 Professional associations' regulations

The Medical and Dental Council, the Nurses and Midwife Council and Pharmacy Board are the principal regulatory bodies for HRH in the country, while the Gambia Association of Public Health Officers (GAPHO) handles the affairs of PHOs. The councils are autonomous bodies involved in professional regulation, certification, accreditation and registration. The registration system exists to protect the public and it is the hallmark of the trust and confidence that society has in the professions. It is also a necessary recognition of the vulnerability of clients/patients and the need for protection from unqualified practitioners. All qualified health workers are required to register with their professional councils and pay an annual registration fee.

However, the regulatory bodies are very resource constraint and lack capacity. Considerable time of the registrars is further taken for writing confirmation of registration status letters for professionals who are looking for employment abroad. Mechanisms for dealing with malpractice and professional misconduct are inadequate and responsiveness of the health system to clients' needs and rights is compromised.

Professional practice acts promulgated to meet the needs of the time are outdated and need to be revisited with a view to amending them where necessary.

There is no system in place for staff performance appraisal. Quality assurance culture, guidelines and mechanisms are also lacking. Reviewing and developing comprehensive job descriptions for all cadres is in the pipeline.

6.4 HRH information

A computerized Human Resources Information System (HRIS) was developed in 2003, as part of the Health Management Information System (HMIS). Presently the process of reviewing the database is in progress and hopefully it will be done in 2009. The present HRIS captures personnel information data such as: name, age, designation, sex, marital status, qualifications, location, place of birth, etc. however, it does not capture the posting history of workers as well as the type of training acquired which we want to incorporate when we revised it.

An HMIS unit exists, which captures six components of health service data including HRH.

In 2007, a new revised data collection tool was developed for HRH, which is expected to be filled every quarter by health facilities. The data will then be processed through the HMIS system. However, this tool only captures the number of health workers, sex, attrition and in-service trainings attended. The HRIS does not capture private sector health workers. Lack of private sector HRH data is one of the weaknesses of the HRIS.

6.5 HRH research

Although there is a health systems research unit under the Directorate of Planning and Information with an officer trained on research proposal development, research methodology, data collection, analysis and report writing, indications are that only one research on attrition of HRH has been conducted. It was funded by the Participatory Health Population and Nutrition Project (PHPNP) – a World Bank funded project. The result has helped in the development of the HRH Policy and Strategic Plan as well as in HR planning and management. A proposal has been made to conduct a survey on the impact of staff incentives on motivation and retention in 2009.

6.6 Stakeholders in HRH

No.	Name	Roles	Level
1	Department of State for Health	– Initiate HRH research – Provide relevant HRH data – Provide motivation and retention	National
2	Department of State for Education	– Improve the standards of the health training institutions – Increase annual intakes – Train health workers	National
3	Ministry of Finance	Provide funds in support of HRH	National
4	Personnel Management Office	– Recruitment of HRH Staff promotion	National
5	Professional associations	– Regulate professional standards – Registration and accreditation.	National
6	WAHO	– Technical support – Software and systems installation – Facilitate regional HRH networking – Harmonize HRH data	International
7	WHO	– Technical and financial support – Software and systems installation – Support HRH research	International

Annex 1: Health Workforce Status

Skill level	Total	Total women	Urban	Rural	Public	Private
Physicians (generalists)	95	34	54	41	86	9
Physicians (specialists)	80	15	65	15	45	35
Professional/registered nurses	162	85	98	64	140	22
Enrolled nurses	195	95	128	67	153	42
Auxiliary nurses	558	302	319	239	528	30
Registered midwives	115	56	71	44	85	30
Enrolled midwives	223	115	175	48	181	42
Dentists	12	2	10	2	7	5
Dental technician	11	3	8	3	5	6
Dental assistant	24	9	14	10	18	6
Pharmacists	13	2	13	0	5	8
Pharmacy technician	6	0	4	2	1	5
Pharmacy assistant	56	18	31	25	46	10
Lab scientist	15	2	11	4	9	6
Laboratory technician	24	4	16	8	14	10
Laboratory assistant	60	18	29	31	50	10
Radiographer technicians	15	2	9	6	7	8
Physiotherapist	6	1	6		2	4
Medical assistants/assistants medical officer	-	-	-	-	-	-
Community health nurses	132	53	30	102	120	12
Ophthalmic nurses	26	5	14	12	23	3
Environment & public health workers	79	18	33	46	79	0
Health management workers/skilled administrative staff	284	22	228	56	250	34
Other health support staff	1604	706	994	610	1151	453
Community health workers	1150	716	35	1115	1150	0
TOTAL	4945	2283	2395	2550	4155	790

Annex 2: Definitions of Health Workforce Data

Health Workforce: Aggregated Data

In the aggregated data, the health workforce is grouped into the following 10 categories:

Physicians
Includes generalists and specialists.

Nurses
Includes professional nurses, auxiliary nurses, enrolled nurses and other nurses, such as dental nurses and primary care nurses.

Midwives
Includes professional midwives, auxiliary midwives and enrolled midwives. Traditional birth attendants, who are counted as community health workers, appear elsewhere.

Dentists
Includes dentists, dental assistants and dental technicians.

Pharmacists
Includes pharmacists, pharmaceutical assistants and pharmaceutical technicians.

Laboratory workers
Includes laboratory scientists, laboratory assistants, laboratory technicians and radiographers.

Environment and public health workers
Includes environmental and public health officers, sanitarians, hygienists, environmental and public health technicians, district health officers, malaria technicians, meat inspectors, public health supervisors and similar professions.

Community health workers
Includes traditional medicine practitioners, faith healers, assistant/community health education workers, community health officers, family health workers, lady health visitors, health extension package workers, community midwives, institution-based personal care workers and traditional birth attendants.

Other health workers
Includes a large number of occupations such as dieticians and nutritionists, medical assistants, occupational therapists, operators of medical and dentistry equipment, optometrists and opticians, physiotherapists, podiatrists, prosthetic/orthotic engineers, psychologists, respiratory therapists, speech pathologists, medical trainees and interns.

Health management and support workers
Includes general managers, statisticians, lawyers, accountants, medical secretaries, gardeners, computer technicians, ambulance staff, cleaning staff, building and engineering staff, skilled administrative staff and general support staff.

Annex 3: Health Workforce Classification Mapping

International classification			National classification	
Category	**Skill level**	**Definition [ISCO-88]**	**Name of equivalent national category**	**National definition(s)**
1. Physicians Also called doctors or medical officers	Generalist	At least five years of university, some years of internship depending on the country might be compulsory. They have a full array of clinical skills.		
	Specialist	At least have five years of university; some years of internship depending on the country might be compulsory, and specialist training. They have a full array of clinical skills and specialization.		
2. Nurses	Professional registered nurses	Also called professional or licensed nurses (or Infirmiers Diplômés d'Etat). Their education last about three, four or more years in nursing school, and lead to a university or postgraduate university degree, or the equivalent. They have full range of nursing skills.		
	Enrolled nurses	Also called nurse technician or associate nurse. Education last about three to four years and leads to an award not equivalent to a university first degree (post-secondary school). Common nursing skills. They can perform simple as well as complex medical procedures and usually operate under the supervision of professional registered nurses or physicians.		
	Auxiliary nurses	Also called assistants. Some training in secondary school. A period of on-the-job training may be included, and sometimes formalised in apprenticeships. Basic nursing skills, no training in nursing decision-making.		
3. Midwives	Registered midwives	Also called professional or licensed midwives (or Sages-femmes Diplômés d'Etat). Their education last about three, four or more years in nursing school, and lead to a university or postgraduate university degree, or the equivalent. They have full range of midwifery skills.		

International classification			National classification	
Category	**Skill level**	**Definition [ISCO-88]**	**Name of equivalent national category**	**National definition(s)**
	Enrolled midwives	Also called nurse technician or associate midwife. Education last about three to four years and leads to an award not equivalent to a university first degree (post-secondary school). Common midwifery skills		
	Auxiliary midwives	Also called assistants. Some secondary school training. A period of on-the-job training may be included, and sometimes formalized in apprenticeships Basic midwifery skills.		
	Traditional birth attendants	Mainly, on-the-job training and sometimes formalised in apprenticeships. (matrones traditionnelles, TBAs).		
4. Dentists	Dentists	At least five years of university leading to a dentistry degree. Full array of dentistry skills.		
	Dental technician	From two to three years in dentistry school, with an award not equivalent to university degree (post-secondary school). Common dentistry skills.		
	Dental assistant	About two to three years in secondary school training. A period of on-the-job training may be included, and sometimes formalised in apprenticeships. Basic dentistry skills.		
5. Pharmacists	Pharmacists	At least five years of university leading to a pharmaceutical degree. Full array of pharmaceutical skills.		
	Pharmaceutical technician	From two to three years in pharmaceutical school, with an award not equivalent to university degree (post-secondary school). Common pharmaceutical skills.		
	Pharmaceutical assistant	About two to three years in secondary school training. A period of on-the-job training may be included, and sometimes formalised in apprenticeships. Basic pharmaceutical skills.		

International classification			National classification	
Category	**Skill level**	**Definition [ISCO-88]**	**Name of equivalent national category**	**National definition(s)**
6. Physiotherapist		From two to three years in physiotherapy school, with an award not equivalent to university degree (post-secondary school). Common physiotherapy skills.		
7. Medical assistants Also called assistants medical officers		From to two to three years in medical post-secondary school plus at least 1.5 years in an up-grading programme. Advanced clinical skills.		
8. Clinical officers		From to two to three years in post-secondary school. Common clinical skills.		
9. Laboratory scientists	Lab scientist	At least five years of university degree. Full array of laboratory procedures.		
	Laboratory technician	From two to three years in laboratory technology school, with an award not equivalent to university degree (post-secondary school). Common range of laboratory procedures		
	Laboratory assistant	About two to three years in secondary school training. A period of on-the-job training may be included, and sometimes formalised in apprenticeships. Basic laboratory procedures.		
10. Radiographer technicians		From two to three years in school of radiography, with an award not equivalent to university degree (post-secondary school). Common range of radiography skills.		
11. Environmental and public health officers	Environmental and public health officers professionals	At least five years in university or equivalent. All health workers involved in providing social services to the community looking for a better environment and therefore promoting health with high skill level. For instance epidemiologists or sanitation engineers, among others.		

International classification			National classification	
Category	**Skill level**	**Definition [ISCO-88]**	**Name of equivalent national category**	**National definition(s)**
	Environmental and public health officers technicians	From two to three years training. This includes all environmental health, health inspectors, health promotion officers, health educators and all who is concerned with public health promotion. (Please provide the full list of what you include under this category.)		
12. Other technicians and health cadres		From two to three years in a determined health school. This category can be used for health cadres like nutritionist/dieticians, optometrists, social worker, among others. (Please provide the full list of what you include under this category		
13. Community health workers		A period of on-the-job training may be included, and sometimes formalised in apprenticeships.		
14. Administrative and support staff	Skilled administrative staff	Having obtained a professional degree. All those related with tasks like: directors, management, financial services inspector, accountants, statisticians, economists, engineers.		
	Other support staff	Have an associate degree or less. All those related with tasks like: secretaries, electrician, drivers, security guards, cooks.		
15. Others	Please list the health workers to be include under this category and provide a definition of them			

Annex 4: Members involved in the Working Group

Name	Position/title	Organization	Contact address
Sekou Omar Toure	Director	Directorate of Planning and Information	
Mamat Cham	HRH Focal Person	Directorate of Planning and Information, HRH Unit	
Ousman N. Jarjue	HR Officer	Directorate of Planning and Information, HRH Unit	
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Modou Ceesay	Health Economist	WHO Country Office	