REPUBLIC OF THE GAMBIA

MINISTRY OF HEALTH

DIRECTORATE OF HUMAN RESOURCES FOR HEALTH (DHRH)

HUMAN RESOURCES FOR HEALTH OVERVIEW

MAY 2023

Human Resources for Health (HRH), The Gambia

The Gambia HRH policy, aligned with the new National Health Policy (2021-2030), has been revised and followed by the development of the HRH Strategic Plan (2022-2026). However, with the increased demand for healthcare workers during the COVID-19 pandemic, the planned provisions of the HRH plan were disrupted, leading to some delays in the implementation of the HRH Strategic Plan. However, the coordinated implementation of the HRH Plan is considered an absolute priority.

The staffing norms for all three levels of service delivery (primary, secondary, and tertiary health facilities) have been reviewed and updated. Staffing norm is a human resource planning tool that gives an indication of the number and caliber of staff required in any given health facility. The staffing norms are now in line with the needs of the health sector and align well with the package of essential care developed by the MoH with technical support from partners.

In a bid to meet the required staffing norm, the MoH, with support from partners, undertakes accelerated training of medical specialists and other cadres of healthcare professionals with the greatest skill gap.

Gambia Health workforce profile

The Gambia has a Human Resources for Health (HRH) profile, with the majority of the professional health staff located in urban (78.89%) rather 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 percentage of all cadres. More than two-thirds of physician specialists, dentists, pharmacists, and laboratory workers are found in the GBA.

Over the years, the MoH has engaged in addressing HRH issues in a comprehensive and holistic manner. Thus recognizing HRH projection and plan needs in terms of quantity and quality for both the public and private sectors. Also, the roles, linkages, and relationships between the public and private health sectors have been adequately addressed in the national and HRH policies.

Current HRH Situation

The current HRH situation, such as the health worker population density threshold, etc., is as follows: The skilled health worker density threshold nationally is 1.55 per 1000 population (3791) and sub-nationally is as follows: Western Region I (WRI) 2.22 (2190), Western Region II (WRII) 0.86 (469), Lower River Region (LRR) 1.54 (137), Central River Region (CRR) 1.29 (338), Upper River Region (URR) 0.73 (214), North Bank East Region (NBER) 1.90 (252), and North Bank West Region (NBWR) 1.07 (142). See tables 1 and 2 below for the density threshold for selected health professionals.

Density Threshold of Selected Health Professionals

No.	Cadre	Number of Health Workers	Density threshold per 1000 pop
1	Medical doctors	231	**0.09**
2	Nurse midwives	667	**0.27**
3	General Nurses	1104	**0.45**
4	Public health personnel	306	**0.13**
5	Pharmacy personnel	116	**0.05**
6	Laboratory personnel	189	**0.08**

It is important to note that no health professional cadre has met the 4.45/1000 population recommended density threshold of the WHO.

While there are regional variations in terms of density thresholds for various cadres, the data shows that no region has met the WHO-recommended threshold.

Regional Density Threshold of Skilled Health Workers

No.	Region	No. of HWs	Density threshold per 1000pop	Pop estimate (2021)
1	**WRI**	2190	2.22	985,183
2	**WRII**	469	0.86	544,354
3	**LRR**	137	1.54	89,157
4	**CRR**	338	1.29	262,851
5	**URR**	214	0.73	291,293
6	**NBER**	252	1.90	132,740
7	**NBWR**	142	1.07	133,320
	NATIONAL	3742		**2,438,899**

The data from this table above indicates all the regions are understaffed. Going by the recommended WHO density threshold of 4.45 health workers per 1000 people, West Coast Region II (WRII) and Upper River Region (URR) are the most affected. There are great discrepancies in regional health worker population ratios. Regional health staff are most numerous in the Western Region I and the least numerous in the Lower River Region. However, when health worker population ratios are taken into account, the Upper River Region has fewer health workers per 1,000 people than any other region.

The urban area constitutes about 78.89% of the total health workforce, while the rural area is 21.11%. At the service delivery level, the tertiary, which comprises all the general, specialized, and teaching hospitals, has 52.76% of the health workforce providing services, secondary has 11.82% of the health workforce, and primary has 28.09% (HRH Profile, 2021).

The HRH situation shows an insufficient staff mix and imbalances in health workforce distribution, with support staff numbers close to excessive levels and weak institutional management capacities for information, supervision, and monitoring.

Currently, there are two hundred and twenty-nine (229) health facilities, including health posts, in the country (171 are public health facilities and 58 are private). (HRH Profile, 2021)

Health Workers Stock and Trends

It takes the context of HRH as defined by WHO: "all people engaged in actions whose primary intent is to enhance health; this includes those who promote and preserve health, those who diagnose and treat disease, and health management and support workers who help make the health system function but who do not provide health services directly" It therefore looks at the type or cadre of health workers and where they are deployed to work in the country.

The active HRH stock of a country indirectly indicates how well the other building blocks of the health system are working. It also reveals the level of allocative efficiency (of health resources) and equity of access to services in the country.

Health Worker Density per 1000 Population Per Cadre

Cadre	Density threshold per 1000 pop	
	Male	**Female**
Medical doctors	0.06 (141)	0.04 (90)
Nurse midwives	0.10 (251)	0.17 (416)

Nurses	0.19 (472)	0.26 (631)
Public health personnel	0.08 (188)	0.05 (118)
Pharmacy personnel	0.02 (59)	0.02 (57)
Laboratory personnel	0.04 (103)	0.04 (86)

This indicator presents ratios of various health professionals to 1,000 population-based on the HRH stock of all the public sector health facilities in the country. (HRH Profile 2021)

Health workforce density

The low density of all cadres of the health workforce is testimony to the general shortage of health workers in the public sector. Hence, it reveals that even the core of the most critical health professionals for the delivery of clinical and public health services to the populace is grossly inadequate, with less than one medical officer per 10,000 people, about two midwives per 10,000 people, and just one (01) anesthetic officer per 100,000 people in the country.

Consequences of inadequate professional healthcare workers in primary care health facilities

The uneven distribution of critical healthcare professionals in favor of tertiary and secondary levels of care (which are primarily urban-based) but at the expense of the primary level of care (which is typically rural) exacerbates the generally severe shortage of all cadres of healthcare professionals at all levels of service delivery. The shortage of staff has led not only to an increase in workload in all peripheral health facilities and compromised quality of care but also to difficulties or inabilities to respond to dire emergencies.

Furthermore, with the on-going COVID-19 pandemic, the MoH made human resource management for the health sector a key priority for the government and other implementing partners. The Ministry of Health, with the support of partners, conducted a capacity assessment to inform the strategic deployment of staff to cover critical gaps that emerged during the pandemic response. Thus, training plans were developed and tailored to build the capacity of all public health care workers.

Capacity building related to COVID19

In anticipation of opening new COVID-19 treatment centers, MoH with support from partners conducted training of health workers in the management of mild and moderate COVID-19 patients.

Enhancing critical care for COVID-19 Patients

Trainings were conducted to equip health workers from the COVID-19 treatment centers with knowledge and skills for effective management of severe and critical cases of COVID-19.

Capacities were developed in management of severe and critically ill cases of COVID-19 patients.

Capacity Building on mechanical ventilation for COVID-19 patients

Medical doctors and Nurses from, theatre, ICU and the COVID-19 treatment center (sanatorium) were trained on mechanical ventilation. The training was on the basis of identified inadequate capacity in non-invasive and invasive ventilation.

Decentralizing skills on infection prevention and control (IPC) measures

Trainings were conducted to ensure that all Health Care workers in Government and Private Health Facilities are trained on IPC to ensure safety for both staff and patients**.**

Major trainings were conducted on surveillance, sample collection, testing and reporting as well as communication and psycho-social care

FOCUS KEY INTERVENTIONS

1. To conduct Health Labor Market Analysis

Health Labour Market Analysis (HLMA)

A health labour market analysis provides the following evidence and insight (1) the supply of health workers (those available and employed or willing to be employed at current wages levels); (2) the demand for health workers (the number of funded positions available to employ health workers from the combined ability and willingness to pay from both public and private sectors); (3) the population health needs; (4) the interaction and mismatches between supply, demand and need; and (5) the policy and financial feasibility and impact of different policy options

2. To Conduct Training Institution Service Availability Mapping (TISAM)

Training Institution Service Availability Mapping (TISAM)

Determine the country's capacity for the production of health professionals and the factors that would favour scaling-up their production

1. Identify institutions training health professionals and document their characteristics (ownership, location, physical infrastructure, funding).
2. Determine the productivity over the last five years for each cadre of health professional being trained by the Institution.
3. Determine the extra capacity of the institution for production of health professionals.

4. Establish the needs for maximum utilization of existing capacity

3. Establish a National Database of Human Resources for Health Information System and Subscribe/ update the National health workforce accounts

3, Commitment to a regular update on the National Health Workforce Account (NHWA)

The purpose of a national health workforce account (NHWA) is to standardize the health workforce information architecture and interoperability as well as track HRH policy performance towards universal health coverage. The implementation of NHWAs facilitates a harmonized, integrated approach for regular collection, analysis and use of standardized health workforce information to inform evidence-based policy decisions.

4. **Comprehensive Training need Assessment**

A requirement to inform the development of a long/medium comprehensive training plan for a supposition on the 2005 -2020 Training plan