

2.0 SITUATION ANALYSIS

2.1 Population of Ghana

Based on the 2000 National Population census, the regional breakdown of the population of Ghana is given in Table 1. The current population stands at 21.8 million and the assumption is that the population of Ghana will grow by 2.4% each year. Using this growth rate and applying it equally to each region, Table 1 shows that by 2011, the total population of Ghana will have increased to 24.5 million, (National Statistical Service 2000)

Table 1: Population by Region for 2006 and Projected for 2011

Region	Total Population 2000	Total Population 2006	Projected Total Population 2011
Ashanti	3,612,950	4,165,447.75	4,689,877.23
Brong Ahafo	1,815,408	2,093,022.92	2,356,534.31
Eastern	2,106,696	2,428,855.12	2,734,647.76
Central	1,593,823	1,837,552.81	2,068,900.54
Greater Accra	2,905,726	3,350,073.99	3,771,848
Northern	1,820,806	2,099,246.39	2,363,541.32
Upper East	920,089	1,060,790.39	1,194,343.81
Upper West	576,583	664,754.94	748,447.525
Volta	1,635,421	1,885,512.04	2,122,897.83
Western	1,924,577	2,218,886.21	2,498,243.78
National Total	18,912,079	21,804,142.6	24,549,282.1

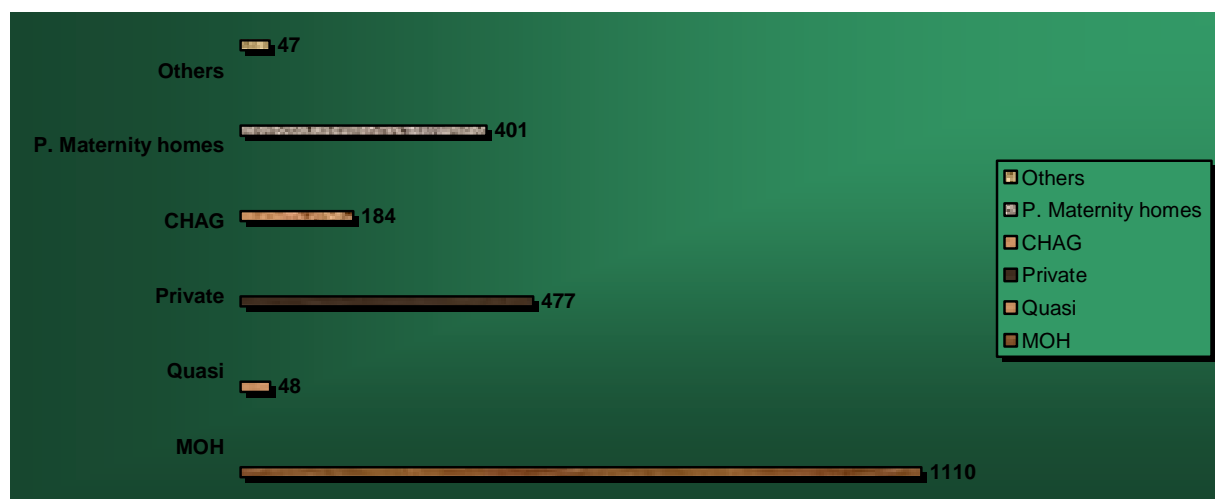
Source: 2000 National population census.

2.2 Present Health Sector Facilities

Figure 1 shows the number of health facilities by organization in Ghana. The Ministry of Health, which is being represented by the Ghana health Service and the Teaching hospitals, owns about 49% of the total health facilities. The private sector owns about 21%, CHAG institutions own 8% whilst the private maternity homes own about 17% of total health facilities. The others include Islamic mission and Planned Parenthood Association of Ghana. Details of facilities in regions are indicated in Annex 1 of this document.

This clearly indicates the contribution of the Private sector and the Christian Health Association towards the health care delivery in Ghana. Even though there are about 200 centers for alternative medicine practices, there are 50 centers temporarily registered with Traditional and Alternate Medicine Directorate of the Ministry of Health.

Figure 1: Health facilities in Ghana



2.3 Present Numbers and Composition of Health Staff

Figure 2A; shows the total workforce employed in the health sector. About 52,258 health workers are currently working formally in the health sector. The composition is made up of public, CHAG, private, Islamic mission, quasi and other organizations. The Ministry of Health employs a total of 42,299 staff made up of staff in GHS, Teaching Hospitals, CHAG, and health training Institutions, regulatory bodies, and headquarters. This figure represents about 81.5 % of the total health sector workforce. Details of distribution in categories are represented in annex 2 of this document.

Table 2: Health workforce distribution by Agency.

INST	GHS(Re)	CHAG	Private	HTI	Regulatory bodies	Islamic M.	Quasi	Exp	NAS	KBTH	KATH
%	54	13	10	2	0.6	0.6	8	0.4	0.4	6	5

Figure 2A. Health workforce distribution by Agency.

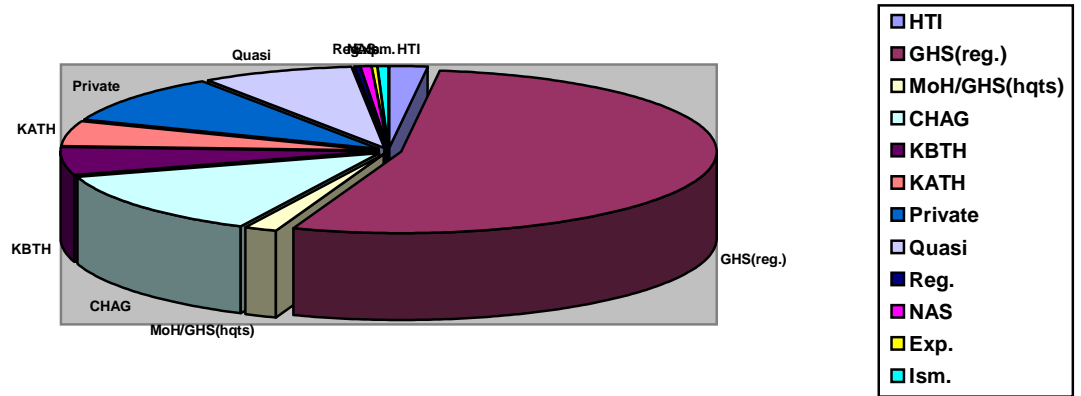


Table 3: Distribution of Health workforce by category

Category of staff	Total number
Medical Officers	2,026
Dental Surgeons	31
Pharmacists	1,550
Expatriate Doctors	200

Professional Nurses	7,304
Enrolled Nurses	2,956
Community Health Nurses	3,246
Registered Midwives	2,810
Medical Assistants	430
Allied Health Professionals	588
Traditional birth Attendants	367
Non Clinical & Clinical Support Staff	27,918
Traditional Practitioners	21,182

Table 3 shows staff categories in the health sector. The staff include 2,026 medical officers, 1,550 pharmacists, 31 dental surgeons, 200 Expatriate doctors, 7,304 professional nurses, 2,956 Enrolled nurses, 3,246 Community Health nurses, 2,810 midwives, 588 allied health professionals and 27,918 non-clinical (administrators, accountants, drivers, technical officers etc) and clinical support staff (health aides, ward assistants etc). This figure represents approximately 38% of total health workforce officially employed. It is also clear from the figure that as compared to clinical health care providers, the composition of support staff seems to be very high.

Although the total health staff are woefully inadequate, figure 2B shows a clear picture of more highly trained professionals e.g. (Doctors, Pharmacists, Nurses and specialized professionals) than the middle level workforce e.g. (community health nurses, enrolled nurses and medical assistants.) This gives a workforce with a weaker base and inappropriate skill mix.

Apart from the total health workforce in formal employment, about 21,791 people countrywide are registered to be engaged in traditional medicine practice; whilst 367 persons are known registered Traditional Birth Attendants (TBAs). This indicates that in Ghana, about 69,000 people are involved in health care delivery. From observing the culture of the country and the fact that most small communities would have recognized traditional health practitioners, it is evident that there would be many more traditional health practitioners than has been captured in the number above. The Traditional Medicine sector is estimated to employ about 200 thousand workforce (Census report, TAMD, 2003).

2B.Distribution of health workforce by category

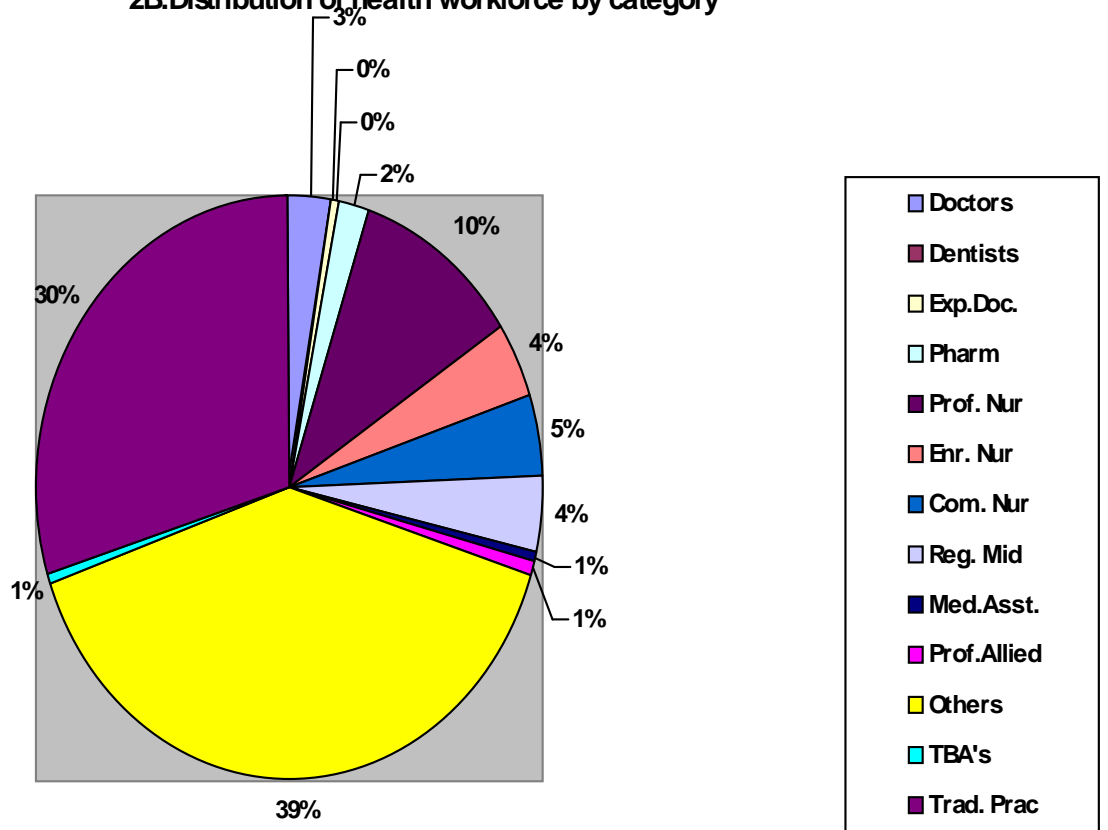


Table 4A: Population per staff member in Ghana for selected Cadres, 2005

Staff Category	Population per Staff Member	Staff Category	Population per Staff Member
Medical/Dental Officers	1:10,700	Trad. Med. Pract.	1: 500
Pharmacists	1:14,286	Allied Health	1:37,075
Nurses	1: 1,587	Medical Assistants	1:43,600

Table 4B: Population by Profession in Selected Countries.

Country	Doctors	Nurses	Pharmacists
Ghana	1:10,700 in 2005	1: 1,587 in 2005	1:14,286 in 2005
Togo	1:16,667 in 2001	1:5,887 in 2001	1:33,333 in 2001
Uganda	1:20,000 in 2002	1:20,000 in 2002	1:200,000 in 2002
South Africa	1:1,449 in 2001	1:257 in 2001	1:4,166 in 2001
USA	1:182 in 2000	1:130 in 2000	1:1,470 in 2000
Cuba	1:169 in 2002	1:134 in 2002	N/A

Doctor/1000 Population ratios (World Bank 2001)

- High income countries – 2.8/1000
- Middle-income countries – 1.8/1000
- Low-income countries – 0.5/1000
- Sub-Saharan Africa – 0.1/1000

Considering the ratios indicated above, it is clear that for Ghana to attain a middle level income status as envisaged in the vision of the government there is the need to accelerate the production and retention of critical health staff.

2.4 Gender distribution of Public Sector Health Staff

The total number of women working in the Ministry of Health (Teaching Hospitals, health training Institutions, Ghana Health Service and CHAG) is approximately 22,000 and that represents 59% of the total workforce. It is evident that while the nursing and midwifery professions are female dominated, the medical, allied and other clinical professions are male dominated. (Refer Annex.... for details)

2.5 Age Distribution of Public Sector Health staff:

The largest section of the workforce (37.6%) falls within 40-50 age group. (See Annex for details)

Staffs in the age range of 18 to 39 years, who form about 29.5% of the total workforce, are those who are likely to migrate for greener pastures in mostly the advanced countries. (Dovlo, D.Y. 1999).

It is also clear from the age distribution that staff that are close to retirement are mostly Medical Assistants, enrolled nurses and midwives. They constitute about 33.9%.

2.6 Distribution Patterns of Health Sector staff

a) Geographical:

Figures 2C and 2D depicts the geographical presentation of doctors and nurses in the country. There is an indication that the highly skilled professionals like Doctors, and Nurses are concentrated in the Greater Accra region as well as in Korle Bu and Komfo Anokye Teaching hospitals.

b) Public –Private

With reference to table 2(health workforce distribution), majority of the highly skilled health staff are in the public sector. Despite this the private self financing sector looks after 10% of Ghanaians mostly in the urban areas.

Reference to figure **1B**: the private sector has a large number of health facilities. Despite this they appear to have proportionately smaller numbers of staff than the public sector. Most of the data gathered on the private sector was through a census conducted with the support of Danish international development Agency, (DANIDA 2001). This data revealed that there were more practitioners/facilities than were known to exist than any other data source. There has been no update since 2001.

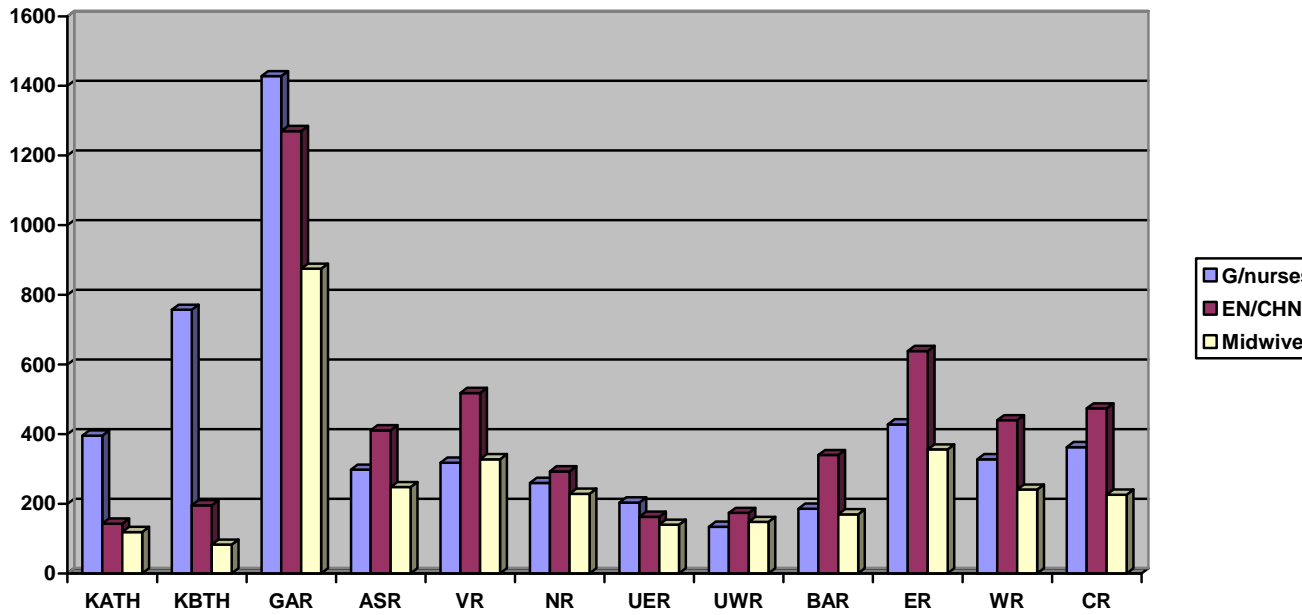
A sampling of private practitioners in Accra (SPMDP, 2001) showed their average age to be 60 years. This presents a crisis on the horizon for private sector human resource for health.

c) Public -Mission

Table 2 shows that the mission hospitals and clinics staff are mostly semi-skilled, employing over 50% auxiliary and ward assistants. The Mission Institutions are predominantly located in semi-rural areas.

In the past, even though the Islamic mission has been providing health care, their contribution had not been captured in health data for the Ministry of health. This document addresses that issue.

Figure 2 D: Geographical distribution of Nurses



FINANCING THE SECTOR'S HUMAN RESOURCES

2.7.1 Present Expenditure on Personnel Emolument by Agency

Table 5A provides details of the 2005 salary and the Additional Duty Hour allowance expenditure by the MOH, GHS, the Teaching Hospitals and sub vented organizations. The sector allocated 26.5 billion cedis for recruitments. This amount was significantly low as the sector had a backlog of staff to be recruited formally. The amount could support only 20% of the total recruitment needs of the sector.

Table 5A: 2005 Salary Expenditure budgeted for by Agency in billion cedis

Cost Item	MOH	GHS	Teaching Hospitals	Sub vented Organizations	Training Institutions	Total
Basic Salary	30.72	410.87	84.30	13.68	55.53	595.1
Recruitment	26.53(All sector)					26.53

**Additional
Duty Hours
Allowance**

HQ (MOH/GHS/Regulatory Bodies)	KBTH	GHS (Regions) and CHAG	KATH	Psychiatry Hospitals	TTH	Tax	Total
28,076,621,994	85,343,116,584	538,784,603,578	47,769,723,003	20,732,576,250	12,160,742,421	92,654,306,036	825,521,689,866

Table 5B: 2005 Total Sector Allowances for Personnel from budgetary support

Cost Item	Budgetary allocation (Billions) in cedis		
	2004	2005	2006
Trainee Allowances	18.0	21.1	
Expatriate Doctors	11.5	11.5	
Deprived Area Incentive Scheme	10.5	-	
Total			

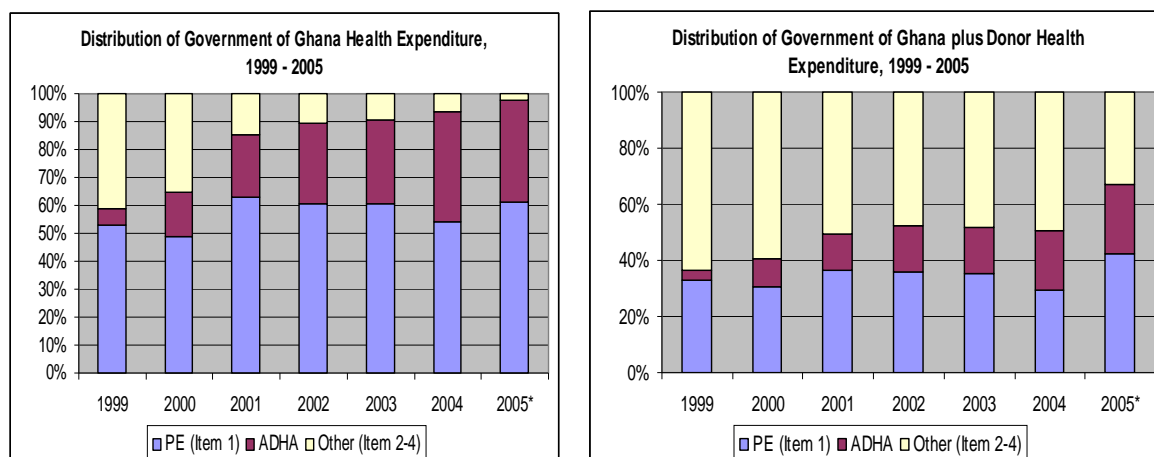
Table 5B above shows allowances paid to personnel in the sector between 2004 and 2005. An estimated total amount of 23.0 billion cedis was paid to expatriate Doctors from Cuba and Egypt as allowances during the period. Again, in 2004, 10.5 billion cedis was paid to Health workers in 55 deprived districts from the Highly Indebted Poor County (HIPC) inflows. This incentive scheme was however not implemented in 2005

due to difficulty in accessing funds from HIPC inflows. Thus, raising doubts about the sustainability of this scheme. The Ministry has therefore re-strategize ways of accessing funds for this scheme by incorporating the budget into the annual Personnel Emolument vote of the sector.

2.7.2 Additional Duty Hour Allowance as a retention strategy and its implications on the wage bill

One strategy of health worker retention for the past years has been the payment of ADHA (additional duty hour allowance). However as indicated clearly on table 5A above and figure 3 below, the ADHA has been the main driver of the escalating wage bill in the health sector. The health worker productivity mapping (2006) indicates that the ADHA payments and salaries in 2005 account for 97% of total GOG health expenditure and 67% of total GOG and donor health expenditure. Analysis of tables' 5A and figure 3 tends to support this claim. The sector is currently negotiating for a comprehensive salary structure that will acknowledge the contributions of various categories of health workers to the service delivery. The salaries shall respond to roles of health workers and productivity. The implementation of this salary structure has eventually abolished the ADHA.

Figure3: Distribution of Health Expenditure from 1999-2005



Adapted from, health worker productivity mapping. (Ghana, March 2006)

2.8 Staff Attrition

Attrition in the health sector covers the following factors:

- a) Vacation of posts
- b) Dismissals
- c) Resignations

- d) Retirements
- e) Termination of Appointments
- f) Deaths

Figures 4A, 4B and 4C depict a picture of the attrition rate of Nurses and Doctors in the Komfo Anokye Teaching hospital and staff in Ghana Health Service from 2003 to 2006. There is a downward trend, showing a reduction in the rate of attrition, more especially with vacation of post and resignations, which seem to be the critical challenges.

Fig. 4A: Attrition of Doctors in Komfo Anokye Teaching Hospital

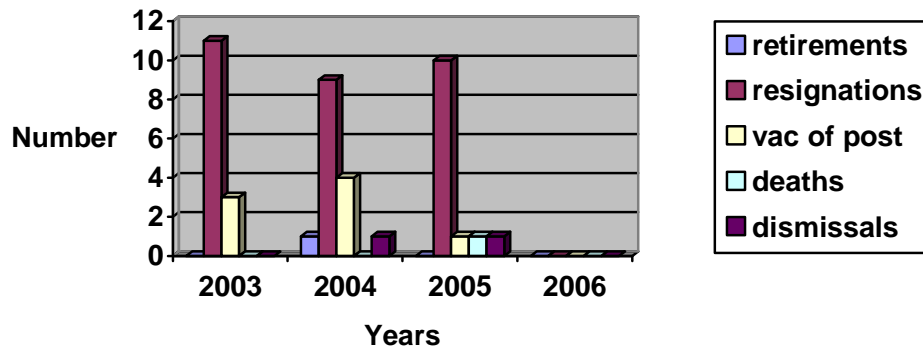


Fig. 4B: Attrition of Nurses in Komfo Anokye Teaching hospital

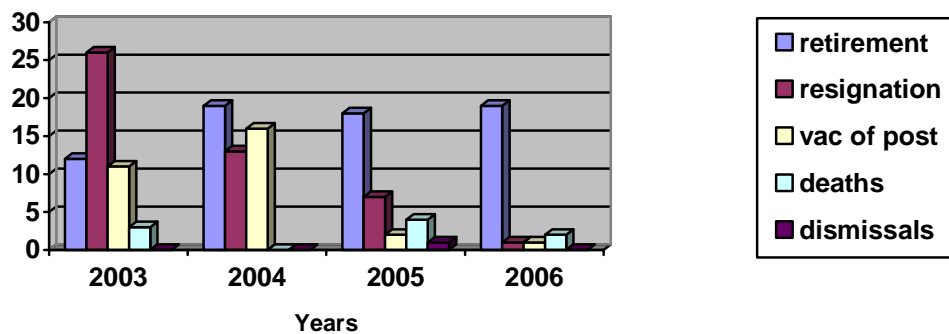
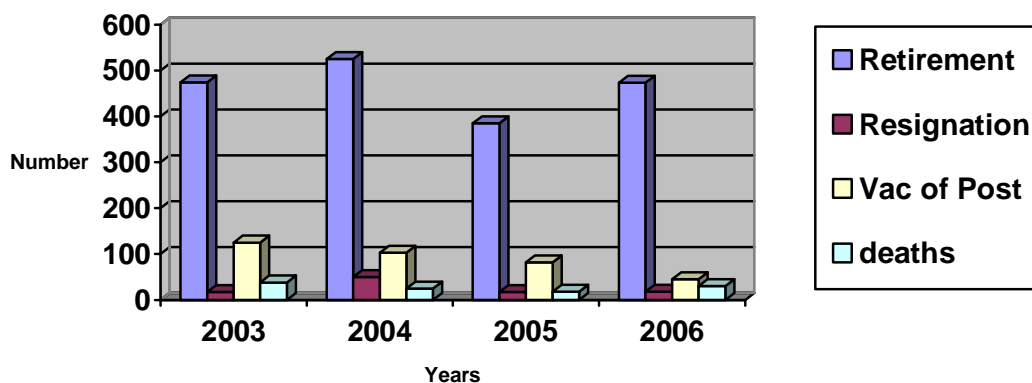


Fig. 4C: Attrition of staff in Ghana Health Service



2.9 Training of Health Professionals

Training of Health professionals can be categorized into Pre-service, Post basic (Post graduate) and in-service training

2.9.1 Pre-service training

Currently there are several training policies for the various categories of health workers developed from the decrees and Acts that established the professions. The current HRH policy document gives a policy direction on pre-service training, but does not adequately provide guidelines for the Training Institutions. Although training of health professionals has been a shared responsibility between the Ministries of Health and Education, there has not been clearly defined roles and collaboration. There is no comprehensive training policy to clarify roles and address training issues.

However, the Ministry has taken steps to streamline certain critical pre-service training areas. One of such measures has been the extension of house-jobs from one year to two years for doctors. The first year of the house job is designed to take place in the Teaching hospitals and the second year in accredited regional and district health facilities. This policy is aimed at addressing the issue with skilled competencies and redistribution of staff. However, this policy has not been fully implemented due to poor coordination.

The Ministry's policy on increasing production of health workers has seen implementation difficulties. There has been the expansion of all existing health training Institutions and setting up of new institutions and programs as indicated in table 6

below. Even though efforts have been made to expand the training institutions, a lot more needs to be done in terms of infrastructure to meet the increasing intake.

Table 6: ESTABLISHMENT OF NEW HEALTH TRAINING

TYPE	INSTITUTION			
	MOH	CHAG	PRIVATE	QUASI
Ghana college of Physicians & Surgeons	1	-	-	-
General Nursing	1	1	3	-
Direct Midwifery	8	-	-	-
Diploma in Community Health Nursing	2			
Community Health Nursing	2		-	-
Medical Laboratory Technology	-	-	1	-
Health Assistants Clinical	7		2	
TOTAL	21	1	6	-

INSTITUTIONS.

The last five years has seen the establishment of the Ghana College of Physicians and Surgeons and five general nursing schools. There has been an introduction of new programmes for direct midwifery, health assistants (clinical) and diploma in Community Health nursing. The Ministry of Health has established a total of 21 health training programmes over the last 5years. Some of these new programmes led to the establishment of new Health training institutions while others were introduced in existing institutions. CHAG and the private sector together have also opened 7 new schools in the areas of general nursing and health assistants clinical.

The policy of the Ministry to increase production together with strengthening capacities in most of the health training institutions have resulted in a 50% increase in admissions into the Health Training Institutions and a 20% increase in all admissions into the Universities for the past three years, as indicated in figures 5A and 5B below. Despite these gains in the past four years, the capacity of the Health training Institutions to train sufficient numbers to meet national requirements remains inadequate in terms of infrastructure/space, logistics, and teaching staff as well as funding. The impact of the increasing production will be felt after three years of training for diploma programmes and after seven years of training of Medical doctors.

There was stagnation in enrolment into the medical assistant's programme as indicated in figure 5 below. There is a clear indication that the current Medical assistants' program is not attractive to nurses and so there has been dwindling numbers applying for the program in the past three years.

The University of Development Studies in Tamale started a one and half-year program for serving nurses to attain qualification as nurse practitioners. However, because

adequate consultation was not made with the Ministry of Health before the program was started; there have been some problems with placement of the graduates in the health sector.

Another area that has not received adequate recognition by the health sector is the training of herbal medicine practitioners (B.Sc Herbal Medicine) by Kwame Nkrumah University of Science and Technology. Basically, the problem is whether to place them in the formal sector or the informal sector and also how to integrate their work with the orthodox practitioners.

A summary of the average pre-service training intake and outputs in the country over the last three years is given in figures 5A and 5B. Details of the training schools, under the MOH, the Universities, CHAG, the private sector and middle level training are given in the Annex.....

Fig. 5A Intake and output of selected programs.

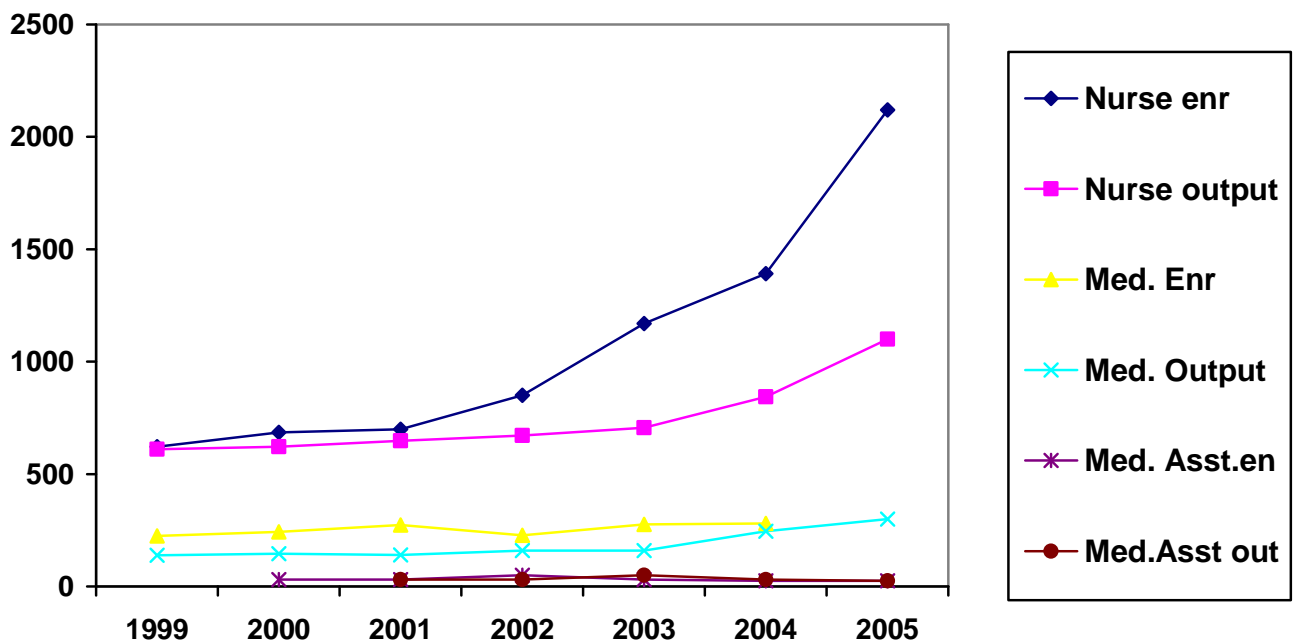


Figure 5A above indicates intake and output of selected programs from 1999 to 2005. The figure shows a drastic rise in the intake and output figures of nurses. There is a gradual increase in the medical officers' intake whilst that of medical assistants is not showing any rise.

Fig. 5B: Intake into selected health programs (2002-2005).

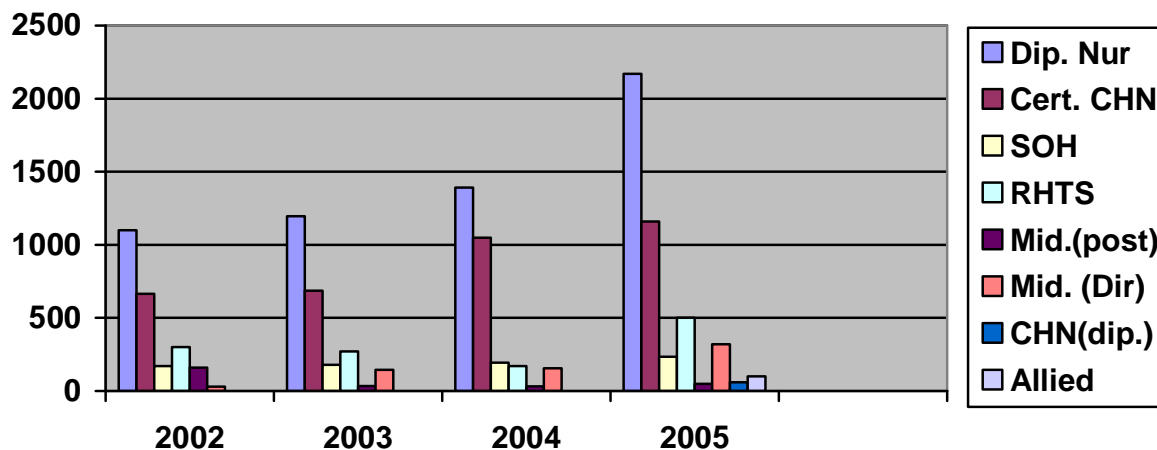


Figure 5B above shows the intake into some health programs from 2002 to 2005. The figure clearly confirms the Ministry's policy for the past four years on increasing intake into the Health Training Institutions.

2.9.2 In- Service Training

The GHS has developed in-service training policies, which have been in use for the past years by other public service agencies. The policies spell out the training needs, frequency of training and areas of training with respective curricula and credit points for career progression. Basically, the private institutions are supposed to adapt the in-service training policies of GHS. Various professional regulatory bodies have continuing professional education programs for their professional staff to enable them renew their license to practice.

Funding of in-service training has been from the annual budgetary allocations to the agencies and institutions. Development partners including USAID, JICA, Population Council, Quality Health Partners, World Health Organization, DANIDA, have been providing both technical and financial support for in-service training.

2.10 Human Resource Policy and Planning Situation

There is an HR policy and strategies document developed in 2002 and in line with the National Health development policy, GPRS1 and the 5-year program of work of the Health sector.

The Ministry of Health has responsibility for public sector infrastructure, financial and human resource mobilization including training. The Ministry of Health is the policy

centre for national health services and has therefore been playing the lead role in HR planning in collaboration with the agencies. The Agencies develop their own HR plans within the framework of the goals of the National HR goals and strategies.

There are no formalized strategies for distribution of graduates from the Medical Schools, College of Health Sciences, and the Health Training Institutions. Personnel move to places of their choice creating imbalances in the sector. The Ministry has recently established an inter-agency committee to distribute staff based on annual recruitment plans and available staff. The Ministry's Human Resource Directorate coordinates the work of this committee. The process will involve the submission of agency-specific recruitment needs to the committee and based on the number of personnel available, the committee distributes to the agencies.

In 1992, the Ministry of health developed staffing norms for the entire health sector. This has been used by GHS, CHAG and the Teaching Hospitals. Attempts were made in 2003 to review the norms. However, analysis of the existing norms indicates that the current staffing strength does not meet the required norms. (Refer to tables 7 -13 for the current staffing norms)

2.11 Human Resource Management Situation

There are Human Resource Directorates in the Ministry and at the agency level. Currently the policy for recruitment, placement, and promotion within the agencies is an adaptation of an old policy from MOH (Reference HR operational document, GHS). The Directorates have training, planning and management units. There are Human Resource Managers at the regional levels and at the Teaching hospitals. There are also training Coordinators responsible for in service training at the regional levels and at the teaching hospitals. Ministry of Health's Human Resources Directorate takes overall responsibility for Human Resources for the Health Sector in the country.

The main functions of this Directorate are;

- HRH policy and strategy initiation, formulation and review.
- HRH planning and distribution of new health professionals among the agencies
- Coordinates pre-service training and responsible for linking up with relevant Universities for internship arrangements for graduates in Health facilities
- HRH development and staff training functions and coordinates health sector fellowship scheme.
- HRH monitoring and evaluation
- Responsible for other HRH functions, that is cross cutting and likely to generate conflicts and mistrusts among the executing agencies.

HR functions in the agencies include:

- HRH policy implementation
- Initiation and formulation of HRH operational guidelines within agencies
- HRH intra agency planning, recruitment and deployment
- In service training and HRH career progression issues within agencies

- HRH management issues within agencies
- Performance management
- HRH monitoring and evaluation within agencies
- Management of fellowships within the Agency
- Contributes to policy initiation, formulation and review

2.11.1 Occupational Health and Safety

The development of health and safety issues in the health sector is currently at the rudimentary level. The challenges include: inadequate supplies and the use of obsolete equipment which prevents Health staff from effectively performing their functions.

2.11.2 Leadership and Supervision

Leadership in this context refers to the capacity at all levels of policy and service delivery to provide direction, align people, mobilize resources and attain goals. HRH leadership at both national and agency levels have been able to provide direction and mobilize resources though not adequate. Again, a lot has been achieved in the areas of professional associations strengthening. HRH leadership has in the past years been able to identify and select champions and advocates, hence the introduction of new salary structure for health workers and the formation of HRH task group. However, HRH leadership at all levels has not been able to improve on capacity for multi-sector and sector wide collaboration. There are weak institutional capacities for effective supervision and monitoring at all levels of service delivery.

2.11.3 Staff Performance and Management

There is a staff performance appraisal system that is coordinated by the Office of Head of Civil Service. This system has become an ineffective tool for management because staff at all levels are mostly appraised only when they are due for promotions. Both hard working staff and poor performers are all graded "satisfactory". GHS has recently made efforts to develop their own performance appraisal system, which is at a pilot stage. Other Agencies are yet to develop similar appraisal systems.

2.11.4 HRH Retention

Over the last five years the Ministry of health has instituted measures to attract and retain health workers in the country. These measures include;

- Provision of hire purchase saloon cars
- Tax waiver for imported saloon cars
- Provision of housing schemes for health workers
- Continuing professional development
- Payment of additional Duty Hour allowance
- Establishment of Ghana College of Physicians and Surgeons to localize postgraduate training for Doctors.
- Consolidated Salary
- Improved HR management practices in recruitment, placement, redeployment and promotions

The strategy to institute Housing scheme for Health workers has not been fully implemented. Some agencies secured plots of land for their staff to be developed on individual basis. Vehicle hire purchase schemes (revolving fund) was initiated in 2004 and to date a total number of 1082 saloon cars have been distributed to health workers and the breakdown is indicated in the figure below.

Fig. 6: Hire purchase vehicles for Health staff

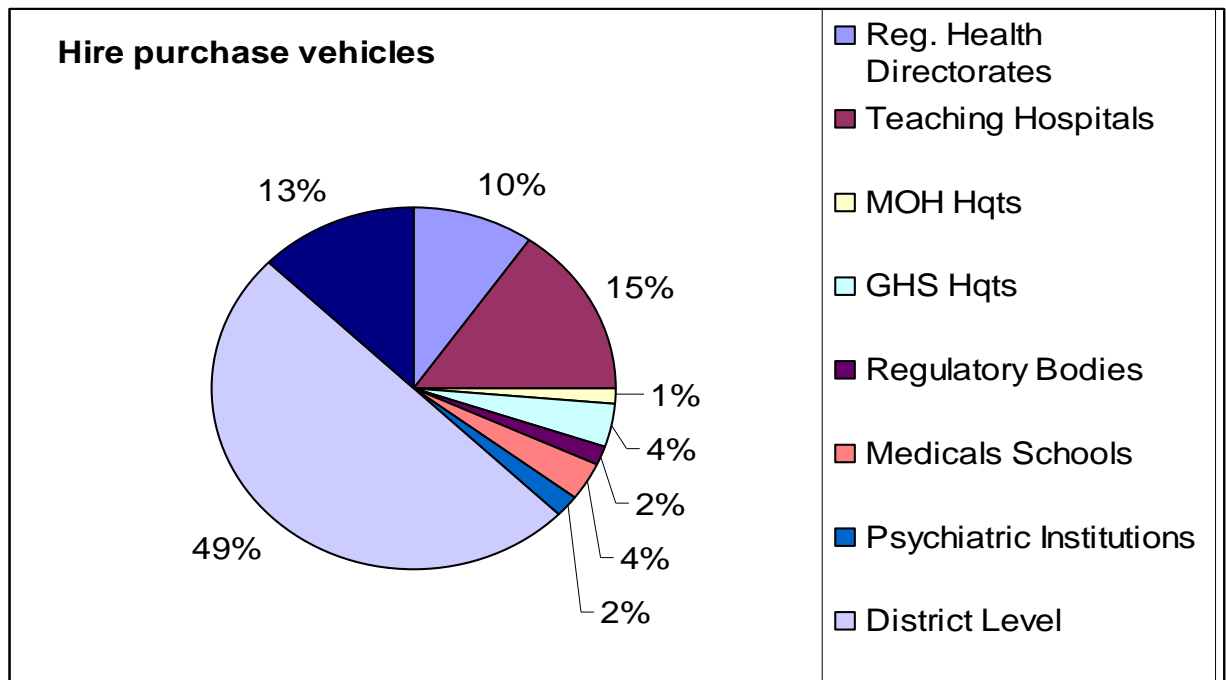
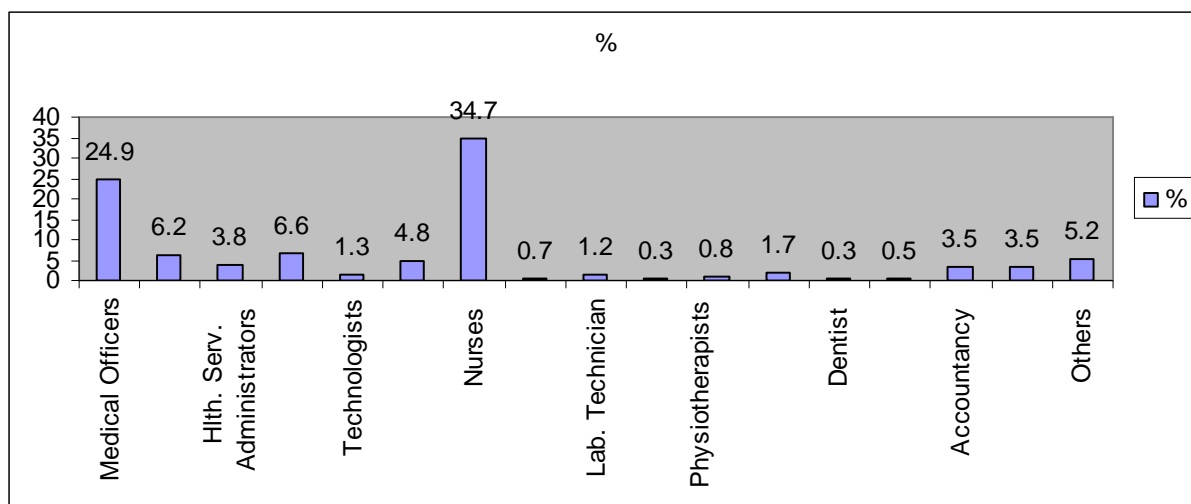


Fig. 7:



2.11.5 “Brain Gain Project”

The Ministry in collaboration with International Organization for Migration (IOM) has initiated the Migration for Development in Africa (MIDA) project starting the brain gain project in 2005. The project, which is being piloted for three years is sponsored by the Netherlands government and is supposed to end in 2007. The project is designed in such a way that Ghanaian health professionals resident in Europe would have the opportunity to work on short term basis in Ghana on vacation. In 2005, two medical officers based in the United Kingdom were engaged in CHAG institutions and four lecturers were engaged at the University of Ghana Medical School. There have been encouraging reports on the performance and conduct of the professionals engaged in the project and the Ministry hopes to scale up the numbers in subsequent years.

2.12 Current Staffing Standards (norms)

The tables below depict the current staffing norms for Facilities in the Health sector. Efforts are however being made to review these norms according to prevailing facility needs.

Table 7

LEVEL B FACILITIES

LEVELS	A	B	C	D
	Clinic/ Rural MCH	Health Centers/		Polyclinics

CATEGORY				
Medical Officer				3
Medical Assistant			1	1
Nurses - General	1 MID	1 SRN	1 SRN	15
Public Health Nurse	2 CHN	2 CHN	2 CHN	-
Pharmacy		1 MID	1 MID	4
Laboratory				3
Radiology				2
Medical Records				4
Administration				2
Dental				3
Enviromental				
Psychiatry				4
Ward Asst/Clinic Asst.				
Orderlies/Labourer		2	2	4
Stores				
Transport				2
Security/Watchman	1	1	1	2
Nutrition				2
Epidemiology		1	1	1
Total	4	6	9	52

Indicator				
Avg Daily OPD Attendances		1 - 10	11 - 60+	90 - 250+

Table 8
DISTRICT HOSPITAL

LEVELS	A	B	C
CATEGORY			
Medical Officer	2	3	4
Medical Assistant	1		
Pro. Nurses	15	21	36
Auxilliaries Nurses	10	14	24
Dental	1	2	3

Pharmacy	2	3	4
Administration	2	3	4
Laboratory	3	3	4
Radiology	2	2	2
Medical Records	4	4	4
Catering	5	5	5
Stores	2	2	2
Laundry	3	4	5
Transport	2	2	2
Revenue Collector	1	1	2
Orderlies/Labourer	8	10	13
Ward Asst/Clinic Asst.	3	3	3
Seamstress			
Maintenance	1	1	2
Anaesthetist	1	1	2
Mortuary	1	1	2
Security	2	3	3
Total	71	88	126
<u>Indicators</u>			
Average Bed Occupancy	30	50	70+
Avg Daily OPD Attendance	1 - 30	31 - 90	91+
Average Daily Admission	1 - 8	9 - 20	21+

Table 9

**REGIONAL
HOSPITAL**

LEVELS	A	B	C
CATEGORY			

Medical Officer/Specialist	9	12	16
Pro. Nurses	90	108	121
Auxilliary Nurses	60	72	81
Dental	6	7	8
Pharmacy	10	12	21
Administration	8	8	12
Physiotherapy	2	3	4
Laboratory	6	8	12
Radiology	3	3	5
Medical Records	6	10	10
Catering	10	13	18
Stores	3	3	3
Laundry	8	9	8
Transport	3	3	5
Revenue Collector	4	8	10
Orderlies/Labourer	26	26	43
Ward Asst/Clinic Asst.	10	10	10
Seamstress			
Maintenance	1	3	3
Anaethetist	2	3	3
Mortuary	2	2	2
Security	5	5	5
Total	274	328	400

<u>Indicators</u>			
Average Bed Occupancy	150	200	250+
Avg Daily OPD Attendance	100	180	260
Average Daily Admission	12	18	24

Table 10 CLINICAL POSITIONS IN TEACHING HOSPITALS

DIRECTORATE	SUB-SPECIALTY	CONS.	SPEC	RES	H/OFF,	TOT.
OBSTETRICS AND GYNAECOLOGY	General(Obstetrics & Gynaecology)	10	4	2	15	23
	Urogynaecology	2	1	1		3
	Gynaecological Oncology	2	1	1		3

	Endocrinology / Fertility Regulation	2	2	1		4
	Ultrasonography	2	1	1		3
	Maternal / Fetal Medicine	2	1	1		3
Sub total		20	10	7	15	52
CHILD HEALTH	<i>Pediatrics (General)</i>	5	4	2	15	23
	Cardiology	1		1		2
	Neurology	1		1		2
	Respiratory medicine	1		1		2
	Paediatric Emergency	2	1	1		3
	Nephrology	1		1		2
	Gastroenterology	1		1		2
	Endocrinology	1		1		2
	Infectious Diseases	2	1	1		3
	Neonatology	2	2	1		4
	Oncology / Haematology	1		1		2
Sub total		18	8	12	15	53
MEDICINE	<i>Internal Medicine (General)</i>	5	4	2	15	23
	Cardiology	2	1	1		3
	Endocrinology	2	1	1		3
	Neurology	2	1	1		3
	Renal Medicine	2	1	1		3
	Gastroenterology	2	1	1		3
	Clinical Pharmacology	1				1
	Respiratory Medicine & Tuberculosis	2				1
	Dermatology	2	1	1		3
	Rheumatology	1				
	Infectious Diseases	2	1	1		3
	Geriatrics	1				1
Sub total		24	12	14	15	65
SURGERY	<i>General Surgery</i>	5	4	2	15	23
	Paediatric Surgery	2	2	1		4
	Plastic Surgery	2	2	1		4
	Urology	3	1	1		3
	Traumatology /Orthopaedics	5	4	2		8
	Neurosurgery	3		2		4
	Cardio/ Thoracic Surgery	3		2		4
	Vascular Surgery	1		1		2
	Hand Surgery	1		1		2
Sub total		29	13	13	15	70
DENTAL, EYE, EAR, NOSE, THROAT						
Oral Health	Oral / Maxillofacial Surgery	1	2	1		4

	Restorative Dentistry – Prosthodontics - Periodontics - Conservation	1 1 1				3
	Orthodontics	2	3	4		8
	Public Health (oral)	1				
Eye	Ophthalmology	3	2	2		6
Ear, Nose, and Throat	ENT	3	1	1		3
Sub total		12	8	8		52
CRITICAL AND INTENSIVE CARE	Intensive and intensive Care	10	2	2		6
ANAESTHESIA		10	4	2		8
PUBLIC HEALTH		2		1		2
POLYCLINIC	Family Medicine	3	6	5		29
LAB BASED MEDICINE	Pathology -Anatomic Histocytology Forensic	2 2 2	2	2 1 1		11
	Chemical Pathology	2	1	1		3
	Radiology/ Imaging	4	2	1		4
	Microbiology -(Bacteriology) (Parasitology) (Virology)	2 1 1	1	1 1 1		9
	Haematology	2	1	1		3
Sub total		20	7	11		38
RADIOTHERAPY	Radiation Oncology	2	3	1		5
	Nuclear Medicine	1		1		2
Sub total		3	3	2		8
PSYCHIATRY		3				3
	Cumulative	132	67	71	60	330

MEDICAL DOCTORS

1 Consultant/Specialist: 20 beds
1 Consultant: 1 Resident
1 Major specialty area: 15 House Officer

4.1.2 NURSES (1007)

SERVICE OUTPUT ANALYSIS AND DETERMINATION OF NURSING STAFF NEEDS FOR TEACHING HOSPITALS

DEPT. UNIT	BEDS AVAILAB	OCCU. RATE	BEDS OCCUP.	NO. OF WARDS	NO. OF NURSES	REMARKS
MEDICINE	198	70%	139	5	139	1:3 3Shift
OBS. &GY	146	134%	198	5	198	+MID
CH. H'TH	148	133%	197	5	197	1:3 for 3 shift
SURGERY	283	85%	241	10	241	1:3 for 3shift
DE.,ENT	40	53%	21	2	21	Do
INT. CARE	7	71%	5	1	10	2:1 for 3shift
PSYCH.	12	50.2%	6	2	6	1:3 for s shift
CASU'TY	20	100%	20	2	20	Do
REP.HELH					10	Does trg./ser
Ac.& Emerg. (OPD)					9	3shift for 2 consult. Rooms
Thtre. Recov.					45	(1:3)15 Cases/dy
Gen.OPD Recovery	19	66%	13	3	13	1:3 for 3 shifts
Specialist (OPD)					30	Holds 15 clinics with 30 consult. Rooms
Radiat. Therapy	3	100%	3	1	10	1:3 for 3 shifts
Blood Bank					10	Will perform Bleeding
Nurse Anaest					30	
Gen. OPD. At Polyclinic					13	6 consult. Rooms
Treatment Room					5	1 inj. Room for 3 shifts and 2 for Dress. Rm
TOTAL	876		704	36	1007	

4.1.3 PRIVATE HOSPITALS

Clinical staff

Table 11

Cat. Of Staff	Small	Medium	Large
Snr. Doctors	1	2 Specialties	5 Specialties
Jnr. Doctors/Mos	0	0	2
Nurses (SRN)	1	4	6
(AUX)	1	8	14
Pharmacy			
Pharmacist	Nil	Nil	Nil
Technicians	Nil	1	3
Lab.			
Lab. Technologist	Nil	Nil	1
Lab. Technicians	Nil	1	2
X-ray (if there is facility)			
x-ray Technicians	-	-	1
x-ray Assistants	-	-	1
TOTAL	3	16	35

Non-clinical staff

Table 12

Cat. Of Staff	Small	Medium	Large
Orderlies/Cleaners	1	2	3
Health Service Admin.	1	1	1
Security	1	1	1
Accounts Staff	1	1	1
TOTAL	4	5	9
Receptionist/Secretary	1	1	1
Maintenance team	-	-	1
Driver	-	-	1

Summary of desired tutor-student ratios

Table 13

Program	SRN	CHN	PHN	RMN	EHA	EHO	TO	FT	MLT	CCN	PON	MI D
Ratio	1:15	1:10	1:15	1:15	1:15	1:15	1:15	1:15	1:15	1:10	1:10	1: 10

4.2 Summary of Current Human Resource Challenges

- Inequitable distribution of workers at different levels of services delivery.
- Inadequate numbers
- Low morale and motivation of health workforce
- Inadequate supportive/facilitative supervision
- High attrition of health workers
- Weak performance management systems
- Limited training capacity to meet increasing numbers into the training institutions
- Inadequate collaboration between Ministry of Health and Ministry of Education Training Institutions
- Weak Human Resources Information Systems
- Lack of integration and recognition of Traditional, Herbal and alternate medicine within the Public Health system.

