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REVIEW ARTICLE **OPEN ACCESS**

Beyond Workforce Shortages: The Role of Regulatory Design in Shaping Access to Pharmaceutical and Dental Services in The Gambia

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ABSTRACT

Access to healthcare services in The Gambia is shaped not only by workforce availability but also by the structure and implementation of regulatory frameworks. With a population exceeding 2.7 million (World Bank, 2023), demand for pharmaceutical and dental services continues to grow, yet the supply of trained professionals remains limited and unevenly distributed. This study examines how regulatory design influences workforce utilization, service accessibility, and environmental health practices. The analysis draws on a qualitative policy review combined with field-based insights from over 30 practitioners—including pharmacists, dental professionals, nurse dispensers, environmental health officers, inspectors, and rural drugstore operators—as well as more than a dozen students and business stakeholders. Findings reveal significant inconsistencies in professional recognition and supervisory structures. While pharmacy and nursing frameworks allow for some degree of task-sharing, the dental sector remains largely restricted to dentists, limiting service expansion. The study also identifies a persistent gap between environmental legislation and actual healthcare waste management practices, contributing to public health and ecological risks. Comparative insights from West Africa highlight that countries with more inclusive regulatory models demonstrate improved service coverage. The paper concludes that regulatory fragmentation, combined with workforce shortages, contributes to urban concentration of services and the emergence of informal practices. Integrated reforms are proposed to align workforce development, regulatory equity, and environmental compliance. This study contributes to the literature by integrating regulatory analysis, workforce distribution, and environmental compliance within a single systems framework, with specific application to The Gambia. Unlike existing studies that examine these domains independently, this paper demonstrates how their interaction produces compounded access constraints.

Keywords: *Health regulation; Workforce distribution; Pharmaceutical governance; Dental services; Task-shifting; Healthcare access; Environmental health; Healthcare waste management; Regulatory equity; The Gambia; West Africa*

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INTRODUCTION

Health system performance in low-resource settings is shaped by a dynamic interaction between workforce capacity, regulatory design, and institutional effectiveness. These elements rarely operate in isolation; rather, they reinforce or constrain one another in ways that directly affect service accessibility and quality. In The Gambia, this interaction is particularly pronounced due to the country's relatively small but rapidly growing population, estimated at over 2.7 million [1], alongside limited domestic training capacity for specialized health professions.

Despite incremental investments in infrastructure and service delivery, the availability of skilled health professionals remains constrained. Earlier national workforce assessments indicated that the country operated with fewer than 20 pharmacists and dentists combined at certain points, with a strong concentration in the Greater Banjul Area [2]. Although recent years have seen modest improvements through overseas training and private sector participation, the overall distribution of professionals remains uneven, with rural and peri-urban communities continuing to face limited access to specialized care.

This imbalance is not unique to The Gambia, but its effects are intensified by regulatory structures that have not fully adapted to workforce realities. In several West African countries, including Senegal and Ghana, tiered workforce models have been adopted to mitigate shortages. These models incorporate mid-level cadres—such as pharmacy technicians, dental therapists, and community health workers—into

formal regulatory frameworks, thereby extending service coverage without compromising standards [3]. Ghana, for instance, has institutionalized the role of dental auxiliaries within its oral health system, contributing to broader access to preventive care.

By contrast, the Gambian system demonstrates asymmetry in regulatory flexibility across sectors. While pharmacy and nursing have evolved to include multiple cadres under structured supervision, other sectors—particularly dentistry—remain more restrictive. This uneven development suggests that workforce shortages are not solely a function of training capacity but are also shaped by how regulatory frameworks define and limit professional participation.

In parallel, environmental health considerations—especially those related to healthcare waste management—have gained increasing importance. The safe handling and disposal of medical and pharmaceutical waste are governed by national legislation, yet implementation remains inconsistent, particularly at the facility level. This introduces an additional dimension to health system performance, linking service delivery to environmental risk.

Against this background, this study examines how regulatory structures influence three interconnected areas:

- **Professional recognition and workforce utilization**, with emphasis on inclusion and scope of practice
- **Access to pharmaceutical and dental services**, particularly in underserved regions
- **Environmental health practices**, focusing on the gap between legal provisions and operational realities

By situating these issues within both national and regional contexts, the paper aims to contribute to a more integrated understanding of health system constraints in The Gambia.

Institutional and Legal Framework

Institutional Structure

Healthcare governance in The Gambia is organized through a set of statutory and administrative bodies with distinct mandates, yet with areas of functional overlap that influence implementation outcomes.

Table 1: Institutional Framework for Health Governance and Regulation in The Gambia [7]

Institution	Role
Ministry of Health	National policy formulation, planning, and coordination of health services
Medicines Control Agency (established under the 2014 Act)	Regulation of medicines and quality assurance
Pharmacy Council of The Gambia	Professional registration, ethical oversight, and practice standards
Medical and Dental Council of The Gambia	Licensing and regulation of medical and dental practitioners
National Environment Agency (NEA)	Environmental monitoring, waste regulation, and enforcement

While each institution operates within a defined legal mandate, coordination challenges arise in practice, particularly in areas requiring joint oversight, such as:

- Inspection of healthcare facilities
- Enforcement of waste management standards
- Licensing and supervision of multi-functional premises

These overlaps can lead to gaps in enforcement or duplication of roles, especially where inter-agency communication mechanisms are limited or informal.

Legal Framework

The regulatory environment is anchored in several legislative instruments, some of which have undergone revisions or are supported by subsidiary regulations.

Table 2: Key Health-Related Legislations in The Gambia [8-13]

Legislation	Year	Function	Notes on Amendments / Practice
Medicines and Related Products Act	2014	Regulation of medicines, licensing of premises, establishment of Medicines Control Agency	Replaced earlier fragmented drug control provisions; forms current backbone of pharmaceutical regulation
Pharmacy Act	2014	Defines professional practice and registration of pharmacy personnel	Implementation guided by evolving council regulations rather than major recent statutory overhaul
Medical and Dental Practitioners Act	"Pharmacy Act (Cap. 41:03, Laws of The Gambia)" "Medical and Dental Practitioners Act (Cap. 41:06, Laws of The Gambia)"	Governs registration of medical and dental professionals	Limited expansion to include auxiliary cadres in dentistry
National Environment Agency Act	1994 (with subsequent regulations)	Environmental protection, including hazardous waste management	Supported by environmental quality standards and waste regulations
Public Health Act	1990 (revised provisions applied)	General health protection and sanitation	Provides broad enforcement powers at community level

Although these laws collectively establish a comprehensive framework, a key challenge lies in **operational alignment**. For instance:

- Pharmaceutical regulation is relatively centralized under the 2014 Act
- Environmental compliance operates under a separate enforcement structure
- Professional regulation is segmented across councils

This fragmentation can result in **inconsistent application of standards**, particularly in areas where mandates intersect.

Unequal Professional Recognition

Inclusive Sectors: Pharmacy and Nursing

The pharmacy and nursing sectors in The Gambia demonstrate relatively **adaptive regulatory structures**, incorporating multiple cadres within formal systems of practice. This aligns with global recommendations on task-sharing, which emphasize the importance of optimizing available human resources in settings with limited specialist capacity [12].

In practice, this has allowed:

- Pharmacy technicians to support dispensing and inventory management
- Nurse dispensers to provide essential pharmaceutical services in drugstore settings
- Delegation of routine tasks under professional supervision

These arrangements contribute to continuity of care, particularly in facilities where highly trained professionals are not always present.

Dental Sector Constraint

In contrast, the dental sector remains structurally narrow, with formal recognition largely limited to dentists under the Medical and Dental Council framework. Unlike in several neighboring countries, auxiliary dental cadres are not systematically integrated into the regulatory system.

Regional comparisons highlight this gap:

- **Ghana and Nigeria** formally recognize dental therapists, hygienists, and technicians, allowing them to deliver preventive and basic restorative services [4].
- **Senegal** incorporates mid-level oral health workers into its public health system, particularly in community-based settings [5].

The absence of similar structures in The Gambia restricts the system's ability to expand oral health services, particularly in underserved areas.

Workforce Gap and Service Implications

The combined effect of limited professional numbers and restrictive regulatory structures creates a **persistent service gap**.

Evidence and field observations indicate:

- Continued shortages of dentists and pharmacists relative to population needs
- Strong concentration of services in urban centers
- Limited availability of preventive and routine care in rural areas

This situation has several implications:

- Increased reliance on centralized facilities

- Delayed treatment for non-emergency conditions
- Emergence of informal or unregulated service providers

From a systems perspective, the issue is not only one of scarcity but of underutilized potential within the existing workforce structure [14].

Pharmaceutical Regulatory Inequity

Supervisory Structure and Practice Realities

Under the Medicines and Related Products Act (2014) and associated regulatory practices, pharmacists are permitted—subject to approval—to supervise more than one licensed pharmaceutical premise. In contrast, pharmacy technicians and nurse dispensers are generally restricted to single-facility practice within defined scopes [11].

Although not always codified as fixed numerical limits within the primary legislation, this differentiation is reflected in licensing practices and enforcement norms.

Structural Implications

This regulatory differentiation produces several observable system effects:

Concentration of Operational Control

With a limited number of pharmacists in the country, the ability to supervise multiple premises can lead to **concentration of ownership and operational influence**, particularly in urban areas.

Constrained Professional Mobility

Mid-level cadres, including pharmacy technicians, face restricted opportunities for expansion, limiting their ability to [15]:

- Establish independent practices
- Serve underserved regions
- Progress within the regulatory hierarchy

Perceived Inequity

Differences in supervisory rights contribute to a perception of unequal regulatory treatment, particularly where training and experience among mid-level cadres are substantial.

System Efficiency Trade-offs

While supervisory restrictions are designed to maintain quality and safety, they may also reduce system responsiveness, especially in contexts where workforce shortages are already acute.

Regional Perspective

In parts of West Africa, regulatory frameworks are gradually evolving to allow graduated responsibilities for mid-level cadres, particularly in primary care and community pharmacy settings. These models maintain oversight while enabling broader service coverage.

The Gambian system, while maintaining strong regulatory intent, may benefit from incremental adaptation, ensuring that standards are upheld without unnecessarily constraining access [16].

Analytical Interpretation

Taken together, these dynamics suggest that pharmaceutical regulation in The Gambia operates within a **tension between control and access**:

- Strong regulation ensures quality and safety
- Limited flexibility restricts scalability

Balancing these objectives requires a context-sensitive approach, where regulatory structures are aligned with actual workforce capacity and population needs.

Workforce Scarcity and Access

Empirical Context

Across Sub-Saharan Africa, structural imbalances in human resources for health remain a defining constraint. The region accounts for approximately 3% of the global health workforce while bearing over 20% of the global disease burden [6]. Recent evidence further highlights that workforce shortages in the region are compounded by maldistribution and limited deployment to rural areas, reinforcing access inequalities [7]. The Gambia reflects this broader pattern, though the effects are intensified by its relatively small domestic training base and reliance on a limited pool of highly skilled professionals [17].

Available national and regional data indicate that shortages are particularly pronounced in specialized fields such as pharmacy and dentistry. While precise current figures fluctuate due to migration, private sector entry, and external training, earlier national profiles and stakeholder accounts consistently point to:

- A limited number of pharmacists and dentists relative to population size
- A high concentration of professionals within the Greater Banjul Area
- Minimal presence of specialized services in rural regions

This distributional imbalance has practical consequences. Facilities outside major urban centers often depend on mid-level cadres or general health workers, while some communities experience delayed or foregone care due to distance and cost barriers.

Comparatively, countries such as Ghana and Senegal have made incremental progress in addressing similar shortages by expanding mid-level workforce participation, particularly in primary care and oral health services. These examples suggest that workforce scarcity, while real, can be partially mitigated through regulatory adaptation.

System Dynamics of Access Constraint

The relationship between workforce availability and regulatory structure in The Gambia can be understood as a reinforcing system cycle rather than a series of isolated challenges [18].

Figure 1.

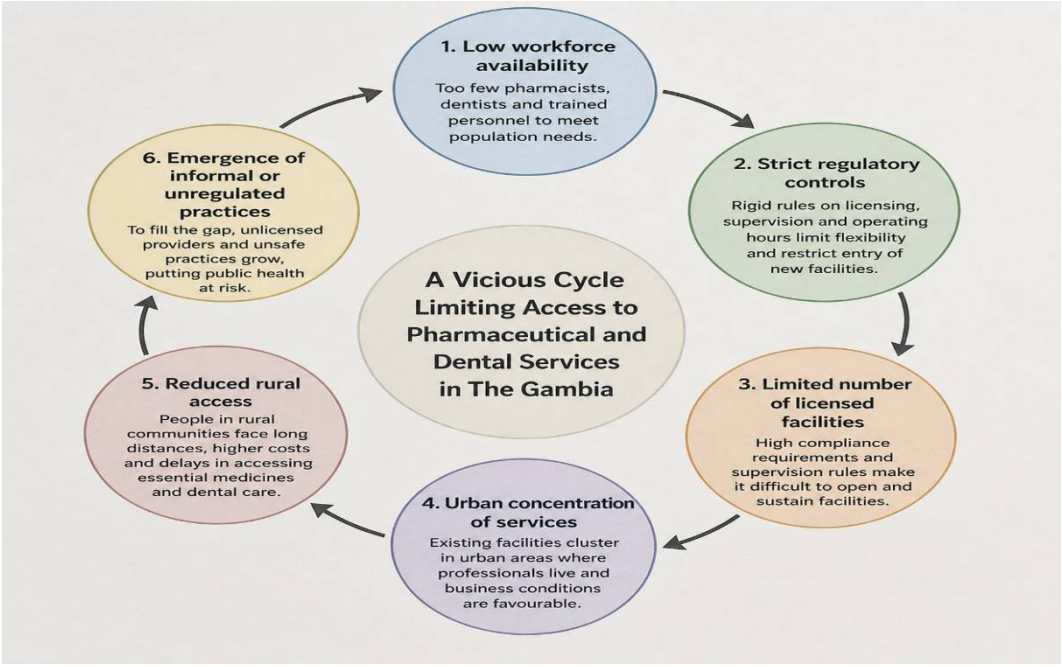

Fig 1: Vicious Cycle Limiting Access to Pharmaceutical and Dental Services

Each stage in this cycle both results from and contributes to the next:

- **Limited workforce** necessitates tighter regulatory oversight to maintain standards
- **Strict supervision requirements** constrain the establishment of new facilities
- **Fewer licensed facilities** concentrate services in economically viable urban areas
- **Reduced geographic access** increases reliance on informal providers

Field observations suggest that informal practices do not emerge primarily from disregard for regulation, but from unmet demand within constrained systems. This underscores the importance of aligning regulatory frameworks with actual workforce capacity and population needs

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MATERIAL AND METHODS

Study Design

This study adopts a qualitative policy and systems analysis, combining documentary review with field-based insights. The objective is not only to interpret regulatory provisions but also to understand how they are experienced and applied in practice. Data were collected between January–March, 2026 across both urban (Greater Banjul Area) and selected rural settings in West Coast and North Bank and Upper River Regions.

This approach is particularly appropriate in contexts where:

- Quantitative data are limited or fragmented
- Regulatory effects are mediated through institutional and professional behavior

Study Participants and Sampling

A purposive and experience-based sampling approach was used to capture a broad cross-section of perspectives within the health system.

Participants included:

More than 30 professionals, drawn from:

- Pharmacists (community and regulatory roles)
- Pharmacy technicians
- Dentists and dental practitioners
- Environmental health officers
- Regulatory inspectors
- Rural drugstore operators
- Private sector partners within the pharmaceutical supply chain

More than 12 students, including:

- Pharmacy students
- Dental students
- Nursing trainees at different stages

Participants were selected to reflect:

- Different levels of professional authority
- Urban and rural perspectives
- Both service delivery and regulatory oversight roles

Data Collection Approach

Data were gathered through informal semi-structured engagements, conducted over multiple interactions. This approach allowed for:

- Greater openness in discussing regulatory and operational challenges
- Exploration of sensitive issues such as enforcement practices and professional tensions
- Capture of experiential insights often absent in formal surveys

Discussion areas included:

- Regulatory constraints and licensing processes
- Workforce deployment and supervision realities
- Access challenges in different settings
- Observed practices in healthcare waste management

Analytical Strategy

The data were analyzed using a thematic approach, structured around three core domains:

1. Regulatory structure and professional recognition
2. Workforce distribution and service access
3. Environmental compliance and waste management practices

Patterns were identified through:

- Cross-comparison of stakeholder perspectives
- Alignment with existing legal frameworks
- Consideration of regional policy models

Rather than treating each issue independently, the analysis focused on interconnections and system-level dynamics.

Ethical Considerations

Given the informal nature of engagements:

- No identifying information was recorded
- Participation was voluntary
- Responses were treated with confidentiality

This approach ensured that participants could speak freely, particularly on issues involving regulatory critique and institutional practice.

Environmental Health and Waste Management

Legal Framework

Environmental regulation in The Gambia is anchored in the National Environment Agency Act (1994), supported by subsequent regulations and environmental quality standards. The Act mandates:

- Safe handling and disposal of hazardous waste
- Licensing and monitoring of waste management activities
- Protection of public health and the environment

Healthcare facilities are expected to comply with these provisions, particularly in relation to medical and pharmaceutical waste.

Observed Practices in the Health Sector

Field observations and stakeholder accounts indicate a gap between legal requirements and operational realities.

Table 3: Healthcare Waste Management Practices in The Gambia

Practice	Observed Status
Open dumping of healthcare waste	Common in some settings
Burning of waste near facilities	Frequently reported
Use of informal collectors	Occasional but present
Controlled disposal systems	Limited and inconsistent

These practices are often influenced by:

- The limited infrastructure for waste management
- Cost constraints
- Weak enforcement mechanisms

Regional Context

Similar challenges have been documented across parts of West Africa, where healthcare waste management systems are still developing. Empirical studies from the region have documented inconsistent waste segregation and disposal practices within healthcare facilities, often linked to infrastructure and enforcement constraints [19]. The World Health Organization [4] notes that in many low-resource settings:

- Segregation of waste is inconsistent
- Disposal infrastructure is inadequate
- Regulatory enforcement remains uneven

However, some countries have begun to introduce centralized waste treatment systems and stricter monitoring frameworks, demonstrating that improvement is achievable with coordinated investment.

Public Health and Environmental Implications

The gap between legal provisions and actual practice has several implications:

- Exposure to hazardous materials for healthcare workers and nearby communities
- Environmental contamination, including soil and water systems
- Potential contribution to antimicrobial resistance, particularly where pharmaceutical waste is improperly disposed

These risks extend the impact of regulatory gaps beyond service delivery into broader public and environmental health domains.

International and Regional Context [3]

Global and regional frameworks provide guidance on addressing the types of challenges identified in this study:

- The **World Health Organization (WHO)** promotes **task-shifting** as a strategy to optimize limited human resources
- The International Pharmaceutical Federation (FIP) advocates for tiered workforce development, allowing different cadres to operate within defined competencies
- The FDI World Dental Federation supports the inclusion of dental auxiliaries to expand access to oral health services

Countries that have adopted these approaches—particularly within West Africa—have demonstrated improvements in service coverage and accessibility, while maintaining professional standards.

Reform Recommendations [4]

Based on the findings, several interrelated reforms are proposed:

Dental Sector

- Introducing formal recognition of dental therapists, technicians, and assistants
- Developing regulatory guidelines for scope of practice and supervision

Pharmaceutical Sector

- Review supervisory frameworks to allow more balanced participation across cadres
- Introducing graduated responsibility models based on training and experience

Regulatory Governance

- Strengthening separation between regulatory and service provision roles
- Enhancing transparency and accountability in licensing and inspection processes

Workforce Strategy

- Expanding training pathways for mid-level cadres
- Introducing incentives for rural deployment, including housing, allowances, or career progression

Environmental Health

- Strengthening of enforcement of the National Environment Agency Act
- Developing dedicated healthcare waste management systems, including centralized treatment options
- Introducing penalties for non-compliance alongside capacity-building measures

Integrated Reform Model

Table 4: Strategic Reform Areas in Pharmaceutical and Dental Systems

Area	Current Challenge	Proposed Reform
Dental Regulation	Limited to dentists	Inclusive multi-cadre framework
Pharmaceutical Supervision	Uneven distribution of authority	Graduated and balanced supervision
Workforce Deployment	Urban concentration	Incentivized rural distribution
Governance	Overlapping roles	Clear institutional separation
Waste Management	Informal and inconsistent	Regulated and enforced systems

This integrated approach recognizes that reforms in one area are unlikely to succeed without parallel adjustments across the system.

LIMITATIONS OF THE STUDY

While this study provides useful insights into the interaction between regulatory frameworks, workforce distribution, and environmental health practices in The Gambia, several limitations should be acknowledged.

First, the study is based primarily on qualitative insights derived from informal semi-structured engagements with practitioners, students, and sector stakeholders. Although this approach allowed for open and experience-based discussions, it did not involve recorded interviews or standardized survey instruments. As a result, the findings rely on interpretive analysis rather than quantifiable measures, which may limit the extent to which conclusions can be generalized.

Second, recent and comprehensive national workforce data for pharmacy, dental, and environmental health sectors remain limited or fragmented. The analysis therefore draws partly on earlier national reports and stakeholder accounts to describe workforce distribution. While these sources are consistent in highlighting structural shortages, the absence of up-to-date consolidated datasets presents a constraint.

Third, the study did not include direct facility-level observational audits, particularly in relation to healthcare waste management practices. Observations in this area are based on practitioner reports and sector experience rather than systematic environmental assessment, which may affect the precision of reported compliance levels.

Finally, given the relatively small size of the Gambian health system and the interconnected nature of professional roles, there is a possibility of response bias, particularly where participants discussed regulatory practices or institutional challenges. Efforts were made to mitigate this by engaging participants across different roles and settings, including rural and private-sector perspectives.

Despite these limitations, the study offers a contextually grounded analysis that highlights structural patterns and system-level interactions relevant to health policy and regulatory reform in The Gambia.

DISCUSSION

The findings of this study suggest that healthcare access in The Gambia is shaped less by isolated deficiencies and more by interconnected structural constraints. The system cycle presented in Figure 1 illustrates how these constraints reinforce one another. Workforce shortages, while significant, do not operate independently; they are mediated by regulatory frameworks that determine how available human resources can be utilized.

A notable feature of the system is the coexistence of flexible and restrictive regulatory models within the same national context. Pharmacy and nursing sectors demonstrate a degree of adaptability, yet internal disparities persist. The dental sector, by contrast, remains comparatively rigid, limiting its capacity to respond to population needs.

The environmental dimension further illustrates the challenges of translating legal frameworks into practice. The existence of comprehensive legislation alongside inconsistent implementation reflects broader issues of institutional capacity and coordination.

Regional comparisons reinforce the view that incremental regulatory reform is both feasible and effective, particularly when aligned with workforce realities. The Gambian system, while structurally sound in many respects, would benefit from a more integrated and adaptive approach.

CONCLUSION

This study highlights the central role of regulatory design in shaping healthcare access in The Gambia. While workforce shortages remain a critical concern, their impact is amplified by structural and regulatory constraints that limit flexibility and system responsiveness.

Addressing these challenges requires a coordinated approach that includes:

- Alignment of regulatory frameworks across sectors

- Expansion and optimization of workforce roles
- Strengthening of environmental health enforcement mechanisms

Without such reforms, existing disparities in access—particularly between urban and rural areas—are likely to persist. Conversely, targeted and context-sensitive adjustments offer a pathway toward a more equitable, efficient, and resilient health system.

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CONFLICT OF INTEREST

The author declares no conflict of interest related to this study.

REFERENCES

1. World Health Organization. (2008). Task shifting: global recommendations and guidelines. Geneva: WHO Press.
2. World Health Organization. (2010). Health systems financing: the path to universal coverage. Geneva: WHO Press.
3. World Health Organization. (2014). Safe management of wastes from health-care activities. 2nd ed. Geneva: WHO Press.
4. World Health Organization Regional Office for Africa. (2022). The health workforce in the African Region: findings of a 2022 assessment. Brazzaville: WHO AFRO.
5. World Bank. (2023). World Development Indicators. Washington DC: World Bank..
6. International Pharmaceutical Federation. (2020). Workforce Development Goals. The Hague: FIP.
7. FDI World Dental Federation. (2021). Vision 2030: Delivering optimal oral health for all. Geneva: FDI.
8. Ministry of Health, (2014). The Gambia. Human resources for health country profile. Banjul: Ministry of Health.
9. Republic of The Gambia. (2014). Medicines and Related Products Act. Banjul: Government Printer.
10. Republic of The Gambia. (1994). National Environment Agency Act. Banjul: Government Printer.
11. Republic of The Gambia. (1990). Public Health Act. Banjul: Government Printer.
12. Republic of The Gambia. (2010). Medical and Dental Practitioners Act. Banjul: Government Printer.
13. Republic of The Gambia. (2020). Pharmacy Act. Banjul: Government Printer.
14. Chen L, Evans T, Anand S, et al. (2004). Human resources for health: overcoming the crisis. Lancet. ;364(9449):1984–1990.
15. Frenk J, Chen L, Bhutta ZA, et al. (2010). Health professionals for a new century: transforming education to strengthen health systems. Lancet. 376(9756):1923–1958.
16. Nash DA, Friedman JW, Kardos TB, et al. (2014). Dental therapists: a global perspective. Community Dent Oral Epidemiol. 42(1):1–10.
17. Gallagher JE, Mattos Savage G, Crummey SC, Sabbah W, Varenne B, Makino Y. (2023). Oral health workforce in Africa: a scarce resource. Int J Environ Res Public Health.20(3):2328.
18. Mbouamba Yankam B, Adeagbo O, Amu H, Dowou RK, Nyamen BG, Ubechu SC, et al. (2023). Task shifting and task sharing in the health sector in sub-Saharan Africa: evidence, challenges and opportunities. Pan Afr Med J. 46:11.
19. Owusu AA, Kploanyi EE, Blankson PK, Manu A, Goka RY, Armah RN, et al. (2023). Waste management practices among dental surgery staff in Accra: a cross-sectional study. PAMJ One Health. 10:5.

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