ACTA FACULTATIS MEDICAE NAISSENSIS

UDC: 614.253.83

Scientific Journal of the Faculty of Medicine in Niš 2010;27(1):5-11

Original article ■

Need Assessment: A Case Study On Aid Delivery To Serbian Health Care Sector

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SUMMARY

The aim of this paper was to determine how the needs of the Serbian health sector have been identified by the main donor and its implementation partners. The conceptual and analytical framework was synthesized and developed from the literature review and based on The Sphere Project, WHO and World Association for Disaster and Emergency Medicine protocols/ standards. The investigation has been conducted in the context of the Serbian health care system by the analysis of the donor needs assessment practice between 1999 and 2003. The study was performed using qualitative approach - interviews and documentary sources. The results indicate that the health needs assessment (HNA) have been carried out by the studied international non-governmental organizations (NGOs); there was no adopted HNA guidelines; HNA teams consisted of medical doctors, local staff, with no training in HNA; knowledge and practice on the concept of Linking Relief to Rehabilitation and Development (LRRD) was on the very low level; finally, the identified needs influenced the project objectives but also, there were some non - identified needs that consequently lead to the failure in setting up the project objectives. HNA practice in identification of the real needs and priorities of the Serbian health sector show that there are 'needs - influenced' project designs, but the fact that not all stakeholders' views that were taken into account could undermine the development process of this sector. Results of the study demonstrate a need of further research to quantify humanitarian health care support in Serbia in the current economic situation.

Key words: **International Cooperation, needs assessment, Health Care Sector**

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INTRODUCTION

Disasters, natural or "man - made", occur every day all round the world. In the case of Haiti, we saw that the international community, aiming to help, get involved in many ways in order to save lives and prevent further disasters. However urgent the situation is, there should not be a rush to deliver aid before carrying out a comprehensive assessment of needs (1). Due to its effects on future development, positive or negative, humanitarian aid has to be planned with awareness. Therefore, there is a rising recognition of the need to link relief aid with development aid (2-4).

The Serbian health care system has gone through a rapid change during the last decades. In Serbia, especially after the bombardment in 1999, many international agencies and organizations took part in aid distribution to the health sector, but the major donor was the European Commission Humanitarian Office (ECHO)(5). The motive of this paper is based on the following argument: 'the way in which needs are defined and prioritized has the real-world implications for millions of people, and therefore, it should be given 'greater priority in practice' (6).Until now, this subject has received much less attention from researchers in Serbia than in other countries in transition (7).

The aim of this paper was to determine how the needs of the Serbian health sector have been identified by the main donor and its implementation partners.

AIMS

The main objective was to examine and analyze the donor/NGO practice of 'needs assessment' in Serbian health sector between 1999 and 2003. The specific research objectives were to determine to what extent the "needs assessment" was employed in the project design by ECHO, International Rescue Committee (IRC), Médecins du Monde - Grèce (MDM-Gr), and Hellenic Rescue Team (HRT) in the Serbian health care system, to determine the extent of Linking Relief to Rehabilitation and Development (LRRD) approach consideration and to determine the extent to which "needs assessments" influenced the health care project design.

MATERIAL AND METHODS

The conceptual and analytical framework was synthesized and developed from the literature review and based on the Sphere Project (8), WHO (9) and World Association for Disaster and Emergency Medicine (WADEM) (10) protocols / standards. The investigation has been conducted in the context of Serbian health care system.

The study was performed using qualitative approach - interviews and documentary sources. The questionnaire was originally developed by the study team on the basis of results of previous research international studies. The questions are shown in Table 1.

Table 1. *Interview questions*

I	Have field visits been performed?
	Have data been collected and where from?
	Have all available sources of data been used?
II	Has a participatory approach been used?
	Has a stakeholder analysis been done?
	Has a Log Frame been used?
III	Has a LRRD approach been considered?
	Have needs assessment reports been done?
	Have the reports been supported with evidence?
	Have existing guidelines on needs assessment been used?

The subjects were: one of the major donor organization in Serbian health sector, ECHO, and its three implementing partner NGOs: IRC, MDM-Gr, and HRT. Data on the organization were collected by interviewing the former employees of the searched organizations, at the time of the research, still accessible in Serbia, as well as representatives from other institutions relevant for information cross-checking (Figure 1). Respondents were asked directly to describe the needs assessment conducted by their organization. Further examination of the LogFrame, participation, stakeholder analysis and LRRD consideration would make that practice much clearer. For example, the LogFrame is an important tool in project management and it is an obligatory part of the ECHO Grant application. It is not enough to ask 'has it been used'. It requires some additional questions and investigate the practice on at least two of the five steps in the LogFrame approach: 'stakeholder analysis' and 'situation analysis'. These questions reveal more about needs assessment in practice (11, 12).

This study investigated "who constitutes 'a team' for needs assessment in Serbia". Since the needs assessment is the first stage of the project cycle (8), it influences the whole project design and its stages. This was examined by comparing the identified needs with the project objectives set out in the project proposals.

Due to time constraints, only one donor agency and its three partner NGOs were selected for investigation (Figure 1). ECHO was selected because it has been a major Serbian donor from 1999 to 2003, as well as a major regional and world donor agency (5). Although ECHO has many NGO partners, IRC, MDM Gr and HRT were chosen since all of these organizations originally worked in the South Serbia.

The organizations and institutions from Boxes B, C and D are chosen to cross-check the information collected

in the main research.

A	B	C	D
ECHO - European Commission Humanitarien Office	**DFID** - UK Department for International Development	**MoH** - Ministry of Health Serbia	**IPH Niš** - Institute of Public Health Niš
IRC - International Rescue Team	**WHO** - World Health Organization	**IPH Serbia** - Institute of Public Health Serbia	**MSF Greece** - Médecins Sans Frontières-Grèce
MDM Gr - Médecins du Monde-Grèce	**EAR** - European Agency for Reconstruction EC Delegation		
HRT - Hellenic Rescue Team			

Figure 1. *Categories of the selected organizations for the research*

RESULTS AND DISCUSSION

Participation *is a way of information gathering, and is a cornerstone of development and people empowerment.* Stakeholder *analysis influences the project design and further development. Has it been done or not, as well as the LRRD approach consideration promoted by the EU agencies (5), shows whether the NGO in the emergency situation and aid planning has considered ownership, sustainability and people/ stakeholder empowerment as important components of the long-term sector development.*

The Serbian health care system has three levels of health care provision-primary, secondary and tertiary (Figure 2). Primary care is responsible for providing the basic health care and preventive services through the network of primary health care institutions (Health Houses with their smaller units, outpatient clinics). Secondary health care is provided in hospitals and health centers at the district level. Tertiary health care can be obtained in Clinics and Clinical Centers and specialized hospitals (for example, for TB or oncology treatment, or for mental health). Four clinical centers in the biggest cities are also the teaching units (Novi Sad, Beograd, Kragujevac, and Niš).

Apart from this structure is the Serbian Institute of Public Health (IPH) which provides public health services through a network of regional IPHs (13). The private health system is not very well - developed. According to the 2007 decree on health Institution, there are 343 health institutions: 208 at primary, 76 at secondary, 27 at tertiary level and 32 which cross more than one level of the health care. There are over 112 permanent staff working in the public health care provider network in Serbia (13).

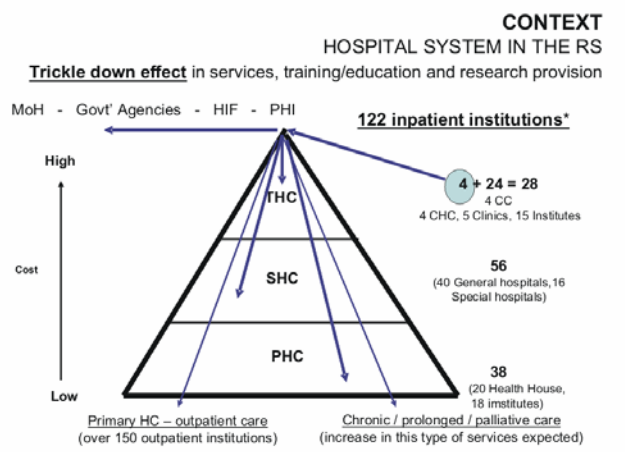

Figure 2. *The Serbian health system*

(Source: Jekic I. The National Conference on Tertiary Health Care Project Reconstruction and modernization of 4 CC's in Serbia (EU Project Capacity building of the Ministry of Health for Tertiary Care Services in Serbia). Belgrade, Sava Centar, 2009)

Health sector funding is based on compulsory social health insurance, financed by salary contributions [12.3% of salary], paid by employees and operated by the Health Insurance Fund' (HIF) (14). Two of health expenditure parameters are shown in Figures 3 and 4.

The events before 1999 (such as wars, declining of economy, embargo, international isolation and the large number of refugees) weakened Serbia, and had consequences for the health sector and the health of the population (Figure 5).

All interviewees stated that needs assessments had been conducted and that project proposals had been drawn up in accordance with the needs assessment results and that Needs Assessment Reports have been written. **IRC** ex-employees explained that they went on field visits, collected data from the relevant institutions, analyzed them, and finally designed the project. The **MDM Gr** interviewee explained 'needs assessments' as follows: *'our doctors used to go to the health facilities and introduce the organization to the directors, (i.e. who we are, what we want, how much we would spent and on what), and then we ask them to tell or send us a list of needs'*. **The HRT** respondent pointed out that needs assessments have been done and documents confirmed that this organization produces well-organized Needs Assessment Reports.

According to the obtained information, ECHO has not taken an active role in 'needs assessment', only through collecting data at coordination meetings with the MoH, the WHO and NGOs working in Serbia.
ECHO relied on the needs assessments done by the NGOs, 'familiarity with the context and situation' and also two project proposals were 'already on the desk in the ECHO office' when it was re-opened in 1999 after

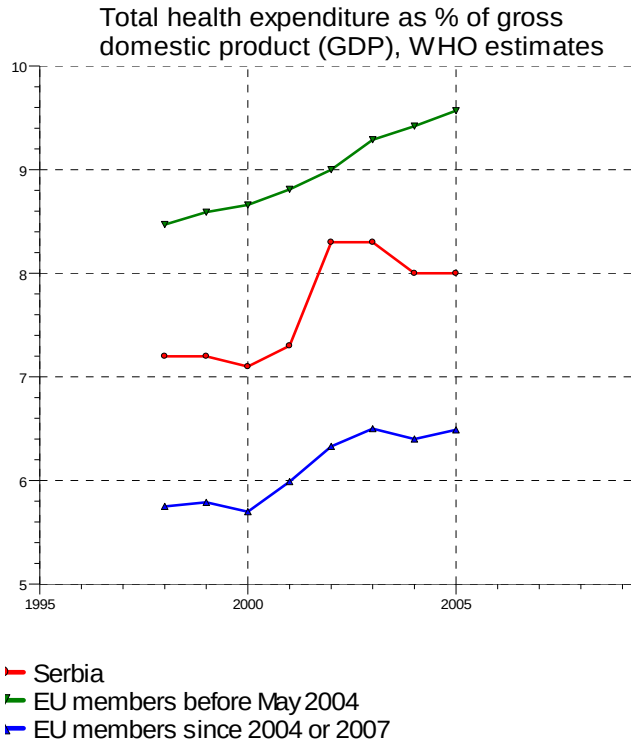

Figure 3. *Health Expenditure as percentage of GDP (gross domestic product): Comparative presentation of Serbia and EU (before and after the enalrgement in 2005) (HFA db, 2009)*

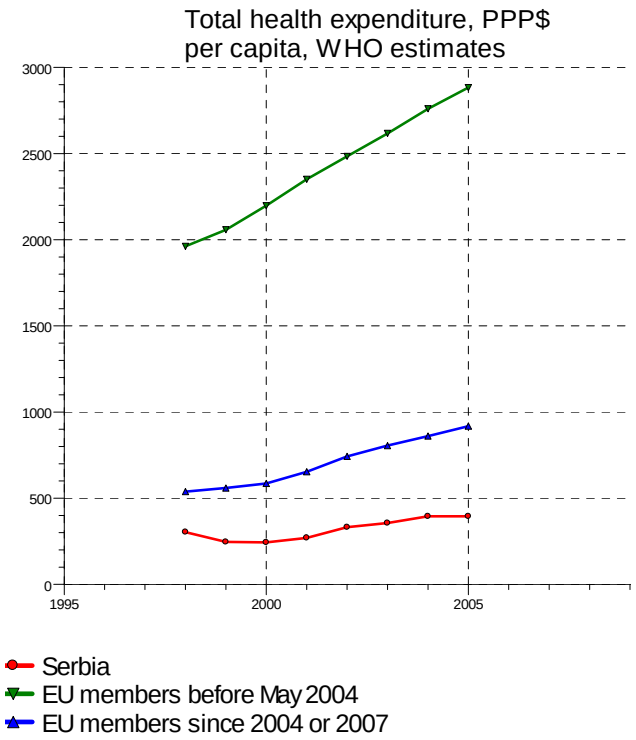

Figure 4. *Health Expenditure, PPP$ per capita: Comparative presentation of Serbia and EU (before and after the enalrgement in 2005) (HFA db, 2009)*

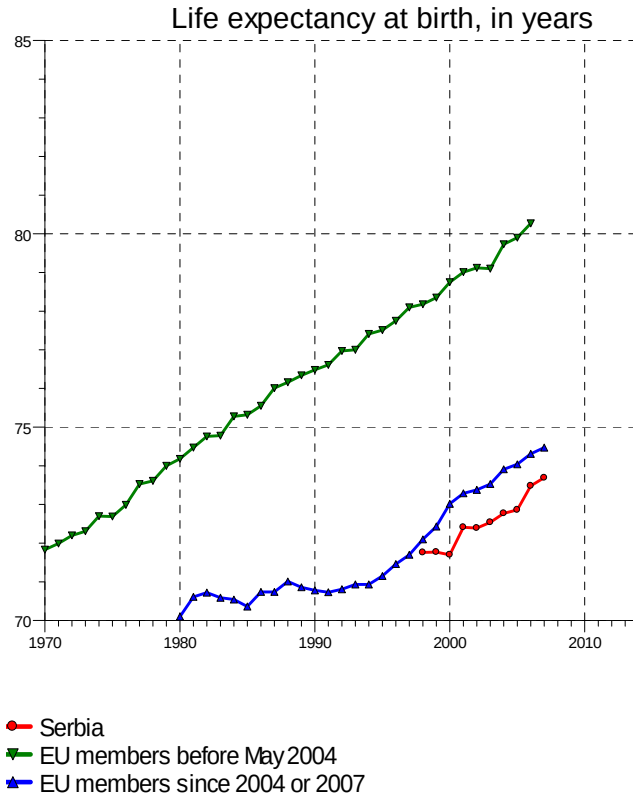

Figure 5. *Life expectancy: Comparative presentation of Serbia and EU (before and after the enalrgement in 2005) (HFAdb, 2009)*

the bombardment. Needs assessments have been considered as a necessary part of project management and have been done by the ECHO partners. According to their official policy ECHO should carried out needs assessments.

However, the 'needs assessment' had different meaning and understanding to different interviewees.

IRC used to perform the needs assessment by conducting field visits to certain health institutions, collecting data from the local IPH, using assessment forms and questionnaires, and holding discussions with health professionals.

The information available from **MDM Gr** 'Needs Assessment Report' and interviews do not give a clear picture about when needs assessment took place. The interviews suggest that needs assessment was done during the project itself (some hybrid stage of the project cycle). Management staff was directly asked what the health institution needed.

Only the basic components of conducting needs assessment were used by the studied NGOs.

Principles of the Logical Framework Approach (LFA) were not familiar with any of interviewees (ECHO, IRC, MDM Gr, HRT), although the LogFrame Matrix was used in the project preparation by all NGOs.

For example, stakeholder analysis has not used the 'step by step' approach; the stakeholder matrix and

strategy have neither been developed. However, the NGOs included some stakeholders, which were, according to their opinion, the most important.

The **IRC** and **MDM Gr** documents suggest that participation was practiced as an approach, but in a very limited form.

Participation should be a link to development and empowerment of people. Here, the research findings reveal that participation was 'information giving' and at the level of health institutions, Institute of Public Health (IPH) and Ministry of Health (MoH) without inclusion of the 'final beneficiaries' - i.e. the patients. There was no evidence on direct participation of vulnerable people, i. e. 'refugees, internally displaced persons (IDPs) and social cases', even as 'information givers'.

None of respondents was familiar with the LRRD approach, although there was the LRRD section in the ECHO project proposal form. The weaknesses which emerged related to the LRRD issues are the lack of NGO capacity and the lack of trained local staff in LRRD methods/approaches.

Regarding the LRRD approaches, ECHO's strongest link should have been the European Agency for Reconstruction (EAR). EAR is the EU agency whose mandate is to support the countries of South - Eastern Europe in development and in building a stable future. Both agencies worked in Serbia between 2000 and 2003. At the interview with EAR representatives, it appeared that ECHO and EAR had almost no established relationship, apart from the very first project on 'drug distribution'. EAR has been working on supporting the health system reforms in Serbia until December 2008 and had no follow up information on ECHO projects.

The third group of questions refers to the form of presenting the needs assessment findings. The reports were produced by all the researched organizations (IRC, MDM Gr, HRT), but the quality depended on each organization. There have not been strict guidelines from ECHO. Therefore, there is a marked difference between IRC and HRT (which have provided a full range of data supported with graphs and reference lists) and MDM Gr.

Although there are no standard guidelines on 'needs assessment' used by these organizations, IRC noted that they used MSF's guidelines concerning the refugee issues.

In all these organizations, the needs assessment teams consisted of doctors employed by NGOs. For this purpose, professionals were not employed nor have these doctors been trained to conduct needs assessment. Apart from collecting the information from official sources, the major source of data about the 'real' needs in the health sector was the doctors. This was 'a starting point' for the needs assessment. For example, a gynecologist was aware of health problems in this field, and the NGO decided to develop a project tackling this issue.

In case of Serbia, it was difficult to find out whether needs assessment influences the project design. Needs assessments have been carried out with some omissions, and needs assessment reports have been produced. Needs assessment reports review (IRC and HRT) has shown the appropriate collection of data, analysis and identification of the correct needs (crosschecked with IPH Serbia, MoH, WHO reports, and UK Department for International Development (DFID) reports). Despite some omissions in conducting the needs assessments, the identified needs were common. Needs in 1999 and 2000 were related to extreme emergencies. The state and the health sector were verging on collapse. Supply of equipment, fuel, consumables and drugs were the highest priority. Therefore, these particular needs, identified by NGOs, influenced the project designs, but some other issues came out from the research and gave new insight into the needs assessment and project design. Firstly, all interviewees stressed that 'all needs assessment findings should fit in with the donor requirements or objectives, if the NGO is going to apply for a grant'. It was said that some used to propose certain projects, based on the results from the 'needs assessments', but for some reason they were rejected. No explanation as to why this happened. Secondly, some of interviewees pointed out that the project objectives were copied from project to project with slight changes, which suggests that the practice has become routine, and it directly diminishes the importance of needs assessment. Thirdly, the ECHO Report (5) and WHO clearly stated, even in 1999, the need for healthcare reforms i.e. the need for introduction of the health management principles since it has been emphasized as an essential of the reforms. This was not identified by studied organizations in the Needs Assessment Reports, not even as a long - term need/objective.

The lack of participation at all levels (i.e. exclusion of patients/clients) and lack of stakeholder views raise doubts regarding the real needs of the health sector. The evidence on 'needs' arisen by some stakeholders (in WHO and ECHO Reports), but not found in Needs Assessment Reports makes ground for a serious debate. Some needs had not been identified and consequently they could not have influenced the project designs.

The most common constraints in performing the proper needs assessments in former Serbian projects are: the lack of capacity of NGO staff to understand what the process itself means and what its role is; the lack of capacity among team members (such as lack of training). Consequently, needs assessments were conducted by intuition, although they should have been led by the ECHO Project proposal forms, but there was no real understanding of them by the NGOs.

The study itself had some limitation, although it is considered that qualitative indicators reflect personal perception rather than objective data. Also, two weeks

for the field research is too short. More respondents need to be included in the research, especially patients and health professionals. A major limitation of this research is that ECHO and its partners have closed their missions in Serbia and do not have appointed representatives here.

The needs assessment process requires significant attention. It needs to be conducted professionally. NGOs need to adopt some guidelines or develop their own, and all necessary steps (like LFA, stakeholder analysis, and participation), which need to be completed before projects are designed. This should be the cornerstone of further sector development. Significant attention should be given to the 'needs assessment', the first stage of the project cycle, for two reasons: firstly, because of the influence it could have on the whole project design, and secondly, because of the effect that emergency aid project could have on development processes in a country.

CONCLUSIONS

Based on the study findings, the examined 'need assessment' principles were not known or they were ignored, but in case of Serbia, familiarity with the country context by doctors, the exclusive members of needs assessment teams, appeared to be the main strength of the needs assessment process. Therefore, identified and assumed needs of the Serbian health sector (1999 - 2003) were appropriate. Also, the needs that have been identified to influence the project designs and project objectives were established accordingly. Results of the study clearly demonstrate a need of further research to quantify humanitarian health care support in Serbia in the current economic situation.

Acknowledgements

I wish to acknowledge that this paper emerged as a product of my postgraduate education at the University of Birmingham, UK, and many years of working experience with international institutions.

I would also like to thank to all the respondents in this research for generously giving up their time and MSF in particular for hosting me during my fieldwork.

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PROCENA POTREBA: STUDIJA SLUČAJA PRUŽANJA POMOĆI ZDRAVSTVENOM SEKTORU SRBIJE

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Sažetak

Cilj ovog rada bio je da se utvrdi kako su potrebe zdravstvenog sektora Srbije bile identifikovane od strane glavnog donatora i njegovih implementatornih partnera. Konceptualni i analitički okvir sastavljen je i razvijen na osnovu pregleda literature i baziran na standardima/protokolima projekta 'Sfera', SZO i Svetske asocijacije za urgentnu medicinu i medicinu u slučaju katastofe. Istraživanje je sprovedeno u kontekstu zdravstvenog sistema Srbije analizom procene potreba od strane donatora u peridu 1999-2003. godine.

Studija je izvedena korišćenjem kvalitativnog pristupa-intervjui i dokumentarni izvori. Rezultati istraživanja ukazuju da je procena zdravstvenih potreba (PZP) bila sprovedena od strane međunarodnih nevladinih organizacija (NVO) koje su istraživane; nije bilo usvojenih PZP vodiča; PZP timove činili su domaći lekari, zaposleni u NVO, bez obuke u PZP; znanje i praksa u oblasti 'povezivanja humanitarne pomoći sa obnovom i razvojem' (PHPOR) bili su na veoma niskom nivou; na kraju, identifikovane potrebe uticale su na postavljanje ciljeva projekata, ali bilo je i nekih neidentifikovanih potreba, što je posledično dovelo do nepostavljanja ciljeva projekta povezanih sa tim. PZP praksa u identifikaciji stvarnih potreba i prioriteta zdravstvenog sektora Srbije pokazuje da ima projekata urađenih 'na osnovu potreba', ali sama činjenica da stanovišta svih zainteresovanih strana ('stakeholders') nisu uzeta u obzir, mogla bi podriti proces razvoja ovog sektora. Rezultati studije ukazuju na potrebu za daljim istraživanjem da bi se kvantifikovala humanitarna pomoć zdravstvenoj zaštiti u Srbiji u trenutnoj ekonomskoj situaciji.

***Ključne reči*: međunarodna saradnja, procena potreba, zdravstveni sektor**