Royal College of Obstetricians & Gynaecologists

# Health and Training Needs Assessment

## Global Health Toolkit No. 6

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## Introduction

This is part of a series of templates, or 'toolkits' developed by the Royal College of Obstetricians & Gynaecologists for global use. The template is designed to be generic and adaptable for use in almost any country or region, in conjunction with local O&G leaders. It is a step-by-step guide to health and training needs assessment and should form part of an agreed programme of work.

Health needs assessment (HNA) is, first and foremost, a tool for change; a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. As the RCOG is an education and training provider, this template includes a training needs assessment which, if required, must be completed in conjunction with a health needs assessment. Improvements to women's health through training and education will not be achieved if the training is not designed to meet prevailing health needs in the population.

The RCOG will be responsible for ensuring that its faculty and representatives are adequately trained for the task and will expect the host country to work with the College to provide access to data, patients, health care staff and facilities. The RCOG will share the findings and recommendations of the needs assessment will all relevant stakeholders.

## 1. Why a needs assessment is required

A health needs assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

If the RCOG is to develop a project in any area, a HNA should be undertaken so that the project can be developed to meet the health need. Where applicable, a training needs assessment should be undertaken after the health needs assessment – training should be designed to meet the prevailing health needs of the population.

In the particular case of women's health, there are marked inequalities between countries and within countries (see WHO evidence, for example) and an HNA can identify those inequalities.

Benefits from undertaking an HNA can include:

- Strengthening community involvement in decision making
- Improved public/patient participation
- Improved team and partnership working
- Professional development of skills and experience
- Improved patient care
- Improved communication with other agencies and the public
- Better use of resources.

The extent of these benefits depends upon the scale of the HNA to be undertaken, the culture within the area, data quality and the level of cooperation with local health agencies.

## 1.1 Elements of a health needs assessment

A basic health needs assessment has three key elements:

| Element | Involves |
|---|---|
| Epidemiological | Description of the problem:<br>• incidence and prevalence<br>• availability, effectiveness and cost-effectiveness of interventions/services<br>• possible models of care<br>• outcome measures. |
| Experiential | Assessment of stakeholder views and experiences, including professional and patient groups. |
| Comparative | Contrasts the services provided in one region with those available elsewhere. |

The level of detail and investigation of these elements will be dependent on the requirements of the project and the funding available. The elements can be used to form the basis of a standardised approach to HNA.

## 1.2 Challenges of needs assessment

Some of the challenges that may be encountered when undertaking an HNA are set out below, together with suggestions for overcoming them:

- Working across professional boundaries – tackling territorial attitudes preventing power or information sharing
    - develop positive relationships with those people; they need to understand that you do not pose a threat to their work
    - develop an understanding of organisational structures/priorities/objectives
    - ensure that others are clear about the benefits to their organisation/profession of conducting HNA.

- Language barriers [even when English is the main language, it may not be someone's first language, or there may be cultural differences in how the language is spoken]

    - consider setting out some definitions of common terms (not just O&G terms)
    - consider ways of jargon busting to keep communication accessible to all involved
    - make sure that translators are clear about the approach to take with patients, etc and discuss in advance any terms that may not be familiar.

- Lack of commitment from the top:

    - identify and establish who needs to be in agreement with the HNA at 'the top'
    - consider ways of communicating the value and benefits of the HNA to key senior stakeholders
    - be clear that without a needs assessment, the RCOG will not engage further.

- Difficulties in accessing relevant local data:

    - this is likely to be a problem in many areas, where record-keeping may be sporadic at best, and non-existent at worst. Central and local government sources may be able to contribute data (however flawed); NGOs and community organisations may provide additional information
    - depending on funding available, data may need to be collected by observation over an agreed period, and broader assumptions made on the basis of a short study.

- Difficulty in accessing the target population:
    - identify any organisational resistance to enabling access to the target population and discuss strategies with the host country programme leaders
    - review intended methodology for accessing target population and consider whether there are other, more creative ways, of accessing population.

- Difficulty in translating findings into effective action:
    - review findings in line with the RCOG global health strategy: is the project brief correct and does it continue to be strategically relevant? Do the findings of the HNA match the brief for the project?
    - consider findings in terms of short- and long-term action – clarify what can be achieved in the short-term and build on progress towards long-term goals
    - explore resource implications, and whether findings can assist in developing debate/discussion on resource allocation.

## 2. What constitutes health needs?

A health need can be:

- Perceptions and expectations of the profiled population (felt and expressed needs)
- Perceptions of professionals providing the services
- Perceptions of managers of commissioner/ provider organisations, based on available data about the size and severity of health issues for a population, and inequalities compared with other populations (normative needs)
- Priorities of the organisations commissioning and managing services for the profiled population, linked to national, regional or local priorities (corporate needs)

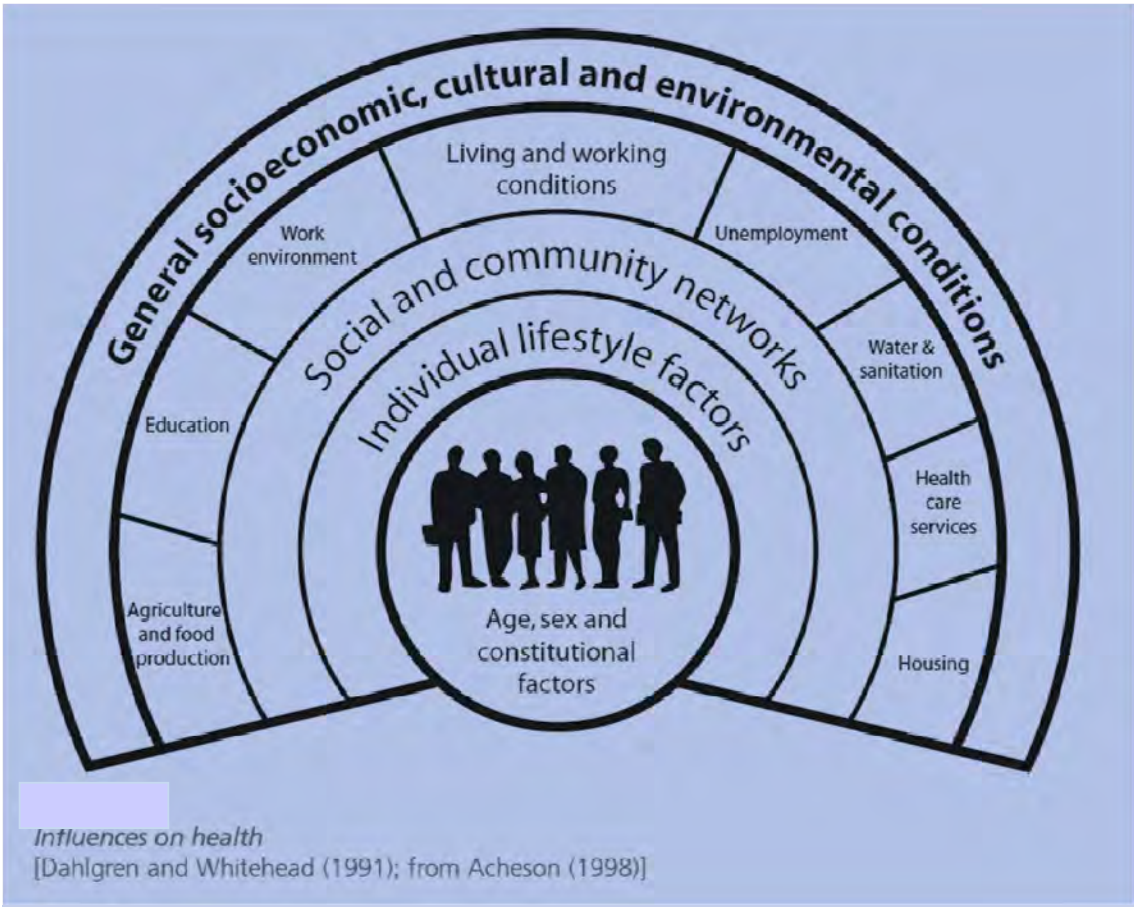
An HNA should involve comparing and balancing these different needs when selecting priorities. The RCOG will need to be clear with the host country that the identified health needs of women should outweigh corporate needs.

## 3. Determinants of health

This is a concept based on the model of Dahlgren and Whitehead (1991) (see diagram below) which suggests that there are complex, multi-layered influencing factors with an impact on the health of individuals.

At the centre are factors including age, gender and genetic inheritance. In the second layer are behavioural patterns such as smoking, diet and physical activity. In a third layer are social position, economic resources and the material environment. The fourth layer includes the wider or underlying determinants, consisting of social and community networks, work environment, housing and living conditions, education and transport. In the outer layer are the economic, political, cultural and environmental conditions present in society as a whole.

Tackling health inequalities requires action within all these layers of influence, and HNA can be used to identify, assess and prioritise where effective action should be targeted. The HNA should therefore collect information about the wider determinants of health, not only specific data about women's health presentation. This could be difficult for some countries and regional data may not be available. Some assumptions may need to be made in a region, based on national data (e.g. WHO/Unicef data).




*Influences on health*
[Dahlgren and Whitehead (1991); from Acheson (1998)]

## 3.1 Population

HNA populations can be identified as people sharing:

- Geographic location – small villages, urban neighbourhoods, cities, regions
- Settings – schools, prisons, workplaces
- Social experience – refugees, specific age groups, ethnicity, religious groups, socio-economic level
- Experience of a particular medical condition – eg fistula, diabetes.

Often a target population will be identified through a combination of main and subcategory groups, eg older women in a rural area with fistula.

## 3.2 Levels of prevention of ill health

There are three levels at which interventions can be effective in tackling ill health for individuals and within populations:

**Occurring** – preventing the problem occurring at all (primary prevention)
**Recurring** – preventing the problem progressing or recurring by detecting and dealing with it (secondary prevention)
**Consequences** – preventing the consequences or complications of the problem (tertiary prevention).

This is important in relation to identifying which (if any) exists within the healthcare infrastructure available for the population being assessed, and for recommendations for intervention and change to meet need.

## 3.3 HNA selection criteria

HNA is worthwhile undertaking only if it results in changes that will benefit the population. It is essential to be realistic and honest about what is capable of being achieved and over what timeframe.

Four criteria should be used in selecting issues for intervention:

- **Impact** – which health conditions and determinant factors have the most impact, in terms of size and severity, on the health functioning of the population?

- **Changeability** – can the most significant health conditions and determinant factors be changed effectively by those involved in the assessment? Who else needs to be involved to effect change?

- **Acceptability** – what are the most acceptable changes needed to achieve the maximum impact?

- **Resource feasibility** – are there adequate resources available to make the required changes?

As the RCOG may be undertaking the HNA in conjunction with a training needs analysis, these four criteria need to be applied across both assessments to ensure that the training recommendations are directly linked to improvements to meet health needs.

### 3.4 Health functioning

Health functioning can be defined as the individual's or population's experience in terms of whether the health condition or determining factor:

- Negatively affects social roles of caring, partnering, friendship, sexual relationships, employer/employee relationships
- Negatively affects the population's level of mobility (physical ability)
- Causes physical pain
- Contributes to mental illness
- Negatively affects energy levels (vitality).

Fistula, for example, can impact on all of these criteria.

### 3.5 Stakeholders

These are the different partners or sectors who should be involved in decisions about health, regeneration and other programmes. Stakeholders for HNA may include representatives from central and local government, education, social services, local community groups, local and international NGOs working with the target population, as well as from health agencies. Most importantly, they should include members and representatives from the target population.

### 3.6 Community engagement

A general term used in this context to describe the active participation of local people in defining priority issues and being part of the solution-determining process.

## 4. Quality assurance (QA)

### 4.1 QA provided by RCOG

The RCOG will undertake to quality assure its own work and that of any representatives acting on its behalf. The RCOG will ensure that anyone acting on its behalf is fully

competent to undertake the work required. Any output from work undertaken will be reviewed by the RCOG Education Quality Assurance Committee.

The RCOG may also seek input and advice on QA matters from other organisations in relation to specific and specialised work, for example other Royal Colleges, NICE International, other NGOs, and the World Health Organisation. Authorisation will be sought from the 'host' country before taking action.

## 4.2 QA provided by the 'host' country

The RCOG requires the 'host' country (or an institution within it) to agree appropriate quality assurance governance arrangements, to be agreed between the parties. Where no appropriate QA governance exists, the RCOG will assist the host country with establishing such governance and advising on the types of people to undertake this work.

## 4.3 Openness and accountability

The HNA and any subsequent recommendations for action or intervention should be made available to all stakeholders involved in the project or who were involved in providing information for the needs assessment. This can encourage greater cooperation when making requests for information in the future, and contribute to better and more inclusive decision-making. It is particularly important to share findings when they contradict information supplied by third parties, and/or when the recommendations coming from the findings are different from the activity requested from the local partners.

## 4.4 Access to clinical records

A health needs assessment for the RCOG should not normally require detailed access to clinical records, unless they are anonymised. If a specific health issue is being assessed that requires access to patient records, the RCOG assessor should adhere to same levels of confidentiality expected in the NHS and, ideally, patient consent should have been obtained (although it is recognised that this is likely to be difficult, if not impossible, in some of the countries in which the RCOG will work).

## 4.5 Access to patients/former patients

If quantitative research requires interviewing patients/former patients alone or in groups, the assessor(s) are expected to follow the same protocols as would be expected in the NHS,

including patient safety best practice. Where the assessor is male and the patients are female, an additional female observer must be present. Patients and former patients must be treated with utmost courtesy and respect by RCOG representatives.

## 5. Getting started

### 5.1 Choosing an appropriate assessor

The RCOG may not have the luxury of assigning a dedicated assessor for the needs assessment, and the person undertaking the assessment may be responsible for other aspects of a project. Although having an assessor who has clinical knowledge of O&G and wider health issues is advantageous, it is not essential. What is required is someone with:

- Experience of qualitative and quantitative research and analysis
- An understanding of health systems and the impact of systems on individuals at any point in that system
- The ability to determine the right questions to ask
- Tenacity

Whether that person is a Faculty member, a medical student, someone from a partner organisation, etc. can be decided depending on the scale of the needs assessment. A national assessment may need a clinical lead; an assessment of a single hospital and referral area may be suitable for a medical student to undertaken in a few weeks.

If the assessment is undertaken by a partner organisation (e.g. a local NGO or health body), the RCOG should appoint someone suitable to undertake a verification.

### 5.2 Identifying the population

This may seem obvious but identifying the correct cohort of the population and their health issues can be difficult, particularly if health data is minimal or non-existent. Stating that the HNA will study the health issues of all women and girls in a particular geographical area may *appear* to be a good place to start, and there may be WHO and Unicef research, for example, that can provide some high-level data but it may not achieve the outcomes required for a project centred on specific conditions (for example, a fistula project, or designing a subspecialty training programme). The work that the RCOG will be undertaking is likely to require far more detailed investigation of particular health issues (e.g. the occurrence of fistula; average waiting time for an operation).

Questions for the assessor to answer before commencing the assessment:

- Has the main population been clearly defined?
- Have any sub-population groups been clearly defined?
- Why have this population and any sub-population groups been chosen?

- Are there any specific issues about this population that makes it significantly more important than other local populations for assessing health needs?

### 5.3 Identifying who else needs to be involved

Working with the local partner, the RCOG will need to identify stakeholder and community groups that should be involved in the HNA. The list of stakeholders will depend upon the scale of the project and, therefore, the scale of the HNA. Only those people who can help to progress the HNA should be included – do not be tempted to include a range of non-relevant organisations or people simply to be seen to be inclusive or due to local 'politics'. It will waste time, resources and will not help local women. However, a good-practice HNA *will* include patient engagement and the RCOG may need to be adamant about this, if it will add value to the process.

## 6. Identifying health priorities

Choosing priorities is the real focus of the health assessment process. It involves making hard decisions. Involving stakeholders in the decision-making about priorities is essential if they are going to be carried through and acted on.

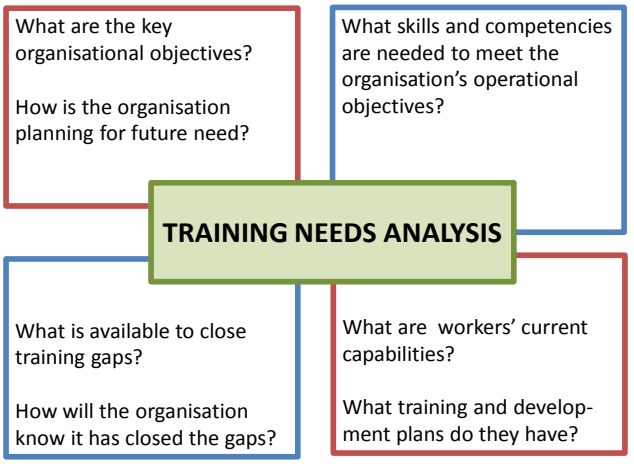
By prioritising, the project team should be trying to exclude anything that does not meet the first two HNA selection criteria – impact and changeability (see section 3.3). This step involves working in-country, and collection of reliable data about health issues (and the wider determinants as outlined in section 3) affecting the target population.

Because we live with economic and political realities, the priorities will require a test of reasonableness, particularly in low resource countries but the RCOG should, nevertheless, make all recommendations that it sees fit to provide a health service to meet need.

## 7. Assessing training needs linked to health priorities

Before any training plans can be developed, a training needs analysis (TNA) needs to be undertaken, linked directly to the health needs assessment. The RCOG should encourage the organisation, region or country to design a training programme to meet the health needs of women, not just the aspirations of doctors or politicians.

The TNA should first assess (a) the training pathway for each level of health care worker involved in women's health, at any point that women interact with the health infrastructure, and (b) what is expected of health care workers at every stage of their training and continuous professional development. The specifics will change with the country and the agreed outcomes of the project but, essentially, will need to answer the following questions:




A gap analysis will be required to enable the RCOG and the host country to develop a training programme and curricula (see the Curriculum Development template) linked to the recommendations from the Health Needs Assessment. A gap analysis compares the current situation with the required end result, to identify what action is required to achieve the latter. It does not require any 'test of reasonableness' – it should simply be an impartial identification of activity needed to bridge the gap.

## 8. Financial and risk management

The RCOG will need to undertake a risk assessment with the host country, in terms of risk to success of the project, personal security risk to RCOG representatives, and financial risk to the RCOG of undertaking any piece of work. The outcomes of a risk assessment will differ with each proposal, as will mitigation, acceptance or rejection of risk. Use a standard RCOG risk assessment template and adapt as required.

Below is a simple list of the most likely areas of risk for consideration:

| |
|---|
| Personal/physical security of RCOG representatives |
| Financial risk to the RCOG – is the host country covering the RCOG's costs; does the project require external fundraising; what are payment terms |
| The RCOG cannot identify a suitably qualified person to undertake the Needs Assessment |
| The data quality provided by the host country does not permit robust analysis |
| There is no political or senior 'ownership' of the project in the host country |
| There is senior 'ownership' in the host country but that is not shared by stakeholders lower down the organisational structure |
| There is resistance or outright obstruction when trying to access patients or former patients |
| Recommendations from the HNA/TNA are rejected by the host country |

| |
|---|
| The host country is unable or unwilling to make changes or undertake recommendations due to resource implications |
| Cultural differences between clinicians lead to differences of opinion as to priorities |
| Political priorities changes during the project (funding may cease; health or training priorities may change) |

Risk factors must be owned by not only the project lead(s) but by the RCOG as a whole, through the appropriate governance route. Changes to risks should be captured as they occur and dealt with immediately.

## APPENDIX 1

**HEALTH NEEDS ASSESSMENT CHECKLIST**

**The project lead for the RCOG should start completing this checklist at the beginning of the HNA process and add to it as the work is undertaken.**

| | |
|---|---|
| What population, where located? | |
| What are the aims and objectives? | |
| Who is carrying out the HNA? | |
| Who is included in the stakeholder group? | |
| What resources are required? | |
| How has a profile of the population developed? | |
| What data are available on the health of the population? How reliable is that data? | |
| How has information been gathered about the population's and healthcare professionals' perceptions of needs? | |
| What barriers have been encountered? | |
| How have these barriers overcome? | |
| What are the key issues for the population? | |

| | |
|---|---|
| What priorities have been chosen and why, in terms of impact on women? | |
| What interventions are being considered for this priority and what evidence informed your decision? | |
| How will resource needs be met? | |
| How will interventions contribute to reducing Inequalities for women and girls? | • Co-dependencies<br>(Non-health or non-O&G health issues that impact on O&G provision and access)<br><br>• Assessment of funding and political support (where relevant), including potential threats to delivery |

## Also in the Toolkit series:

- Curriculum Design
- Developing a Subspecialty Training Programme
- Establishing a Training Centre for Courses
- Exam Preparation
- Guideline Development and Adaptation
- Health and Training Needs Assessment
- Service Review and Audit

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