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Assessment of Capacity-Building Needs Challenges and Opportunities

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A B S T R A C T

The present research work asses the capacity-building needs and perceived challenges and further opportunities in the school health & nutrition program. In this research, demographic factors act as a control variable. The deductive research approach was applied with positivist philosophy. The focal teachers and school health & nutrition supervisors were the respondents for this study that was chosen from convenience sampling method. The statistical tests were applied through SPSS software. The reliability of all variables was above 0.8. The response rate was 98 percent. The statistical confirmed that demographic has no impact on variables association. The liner regression models demonstrate that perception and knowledge, workload capacity, facility & support service capacity and system, structural & role capacity have significant positive effect on the skills and practices of SH&NSs and teachers. This research is one of the rare studies in Pakistan which examine a comprehensive model using; perception and knowledge, workload capacity, facility & support service capacity and system, structural & role capacity as an independent variable and skills and practices of SH&NSs and teachers as a dependent variable and test the ecology of human performance theory in Pakistani context.

Keywords: Perception, Capacity, System, Skills, School health & nutrition supervisor.

BACKGROUND OF THE STUDY

The evidences of School Health Program (SHP) were found since the colonial era of mankind. The devoted efforts for the promotion of school health program were found after 1850s. During 1850-1950, numerous organization and professional societies focused their attention toward the promotion and development of school role in promoting and maintaining health. The most influential work was conducted by American Medical Association and the National Education Association in 1927 and presented their report "Health Supervision and Medical Inspection of Schools". In their research work the success of School Health program was laid on the triangle coordination among medical services, physical education and health education. The influential initiative of this program was the School Health Education Study (SHES) which was conducted in 1960s. This research study described that health sector as a multi-dimensional and vibrant entity and divided into 10 conceptual areas; development and growth of human, delicate health practices, disease and accidents, food and nutrition, substances that alter human mood and the active participation of family members in fulfilling human needs (Institute of Medicine, 1995).

In Pakistan, different elements of school health program were delivered in fragmented ways. During 1970s, school health program became a vital part of health services delivery. In 1980, school health program was initiated in some form, with special focus on school children screening for this purpose medical staff were appointed at rural level. But lack of monitoring and financial resources this program could not achieved their objectives. In the year 2009, School Health Program was initiated in all over the Punjab to achieve Millennium Development Goals (MDGs) for education, health and child protection. The effective coordination among health department, education department and donor agencies are considered necessary to achieve the desire outcomes of this program. The successful implement this program at grass root level, supporting capacity building

and school council involvement are necessary (UNESCO, 2010).

WHO (2006) report depicted that in order to gain maximum outcome from school health program, every country needed appropriate system for program execution and well-coordinated strategy. According to FAO (2007), the successful school health program has number of fundamental elements like persuasive nutrition material, opportunities related to nutrition program, technical support in training and support (capacity building), effective monitoring and evaluation mechanism. The capacity building plays a vital role in strengthening any program and has four key elements; tools, skills, human resources and structures, system and role. The concept of capacity building is similar to organization building and institutional strengthening (McLoughlin *et al*., 2020). It facilitates program to execute independently of alteration of technologies, personalities and social structures crises. Capacity building facilitate in developing sustainable and robust systems (Potter & Brough, 2004).

To implement any community related program, need for training and skills improvement are essential elements. In the absence of effective training program and supervisory support, field workers perform their work with frequent deficiencies (Mason et al., 2006). During employment period of any community worker the need for training is critical, training is an interdisciplinary approach. The performance of community worker can be enhancing per-service and in-service training (Javanparast *et al*., 2012).

There is extensive research work is available on School Health & Nutrition Program. The past practices showed that school health program in Pakistan did not deliver the potential/expected outcomes but such programs running in other parts of world bring about constructive outcomes. Hence, current study is to investigate the role of capacity building and opportunities for further development in School Health & Nutrition Program in Punjab Pakistan.

Statement of the Problem

In the advancement of knowledge and interventions in nutrition, various countries are still facing high prevalence of numerous preventable health/nutrition indices that are compromising the quality of life of community specially the school children (Murtaza *et al.*, 2015). Pakistan National Nutrition Survey 2011 (NNS-2011) reported that 45 percent children aged under 5-years are stunted that is also affecting the cognitive & learning ability of children (Khan *et al*., 2021). The occurrence of other micronutrient deficiency indices is also very high in Pakistan that contributing low performance of school children. In such countries, the prompt screening and referral of children with any deficiency to health facility is integral part of community health program to avoid prolonged impact / consequence (Aroor *et al*., 2014; Haque *et al*., 2016). Although, government took initiative by launching "School Health & Nutrition Program" to improve health and nutrition situation of this vulnerable group but the situation is still worse. Scientific-evidences based revamping of "School Health & Nutrition Program" is need of time to convert it to sustainable program. Instead of revamping of program, health department is applying different tactics and starting new parallel projects/programs (Rashid *et al*., 2021). Moreover, research-based knowledge on flaws of program, potential opportunities, and capacity building needs for improving skills and practices of "School Health and Nutrition Supervisors" are merely lacking. Regarding Most of the "School Health and Nutrition Supervisors" are from social science and allied disciplines, having very little knowledge of nutrition and command on nutritional assessment that instigate the need for trainings, assessment tools and support services from department for improved practices and contextual understandings of nutrition (Sharma *et al*., 2021). Though, primary & secondary healthcare in Punjab has effective systems and structure to control, and "School Health & Nutrition Program" is under control of provincial program unit but devolution to district level may helpful to improve the implementation. Some approaches for improvement are extrapolated from experience of other countries - those have different scenarios, setups and mind-set of community, which do not fit in Pakistan's situation.

LITERATURE REVIEW

Need for Training (Skills)

Capacity building and training have strong binding to achieve sustainable development goals (Nkomani et al., 2021). Crocker *et al*. (2016) developed a conceptual framework to evaluate training outcomes; performance of individual, learning and improved programming. The importance of capacity building and training in stakeholder engagement (Eales *et al*., 2017). Both

variables are inter-correlated and enhance the performance of all stakeholders. Both variables benefit in number of ways like decision making and critical analysis the problems. In development activities, the importance of training and capacity building are long lasting. Gordon and Chadwick (2007) reviewed the impact of training and capacity building through assessment framework and case studies method. The organization potential in utilizing capacity are primarily depends on quality of training, capacity building activities, skills, knowledge and networks. In a study related capacity building assessment, Goytia *et al*. (2013) described the importance of research in capacity building in community level projects and developed a research capacity building training model for education sector.

The vital part of any human resource investment strategy is staff training, that transform employee service delivery system into high performance, improve services quality and customer satisfaction. The skills of employees can be enhanced through training in a number of ways; marketing design strategy, consensus management, maintenance of integrated information system and performance management. In capacity building there are number of affective approaches; training, formal education and networking. The most effective and strongly recommended technique are training method. The effective training program build human capacities at an awareness raising level. Furthermore, training emphasis on learning by doing and formal education as well (UNEP, 2006).

Need for Continuous Education (Knowledge)

Regarding the need for continuous educational need, Bagayoko *et al*. (2013) examined the impact of distance continuing education on capacity building, enhance satisfaction and performance of healthcare professionals in isolated healthcare facilities. The outcomes depicted that continuing medical education is consider most importance for further development and capacity building. In their study multiple challenges were discussed like student evaluation and tracking system, IT infrastructure and institutional leaning management. In the research report of Billett *et al*. (2012) proposed six elements for effective continuing education and training system; organization and prerequisite of learning experiences, support for developing work-related competences, vigorous involvement of learners, development of learner agency, nationally recognized professional certification and fulfillment of specific workplace requirements. Christy and Hemavathy (2016) revealed that the ultimate advantages of continuing education are systematic and professional advancement, innovations in technology, rapid social changes and new and emerging patters for healthcare development. The European Commission report on "Adult and continuing education in Europe; Using public policy to secure a growth in skills", described the importance of continuing education. As per the report, adult and continuing education performed a dual function in economic growth and contributing in employability (Franco & Tracey, 2019). Furthermore, responding to broader social disputes, encouraging social consistency, and ensure considerable growth in skills and abilities of European people in innovation. In their research article, *Marjan et al.* (2014) used a new concept for continuing education as "lifelong learning (LLL)", which means that learner show regularity in learning during their entire life. They further divided continuing education in formal, informal and non-formal learning. From organization aspects, it improves knowledge and skills of workforce at individual level, it supports for upward career development, job enhancement and personal improvement.

Need for Improvement in Practices and Availability of Tools

Billah *et al*. (2017) stated that the screening and assessment activities in community health programs are important with the purpose of identifying the potential risk as well as nutritional needs. According to Haileamlak (2013) investigation, the valuable elements of school health programs are appropriate screening and assessment including, nutritional parameters (through anthropometric measurements), common skin diseases, physical disabilities, dental hygiene and hearing & vision impairments. Hughes (2008) described the determinants of mismanagement and affirmed that majority of health screening and medical mistakes are attributable to lack of practices and inadequate facilities. According to Hughes healthcare have six basic aims; safe, effective, patient centered, efficient, timely and fair. The quality of healthcare sector can be improved through effective implementation of quality improvement strategies; Health-provider reminder systems, facilitated relay of clinical data to providers, Audit and feedback, Provider education, Patient education, Promotion of self-management, Organizational change and financial incentives, regulation and policy (Prowse *et al*., 2020).

As malnutrition occurrence specifically in children are too high in Pakistan therefore, primary community workers need to be vigilant in screening and identification of those children who need to refer for treatment/intervention to health facility. Early detection results in prompt management and, in the end, better and enduring outcomes (Ali *et al.*, 2013).Therefore, the precise and accurate screening as well as availability of screening tools are substantial for improved practices. Improvement in screening competency and subsequent referral through training (capacity building) is essential to enhance the effectiveness of program as imperfections and/or weaknesses in screening and ultimately belatedly referral might lead to not only confrontational results in academic outcomes, likewise lifetime hear and visual impairment of children (Wang *et al.*, 2011).

Mbewe *et al*. (2013) studied the depression and anxiety disorders among people with epilepsy through self-developed screening tool. The result depicted that brief screening tool was to facilitate rapid diagnosis and treatment of neglected illiterate patients.

Organization, System and Structural Needs

Allen *et al*. (2016) described the importance of capacity building of organization and system for improvement in proficiency of community health workers (CHWs) performing their work in healthcare care set-up by exploring the capacity building needs of CHWs in US. In the study of Abera *et al*. (2014) discussed the system and structural issues and challenges of Public Health Community Workers in Ethiopia by exploring the supply and availability, time restriction, lack of rooms, poor supervision, unavailability of specialists and absence of treatment guidelines (Ali *et al*., 2021). In another research study, Rudan and Sirdhar (2016) identified coordinated structure, function and five basic needs to evaluate the global health research system. They emerged five basic health needs; coordinate funding among donors, prioritize research ideas, promptly accept successful research, rapid acceptability and dissemination of outcomes and evaluate return on investment in health research. The outcomes described that it is essential to formulate an effective system and structure that coordinate all the needs among donors and evaluate their invested money in health. Owiredu *et al.* (2017) conducted a research project to identify the evidence-based recommendations for health system capacity building. The targeted population was health care workers and district health managers. The outcome depicted into effective services delivery and local program management. Moreover, Maruthappu *et al*. (2015) emphasized on an integrated healthcare among all the healthcare system. They classified the patients into three groups; multi-morbid patients, moderate patients and elderly. Effective integration among patients' groups has been confirmed to achieve progress in quality, cost control, efficiency and coordination of health care.

Workload, Facilities and Support Services Needs

Olthof *et al*. (2018) studied the factors that are vital to improve patient care and hospital logistics, and association between patient complexity and nursing staff actual and perceived workload. The outcomes depicted that there was no association between actual workload and patient complexity but perceived workload has strong association with patient complexity. In a related research study, Bruggen (2015) conducted an empirical experiment to analyze the association between workload and performance. The association between workload and performance is assumed to be positive to perform better under difficulty situations. The performance of individual remains low at low level of workload, average at moderate workload and at high workload performance also remain at high level (Aslam *et al*., 2022).

Ahmad *et al*. (2015) observed the fundamental features of capacity building and role of supervisory and organizational support for career development. The outcomes portray that capacity building enhance individual performance, whereas organizational and supervisory support has no association with employee's performance. Kozuki *et al*. (2017) conducted a cross-sectional survey to investigate and identify gaps and strengths in existing facility capacity for neonatal care and postpartum care. The existing facility capacity include equipment availability, medication, supplies, knowledge and performance of health workers. The results depicted that key supplies were missing, healthcare workers have no emergency and newborn training, staff availability and transport facilities were not proportional increase with population, and experience workers performance were worse. Lehtonen (2006) identified the success factors and attributes of collaborative relationships in facility services. The nature of collaborative relationship in facility services was alike to supply chain management. It includes cooperation capabilities and collaborative approach and

in long run, two-way knowledge sharing and goal congruence.

Role of Capacity Building in Health Education

Potter and Brough, (2004) explored the systemic capacity building and hierarchy of needs in the context of Indian health and family welfare sector through nine distinct inter-reliant components and four main elements comprising "System, structure and Role". The systemic capacity building was proved beneficial to improve programs monitoring and design, efficient use of resources and to identify the deficiency in particular areas. The practical implement capacity building pyramid in Indian health sector. Ravitz *et al*. (2014) implement capacity building tools to improve the performance of front-line healthcare staff through work based continuing education. The outcomes depicted that improvement of health workers knowledge through multi-model, work-based and interactive curriculum development for lifelong learning.

Prashanth *et al*. (2014) contextualized theoretical framework for capacity building of health managers at district level. Factors were identified at institutional, environmental and individual levels. These factors were organizational change, perceived self-efficacy and organization commitments. NSW Health Department (2001) presented a framework for building capacity to promote health, the main areas of focuses were capacity building within programs or within community. These documents highlight five key variables for capacity building; development of workforce, organizational change, partnership, leadership and allocation of resources. They claimed that this framework enhanced the capacity building of people performing their work in health promotion programs and address the future health challenges (Murad *et al*., 2022).

H_1: There is a positive relationship between knowledge and skill & practices of SH&NS

H_2: The workload capacity significantly positive effect on the skill and practices of SH&NS

H_3: The Facility & Support service capacity positive significantly effect on the skill and practices of SH&NS

H_4: The System, structural and role capacity significantly positive effect on the skill and practices of SH&NS

Supporting Theory

Ecology of Human Performance (EHP) Theory

The EHP theory is based on the interrelationship of four elements; person (client), task (occupation) and context (environment) and performance. The EHP framework developed five different strategies to enhance the performance as described by Dunn *et al*. (1994);

- **Establish or Restore**
  Person occupation improve skills and abilities.
- **Alter**
  Select the best environment (context) on the basis of their current skills and abilities to alter the current environment.
- **Adapt**
  Adjust to the current environment.
- **Prevent**
  Avoid the further development or occurrence in client, occupation and environment for dysfunctional performance.
- **Create**
  Generate favorable circumstances to achieve better performance.

The interaction between person and context directly affects human performance and behavior. EHP framework play an imperative role in determining which intervention would be appropriate after the screening process. Senia (2015) used EHP framework to study the current capacity building needs of occupational therapists related to older driver screening, assessment and intervention.

The selection of ecology of human performance was depend on following two reasons. Firstly, EHP theory is a client-centered which permits to each individual to observe in a distinctive and complex ways that include their previous work experience, skills, attributes and needs (Senia, 2015). Secondly, EHP theory comprise of process of self -learning (Dunn *et al*. 1994). Teachers and School Health and Nutrition Supervisors play a frontline personnel's in disseminating community health education through school going children. Both have different demographical background; experience, gender and level of education. Therefore, EHP framework is used to recognize their individual needs and specific skill set.

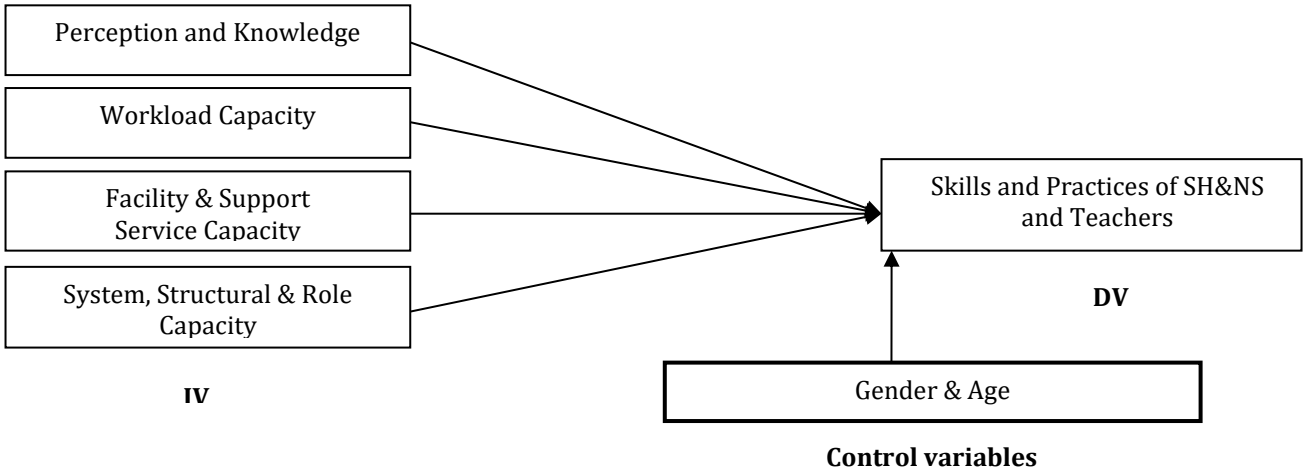

Figure 1. Research Model. Source: Authors prepared.

RESEARCH METHODOLOGY

Research Approach & Strategy

According to Saunders *et al*. (2009), the deduction research approach has some basic steps; formulation of hypotheses, definition of basic concepts and terms related to hypotheses, testing the hypotheses, conclusion generated from hypotheses, and finally alter the existing theory in the light of results if required. Hence, in the current study of capacity building needs, challenges and opportunities of SH&NP through deduction approach. In the current research work, survey strategy was incorporated with adapted questionnaire from reliable sources.

Target Population

The population for current study was the SH&NS and focal teachers in every male and female school. The study was conducted in Okara and Pakpattan. The selection of these district was on convenient bases.

Sample Size & Sampling Technique

In this research work, researchers employed Krejcie and Morgan (1970) table for known population. The population for this study is 2616 from concerned district office and official's websites. The final sample size was 335 at 95 per cent confidence level and 0.05 margin of error. In this research work, samples are selected form convenience sampling technique. Data was collected on convenience bases only from two districts, Okara and Pakpattan Pakistan. In many previous research of similar nature used convenience sampling to generate a sampling frame.

Measurement of Scales

The perception and knowledge with six items adapted from UNDP Capacity Assessment Methodology User's Guide (2008). The workload capacity with six items adapted from Hoonakker *et al*. (2011) and Kyndt et al. (2010). The facility and support services capacity with five items adapted from Service Availability and Readiness Assessment Mapping (SARAM) tool (2012). The system, structural and role capacity with five items adapted from World Health Organization (WHO) guidelines 2012. The skills & practices with five items adapted from UNDP Capacity Assessment Methodology User's Guide (2008).

RESULTS AND DISCUSSION

Reliability

According to Sekaran (2003) the acceptable value of Cronbach's Alpha (α) is ranging from 0.6 to 1.0. The Cronbach's Alpha (α) values of criterion and predictors are above 0.6. This means that all the items are highly consistent and acceptable for further study (Table 1).

Table 1. Reliability of Study Variables.

Sr. No	Variables type	Scale Name	No of Items	Cronbach's Alpha
1	Independent	Perception and Knowledge (PK)	6	0.809
2		Workload Capacity (WC)	6	0.799
3		Facility Support Service Capacity (FSC)	5	0.853
4		System, Structural and Role Capacity (SSC)	5	0.836
5	Dependent	Skills and Practices (SP)	5	0.802

Source: Authors prepared.

Regression Analysis

Perception & Knowledge (PK) and Skills & Practices (SP)

The model summary table describes the model fit test with the help of R-square (R^2). In the model table R^2= 0.351 which describes that 35% variance exist between Perception & Knowledge and skills & practices with adjusted $R^2$is 0.349. The ANOVA table determines the liner regression with F-statistics at 0.00 significant level. In ANOVA table the value of F-statistic was 176.696 at 0.00 significance level, which means test is significant. In Coefficient table the regression was formulated with the value of Beta and dependent variable (PK) at significant level 0.05 (Table 2-4).

Table 2. Model Summary of Perception & Knowledge and Skill & Practices.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.592[a]	.351	.349	.67612

a. Predictors: (Constant), PK

Source: Authors prepared.

Table 3. Analysis of Variance of Perception & Knowledge and Skill & Practices.

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	80.774	1	80.774	176.696	.000[b]
Residual	149.484	327	.457		
Total	230.258	328			

a. Dependent Variable: SP

b. Predictors: (Constant), PK

Source: Authors prepared.

Table 4. Coefficient of Dependent Variable Skill & Practices.

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.067	.210		5.075	.000
	PK	.673	.051	.592	13.293	.000

a. Dependent Variable: SP

Source: Authors prepared.

Workload Capacity (WC) and Skills & Practices (SP)

The model summary table describes the model fit test with the help of R-square (R^2). In the model table R^2= 0.420 which describes that 42% variance exist between Perception & Knowledge and skills & practices with adjusted R^2 is 0.418. The ANOVA table determine the liner regression with F-statistics at 0.00 significant level. In ANOVA table the value of F-statistic was 236.803 at 0.00 significance level, which means test is significant. In Coefficient table the regression was formulate with the value of Beta and dependent variable (PK) at significant level 0.05. The value of un-standardized beta coefficient is 1.323 and standardized beta coefficient value is 0.648 at 0.00 significant level (Table 5-7).

Table 5. Model Summary of Workload Capacity and Skills & Practices.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.648a	.420	.418	.63906

a. Predictors: (Constant), WC

Source: Authors prepared.

Table 6. Analysis of Variance of Workload Capacity and Skills & Practices.

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	96.711	1	96.711	236.803	.000[b]
	Residual	133.547	327	.408		
	Total	230.258	328			

a. Dependent Variable: SP
b. Predictors: (Constant), WC

Source: Authors prepared.

Table 7. Coefficient of Workload Capacity and Skills & Practices.

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.323	.166		7.974	.000
	WC	.667	.043	.648	15.388	.000

a. Dependent Variable: SP

Source: Authors prepared.

Facility Support & Service Capacity (FSC) and Skills & Practices (SP)

The model summary table describes the model fit test with the help of R-square (R^2). In the model table R^2= 0.210 which describes that 21% variance exist between Perception & Knowledge and skills & practices with adjusted R^2 is 0.208. The ANOVA table determines the liner regression with F-statistics at 0.00 significant level. In ANOVA table the value of F-statistic was 86.919 at 0.00 significance level, which means test is significant. In Coefficient table the regression was formulated with the value of Beta and dependent variable (PK) at significant level 0.05. The value of un-standardized beta coefficient is 2.035 and standardized beta coefficient value is 0.458 at 0.00 significant level (Table 8-10).

Table 8. Model Summary of Support & Service Capacity and Skills & Practices.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.458[a]	.210	.208	.74585

a. Predictors: (Constant), FSC

Source: Authors prepared.

Table 9. Analysis of Variance of Support & Service Capacity and Skills & Practices.

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	48.352	1	48.352	86.919	.000[b]
	Residual	181.906	327	.556		
	Total	230.258	328			

a. Dependent Variable: SP
b. Predictors: (Constant), FSC

Source: Authors prepared.

Table 10. Coefficient of Support & Service Capacity and Skills & Practices.

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.035	.196		10.402	.000
	FSC	.443	.047	.458	9.323	.000

a. Dependent Variable: SP

Source: Authors prepared.

System, Structural and Role Capacity (SSC) and Skills & Practices

The model summary table describes the model fit test with the help of R-square (R^2). In the model table R^2= 0.842 which describes that 84% variance exist between Perception & Knowledge and skills & practices with adjusted R^2 is 0.842. The ANOVA table determines the liner regression with F-statistics at 0.00 significant level. In ANOVA table the value of F-statistic was 1748.482 at 0.00 significance level, which means test is significant. In Coefficient table the regression was formulated with the value of Beta and dependent variable (PK) at significant level 0.05. The value of un-standardized beta coefficient is 0.499 and standardized beta coefficient value is 0.918 at 0.00 significant level (Table 11-13).

Table 11. Model Summary of System, Structural and Role Capacity (SSC) and Skills & Practices.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.918[a]	.842	.842	.33308

a. Predictors: (Constant), SSC

Source: Authors prepared.

Table 12. Analysis of Variance of System, Structural and Role Capacity (SSC) and Skills & Practices.

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	193.980	1	193.980	1748.482	.000[b]
	Residual	36.278	327	.111		
	Total	230.258	328			

a. Dependent Variable: SP

b. Predictors: (Constant), SSC

Source: Authors prepared.

Table 13. Coefficient of System, Structural and Role Capacity (SSC) and Skills & Practices.

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	.499	.081		6.124	.000
	SSC	.875	.021	.918	41.815	.000

a. Dependent Variable: SP

Source: Authors prepared.

DISCUSSION

H_1: There is a positive relationship between knowledge and skill & practices of SH&NS

Knowledge is a continue process and many researchers used the term lifelong learning (LLL). In the study of Arne (2017) organization personnel were aware of lifelong learning needs. They want to continue their study to gain certain benefits; soft skills, up-to-date methods, daily routine worker becomes easier, and better employment chances. Their study revealed the public officers given great importance with 51%. The findings of this study support

the researcher hypothesis and findings. Bagayoko *et al*. (2013) described the role of continuing distance education through ICT as a capacity building tool for healthcare professional in remote areas of Africa. The findings depicted that continuous medical education was the high rated benefits of ICT followed by field shared experience and training. The perceptions among healthcare professional and general public for adoption of innovation in education were giving potential benefits during professional career. The outcomes of this research support researcher hypothesis and problem.

H_2: The workload capacity significantly positive effect on the skill and practices of SH&NS

Bruggen (2015) conducted a research study to analysis. the impact of workload on performance and quantity & quality of output. The results depicted that inverted-U shape relationship between workload and performance. The employee output rises with increase in workload to a certain level after that decrease significantly. The results significantly correlate with researcher study. M. Jeon *et al*. (2014) explored the relationship between emotions and perceived workload. This study forecast that anxious applicants feels more workload than annoyed applicants. In demanding task, happy drivers showed higher perceived workload. The hypotheses results depicted that perceived workload became lower in anger situation and also have low subjective judgment risk and low driving performance. On the other side, perceived workload became higher in fear situation with high subjective judgment and high driving performance. These outcomes were in-line with the current study results related to workload enhance the skills and practices of SH&NP.

H_3: The Facility & Support service capacity significantly positive effect on the skill and practices of SH&NS.

Walsem *et al*. (2017) examine the association among unmet healthcare, social support service needs and health-related quality of life. Socio-demographic factors were also considered. The statistical results unmet needs, social support services and socio-demographic have 42% variance in health-related quality of life. These outcomes were supporting the current hypothesis towards support services at individual and organization level. Kozuki *et al*. (2017) conducted a cross sectional survey to identify the gaps and strengths in existing healthcare facility in postpartum care. The data was

collected on equipment availability, medication, supplies and healthcare performance & knowledge. The results depicted those facilities provides better healthcare with the support of management, peers and general public. Without co-operative support the staff was not motivated to provide better healthcare services in the community. The findings of this research work support researcher hypothesis and research questions. Smith *et al.* (2013) analyzed the association between unmet service needs and health-related quality of life. The results illustrated that most common unmet service needs were financial, mental health and support group services. In order to improve the health-related quality of life, facility & support services were essential at individual and organizational level. The discussion and conclusion of this research study support the research study theme.

H_4: The System, structural and role capacity significantly positive effect on the skill and practices of SH&NSs.

Rudan and Sirdhar (2016) examine the role of structure, function and five basic needs of the global health research system. The results suggested that in health research, tools development is necessary that help donors to synchronize funding and fairness among various support areas and also evaluate the value for invested money. These findings support the current research theme and in-line with the research results. Owiredu *et al*. (2017) conducted research to build health system capacity through implementation research. This research work exhibits the importance of implementation research to improve the healthcare delivery and challenges. The conclusion suggested that training and processes enhanced program management of local programs, improve health delivery services, improved data management and career development. The conclusion of this research work supports the current research setting and carry forwarded the role structure and system in the improvement of health service delivery.

CONCLUSION

The objectives of current research work are to evaluate the capacity building needs, challenges and further opportunities in SH&NP at district level. The contributing

factors in capacity building are knowledge, workload capacity, facility support & service capacity and system, structural & role capacity. Researcher hypotheses that these factors significantly affect skills and practices of SH&NS to screen school children. The statistical results confirmed that all study variables have significant association with skills and practices.

RESEARCH LIMITATIONS

The current study was accomplished with in a limited geographical area (two districts Okara & Pakpattan); thus, the results may not applicable to all parts of the province as different districts have different set-up/scenarios and opportunities. In order to overcome these limitations, future research should be conducted more in-depth and with representative of samples from whole province.

FUTURE DIRECTIONS & RECOMMENDATIONS

The findings of current study support more in-depth further research throughout the Punjab to overcome the limitations of present study in probing capacity building needs of program and SH&NSs. Inclusion of other officials (at district and provincial level) / practitioners (i.e., Medical Officers) pertained to nutrition program should be addressed in future study. Moreover, further research should also incorporate the ascertaining of number of children screened by SH&NSs (monthly or yearly) and number of supervisors for screening of adolescent girls (in girl's high schools) along with response of children and their parents for identifying the capacity building needs.

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