GAP ANALYSIS AND THE PERFORMANCE OF PRIMARY HEALTH CENTRES IN THE IMPLEMENTATION OF THE SCHOOL HEALTH PROGRAMME OF NRHM

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ABSTRACT

Child health is an important component of family welfare which is a major determinant of human development and hence the economic growth of any country. Several government schemes are available to take appropriate care of the children under the national rural and urban health mission. The child health and immunization programme, school health programme, and the adolescent and sexual health programme take over at different stages of development of a child. The School Health Programme has a target of completing two screenings per year covering all the government and aided schools. The success of the programme depends on the implementation of the various strategies adopted by the state from the preamble set by the Ministry of Health and Family Welfare.

Weighted scoring of a checklist to assess the various Primary Health Centres was chosen and a gap in the implementation of the programme was studied The reasons for the gap in the system was analysed and whether they were associated or not with the success of the programme was found with the help of a Chi Square test. The three main attributes which contributed to the success of the programme were 'training given to the staff', 'supply of resources' and the 'parental cooperation'. The study shows that the strength of association of training given to the staff with the success of the programme was stronger when compared to the other two attributes. This implies that success of the school health programme will depend largely on the staff training. Training is complete when the adopted cascade strategy of training the state level trainers who in turn train the district and mandal level trainers and ultimately reach the grass root level programme implementers or the PHC staff and the school teachers. This has a multitude of effects where, when the training aspect is looked into, all the other aspects of success fall in place.

KEYWORDS: Association, Gap Analysis, GDP, NRHM, PHCs, School Health Programme, TFR, WHO

INTRODUCTION

The health of a country is collectively, the health of its population. A healthy population is vital for a growing economy. The GDP of the country reflects the health of its productive population. Thus, attention on child health today, strengthens the health of the working population tomorrow. Children are the future pillars of a country. It is important to safeguard, restore and enhance their physical, mental, social, intellectual and spiritual wellbeing, for their optimum development into strong individuals. The Human Development index is a measure of economic development and economic welfare. The Human Development Index examines three important criteria of economic development (life expectancy, education and income levels) and uses this to create an overall score between 0 and 1. 1 indicates a high level of economic development, 0 a very low level. The HDI combines:

- Life Expectancy Index. Average life expectancy compared to a global expected life expectancy.

- Education Index

- Mean years of schooling

- Expected years of schooling

- Income Index
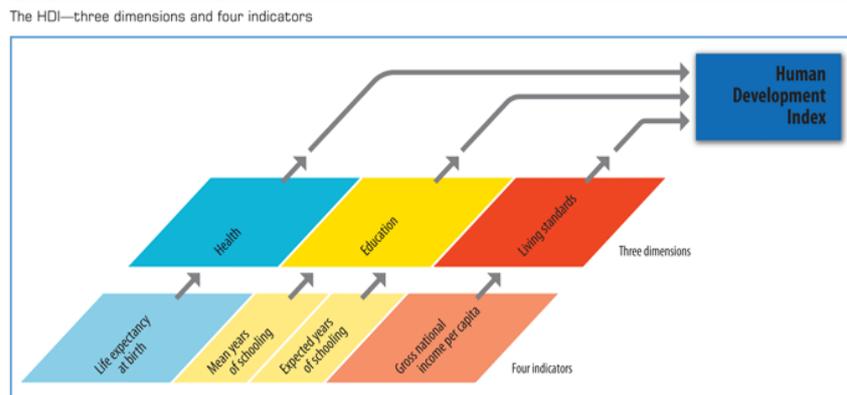
Note: The Indicators Presented in this figure follow the New Methodology, as defined in box 1.2
Source: HDRO

Figure 1: Components of Human Development Index

Several health schemes have been made available to children right from the time they form in the womb of the mother to their adolescent age. The 'Maternal Health and Nutrition Programme' safeguards the health of the newly formed foetus till the time the infant is born. Postnatal care and follow up is affected as the 'Child Health and Immunization Programme' is upto the age of five years. Tracking the health of a child thereafter becomes a very cumbersome issue in an enormous population. This paved way for the 'School Health Programme' which is a coordination of the education sector and the health sector. This programme is directed to the child of school going age till the period of adolescence. After which the 'Sexual and Adolescent Health Programme' takes effect as they bloom into healthy adults and perfect pillars of the community. The main objective of SHP is to identify health problems of the child at an early stage and treat them promptly with due referral systems to specialty centers as per the necessity.

School Health Programme under NRHM

WHO's Global School Health Initiative, launched in 1995, seeks to mobilise and strengthen health promotion and education activities at the local, national, regional and global levels. The initiative is designed to improve the health of students, school personnel, families and other members of the community through schools. India being the second most populated country in the world poses a risk of care deprivation to the younger age groups, especially the child born with several siblings. Although several Family Planning and Welfare Schemes have contributed to the reduction in the Total Fertility Rate (TFR) to 2.55, an optimum living of the community as a whole would be possible only if it reaches a target of 1.8 children born per woman.

This situation, along with the reduced per capita income, threats to decrease the standard of living, education and health indicators of the households. As a result, it would succumb to child labor and exploitation. The Ministry of Health

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and Family welfare thus introduced the 'School Health Programme' under the National Rural Health Mission. The components of the School Health Programme as per the preamble include:

- Screening, health care and referral

  o General screening, assessment of anaemia, nutritional status, visual acuity, hearing problems, dental check up, common skin conditions, heart defects, physical disabilities, learning disorders, behavioral problems, etc.

  o Basic medicine kit will be provided to take care of common ailments prevalent among young school going children.

  o Referral Cards for priority services at District / Sub-District hospitals.

- Immunization

  o As per national schedule

  o Fixed day activity coupled with education about the issue

- Micronutrient (Vitamin A & Iron and Folic Acid) management

  o Weekly supervised distribution of Iron-Folate tablets coupled with education about the issue

  o Administration of Vitamin A in needy cases.

- De-worming
  o As per national guidelines

  o Biannually supervised schedule

  o Prior IEC

  o Siblings of students also to be covered

- Health Promoting Schools
  o Counseling services

  o Regular practice of Yoga, Physical education, health education

  o Peer leaders as health educators.

  o Adolescent health education

  o Linkages with the out of school children

  o Health clubs, Health cabinets

  o First Aid room/corners or clinics.

- Capacity building

- Monitoring & Evaluation

- Mid Day Meal

The School health programme is the only public sector program specifically focused on children of school going age. Its main focus is to address the health needs of children, both physical and mental. In addition, it provides for nutrition interventions, yoga facilities and health counseling. It increases the efficacy of other investments in child development and ensures good current and future health along with better educational outcomes which in turn improves social equity.

Though there are several strategies formulated and followed, the success of a programme largely depends upon two main factors, namely 'the strategic plan' and 'the implementation framework'. The system is required to undergo a number of systematic assessments time and again to check for the inefficiencies and to bridge the gaps in the systems so as to reach the national targets. This is called as the need-gap analysis. The strategic plans and the implementation frameworks have to be revised as per the results so as to bring about betterments in the system. The main objectives of the school health programme are:

- Early detection and prevention of diseases.

- Promotion of health and well being of the students through follow up care.

- Development of healthy attitude and behavior amongst the students.

- Ensure a healthy environment for children at school.

- Increased learning capabilities due to good health and nutrition.

- To reduce dropouts.

The hierarchy of the scheme includes at State level one Joint director from health department and two state Coordinators from health and education departments. At District level one officer from health department and one officer of education departments. At mandal level, medical officer of the PHC and Mandal Education officer are included. At School level head master of the school and the health provider are also included.

Significance of the Study

The school health programme is a programme for the school health service under NRHM, which has been necessitated and launched in fulfilling the vision of NRHM to provide effective health care to population throughout the country. The study is undertaken to analyze the strengths and weaknesses of the School health programme, so that the performance of the PHC can be assessed.

Scope

The study is conducted only in four districts of Andhra Pradesh covering 159 PHC's which are implementing school health programme of NRHM.

Objectives of the Study

- To analyse the gaps and reasons for the gaps in the implementation of the programme

- To study whether any association exists between staff training, resources supplied and parental cooperation with that of performance of the PHC for the school health programme,

- To examine which attribute is having more impact on the performance of the PHC.

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Research Methodology

Convenience sampling has been adopted for selecting the sample and a total of 159 schools were taken as a sample for the study. In the first district a total of 63 schools, second district 41 schools, and third district 22 schools, in the fourth district a total of 33 schools are selected for the study. Data is collected by both primary and secondary sources.

The primary data was collected by direct observation of the Primary Health Centres and some of the schools under them. Secondary data regarding the programme was collected from the school health records of the primary health centres. The programme utilizes a variety of forms such as the

- F1/W1 form for data collection during screening of school children. This is also called as the CHIP format or the Children Holistic Improvement Program, which records the medical findings system wise.

- F2/W2 form which is the consolidated data for all the schools under the particular primary health centre. This form has to be submitted to the CHNC or the community health nutrition cluster office.

- F3/W3 forms are the referral and follow up form which contains the details of the students who are referred to higher specialty centres. It contains the names of the student, the school, the name of the health provider, the diagnosis of the patient and purpose of reference. There is another W3 referral tracking form used as a record at the district level. It contains the health ID number, beneficiary name, health and demographic details.

- F4/W4 form is the weekly progress report form to be submitted every Monday. It contains the name of the subcentre and the number of children scanned in each school under them, % of schools covered, % of children referred, and number of children referred, etc.

- F5/W5 form is the district wise screening progress report. It is similar to the CHIP format, but the data is consolidated for that district for that week or month.

Apart from these forms at the school level, the school maintains a medical register where the health providers sign and write their purpose of visit. They also maintain a sick register where the sick children details are recorded and followed up. In addition to this, the schools also maintain the School Health Examination Record (SHER cards) for each student. The health providers update the card after each medical checkup. The referred children are given a referral chip for approaching the hospital rendering higher level of care.

Hypothesis

The various hypotheses which have been formulated for the present study are:

- There is no significant association between the training of staff and the Performance of the PHC for the SHP.

- There is no significant association between the resources supplied to the PHCs and the performance of the PHC for the SHP.

- There is no significant association between the parent cooperation for child care and the performance of the PHC for the SHP.

Tools of Analysis

The 'checklist and scoring method' was used to record and evaluate the PHCs and their respective schools. The scores of the PHCs under the district were taken as an average score for that district. These scores were then compared with the check list index scores to find out the gaps in the system. The scoring method used was a 'weighted scale' method. Chi-square test is used to test the hypothesis which has been laid down. In addition, to measure the strength of association, the Karl Pearson's coefficient of contingency, which is a function of the chi square statistic, is also used.

Analysis and Interpretation of Data

The School Health Programme, a revitalized venture has set forth the goal of complete screening of all the children studying in the government and aided schools of Andhra Pradesh, twice a year with appropriate referrals. With these targets, the system was analysed for gaps in the implementation framework so as to identify the difference between what is actually being followed and what has been expected out of the programme. Evaluation of the performance of the PHCs for the School Health Programme implementation with the help of a weighted score checklist revealed a lag in the system. Based on weighted scale method of scoring, the maximum score for a PHC is 59 and the minimum score is 4. The score for an average performing PHC or a PHC with an active School Health Programme is 45. The score for a PHC below which the School Health Programme is totally inactive is 27.

The scores thus obtained for each district after totaling the scores for individual criteria under the checklist are as follows:

- I district   - 20. 88
- II district   - 26.67
- III district - 45
- IV district   - 39

Thus, we infer that there is definitely a gap in the implementation of the programme, which gives us a lag between what the prevailing situation is and that which has to be followed. The next step is to analyse the reasons for the gap or the lacunae. In this context we will have to list out the implementation framework and the obstacles or pitfalls at each step of the programme.

Table 1: Results of the Chi-Square Test and Coefficient of Contingency

Attributes	DOF	Calculated Chi-Square Value	Table Value of Chi-Square at 5% LOS	Inference	Karl Pearson's Coefficient of Contingency
• Association between training of staff and the performance of the PHC for the SHP	1	158.9977	3.841	Reject the Null Hypothesis	0.707
• Between the resources supplied to the PHCs and the performance of the PHC for the SHP	1	42.407	3.841	Reject the Null Hypothesis	0.4436
• Between the parent cooperation for child care and the performance of the PHC for the SHP	1	40.256	3.841	Reject the Null Hypothesis	0.4034

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The calculated Chi square values for the three attributes, namely, training given to the staff, supply of resources and parental cooperation are 158.9977, 42.407 and 40.256 respectively. These three values are far above the table value and hence we reject the null hypothesis. Thus the success of the School Health Programme is dependent on the three attributes. The Karl Pearson's coefficient of Contingency values (C) are 0.707, 0.4436, and 0.4034 correspondingly. This implies that the first attribute (training given to the staff) has strong association with the success of the programme as it is the highest value. The second and third attributes are also associated with the success of the programme but to a lesser extent when compared with the first attribute.

Obstacles or Pitfalls at Each Step of the Programme

- At State level/District level

    o Miscommunication of duties and targets

    o Inadequate training to staff

    o Shortage in resource supply

- At Primary health centre

    o Lackadaisical; attitude of the staff

    o Untrained and incapable staff

- At school level

    o Object to cooperate

    o Not serious about the programme

    o Incapable to perform due to shortage of resources

- Problem from the child

    o Fear about the health condition

    o Ignorant about the health issues

- From the Parents

    o Ignorance

    o Not serious about the health issue of the child with many siblings

    o No time to spend for the children of daily wage labourers

CONCLUSIONS

From the above study, it is evident that though several hurdles have been identified in the system implementation at each level, the three major attributes namely, 'lack of training given to the staff', 'lack of adequate resource supply' and 'absence of parental cooperation' do play a major role in the success of the School Health Programme, or in other words, the programme becomes ineffective when these three attributes are not given due consideration.

Thus, training given to the staff is a cascade of events from the state level to the grass root levels. Training is said to be complete only when the content or message intended to be communicated reaches the staff of the PHCs and the school staff who also pass on the information to the parents, thus synergizing the effect on the success of the programme, they contribute further by optimum utilization of the resources provided to them. Thus the act of staff training has a multitude of positive effects on almost all the factors contributing to success of the programme.

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