Better education for better health care

A survey of medical officers in charge of primary health centres in rural districts of Andhra Pradesh, India, has revealed significant deficiencies in their knowledge and performance. The situation could be improved by creating closer links between the medical education system and the machinery for health care delivery, organizing refresher courses, and introducing educational programmes with a stronger nutrition component.

The health care needs of the Indian rural population are met through a network of primary health centres and subcentres, where medical officers do curative, preventive and promotional work and have a major responsibility for training.

Assessing leadership quality

In India, as in most developing countries, malnutrition is a significant public health problem. All the national nutrition programmes, along with other nutrition activities, are carried out by staff at the primary health centres under the leadership of the medical officers, who should be fully aware of the impact of nutrition on health.

A study was undertaken to assess the knowledge and performance of these medical officers, with particular reference to nutrition and related matters. A total of 114 officers from 80 primary health centres in Andhra Pradesh State participated in the study. A pretested questionnaire was used which covered the following matters:

- knowledge of nutrition and related subjects;
- performance of medical officers in nutrition-related activities at primary health centres;
- knowledge of general particulars of primary health centres;
- knowledge of their job responsibilities in general and of specific responsibilities relating to nutrition;
- knowledge of responsibilities of different workers in primary health centres.

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The questions were of three types: yes/no/don’t know; multiple choice; and open-ended. Scores were given and the results, expressed as percentages, were graded as ‘poor’ (under 50%), ‘satisfactory’ (50–75%) or ‘good’ (over 75%).

A majority of the medical officers were aged 30–50 years; about 15% were below 30 years of age. Nearly 80% were medical graduates without additional qualifications, and about 20% had less than two years of experience in primary health centres. No special training or orientation in nutrition had been received by 76% after joining the service.

The highest score, 67.7%, was obtained in respect of knowledge of nutrition and related areas, and the lowest, 19.7%, was for the participants’ awareness of their own job responsibilities.

Overall theoretical knowledge on nutrition and related matters was quite satisfactory, although there were gaps. For instance, a majority of the officers could not name the constituents of the home-made rehydration solution, vital to the diarrhoeal diseases control programme. Shortcomings were also brought to light in relation to other important programmes. A quarter of the officers said that immunization was contraindicated in cases of malnutrition. Many respondents were unaware of the importance of growth monitoring, the use of growth charts, and the fact that calorie deficiency is the basic cause of childhood malnutrition.

Only 11% of the respondents obtained satisfactory scores for performance and involvement in nutritional and related matters. Nutrition education was only an occasional activity in almost all primary health centres. A majority of the officers were unaware that the nutritional blindness prevention programme and the anaemia prevention programme were being implemented on a nationwide scale. Many were not aware of the dosage schedule for tablets of vitamin A and those of iron plus folic acid. Very few knew the additional calorie and iron requirement of women during pregnancy. Half of the officers were not involving their communities in health and nutrition activities.

Since the medical officers are the administrative and technical heads of the primary health centres, they should be fully aware of the populations covered, staff structure, and other basic facts. Yet only 23% of the respondents obtained satisfactory scores in this area. Over 50% did not know how many people were covered by their centres or the numbers of staff in different categories. Such ignorance suggests that little, if any, attention was being given to the planning and implementation of the various services offered by the centres.

Only 3% mentioned their responsibility for referral services, an important component of primary care. The majority mentioned their duties in curative care among their general responsibilities, but replies were poor on preventive, promotional, training and administrative responsibilities.

Only 23% were aware of their own responsibilities regarding nutrition. Not
surprisingly, their performance in nutrition education and in national nutrition programmes was observed to be poor. Moreover, many declared that they did not recognize that they had any responsibility in the area of nutrition.

The medical officer should be an efficient trainer, technical guide, and supervisor, and not merely a curative specialist. Yet very low scores were obtained in these areas. The majority were in fact involved in the training of staff responsible for all health and nutrition activities at the grass-roots level. But their awareness of their responsibilities as trainers was poor. Only 16% mentioned that they had taught nutrition during their training programmes. Staff were therefore hardly equipped with sufficient knowledge to fulfil their tasks. There was also a low level of awareness of the responsibilities of the various categories of worker in the centres. Only about 3% of the officers obtained satisfactory scores in this connection.

Scope for improvement

This study has brought to light some important deficiencies in the knowledge and performance of medical officers in primary health centres, particularly in the area of nutrition. Many of the shortcomings could seriously hamper the delivery of primary care services.

There is poor coordination between the medical education system and the health care delivery infrastructure. Medical education is not based on need and tends to have an urban bias. Learning is often a classroom process.

Medical undergraduates are not adequately exposed to the practical aspects of health care in rural communities. Departments of preventive and social medicine should therefore give more attention to this matter and equip themselves accordingly. The managerial aspects of medical officers’ work in primary health centres should be thoroughly dealt with in the curricula of medical schools.

Medical officers in primary health centres are overburdened. Target-orientated activities like family planning, on the basis of which their work is often evaluated, force them to give insufficient attention to other important matters.

Most of the officers were medical graduates without any special training in nutrition. Although many of them had been in the centres for longer than two years, they had not attended refresher courses.

A move towards remedying the situation revealed in the study could be made by creating closer links between the medical education system and the machinery for health care delivery, organizing refresher courses, and introducing educational programmes with a stronger nutrition component.

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