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Training and skill development for 'Asha' in health education (wsr to iodine deficiency disorder in Bangalore Urban District)

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Abstract
Training and Skill development for 'ASHA' health workers in Primary health Centres and also Health Education with reference to Iodine Deficiency Disorder in Bangalore Urban District is main objective of this study. This article has been published based on the information available with Department of Health and Family Welfare Services and literature review. The National Rural Health Mission has fulfilled its promise of one ASHA in every village of the high focus states. Training is defined by some as systematic transfer of relevant knowledge and skills to a job properly. Thus training is the art of enhancing the, knowledge and skill of an employee (Trainee) for doing a particular job in a better way. You may remember, in our earlier discussion, we have analyzed training as job-oriented and generally deals with current needs (for a Job). The best goal of training is, learn (on the part of trainee) very specific behaviours and skills (so one can deal with different situations in the organization),

Keywords: Training and Skill Development, ASHA (Accredited Social Health Activist), Health education, Iodine Deficiency Disorder.

1. Introduction
One of the human resource development activities (HRD) is training and development. The training activity focus to develop a good organization through enhancing its human resource capabilities. We should know that an organization is as good as its people. The aim of organization is survival and growth. To achieve this, organizations have to consider training and development function as indispensable to develop employees to solve intricate problems present as well as to deal with possible challenges that are likely to arise and thereby meet their (employees) aspirations. The training and development function is not simple to tackle. Business organizations who undertake this function or employee development will have to consider learning principles, and styles, organizational climate for learning, and will have to be conscious of outcomes of training so as to manage effectively striking balance between individual and organizations. Leonard Nadler provides ideas about learning approaches for individual's development. He considers three areas focus: (A) the job (B) the individual (C) the organization.

Each of these areas of focus demand or requires different types of learning. Any improvement / development job basically requires training in terms of development of human skill and technical skills. When it comes to development of individual, Nadler relates, education. When it comes to development of or improvement in organizational process, the term organizational development is used. All the above three development I.e job, individual and organization, put together gives the concept of human resource development (HRD). This (HRD), human resource development involves each person / employee belonging to an organization, who can strengthen and develop himself for specific jobs to attain individual needs, job needs and for changing in organizations as Milton Hall, employee training is the process of aiding employees to gain effectiveness in their present and future work through development of appropriate habits of thought and action, skill, knowledge and attitudes, now let us consider how training and development is viewed by various experts. Training is defined by some as systematic transfer of relevant knowledge and skills to a job properly. Thus training is the art of enhancing the, knowledge and skill of an employee (Trainee) for doing a particular job in a better way. You may remember, in our earlier discussion, we have analyzed training as job-oriented and generally deals with current needs (for a Job).

The best goal of training is, learn (on the part of trainee) very specific behaviors and skills (so one can deal with different situations in the organization),

Every organization / institution which expects its people to carry out its work, whether it be a business, a school, a government department, or a public health or medical services, needs a Human Resources Management/ Development plan in which various phases of Human Resources Development work are tied together in to an integrated programme. Public health and medical services especially under the state has to function in both an internal and external environment. The internal environment includes the physical, human and informational aspects associated with each of the individual public health functionaries and how they function themselves are coordinated. The external environment includes patients, competitors, suppliers and other government bodies. A public health and medical services should be able to react favorably with and should immediately respond to, changes in both their internal and external environment.

"Primary health center training can be defined as specific fitness training designed to suit the needs of an organization employees, ensuring that they gain maximum benefits to assist them to be clear headed, relaxed and confident in their work time activity (as well as) relatively negative stress – free)" The team development (You may refer our discussion) involves to bring from latent / potential state to an active state. In HRD process unfold means acquisition of wider knowledge, skills and attitudes to accept/ assume greater responsibilities. Development term is often used to denote executive development and organization development. The term executive development is interchangeably used as management development. Development goals are achieved in organization with the help of specific models.eg: organizational development through the involvement of employee (ODIE) model.

2. Concepts of training

Teachers and trainers hold two different viewpoints. Some trainers opine that knowledge and action are directly related. In today's training activities training provided proceeds as if knowledge and action are directly related. Some teacher's trainers consider or claim that knowledge in itself has no use. Practitioners in various professions or practicing managers do not prefer fresh graduates or post-graduates in management until they gained experience. Yet experience is gained over many years of hardships and hard work. Assumption underlying two concepts of training is listed. We may treat it earlier as arguments on philosophy of training or opinion held by trainers and adult educators.

The "ASHA" Training programme is considered as being vital to achieving the goal of increasing community engagement with the health system, and is one of the key components of the National Rural Health Mission (NRHM). The ASHA is a woman selected by the community, resident in the community, who is trained and deployed and supported to function in her own village improve the health status of the community through securing people's access to health care services. She does this through improved health care practices and behaviors and through health care provision as an essential, feasible and lifesaving at the community level. The term ASHA, whose meaning loosely translates to "hope" in English, was first mooted as an acronym for "Accredited Social Health Activist", but now used as a specific term in itself. The Programme launched in the 18 high focus states and tribal areas of all other states in the year 2006. Within two years over 300,000 ASHA had been selected and deployed. In response to popular acclaim and demand, the programme was expanded in early 2009 to the entire country. Today the programme exists in 31 states and Union Territories –with all but three states (Himachal Pradesh, Goa, and Puducherry) and two Union Territories (Daman & Diu and Chandigarh) having opted for the programme. With nearly 820,000 women being selected, trained and deployed as ASHA, in terms of scale and coverage, there are few precedents to the ASHA programme anywhere in the world.

However despite being hailed as the face of the NRHM, or as the flagship programme of the NRHM, there has also been considerable skepticism, even cynicism about the potential of such a largely 'voluntary' community health worker programme. Doubts have been raised about its ability to yield measurable health outcomes as well as the balance between the health benefits of such a programme, and the long term Human Resource Management problems and costs that it would entail.

Today, the ASHA programme has become an inherent part of the health system. Despite this several issues appears problematic. These include clarity on her current roles and responsibilities, questions of her effectiveness and health outcomes, the adequacy and quality of the training and support systems questions related her working conditions and payments and defining future role. Clarity, this programme more than any other would benefit from evaluation studies to capture the reality of what is happening and accordingly inform decision makers of the options between which they must choose.

The ASHA programme as a process of selection, a process of training, a definition of roles, a process of providing support and monitoring, provisioning of drug kits, and a process of making payments and so on and each of which various widely from state to state, despite common national guidelines. Thus if the programme works are fails it could be attributed to one or the other of these components and not necessarily to all of them, much less attributed to the programme as a whole. Also the subjective patters- the perceptions of key implementers- would make a major difference to programme out comes. Thus asking the question- "does the ASHA programme reduce neonatal mortality," is a far more complex question than, "does measles vaccine prevent measles "or "is chloroquince effective against malaria, "the challenge was to device a methodology that could attempt to look at the complexity and subjective elements objectively. An approach that is neither "positivist" nor" relatives"- which is what perhaps is meant by the turn realistic. (Pawson, R., & Tilly, N (2004). Realistic Evaluation. London: SAGE Publications Ltd.)

Evaluations using cross-sectional studies, provide a good description of the current status, but face difficulties in providing evidence to support the recommendation. Not surprisingly, most recommendations do not get acted upon, although this is as much reflective of the problems of evaluation as it is of programme governance.

The problem of evaluating ASHA is further compounded by multiple and contesting narratives of what constitutes the legitimate role of the ASHA. The discourse on the ASHA's role, centers around three typologies – ASHA as an activist or rights worker, ASHA as link worker or a facilitator, and

ASHA as a community level health care provider. Not only does the 'success and failure" of the ASHA programme mean very different things to different stakeholders, the interpretation of every major finding and the acceptability of every major recommendation would hinge up on the position each person has in relation to this discourse. This is not a value- neutral discourse which 'objective' evidence would settle once and for all. What a good evaluation can do, is only help build up areas of common understanding and consensus between highly divergent positions, so that the common and legitimate social goals that all are agreed up on would be easier to reach.

The goal of this evaluation is to therefore explore the diversity within the ASHA programmes in different states, to provide information on how in different contexts, different choices have been made in relation to programme mechanisms, to understand, why these choices were made and to understand and how these differing mechanisms interacted in their specific context to yield varying out comes. Simply then the goal of this evaluation is- not the simplistic question – Does the ASHA programme work – but rather: "What Components of the ASHA programme work, and Where, under What Circumstances and to what extent does it work.

The findings of this evaluation report will serve as the basis for dialogue with local, state, and national programme managers, in order to functioning of ASHA programmes for better health outcomes. Its recommendations could make use of various "natural experiments" that have occurred on the field, due to varied interpretations of guidelines and differences in process deployed. Health Education is an essential tool of community health. Every branch of community health has a health educational aspect. In the end, community health is just health education, and every community health worker is a health educator. The object of health education is "to win friends and influence people." The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity." Health education is concerned with promoting health as well as reducing behavior –induced disease. In other words, health education is concerned with establishing or inducing changes in personal and group attitudes and behavior that promote healthier living.

3. Training Objectives

ASHA will be health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows.

ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services.

ASHA will create awareness and provide information to the community on determinants of health, counsel women on safe Delivery, Contraception etc., she will mobilize the community and facilitate in accessing health services. She will provide primary medical care and inform about deaths and births in the village. She will promote construction of house hold toilet under total sanitation camp.

She will council women on birth preparedness, importance of safe delivery, breast feeding and complimentary feeding, immunization, contraception and prevention of common infections including reproductive tack infection / sexually transmitted diseases (RTIs and STIs) and care of the young child.

ASHA will mobilize the community and facilitate them accessing health and health related services available at the village / sub- center/ primary health centers, such as immunization, antenatal checkup (ANC) post natal checkup/(PNC), ICDS, sanitation and other services being provided by the government.

She will work with the village health and sanitation committee of the Gram Panchayat to develop a comprehensive village health plan.

She will arrange escort / accompany pregnant women and children requiring treatment / admission to the nearest pre-identified health facility. i.e primary health center / community health center/ first referral unit (PHC/CHC/FRU).

ASHA will provide primary medical care for minor ailments such as diarrhea, fevers and first aid for minor injuries. She will be provider of directly observed treatment short- course (DOTS) under revised National Tuberculosis Control Programme.

She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron folic Acid tablets (IFA), Chloroquine, Disposable Delivery Kits (DDK), Oral Pills and Condoms, etc.

Her role as provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing new born care and management of a range of common ailments particularly childhood illness

She will inform about the births and deaths in her village and any unusual health problems / disease out breaks in the community to the sub-centers / Primary health center

She will promote construction of house hold toilets under total sanitation campaign.

4. Research Methodology

The present study have been obtained from the secondary sources. The secondary sources are Evaluation of Asha Programmes by National Rural Health Mission.

WHO report on Iodine and Health?

Based on the secondary data the demographic profile of Karnataka has been prepared.

The selection of the districts has been based on the rural population as well as the villages with poor health indicators.

Demographic Profile of Karnataka

Male	Female	Total
3, 09, 66,657 (50.69%)	3, 01, 28,640 (49.31%)	6,10,95,297

	Rural			Urban	
Male	Female	Total	Male	Female	Total
1,89,29,354	1,85,39,981	3,74,69,335	1,20,37,303	1,15,88,659	2,36,25,962
(30.99%)	(30.35%)	(61.32%)	(19.70%)	(18.96%)	(38.67%)

Source: Census of India 2011

Number of Asha Workers in Position 2013-2014

Sl. No	Districts	No Of Asha Workers In Position
1	Bangalore (U)	537
2	Bangalore (R)	532

District Wise Population (Census2011)

Sl. No	Districts	Population		
		Total		
		Rural	Urban	Total
1	Bangalore(U)	8,71607	87,49,944	96,21,551
2	Bangalore(R)	7,22179	2,68,744	9,90923

Selection of ASHA
One ASHA worker per 1,000 population

Training of the ASHA candidates
The ASHA candidates will be given training in all preventive healthcare aspects of pregnancy, antenatal care, delivery care, postnatal care, newborn care, neonatal care, diarrhea, acute respiratory infections, first-aid and treatment of minor ailments. The training of ASHA at the Taluka level will be conducted in the places finalized by the DHOs
The overall organization, monitoring and coordination of the ASHA training will be entrusted to a NGOs for ASHA Training.

Budget for Training ASHA
The budget for ASHA training sessions will include cost of Training of Master Trainers, training of trainers, salaries of trainers and coordinators in each district level training institution, to and fro fares for the ASHA candidates for coming for the training, boarding cost at the training institution, cost of training material, wage compensation for the ASHA candidates for the duration of the training, etc. In the new implementation framework a provision has been made for an expenditure of Rs 10,000 per ASHA during a financial year. (Included in previous years PIP)
It is proposed to select app 20,000 ASHAs for the remaining districts in the current year @ Rs 550 per ASHA. The training is to be planned in the forthcoming year.

B) At the sub Centre level
1) Rent facilities to all the sub centers functioning out of rented buildings
There are 8143 sub centers in the State out of which 4460 run in the government buildings and 790 in rent free Panchayat buildings, it is proposed to hire the building for sub center work @ Rs. 500 pm for the 2893 sub centers without buildings.

5. Health Programmes in India
Since India has become free, several measures have been undertaken by the National Government to improve the health of the people. Prominent among these measures are the National Health Programmes, which have been launched by the Central Government for the control/eradication of communicable diseases, Improvement of environmental sanitation, rising the standard of nutrition, control of population and improving rural health. Various international agencies like WHO, UNICEF, UNFPA, WORLD BANK, have been providing technical and material assistance in the implementation of these programmes. A brief account of the programme which is currently in operation like Iodine Deficiency Disorder programme.

6. Iodine Deficiency Disorder
India commenced a goitre control programme in 1962, based on iodized salt. At the end of three decades, the prevalence of the disease still remains high (As per nutrition foundation of India 1983, The National Goitre Control programme, New Delhi). In retrospect, it became clear that the failure was mostly due to operational and logistics difficulties (Clugston, G.A. and K. Bagchi (1986) world health forum, 7:33). That is, the production of iodized salt did not keep phase with requirement. Operational difficulties such as inadequate production, difficulties in prevention of sale of unionized salt in endemic areas resulted in this programme having little impact on the goitre problem in the country. Reassessment of the magnitude of the problem by ICMR showed that the problem was not restricted to the "Goitre/ Belt" as was thought earlier, but is extremely prevalent in other parts of India as well eg: Gujarat, Punjab, Maharashtra, Andhra Pradesh and Kerala). Similarly, the iodine deficiency manifestations were not limited to endemic goitre and cretinism but to a wider spectrum of disability including deaf–mutism, mental retardation, and various degrees of impairment of intellectual and motor functions. (WHO 1985, Iodine deficiency disorder in SE Asia, reg health paper No 10, SEARO New Delhi.) it is estimated that nearly 167 million persons are exposed to the risk of IDD, of which 54 million are having goitre, 2.2 million are cretins and 6.6 million have mild neurological disorders (Government of India, Annual Report 1992-1993, DGHS, New Delhi.

7. Discussions and Findings
From the above discussions it is found that, Iodine Deficiency Disorder is considered as one of National Health Programmes. At the same time adequate information and also training programmes have not been included for ASHA health workers. Lack of man power and reshuffle of manpower due to retirement and administrative constraints the proper training for evaluation of IDD has not been carried out in the primary health centers. Lack of well-established infrastructure in remote areas is also one of the reason for not popularizing the IDD programmes in Primary Health centre levels. Achieving IDD control goal in India requires a 'Mission Approach' with greater co-ordination among all stake holders of IDD control. The 'Mission Approach' has to be adopted by the Government at the highest political level and should have clearly defined objectives and strategies. The plan of action has to be executed with in the defined time frame by a committed team. Fast track procedures and collective action by an intersectional effort are integral components of this approach. Close monitoring and transparent evaluation should be developed in line with the goal, objectives and strategies of the 'Mission Approach'. At present the ASHA health workers have been trained only with reference to preventive healthcare aspects of pregnancy, antenatal care, delivery care, postnatal care, newborn care, neonatal care, diarrhea, acute respiratory infections, first-aid and treatment of minor ailments.

8. Conclusions
Though the IDD has been considered as one of the important National Health Programmes, the adequate knowledge and training to ASHA has not been given by the health educators elaborately. It is vital for the success of control that ASHA workers and others engaged in the programme be fully

trained in all aspects of goitre control including legal environment and public education. Countries implementing control Programmes require a network laboratoris for iodine monitoring and surveillance. These laboratories are essential for (A) Iodine excretion determination, (B) determination of iodine I water, soil and food as part of epidemiological studies, and (C) determination of iodine in salt for quality control. Creation of Public awareness is a sine qua non of a successful public health programme.

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