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Training and skill development for ‘accredited social health activist’ (Asha) in health education

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Abstract

Training and Skill development for ‘Accredited Social Health Activists’ (ASHA) health workers in Primary health Centers 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 and Skill Development and also Health Education is defined by some as systematic transfer of relevant knowledge and skills to a job properly. Thus training and Health Education is the art of enhancing the, knowledge and skill of an employee (Trainee) for doing a particular job in a better way. The best goal of training and health education 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.

Introduction

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 WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Health education is concerned with promoting health as well as reducing behaviour – induced disease. In other words, health education is concerned with establishing or inducing changes in personal and group attitudes and behaviour that promote healthier living.

Health Education Defined

Health education is rather an abstract term meaning different things to different people. To some it is a matter of public relations aimed at publicizing the activities of health departments. Some consider it synonymous with health propaganda. Many equate it with transmission of information of health and disease from the expert professional to the lay client (1). The definition adopted by the National Conference on Preventive Medicine in USA is “Health education is a process that informs, motivates and helps people to adopt and maintain healthy practices and lifestyles, advocates environmental changes as needed to facilitates this goal and conducts professional training and research to the same end”

Concepts in Health Care

The health of an individual is an essential consideration in terms of resources in the development process. UN healthy situation may be as a result of partial or total disability often causing suffering of self and relatives on the social front and lowering the productivity in the working population. The health status of population is affected by a number of social, economic, psychological, hereditary environment and health services acceptability factors.

Good health is a prerequisite to human productivity and the development process. It is essential for economic development. A healthy community is the infrastructure upon which an economically viable society can be built. Unhealthy people can hardly be expected to take any valid contribution towards development programmes. Health is man's greatest possession, for it lays a good foundation for happiness. Health care, in its domain covers 'Application of simple procedure availability of profiles professional management. Specialized investigations state of the art equipment strict quality control through high tech equipment. Timely availability of services both medical and paramedical total coverage of services under one roof.

Health Services

The word health can be traced to its Anglo Saxon root, which means 'hale' sound or whole. Health is defined in the first five year plan of Government of India as a positive state of wellbeing in which harmonious development of mental and physical capacities of the individual lead to enjoyment of a rich and full life. It implies adjustment of the individuals to his total environment, physical and social. WHO puts as a state of complete physical, mental, and social wellbeing and not merely absence of disease or infirmity care of the sick has always been closely linked with the economic and social development of people.

Objectives of Health Education

The main objectives of health education are

(A) Informing people.

For thousands of years, disease and death have been accepted with resignation as normal ingredients of daily life. Today this resignation is unacceptable. Discoveries in medical science have enabled us to reduce them to reasonable proportions. The first directive of health education is to inform people or disseminate scientific knowledge about prevention of disease and promotion of health. Exposure to knowledge will melt away the barriers of ignorance, prejudices and misconceptions, people may have about health and disease. This creates an awareness of health needs and problems and also of responsibilities on the part of people.

(B) Motivating people

The second objective is more important than the first. Simply telling people about health is not enough. They must be motivated to change their habits and ways of living, since many present day problems of community health require alteration of human behavior or changes in the health practices which are detrimental to health, viz. pollution of water, out-door defecation, indulgence in alcohol, cigarette smoking, drug addiction, physical inactivity, family planning, etc. Health education must provide learning experiences which favorably influence habits, attitudes and knowledge relating to individual, family and community health. The accent should be on motivating the 'consumer' to make his own choices and decisions about health matters, that is, what kinds of health actions to be taken, and when and under what conditions to take them.

(C) Guiding in to action

Health education can and should be conducted by a variety of health, education and communication personnel, in a variety of settings, starting with the physician. People need help to adopt and maintain healthy practices and life-styles, which may be totally new to them. Governments have a major

responsibility to provide necessary infrastructure of health services. People need to be encouraged "to use judiciously and wisely the health services available to them". A case in point is the current inadequate or under- utilization of health services provided by the Government. National health programmes such as the family welfare programme, tuberculosis control programmes and expanded immunization programmes have fallen short of achieving their targets for want of individual and community participation. Health administrators are now recognizing that health education provides the 'cement' that binds together the 'bricks' of the health programmes, particularly through enlisting the active participation and action of the people in health programmes. Many governments are now beginning to realize that the services and facilities they provide to improve the socio-economic and health status of the people will not be fully effective unless the people not only make use of these services but also undertake various practical self-help measures to improve their own health status and the communities in which they live.

Research Methodology

Secondary Sources

The present study have been obtained from the secondary sources like various international agencies like Who, Unicef, World Bank. These agencies have been providing technical and material assistance in the implementation programme such as Iodine Deficiency Disorder programme etc.

Approaches to Public Health

There are three well known approaches to public health.

Regulatory Approach

The regulatory or legal approach seeks to protect the health of the public through the enforcement of laws and regulations, e.g. Epidemic diseases Act, Food adulteration Act etc. The best laws are but waste of paper if they are not appreciated and understood by the people. They may be useful in times of emergency or in limited situations, e.g. fairs, festivals and epidemics, but they are not likely to change human behaviour. In areas involving personal choice (e.g. giving up smoking, family planning) laws have little place in a democratic society. The legal approach has also the disadvantage that it requires vast administrative machinery to enforce laws and also involves considerable expenditure.

Service Approach

The service or approach aims at providing all the health facilities needed by the community in the hope that people would use them to improve their own health. The service approach proved a failure when it was not based on the "felt needs" of the people. For example, when water seal latrines were provided, free of cost, in some villages in India under the community Development Programme, people did not use them. This serves to illustrate that we may provide fee service to the people, but there is no guarantee that the service will be used by them.

Educational Approach

The educational approach is a major means to day for achieving change in health practices and the recognition of health needs. It involves motivation. Communication and decision making. The results, although slow, are permanent and enduring. Sufficient time should be allowed to have the desired change brought about. There are certain problems which can be solved only through the education, nutritional

problems, infant and child care, personal hygiene, family planning. The educational approach is used widely today in the solution of community health problems. It is consistent with democratic philosophy which does not 'order' the individual.

The educational approaches may be classified as 1. individual and family approach, 2. Small group approach, and 3. Mass approach. Since individuals vary so much in their socio-economic conditions, traditions, attitudes, beliefs and level of knowledge a single educational approach may not be suitable. Combinations of approaches must be evolved depending upon local circumstances.

The "ASHA" 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.

As different stake holders worked to shape this programme in directions which they thought fit, the design and indeed every component of the ASHA programme, was subjected to vigorous debate before being articulated as policy. Even after becoming policy, at every level of implementation, the programme is subject to varying pressures to shape it in accordance with stakeholder's frame work of understanding of how the ASHAs work leads to improved health status. Even the most rigid of guide lines become malleable under such pressures and the resultant programme yields an interesting variety of field situations across the nation.

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.

ASHA will take steps to create awareness and provide information to the community on determinants to 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.

The 'ASHA' candidates will be given training in all preventive health care aspects of pregnancy, antenatal care, delivery care, newborn care, acute respiratory infections etc. But the training does not focus on Iodine deficiency Disorder which has been considered as one of the important National Health Programme, The adequate knowledge and training to 'ASHA' has not been given by the health educator regarding the Iodine Deficiency Disorder

Iodine Deficiency Disorder one of the leading causes of stomach cancer, endemic goitre and cretinism but to wider spectrum of disability including deaf-mutism, mental retardation and various degrees of impairment of intellectual and motor functions.

The Iodine Deficiency Disorder 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 including legal environment and public education. Countries implementing control programmes require a network laboratories for Iodine Deficiency Disorder and monitoring and surveillance.

India was one of the first countries globally to start a national IDD control program and IDD control programme in Indian has evolved over the years. The dynamic evolution IDD control programme and the efforts for its sustainable elimination in India provides a unique opportunity to study the interaction between research, policy, and programme and decision making process and to identify solutions for the future. Evolution of IDD control programme in India also highlights the complex policy environment in which National Health Programmes operate and to identify key enabling and impeding factors for its sustainability. This paper presents the evolutions of IDD control programme in India and lessons learned there of for successful implementation of National Health Programme.

Iodine deficiency disorder is yet another major nutrition problem in India. Till recently, iodine deficiency was equated with goiter. In recent years, it has become increasingly clear that iodine deficiency leads to a much wider spectrum of disorders commencing with the intrauterine life and extending through child hood to adult life with serious health and social implications. The social impact of iodine deficiency arises not so much from goitre as from the effect on the central nervous system.

Discussion and Findings

Education is primarily a matter of communication. The health educator must know how to communicate with his audience. The purpose communication is to transmit information from one person or group of persons to other persons or groups with a view to bring about behavioral changes.

The key elements in the communication process are the communicator, the message, audience and channels of

communication. Adequate information in health education and also training programmes have not been included for ASHA health workers. Lack of manpower and due retirement and administrative constraints the proper training for evaluation of IDD has not been carried out in the primary health centers.

Conclusions

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 health education in all aspects including legal and environment and public education. Psychologists have shown and established that we learn best from people whom we respect and regard. In the work of health education, we try to penetrate the community through the local leaders- the village headman, the school teacher or the political worker. Leaders are agents of change and they can be made use of in health education work. If the leaders are convinced first about a given programme, the rest of the task of implementing the programme will be easy. The attributes of a leader; are he understands the needs and demands of the community; provides proper guidance, takes the initiative, is respective to the views and suggestions of the people identifies himself with the community; self – less, honest, impartial, considerate and sincere; easily accessible to the people ; able to control and compromise the various factions in the community; possess the requisites skill and knowledge of eliciting co-operation and achieving co-ordination of the various official and non-official organizations.

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