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REVIEW ARTICLE

SELECTION PROCESS OF COMMUNITY HEALTH WORKERS: A QUALITATIVE STUDY FROM A MULTI-STAKEHOLDER PERSPECTIVE IN RAJASTHAN, INDIA

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ABSTRACT

Background: Community Health Workers (CHWs) form a vital link between community and the health system. In India, this role is played by Accredited Social Health Activists (ASHAs)-village level female workers. Studies indicate that CHWs, if selected in consultation with community and in a transparent way, can lead to better acceptability of CHWs in community, better performance of CHWs and expected outcomes of the programme.
Aim: This study looks at the selection process of the ASH As and its effects on the working relationship with her co- workers.
Methods: The study was done in 16 villages from two administrative blocks of Udaipur district of Rajasthan. Study area was selected using multistage purposive sampling. It is based on 48 in-depth interviews with ASHA's co-workers and the health system representatives. Data was collected using interview guides and manually analysed following an inductive approach.
Results: The study showed non-consultative selection of ASHAs. It showed favoritism rather than competency based selection of ASHAs. Such selection not only affected ASHA's attitude, behavior and work performance but also caused strained relationships and unhealthy work environment between ASHAs and her co-workers. Study participants suggested strict adherence to ASHA's selection criteria by a joint village level committee that has representation of all stakeholders associated with ASHA's work.
Conclusion: Unbiased, competency based, consultative selection of ASHA is essential to promote her good performance as well as create enabling work environment to jointly address community health issues.

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INTRODUCTION

Community Health Workers (CHWs) are a crucial link between communities and the health department in many low and middle income countries (Bhutta *et al*., 2013). In India, the first CHW programme was launched in 1977 and now recently in 2005 (Leslie, 1989). The present CHW programme is the part of larger health sector reforms, commonly known as National Rural Health Mission (NRHM) since 2005, It is now a part of national health Mission (NHM) managed by the Department of Health and Family Welfare (DHFW), Government of India-GoI (NRHM Mission Document-Framwork for implementation, 2005-12). The CHWs recruited under NRHM are commonly known as "Accredited Social Health Activist" (ASHA).

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As of today, about 0.9 million ASHAs have been placed across different states of India (http://nrhm.gov.in/communitisation/asha/asha-data.html). Based on the government set criteria, the ASHAs are the female residents and daughter-in-law of the village they serve and must have formal school education of at least eight years (http://nhsrcindia.org/index.php?option=com_dropfiles&task=frontfile.download&id=1173; http://mohfw.nic.in/ NRHM/RCH/guidelines/ASHA_guidelines.pdf).

They are trained for 23 days, supervised on a monthly basis by ASHA facilitators and Medical Officers at the Primary Health Centres (PHCs), and receive performance based incentives from the health department. Their roles and responsibilities include community awareness generation, mobilisation and participation in health services delivery (http://nhsrcindia.org/). Almost all their functions are in support to the Auxiliary Nurse

Midwifes (ANMs)-female health workers of DHFW who are stationed at Sub-centres over the population of 3000-5000. This "ASHA-ANM" joint functioning model is applicable in all states of India, except Rajasthan where ASHAs are also expected to support *Anganwadi* workers (AWW)-female community workers of Department of Women and Child Development (DWCD). Thus in Rajasthan, ASHA's selection, training, supervision and incentives are also expected to be supported by DWCD along with DHFW.

Literature suggests that the premise for promoting community engagement in CHW's selection is to ensure transparency in the process; better acceptance of CHWs by the community; chances of better accountability of CHWs to the community; hence better performance of CHWs and expected outcomes of the programme (http://www.mchip.net/ sites/ default/ files/ mchipfiles/07_CHW_Recruitment.pdf). In case of CHWs' selection in various countries like Ethiopia, Nepal, Mali and Pakistan community participation and consultation forms the basis of their selection(8). In India, while the selection of ANMs is the prerogative of DHFW and that of AWWs is of the DWCD, ASHA's selection is entrusted to the village level political body (known as *Panchayat)* and its leader (known as *Sarpanch*) in consultation with rest of the villagers through a formal village level meeting (known as *Gram Sabha*). The *Panchayat/Panchayati Raj* Institution (PRI) are local governance institutions spread across India to promote decentralised planning, implementation and monitoring of various government programmes and to ensure people's participation in decision making and seeking accountability from the system. For ASHA Selection, these meetings are also expected to be attended by the officials from health and aligned department representatives, including DWCD, to ensure consultative selection of ASHAs. This study looks at the operationalization of this process of ASHA selection in reality and how this reality affects the working relationship between ASHAs and her co- workers (ANMs and AWWs).

MATERIALS AND METHODS

This paper is the part of the larger doctoral level study (2009-2014) conducted to understand the coordination between ASHAs, ANMs and AWWs using mixed methods. The findings presented in this paper are based on 48 in-depth interviews (IDIs) that were conducted with the two groups of ASHA's co- workers and the health system representatives i.e. officials from DWCD and DHFW.

Study area

The study was done in 16 villages of two administrative blocks of Udaipur district in Rajasthan. The reason for first selecting Rajasthan and then Udaipur from Rajasthan was that both are classified as high priority zones under NRHM, due to their high infant mortality rate, i.e. 63 (Rajasthan) and 62 (Udaipur) against 57 as national rate (http://www.Sihfwrajasthan.com/ ppts/full/nfhs--iii.pdf; http://www.thehindu.com/todays-paper/ tp-national/rajasthan-identifieshighfocus-districts/article2092416.ece).

Moreover, Udaipur has a high tribal population proportion, that is, 46% compared to 12% in the entire state. One of the administrative blocks selected from Udaipur district has significant (80%) rural but tribal population whereas the other mainly has (80%) rural but non-tribal population. Thus, the eight villages from tribal block and the other eight from the non-tribal block represented the district scenario. The village selection was done using multi-stage purposive sampling.

In India, the government health institutions are organized with the Sub-center at the lowest level followed by a Primary Health Center (PHC) at the population of 25000 to 30000, a Community Health Center (CHC) at the population of 0.1 million and the district and state level hospitals to cover the overall district and state population for secondary and tertiary care. For 16 villages' selection, eight PHCs (four per block) from Udaipur district were selected based on their geographical representation of the two administrative blocks and proportion of population covered. A total of 16 sub-centers from eight PHCs (two per PHC) were then selected based on their population coverage; availability of ANM; and ANM's years of work experience. Finally, 16 villages from 16 sub-centers (one per sub-center) were selected based on their population coverage; the availability of *Anganwadi* Center (AWC), AWW, ASHA; and years of work experience of AWW and ASHA. Census 2001 of GoI and block level data from the two departments was used in this selection.

Participants

Table 1 presents the summary of the study participants. Apart from these, 15 ASHAs were also interviewed but their interviews are not included in the analysis as none of them reported their consultative or non-consultative selection as the reason for their good or poor work performance and coordination with co-workers (ANMs and AWWs).

Table 1. Category of study participants and their total number interviewed

Category	Participants	Number Interviewed (N)
Co- workers of ASHAs or community workers	ANMs	15
	AWWs	16
Health System Representatives	DWCD Personnel	11
	DHFW Personnel	6

From each of the 16 villages, one AWW and ANM were selected for interview. This is because, as per government norms, a tribal and rural village of 700 and 1,000 above population should have one ASHA, one AWW and must be covered by one ANM. The selection of 16 villages, as explained above, ensured that each selected village had an average specified population size and one ANM, ASHA, and AWW with at least 3 years of experience of working together. One ANM dropped out of the study due to her personal reasons. The AWWs posted at mini-AWCs within a selected village and second ANMs newly recruited at the selected sub-centres were not included in the study. The selection of DWCD and DHFW personnel was based on their total years of work experience at the same post and geographical area; and their availability and willingness to participate in this study.

Study instrument

The IDIs were based on interview guides that had open ended questions on the experience of joint working between three groups of community workers; factors that are considered important for affecting this joint working; and suggestions for improving joint working between the three groups of community workers. The list of all factors associated with work performance of ASHA hence their effect on co-ordination between ASHA and her Co-workers is published elsewhere (Sharma *et al*., 2014). If the participant indicated "selection process of ASHAs" as one of the factors, the instrument also provided scope for further probing on its effects and suggestions to improve the situation in future. Since no ASHA mentioned this as a factor impeding her performance and coordination, the analysis is based on the views of her co-workers and the health system representatives only.

Data collection and management

All interviews were conducted by obtaining informed verbal consent from the study participants. The majority interviews were conducted at the participants' home rather than official premises. Each interview took an average 45 minutes. The majority interviews were audio-recorded whereas field notes were used in some cases where permission for audio-recording was not granted. All interviews in the audio and written notes format were translated from Hindi to English before final analysis.

Data analysis

An inductive approach with open coding was used to analyze the data manually, using Microsoft Excel. Each interview was first coded independently to identify the factors that were said to affect ASHA's work performance and coordination with co-workers. The code list of all interviews was then compared followed by grouping and re-grouping to derive at one common list of codes from all the interviews. The text from the interviews of all those participants who indicated ASHA's selection as an important factor was further classified into three sub-codes i.e. 1) the problem-selection process, 2) the effect- working relation with the co-workers; and 3) the solution- suggestions to improve the selection process.

Ethical consideration

The Public Health Foundation of India (PHFI) Institutional Ethics Committee (IEC) approved the research. Informed verbal rather than written consent was taken from all study participants due to the observed reluctance of many respondents from signing on any paper formats due to the fear from senior officials for disclosure of any information. Any compulsion for written consent would have biased the data and affected its quality. The majority interviews were conducted at the residence of the participants to ensure their comfort and confidentiality. Coding of audio-files and interview transcripts ensured confidentiality of participants at all stages of data processing and presentation. The names of selected blocks, PHCs, sub-centres and villages are not mentioned in this paper to ensure confidentiality of the study participants.

The responses from individual participants are grouped as "ASHA's co-workers" and "health system representatives" while presenting the findings to mask their identity and ensure confidentiality.

RESULTS

This section explores the three component of the study 1) what is the problem; 2) how and who gets affected; 3) what should be done to improve the situation. The summary is presented in Table 2.

The problem- selection process

Since the initiation of ASHA program in the study area the process of selection was done by the *Panchayats* without consultation with *Gram Sabhas* or DWCD or Health department. ASHAs were selected based on only *Panchayat* members' discretion to fasten the recruitment process. Non-consultative and *Panchayat* dominated ASHA recruitments were said to be continuing even today in the study area. Bias and favouritism of *Panchayat* towards its own family members, relatives, friends; people from same caste, political party selected as ASHAs was shared. Such selection was said to be at the cost of other competent and deserving candidates who are either not informed about such vacancies or are rejected without any valid reasons. This has resulted in flouting the basic ASHA selection criteria as stated by the government.

"The Sarpanch appoints ASHA from amongst people known to him so as to increase the number of his supporters. He does not take ANM or AWWs' opinion. He has been doing such appointments in the past"...ASHA's Co-worker

"ASHA is not from the same village and has been appointed by Sarpanch based on his own judgment. This is because ASHA's husband is working with Sarpanch"... ASHA's Co-worker

"Appointment of ASHA is a political problem as there is a local competition and they (Panchayat leaders) want their own candidate to be chosen"...Health system representative

"*They would ask to give two to three names of the females but the Sarpanch would keep whomsoever he wants, who is known to him, who meets him often and who is of his own caste even if the person is less educated. If names given by us belong to different political party then he would keep the one who belongs to his own party. Even the DWCD official does not have any say in ASHA's appointment*"… Health system representative

"The Panchayat doesn't know about ASHA's roles, what capabilities are needed in her to perform and how well she will perform. But they only want their own candidate to be placed. The Panchayat appoints their own person without informing the rest in the village in Gram Sabha. After the Gram Sabha is over, the Panchayat members sit secretly and appoint their own person as ASHA. So the actual deserving candidate doesn't even come to know anything"… Health system representative

The effect- working relation with the co-workers

The study participants mentioned that the non-consultative and biased selection of ASHAs by local political leaders has strained the working relationship between ASHAs and her co-workers. The ASHAs are selected on the basis of Panchayat's favouritism rather than competency and such ASHAs were said to be less competent, less motivated, non-compliant, non-accountable, fearless and overconfident. Such attitude, behaviour and work performance of ASHA was said to affect her coordination with her co-workers.

As the ANMs and AWWs are expected to ask for support from ASHAs in their work, the political backing of ASHAs caused fear, helplessness and loss of authority among these co-workers on their ASHAs rather than a coordinal work relationship necessary for their joint work in the village. Instead, such ASHAs were said to threaten ANMs and AWWs if any of them questioned ASHA's work or complained against her non-performance or lack of support extended to any co-worker. Moreover the local community was said to be helpless to resist or revoke or request removal of such ASHAs due to the power dynamics between them and the *Panchayat*. Any non-performance by politically backed ASHA was said to go unquestioned and rather lead to incomplete and poor quality work of ANMs and AWWs for which they were questioned and harassed by their authorities. Such victimization of ANMs and AWWs due to ASHA's political positioning in the system was said to demoralize these co-workers.

"*They (ASHA) do not listen to any requests for support from ANMs. They threaten to get the ANMs transferred. Such politically connected ASHAs threaten to disturb law and order at times. They say that no one can do anything against them even if they do not work as they have their relatives everywhere*"*… ASHA's Co-worker*

"As Panchayat recruit ASHAs, they can't be scolded by us even if they don't work. At many places ANMs and AWWs keep silent and let ASHA sign her attendance even without work. No one wants to point finger on her even if the ASHA doesn't work. The Panchayat favours and believes more on ASHA's word. ASHA is not regular in Panchayat meetings also but no one questions her. Her husband signs her attendance on her behalf. AWW is just working with ASHA because of the fear of the Panchayat. Initially villagers were not aware who was their ASHA but now after knowing about her, the villagers also can't do anything about it."... ASHA's Co-worker

Similarly the health system representatives revealed their helplessness and fear in any effort they made to improve the joint work between ASHAs and her co-workers. These representatives said that they receive threats of job transfer, retrenchment and even threats to life if they attempt to take any action on non-performing but politically backed ASHAs. Other than the community, co-workers and health system representatives, it was surprising to note that such ASHAs that were selected by *Sarpanch* from one political party were harassed by the leader/s of opposition, if the opposition wins and came to power after the next elections.

"*Since the ASHAs are recruited by political bodies, the health and WCD department cannot force her to work. If the ASHA is not working and the Medical Officer wants to replace her, the political parties attached to her threaten the Medical Officer and other seniors. Like this it becomes difficult for us to work. In one such case, various department notices were sent to one ASHA but she is still not removed as her husband is a politician. This also affects the moral and attitude of ANMs and AWWs towards work*"… Health system representative

"The appointment of such politically influenced ASHAs is very high in this block, I don't know why? I have also worked in other blocks for 12 years but I did not see Panchayat intervening so much. But here every day I get one or the other phone call from Panchayat leaders. They keep telling me-we will transfer you to a different department if you take any action against this ASHA"… Health system representative

The solution- suggestions to improve the selection process

In relation to the non-consultative and biased selection of ASHAs, the response from the study participants was mixed in terms of solutions. While some suggested that *Panchayats* should not be part of selection of the ASHA at all others suggested that ASHA's selection should be done by the DHFW or DWCD. The remaining participants suggested consultative ASHA selection by government departments and village level bodies. They emphasized on the participation of community level stakeholders such as *Gram Sabha*, Panchayats, ANMs and AWWs along with the health system representatives. Apart from the adherence of government prescribed selection criteria, they suggested that ASHA's knowledge, motivation to work and family background should be checked by the joint selection committee before final selection.

"Females whose in laws are political leaders should not be appointed as ASHA as they do not work and our work suffers"*... ASHA's Co-worker*

"ASHA should be recruited by either of the department on the basis of her talent, knowledge and motivation to work rather than relationship with Panchayat members"... ASHA's Co-worker

"According to me these people- AWWs, ANMs, WCD and health department's supervisors along with Sarpanch from village's side together must decide about ASHA because after all the ASHAs have to work with both the departments. This small selection committee of 4-5 people can decide mutually".... Health system representative

"ASHA's appointment should not be through Panchayat. She should be either appointed by WCD or health department or both but not Panchayat. This way at least her monitoring would be proper and she would be able to put her entire mind in work rather than politics. She should be appointed as per her qualification in the same manner as others (ANMs) are appointed. One should be appointed based on 4-5 points i.e. she should be 10th pass, she should reside at the village, she should be the daughter-in law of this village. If there are some widows then they should be preferred. "... Health system representative

Themes Table 2. Summary of the Key Findings

What is the problem?	• Non-consultative ASHA selections made in the past and present • Panchayat's decisions are made without proper knowledge of ASHA's roles • Personal relations over candidate's competency preferred for selection • Government set ASHA selection criteria not adhered • Information on available vacancies withheld from public to recruit favourites • No valid justification for rejections/selections of candidates given by Panchayat
How and who does it affect?	• ASHAs' attitude, behaviour, work performance and relationship with co-workers was said to be affected due to their political backing by Panchayats. The same was also said to increase their non-accountability and forgery in attendance records. On the contrary, the change of political party in power was said to create troubles for ASHAs selected by previous Panchayat leaders, if from opposition political party. • Co-workers were said to be instilled with fear, helplessness, loss of authority on ASHAs and faced victimization because of the biased behaviour of department officials towards ASHAs as she is directly associated with Panchayat unlike them. • Health system representatives said to have received threats from politicians thus felt powerless and helpless to take any action on politically backed ASHAs • Community (villagers) was said to be helplessness in raising voice against such politically backed non-performing ASHAs
What is the solution?	• Selection authority should be- 1) Only Health department; 2) Only WCD officials; 3) Only health and WCD officials; 4) Only Panchayat in consultation with Gram Sabha and ANM and AWWs; 5) Joint village level committee of department officials, Panchayat representatives, ANM and AWW • Selection procedure- 1) strict adherence of government led selection criteria (education/village domicile etc.); 2) avoidance of family members/relatives/political party supporters' selection; 3) de-briefing candidates on their roles and accountability before selection; and 4) knowledge and motivation of candidate must be considered before selection

DISCUSSION

While there are studies that have proved effective engagement of *Panchayats* in contributing to public health initiatives in India, this study looked at how the "power" associated with *Panchayats* is affecting the NRHM's ASHA programme in Rajasthan (Kumar and Kumar, 2008). There are other studies, which have looked at the politicization of ASHA model. A study from Bihar state in India showed that 65 % ASHAs were recruited by local village leader and in only 10% of the cases, *Gram Sabha* was involved (http://www.globalhealthequity.ca/webfm_send/96).

The study from Rajasthan also showed that about 53% ASHAs said to have got selected by the politician or *Sarpanch* or *Gram Sabha* (Uttekar *et al*., 2007). Another study from multiple states in India showed that less than 25% ASHAs indicated occurrence of any village level group discussion or *Gram Sabha* meeting for the purpose of their selection (Nandan, 2008). However, this is the first study to show that such non-consultative and biased selection of ASHAs by *Panchayats* is one of the reasons for poor work relationship between ASHAs and her co-workers-the essential condition for joint working of the three groups of community workers to jointly improve village health status.

Considering the fact that the *Panchayats* and *Sarpanchs* are elected people's representatives in India who are given constitutional powers to take decisions for the benefit of their population, the evidence from this paper shows the misuse of this power by these leaders for personal and political gains.

The evidence also shows that favouritism rather than competency based selection of ASHAs by these leaders has a spiralling effect on the overall system due to which not only the ASHA's own work performance many deteriorate but an unhealthy work environment is created for all, especially ASHA's co-workers.

It seems that the entire system (except ASHAs) is subdued under these local politicians. The political protection from these leaders seems to wave off any fear of non-performance and accountability among ASHAs. Continued existence of such ASHAs on the posts despite their non-performance seems to be the favour government departments have to make to pacify these local politicians.

While the study methodology limits us to comment anything on the width of this problem in Rajasthan but the insights from the majority of study participants who indicated non-consultative and biased selection of ASHAs in their region and its effects in multiple ways on variety of stakeholders associated with ASHAs allows us to say that the problem is serious and needs attention. The suggestions made by the study participants to correct the situation were mixed. While the lessons from the other countries and the plain logic that when the CHWs are part of the community and work for community, community's engagement (in this case *Panchayat and Gram Sabha*) in CHW's selection should be mandatory seems convincing, the evidence from this study shows that regardless of the simplicity of the logic its operationalization is tricky and not so simple.

A health workers' book developed by Hesperian Health Guides states that the biased selection of CHWs is a problem reported from many countries (http://hesperian.org/wp-content/uploads/pdf/en_hhwl_2012/en_hhwl_2012_02.pdf). As a solution, the report states that in case of Philippines, the selection of close relatives of leaders and officials as CHWs is not accepted. The same report states example from Mexico (Village health programme in Ajoya) and Philippines (Makapawa Programme) where serious efforts are made to first make the community aware about their health needs, need for CHWs and qualities in their CHW before finally letting the community vote and decide who should be their CHWs. Such community engagement processes could be time taking but

more efficient in operationalising meaningful community participation for selection of CHWs rather than biased selection of ASHA carried out in a hurry as evident from this study from Rajasthan. A report by "Partners in Health" also talks about the CHW selection adopted in Rwanda and Malawi (http://www.pih.org/library/pih-program-management-guide).

Both models show the engagement and consultation between community people, community leaders and health department representatives. In both models, the emphasis is given to making the selection committee stakeholders aware about the roles and responsibilities of CHWs prior to starting the selection process. Also, in case of Rwanda, CHW's selection is just not based on the subjective judgement or fulfilment of specific laid down criteria, it is also based on a practical test conducted at nearby health institution to objectively select the most suitable candidate as CHW. Thus in India while the consultative platforms for ASHA selection e.g. Gram Sabha meetings and Village Health and Sanitation Committee (VHNDs) already exist, the real issue is not community and *Panchayat* vs. departmental engagement in ASHA selection. But the actual issue is how to ensure that the procedure followed for ASHA selection in these joint meetings is un-biased and consultative.

Finally, based on the lessons learnt from the existing literature and findings from this study, the authors suggests that it is important to address the following issues adequately in order to ensure unbiased selection of ASHAs in Rajasthan. These are: 1) community, including *Panchayat* members, should be sensitized about ASHA's roles and responsibilities and the seriousness of her job; 2) the protocol for announcement of ASHA posts across village should be designed and followed; 3) strict adherence of the protocol on the participation of concerned department's personnel in ASHA selection process must be followed; 4) design and adoption of monitoring mechanisms that can ensure or verify that the ASHA's selection was un-biased and consultative; and 5) public announcements of the name of the selected ASHA for villager's knowledge.

Overall, it is important that the participation of department officials in joint meetings for ASHA selection is not just symbolic but serves a meaningful purpose. Also, the system needs to ensure that the DHFW and DWCD officials play a more proactive role in ASHA selection when the majority of ASHA's work, their training, supervision and incentives are aligned with these two departments in Rajasthan.

Conclusion

The ASHAs have proved to be an important link between the community and health service system in the past. For this initiative to continue in the right direction, it is important that the right candidate is selected as ASHA for long term benefits of the village. Thus it is the joint responsibility of all those associated with ASHA's work and ASHA's selection that they identify this right candidate based on government norms, her competencies and motivation to serve the village community than on the basis of any personal or political affiliations or gains.

A consultative process involving all the key stakeholders needs to ensure that the selection process is un-biased and a right candidate is selected for this position. This can lay the foundation of congenial work environment between ASHAs and her co-workers to jointly work as a "community health team" for improving the health of the village.

REFERENCES

ASHA Data: National Rural Health Mission. Ministry of Health and Family Welfare, Government of India, June 2013). (http://nrhm.gov.in/communitisation/asha/asha-data.html).

ASHA guidelines: Guidelines on community processes. National Rural Health Mission. Ministry of Health and Family Welfare, Government of India. 2013; Part A: 1-34. (http://nhsrcindia.org/index.php?option=com_dropfiles& task=frontfile.download&id=1173).

Bhutta, Z.A., Lassi, Z.S., Pariyo, G. and Huicho, L. 2013. Global experience of Community Health Workers for delivery of health related Millennium Development Goals: a systematic review. Country Case Studies and Recommendations for Integration into National Health Systems. Karachi, Pakistan: WHO.

Guidelines on Accredited Social Health Activists (ASHA):National Rural Health Mission. Ministry of Health and Family Welfare, Government of India. New Delhi. (http://mohfw.nic.in/NRHM/RCH/guidelines/ASHA_guidelines.pdf).

Jaskiewicz, W. and Deussom, R. 2013. Recruitment of Community Health Workers. (http://www.mchip.net/sites/default/files/mchipfiles/07_CHW_Recruitment.pdf).

Kanth, V., Cherian, A. and George, J. The contribution of Accredited Social Health Activist (ASHA) under National Rural Health Mission (NRHM) in the implementation of Comprehensive Primary Health Care in East Champaran district, Bihar (State) India. Emmanuel Hospital Association. (http://www.globalhealthequity.ca/webfm_send/96).

Kumar, S. and Kumar, Y. 2008. Promoting sanitation through decentralised governance: A case study of Rajukhedi Panchayat in India. Beyond Construction-Use by all: A collection of case studies from sanitation and hygiene promotion practitioners in South Asia. WaterAid, :201-211. (http://protosh2o.act.be/VIRTUELE_BIB/Werken_in_het_Water/SAN-Sanitatie_en_ Hygiene/ W_ SAN_ E41_ Beyond_ construction.pdf#page=210). .

Leslie, C. 1989. India's Community Health Workers scheme: a sociological analysis. Ancient Science Life; IX: 40-53.

Nandan D: Assessment of the functioning of ASHAs under NRHM in Uttar Pradesh. State Institute of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India, 2008. (http://www.nihfw.org/doc/RAHI-IReports/Lucknow/ LUKNOW.pdf (cited 10 September 2014).

NRHM Mission Document-Framework for Implementation (2005-2012): Ministry of Health and Family Welfare, Government of India. (http://www.nird.org.in/brgf/doc/RuralHealthMission_Document.pdf).

Partners in Health: Improving outcomes with community health worker. Program Management Guide, 2011, Unit 7.

(http://www.pih.org/library/pih-program-management-guide).

Sharma, R., Webster, P. and Bhattacharya, S. 2014. Factors affecting the work performance of community health workers in India: a multi-stakeholder perspective. Global Health Action, 7: 25352 - http://dx.doi.org/10.3402/gha.v7.25352

SIHFW website. Government of Rajasthan. Jaipur, Rajasthan, India. (http://www.sihfwrajasthan.com/ppts/full/nfhs--iii.pdf).

The Hindu: Rajasthan Identifies ''High Focus Districts.'' Jaipur, Rajasthan, India, (10th June 2010). (http://www.thehindu.com/todays-paper/tp-national/ rajasthan-identifieshighfocus-districts/article2092416.ece).

Update on the ASHA program: National Rural Health Mission. Ministry of Health and Family Welfare, Government of India, July 2011. (http://nhsrcindia.org/).

Uttekar, B., Bhargey, S., Khan, W., Deshpande, Y., Uttekar, Y. and Sharma, Y. *et al*. 2007.Assessment of ASHA and Janani Suraksha Yojna in Rajasthan. Centre for Operational Research and Training (CORT). (http://www.cortindia. in/RP%5CRP-2007-0302.pdf).

Werner, D. and Bower, B. 2012. Selecting Health Workers, Instructors and Advisors. Helping Health Workers Learn-A book of methods, aids, and ideas for instructors at the village level. Hesperian Health Guides., Chapter 2:2-18. (http://hesperian.org/wp-content/uploads/pdf/en_hhwl_ 2012/en_hhwl_2012_02.pdf).

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