GOVERNMENT OF INDIA
HEALTH AND FAMILY WELFARE
LOK SABHA

UNSTARRED QUESTION NO:1470
ANSWERED ON:04.03.2011
QUALITY HEALTH CARE UNDER NRHM
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Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) the achievement, availability and access to quality health care under the different component like Accredited Social Health Activists (ASHAs), Village Health and Sanitation Committees (VHSCs), Rogi Kalyan Samities (RKS), District Health Action Plan (DHAP) made under the National Rural Health Mission (NRHM), State-wise;

(b) the funds allocated and utilised under different schemes, State-wise;

(c) the bottlenecks identified in implementation of NRHM in the country; and

(d) the steps taken by the Government to overcome these bottlenecks?

Answer

MINISTER OF THE STATE IN THE MINISTRY OF HEALTH & FAMILY WELFARE (SHRI GHULAM NABI AZAD)

(a): Achievement/availability of ASHA, VHSC,RKS and DHAP is at Annexture-I. All these components of NRHM alongwith infrastructure upgradation, manpower augmentation, capacity building and supply of drugs and equipments are aimed at improving access and quality of healthcare.

(b): State-wise details of funds allocated, release and expenditure is at Annexture-II.

(c) & (d): During the implementation of the NRHM some of the major challenges witnessed in various States include the following:

a. Wide variation in absorptive capacity, level of development, status of health indicators across the states and districts leading to variable pace of program implementation.

b. Variation in socio cultural conditions, accessibility and perceived level of difficulties across the districts.

c. Availability of Specialists, Doctors and paramedical staff in the states.

d. Difference in health seeking behaviour of people.

e. Weak capacity for planning at lower level.

Some of the measures adopted to address the above concerns include:

(i) 264 backward districts identified across the country for differential financing and focussed attention.

(ii) To improve availability of personnel in difficult and remote areas, financial incentives to staff posted in such hard to reach and inaccessible areas.

(iii) Allowing contractual appointment under NRHM to immediately fill gaps and to meet the requirement of manpower.

(iv) To overcome shortage of Specialists, Multi skilling of the available doctors through trainings such as LSAS, BeMONC, CeMONC taken up.

(v) Building capacity at the field level to facilitate formulation of plans according to the local needs.

(vi) States are supported to take up IEC activities to change the health seeking behaviour of people.