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National Rural Health Mission's impacts: A Public Welfare initiative in the Indian Wellness Region

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Abstract
The National Rural Health Mission (NRHM) is a safe motherhood scheme by the Ministry of Health and Family Welfare, Government of India. This scheme was launched on April 12, 2005. The scheme was launched by the Government of India to meet the target set by the Millennium Development Goals (MDGs) of the United Nations. It examines the role and functioning of NRHM in providing basic health care services in rural India. It aims to provide basic health facilities and quality services in India, focusing on fertility, infant mortality rate (IMR), maternal mortality rate (MMR), total fertility rate (TFR), child health and adolescence (RMNCHA), etc. The scheme is one of the most important public health priorities for providing antenatal, perinatal, and postnatal care to women. Under which the scheme aims to provide integrated, comprehensive, and effective health care to women and children from deprived and vulnerable sections of society, This study also highlights the character of NRHM in providing equitable, affordable. This study mainly focuses on the vision, implementation, key issues, impact, achievements, and evaluation of the National Rural Health Mission program.

Keywords: National Rural Health Mission, Infant Mortality Rate, Maternal Mortality Rate, Empowered Action Group, Health Sector.

Introduction

A good health is vital for the happiness and wellbeing of an individual as well as for the society. According to WHO (1978), “Health is a state of complete physical, mental & social wellbeing, & not merely an absence of disease or infirmity”. It includes matters of drinking water, sanitation, family welfare & epidemics (Visaria & Bhat 2011). The current status of health of rural population in India is not only distressing but also grave. The performance of health systems, including that of the public health system in the rural areas, is the major cause of concern. The disparities in health indicators between the rural and urban areas, and also across the states, are huge. The document of the Task Force on Medical Education for the National Rural Health Mission provides evidence of the disparities (Ashtekar, 2008). The correct and successful implementation of the NRHM can be a case of actual transfer of resources to the poor by ensuring access to better health. A country's ability to thrive economically is largely dependent on the health of its population, as only individuals who are in good physical and mental health can contribute to

the nation's improved output. That's why improving people's health has received enormous importance everywhere in the world. Since the post-independence era, the Indian government has been implementing various programs to work toward the goal of "Health for All," and as a result, it is making significant efforts to provide health services to all states in the country. In this regard, the National Rural Health Mission, one of the great experiments undertaken by the government to improve health status, was launched on April 12, 2005. (Ministry of Health and Family Welfare. 2007).

The right to health was acknowledged as a primary human need in the Alma-Ata Declaration of 1978. But after the Alma-Ata Health Conference, when equity and efficiency in primary health care were emphasized, health care became a priority for the Government of India. The health status of a country or region is a strong indicator of its social and economic development. Because it plays an important role in establishing the Human Development Index (HDI) of the country. National health is very important for the prosperity of the country. Health services and infrastructure in India are generally unequal. These disparities exist not only between rural and urban areas of India but also between women from different rural and urban areas.

Background of the National Rural Health Mission:

The National Rural Health Mission (NRHM) is an important scheme launched by the Central Government on April 12, 2005, under the Tenth Five-Year Plan. This was a historic day in India when the honorable Prime Minister, Dr. Manmohan Singh, launched the Health Care Program for the health needs of the people in rural areas with a time frame of 7 years from 2005 to 2012. This mission was started by improving the reach of national rural public health services with the aim of providing integrated, comprehensive, and effective health care by upgrading the physical and professional infrastructure of village subcenters, primary health centers, and district hospitals, especially women and children. The main purpose of the mission is on establishing a fully functional, community-owned, decentralized health delivery system with inter-sectoral convergence at all levels to ensure simulation actions on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. It aims to reduce the infant mortality rate (IMR) and maternal mortality rate (MMR) and provide universal access to public services such as women's health, child development and nutrition, clean drinking water, better sanitation, and education. (Husain, 2019). The scheme deals with providing all the facilities at one place for various levels (like the Reproductive Child Health Project, Integrated Disease Surveillance, Malaria, Kala-azar, Tuberculosis, and Leprosy, etc.). To achieve the objectives of the said scheme, Janani Suraksha Yojana, Janani Shishu Suraksha Programme, Mission Indradhanush, Kilkari, Mother and Child Tracking System, Rogi Kalyan Samiti/Hospital Management Society, National Mobile Medical Unit (NMMU), and National Ambulance Service (NAS) programs like Asha Worker (Accredited Social Worker), etc. were started. The mission was implemented in all states and Union Territories, a special focus has been given to 18 states. including eight Empowered Action Group (EAG) states like Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chaattisgarh, Orissa, and Rajasthan), eight North Eastern States (like Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, and Tripura) the hilly states of Himachal Pradesh and Jammu and Kashmir Villages and towns with a population of less than 50,000 are covered under this mission. The role of trained ASHAs in the implementation of this scheme is very important. There is approximately 1 ASHA working for every 1000 rural people. (Nandan, 2011).

Objectives of the National Rural Health Mission:

- To reduce the infant mortality rate (25/1000) and maternal mortality rate (1/1000).
- Reducing the total fertility rate (TFR) to 2.1.
- Control of diseases like anemia in women aged 15–49 years.
- To halve the annual incidence and mortality rate of tuberculosis.
- Annual malaria incidence is <1/1000.
- To reduce the prevalence of microfilaria to less than 1 percent in all districts.
- Access to comprehensive primary health care, gender, and demographic balance are important for the prevention and control of communicable and non-communicable diseases.
- Universal access to public services includes health care, food and nutrition, and sanitation for people, especially the health and immunization of poor women and children.
- Increasing government expenditure on health care and managing insurance schemes for proper treatment of common people.
- Increase public expenditure on health infrastructure from 0.9% of GDP to 2-3% of GDP in the next 5 years.
- Preparing a village health plan with the help of the panchayat, structurally improving the health-related system, and strengthening rural hospitals.
- To achieve the goals of National Population Policy 2000 and National Health Policy 2002.
- To revive local health traditions and mainstream AYUSH (Ayurveda, Unani Siddha, Homeopathy, Yoga, and Naturopathy) into the public health system.

(Source: National Health Mission Rural Statistical Annual Report 2021-22)

NRHM illustrative- Structure

5 to 6 Villages

Sub-Health Center Level

- The first level of contact is between the primary health care system and the community.
- Nurses posted at sub-centers conduct institutional deliveries and refer only complex cases to PHC.
- The sub-centers look after family welfare, nutrition, vaccination, etc.
- According to the Ministry of Health and Family Welfare, the number of sub-centers (SHCs) in rural areas is 157,935 and 3,894 sub-centers (SHCs) in urban areas.

30 to 40 Villages ↓

Primary Health Center

- The PHC is a referral unit for about six subcentres.
- The many activities of a PHC include curative, preventive, and promotional health care, as well as services like 3 staff nurses and 1 LHV for 4-5 SHCs. The emergency services 24*7 handled by nurses.
- According to the Ministry of Health and Family Welfare, the total number of primary health centers (PHCs) in rural areas is 24,935 and 6,118 in urban areas.

1 Lakh Populations 100 Villages ↓

Block Level Hospital/Community Health Center

- CHCs act as the first referral units to four–five PHCs.
- Provides facilities for maternity care and specialist consultation.
- According to the Ministry of Health and Family Welfare, the number of community health centers is 5,480 in rural areas and 584 in urban areas.

Review of Literature

- **Mukherjee (2021)** attempted to analyze how NRHM is working in India. Because of this, the 100 doctors who were interviewed in Odisha, Assam, were working in rural areas of Jharkhand and Chhattisgarh. After examining the data, she came to the conclusion that NRHM had brought about some marginal improvement in the rural health care infrastructure. But because of manpower, health, basic infrastructure, lack of health insurance prevention, and reasons for inefficiencies in the implementation of AYUSH, it cannot be said that NRHM is helping in providing adequate health services to the people in rural areas. A 100% percentage is effective.
- **Sharma, A. K. (2022)** Through the presented study, it has been shown that through the National Rural Health Mission, the impact on the health of rural women is to be studied. In order to improve the health-related situation more effectively, both rural and urban, there is a need to strengthen the primary health systems of the areas. Through the creation of the structure of new institutions through this mission, health, new ideas, decentralization of services and provision of resources, medication-assisted recovery (Medication Supported Recovery, MSR), and considering the general condition of pregnant women, the state of 2017 has been inspired to promote Mission NRHM. Aspirants in National Rural Health can find it a convenient and beneficial experience, but all women in rural communities are still deprived of access to various health policies. And he has also criticized many types of health-related schemes, saying that in today's era, pregnant women in rural areas are deprived of health and nutrition-related policies.

Research Methodology

This research is a descriptive study in which necessary facts have been collected through books, journals, magazines, newspapers, reports, the internet, publications and various websites etc.

Objectives of the study

- to comprehend the idea underlying NRHM.
- to study the ways in which different projects and activities were carried out under the NRHM using a variety of government of India publications and reports as a base.
- to study how the NRHM programs affect health infrastructures and key health metrics such as the growth, birth, death, and infant mortality rates, as well as the overall fertility rate.

Implimentationa of the NRHM

India's health sector is said to have seen significant change in the 21st century. In the year 2000, two significant developments occurred in the world of health. One of these was the National Population Policy (NPP 2000) announcement, and the other was India joining the 191 United Nations member states as a

signatory to the Millennium Development Goals (MDGs). After two years, the National Health Policy 2002 was unveiled, which took into account the MDGs and the NPP 2000's concerns. The National Health Policy served as the model for the NRHM, which was implemented in 2005. (Meit et al. 2018).

Several efforts have been carried out under NRHM in the following areas in an attempt to fully operationalize and account for India's public delivery system:

Increasing human resources for health- According to the 12th Five-Year Plan report, after six years of implementation of NRHM, 82 medical colleges have been added and 9751 seats have been increased. 595 ANM schools, 1227 GNM schools, 1026 nursing courses, 405 post-basic B.Sc. nursing courses, and 327 M.Sc. nursing courses have been added. One of the major steps taken under NRHM is the induction of 148361 contractually skilled service providers in public health services. Of these, 60268 are ANMs, 33667 are staff nurses, 21740 are paramedics, 11575 are AYUSH doctors, 4616 are AYUSH paramedics, 9432 are medical officers, and 7063 are specialists. Apart from these, more than 500 management and public health consultants have been inducted into state management roles. They play an important role in improving the quality of program management.

Another activity under NRHM was to train various categories of service providers and program managers to enhance their skills. For this, 21 days of SBA training are provided to ANMs and staff nurses to provide skilled birth assistance in each PHC and potentially each sub-center. 8 days of IMNCI training are provided to ANMs, staff nurses, and Anganwadi and ASHA workers.

The NRHM has implemented a few strategies to attract and keep qualified workers in rural and isolated locations. Among these strategies are:

- providing doctors, nurses, and midwives in remote areas of the majority of states both non-financial incentives (like preference for post-graduation and promotion) and financial incentives (like difficulty allowance or performance-based incentives linked to institutional delivery, C-section, sterilization etc.).
- provides alternating postings in regions such as Karnataka, Nagaland, and Tamil Nadu.
- Compulsory rural bond system for medical students attending government colleges in places like Tamil Nadu, Nagaland, Kerala, and Meghalaya.

1. **Strengthening of Community Processes-** NRHM has launched several programs to increase public engagement and promote and strengthen community processes. These programs include:

- **Accredited Social Health Activist (ASHA)-** The ASHA program is an essential element of the National Rural Health Mission (NRHM) of the Government of India. NRHM aims to create one ASHA per 1,000 people who works as a public health worker, facilitator, and facilitator at the community level. ASHAs play a positive and active role in supporting pregnant women at local health centers in institutional deliveries, vaccination, promotion of family development, sterilization, first aid for basic diseases and injuries, disease control programs (malaria, kala-azar, and lymphatic filariasis), etc. Is. Governments define the role of ASHA in different ways. In achieving the objectives of the National Population Health Policy, as a bridge between the citizens as well as the health care outlets of the nation and as part of improving behavior, etc., ASHA aims to raise awareness about problems such as maternal issues, disease, nutrition, hygiene, socio-economic factors, as well as early adolescence and female reproductive health counselors. Presently, there are 1,814,216 ASHAs selected across the country, of which 5,20,101 are in the high-focus states, 56,608 in the north-east states, 3,23,406 in the

non-high-focus states, and 9,14,101 in the union territories. Out of the proposed total of 1,898,817, almost 95.54% of ASHAs have been selected overall. (Rather & Ahmad, 2022).

- **Auxiliary Nurse midwife (ANM)-** Auxiliary Nurse midwife or nurse, commonly known as ANM, is a rural-level female health worker in India who works at health sub-centers. Known as the first contact person between the community and health services. Their services are considered vital to providing safe and effective care to rural communities. It helps communities achieve the goals of national health programs. A sub-center is a small village-level institution that provides primary health care to the community. The sub-center works under the Primary Health Center (PHC). Each PHC usually has about six sub-centers. Before the launch of NRHM in 2005, there was a provision for one ANM per sub-center. Later, this ANM was not enough to meet the health care needs of a village. In 2005, NRHM made provision for two ANMs (one permanent and one contractual) for each sub-center. (ibid)
- **Anganwadi-** Anganwadi is a government-supported center at the village level with a program of integrated child development services to meet the nutritional, health, and educational needs of young children. Anganwadi caters to the needs of children up to 6 years of age, adolescent girls, pregnant women, and mothers nursing infants. Each Anganwadi is built for a population of approximately 400–800 people. Depending on the population, there may be one or more Anganwadi centers in the Gram Panchayat area. For every 25 Anganwadi workers, an Anganwadi supervisor is appointed, who is called Mukhya Sevika, and who provides guidance to the Anganwadi workers and helpers regarding the work. Anganwadi is a center for spreading awareness about the needs and care of young children. (ibid).
- **Village Health Sanitation and Nutrition Committee (VHSNC)-** It is a committee at the village level to ensure community empowerment and sanitation at the grassroots level of NRHM, which functions as a sub-committee in the Gram Panchayat. Their main objectives are to create awareness, survey nutritional status and nutritional deficiencies (focusing on women and children), and monitor the functioning of Anganwadi centers. VHSNC members include representatives of Panchayati Raj and Asha, ANM and Anganwadi workers, representatives of women (from self-help groups), and marginalized communities. A total of 483496 VHSCs have been formed in the country, covering about 76% of the villages. (Malik, 2020).
- **Rogi Kalyan Samiti/Hospital Management Society**-It is an effective management structure and registered scheme. Its members act as a trust to manage the affairs related to the hospitals. And is responsible for ensuring better facility management and maintenance for patients in hospitals. So far, 31,763 patient welfare committees have been formed in almost all district hospitals, community health centers, primary health centers, and sub health centrs involving community members. (ibid).
- **The community monitoring program-** The community monitoring program, which is intended to collect information regarding community health needs, how they are met, and provide feedback through public hearings (Jan Sunwais), has been introduced by the nine states of Assam, Chattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, and Tamil Nadu. Due to increased utilization of services and greater accountability in the facilities as a result of this program, it has recently spread across the entire state of Maharashtra, Karnataka, and also in phases in Bihar and Madhya Pradesh. (ibid).

2. Innovative Health Care Services provide by NRHM-

- There are some of the effective & innovative health care services have been introduced in various states under NRHM & they have resulted significant change in the present public health scenario

(ibid).

- **Janani Suraksha Yojana-** Janani Suraksha Yojana, under the National Rural Health Mission, aims to reduce maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. Due to this, this scheme was implemented in April 2005 for safe motherhood and child care. Under this scheme, pregnant women are given assistance in the form of cash at the time of and after the birth of their children by government health facilities. It is a 100% centrally sponsored scheme (Ministry of Health and Family Welfare). Among the 10 lowest-performing states under JSY, ASHA (Accredited Social Activist) has been selected as an effective medium among poor pregnant women by the government in 8 EAG states: Assam, Jammu and Kashmir, and the North Eastern States. (Hogue & Vasquez 2020).

Funds given to ASHAs for institutional delivery

Rural area			Urban area		
woman	ASHAs	Total	Woman	ASHAs	Total
1400	600	2000	1000	200	1200

- **Janani Shishu Suraksha Yojana-** The Janani Shishu Suraksha Program was launched by the Government of India on June 1, 2011. Through this scheme, an institutional and safe proposal is being made to reduce the maternal mortality rate and infant rate through the currently operated health-related services by providing proper pre- and postnatal care for pregnant women and by training doctors in a clean environment. This is a major initiative to complete the process. It is an initiative to provide services like normal delivery and caesarean sections, newborn babies, and sick babies (up to 30 days of birth) to pregnant women, completely free of charge and at cash cost, in government health institutions in both rural and urban areas. (ibid).
- **Mission Indradhanush-** The Mission Indradhanush campaign was implemented by the Union Health Ministry of the Government of India on Good Governance Day, December 25, 2014, to vaccinate all children. The objective is to vaccinate these children by 2020 who are not vaccinated, have diseases like diphtheria, tetanus, polio, tuberculosis, measles, hepatitis B, or are partially vaccinated. Subsequently, the Prime Minister launched Mission Indradhanush-2.0 on October 7, 2017 to accelerate the vaccination program. It aims to achieve the Sustainable Development Goals by eliminating child mortality by 2030. Its main objective is to reach every child up to 2 years of age and all pregnant women who have been deprived of vaccination. (ibid).
- **Innovative Ambulance Service & helpline for Obstretics & medical Emergencies-**Under NRHM, emergency ambulance services have been started in all the states to provide transportation facilities to pregnant mothers for delivery, and call center service has been started to provide them with 24*7 medical assistance and health care services. NAS (National Ambulance Services) enables these people to provide ambulance services by just dialing 102 or 108. ambulance and free bus pass in Andhra Pradesh for BPL pregnant women and ST/SC women in Madhya Pradesh for BPL women Janani Express Scheme, ambulance schemes to provide round-the-clock transport for maternity and other medical emergencies in West Bengal, Janani Suresha Vahini, and Aaragya Kavach Scheme in Karnataka are some examples of ambulance schemes. To increase awareness among the rural population about the importance of health care. (ibid).

- **Mobile Health Units: Connecting with Rural India's Population-** To reduce physical barriers to accessing health services, mobile health care services and units were introduced, and various modes of transport vehicles such as buses, trains, vans, boats, and helicopters were used in rugged and inaccessible areas. Went. In Uttarakhand, mobile health clinics (MHCs) provide reproductive and child health (RCH) services in hill villages; in Madhya Pradesh, the Deen Dayal Mobile Hospital Scheme provides basic health care with ANC, PNC, immunization, and routine check-up provision in rural areas. Provides services. In Tripura, there are mobile helicopter services that provide specialized services in 12 remote, inaccessible areas. Additionally, in Kerala, NRHM has launched floating dispensaries that provide basic health services and also act as ambulances to reach nearby PHCs and CHCs during emergencies. These are aimed at increasing the visibility of government health facilities. (NHM, 2011).
- **Sneha Sparsha scheme (touch of love)-** The Sneha Sparsha scheme was launched in Assam under NRHM on April 15, 2013, and is a unique health care initiative for children below 12 years of age belonging to families with an annual income less than Rs. 2.50 lacs. The treatment includes thalassemia, which requires a bone marrow transplant, liver and kidney transplants, and a cochlear implant.
- **Kilkari Scheme-** This scheme was launched by the Government of India on December 25, 2015. This is a scheme in which advice related to the health of a mother and child is given free of charge on mobile. This scheme was run by the National Health Mission.
- **Reproductive and child health-** This is a sector-wide flagship program by the Government of India under the National Health Mission to deliver the RCH targets of reducing maternal and child mortality and total fertility rates. Its main objective is to provide access to quality reproductive, maternal, newborn, child, and adolescent health services and to reduce social and geographical inequalities.

3. The Impact of Implementation of NRHM

With the funding assistance & technical support from the Central Government, NRHM has been working towards the prosperity & improvement of health in rural areas. The maintenance of infrastructure and health care facilities at all health care levels are the main objectives of NRHM.

- **Impact on Health Infrastructure across-** The contribution of NRHM towards health infrastructure is illustrated. It shows that there has been a successive increase in the number of sub-centers, PHCs and CHCs from 2005 and 2023.

S.No.	Indicators	2005 Baseline	NRHM targets	Achievement (2023)	% Improvement in Baseline
1.	IMR	58/1000 lives births	30	26.619/1000 Lives births	54%
1.	MMR	254/10,000	100	52/10,000 Lives births	79%
3.	TFR	2.9	2.1	1.99	31%
4.	Maintain TB Cure Rate	86%	Above 85%	92%	6%
5.	Malaria Morality per 10,000	_	Reduce by 50%	91%	_

6.	Dengue Morality Reduction Rate	_	_	0.5%	_
7.	Public health as % of GDP Sub centers	0.9%	2-3%	2.1%	33%
8.	Sub centres	146,026	178,367	157,935 (rural)	9%
9.	PHCs	23,236	29,213	24,935 (rural)	7%
10.	CHCs	3,346	7,294	5,480 (rural)	68%
11.	ASHAs	_	250,000 (in 10 states)	1,814,216	100%

(Source: National Health Profile (2023) Ministry of Health & Family Welfare, India Social Development Report 2023: Challenges of Public Health)

The contribution of NRHM towards health infrastructure of **18 high focus states** is illustrate: state wise comparisons of health infrastructure in 18 high focus states (from 2006 to 2023) NRHM played an important role in addressing the basic health care issues of the rural population, including sub-centers (SC) and primary health centers (PHC) for urgent health needs and the community in cases of complex procedures and specialist care. Health centers (CHCs) and district hospitals are chosen. The sub-center is the first point of contact for seeking public health care; a primary health center serves as the first point of contact with a qualified doctor; and CHC provides specialist care, including Ayurveda, Yoga, Naturopathy, Unani Siddha, and Homeopathy (AYUSH) care. NRHM has many achievements, like improved infrastructure for health delivery, institutionally established standards, trained health care workers, facilitated financial management, suggested central procurement of drugs, equipment, and supplies, mandated the formation of village health and hospital committees, and community monitoring of services (Jacob, 2020). to target mortality, morbidity, and inclusive social development, NRHM has led a comprehensive war on malnutrition, poor health, and ignorance since its inception (Ministry of Health and Family Welfare, Government of India, 2009). Therefore, NRHM has made a significant impact on the public system of health care in the country. (Sankar et. al. 2024).

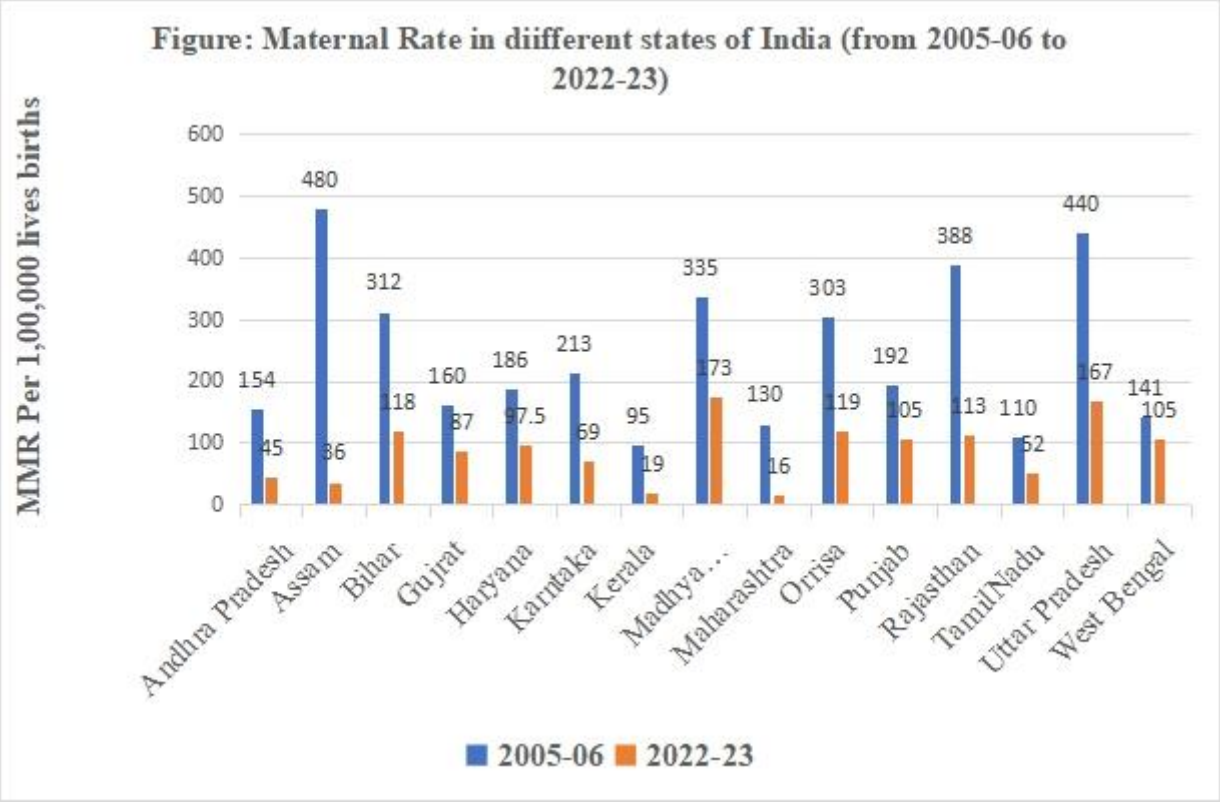
Year	**2006**						**2023**					
18 High Focused States under NRHM	Subcentres	PHC	CHC	Rural hospitals	Ayush Hospitals	AYUSH Dispensaries	Sub-centres	PHC	CHC	Rural Hospital	AYUSH Hospitals	AYUSH Hospitals
Arunachal Pradesh	379	85	31	36	2	47	286	97	54	52	12	63
Assam	5109	610	100	100	5	496	4609	978	110	1088	4	486
Bihar	8858	1641	70	101	26	634	9729	1883	70	1325	8	2175

Chattisgarh	4692	518	118	116	13	691	5161	783	157	416	14	1093
Himachal Pradesh	2069	439	66	86	29	1122	2065	474	78	98	31	1129
Jammu & Kashmir	1888	374	60	61	5	500	2265	637	84	1402	2	417
Jharkhand	3958	330	195	47	3	206	3958	330	188	545	5	333
Manipur	420	72	16	41	1	9	421	85	17	23	21	265
Meghalaya	401	101	25	26	2	11	422	108	27	28	10	12
Mizoram	366	57	9	10	6	1	370	57	9	29	8	17
Nagaland	397	84	21	123	2	0	396	126	21	21	2	203
Madhaya Pradesh	8874	1192	229	229	58	1623	8869	1156	333	1659	14	1301
Orissa	5927	1279	231	329	43	1301	6688	1305	377	334	23	1773
Rajasthan	10512	1713	325	337	107	3739	14221	1610	431	2649	126	3876
Sikkim	147	24	4	5	8	2	147	24	2	24	-	12
Tripura	539	73	10	14	10	106	828	83	18	21	2	111
Uttarakhand	1631	222	49	24	17	5033	1848	257	55	666	10	533
Uttar Pradesh	20521	3660	386	397	1973	1871	205521	3496	773	515	1983	2014
India	144988	22669	3910	4256	3153	20799	151684	24448	5187	15398	3169	25967

(Source: National Health Profile (2023), Ministry of Health & Family Welfare)

Table: The health infrastructure, including **subcenters, PHCs, CHCs, rural hospitals, Ayush hospitals, and Ayush dispenseries,** has improved significantly statewide since 2006, as this table illustrates.

Impact on Health Indicators: NRHM aims to reduce Infant Mortality Rate (IMR) to 26.619 per 1000 live births by 2023, Maternal Mortality Rate (MMR) to 97 per 1,00,000 live births and 1.91 Total Fertility Rate (TFR). The target has been set to reduce the rate to 2.1 by the year 2030.NRHM respects it for having led to tremendous change in the Indian health sector. (Express Healthcare, 2024).



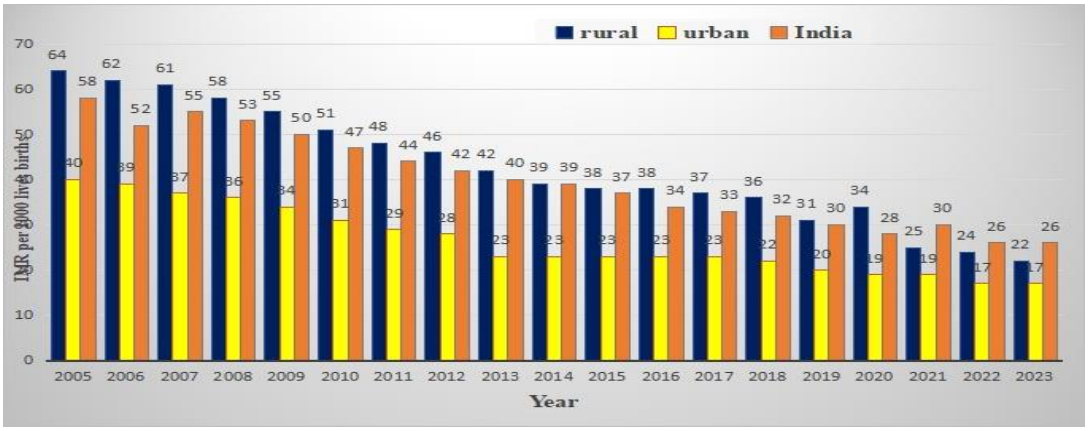
(Source: National Health Profile (2023), Ministry of Health & Family Welfare)

It shows that since 2004–2005, there has been a gradual reduction in MMR in the states. MMR in Assam, Uttar Pradesh, Rajasthan, Madhya Pradesh, and Bihar was significantly higher (i.e., 480, 440, 388, 335, and 312, respectively) than in other states. The MMR has been reduced in the states with the help of the combined initiatives of the Center and States, which promoted institutional deliveries as well as early identification of pregnancy-related complications and better surgical intervention. Besides these, the implementation of various schemes like JSY, Chiranjeevi Yojna, and maternal care programs in states has also significantly contributed to reducing MMR.

Infant Mortality Rate: Number of infant (aged under 1 year) deaths per 1,000 live births.

Neonatal and Postneonatal Infant Deaths: Neonatal infant deaths occur within the first 28 days from birth. Postneonatal infant deaths occur after 28 days from birth to under 1 year of age.

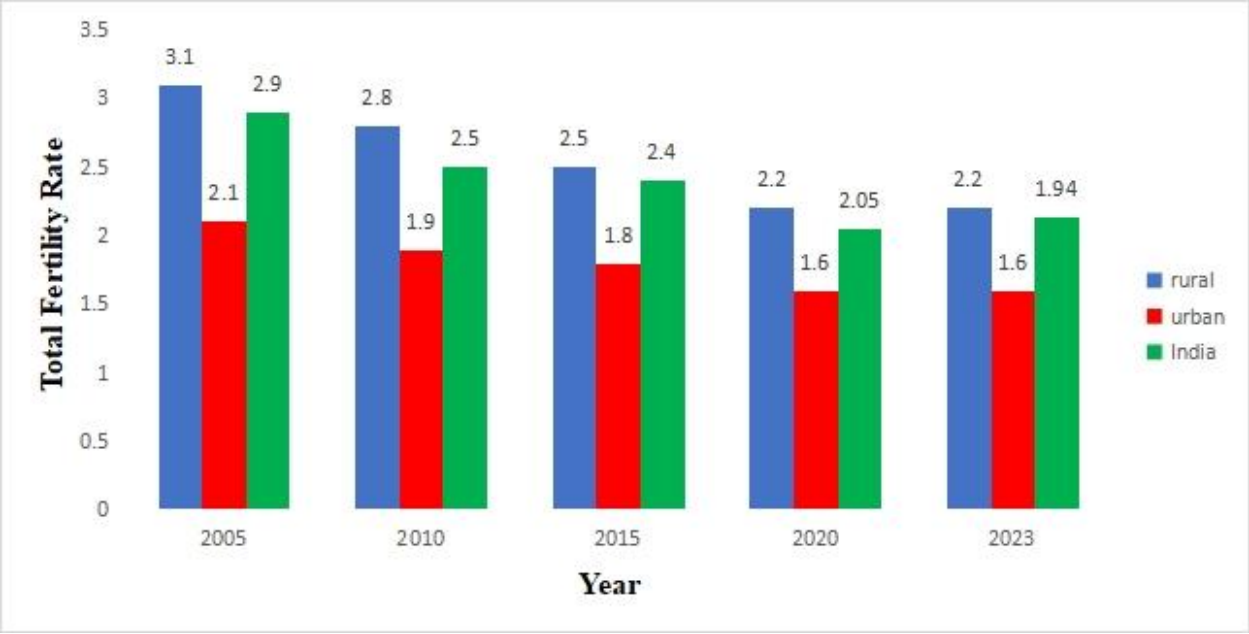
Infant Mortality Rates by sex in Rural, Urban and India from 2005-23



(Source: National Health Profile (2023), Ministry of Health & Family Welfare)

Figure: The child's health is one of NRHM's other main concerns. It displays the infant mortality rate (IMR) for India as a whole from 2005 to 2023, as well as for rural and urban areas. It implies that the country's IMR in rural areas is higher than that in urban areas and even higher than the IMR for the entire country. The IMR has, however, significantly decreased for the entire nation as well as for rural and urban areas, as seen in the figure, from a rate of 64, 40, and 58, respectively, per 1000 live births in the year 2005 to a rate of 22, 17, and 26, respectively, in the year 2023. The infant mortality rate in both rural and urban areas, as well as the country's total IMR, has significantly decreased as a result of the NRHM mission's initiatives for institutional births with the assistance of ASHAs and round-the-clock PHC services. But we haven't yet reached the desired infant mortality rate of 25 per 1,000 live births.

Total Fertility Rate in Rural, Urban areas & in India as a whole (from 2005 to 2023)



(Source: National Health Profile (2023), Ministry of Health & Family Welfare)

Apart from the decline in both IMR and MMR, there has also been a significant drop in the total fertility rate (TFR). The figure shows the rate of TFR in rural and urban areas as well as in India as a whole from 2005 to 2023, depicting a declining trend. In India, the TFR as a whole has declined from 2.9 percent in 2005 to 1.94 percent in 2023. In rural and urban areas, a decrease in TFR has also been observed from 2005 to 2023. However, the gap between the TFR of rural and urban areas is still present, with 1.6 percent TFR in urban areas and 2.2 percent TFR in rural areas for the year 2023.

Conclusion

The government of India's NRHM program has been a historic cornerstone initiative, successfully lowering IMR, MMR, and TFR while also providing the rural populace, especially the most vulnerable, with high-quality, reasonably priced healthcare services. Furthermore, the NRHM played a key role in the creation of new infrastructure for the health sector as well as the renovation of old infrastructure. Conversely, NRHM undoubtedly concentrated on growing its infrastructure, personnel, and service area. But quality features had not gotten enough attention. The Indian public health system is still plagued by inadequate funding, subpar performance management, and a lack of accountability measures. However, NRHM was unable to meet all of its set goals in order to improve public health standards in India. The

various innovative health care schemes & incentives taken under the mission have changed the existing health scenario in rural India. Infact it is said to be the first rural health care policy that has promoted intervention & innovation as per local needs & thereby has able to bridge the gap of lack of institutional deliveries among rural women (Banarjee & Kamble, 2015). One of the shortcomings is that the major health indicators (like MMR, IMR, TFR etc.) have registered gradual decline but in slow pace. Further, it has also failed to address the issues like social inequalities, socio-economic differences, urban- rural disparities, weaken cast system & gender inequality. The reason behind this may be the lack of adequate funds allotted under the mission as well as the corruption of the officials. the NRHM has proved to be one of the successful schemes of the Government of India & it has able to change the existing health scenario in rural India.

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References

1. Ashtekar, S. (2008). The National Rural Health Mission: Stocktaking. *Economic and Political Weekly.* 43 (37), 23. 43(37):23-26 DOI:10.2307/40277944
2. Banarjee, M . & Kamble, G. (2015). Innovative Rural Health Care Services & Its Social Impact- A State Wise Comparative Analysis. *International Journal of Research in Economics & Social Sciences*. 5(6). pp. 239-250.
3. Express Healthcare. (2019). Milestones in Indian Healthcare. Available at: https://www.expresshealthcare.in/features/milestones-in-indianhealthcare/191620/ (Accessed 25 January, 2021).
4. Franco, S.J. (2012). urban–rural classification scheme for counties. *National Center for Health Statistics. Vital Health Stat* 2(154).
5. Guyer, B. (2010). Annual summary of vital statistics: Trends in the health of Americans during the 20th century. *Pediatrics* 106(6):1307–17.
6. Ghosha, A., & Ghosh, R. (2020). Maternal health care in India: A reflection of 10 years of National Health Mission on the Indian maternal health scenario. *Sexual & Reproductive Healthcare*. https://doi.org/10.1016/j.srhc.2020.100530.
7. Husain, Z. (2019). Health of the National Rural Health Mission, Economic and Political Weekly, 46 (4), 53. https://www.researchgate.net/publication/228388644.
8. India: Ministry of Health and Family Welfare. (2007). National Rural Health Mission New Delhi. Available online at http://nhsrcindia.org/sites/default/files/1st%20CRM%20Main%20Report%202007.pdf (Accessed 25 January, 2021).
9. Jacob, K. S. (2021). For a New and Improved NRHM. The Hindu: 7th August. Available at: https://www.thehindu.com/opinion/lead/For-a-new-and-improved NRHM/article13649004.ece/ (Accessed 25 January, 2021).

10. Kumar, R. (2023). Impact of National Health Mission of India on Infant and Maternal Mortality: A Logical Framework Analysis. *Journal of Health Management* 23(1) 155–165. DOI: 10.1177/0972063421994988.
11. Martin J. A. et al. (2015). Births: Final data for National vital statistics reports. Hyattsville. *National Center for Health Statistics. 2017*. 66 (1).
12. Meit M, K. et al. (2018). The 2018 update of the rural-urban chartbook. Rural Health Reform Policy Research Center.
13. Malik, G. (2020). A Follow-up Study of Auxiliary Nurse Midwives (10+2) Vocational Course Trained at Lady Reading Health School. Delhi. *an unpublished M.Sc. thesis*.
14. Mukharjee, S. (2021). A study on the effectiveness of NRHM in terms of reach and Social Marketing Initiatives in Rural India. *European journal of Scientific Research*. 42(4): 587–603.
15. National Rural Health Mission's ASHA guidelines Centre for health promotion. (2005). National Rural Health Mission: identify the gaps, Rural Technology Development Centre, Himachal Pradesh.
16. Nandan, D. (2010). National Rural Health Mission: Turning into Reality. *Indian Journal of Community Medicine.* 35(4): 453–454. doi: 10.4103/0970-0218.74338.
17. Rowland Hogue C.J. & Vasquez, C. (2020). Toward a strategic approach for reducing disparities in infant mortality. *Am J Public Health* 92(4):552–6.
18. Rather, T., & Ahmad, W. (2022). Impact of National Rural Health Mission: A Public Welfare Programme of the Government on Indian Health Sector. *Journal of Xidian University*. Published in *Research Gate. 16*(01). DOI:10.37896/jxu16.1/022.
19. Singh, G. K. (2014). rural-urban disparities in all-cause mortality and mortality from major causes of death in the USA. *Urban Health* 91(2):272–92.
20. Sharma, A. k. (2022). The National Rural Health Mission: A Critique study. *Sociological Bulletin. 63*(2), 287-301. Sage Publication. New Delhi. https://www.jstor.org/stable/24431852..
21. Sankar, H. et. al. (2024). National Rural Health Mission reform in light of decentralized planning in Kerala, India: a realist analysis of data from three witness seminars. *BMC Public Health*. 24. Article number: 678.