India's National Rural Health Mission (NRHM): Examining the Scope and Impact

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ABSTRACT

Background: The National Rural Health Mission (NRHM), initiated in 2005, seeks to enhance access to healthcare and improve health outcomes for rural communities in India, explicitly emphasising maternal and child health.

Objective: This article assesses the National Rural Health Mission's effects on child development, focusing on significant initiatives like promoting institutional births, immunization efforts, and community involvement through Accredited Social Health Activists(ASHAs).

Method: By examining various studies and reports, this research highlights its objectives, functioning, major schemes and notable advancements in child health metrics, including declines in infant mortality rates (IMR) and rises in vaccination coverage. Nonetheless, issues such as insufficient infrastructure and high out-of-pocket costs persist.

Results: The results indicate the need for integrating child health initiatives within more extensive public health strategies to guarantee sustained development and better health outcomes for children in rural regions. National Rural Health Mission is one of the significant health related initiatives of Govt. of India. The National Rural Health Mission (NRHM) is a strategic initiative aimed at improving the health outcomes of rural communities through a comprehensive and inclusive approach. The mission's core objectives focus on reducing maternal morbidity and child mortality, ensuring equitable access to affordable healthcare services, and strengthening primary healthcare systems to make medical care universally accessible. It also prioritizes the prevention and management of both communicable and non-communicable diseases through integrated healthcare delivery. Additionally, the NRHM emphasizes stabilizing population growth while addressing critical areas such as maternal and child health, adolescent health, and family planning, thereby fostering holistic and sustainable health development in rural areas.

Keywords: National Rural Health Mission, NRHM, child development, maternal health, infant mortality rate, healthcare access, rural health outcomes.

INTRODUCTION

The United Nations _Alma Ata Declaration 1978 called on ―all governments to formulate national policies, strategies and plans of action to launch and sustain primary health systems.‖ However, the health system in India received low priority in the central and state budgets. Even less than 1% of the GDP on health expenditure was found in 1999, one of the weakest in the world (Zakir, 2008). The National Health Policy (2002) recognised the poor health situation and proposed various reforms, including involving rural doctors and promoting medical tourism. Following this, India's Congress-led United Progressive Alliance (UPA) government made public health a crucial component of its standard minimum program after coming to

power at the centre in 2004. The UPA administration acknowledged the necessity for a robust and coordinated strategy to tackle issues in rural India, which led to the establishment of the National Rural Health Mission (NRHM) as its main health initiative in 2005 (Scheme 1) (Hussain, 2011). As a result, NRHM was launched on April 12, 2005, throughout India, with the government dedicated to making essential enhancements to the primary healthcare delivery framework.

The mission's primary aim was to lessen disparities in healthcare access, especially in rural regions where over 70% of the population resides (MoHFW, 2005). Essential aspectsof the NRHM involve improving healthcare facilities, reducing maternal and infant mortality rates, and addressing widespread diseases such as tuberculosis and malaria (MoHFW, 2005). The NRHM was explicitly designed to address the needs of rural areas in 18 states identified in 2005 as having inadequate infrastructure and low public health measures. The mission sought to address these problems by strengthening the healthcare system's capacity to manage more resources and advocating for policies that improve public health management and service delivery throughout India. Moreover, NRHM aimed to address broader health determinants—including nutrition, sanitation, hygiene, and access to safe drinking water— through a coordinated approach, highlighting how these elements are interconnected in achieving the best health results (PEO, 2011). One of the significant initiatives under NRHM was the recruitment of Accredited Social Health Activists (ASHAs), who act as critical intermediaries between the community and healthcare services. The enhancement of public health infrastructure was also emphasised, especially at the village, primary, and secondary tiers. In addition, the mission promoted inter-sectoral collaboration, community empowerment, and improved management capacity to advance public health systems and services.

The Janani Suraksha Yojana (JSY) was sent to lessen infant and maternal death rates, boosting institutional conveyances. The NRHM additionally planned to operationalise well- being offices in each block to satisfy Indian Public Health Standards (IPHS). Moreover, the combination of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy) into the general well-being framework was an essential move to give far- reaching medical care administrations to underserved rustic populaces (PEO, 2011). The NRHM incorporated the reproductive and child health (RCH) program, family government assistance administrations, and different public infectious prevention programs focusing on diseases like intestinal sickness, filariasis, dengue, uncleanliness, tuberculosis, and polio while barring Helps and malignant growth programs. A pipe-type approach was used to guarantee that assets from public-level plans were diverted through State Health Societies to District Health Missions (PEO, 2011), assigning the local level as the focal centre point for well- being and family government assistance administration arranging and the board.

Financial management within NRHM includes the evaluation of untied funds allocated to VHSCs, Sub-centers (SCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs). Furthermore, the commoditization process mandates local Panchayat involvement in the governance of VHSCs, hospital development committees, and district health societies, thereby empowering communities to take ownership of the public health system. Success metrics for communitisation include the establishment of VHSCs, recruitment of ASHAs, and formation of Rogi Kalyan Samitis at various healthcare levels, including District Hospitals (DHs), Sub-Divisional Hospitals (SDHs), CHCs, and PHCs. This paper reviews NRHM‘s progress, including its functioning, significant schemes, and impact on child development and presents data to analyse the effect of these interventions on rural healthcare outcomes. Furthermore, when we look at the Child and Maternal Health Services (CMHS) education and media access were key factors in the about 2% increase in pro-rich inequality in the use of CMHS that followed the NRHM. States with high focus groups had a 3% increase in inequality, but southern states fared better. Healthcare policy decentralisation may improve equality (Gandhi et al., 2022).

DESIGN AND METHODOLOGY

This study is purely based on the secondary sources and secondary data. Document analysis, and review were the major methods used in this study. Government Documents related to NRHM were analyzed and

key points were extracted. The NRHM framework for implementation is one of the key documents analyzed for key facts. For sketching the review of related studies google scholar was analyzed with the keywords NRHM, Rural Health in India, and Health and India. Comprehensive studies were only selected for the Google Scholar review.

Related Studies and Trends

The National Rural Health Mission (NRHM), which aims to improve healthcare access for rural people, especially vulnerable groups**,** including women and children, is outlined in the NRHM Framework for Implementation (2005). The framework lays the groundwork for further evaluations of NRHM's influence on rural health outcomes by strongly emphasising capacity building and community involvement. Planning Commission (2011) inspects the program's effectiveness in seven states regarding infrastructure development, communitisation, and maternal and child health. It highlights problems with money utilisation and personnel shortages in rural health clinics, and the research commends ASHAs for increasing institutional births and vaccination rates. Though NRHM has improved health outcomes, and indicates that better monitoring and regional modifications are necessary to resolve healthcare delivery gaps. NRHM has improved healthcare infrastructure by building new facilities and hiring staff in areas where healthcare falls short of national standards, according to the NITI Aayog's report (Sharma, 2018). However, the mission's overall impact has been restricted by shortages of skilled medical staff, especially in outlying places. With an emphasis on mother and child health, targeted interventions and resource allocation are advised to improve healthcare outcomes in these areas. The efficacy of ASHAs in the context of the NRHM framework is investigated in the research of Bajpai and Dholakia (2011).

According to the analysis, ASHAs have improved child health outcomes by raising institutional delivery and vaccination rates. However, poor training, low pay, and heavy workloads impact their performance. To enhance the impact of ASHAs, the study suggests improved training, monetary incentives, and community support. Rather (2022) observes how the NRHM was implemented in response to the Millennium Development Goals and assesses how well it has worked to lower infant mortality, maternal mortality, total fertility rate, and other metrics. NRHM has increased access to reasonably priced healthcare in rural regions through new healthcare facilities and decentralised services, mainly for disadvantaged populations. The study emphasises how NRHM uses cutting-edge tools and frameworks to support the healthcare system. Husain (2011) evaluates the efficacy of NRHM, noting advancements in maternal health metrics and healthcare access while pointing out persistent issues like inequalities in service delivery, poor infrastructure, and financial shortages. Husain calls for a strategic review to better satisfy the mission's objectives for improving rural health and highlights the value of local government and community involvement for increased effect. A rational evaluation methodology by Kumar (2021) highlights notable gains in healthcare spending, workforce expansions, and essential health indicators such as institutional deliveries and vaccination rates. According to the research, maternal death decreased from 254 to 122 per 100,000 live births, while infant mortality decreased from 58 to 33 per 1,000 live births. Despite these advancements, high out-of-pocket costs continue to exist, indicating that more financing and capacity-building are required for universal health care.

Objectives of NRHM

The National Rural Health Mission (NRHM) was sent off, determined to develop rural communities' health status further. To accomplish this, the mission had a few key goals. Firstly, it aims at reducing maternal morbidity and child mortality. Also, it meant to give all- inclusive admittance to reasonable medical care administrations, making medical services open to all. The mission also centred around forestalling and controlling transferable and non- transmittable sicknesses and administering coordinated essential medical care. Furthermore, it intended to balance out populace development while guaranteeing maternal and child health, adolescent health, and family arranging. The NRHM likewise perceived the significance of nourishment, water, and sterilisation in medical services and looked to coordinate these determinants into medical care frameworks. Moreover, it planned to normalise and redesign medical services quality, address

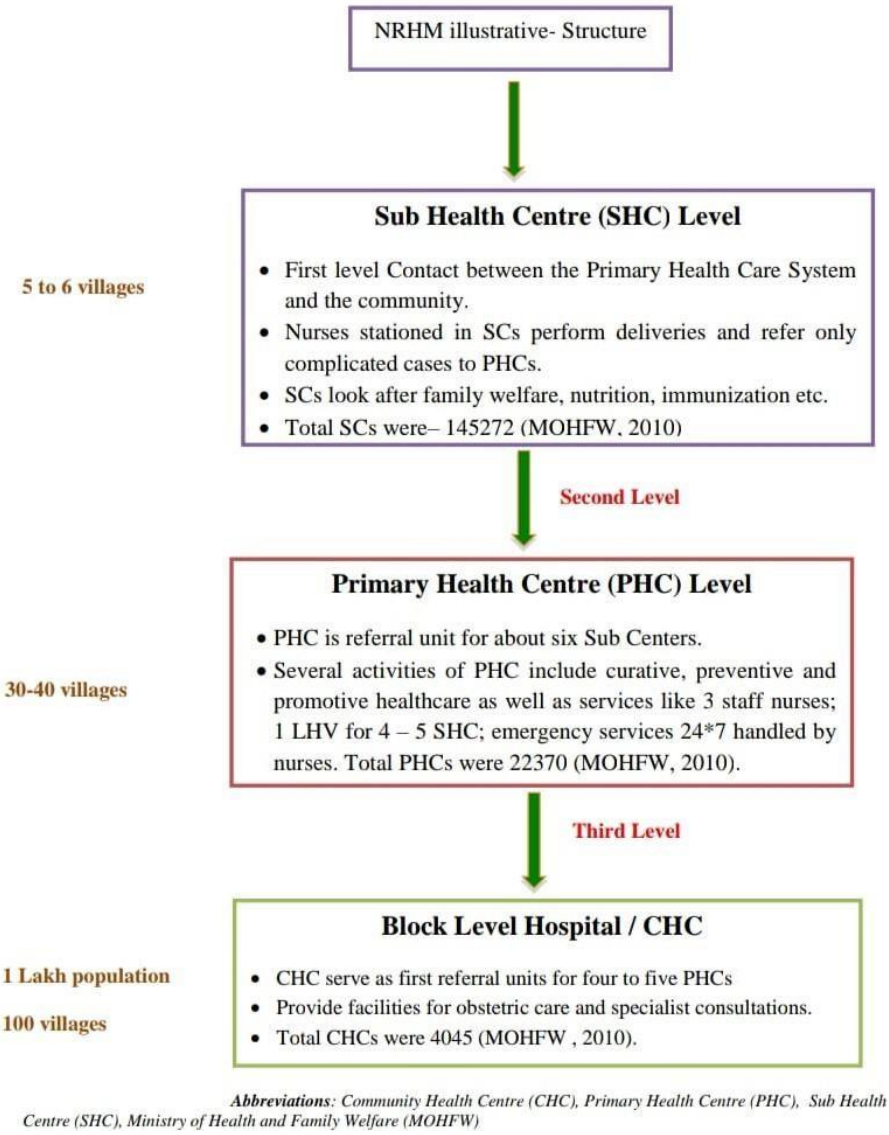
social determinants of well-being like ladies' education and strengthening, and advance solid ways of life in provincial communities (MoHFW, 2005).

Functioning of NRHM

The focal point of the Public Rustic Wellbeing Mission (NRHM) in India is to improve medical services through sub-centres (SHCs), primary health centres (PHCs), and community health centres (CHCs). In rural regions, SHCs are the underlying resource that gives maternal and child medical care, vaccinations, and fundamental health administrations. PHCs are the pillarof country health administrations, conveying short-term care, minor medical procedures, and preventive health projects. They are also used as a reference unit for SHCs. CHCs are more prominent offices that take care of populations of around 80,000 to 120,000 individuals, offering specific consideration, for example, ongoing administrations, crisis care, and medical procedures.

They act as reference habitats for PHCs and have further developed clinical staff and gear. SHCs, PHCs, and CHCs structure a layered medical services framework under NRHM, tending to essential and particular medical care needs in India's country districts.

Figure 1 Impact of National Rural Health Mission



Source: Rather, T, (2022), Impact of National Rural Health Mission: A Public Welfare Programme of the Government on Indian Health Sector.

Components of NRHM

According to the National Rural Health Mission (NRHM), several components aim to enhance healthcare in rural regions by targeting various aspects of healthcare delivery through several vital components. They are demonstrated as follows.

- Part (A): Accredited Social Health Activists (ASHA)

Chosen by the panchayat, ASHAs are female wellbeing activists who go about as a scaffold between the local area and the general wellbeing framework. ASHAs are answerable for upholding vaccination, reproductive and child health (RCH) benefits, and advancing cleanliness practices like toilet construction. They work intimately with the town wellbeing group and get preparation, drug units, and execution-based remuneration, emphasising high- need states (Niyati & Nelson Mandela, 2020; Rahul et al., 2021).

- Part (B): Strengthening Sub-Centres (SCs)

Sub-focuses, the underlying resource for country medical services, get loosened assets of Rs. 10,000 yearly to address neighbourhood medical care needs. The ANM oversees these assets as a team with the village health committee. Sub-focuses are likewise given fundamental allopathic and AYUSH drugs. The NRHM tends to update sub-focuses, the development of new offices, and the work of extra ANMs or multipurpose specialists were significant (Narlawar & Sourav, 2018; Vij, 2019).

- Part (C): Strengthening Primary Health Centres (PHCs)

The mission centres around upgrading the nature of PHC administrations, guaranteeing sufficient medication supply, and giving vital gear like auto-crippled needles for vaccinations. Around half of the PHCs are moved up to offer 24-hour assistance, particularly inhigh-centre states. Furthermore, there is work to address the deficiencies of specialists by coordinating with AYUSH experts. PHCs are likewise upheld for the treatment of both transmittable and non-transferable infections, and standard treatment conventions are implemented.

- Part (D): Strengthening Community Health Centres (CHCs) for First Referral Care

CHCs, furnished with 30-50 beds, are moved up to work as 24-hour reference units. This incorporates guaranteeing the accessibility of experts like an aesthetists. New public health guidelines are laid out for CHCs, focusing on infrastructure, staffing, gear, and executives. Rogi Kalyan Samitis are framed to advance local area contributions to the executives in medical clinics, while resident contracts are carried out to set assistance norms (Lahariya, 2020; Mohan & Kumar, 2019).

- Part (E): District Health Plan

The District Health Plan coordinates village-level health plans with state and public needs in regions such as health, water, sterilisation, and nourishment. These plans structure the underpinning of medical care activity in the rustic areas, consolidating midway-supported plans for further developed coordination and viability. The District Health Mission monitors execution, with the executive units supporting system execution (Chauhan et al., 2018; Dawa et al., 2021).

- Part (F): Converging Sanitation and Hygiene under NRHM

NRHM incorporates the Total Sanitation Campaign (TSC), which includes drives like household toilets, women‘s sanitary complexes, the development of sanitation, and school sterilisation programs. Village Health and Sanitation Committees Boards of trustees workon advancing health, disinfection, and cleanliness in provincial regions, with ASHAs assuming an essential part in upholding sterilisation at the family level (Nandan, 2015; Nayak et al., 2020).

- Part (G): Strengthening Disease Control Programmes

NRHM upgrades public projects to control illnesses like jungle malaria, tuberculosis, kala-azar, and filariasis. Integrated Disease Surveillance is improved to guarantee better checking at the town level. Nonexclusive medications, both allopathic and AYUSH, are provided for everyday afflictions at all well-being office levels (Dutta & Fischer, 2021; Nallamalla, 2022).

- Part (H): Public-Private Partnership (PPP) for Health Goals

With 75% of medical care administrations given by the private area, NRHM centres around refining guidelines for private area commitment in medical care. Public-private associations are supported, with the public area characterising the structure for a coordinated effort. Portrayal of the private area is guaranteed at the district and state levels, with an accentuation on topical and geographic requirements (Kelkar & Kelkar, 2021; Venkatraman & Lahariya, 2024).

- Part (I): Implementation of New Health Financing Strategies

NRHM is investigating innovative health financing supporting techniques, such as pooling risk for hospital care and guaranteeing that financing is coordinated because of patient necessities. Community Health Centers (CHCs) are progressing to instalment frameworks because of repayment for administrations, and straightforward region-level well- being bookkeeping frameworks are being laid out. The program likewise supports receiving community- b ased healthcare coverage plans to stretch out inclusion to low-income families (Gangwar, 2020; Golechha et al., 2024).

- Part (J): Adapting Health/Medical Education to Address Rural Health Concerns Endeavours are being made to extend medical education facilities to take care of the medical services necessities of rustic regions. The mission proposes the foundation of a National Institution for Public Health Management and a Commission for Excellence in Healthcare to guide medical education and research, specifically focusing on better serving rural populations (Bangdiwal et al., 2011; Kedia, 2022; Wadia, 2012).

Major Schemes Under NRHM

The Ministry of Health and Family Welfare, Government of India, implemented the framework over the years, and several significant schemes have been implemented under NRHM to address different health challenges. Such schemes are described as follows.

Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a protected motherhood mediation under NRHM that aims to diminish maternal and neonatal mortality by advancing institutional conveyance (Government of India, 2005). The plan gives monetary help to pregnant people for institutional conveyance, and it is determined to urge them to convey in an emergency clinic or other medical services office instead of at home. The plan likewise accommodates free transportation to and from the medical services office and free consideration and therapy for complexities during conveyance. Under JSY, pregnant ladies are qualified for an instalment of Rs. 1,400 for institutional conveyance in an administration clinic and Rs. 1,000 for institutional conveyance in a confidential clinic (Legislature of India, 2005). The plan likewise accommodates an instalment of Rs. 1,000 to Accredited Social Health Activists (ASHAs) for taking pregnant ladies to the medical care office and offering help during conveyance.

Janani Shishu Suraksha Karyakram (JSSK)

Janani Shishu Suraksha Karyakram (JSSK) is a free and credit-only help that gives care to pregnant ladies, moms, and babies in government well-being organisations (Ministry of Health and Family Welfare, 2011).

The plan accommodates free consideration and treatment for pregnant ladies, including free conveyance, free cesarean segment, and free treatment for complexities during conveyance. The plan likewise accommodates free consideration and treatment for infants, including free inoculation and free treatment for sicknesses. JSSK likewise accommodates free transportation to and from the medical care office and free food and housing for pregnant ladies and their families during their visits to the clinic (Ministry of Health and Family Welfare, 2011). The plan intends to decrease personal use of medical care for pregnant ladies and babies and further develop well-being results for this populace.

Rashtriya Bal Swasthya Karyakram (RBSK)

Rashtriya Bal Swasthya Karyakram (RBSK) is a child health screening and early intercession program that gives exhaustive medical services to youngsters as young as 18 (Ministry of Health and Family Welfare, 2013). The plan accommodates free health evaluation for children, including evaluating for birth abandons, formative postponements, and sicknesses like frailty and hunger. RBSK likewise accommodates free treatment and the executives of ailments and conditions identified during screening, including free prescriptions and medical procedures (Service of Wellbeing and Family Government Assistance, 2013). The plan intends to develop health results for children further and to decrease horribleness and mortality among this populace.

National Mobile Medical Units (NMMU)

National Mobile Medical Units (NMMU) is a plan that offers clinical types of assistance to provincial and far-off regions through versatile clinical units (Ministry of Health and Family Welfare, 2008). The plan accommodates versatile clinical units that move to countries and distant areas, offering clinical assistance like finding, treatment, and reference administrations. NMMU offers free clinical aid, including free analysis, treatment, and medicine (Ministry of Health and Family Welfare, 2008). The plan expects to develop further admittance to medical care administrations for the country and distant populaces and to diminish well-being disparities here.

Accredited Social Health Activist (ASHA)

Accredited Social Health Activist (ASHA) is a community health worker program that intends to administer wellbeing to provincial networks (Government of India, 2005). ASHAs are prepared local area wellbeing labourers who give wellbeing administrations, such as wellbeing instruction, family arranging, and maternal and youngster wellbeing administrations. ASHAs likewise help pregnant ladies during conveyance and go with them to the medical care office (Government of India, 2005). The plan means further developing health results for rustic networks and decreasing well-being disparities here.

Role of Different Institutions in NRHM

According to the National Rural Health Mission, the Panchayati Raj Institution and NGOs play a significant role.

Role of Panchayati Raj Institution

The National Rural Health Mission (NRHM) has envisioned an essential part of Panchayati Raj institutions (PRIs) in accomplishing its goals. In the first place, states are expected to focus on decaying assets, functionaries, and projects for health to PRIs through Memorandums of Understanding (MoUs). At the district level, the district health Mission will be driven by the Zila Parishad, which will regulate and deal with all general well-being foundations, including sub-centres, Primary Health Centres (PHCs), and Community Health Centres (CHCs). Accredited Social Health Activists (ASHAs) will be chosen by and responsible for the village Panchayat, while the village health committee will set up the village health plan and advance intersectoral joining. Each sub-centres will likewise have a Loosened Asset of Rs. 10,000 for

every annum for neighbourhood activity, mutually overseen by the auxiliary Nurse Midwife (ANM) and the Sarpanch. Furthermore, PRIs will be involved in Rogi Kalyan Samitis to guarantee a great medical clinic. The executives and their individuals will prepare to upgrade their abilities. Furthermore, wellbeing-related information bases will be accessible to all partners, including Panchayats at all levels, to advance straightforwardness and informed navigation.

Role of NGOs in the Mission

The National Rural Health Mission (NRHM) has laid out a hearty institutional plan at the Public, State, and local levels to guarantee the successful execution of its projects. A Standing Coaching Gathering has been set up to give direction and backing to Accredited Social Health Activists (ASHAs). Furthermore, individuals from Assignment Gatherings have been shaped to work with cooperation and coordination among different partners. To assemble the limit of ASHAs and District Health Managers (DHMs), provision has been made for training, Behavior Change Communication (BCC), and specialised help. Besides, health resource associations have been locked in to assist recognised populace bunches on select subjects. Besides, a framework for checking, assessment, and social review has been set up to follow progress and guarantee responsibility.

Impact of NRHM on Child Development

The National Rural Health Mission (NRHM) has significantly impacted child development in India. As per a review distributed in the Lancet, NRHM has prompted a decrease in infant mortality rates (IMR) and under-five death rates (U5MR) in country regions (Lim et al., 2010). The investigation discovered that between 2005-06 and 2009-10, IMR declined by 23.1%, and U5MR declined by 26.3% in rural regions. One more review distributed in the Bulletin of the World Health Organization found that NRHM has worked on the nourishing status of children under five years old (Bhutta et al., 2013). The investigation discovered that the extent of children with extreme unhealthiness diminished from 12.8% to 8.1% between 2005-06 and 2009-10.

NRHM has likewise further developed vaccination inclusion among children. As per a report by the Ministry of Health and Family Welfare, Government of India, the inoculation inclusion among kids younger than five years expanded from 43.5% to 61.1% between 2005- 06 and 2009-10 (MoHFW, 2011). The percentage of children with diarrhoea who take oral rehydration solution (ORS) has risen from 26% to 51% (Kumar,2021).

Budget Allocation of NRHM

The budget allocation for the National Rural Health Mission (NRHM), presently coordinated into the bigger National Health Mission (NHM), has undergone extensive changes since its send-off in 2005. At its beginning, the NRHM was acquainted with a financial plan close to ₹1,500 crores (around $200 million) aimed toward handling medical care imbalances in country locales (Ministry of Health and Family Welfare, 2005).). By the monetary year 2010-2011, the spending plan had ascended to around ₹18,000 crores (roughly $2.4 billion), demonstrating an expanded obligation to upgrade maternal and youngster wellbeing administrations, further developing sterilisation, and tending to transferable infections (Economic Times, 2011).

In the years that followed, explicitly from 2015 to 2016, subsidising expanded to ₹22,000 crores (roughly $3 billion), flagging an essential move towards consolidating wellbeing administrations with overall formative targets like sustenance and sterilisation ((Government of India Budget Documents, 2015). The vertical pattern in designations endured into the 2022-2023 monetary year, with the NHM financial plan set at around ₹37,000 crores (almost $4.9 billion), pointed toward handling new well-being difficulties, for example, non- transferable illnesses and psychological well-being worries, while likewise improving computerised wellbeing drives to more readily support conveyance in distant regions (Ministry of Health and

Family Welfare, 2022). This adjustment of financial plan appropriation features the Indian government's continuous devotion to bracing medical care frameworks in provincial networks.

Achievements of NRHM

The NRHM has essentially changed the Indian health framework in different ways. In the first place, roughly 750,000 ASHAs have drawn in with nearby networks, effectively reassuring ladies from fundamental gatherings to look for institutional consideration (the recipients under the Janani Suraksha Yojana rose from 700,000 of every 2005-2006 to over 8.6 million in (2008-2009) (Express healthcare, 2019). Second, the NRHM has been vital in handling significant medical care difficulties faced by rustic populaces, as they fundamentally rely upon general well-being administrations, which incorporate Sub-Centers (SCs) and Primary Health Centers (PHCs) for urgent health requirements. At the same time, Community Health Centers (CHCs) and district hospitals are preferred for more complex treatments and specialist The Sub-Center fills in as the underlying resource for general health administrations, offering preventive consideration, and a CHC conveys particular treatment, enveloping AYUSH (Ayurveda, Yoga and Naturopathy, Unani Siddha, and Homeopathy) administrations.

Third, NRHM has numerous achievements to its name, including expanded health funding, the upgraded foundation for medical care conveyance, the foundation of institutional principles, the preparation of medical care staff, and the arrangement of specialised help; it worked on monetary administration, upheld the digitisation of health information, pushed for focal acquisition of meds, gear, and supplies, and required the development of town wellbeing and clinic boards of trustees alongside local area oversight of administrations (Jacob, 2011).

Fourth, to battle mortality and horribleness and advance comprehensive social turn of events, NRHM has prompted an expansive mission against undernutrition, chronic weakness, and absence of information since its send-off. The Public authority of India started the NRHM in April 2005 with the reasonable objective of conveying quality medical services to the most far-off regions by guaranteeing it is open, sensible, and responsible ((Ministry of Health and Family Welfare, Government of India, 2009) this way, NRHM has significantly affected the public medical care framework the country over.

Table 1 Achievements of the scheme NRHM

S. No	Indicators	2005 Baseline	NRHM Target	Achievement	% improvement in Baseline
1	IMR	58 / 1000 live births	30	42 / 1000 Live births (2012)	28 %
2	MMR	254 / 100,00 live births	100	178 / 100,00 Live births(2010 - 12)	30 %
3	TFR	2.9	2.1	2.4 (2012)	17 %
4	Maintain TB Cure Rate	86 %	Above 85 %	88 %	2 %
5	Malaria Mortality per 10,000		Reduce by 50 %	60 % by 2012	49 %
6	Dengue Mortality Reduction Rate			50 % by 2010 and sustaining at that level until 2012	

7	Cataract operation			Increasing to 46 lakhs until 2012	
8	Public Health as % of GDP Sub-centers	0.9%	2 – 3 %	1.04% (2011 – 12)	16 %
9	Sub Centres	146,026	178,267	148,366 (2012)	2 %
10	PHCs	23,236	29,213	24,049 (2012)	3 %
11	CHCs	3,346	7,294	4,833 (2012)	44 %
12	Medical Officers (Allopathy)	20,308		28,984 (2012)	43 %
13	ASHAs		250,000 (in ten states)	889,736 (2012)	100

Source: Narwal, Rajesh. Success and Constraints of the National Rural Health Mission: Is there a Need for Course Correction for India's Move Towards Universal Health Coverage" in, India Social Development Report 2014: Challenges of Public Health (Edition – I), Oxford University Press, p. 128

CONCLUSION

The National Rural Health Mission has extensively advanced kid improvement through centred medical services drives in India. By focusing on upgrades in maternal and child health results, the NRHM has raised the paces of institutional conveyances and immunisations, bringing about critical abatements in baby death rates. The impact of Accredited Social Health Activists (ASHAs) has been significant in associating medical care administrations with country populaces, expanding mindfulness,and working with admittance to fundamental health assets. Despite these victories, difficulties with progress, such as a deficient medical services framework and high personal costs, continue to hinder further headways. To guarantee enduring improvement in child health results, it is vital to sustain medical care frameworks by putting resources into foundation, further developing preparation for medical services faculty, and laying out hearty observing frameworks. Future approaches should accentuate the arrangement of kid well-being drives with more extensive general health procedures to access complete and fair medical care for all children in India. A continuous joint effort among government substances, nearby networks, and partners will be fundamental for propelling child advancement goals inside the NRHM system.

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