

National Family Health Survey-6 (2023–24): Comparative Observations on Progress and Persistent Gaps in India's Maternal, Child and Non-Communicable Disease Indicators

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Dear Editor,

The National Family Health Survey (NFHS) remains India's largest and most comprehensive source of population, health and nutrition data, and the recently released sixth round, NFHS-6 (2023–24), offers a timely opportunity to take stock of the country's progress since NFHS-5 (2019–21).^{1–3} Conducted in two phases between May 2023 and December 2024, NFHS-6 collected information from 679,238 households, 716,397 women and 100,977 men across the country, generating national, state and district-level estimates that are widely used to evaluate flagship programmes such as Ayushman Bharat, Poshan Abhiyaan, Anaemia Mukh Bharat, Janani Suraksha Yojana and Mission Indradhanush.^{1,4} We offer here a set of comparative observations drawn from the India Fact Sheets of the two rounds, read through the complementary lenses of the Sustainable Development Goals (SDGs) and the One Health framework.

On the demographic front, the proportion of the population below 15 years declined marginally from 26.5 to 25.5%, while the share aged 60 years and above rose from 11.8 to 12.9%, a shift with direct implications for the future organisation of geriatric and chronic-disease services.^{1,2} Encouragingly, the proportion of women aged 20 to 24 years married before the age of 18 fell from 23.3 to 20.1%, adolescent pregnancy edged down from 6.8 to 6.7%, and the total fertility rate held steady at 2.0 children per woman, consistent with sustained replacement-level fertility.

Maternal health indicators showed consistent gains between the two rounds. First-trimester antenatal registration rose from 70.0 to 76.2%, and the proportion of women completing at least four antenatal visits increased from 58.5 to 65.2%. Iron-folic acid consumption for at least 100 days improved from 44.1 to 54.9%, though consumption for the fuller 180-day course remained comparatively low, rising only from 26.0 to 37.8% - a gap suggesting a shortfall in counselling and follow-up rather than in supply. Institutional deliveries increased from 88.6 to 90.6%, and births attended by skilled personnel rose from 89.4 to 91.3%, consistent with continued strengthening of services under Janani Suraksha Yojana and LaQshya.^{1,7,8} These national averages, however, conceal persistent inequalities: antenatal care utilisation, institutional delivery and skilled birth attendance remain consistently lower among rural residents, scheduled caste and scheduled tribe populations and women in the poorest wealth quintiles, a pattern that recurs across successive NFHS rounds and is plausibly sustained by inequitable distribution of health infrastructure, out-of-pocket costs and socio-cultural barriers to care-seeking.^{1,2,8}

Child health indicators told a broadly similar story of improvement, with one notable exception. Full immunisation coverage among children aged 12 to 23 months rose from 76.6 to 82.6%, coverage of the second dose of measles-containing vaccine from 58.6 to 71.8%, the birth dose of hepatitis B vaccine from 67.4 to 77.6%, and rotavirus vaccine coverage climbed sharply from 36.4 to 85.4%, reflecting the rapid scale-up of newer antigens under the Universal Immunisation Programme.^{1,8} Vitamin A supplementation improved from 71.2 to 74.6%, and the prevalence of

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symptoms of acute respiratory infection fell from 2.8 to 1.9%. Diarrhoea prevalence, in contrast, rose slightly from 7.3 to 7.9% despite the fact that 68.8% of affected children were taken to a health facility or provider - a reversal that, moving as it does in the opposite direction to nearly every other child-health indicator, points more plausibly to a water, sanitation and hygiene (WASH) gap than to a clinical-care gap.¹

The most concerning shift between the two rounds was in the burden of non-communicable disease. The prevalence of high blood sugar or current medication use for diabetes rose from 13.5 to 17.8% among women and from 15.6 to 20.9% among men, while overweight or obesity (BMI ≥ 25 kg/m²) increased from 24.0 to 30.7% among women and from 22.9 to 27.3% among men. NFHS-6 additionally recorded hypertension in 19.4% of women and 22.1% of men.^{1,9} Taken together with the rising elderly share of the population noted above, these figures describe a compounding burden that will require geriatric and non-communicable disease services to be planned jointly rather than as separate verticals.

Read through a One Health lens, several of these patterns acquire an added dimension. The persistence of childhood diarrhoea alongside improving institutional care access is more consistent with unresolved water and sanitation infrastructure gaps than with a deficiency in clinical services, while the rising burden of obesity, diabetes and hypertension reflects changes in food systems, urbanisation and the built environment rather than healthcare access alone.⁶ Viewed against the SDGs, indicators aligned with SDG 3.1 to 3.2 (maternal and child health, immunisation) and SDG 5 (gender equality, reduction in child marriage) appear broadly on track between the two rounds, whereas those relevant to SDG 3.4 (premature mortality from non-communicable disease), SDG 2 (nutrition, given persistent undernutrition alongside rising adult obesity) and SDG 6 (water and sanitation, given the diarrhoea reversal) continue to present significant challenges.^{5,7}

These comparative findings carry several practical implications. The residual gap in antenatal care completion argues for expanding ASHA/ANM home-visit tracking and mobile-based reminder systems in low-coverage districts rather than a uniform national campaign. The divergence between short-term and long-term iron-folic acid adherence suggests that supply-chain availability has improved faster than counselling and follow-up, and that policy attention should now shift from distribution towards adherence monitoring during

the second half of pregnancy. The diarrhoea reversal supports district-level convergence between health services and the Jal Jeevan Mission and Swachh Bharat Mission rather than additional resourcing through the health sector alone. The scale of the rise in diabetes and hypertension argues for front-loading population-based screening under the National Programme for Prevention and Control of Non-Communicable Diseases rather than waiting for the burden to translate into hospitalisation-level demand.^{9,11} Finally, the pace of decline in child marriage - roughly three percentage points over four to five years - suggests that existing interventions such as education and conditional cash transfers are working but require acceleration specifically in lagging states and districts rather than uniform national scale-up.

As with any cross-sectional survey, NFHS-6 cannot establish the causal pathways underlying these changes, and the observations above should be read as descriptive trends rather than proof of cause and effect. The linkage drawn here to One Health domains and SDG targets rests on established conceptual and programmatic associations rather than on direct statistical validation, and the influence of the COVID-19 pandemic period on some indicators has not been separately accounted for.

Taken together, NFHS-6 depicts a health system that continues to register genuine gains in maternal and child health, immunisation and gender-related indicators, even as it confronts a widening burden of non-communicable disease and unresolved inequities in access. Sustaining progress toward India's 2030 SDG commitments will require multisectoral coordination that extends beyond the health sector into water and sanitation, food systems, urban planning and social protection - an approach for which the One Health framework offers a useful integrating structure.^{10,11}

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