In this chapter how and to what extent household and livelihood promoted in this country due to National Rural Health Mission would be presented. The ever rising cost on health care used to be a great cripper of household in poor economies world over including India. Almost 57 million people used to die in this world every year and out of that figure 15 percent used to be children. Most of such deaths occurred in poor countries and mostly due to reasons which could be easily averted. Common problems like cough, cold and fevers had remained major death causes for India during last century. However with advancement in nutritional level, sanitation and health infrastructure scene had definitely improved somehow. National Rural Health Mission had proved quite effective in this regard. With range of facilities available people could easily avail medical facilities in case of emergency. Certainly NRHM was a major support for the household in the rural part of the country (C. Aparajita, 2012).

The comparative analysis of data of the District level household surveys 2002-04 and 2007-08 by the research scholar provided some valuable inputs on household consolidation in the country. The DLHS 4 which most probably would appear in the year 2013 would further expect to exhibit some more positive consolidation in rural household. However it could not exactly ascertained in clear terms that how much consolidation caused specifically due to National Rural Health Mission.

Several reports had said that in last few decades, India had experienced the Improvements in the nutritional and health infrastructure, social development and eradication of major killer diseases. However, regional, lingual, ethnic, urban-rural, male-female inequalities were clearly viewed as a major public health challenge in this country. In addition, poverty and unhealthy environment related causes were taking burdensome toll, mainly in the demographically backward states, not withstanding the overall declining trend of infectious diseases. Accidents and injuries and diseases of central nervous system were shown a significantly increasing trend, where as coughs and fevers were on decline. Though National Rural Health Mission had succeeded in reducing fatality of diseases to a certain extent; there was however, a great need for
improved and effective area-specific health programs to achieve the desired goals (Ganapati, 2011).

*World health organization* reports had suggested that India like many other countries of the world was facing a double burden of disease. The report also said India was definitely able to somehow reduce the burden due to high levels of maternal, child mortality, and infectious diseases particularly among the poor, and growing incidence of non-communicable diseases in the well-to-do sections of the middle classes (WHO, 2011).

However reduction in burden of diseases was less than China which had outperformed India in tackling the double-burden of diseases that included infectious diseases affecting the poor on the one hand and chronic lifestyle ailments typical of fast urbanization on the other. While India's life expectancy had shot up to 66 years in 2011, up from 61 years in 2000, China had improved the same to 74 years during the last 10 years. The average life expectancy of a male in India was now 64 as compared to 60 a decade ago, while a female lived 67 years. The life expectancy and overall health of Indians had been impressive notwithstanding high levels maternal and child mortality, high income disparities, and increasing infectious and non-communicable diseases such as heart diseases, stroke, diabetes and cancer (The Economics Times, 2011).

It was found by the research scholar during case studies that *household* and *livelihood* were promoted by the *National Rural Health Mission* mainly through two angles. Firstly, by engaging almost 2 million people in the public health sector and secondly cutting short the family expenditure on health due to reduction in *burden of diseases*. It was estimated that *National Rural Health Mission* created new employment opportunities and provided employment to almost 2 million people and most of them were women. Indirectly *National Rural Health Mission* also created massive spurt in the rural health sector and increased demand for subsidiary sector such as transportation, connectivity, sales of medicines and other logistics (Binayaka, 2012).

In fact, it became evident under the research that though the mandate of *National Rural Health Mission* was not directly or visibly said anything about household promotion despite research scholar could find that *National Rural Health Mission* benefitted households on massive scale both directly and indirectly. Direct benefits were mostly in manner of paving way for large-scale employment and the successful implementation of *National Rural Health Mission* further benefitted households indirectly. Reduction in Infant Mortality Rate, Maternal Mortality Rate, Burden of Diseases and marked increase in
coverage of immunization, ambulatory, referral and OPD/IPD services also benefitted households indirectly.

The effect of *National Rural Health Mission* could be most perceptible in rural part of the country. Being the leader of the household women could natural beneficiary of any positive makeover of the health services. India, a country, almost 62 children used to die each year out of every one thousand children and almost 340 women used to die each year out of every 0.1 million pregnant women till the year 2005. After the successful execution of *National Rural Health Mission* over the last five years, those figures stood at below 47 and 230 respectively in the year 2012.

One of the main highlight of *National Rural Health Mission* could be also that households benefitted without any explicit arrangements. Under *National Rural Health Mission*, the numerical adequacy for women established without any special arrangements especially reservation. It could be a realization of the emotions, commitments, and concern that any woman usually used to possess. It would definitely become a most distinguished milestone in the efforts of establishing gender justice and equality in the country. It could note that rural working woman in India found having specific ‘*time - money use pattern*’. They were most efficient in managing their time for varied kind of labor like household, livelihood and employment related labor (NSSO, 2006). Woman under *National Rural Health Mission* were most of time able to manage all three forms of labor in order to increase their income and well-being of respective households. Similarly rural woman were also able to manage their money in most ethical manner which not only promoted their savings but they became enabled in investing their savings in other productive activities such as dairy, poultry, agriculture, knitting-weaving and sale- supply of consumer goods on part time basis. They became able to perform such varied activities manly due to distinct money use and time use pattern of rural woman in India and therefore this was the most crucial aspect of household and livelihood promotion under *National Rural Health Mission*. It would be required mention here that during case studies when asked by the research scholar it was admitted by several ANMs, ASHAs and AWWs that due to low salary being paid, finding it not enough they had to get them engage in other livelihood activities especially what could be possible in rural areas such as small dairy, poultry, PCOs which most of time managed by other family members. Some purchased one–two cows or buffalos or goats, not only provided some additional income but at the same time, they substantially nourished the family. At some places, they invested in agriculture and started producing vegetables for both personal use
and sale purposes. In most cases sanitation and hygiene, level of education of the children also improved. In addition increased awareness resulted in better management of soil- water for agriculture.

With reduction in burden of diseases and increased sense of security against illness, the economy of the family or household witnessed tremendous solidarity. Therefore, it could say that women workforce engaged in large number under National Rural Health Mission in rural areas resulted in better management of not only respective household but their other livelihood also. National Rural Health Mission also benefitted other socio-economic sector and spillover effects were evident. National Rural Health Mission was termed quite successful in creating large-scale awareness on several issues such as sanitation, hygiene, nutrition and gender issues involving development. National Rural Health Mission also promoted women activism in the society largely. The increased women activism naturally strengthened position of the respective women in not only respective households but in the society as a whole. Increased level of women activism also promoted other developmental activities such as self-help groups, microfinance, skill development, and employment programs at the micro level.

Therefore several spillover effects of National Rural Health Mission in the country were widely evident. National Rural Health Mission had created several employment opportunities for students from Social work, Applied Sociology, Social Welfare, Rural management, Hospital management. In addition, a large number of vacancies of ANMs, Paramedics and Doctors persisted due to shortage of such work force which required created and filled in future. One could hardly found any such work force being unemployed in the country those days. The demand would rise further as public health services expected to consolidate in coming days.

The success achieved in the field of primary health care definitely created conducive situation for promotion of household and livelihood. Similar replica could be also achieved due to other developmental programs especially Sarva Shikha Abhiyan (SSA)’.

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