The research had successfully identified the execution and achievements of National Rural Health Mission. The research which was implemented during July 2009 to March 2012 had virtually taken the entire country intact. The overall research was conducted mainly through qualitative methods inclusive of 52 case studies, 18 interviews, and massive survey of literature. All research questions and problems were answered vide Chapters 7, Chapter 8 and Chapter 9 respectively. The execution was described in Chapter 7 and its 15 sub chapters. Achievements were described in Chapter 8 and Promotion of Livelihood was described in Chapter 9. Different methods were used to investigate different issues. Literature review was conducted to explore the overall frameworks, targets, and objectives of National Rural Health Mission. The public health data in the country was explored to a great extent and validity and reliability of those data also investigated. Various stages and components of execution of National Rural Health Mission were explored authentically and methodically under the premises of literature review and case studies, further interviews were conducted in order to clear several doubts and confusions. Achievements of National Rural Health Mission was investigated and confirmed with secondary data sources as this research could no way generate its own data. Funds flow and utilization were also analyzed as how funds were provided and utilized by respective states. Statistical analyses were conducted to analyze various performances of different states for each and every program under National Rural Health Mission.

The research had found that National Rural Health Mission was aimed to correct the public health indicators of the country (MOHFW 2005). The execution of the National Rural Health Mission was investigated and it was found that action points were identified prior to implementation and time lines were suggested to all stake holders to obey and implement those action points (MOHFW 2005). Dedicated institutional arrangements were made in order to carry forward the mission objectives. At central level Mission Steering Committee, at State level State health mission and state health society, at district level district health mission and district health society were constituted. Like was Rogi Kalyan Samities were constituted for each and every public health
facilities in the country. Untied funds made available to each health sub centers. All earlier health societies were merged to one health society from state level to district level. Increased roles were assigned to local bodies, NGOs, and developmental partners. Sectoral and intersectoral convergences were mooted with Department of women and child developments and some other departments for consolidating varied and diversified efforts. Private public partnerships or PPP were given a formal shape and areas such as medical education, training, program management-monitoring use of ICT were identified. Both at national and international level partnerships were established for getting the knowhow and technical assistances. All the existing and new health programs in the country were brought under the umbrella of National Rural Health Mission. Efforts were made to increase the number of health facilities and upgrade existing public health facilities as per provisions of Indian Public Health standards. Empowered Action Group had already identified some states, which were lagged far behind (EAG 2003), and they were declared high focus states under National Rural Health Mission.

Management of the public health in the country had considerably improved due to introduction of Program Management Units at State, Divisional, District, and Sub district levels. There was an inbuilt system under the National Rural Health Mission framework to timely disseminate the work done reports and this could be credited to the introduction of Program Management Units. Provision of Program Management Units was conceptualized after succumbing failures on the front of RCH-I program. Further, the Program Management Units were established in each Primary Health Centers of the country. It had provided opportunities for better program management, funds utilization, and timely flow of work done reports.

Contractual appointments were preferred in place of permanent employments. Flexi pool funding approach was adopted for health program and priority areas whereby funds were made available as per need and demand. Adequate supply of logistics and medicines were ensured. Solar fridges were installed in power deficient and remote areas to maintain the cold chain for vaccines. Adequate number of work force was deployed in each state of the country. Work force was provided multi skill training for discharging their duties. Micro plan and health action plan were prepared and year wise program implementation plan was made for each health facility in the country. Regular and sustainable monitoring and supervision were ensured. Time limits were prescribed for submission of work done reports and funds utilization certificates. A specific National Rural Health Mission format for reporting the work done and funds
utilization were prescribed for each health facilities in the country. All those work done reported by various public health facilities in the country were ultimately compiled in form of MIS or Executive summary on **National Rural Health Mission** and made public through web enabled services.

**National Rural Health Mission** had led to launch of several new schemes in the country. A new band of health activists in the name of **Accredited Social Health Activists** introduced in the country to ease over burdened **Auxiliary Nurse and Midwives or ANMs** which were handling the health sub centers. Second post of ANMs in each health sub centers also provisioned and provided to almost 56783 health sub centers. **Janani Suraksha Yojna, Rogi Kalyan Samiti** could be truly termed as landmark interventions in the rural health sector of the country. There were definite indications that **Janani Suraksha Yojna, Rogi Kalyan Samiti** was quite successful in providing a social security cover to low income families. Under JSY cash incentives were provided to each pregnant woman and under **Rogi Kalyan Samities** untied funds were provided to each health facilities to tackle the emergency situations like lack of life saving drugs, foods, and ambulances, diagnostic and to maintain other patient welfare activities. All those interventions implemented under **National Rural Health Mission** provided a formidable basis for social security to economically vulnerable families.

Due to successful execution of **National Rural Health Mission** the public health system was promoted to a great extent. **NRHM mission documents** had expected to reduce the Infant Mortality Rate (IMR) to 30 per 1000 live births, which remained at 47. The maternal Mortality Rate (MMR) expected to come down to 100 per 100,000 live births, which remained around 210-220. The total Fertility Rate expected to 2.1 by 2012 but it remained at almost 2.4. The malaria Mortality rate, **Kala Azar** mortality rate, Filarial /Microfilaria Rate, Dengue Mortality Rate also not improved as expected though they certainly moved positively. Nevertheless, Leprosy Prevalence Rate was manageable to almost below 1 percent. Country had won a major battle against polio as no cases of polio were reported from any part of the country since January 2011 onwards. The country was most likely to be declared polio free.

A government set up adopting a project based and time bound approach to tackle its crippling public health was most innovative idea and human resources management or HRM could be a factor contributing to this. Contractual appointments involving limited period of contracts, fixed salary and distinctive terms of service enabled health system to hire persons urgently, swiftly and for a shorter project periods. Such HR practices were most common in private sector in India after economic liberalizations started in early nineties but now some
government departments also adopting such approach was quite remarkable. Rapid migration of public workforce, training, personnel data and access, private practice by doctors or dual income, transfer-posting, recruitments, tensions between contractual and permanent staff were some great challenge for HR Management under NRHM.

Gaps in work force was estimated under this research and it was found that gap in work force was most significant. Funds being available infrastructure and logistics may be created but without work force, they would be a waste and work force could not be created overnight. Country’s health workforce was almost short of 0.6 million doctors and 1.0 million paramedics (Azad 2011) and with such deficiency public health services could not be termed adequate as per Indian public health standards. Deficient work force also halted the growth of number of health facilities as per Indian public health standards population norms.

In order to judge and substantiate the actual and factual position of public health in India with respect to some developed countries a comparative account of certain health indicators were accomplished under the research. In addition, this exercise was also repeated among different states and union territories of India. The health indicators of India and some developed countries of world were mentioned; therefore please see in Table-23. Tabulation of Table-23 was done to demonstrate India’s and some developed countries respective positions and the target India required to travel in the field of public health. Similarly, the health indicators of the Indian states were mentioned; please see in Table-24. It would be clear from Table-23 and Table-24 that lot of dissimilarities persisted in the health indicators of the country in comparison of some developed countries, and within the country, several states showed highly dissimilar health indicators among themselves.

At international level as it would be evident from table 23 that the IMR was as high as 105 for Afghanistan and as low as about 4 for Australia, Austria, France, and Germany. The IMR was at 50 for India. Even within India IMR found to be lowest at 10 for Goa and Kerala and high at 70 for Madhya Pradesh. The MMR was as high as 1800 for Afghanistan and as low as about 4 for Australia, Austria, France, and Germany. The MMR was at 320 for India. The density of physician per 10 000 population were 2 and 6 for Afghanistan and India respectively whereas it was at 38, 36 and 35 for Austria, France and Germany. Similarly the density of nursing and paramedical per 10 000 population was at 5 and 13 for Afghanistan and India but at the same time it was 66, 81 and 80 for Austria, Germany and France.
The spillover effect of National Rural Health Mission was also evident in form of increased awareness on sanitation, hygiene, and nutrition. The said reduction in burden of diseases (WHO 2012) definitely promoted household - livelihood in rural areas, although they could not be fully accounted by this research. Several ASHAs, AWWs, ANMs were found working for some alternate livelihood such as small dairy, poultry, weaving which further promoted their respective households and alternate livelihood also. It was found that almost 1 million women were working in public health sector of India, which was one of the largest ever-recorded women work forces in a single public sector. This number could grow further as extension of number of health facilities was required and expected. Even the work of almost 2.4 million AWWs was also converged with NRHM. Women implemented core health schemes such as immunization, institutional delivery, nutrition, awareness, hygiene, sanitation, OPD/IPD, and other peripheral activities thus contributed significantly to promote the slothful health indicators of the country. However it was apparent that urban population was not adequately covered further it required improving the quality, sustainability and public amenities at public health facility in the country.

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