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MATERNAL HEALTH CARE IN NAGALAND-SOME CONTEMPORARY ISSUES

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ABSTRACT

This paper is an attempt to analyze the impact of financial assistance on maternal health care in Nagaland. The paper discussed on the two important governmental schemes of Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK) and examines if it has help in increasing the institutional delivery and reduce the maternal death in the state. It is found that there is an increasing trend in the number of institutional delivery and a declining rate of home delivery assisted by Skill Attendant at Birth (SBA). There is also a declined in the maternal deaths during the last 3 years. However, there are several impediments in the implementation of these schemes. Though launched in the country to benefit the lower strata of the rural women, there are several hurdles in the implementation and fail to reach the targeted group in rural areas due to shortages and bottlenecks in the system.

KEYWORDS: *Institutional Delivery, JSY, JSSK and MMR, Maternity Health Services.*

INTRODUCTION

The adage "health is wealth' cannot be more true"; the good health of a person ensures a prosperous future. Improved maternal health care can scale-up not only newborn care but other health outcomes in the family. Recognizing the importance of Health in the process of economic and social development, improving the quality of maternal health care of the country has been the top priority of the government policy makers. The Millennium Development Goals (MDGs) of Maternal Mortality Rate (MMR) for India was set at 100, but the MMR was 212 per 100,000 live births in 2007-09(SRS 2011). India accounts for 19% of all maternal death worldwide (WHO, UNICEF, UNFPA and the World Bank 2010) and therefore, achieving the MDG needs a lot of effort. Access to health care with equity and universal coverage are critically linked with public financing health care services. India is one of the developing countries with disproportionate spending on consumption expenditure and health care. In a survey done by the GOI in 2005 found that the households' out-of-pocket (OOP) health expenditure during 2001-02 was estimated to be Rs. 72759.00 crores which accounts for 3.2% of the GDP at current market price (Neogi, Sourav 2014). Therefore, besides the supply issues, in India, financial factor like the cost of the services, income of the family, distance and location of the health facilities prevent the accessibility to health care. As per 60th NSSO data (2004) for child birth in public health facilities, on an average, an Indian spent about Rs. 1169.00 in rural area and Rs. 2806.00 in urban areas. The cost of delivery in private hospital is most likely to be double. These exorbitant costs creates additional burden and discourages people from availing maternity health services among the rural masses. Families are often unwilling to allocate more than minimal resources to preventive care and treatment for women's health (Schuler et al, 2002).

The present paper made an attempt to analyze the impact of financial assistance to maternal health care in Nagaland. To find out if there is an increasing trend in the institutional delivery due to governmental schemes such as Janani SurakshaYojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK).Further, it is an attempt to find out if institutional delivery is making a change in the maternal death, to sort out the challenges and to suggest measures for the implementation of this schemes for maternal health care services in Nagaland.

DATA AND METHODOLOGY

The analysis uses information and data from National Family Health Survey (NFHS)-3, NFHS-4, District Level Health Survey (DLHS)-4, SRS-2011, population census 2011 and related health information from the official source of Health Management and Information System(HMIS)-Nagaland, Maternal Health section, Reproductive Child Health (RCH)–National Health Mission (NHM), Programme Implementation Plan, National Rural Health Mission(NRHM) 2007 to 2016, other record and reports from the department of Health and Family Welfare, Economic and Statistical Handbooks of Nagaland, related articles on the issues from published and unpublished works etc. The study covers the entire Health Units conducting institutional delivery of the 11 districts of Nagaland and the data pertains to the period from 2007 to 2014.

BRIEF REVIEW ON MATERNAL HEALTH CARE

According to World Development Report 2012, India has the largest no. of maternal deaths at 68000, accounting for 1/8th of all maternal deaths in world. Problem arises due to the fact of high cost involves in availing medical care in India. In a year about 24% of the people hospitalized are from Below Poverty Line (BPL) and maternal healthcare costs exceed the capacity to pay by households in the poorest income group. With practically no capacity to pay for delivery at a public facility, 81% of women in the poorest decile deliver at home (Bonu et al. 2009). In a study conducted by USAID in 2008 for the state of Uttar Pradesh (UP) reported that the high monetary cost as the major factor for not opting institutional delivery. It becomes burdensome for a poor family to borrow money and to opt for institutional delivery, as having incurred substantial debt comes with an exorbitant rate of interest. In Gujarat scheme encourages women from households below the poverty line to seek institutional delivery services at a private hospital, in which 97% of women are enrolled in the scheme and deliver at health facility, saving a substantial amount in delivery fees. However, most women still incurred some Out of Pocket (OoP) expenditures and do not benefit adequately from some services offered under the scheme. For instance, only 30% use the postnatal care services (Bhat et al. 2009).

Complication of pregnancy and child birth delivery are considered the leading cause of maternal death in all the developing countries of the world. In Africa at least 30 million women become pregnant in a year of which 2.265million mothers die due to causes related to pregnancy and childbirth. Study done by Barros, Santos, and Bertoldi (2008), found that there is high level of equity in maternal healthcare for all income groups in Brazil. The public healthcare system finances 81% of all deliveries, and 95% of deliveries among the poorest 40%, and less than 1% of whom report some OOP expenditure. Even among the richest 20% of households, only 17% pay out-of-pocket; for the rest, the deliveries are financed by private health plans (50%) and the public health system (33%).In Tanzania, maternal healthcare costs make up to 5.32% of the total annual household expenditures among the poorest quintile; such expenditures for the richest quintile comprises of 2.73% of household expenses annually. (Borghi et al. 2004; Kawnine et al. 1998; Prata et al. 2004). In rural Bangladesh home delivery is preferred to institutional delivery due to low cost associated with it, around 71% of births take place at home. Institutional delivery is considered only for Emergency Obstetric Care (EOC).The Government of Bangladesh piloted a Demand-Side Financing (DSF) scheme known as the maternal health voucher program in 21 sub-districts from 2006 and expended it to 33 sub districts in 2007. It was found that there is an increase in the proportion of the institutional deliveries at the private facility from 19% in 2010 to 31% in 2012. There is considerable increased institutional delivery in the public health facilities too, however private facilities continues to be the largest contributor to the institutional delivery comprising of 13% to 21% between the years 2010 to 2012 (Forhana Rahman Noor, Ubaidur Rob; 2013)

There is vital need across the developing countries of the world to increase public financing for Maternal, Neonatal and Child Health (MNCH) care services and to expand access to services and to lessen the cataclysmic impact of health expenditures. Escalating the quantitative and qualitative aspects of health services such as building more facilities, providing more trained personnel in rural areas, and ensuring that medical supplies are continuously available will help reduce travel costs and time costs associated with traveling long

distances to obtain necessary care. In fact the provision of free, accessible public hospital services will protect the poor households from large hospitalization expenses relating to Caesarean- sections (C-section) and deliveries with complications.

RESULTS AND DISCUSSIONS

Maternal health care is the major focus area under the Reproductive Child Health (RCH), with the NRHM vision and the Millennium Development Goals to provide quality assured services. The government of Nagaland is putting effort to expand and strengthen its existing 120 delivery points (2013-14) out of the 554 Health Units in the state. This health Units (24*7 and non-24*7delivery points) are equipped to undertake non-emergency deliveries, ensuring Ante Natal Care (ANC) / Post Natal Care(PNC) services and referral services for high risk pregnancies to higher institutions and provision of financial assistance for institutional delivery to the rural women. Up to 2013-14 there are 18 Private Accredited Health Institutions signed Memorandum of Understanding (MoU) as Public Private Partnership (PPP) for the implementation of JSY.

JANANI SURAKSHAYOJANA (JSY)

Under the umbrella of NRHM in 2005 the Janani SurakshaYojana (JSY) was introduced in April 2005 to provide equitable, affordable and quality care for pregnant mother opting for institutional delivery in Public Health Institutions or Accredited Private Medical Facilities. To achieve this goal, cash incentive for institutional delivery for mother and Accredited Social Health Activist (ASHA) for facilitating antenatal services and deliveries was introduced which proved to be one of the reasons for an increase in institutional delivery across the region of the country (Lahariya 2009). The institutional deliveries to total deliveries increased from 56.7 % in 2006-07 to 78.5% in 2010-11(GOI 2011).

Under this scheme the states are divided into two categories- the Low Performing States (LPS) and the High Performing States (HPS) depending on the level of institutional deliveries in the pre-2005 period. Accordingly, Nagaland been on the HPS category has the following entitlement- home delivery attended by a Skilled Birth Attendant (SBA) should be incentivize an amount of Rs. 500.00 and if delivery take place in a health institution should be of Rs 700 for rural women and Rs. 600.00 for urban women respectively. Under this scheme an ASHA is also entitled to get Rs. 600.00 for facilitating institutional delivery. In Nagaland, the trend in institutional delivery cases since the introduction of JSY in 2007-08 indicates the total number of JSY beneficiaries across the state in table 1. The given data in is the sum total of JSY beneficiaries in the Public Health Facilities and Accredited Private medical institutions. The table indicated that the no. of JSY beneficiaries over the year is increasing from 9943 in 2007-08 to 16559 in 2014-15.

Table 1: Total no. of deliveries (institution & home) reported and JSY beneficiaries in Nagaland

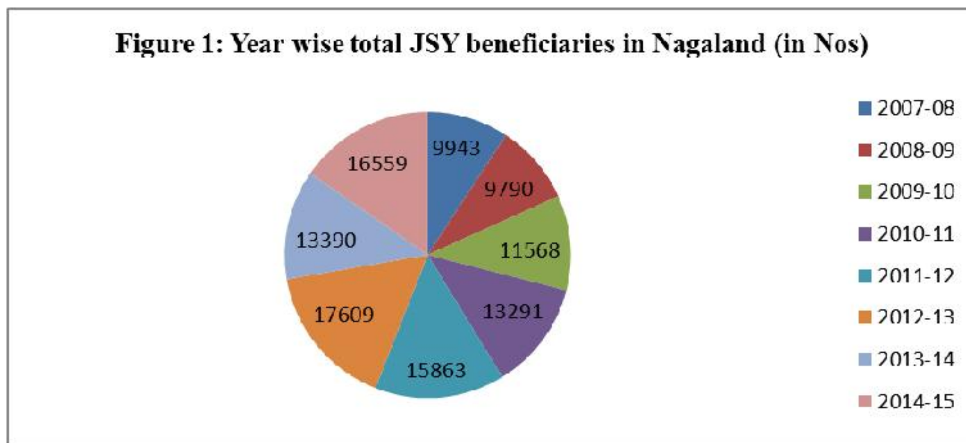
Year	Total delivery reported (HMIS)			Total no. of mother benefited from JSY(MH-RCH)		Total JSY beneficiaries	Increasing trend in JSY beneficiaries
	Institutional	Home	Total	Institutional delivery benefited from JSY	Home delivery		
a	*b*	*c*		*d*	*e*	*f=(d+e)*	*g*
2007-08	NA	NA	NA	9943		9943	--
2008-09	NA	NA	NA	9790		9790	-153 (-1.53)
2009-10	NA	NA	NA	11568		11568	1625 (16.34)
2010-11	11453 (66.81)	5689 (33.18)	17142 (100)	13291		13291 (77.53)	3348 (33.67)
2011-12	13162 (69.12)	5878 (30.87)	19040 (100)	13010 (98.84)	2853 (48.53)	15863 (83.31)	5920 (59.53)
2012-13	15183 (73.31)	5525 (26.68)	20708 (100)	16491 (108.61)	1118 (20.23)	17609 (85.03)	7666 (77.09)
2013-14	15601 (73.39)	5656 (1.20)	21257 (100)	11490 (73.64)	1900 (33.59)	13390 (62.99)	3447 (34.66)
2014-15	17232 (77.11)	5113 (22.88)	22345 (100)	15351 (89.08)	1208 (23.62)	16559 (74.10)	6616 (66.53)
Total	72631 (72.27)	27861 (27.72)	100492 (100)	NA*	NA*	108013 (107.48)	

Source: Maternal Health section, Reproductive and Childs' Health (RCH), HMIS- NRHM, Nagaland; Kohima 2015 Figures in the table indicate no. of beneficiaries and in parentheses are percentages

Note: NA (not available), NA: Not application due to non segregation of data from 2007-08 to 2010-11.*

% of JSY beneficiary is calculated to the no. of deliveries reported.

In 2012-13, out of the total 20708 deliveries cases reported through the HMIS portal, 85.03%of women benefited from JSY scheme, which comprises of 20.23% achievement of the total home delivery cases and achieving 108.61% against the total institutional delivery reported. With the available data and taking the FY 2007-08 as the baseline the increasing trend in the no. of JSY beneficiaries is indicated in column 'g' in the table. The year 2008-09 shows a negative trend in the number of JSY beneficiaries but has tremendously risen from 16.34% in 2009-10 to 77.09% in 2012-13. There was a gradual slow down to 34.66% in 2013-14 but again rose to 66.53% in 2014-15 since 2007-08.



Source: Maternal Health section, Reproductive and Childs' Health (RCH), NHM, Nagaland; Kohima 2015

Data available shows that from 2007-08 to 2014-15, total of 108013 pregnant women had been benefited from JSY scheme. The above figure 1 indicates the year wise JSY beneficiaries over eight (8) financial years. The year 2012-13 achieved the highest number of i.e 17609 beneficiaries contributing to about 16.30% of the total achievement. It consisted of 16491institutional deliveries and 1118 home deliveries. As also reflected in table 1 the total number of JSY beneficiaries is increasing each year while home delivery is on a declined from 2853 in 2011-12 to 1208 in 2014-15. In 2014-15, 89.08% of the reported institutional deliveries are benefited from JSY scheme which means 68.69% of the reported deliveries are benefited.

JANANI SHISHUSURAKSHA KARYAKRAM (JSSK)

In connection with the concern for safe delivery concerning both the mother and the child's safety, the Government of India (GOI), under the Ministry of Health and Family Welfare (MoHFW) launched the JSSK to eliminate out-of-pocket expenses for institutional delivery for mother and sick infant in all government health institution. Along with the rest of the country, Nagaland launched JSSK on 4th August 2012.The state implemented the same from 1st September 2012 onwards. Under this initiative cashless delivery for pregnant women and sick neonate (now infant) which includes drugs and consumables, diagnostics, blood transfusion, diet and free referral transport from home to facility, facility to facility (in case of complication) and facility to home are being provided. This is to supplement the existing JSY to promote institutional delivery. The progress and achievement of the scheme is tabulated as under:

Table 2: Total No. of JSSK beneficiaries reported from districts in Nagaland

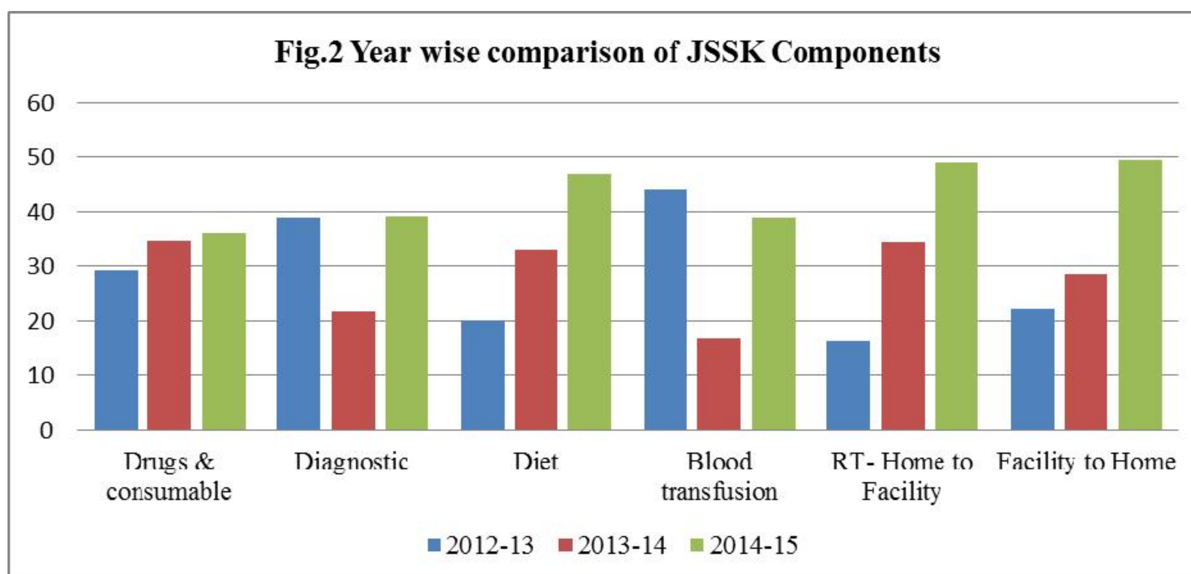
Components	2012-13	2013-14	2014-15	Total
Drugs & consumable	5639 (29.25)	6648 (34.49)	6987 (36.25)	19274 (100)
Diagnostic	5600 (38.96)	3121 (21.71)	5650 (39.31)	14371 (100)
Diet	5623 (20.22)	9161 (32.95)	13017 (46.82)	27801 (100)
Blood transfusion	76 (44.18)	29 (16.86)	67 (38.95)	172 (100)
RT- Home to Facility	4330 (16.51)	9024 (34.42)	12859 (49.05)	26213 (100)
Facility to Facility	57 (3.76)	1379 (91.20)	76 (5.02)	1512 (100)
Facility to Home	5316 (22.20)	6810 (28.44)	11817 (49.35)	23943 (100)

Source: MH Section, RCH. NRHM, Nagaland; Kohima 2015

Figures in the table indicate no. of beneficiaries and in parentheses are percentages

Note: JSSK was launched and implemented in the state only from September 2012, therefore data for FY 2012-13 consisted only of 7 months i.e.from 1st September 2012 to 31st March 2013.

Since the 3rd year of its (JSSK) implementation in Nagaland from 2012-13 to 2014-15, the total no. of beneficiaries are indicated in the above table as shown. Under the component of drugs and consumables 19274 pregnant women had benefited, 14371 beneficiaries for diagnostic 27801 under diet, and 172 for blood transfusion.



Source: Maternal Health section, Reproductive and Childs' Health (RCH), NHM, Nagaland; Kohima 2015

As shown in figure 2, there is an increasing trend in all the component of JSSK beneficiaries except for blood transfusion and Facility to facility referral transport which was 76 beneficiaries in 2012-13, 29 beneficiaries in 2013-14, and 67 beneficiaries in 2014-15 respectively under blood transfusion. There was also a sudden declined in the number of beneficiaries under diagnostic from 5600 in 2012-13 to 3121 during 2013-14. This was due to delay in purchased and disbursement of central procurement mechanism. Besides, there are misreporting cases of JSSK entitlements as most of the components get jumble up with the other general supplies at the Health Units and many times the health reporter is unable to identify and report back accurately. This has being the major cause of difference between JSY (institutional deliveries) and JSSK beneficiaries though both are meant and targeted for the same group of people. It is significantly proven that timely referral transport facility can save a number of maternal deaths. To obviate out of pocket expenses to maternal and neonatal (now infant) health care service

the referral transport entitlements are:1. Transport from home to health facility, 2. Referral to higher facility in case of need and 3. Drop back from health facility to home.

Upto31st March 2015, 26213 mothers had been benefited under home to facility referral transport, 1512 mothers from facility to facility referral and 23943 under facility to home referral transport. As per guideline and the state ROP approval, referral transport under JSSK is further categorized into state owned vehicles and other private vehicles carrying pregnant mother for institutional deliveries and the reports for utilization of services from across the 11 districts of Nagaland are shown in the table 3.

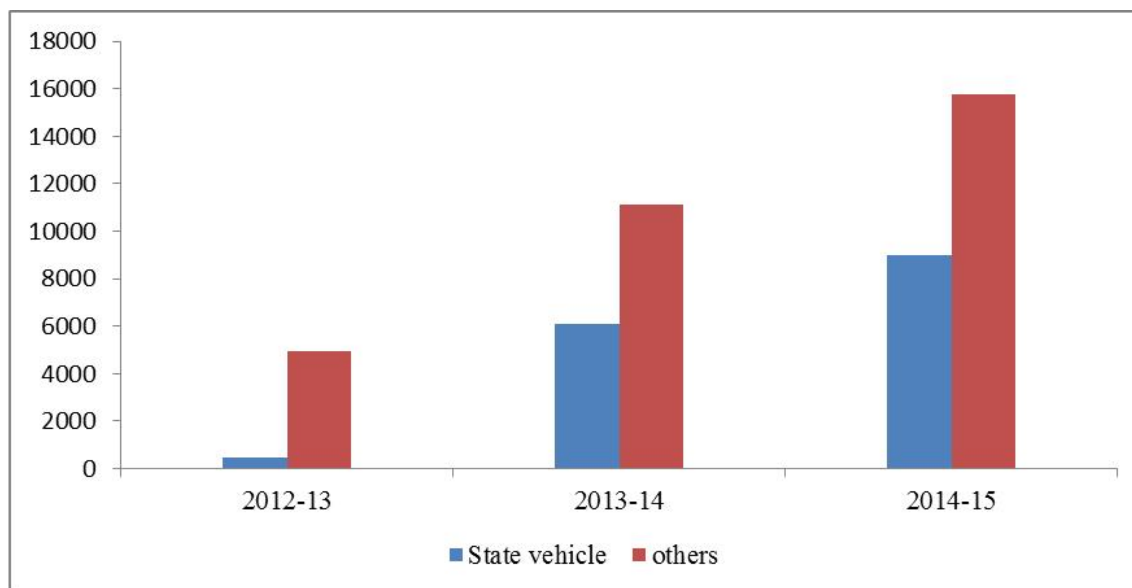
Table 3: Referral Transport service under JSSK

Referral Transport	2012-13		2013-14		2014-15		Total		Total (state vehicle & others)
	State vehicle	others	State vehicle	others	State vehicle	others	State	others	
Home to Facility	1654 (34.63)	2676 (54.30)	1936 (31.68)	7088 (63.83)	4020 (44.72)	8839 (56.07)	7610 (38.29)	18603 (58.51)	26213 (50.73)
Facility to Facility	20 (0.41)	37 (0.75)	37 (0.60)	1342 (12.08)	40 (0.44)	36 (0.22)	97 (0.48)	1415 (4.45)	1512 (2.92)
Facility to Home	3101 (64.94)	2215 (44.94)	4137 (67.70)	2673 (24.07)	4929 (54.83)	6888 (43.69)	12167 (61.22)	11776 (37.03)	23943 (46.34)
Total	477 (100)	4928 (100)	6110 (100)	11103 (100)	8989 (100)	15763 (100)	19874 (100)	31794 (100)	51668 (100)

Source: Source: MH Section, RCH. NRHM, Nagaland; Kohima 2015
Figures in the table indicate no. of beneficiaries and in parentheses are percentages

Out of the total 51668 referral transport services under this scheme from 1st September 2012 to 31stMarch 2015, 31794 cases of referral services are catered by other private vehicles which is 61.53% of the total referral transport and 38.46 % by state own ambulances.

Figure 3: Comparison of state and other Referral Transport service under JSSK



Source: Maternal Health section, Reproductive and Childs' Health (RCH), NHM, Nagaland; Kohima 2015

In 2012-13 about 8.82% of institutional deliveries are benefited by state vehicle, while 89.32% of the referral services are done by others (private vehicles). Similarly, in 2013-14 with 64.50% private vehicle services and 35.49% by state vehicles. While in 2014-15, it was 63.69% by private vehicles and 36.31% state's vehicles respectively. The data indicated that most of the pregnant women seek institutional service either by private/hire vehicle rather than the state ambulances. Till 2014-15 there were 76 ambulances to cater service to 1980602 populations (2011 census) across 554 Health Units in the state.

MATERNAL MORTALITY RATE (MMR)

Ronsmans et al. (2009) said that majority of maternal deaths could be prevented by empowering women, families and communities to make timely decisions and carry out appropriate actions without any financial restraint. The high MMR, even with the use of skilled attendants, suggests that women seek professional care too late, and possibly only when there are obstetric complications. Apart from birth traditions, the high cost of maternal care has been identified as a key factor for delaying to pursuit for proper maternal healthcare service in rural areas. As per SRS 2001-03, the MMR for India was 301 and gradually came down to 212per 100,000 live births in 2007-08 (SRS 2011).

In Nagaland the death rate is 3.2 as per SRS 2013, but there is no MMR for Nagaland however, and as per data available MMR was 160 in 2014-15 according to State Health Society (NHM; Nagaland 2015-16).The target set for the Financial Year(FY) 2016-17 is < 100. Below is the table 4 indicating the causes of maternal death reported from the districts of Nagaland available from 2012-14.

Table 4: Causes and number of Maternal Death reported in Nagaland from 2012-15

Causes of Maternal Death reported	2012-13	2013-14	2014-15	Total
Obstructed Labour	2 (8.00)	1 (10.00)	--	3 (6.97)
Haemorrhage	15 (60.00)	1 (10.00)	--	16 (37.20)
Haemorrhage shock (Molar Preg.)	1 (4.00)	--	--	1 (2.32)
Sepsis	1 (4.00)	--	--	1 (2.32)
Retained Placenta/PPH	1 (4.00)	2 (20.00)	2 (25.00)	5 (11.62)
Other(pain abdomen, cardio respiratory failure, pulmonary embolism	4 (16.00)	1 (10.00)	--	5 (11.62)
Septicaemia due to typhoid fever	1 (4.00)	1 (10.00)	--	2 (4.65)
UID Related cases (s. anemia, renal failure	--	2 (20.00)	--	2 (4.65)
Eclampsia/ Epilepsy	--	2 (20.00)	1 (12.5)	3 (6.97)
Ectopic Pregnancy	--	--	1 (12.5)	1 (2.32)
Mismanaged labour shock	--	--	1 (12.5)	1 (2.32)
Severe Anaemia	--	--	3 (37.5)	3 (6.97)
Total	**25 (100)**	**10 (100)**	**8 (100)**	**43 (100)**

Source: MH Section, RCH. NRHM, Nagaland; Kohima 2015

Figures in the table indicate no. of beneficiaries and in parentheses are percentages

The total number of maternal deaths reported was highest in 2012-13 with 25 maternal deaths, and the maximum causes of this deaths been Haemorrhage and others relating to abdomen pain, cardio respiratory failure, and pulmonary embolisim.Besides, retained placenta, obstructed labour, eclampsia and severe anemia are the cases reported from the 11 districts of Nagaland.

CHALLENGES

The major challenge in the implementation of these financial aids has been the delay in the release of fund to the delivery points. In fact; it has given a lot of space to controversies with the general public and a hassle for the Health Units in this regard. Several strategies including payment through bearers' cheque have been initiated to promote Direct Benefit Transfer. However, owing to lack of banking facilities in the rural localities, many eligible women to forgo their rightful entitlement as they are compelled to travel to the nearest town incurring a much higher expenditure than the actual entitlements to en-cash the benefit.

Other challenges are due to bottleneck in the functioning of District Hospitals (DHs), Community Health Centre (CHC), Primary Health Centre (PHC) & Sub-Centres (SCs) relating to shortages of medical professionals both specialist/Medical Officers (MOs)/nurses, poor infrastructural health facilities, inadequate staff quarter which prevents the health personnel to stay in their posting.

Perhaps, the entitlements under the JSSK are not viable in most of the health units due to the conditionality's associated with it. Health units with poor infrastructure, ill-equipped or with inadequate manpower with no indoor facilities cannot provide the service entitlement forfeiting the entitlements to the beneficiaries.

CONCLUSION

Over the recent years, JSY has become the largest Conditional Cash Transfer (CCT) program in the world to incentivize pregnant women for institutional delivery (Ambrish Dongrea; 2008). In India increase in Institutional deliveries from 47% (DLHS-III, 2007-08) to 72.9% (CES, 2009), has contributed in bringing about a decline in MMR from 254 (2004-06) to 212 per 100,000 live births in 2007-09 (SRS 2012). This demand driven strategy has help to promote the institutional delivery in the case of Nagaland from 9943 JSY beneficiaries in 2007-08 to 16559 beneficiaries in 2014-15 (Maternal Health-RCH; DHFW, Nagaland) increasing the Institutional deliveries from 11453in 2010-11 to 17232 in 2014-15 and reducing home deliveries from 5689 to 5113 in the corresponding period, despite poor communication facilities and difficult terrain. The increasing access to safe delivery is reflected is reduced MMR in Nagaland to 160 in 2007-09 (SRS 2012) with declining reported cases of maternal death from 25 in 2012-13 to 8 in 2014-15.

However, the MMR can still be reduced further as most maternal deaths are attributed to direct obstetric causes- Hemorrhage, Puerperal sepsis, Obstructed labor, Eclampsia, Complicated abortion which can be prevented by addressing non or under-utilization of services, poor health seeking behavior, poor infrastructure and inadequate skilled care at birth, lack of access to emergency obstetric care/transportation. To accelerate the pace of decline of MMR in order to achieve the NHM and MDG Goal of less than 100 per 100,000 live births, there is a need to address the above mentioned underlying factors, in addition to giving equal impetus on the interventions on social determinants- low female literacy, lack of awareness, poor nutritional status, early age, low status of women, poverty, large family, etc.

Besides, these existing financial aids and the general awareness, many rural women still prefer for home delivery due to problems of transportations, distance of the health facilities and the non-availability of health service providers in times of needs and emergencies, Fear of hospitals, comfort of home and in addition to it the meager entitlement actually provided (NRHM; 2010-11)[1]. *(ASN (2010-11): A study on assessing the health communication needs among the rural population in Nagaland. SHS, NRHM, Department of Health & Family Welfare, Govt. of Nagaland.)* Referral transport funds are made available in the health units of all the remote places but in the absence of ambulances the supplementing amounts from the scheme are too meager to hire for private vehicle when in rural areas there is no/few vehicle(s) and the hiring charges becomes too expensive. Thus, it would be wise to assess if the mission objective to benefit the rural women through this financial assistance (JSY & JSSK) is delivered actually to the targeted group, when it has several impediments due to stringent conditionality's and shortages in the system which is not feasible in the remote areas.

The analysis in the paper brought out a subsequent call for expeditious actions and policy implications such that: (a) the existing delivery points should be suitably equipped with proper infrastructure, manpower, and all other necessary facilities associated with it. (b), unswerving flow of fund to delivery point should be maintained for non-negotiable matter of JSY and JSSK,(c) sticking on the given guidelines of the scheme and maintaining transparency as it utmost priority, each State should be empowered to design which is best and practicable in the area for the implementation of the scheme rather than to some unviable realities, (d) effort should be given to create more awareness among the rural people about the available entitlements in their health unit, (e) besides, implementing authority should monitor and capture feedback from the beneficiaries to know better and solve the grassroots level realities.

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