Concept Note

On

Strengthening Public Health Management Structure at State and District Levels

For the

First Expert Committee Meeting,

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Organized by
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Government of India
And
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Strengthening Public Health Management Structure at State and District Levels

**Background:**

NRHM has brought forth a paradigm shift in the approaches, functioning and delivery of the basic public health care system in the country. Over the years there has been an increasing trend in utilization of public health services mostly by the rural population which comprises 71% of the country’s population with improved health status at national level though there are intra and interstate variations in terms of service delivery and achievements of health outcomes. In states, NRHM has lead to creation or structural reform of the public health management institutions in area of situational analysis of policy, planning, implementation and management of NRHM. The **State Health Society (SHS)** which was established under the **Department of Health & Family Planning** is the nodal institution for guiding its functionaries towards receiving NRHM fund, financial management including fund disbursement to **District Health Societies (DHS)**, Directorate of Health & Family Welfare, NGOs and other agencies for implementation of NRHM and other diseases control programmes, performance monitoring, inter-sectoral coordination, advocacy and is accountable to NRHM fund received from the Ministry of Health & Family Welfare, Government of India. The State Health Society, through the **State Health Programme Management Unit (SPMSU)** which is mostly managed by contractual employees acts as a resource repository for the State and is supported by other para-statal organizations such as the **State Institute of Heath & Family Welfare (SIHFW)**, SPMSU, State Health System Resource Center (SHSRC) and technical agencies on health system development, medical service corporations etc. The Directorates of Health & Family Welfare under the Department of Health & Family Welfare, manned by the regular government employees has been traditionally responsible for the planning and delivery of public health services, is at the receiving end of NRHM fund for implementing and monitoring of other disease control / eradication programmes. In the current scenario of public health management, there are various major constraints and critical challenges that operate across the states. Successful implementation of NRHM calls forth improvement in standards at all levels of planning and implementation to ensure efficiency and effectiveness in the public health system.

Time has come to reflect and act upon the major constraints and weaknesses of the current public health management system in the Directorate of Health & Family Welfare, with an aim to revitalize and work towards effective integration of key public health functionaries for improved health status of states. The necessary architectural
correct in public health care delivery system and administrative reform in states will lead to increase absorption of funds within the public health system. With this as the background, a **National Task Force** was constituted in 2008 under the Chairmanship of **Directorate General of Health Services, Ministry of Health & Family Welfare (MoHFW), Government of India** to bring a public health focus into health system and to formulate standards and norms for state and district level public health management. A sub–task group had also been set up to work on just the public health act under the task force.

The draft Task Force Report on key issues in Public Health and draft National Health Bill 2008 were presented and discussed at the **Human Resources and Management of Health System workshop** which was held at Pondicherry from 16th–18th October, 2008 organized by the **Ministry of Health & Family Welfare, Government of India** in collaboration with **WHO Country office for India, DFID** and **National Health System Resource Center (NHSRC)**. One of the key areas for discussion at the workshop was the disconnection and lack of integration between the State Health Society and the Directorate of Health & Family Welfare. It was suggested to develop a robust mechanism for integration of the State Health Mission under State Health Society into the state health services structure for effective and successful implementation of NHRM and public health delivery services in the long run. The state representatives were also requested to provide suggestions on the draft report and to initiate measures for strengthening and streamlining the current public health management.

Recently, it has been decided to look into the public health management issues with a renewed efforts and scope with the constitution of a **National Expert Committee on Integration** under the Chairperson of **Thirumati Girija Vaidnadhyan**, Health Secretary and Mission Director of the Department of Health & Family Welfare, Government of Tamil Nadu, with the State Health Secretaries/Commissioner and Mission Directors of seven states of Gujarat, Madhya Pradesh, Bihar, Chattisgarh, Meghalaya, Orissa and Karnataka and Director of Finance (NRHM) as members of the Committee. The Expert Committee will support in devising strategies for effective implementation of NRHM through effective integration of key health functionaries.

The **First meeting** of the Expert Committee was held on the 3rd of September 2011 at **Nirman Bhawan**, New Delhi under the chairmanship of **Shri Amit Mohan Prasad, Joint Secretary of NRHM** and participated by members of Expert Committee, Dr. Sajjan Singh Yadav, Director (NRHM–II), and officials of MoHFW & NHSRC.

The agenda of the meeting was as follows:
- To discuss the issues of integration between State & district Health Societies with the Department of Health & Family Welfare of the state.
- To discuss on a regime for monitoring and evaluation of both the physical and financial aspects of NRHM
- To discuss the draft framework for implementation of National Urban Health Mission (NUHM)

The meeting was successfully convened with the proactive participation and significant inputs from the members of states of Tamil Nadu, Gujarat, Madhya Pradesh, Bihar, Chattisgarh and Karnataka.

**Review of the current Public Health Management Institutions in states**

As per the rapid review of the structure and functioning of the directorates at state level and district health management as well as other newly emerging public health management institutions in various states; it was observed that major constraints and challenges operates across states which requires to be adequately addressed and responded to for improvement in public health management and increase the absorption of funds within the public health system. Some of the key challenges identified are as follows:

**Excessive centralization**

Due to lack of well defined organizational structure with clear work allocation and hierarchy in the system, there is ineffective and inadequate delegation and distribution of work which leads to centralization of authority and functions to few individuals at state and district levels resulting in inaction, delayed action or amiss.

**Arbitrary structures of Directorates and division with non–functional “section” team**

The constitution of directorates and divisions in states are rather responsive to immediate necessities and not norm based which leads to dysfunctional, inefficiencies and redundancies in the system. There is no functional team comprising of multi–level technical, multi–disciplinary teams to assist in development and implementing major public health programmes in the structure of directorate. The so called “section” team under each division is inadequately and inappropriately staffed to perform as per the demands and needs of the programme and mainly deals with administrative issues.

**Short tenure, inadequate and inappropriate eligibility criteria for key administrative posts**
The key functionaries of directorates lack qualification, expertise and necessary experiences in public health which hampers the quality and focus of the public health management. Another major issue affecting the performance is the short tenure of key functionaries at all levels on account of superannuation, late promotions and arbitrary transfers and postings.

Mismatch between Institutional structure and public health issues
There is clear lack of focus and efforts on critical public health issues such as under-nutrition, maternal mortality, infant mortality, prevalence of malaria etc as reflected in the structure and functioning of various divisions/sections and key functionaries chosen to manage the otherwise key public health programmes.

Governance issues
The problems of governance affect the senior level of public health management in most states, which is marked in low performing states. Some of the governance issues are lack of tenure, standardized performance reviews and accountability and arbitrary and ad-hoc appointments for key posts of chief and district medical officers, lack of community participation and involvement of panchayat at village levels affects the functioning, delivery and performance of public health system.

Separation of clinical and administrative streams
Among the states, only Tamil Nadu had succeeded in separation of the clinical and administrative streams efficiently for the last 50 years. In this system, there is clear allocation and demarcation of work as per the qualification, expertise and experiences of the personnel in each stream and both streams have comparable career paths and status at various levels of management. Though this system is being attempted in many states, it had not been fruitful due to disproportionate and irrational influences and notions held by senior clinicians holding administrative posts.

Differentiating Public Health Specialists from Public Health Cadre
There have been evidences of poor and inadequate utilization of public health specialists, in states where these posts were created. Moreover the public health specialists, with specialization in community medicine, are not trained in administrative and managerial skills and knowhow. A system is required for public...
health administrators or cadre, which insists on public health qualification, skills, aptitude and experiences, to effective public health management system in states.

**Public Health Management Education Programmes, short courses, skill development**
There have been tremendous achievements in establishment of public health institutes offering public health management courses and diplomas through PPP model by PHFI in partnership with IHTM (Kolkata), NIHFW (Delhi), KGMC (Wardha), 8 schools of public health by ICMR and other private organizations with an annual intake of total 450 seats. There is a need to increase the quality safeguards and increase in service access to these courses. A database of such programmes with regular updates of directory is required. In addition to these, various short term courses and distance education programmes are being offered by NIHFW, IIHMR, PHFI etc.

**Revitalizing Community Medicine Department**
There is a need for revitalization the department of community medicine in medical colleges to face the emerging public health challenges and challenges in health sector and also respond to space provided by NRHM. Most of these departments lack the necessary knowledge, skills and know–how on various public health areas such as health care financing, informatics, HR development, quality improvements etc and their role is limited in evaluation, appraisals, trainings, district planning and disease profiling etc with varying quality of output.

**Emergence of new state level public health management institutions and parastatal bodies**
The existing rigid structure of the directorates leads to proliferation of various new parastatal organizations such as NHSRC, SIHFW as additional technical support institutions to the department of health & family welfare with requisite skills and aptitude.

**Leadership in Nursing and paramedical cadre, AYUSH streams, Medical Education**
Little priority is given to the management of nursing and paramedical cadre, which constitutes the majority of skilled health workforce. These cadres would be excluded from senior levels of management, even of their own cadre. There is a need to build up leadership or administrators in nursing and paramedical cadre by enabling the capable and leading members of the cadre to access public health qualifications and emerge in leadership role.
**Conclusion:**
It is the need of the hour for states, in particular 18 high focus states where these issues are maximal to adequately address and respond to these aforementioned key issues if at all the public health system has to be strengthened with better absorption of fund and grab the opportunities under the scope of NRHM.

**Implementation of NHRM in States and District levels**

To achieve the objectives of NRHM across the states, respective **State Health Mission** were constituted and **State Health Societies (SHS)** were registered under the respective state Societies registration Act for delegation of administrative and financial powers under NRHM. In states, State Health Society was constituted merging the health societies for leprosy, tuberculosis, blindness control and integrated disease control programme except the State AIDS Control Society. All the National Health Programmes at the State and District level are brought under one umbrella of SHS and it function through the individual sub committees which help to pool all resources available in implementation of the programme. At the district level, **District Health Mission** and **District Health Society** have been formed to implement the activities of the State Health Mission. The vision of the Mission is to provide universal access to equitable, affordable and quality health care services which is accountable at the same time responding to the needs of the people.

**Integration of State Health Societies and Directorate of Health & Family welfare of states at various levels for Implementation of NRHM**

In the last 6 years of experiences in implementation of NRHM through State Health Society and District Health Society at state and district levels, there has been rising concern over the lack of coordination and integration between the SHS and directorate of health & family welfare at state levels. The administrative and financial power under NRHM is centralized to the State Health Mission under SHS through key functionaries with minimal and very limited role of the directorate of health & family welfare. The issues of lack of horizontal integration lead to lack of ownership and control of the NRHM by the state department of Health resulting in inefficient delivery of public health services in the long run. The integration issues at various levels are highlighted under separate headings as follows:
**Key Integration Issues at State Level**

There is a clear disconnect between State Health Societies and directorate of health & family Welfare at state level. Each public health management institute function as separate establishments with different institutional structure and varying technical and managerial competency for implementation of major public health programmes under NRHM by SHS and other fully state funded diseases control, disease eradication programmes, family welfare, school health and universal immunization programmes etc implemented by directorate. There is varying level of coordination issues in areas of planning, execution and management of programmes.

**Key Integration Issues in SHS Management**

The Mission Director (MD) who heads the state Health Mission of SHS has no administrative control over the key functionaries in the directorate at state level and key officers such as Chief Medical and Health Officers (CMHO) at district levels since he is not involved in the appointment, review and transfer or posting of these officials. There is no integration of various vertical programmes under a unified and common platform or structure and these vertical programmes are not responsive to SHS. The SHS and State Programme Support Management Unit (SPSMU) is mostly run by contractual employees and are poorly integrated with regular management employees, who are mostly based in directorate. Moreover, the short tenure of Mission Directors and Secretaries impede the progress of integration in many states. The varying size, structure and capacity of SPSMU is another cause of concern for lack of integration.

**Key Integration Issues in Directorates**

The state directorates function in a rather traditional and old fashioned manner with a rigid institutional structure and dysfunctional divisions/sections for management of public health programmes or key issues. The directorates cannot bring in multi-disciplinary skills for management, financing, planning, policy work etc which may assist or facilitate the smooth and quality implementation of NRHM. Moreover, the directorates do not have role in flow of funds in state health society which is often seen as an inability to exercise control over the program. There is limited capacity and willingness to manage new program, especially those which are not related to clinical care provision by professionals. All these issues factor in for the lack of ownership of NRHM plan and activities on part of the directorates and to see NRHM as transient project that would soon fade away.

**Integration Issues at District Level**
At the district level, the **District Health Society** and **District Programme Management Support Unit (DPMSU)** function under the **Chief Medical and Health Officer (CMHO)** of the directorate; so the problem of integration is lesser though ownership of NRHM by permanent key officials such as CMHO is lacking and expressed discontent about the higher salary of contractual employees under NRHM.

### Areas for Consideration for Strengthening Directorates

It was brought to the notice that the lack of horizontal integration of various vertical public health programmes routed through NRHM fund may be resolved at national level with formulation of clear guidelines and framework with scope for flexibility at state level for fund utilization, defined role of Mission Director (MD) in oversight of vertical programmes since the MD has been responsible only in fund release with no scope of flexibility in re-adjustments and fund utilization under fund heads of vertical programmes both within and outside the ambit of NRHM. The State Health Mission may be integrated in the directorate through deputation of appropriate regular employees. To enhance coordination and integration, various measures such as ensuring that MD is the Secretary of Health, involvement of Director of health services in planning and execution/review as per official protocols, accountability at all levels towards programmes outcomes and conducting common and joint monitoring and reviews on regular basis etc. For a long-term sustainable system of proper program planning and effective implementation, there is a need for strengthening of Directorates in terms of:

- Formation of a public health cadre with adequate qualifications and experience
- Continuous exposure of senior regular officials to short course trainings, academic sessions etc.
- Creation of various **multi-disciplinary functional teams** with multi-disciplinary skills in the field of public health, epidemiology, health care financing and health economics, hospital management, IEC/BCC, community process, human resource management, nutrition, quality improvements, health informatics and communication etc with systematic institutional support and clear career path.
- Development of **Sustainability plan** for Human Resource Management under NRHM
Key Actions areas to be taken up for strengthening Directorate

In the light of the discussions in the Expert Committee meeting, there are certain key action areas identified to be taken up by the Central/State governments and see that these are being followed up regularly. Highlighted below are these action areas:

- MoHFW, GoI to formulate a **guiding policy and principles** for horizontal integration of vertical programmes under NRHM and outside the ambit of NRHM. The guidelines or principles should have scope for provision of well defined roles of Mission Directors as far as oversee of public health programmes and fund management through NRHM is concerned along with scope for flexibility in inter-budgetary head utilization as per the needs and priorities of the state government. The guiding principles may be part of the process in the **12th Five Years Plan (2012–2017)**

- Initiatives and attempts made by the state government for formation of a **public health cadre and specialists post** and the progress made may be reviewed during the 12th five years plan so that the current gap and status may be analyzed in a coordinated and focus manner. Best practices and lessons learnt from Tamil Nadu state may be looked into and adapted as per the local context, situational and needs assessment of public health delivery system and availability of human resource for health.

- **A Human Resource strategy** for strengthening of directorate may be developed so that right persons with the requisite skills such as consultants and well trained officials in SHS may be deployed in the directorates and placement of regular government employees in SHS on deputation. This practice will facilitate in instilling work–culture in directorates through development of skilled health workforce thereby gradually building the ownership of NRHM.

- States may undertake a well formulated **sustainability analysis** to assess the requirements of various posts created, recruited and retained under NRHM in the upcoming 12th five years plan. The management of the huge workforce under NRHM is gradually becoming a challenge that needs to be addressed urgently through various means. Provisions may be made for regularization of key contractual positions under NRHM in due course as per the state rules and
regulation keeping into account that adverse consequences of inaction in this regard.

- States to build in the ownership of directorate of health services of NRHM with proactive engagement and involvement of the Director in planning process, implementation, conducting periodic field visits, joint and common review mission of NRHM. Such practices, if seen and practice in good faith for the welfare of the population and state will naturally act as catalyst for achieving integration between SHS and directorate in due course. States should ultimately work towards effective integration and intra and inter-sectoral convergence to build an efficient and strong public health system.

**Key Issues in the current Monitoring & Evaluation System (M&E) for NRHM**

The NRHM has a pro-poor focus and aims at establishing bottom up planning and monitoring processes and systems so as to enable increased people’s participation, decentralization of health services and accountability of health delivery and care personnel. **Monitoring and Evaluation (M&E)** is a key component of the NRHM as it aims to provide critical indicators that would assist in identifying and developing mid course corrections so that the goals of the NRHM and the Millennium Development Goals are achieved. One of the core strategies of NRHM in achieving its goals is to strengthen capacities for data collection, assessment and review for evidence based planning, monitoring and supervision. NRHM framework proposed accountability through a three pronged approach of internal monitoring (MIS), Community based monitoring and External surveys (SRS, DLHS and household surveys).

Monitoring & Evaluation is an integral component of national PIP and states prepare a **Logical framework Approach (LFA)** therein output and outcome indicators have been spelt out on the lines of the national PIP to monitor the activities through **web enabled HMIS**. In the same line, the district plans had evolved with the district specific objectives and goals. The levels of achievements set by states are being assessed on regular basis by the state itself on common process, outcome and output indicators across states, in 18 high focus states. A robust M&E mechanism is critical for achieving NRHM objectives. States PIPs have clearly defined monitorable physical indicators and there is need to fix facility, block and district wise target for continuous monitoring. The main initiative under the NRHM has been to develop the HMIS system for routine evaluation of the key programme of NRHM priority areas like institutional delivery and maternal care, breast feeding, neo-natal care, routine immunization, pulse polio, save the girl child, PNDT-related issues, integrating RCH with HIV/AIDS,
and adolescent health. The tools for M&E includes the annual Common Review Missions, periodic field visits, quarterly progress reports, financial monitoring reports, HMIS, state specific Monitoring and Evaluation Systems, time to time evaluation of program components by NHSRC and other bodies etc.

Some of the key issues identified are as follows:

- The levels of implementation of these M&E tools and use of data for planning, evaluation and mid-course correction show wide inter–state and intra–state variations in terms of process, quality and outcome.

- Currently, monitoring of ongoing NRHM activities by the directorate establishment is limited and is left to the contractual workforce in State Programme Management Support Unit (SPMSU), district Programme Management Unit (DPMSU) and Block programme Management Support Unit (BPMSU) which lead to not only lack of ownership of NRHM activities by directorate but loss of institutional memory in case of high turnover of contractual employees which is not unusual phenomenon in NRHM.

- Monitoring from the higher levels primarily consists of inadequate field visits & follow–ups and analysis of data uploaded by the states, which in itself have their own set of issues in terms of: reliability, quality of data, interpretation and weak conversion to indicators and information not available in easily accessible and usable form.

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<td>- Regular evaluation of program components through well formulated and well designed research studies by reputed institutions</td>
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<td>- Professional bodies or panel of experts comprising of members with multi–disciplinary skills could evaluate the NRHM and its components. There is a need to first constitute a technical panel comprising of experts in different field of public health as evaluation is different from regular monitoring. The panel should be responsible for developing the study proposal, its design, methodology and tools for the evaluation.</td>
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<td>- <strong>Annual Health Surveys (AHS) and DLHS–IV</strong>(District level households survey) facility survey will generate all the unbiased data to assess and evaluate the outcome and impact of the programmes and interventions from time to time. DLHS data could be considered as third party source of information to provide</td>
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the baseline, midline and end-line surveys for assessing the impact of the health interventions on the community. Annual Health Survey can be utilized for preparing the District Health Profile of each district and could be used as an input for policy initiatives, making mid-course correction, decision making and for review of policy planning.

- The key challenge is interpretation of the information gathered through various sources to lead to an evaluation of the NRHM and its outcomes. Based on the method and the proposal worked out by expert panel, suitable agencies can be selected through an Expressions of Interest (EOI) process.

### Key Actions areas to be taken up for strengthening M&E system

In the light of the discussions in the Expert Committee meeting, there are certain key action areas identified to be taken up by the State governments and see that these are being followed up regularly. Highlighted below are these action areas:

- **A robust M&E mechanism** needs to be developed which should be responsive to local needs. Some of the measures states could adopt are as follows (a) to ensure that a nodal M&E information officer is identified or appointed at every facility upto CHC at block/district levels to handle the flow of information through the specified reporting forms for the various NRHM programmes (b) structuring the information flows through HMIS (c) strengthening of infrastructure such as IT, networking, manpower etc at various levels (d) information flows from the private sector and (e) earmarking upto 3% of the state PIP budget in IT interventions.

- **Capacity Building of staffs** at all levels from facility, district and state levels is critical so that strategic data generated in registers, reports, HMIS may be properly used, referred to and analyzed at their level so that necessary local actions may be initiated on timely and regular basis to rectify and summarize the vast sources of information and facilitate comparisons across categories and over time. Programme managers at all levels need to be acquainted with the power and features of the HMIS portal to assist in their day to day administration. In the area of capacity building, finalization of the training modules and identification of institutes and resource persons for engaging in
Trainings at sub-district level are crucial to enhance the training capacity. Trainings on basic research methodology, analysis tools, and HMIS use may be provided so that key facility staffs will have the ability to access pertinent data needed to make quality decisions based upon actual service and performance trends and conditions. For effective decentralization of planning and monitoring process envisioned in NRHM, the block and district officials should have skills and support system necessary to perform strategic data analysis in tracking and measuring key performance indicators in a supportive and enabling system. The public health managers/programme managers need to constantly review the data entered by the nodal person at the block/district and state levels.

- MoHFW may review of the current HMIS for integration of the physical and financial reports and performance. Currently, the HMIS web portal includes the Finance management reports (FMR) from district upwards, which allows the district and states to enter the FMR on quarterly basis. Since the physical and financial performances are inter-related and inter-linked, there should be a provision where physical related information and reports could be tracked with the operational expenditures and to gain better insight on what will be precisely tracked, documented and analyzed. A cost benefit or cost effective analysis could even be undertaken for different programme heads, if required for sustainability and effectiveness of interventions.

- MoHFW may take up the initiatives of developing some standard benchmarks for physical as well as financial components of NRHM on certain non-negotiable items, in which scope for flexibility is not entertained irrespective of state demands.

- MoHFW may take up regular review on financial component of the NRHM with state representatives from finance divisions and participation of Mission Directors of NRHM and Health Secretary. The review may be undertaken regularly on a six monthly basis.
- For independent evaluation of NRHM by a third party, states may constitute a state level panel comprising experts with multi-disciplinary skills, who would be responsible for developing the evaluation study design and methodology for the evaluation. The evaluation can be carried out by the panel or by a reputed agency selected through an EOI.

### Conclusions

The major challenges, issues and constraints in implementation of NRHM have to be studied in the local context, urgently address and responded to for building up an efficient and effective public health system, which is the key to achieving the desired health outcome of states, in particular the high focus states where these challenges and issues are maximal. Since health is a state subject, any delayed or inaction in recognizing and acting upon these issues on integration and various challenges in NRHM planning, implementation and monitoring would lead to underachievement of health outcomes and overall state of health will be affected. States should adopt a public health focus in delivery of health services by directorate and aim towards reorienting, reform (if required) and repacking the public health delivery system which would involve streamlining and enhancing the capacity of the state to manage public health issues for timely fund absorption in the wake of NRHM. In the process of reform and implementation within health sector, advocacy and regular follow up with other non–health sectors for effective convergence, inter–sectoral integration and mainstreaming at state and national level is crucial and should result in increased fund allocation for health by state/central governments for sustainability and for reaching long term MDG. The central government plays key role in devising and formulating clear, supportive and enabling policy, national guidelines, frameworks and providing appropriate technical support to states for planning, monitoring and evaluation of various programme components under NRHM.