

V-11011/4/2019-NHM-II
Government of India
Ministry of Health and Family Welfare
(National Health Mission)

Nirman Bhawan, New Delhi-110011
Dated the 9th January 2020

OFFICE MEMORANDUM

Subject: Minutes of 8th Meeting of Empowered Programme Committee of National Health Mission held on 19th December 2019.

The undersigned is directed to enclose herewith the Minutes of 8th meeting of Empowered Programme Committee (EPC) of National Health Mission (NHM) held on 19th December 2019 under the Chairpersonship of Secretary (HFW), for information and record.



(Dr. S. C. Agrawal)
Deputy Director (NHM-II)

1. CEO (NITI Aayog)
2. Secretary (Drinking Water & Sanitation)
3. Secretary (Women and Child Development)
4. Secretary (Social Justice & Empowerment)
5. Secretary (Housing and Urban Affairs)
6. Secretary (Rural Development)
7. Secretary (Panchayati Raj)
8. Secretary (School Education and Literacy)
9. Secretary (Higher Education)
10. Secretary (Development of NE Region)
11. Secretary (Expenditure)
12. Secretary (AYUSH)
13. Secretary (Tribal Affairs)
14. DGHS
15. SS(H)
16. AS&FA
17. Dr. Abhay Bang, Director SEARCH, Gadchiroli, Maharashtra
18. Prof. (Dr.) Indra Chakravorty, Chief Advisor, PHED, Kolkata

Copy to:

1. PPS to Secretary (HFW)
2. PPS to AS&MD (NHM)
3. PPS to JS (P)
4. Director (NHM-II)

Minutes of Eighth Empowered Programme Committee Meeting

The Eighth meeting of the Empowered Programme Committee (EPC) of National health Mission was held under the chairpersonship of Ms Preeti Sudan, Secretary (Health & Family Welfare) from 11.00 AM to 2:00 PM on 19th December, 2019 at Room No.249- A, Nirman Bhawan, New Delhi. List of participants is attached at Annexure-1.

The following agenda were discussed and decided as below:

Agenda 1: Provision of incentive for ASHA and ASHA Facilitators after successful certification

Proposal:

In order to acknowledge the achievement of the ASHAs and ASHA Facilitators of receiving certification from NIOS, Joint Secretary (Policy) presented a proposal for giving a cash award of Rs. 5,000 per ASHA/ASHA Facilitator. The cash award was proposed for all ASHAs and ASHA Facilitators who will successfully pass the examination and receive certification by NIOS.

Discussion:

Dr. Abhay Bang stated that this was a crucial activity that needs to be supported to improve the quality of services provided by the ASHA. He also raised the concern that such a proposal may lead to undue demands being made by the certifiers from the ASHA. ED, NHSRC clarified that the 30% marks are allocated to past evaluations, 30% to a theory exam wherein papers were corrected by NIOS at the national level, and only 40% was based on assessment of skills, which was conducted locally. Also examiners were purposively selected from other districts to avoid such potential biases

Dr. Bang also expressed concern at the pace of certification. He suggested the pace should be much faster. Secretary, HFW also agreed to this point and suggested that to expedite the process, certification can be conducted by state institutes as was being done in the case of Community Health Officers of Health and Wellness Centres or institutes like IIPH and institute run by Dr. Bang. In every State, for this purpose master trainers should be developed. The curriculum which is developed by NIOS should be shared with the institutes which will be roped in by States to undertake this training. The training and certifications of ASHA/ASHA facilitators should be taken as a drive. Secretary, HFW advised to ensure safeguards for the scheme so that quality and impartiality doesn't get compromised. AS&FA remarked that State Open Schools can also be chosen for this training. JS- P said that states will need to be provided guidance regarding in what stages the award money needs to be disbursed to the successful ASHA/ASHA Facilitators and steps to be taken to eliminate bias by appointing examiners from other state sites to enable impartiality and quality of evaluation. AS&FA suggested that the support for this should be provided to the States/UTs based on the requirement posed by them in their PIPs within their available Resource Envelope.

M/o AYUSH representative suggested that a module on preventive and promotive practices of AYUSH be added to the ASHA's training course. Secretary (HFW) asked M/O AYUSH representative to develop simple content for ASHA/ASHA Facilitators which could be made available online, and in fact also be made available to the general public to increase awareness on the preventive and promotive aspects prescribed by AYUSH practioners.

Decision of the EPC: After the detailed discussion, the proposal was recommended to be placed for the approval of the MSG provided it lies within the resource envelope, bias is removed in the certification of ASHAs and ASHA facilitators and the payment is made through DBT to the successful ASHA/ facilitators

Agenda 2: Proposal for Revision of Welfare Allowance of patientS for Reconstructive Surgery (RCS) under NLEP

Proposal: Ms. Rekha Shukla, Joint Secretary, MoHFW presented the proposal for revision of welfare allowance of patients for Reconstructive Surgery (RCS) under NLEP for reducing the backlog of RCS to zero in cases of Grade 2 Disabilities. It was proposed to increase the Welfare Allowance from Rs. 8,000/- at present to Rs. 12,000/patient for undergoing major RCS irrespective of his/her financial status. The expected additional financial implication was discussed to be approximately Rs. 93,84,000/ year.JS (RS) justified that this is a welfare measure and will help decrease the morbidity and the disability.

Discussion: Secretary (HFW) agreed with the proposal saying that this measure should be treated as a welfare measure and not as wage loss issue. The support should be provided based on the State/UT requirement posed in their PIP.

Decision of the EPC: After detailed discussion, EPC recommended the proposal provided that the measure should be treated as a welfare measure and not linked to wages. It was also decided that the support will be provided from within the existing resource envelope based on proposals in PIP.

Agenda 3 : Proposal for Inclusion of Latent TB Infection Management component (beyond child contacts 0-5 years and People Living with HIV) for implementation under Revised National TB Control Programme (RNTCP)

Proposal: Mr. Vikas Sheel, Joint Secretary (RNTCP), MoHFW presented on the proposal to include the component of Latent TB Infection Management (beyond child contacts 0-5 years and People Living with HIV) for implementation under Revised National TB Control Programme (RNTCP). Total financial implication of the proposal is Rs.1748.50 crore over a period of 3 years.

Discussion: JS (RNTCP) and Dr. K S Sachdeva, DDG, CTD, MoHFW stated some findings from research studies which show that the risk of developing TB disease after TB prophylaxis treatment in contacts decreases to 90%. It was found that there is a risk of 11.1% in those

contacts who are not provided any prophylactic treatment compared to 1.2% in those who are provided prophylactic treatment. Dr Sachdeva stressed upon the need to include the high risk groups identified for prioritization of the LTBI intervention in India, in addition to the child contacts of less than 6 years of age and PLHIV, which would include:

- Contacts of TB patients-34 lakhs (estimated numbers based on 4.8 household size)
- Patients on anti-TNF treatment, transplant recipients, patients on dialysis – 2.3 lakh (40% LTBI rate of total population)
- Patients with silicosis - 30 lakhs (40% LTBI rate of total population)

Dr Abhay Bang, raised the point that there is non-availability of sufficient field trials on this in India because of which sustainability and cost-effectiveness can't be studied adequately. He also raised his concern over the potential side effects of the drugs used for prophylactic treatment such as hepatotoxicity. He also raised his concerns regarding motivating the family to take up the treatment as the contacts are asymptomatic and the lifetime risk of contacting TB in them is only 10%. Further, he added that using Tuberculin test may increase the chances of false positive cases. IGAR test may be more effective but the cost effectiveness needs to be first evaluated as IGAR test is costly.

JS (RNTCP) mentioned that in earlier treatment protocol, the treatment adherence was a challenge because of which now it is the revised (1 tablet per week for 12 weeks). Dr D. S. Gangwar, AS & FA remarked that if the treatment was so effective, why it was not adopted till now yet and also asked about the cost benefit analysis of the proposal. He mentioned that the findings mentioned by DDG, TB regarding a research study conducted by NIRT, Chennai need to be evaluated whether they are biostatistically significant as 90% reduction in chances of getting TB are claimed through prophylactic treatment in contacts. During the discussion, DDG(TB) also said that once a contact is given prophylactic treatment, studies show that protection is for about 7 years. To this Secretary, HFW raised the question that what about after 7 years? DDG, TB replied that since this prophylactic treatment is given in 6-18 years age group, after 7 years, with growing age, a person's natural immunity improves. He also said that the current rate of decline in incidence of TB is 2.5%. To eliminate TB by 2025, the required rate of decline in incidence should be 10%. For 8% increase in elimination, LTBI prophylactic treatment is required. Secretary, HFW also remarked that compared to Africa where TB- HIV co-infection is 85%, in India it is only 3%. One should also analyse that prophylactic treatment of LTBI maybe more successful in Africa compared to India because of very high co-infection rates in Africa.

Decision of the EPC: The EPC resolve to authorize Secretary (HFW) to decide on the proposal

Agenda 4 : Proposal of incentive to ASHAs for referring Post Kala-azar Dermal Leishmaniasis (PKDL) cases

Proposal: Ms. Rekha Shukla, JS, MoHFW presented the proposal on provision of incentive to ASHA workers for referring Post Kala azar Dermal Leishmaniasis (PKDL) cases and

ensuring complete treatment @ Rs. 500/- per PKDL case detected and completely treated through ASHAs (Rs. 200/- at the time of diagnosis and Rs. 300/- after treatment completion). It is aimed at strengthening the surveillance system and ensuring that all PKDL cases take 12 weeks treatment, thus, eliminating the potential reservoirs of the Kala-azar infection. The PKDL symptoms are observed in 10% of Kala-azar cases. Total financial implication of the proposal is Rs. 6.22 lakhs in the 4 States, namely, Bihar, Jharkhand, West Bengal and Uttar Pradesh.

Decision: As Kala-azar elimination (KAE) is one of the flagship programmes of Govt. of India and is slated for elimination by 2021, after detailed discussion, EPC recommended the proposal for approval of MSG. The support should be provided based on the State/UT requirement posed in their PIPs within their existing Resource Envelope.

Agenda 5: Proposal for Elimination of Lymphatic Filariasis (ELF) from India

JS (NVBDCP) presented the proposal for revision of amount under Elimination of Lymphatic Filariasis Programme of National Vector Borne Disease Control Programme (NVBDCP) under NHM, which has remained unchanged since 2004.

1. Proposal for revision of financial assistance to States for Mass Drug Administration (MDA) @ Rs. 20.78 lakh per district observing MDA for 150 districts across 14 States/UTs from the existing norms of Rs 5.40 lakhs per district.

Proposal: JS (NVBDCP) stated about the pilot districts taken for MDA for Triple drug therapy where partner, BMGF engaged district and block level monitors for 3 months to monitor MDA directly to the population during the campaign period. Historically, the problem with program to control Lymphatic Filariasis is that the field staff during the campaign period distribute the drugs rather than directly administering them to the population. Based on the learnings from pilot, it is proposed to engage supervisory staff for the campaign period to monitor MDA. The approach was revised to administer the drugs as in pulse-polio program booth wise along-with a mop-up round.

Discussion: Secretary, HFW stated that people within the system or SHGs or PRIs should be used for these purposes rather than randomly engaging people from outside the system for a short period of 3 months. Dr. Bang said that tackling LF will not only take care of LF but also scabies. He stressed upon the need for mass communication and involvement of local communities for generating awareness to increase demand generation. He suggested hiring some sort of marketing agency for mass communication and usage of social media for this. It was suggested by Secretary, HFW to involve medical students during MDA. It was also suggested that lumpsum amount should be given to medical college and outcomes should be clearly defined rather than detailing the mobility support. honorarium, POL, etc.

Decision of the EPC: After detailed discussion, EPC recommended the proposal to be placed for approval of MSG. It was decided to involve local communities and PRIs in endemic areas and change the strategy for monitoring and supervision of MDA. It was also decided to recommend to include this activity in the Gram Panchayat Development Plans (GPDP) of endemic areas henceforth.

2. Proposal for revision of amount for Post Assessment of MDA by Medical college (Govt. & Pvt.) or ICMR institution (yearly).

Proposal: To revise the amount given to the Medical colleges/research institutes/regional officials of Health & Family Welfare dept for assessment of coverage and compliance of MDA from the existing norms of Rs. 15,000/- per district to Rs. 50,000/- per district owing to inflation over the period of 15 years (2004 to 2019).

Decision of the EPC: EPC recommended the proposal to be placed for approval of MSG.

3. Proposal for revision of amount for Microfilaria survey (in 8 sites) in MDA districts.

Proposal: To revise the amount of microfilaria survey in 8 sites from the existing norms of Rs.50,000/- per district to Rs.3,28,000/- per district, considering the number of slides (minimum 4000, 500 in each site) and number of sites (total 8 sites) to be surveyed during odd time (between 8.30 PM to midnight) and also considering the inflation from year 2004 (annual average inflation @ 7.02% from year 2004 to 2019). Additionally, the proposal was also submitted for increase in the current rate of Rs. 6/- for manual preparation of slides Rs 20 per slide.

Decision of the EPC: EPC recommended the proposal to be placed for approval of MSG. This activity should be done by the existing lab technicians deployed at the health facilities.

4. Proposal for revision of amount of Additional microfilaria survey (in 10 random sites) for TAS districts.

Proposal: To revise the amount of microfilaria survey in 10 random sites from the existing norms of Rs 70,000 per district to Rs Rs.4,10,000/- per district, considering the number of slides (minimum 5000, 500 in each slide) and number of sites (total 10 sites) to be surveyed during odd time (between 8.30 PM to midnight) and also considering the inflation from year 2004 (annual average inflation @ 7.02% from year 2004 to 2019). Additionally, it was also proposed to increase the rate of Rs. 6/- for manual preparation of slides to Rs 20 per slide.

Decision of the EPC:EPC recommended the proposal to be placed for approval of MSG. This activity should be done by the existing lab technicians deployed at the health facilities.

Agenda 6(a): Proposal for Extension of Janani Shishu Suraksha Karyakram (JSSK) free referral services for 1-5 years age children for admission in Nutrition Rehabilitation Centre (NRCs) and follow up visits to NRCs after discharge and provision of diet for mothers during the stay at NRC / Paediatric inpatient facility under JSSK

Proposal:

It was briefed by Shri Vikas Sheel, JS(P) that the proposal is for extending JSSK free transport services to children aged 1-5 years for admission to NRCs and follow up visits to NRCs after discharge. He also said that presently, JSSK free transport services are available for children aged 0-1 years for NRC admission.

Discussion:

JS(P) briefed that, the transport cost per child, Rs. 500/- per child is being used as the current norm under JSSK for children upto 1 year of age. However, in hilly and difficult terrain the norm for calculation is Rs. 1000/- per child for one trip of referral and drop back. States/ UTs to provide free transport services to the child along with the caregivers and not reimburse the money to the caregivers of the child. The same norm is proposed to be followed if the SAM children aged 1-5 years avail the free transport services under JSSK (CH) for the purpose of NRC/Paediatric Care facility referral and follow up visits.

Dr Sila Deb, JC(CH), said that some States/UTs provide free transport for referral for sick children including sick SAM children from home to health facility/NRC. However, this is being done as per the availability of the transport under JSSK/free ambulance service provided by the State and the service is not ensured for sick SAM children. Moreover, presently for follow up visits, free transport service is not available for the sick SAM children discharged from the NRC which is one of the reasons for sub-optimal follow ups. Therefore budget for this purpose is being proposed to ensure SAM children are brought or referred to the facility in time and 1st and 4th follow up at NRCs take place as it is important for tracking and monitoring of these children for continuum of care.

Dr Abhay Bang supported this proposal. Regarding this proposal, Secretary (HFW) asked why cannot the existing 102 ambulance services be utilized for this activity? She further said that 102 ambulance should be made mandatory for referral services as there is one ambulance for every 53,000 population. JS (P) further communicated that 102 ambulances are not there in every state.

The estimated cost of free transport under JSSK (CH) proposed for 4 lakh 1-5 years SAM children @ Rs 1500 per child is Rs 60 Cr, provided 50% of total sick SAM children seek admission in public health facilities in a year.

Decision: It was decided to recommend to MSG to approve transport cost per child for referral and follow up visits as proposed only for such areas where 102 ambulances are not there as per existing norms.

Agenda 6(b): Proposal for free diet of mother/caregiver of admitted sick SAM child

JS(P) briefed that the proposal is for provision of free diet to the mothers/caregivers of admitted children aged 1-5 years in NRC/Paediatric inpatient facilities. Presently, there are no guidelines for providing free diet to the mother during the stay of sick child in inpatient paediatric facility/NRC. The estimated one day cost of diet for mothers under JSSK is Rs. 100/. The total estimated cost for providing diet for mothers of admitted NRC children: 4 lakhs*100 Rs.*10 days = 40 Cr.

Discussion:

The Secretary (HFW) commented that M/o Ministry of Women & Child Development should also be requested under Poshan Abhiyan. Secretary (HFW) directed to write letter from MOHFW to WCD to share budgetary cost in this regard. Regarding this agenda, the representative from M/o AYUSH communicated that AYUSH can also provide treatment at NRC. To this, Secretary (HFW) stated that M/o AYUSH should undertake a pilot project in few chronic malnutrition districts where SAM prevalence is high and work at the community level to develop protocols regarding what works.

Therefore, the total cost proposed for EPC approval is the sum total of total cost for referral transport under JSSK (Rs. 60 Cr) and the total cost for providing diet for mothers of sick SAM children admitted in NRC/pediatric IPD (Rs. 40 Cr) which is Rs 100 Cr.

Decision of the EPC: The EPC approved the proposal for recommendation to MSG for providing diet for mothers of sick SAM children admitted in NRC/pediatric IPD.

Agenda 7: Proposal for Revision of incentives for identification and follow up of SAM cases after discharge from NRC to from current norm of Rs 150/- to Rs. 300- per SAM child

Proposal:

Shri Vikas Sheel, JS(P) briefed about the proposal regarding the revision of ASHA incentives for referring the sick SAM child from home to NRC / Paediatric inpatient facility and motivating the mother to stay for required days at the NRC / Paediatric inpatient facility till child gets discharged from the existing Rs. 50 per child to Rs. 100 per child. Additionally incentive of Rs. 50/- each may be given for motivating mothers for first and fourth follow up visits at NRC/Paediatric inpatient facility instead of existing Rs. 25/- per follow up visit. In addition, Rs. 25/- for ensuring second and third follow up visits by ASHA for ensuring weight monitoring at the AWC and recording of the child's weight in the follow up card is also proposed.

JS(P) also said the ASHA will follow up for checking the well being of the child including the services of growth monitoring, feeding and linkages with AWCs for nutrition. NRC In-charge will certify the referral, stay and follow up of the child at NRC, whereas, ANM of the area will be certifying the 2nd and 3rd follow up visits of ASHA.

Thus total of Rs. 250/- per child for admission & four follow-ups is proposed. It is also proposed that the ASHA will be entitled for an additional incentive of Rs 50/- (in addition to Rs 250/- per child) if the child is declared out of SAM after the 4th follow up visits in the NRC/Pediatric facility after 120 days of discharge.

Hence, ASHA is proposed to be provided with an revised incentive of Rs 300/- (Rs. 250/- for referral and follow up + Rs. 50/- additional incentive of free SAM status) per SAM child with medical complication from existing amount of Rs. 150/ in case of those SAM children who are admitted to the NRC and during follow up period recovered from SAM status successfully.

The total budget proposed for the activity is as follows: the number of admitted children with SAM and medical complication is estimated to be 4 lakhs and based on revised incentives of Rs300. The total cost is about Rs 12 cr per annum for incentives of ASHA for referring SAM children for admission to NRCs and follow up visits of NRC discharged children as described earlier.

Discussion:

Dr Abhay Bang stated that it is a welcome strategy since SAM is main underlying factor associated with high morbidity and mortality in under-five children as per NFHS 4 data, 7.4% of under-five children are severely wasted (severe acute malnutrition), i.e. an estimated 8 million children have Severe Acute Malnutrition (SAM). A SAM child is prone to frequent infections from diarrhoea, pneumonia, measles, malaria and other infectious diseases. In view of the increased prevalence of SAM in last decade (6.4% in NFHS-3 to 7.4% in NFHS-4), the importance of facility-based management of SAM and regular follow up cannot be undermined. He also raised his concern that every scheme is proposing incentives for ASHA, it should be studied whether ASHA will be able to conduct all work allocated as work load allocated to ASHA seem to be approximately about 12 hrs and average amount of incentives received should also be evaluated.

Dr Sila Deb (JC,CH) said all four follow up were conducted for only 52% of the children admitted in NRC as per Annual Report 2018-2019. Based on the above discussions, Sec(HFW) agreed to the proposal. But said that for follow up visits, 102 ambulance services must be utilized and if 102 ambulance services are not available, then transport cost per child for referral and follow up visits can be allowed.

Secretary (HFW) raised the issue that why can't we think of having ASHA separately for RMNCH+A, and AYUSH system. She asked the AYUSH Ministry representative to think about this. She also laid emphasis to train the Multi Purpose Worker (Male) for multiple activities. She also suggested that nutritional counselors of WCD under ICDS in States can also be involved in this activity. Secretary (HFW) said in order to improve the nutritional status of SAM children, we should also seek budgeting support from Ministry of Women & Child Development.

Decision of the EPC: The proposal is recommended by EPC for enhancing ASHA incentives for referring SAM children for admission to NRCs and follow up of NRC discharged children for consideration and approval of MSG.

Agenda 8: Proposal for Inclusion of Peritoneal Dialysis under NHM Pradhan Mantri National Dialysis Programme (PM NDP)

Proposal: Economic Advisor, Shri Nilambuj Sharan briefed about the proposal on inclusion of Peritoneal Dialysis (PD) under National Dialysis Programme under NHM to the members. It was briefed that introduction of peritoneal dialysis under PMNDP will reduce the hospitalization and transport costs to the patients. It will also reduce the Capex and Opex costs required to establish, run and maintain hemodialysis units. He said under the PMDP, States/UTs would be supported to provide these services free of cost to poor and vulnerable population as in the case of hemodialysis patients.

The total expected patient load (PD therapy): 1.1 lakh, monthly bag requirement per patient will be : 90-120 bags based on that monthly per patient cost will be in range of Rs 18,000- Rs 26,400 (calculated separately for 90-120 patients; per bag price @ Rs 200- Rs 220). Considering these services will be provided free of cost to 50% of patients (poor and vulnerable), the budget requirement works out to Rs. 1250 Cr to Rs. 1852 Cr of which GoI share @60% works out to Rs.750 Cr to Rs. 1111.20 Cr. Total budget for this Rs 2500 cr- Rs3704 cr.

Discussion:

Shri N. Sharan, EA, spelt out the need for inclusion of Peritoneal Dialysis. He briefed to the members that Diabetes mellitus (DM) and hypertension (HT) are the leading causes of End Stage Renal Disease (ESRD). About 200,000 to 2,20,000 new patients develop end-stage kidney failure every year in India and the number of patients who will be put on Peritoneal dialysis in India currently are estimated to be about 100,000. He highlighted that half of patients can be put on Peritoneal Dialysis. Every day maximum 3-4 sittings of Peritoneal dialysis can be done at home by patient or his caregiver after being trained by dialysis nurses.

It was also said that peritoneal dialysis is a cost saving renal replacement modality in the long run. Secretary(HFW) enquired about the source of funds to support this activity and whether same vendor(who is providing hemodialysis can provide and manage Peritoneal Dialysis services or not.

Dr Sandhya Bhullar (Dir, NHM) explained that Peritoneal dialysis is considered as mature renal replacement treatment modality which is a home-based treatment. No service vendor like hemodialysis is required for PD, only staff nurse trained initially is required to train the patient and caregiver. It is cost-effective and safer than hemodialysis as there is no transmission of blood related infections and does not put additional incremental burden on the existing healthcare infrastructure. She further explained to all members that PD can be undertaken at home with minimal supervision and lesser disruption to normal lifestyle. Even patients, who stay far- away from centres that offer hemodialysis (HD) or in cities or towns

with no facilities of HD or in remote places, can safely undertake PD. She highlighted that in countries like Thailand, a combination of peritoneal and haemodialysis is being followed where PD was started to be supported under UHC. Because of the scale of procurement, the rates of PD came down. There is every chance that with bulk procurement, the PD fluid rates will come down and we may also get Indian manufacturer that will help bring rate further down.

To this Shri N. Sharan and Dr S. Bhullar explained the financial implication to all members that support for catheter Initial kit (including transfer set and adaptor), one time patient support for monitoring tools (BP apparatus, IV stand, weighing scale), quarterly replacement of transfer set (Three per year) and PD bag (including training support) are required.

It was explained by Shri V. Sheel, JS(P) and Dr S. Bhullar (Dir, NHM), assuming these services will be provided free of cost to 50% of patients (poor and vulnerable), this expenditure is proposed to be met by the States/UTs from within their resource envelope of NHM. This is not additional expenditure since these patients are anyways entitled to haemodialysis which is not less expensive. Secretary (HFW) also highlighted the importance of preventive screening for NCDs of the target population.

It was also discussed that with the launch of PMJAY, the financial burden for PMNDP for hemodialysis under NHM is expected to go down.

Dr A Gadphyle (Representative from DGHS,) said that it is the Nephrologist who decides whether the patient will be put on HD or PD. He mentioned that there are chances of peritonitis in peritoneal dialysis. Adequate care needs to be taken how to minimize and manage peritonitis in such patients. Moreover, PD is not related to community health but it is end stage renal disease which is mostly managed at tertiary care facility. He raised the issue that why can't we include it under PMJAY?

Dr Bang said that global patients on Peritoneal dialysis are less compared to hemodialysis and there is high mortality rate in people with end stage renal disease. The cost effectiveness of such proposal needs to be looked into though switch from HD to PD is rational and logical. He also shared the experience of District Hospital, Gadchiroli with hemodialysis patients.

JS(P) proposed to include PMNDP in NCD Pool of NHM. Any additional resources required for PMNDP over and above the allocation in NCD Pool can be provided through Health System Strengthening Pool.

Decision of the EPC:

The proposal was recommended to be placed for the approval of the MSG with the condition that the State/UT wanting to implement Peritoneal Dialysis should implement within its overall resource envelope under PMNDP. PMNDP will have two components of hemo and peritoneal dialysis.

Agenda 9: Proposal for Revision of Infrastructure strengthening cost of SHCs, PHCs and U-PHCs for transforming into Ayushman Bharat Health and Wellness Centres (AB-HWCs).

Proposal:

Joint Secretary (Policy) presented a proposal for revision of Infrastructure strengthening component of SHCs, PHCs and Urban PHCs for upgrading into AB-HWCs, which is as under:

Facility	Present financial support (In Rs.)	Revised Maximum Support for the States / UTs (In Rs.)
SHC AB-HWCs	7.00 lakhs	Up to 10.00 lakhs
Rural PHC AB-HWCs	4.00 lakhs	Up to 7.00 lakhs
Urban PHC AB-HWCs	1.00 lakhs	Up to 2.00 lakhs

Discussion:

Joint Secretary (Policy) mentioned that four regional workshops regarding sharing of practical and findings of field visits of AB-HWCs were conducted this year and it was observed that the cost of infrastructure strengthening for SHCs upgradation, PHCs and UPHCs in the scheduled is more. Dr. Abhay Bang suggested that this infrastructure should also include residential facility for field staff.

Secretary (Health & Family Welfare) approved the proposal of revising the budget for SHC AB-HWCs, rural PHC AB-HWCs and urban PHC AB-HWC situated in the scheduled areas from 7.00 lakhs to 10 lakhs, 4.00 lakhs to 7.00 lakhs and 1.00 lakh to 2 lakhs respectively. She mentioned that the Revised upper limits are agreed to be extended for public health facilities in Scheduled areas only (schedule V and VI of the constitution), with the condition that average upgradation cost of all HWCs in the state remains within the previously approved upper limits.

Decision of the EPC:

The proposal was recommended to be placed for the approval of the MSG only for scheduled areas (schedule V and VI of the constitution), with the condition that average upgradation cost of all HWCs in the state remains within the previously approved upper limits.

Agenda 10: Proposal for establish National Programme for Prevention and Control of Rabies(NPPCR) with an aim to reduce mortality due to Rabies.

Proposal:

Joint Secretary, Shri Luv Agrawal presented the proposal and explained the nature and etiology of rabies. He explained that the incidence of rabies is a public health problem and as per WHO estimate, India accounts for 36% of the Global and 65% of the human rabies deaths in South East Asia region. Further, he said that considering the above fact and

commitment of India to achieve SDG goal -3 and target 3.3 to eliminate rabies by 2030, it is important to expand NPPCR.

Discussion:

Secretary (H&FW) raised the point that the challenge in tackling rabies currently is regarding the availability of vaccine in the required quantities and animals, whose bites transmit rabies, are not being vaccinated. Therefore, we need to give more emphasis on these components for rabies control. Also, MoHFW needs to coordinate with Animal Husbandry Dept. for tackling Rabies and jointly by both the departments, policy in this regard should be prepared.

In response to Secretary (H&FW), Dr Abhay Bang remarked that in India mortality due to rabies is as high as number of deaths due to maternal mortality and these are all preventable deaths due to the availability of vaccine. Therefore, there is a need to give special emphasis to this programme.

Secretary (H&FW) also highlighted the issue related to snake bite and said that snake bite is more prevalent and we do not have requisite amount and variety of anti- snake bite venom. We also need to focus on this.

Dr N. Yuvraj, Director-NHM, further added that the Ministry of Animal Husbandry has developed an immunization schedule for street dogs. We may send a concept note to Ministry of Animal Husbandry to immunize street dogs and appropriate notification should be done by the Government that the owner of street dogs is State and responsibility regarding them lies with the State Government.

Thereafter, the first proposal of the programme - capacity building by training of Health Professionals was presented. It was highlighted that the introduction of Intradermal vaccine will reduce the volume of vaccine used by 60-80% and also is less costly as compared to the full course of PEP. To ensure the proper administration of vaccine, there is need to strengthen the skills at State level as well as district level.

It was approved that there would be one or two training per district/Year depending on size of district and there would be two review meeting per district/year.

The proposal for IEC was also proposed for State and District level Advertisement & Publicity. Secretary (H&FW) directed that there should not be any separate budget for this programme and the available budget at central level for IEC can be used for this purpose.

The proposal for operational research was also proposed in the programme. Regarding this, Secretary (H&FW) said that since State and district do not have capacity to do operational research, we may request ICMR to do operational research. This portion should be cut out from the proposal.

Proposal to establish institutional mechanism and Model Anti Rabies Clinic was proposed. It was explained by JS ,Shri Lav Aggarwal that a State level programme management unit is proposed to be established and to ensure the maintenance of vaccine at ARC level, a

provision of Staff Nurse(SN) is done. It was suggested by the Secretary (H&FW) that instead of asking any additional manpower for programme management unit, already existing available staff at State level may be given an additional charge of Nodal Officer for this. And with regards to SN at ARC, the SN will be sanctioned based on requirement posed by the State/UT.

Proposal for provision of ARV and ARS along with refrigerator was also discussed in the agenda and explained by JS that proposal for refrigerator is also in the programme so that vaccine can be kept properly. It was said by the Secretary (H&FW) that every facility has cold chain management system and refrigerator is also available in most of the facility. Therefore, provision of refrigerator was not approved.

For ARV & ARS which is already included in the National Essential Drug List, it was proposed that the procurement will be done by States/UTs, out of funds allocated under National Free Drug Initiatives or State budget.

Decision of the EPC: After detailed discussion, provision for capacity building and procurement of ARV & ARS by States/UTs out of funds allocated under National Free Drug Initiatives was approved. Proposal for IEC was approved with the conditionality that there will not be any separate budget for IEC for this programme under NHM and available budget at central level with IEC division will be used for this purpose. Proposal for human resource for State management unit was not approved and it was suggested that already existing available staff at State level may be given additional charge. With regards to Staff Nurse at ARC, sanction will be based on requirement posed by the State/UT in PIP. Proposal for operational research and refrigerator at ARC was not approved and it was suggested that for operational research, expertise of ICMR will be used and to keep vaccine, the available refrigerator in cold chain should be used.

Agenda 11: Proposal for including Programme for Including Prevention and control of Leptospirosis- State and district level components under NHM-PIP mechanism

Proposal:

Joint Secretary, Shri Luv Agarwal presented the proposed agenda and explained the significance of Programme for Prevention and control of Leptospirosis. It was explained that to address the rising burden of the disease, the Govt. of India launched a Pilot Project on Prevention and Control of Leptospirosis as a "New Initiative" under XI Five Year Plan. The Strategy adopted in the Pilot Project was found to be feasible and replicable. With the lessons learnt in the Pilot Project, the Govt. of India launched the Programme for Prevention and Control of Leptospirosis during 12th Five year plan in the endemic states/UTs (5 States & 1 UT) viz. Gujarat, Kerala, Tamil Nadu, Maharashtra, Karnataka and UT of Andaman & Nicobar Island. SFC approval for the program was obtained on 15.07.2013 with total budget outlay of Rs.3.753 Crores for the plan period.

JS(LA) explained in details the objective of the programme that is reduction in morbidity and mortality due to Leptospirosis in the humans. The strategies of the programme are as under:

1. Development of trained manpower for Leptospirosis diagnosis ,case management, prevention & control and inter-sectoral coordination
2. Strengthening surveillance of Leptospirosis in Humans.
3. Strengthen diagnostic capacity of laboratory in programme states.
4. Create awareness regarding timely detection and appropriate treatment of patients.
5. Advocacy for strengthening of patient management facilities in programme states.
6. Strengthening inter-sectoral coordination at State and district level for outbreak detection, prevention and control of leptospirosis.

He also briefed that according to National Technical Advisory Group for Programme for Prevention and Control of Leptospirosis (PPCL) in the meeting on 13th June 2019 at NCDC, Delhi recommended that Program for Leptospirosis needs to be expanded in all States & UTs which are regularly reporting the leptospirosis cases through NHM. Intensive IEC and training of health care professionals needs to be imparted in all States/UTs. Emphasis needs to be given for early diagnosis, standard case management in programme states.

He further explained that the Programme for Prevention and Control of Leptospirosis has proposed Budget of Rs. 2.39 Crores to be implemented in 8 states and 3 UTs and to be included in Communicable Diseases Pool. The various components includes training, advertisement & publicity, material & supply, surveillance & monitoring and contingency.

Decision of the EPC: After the discussion, the proposal was approved.

Agenda 12: Proposals to revise State Health System Resource Centre (SHSRC) funding pattern under National Health Mission (NHM)

Proposal:

JS (P) presented the proposal to revise the financial allocation to SHSRCs to Rs. 2.5 crore per annum for bigger states and Rs. 1 crore per annum for smaller states.

Decision of the EPC:

The proposal was recommended to be placed for the approval of the MSG provided the amount approved doesn't exceed the existing Resource Envelope of the State/UT.

Agenda-13: Proposal to revise training cost norms for LSAS and CEmONC trainings under National Health Mission

Proposal:

Joint Secretary (Policy) presented the proposed agenda and explained the importance of LSAS and CEmONC. Further, he explained that for training of LSAS and EmOC, the States are being supported under NHM. But we did not get expected result as trained LSAS and EmOC health personnel were not confident enough with the required period of training to conduct C-section. Therefore, in the proposed revised training schedule emphasis on care after birth including ENBC & Resuscitation is given in the revised training content. Hence the name of the training has been changed from Emergency Obstetric Care (EmOC) to Comprehensive Emergency Obstetric and Newborn Care (CEmONC). It is proposed to increase the period of training.

Discussion:

Secretary (H&FW) enquired that why can't online training be conducted for the interested can undergo training. It was clarified by the concerned Deputy Commissioner that since this training is skilled based, therefore it cannot be done online.

It was enquired by Dr. Abhay Bang that since medical colleges have enough number of students, do you really think that they will get chance for hands-on training. It was clarified that the curriculum is defined in such a way that the trainees have to do hands-on training in district hospital under the supervision of trained health personnel.

Decision of the EPC: Based on the above discussion, the proposal for provision for increase in duration of the training from 16 to 24 weeks for EmOC and from 18 to 24 weeks for LSAS was approved. It was also approved to support the training cost of CEmONC and LSAS within the resource envelope of the States/UTs. This should be done for six months first and then evaluated.

Agenda 14: Proposal for revision of ASHA incentives under National Malaria Control Programme are as follows:

- (i) Enhancement of incentive to ASHA workers for blood examination (through rapid diagnostic test 'RDT' or blood slide) of a fever case suspected of malaria from Rs. 15/- to Rs.30/- per patient.
- (ii) Enhancing ASHA incentive from Rs 75/- to Rs. 200/- per confirmed case of malaria for ensuring complete treatment.
- (iii) Provision of Rs 10/- per LLIN as incentive to ASHA worker for distribution of LLINs to the community including IEC/ BCC before, during, and after distribution of LLINs for proper usage, care and maintenance of LLINs by the community.

Discussion:

JS,NVBDCP, Ms Rekha Shukla, stated that India contributes to 79% of total malaria cases in South East Asia region according to World Malaria Report, 2019. At present, it affects all population groups in the country regardless of age and gender, although children and pregnant women remain at higher risk. The malaria incidence and deaths due to malaria have reduced significantly in the recent years. During the period 2000 to 2015, new cases declined by 43% and deaths declined by 59%. From 2015 to 2018, malaria cases have further declined by 63% and deaths have declined by 75%. This has been possible by widespread usage of RDTs at community (village) level by trained ASHAs.

And since Malaria is targeted for elimination (i.e. zero indigenous cases throughout the entire country) by 2030 and to maintain malaria-free status thereafter by preventing re-introduction of malaria based on National Framework for Malaria Elimination in India, 2016-2030 (NFME), it is proposed to increase incentives of ASHA workers for detection and complete treatment of malaria cases, which shall strengthen the surveillance system and to ensure that all fever cases get tested and all positive malaria cases comply with complete treatment, thus leading towards elimination of the disease as envisaged under NFME. She also said that by provision of incentive for distribution of Long Lasting Insecticidal Nets (LLINs) and generating awareness in the community shall increase the usage of LLINs, thereby help in halting the transmission of malaria infection through infected *Anopheles* mosquitoes.

Dr Rajni Ved,(ED,NHSRC) also agreed that the incentives of ASHA for blood examination (through rapid diagnostic test 'RDT' or blood slide) of a fever case and for completion of treatment have not been revised for years, and need to be revised.

The estimated amount towards the incentive to ASHA worker for malaria case detection, ensuring treatment completion, and for community mobilization & LLIN distribution works out to be Rs.173.80 Cr annually. The revised incentives would be implemented/ monitored through the existing state health machinery under State NHM.

Secretary(HFW) and all the members agreed to (1) Enhancement of incentive to ASHA workers for blood examination (through rapid diagnostic test 'RDT' or blood slide) of a fever case suspected of malaria from Rs. 15/- to Rs.30/- per patient.(2) Enhancing ASHA incentive from Rs 75/- to Rs. 200/- per confirmed case of malaria for ensuring complete treatment.(3) Provision of Rs 10/- per LLIN as incentive to ASHA worker for distribution of LLINs to the community including IEC/ BCC before, during, and after distribution of LLINs for proper usage, care and maintenance of LLINs by the community.

Decision of the EPC: The proposal was recommended by EPC to MSG for increasing the ASHA incentives as proposed above under National Malaria Control Programme except increase in the incentive for ASHA related to diagnostic kits

Agenda 15: Proposal for Approval of Community Engagement component for implementation under the Revised National TB Control Programme (RNTCP).

Proposal:

JS(RNTCP) briefed about importance of Community engagement to reach out to the unreached & provide support to patients through their illness. The proposal is for involving TB survivors in Out-reach activities and their training to combat TB. This also has a special mention in the National Strategic Plan (NSP- 2017-25) to combat TB. In this regard, the proposal on community engagement under RNTCP has been proposed..The total budget for period proposed from 2020-2023 is around Rs 308.4 crore.

Discussion

Shri Vikas Sheel, JS (RNTCP) briefed about the proposal that Community engagement is one of the key strategies to reach out to the unreached & provide support to patients through their illness in the National Strategic Plan (NSP- 2017-25) for ending TB by 2025.

He also explained that TB Survivors can play pivotal roles in bridging the gap with the community through experiential sharing, stories, stigma reduction, etc. And there are evidences showing successful programme planning, delivery of services and monitoring outcomes through community's involvement especially from the National AIDS Control Programme. During the meeting, an indicative list of community engagement was also shared. Telengana Model was due explained where community engagement has helped to reach the unreached population.

Secretary (HFW) enquired about the current status of community engagement under RNTCP. To this JS (P) said that currently TB champions are ensuring that every person tested positive for TB will get treated and complete the treatment.

Secretary (HFW) said that the proposal is not clear. There seems to be a duplication. The proposal in its current form is not properly designed. She suggested to make this activity a component of regular outreach activities. The community engagement strategies to combat TB should be designed as in NACP. She also suggested that the budget required for community engagement can be proposed in next budget of GFATM. The budget proposed is high and needs to revised.

Decision of the EPC: It was decided that the proposal needs to be reworked.

The meeting ended with vote of thanks to the chair and all the members.

List of Participants:

List of Officers who attended the 8th Meeting of Empowered Programme Committee (EPC) of NHM held on 19.12.21019 at 11:00 AM in Committee Room No. 249-A, Nirman Bhawan, New Delhi

S.No.	Name & Designation
1	Ms. Preeti Sudan, Secretary(H&FW), MoHFW
2	Dr. Dharmendra Singh Gangwar, AS&FA, MoHFW
3	Sh. Vikas Sheel, Joint Secretary (Policy), MoHFW
4	Sh. Lav Agarwal, Joint Secretary, MoHFW
5	Ms. Rekha Shukla, Joint Secretary, MoHFW
6	Ms. Preeti Pant, Joint Secretary, MoHFW
7	Sh. Nilambuj Sharan, Economic Advisor, MoHFW
8	Ms Mamta Shanker, Economic Advisor, MoDONER
9	Dr. Sumita Ghosh, Addl. Commissioner(MH), MoHFW
10	Dr. Sila Deb, Addl. Commissioner(CH), MoHFW
11	Prof. A.K. Gadpayle, Additional Director General of Health Services GOI, DGHS
12	Prof. Indira Chakraborty, Chief Advisor, PHED, GoWB, EPC Member
13	Dr. A.Raghu, Joint Advisor(Ayurveda), MoAYUSH
14	Dr. Megha Khobragade, ADG, Dte.GHS, MoHFW
15	Dr. K.S. Sachdeva, DDG(TB), MoHFW
16	Sh. N. Yuvraj, Director (NHM-I), MoHFW
17	Ms. Kavita Singh, Director (NHM-Fin)
18	Dr. Sandhya Bhullar, Director (NHM-II)
19	Dr. Abhay Bang, Director (SEARCH), EPC Member
20	Sh. Sujeet K. Singh, Director(NCDC), Dte.G.H.S.
21	Dr. Neeraj Dhingra, Director(NVBDCP), DGHS
22	Sh. Elangbam Robert Singh, Director (RCH/NHM-II)
23	Dr. Rajani Ved, Executive Director, NHSRC
24	Sh. R.P. Shukla, Deputy Secretary, Dept. of Drinking Water & Sanitation
25	Ms Deepa Anand, Deputy Secretary, Dept. of School Edu & Lit.
26	Sh. S. Nayak, Deputy Secretary, NHM-IV, MoHFW
27	Dr. Simmi Tiwari, Deputy Director, NCDC
28	Dr. Raghuram Rao, Deputy Director (TB), CTD
29	Dr. Chhavi Pant Joshi, Deputy Director, NVBDCP, Delhi
30	Dr. S.C. Agrawal, Deputy Director (NHM-II), MoHFW
31	Sh. Visalaksih Jayaraman, Under Secretary (D/o Higher Education), MoHRD
32	Sh. K. Chandra Sekhar, Under Secretary, Ministry of Tribal Affairs
33	Dr. Avdhesh Kumar, Addl. Director, NVBDCP, MoHFW
34	Dr. Nupur Roy, Addl. Director, NVBDCP, MoHFW

S.No.	Name & Designation
35	Dr. Naresh Gill, Asst. Director, NVBDCP, MoHFW
36	Dr. Ajit Shewale, Asst. Director, NCDC, Delhi
37	Sh. Avinash Kumari, Asst. Director (NHM-II), MoHFW
38	Ms. Sumitha Chalil, National Consultant, CTD
39	Ms. Sophia, National Consultant, CTD
40	Sh. Amitava Banerjee, National Consultant
41	Sh. Deepak B, CTD, Delhi
42	Sh. Jayanta Kumar Mandal, SFC, NHM-Fin., MoHFW
43	Dr. Neeta Singh, Sr. Cons-Nutrition
44	Sh. Anil Kumar Gupta, Sr. Consultant, NHM, MoHFW
45	Ms. Sudipta Basa, Sr. Consultant(NHM), MoHFW
46	Dr. Ashish Bhat, Consultant(NHM), MoHFW
47	Dr. Prashant Tiwari, Consultant, NCDC, Delhi
48	Ms. Sonali, Consultant(NHM), MoHFW
49	Mr. Rajeev Bhalla, T.A.(NHM-II), MoHFW