FTS - 80432

V-11011/1/2013-NRHM-II
Government of India
Ministry of Health and Family Welfare
National Rural Health Mission

Nirman Bhawan, New Delhi
Dated the 26th April 2013

**OFFICE MEMORANDUM**

**Subject: Minutes of the Sixteenth Empowered Programme Committee (EPC) of National Rural Health Mission (NRHM) held on 3rd April 2013.**

I am directed to enclose herewith the Minutes of the Sixteenth Empowered Programme Committee (EPC) of National Rural Health Mission (NRHM) held on 03.04.2013 for information and record.

O/C

26-4-13

(Kedar Nath Verma)
DD (NRHM-II)
Telefax: 011 – 2306 2998
Email: kedarverma27@gmail.com

1. Secretary (Planning Commission)
2. Secretary (Expenditure)
3. Secretary (Development of NE Region)
4. Secretary (AYUSH)
5. Secretary (Panchayati Raj)
6. Secretary (Women and Child Development)
7. Secretary (Drinking Water)
8. DGHS
9. Additional Secretary (Health)
10. Additional Secretary & Financial Advisor
11. Mr. A.K. Shiva Kumar, Member UNICEF
12. Dr. K. Srinath Reddy, President , Public Health Foundation of India

Copy for kind information to:

1. PPS to Secretary (H&FW)
2. PPS to AS&MD(NRHM)
3. PPS to JS(P)
4. PPS to JS(AP)
5. PPS to JS(SK)
6. PPS to JS(SG)

3/9/13.

# Minutes of the 16th Meeting of the Empowered Programme Committee of National Rural Health Mission

The Sixteenth meeting of the Empowered Programme Committee (EPC) of National Rural Health Mission (NRHM) was held on 3rd April 2013 at 3:00 pm in room no. 155-A, Nirman Bhavan, New Delhi under the Chairmanship of ShriKeshavDesiraju, Secretary(Health & Family Welfare). The list of EPC members who attended the meeting and other participants is at Annexure-1.

The agenda for the meeting was circulated in advance.The discussions held on each agenda item and decisions taken thereon are detailed below.The items were taken up as under:

1. Consideration by EPC regarding strategies/ schemes for dealing with Non-Communicable Diseases (NCDs) during the 12th Five Year Plan.
2. Proposal to streamline ASHA incentives.

## AGENDA 1

**Consideration by EPC regarding strategies/ schemes for dealing with Non-Communicable Diseases (NCDs) during the 12th Five Year Plan.**

Shri Manoj Jhalani, Joint Secretary (Policy) welcomed the members and requested Shri Anshu Prakash, Joint Secretary, MoHFW to introduce the Agenda item No.1.

Shri Anshu Prakash highlighted the morbidity and mortality due to NCDs and the need for focussed interventions to deal with the major NCDs as listed in the agenda note. It was informed that in consonance with the 12th Plan document, it is now proposed to have a separate flexible pool of funds for NCDs under NRHM to provide for preventive measures, testing, treatment and referral services upto the district level and below. Assistance or interventions for NCDs as per the existing arrangements are not excluded under NRHM. The objectives of NRHM include providing accessible, affordable and quality health care both preventive and curative. It was proposed that schemes for interventions upto the district level (and below) should be specifically financed under an NCD flexi-pool of funds.The States/UTs while formulating their interventions for NCDs upto the District level, would specifically incorporate the same in the State NRHM PIP. Tertiary health care activities would, however, be taken up separately outside the purview of NRHM. Activities and interventions for the following programmes had been accordingly proposed in the agenda items:

i. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)
ii. National Programme for Control of Blindness (NPCB)

iii. National Mental Health Programme (NMHP)
iv. National Programme for Health Care of the Elderly (NPHCE)
v. National Programme for Prevention and Control of Deafness (NPCCD)
vi. National Tobacco Control Programme (NTCP)
vii. National Oral Health Programme (NOHP)
viii. National Programme for Palliative Care (NPPC)
ix. National Programme for Prevention & Management of Burn Injuries (NPPMBI)
x. National Programme for Prevention & Control of Fluorosis (NPPCF)

It was further proposed that the States will have, within the broad parameters and guidelines outlined for each programme,scope of flexibility to address Statespecific felt needs. States/UTs could also suggestactivities and interventions for NCDs not specifically included in the current proposal and the same would be appraised in the State PIPs and a decision taken thereon.

It was informed that the EPC note had been circulated for commentsto the Department of Expenditure, Ministry of Finance, Planning Commission, Dept of Development of North-East Region (DONER), Department of AYUSH, Ministry of Women and Child Development, Ministry of Panchayati Raj, Ministry of Drinking Water, DGHS, Dr. Shiva Kumar and Dr. Srinath Reddy. The comments of the following departments were received and the same alongwith reply thereto by the Ministry of Health & Family Welfarewere circulated at the time of EPC:

- Dept. of Expenditure
- Dept. of AYUSH
- Ministry of Women and Child Development
- Dept. Of Drinking Water

The comments from Planning Commissionwere received only on the evening of 2nd April, 2013 (i.e. on the eve of the EPC meeting).

Thereafter, AS&MD, NRHM explained the proposal of bringing all NCD programmes upto District level under the NRHM umbrella and the benefits of deriving synergies among different interventions being made under NRHM. She explained that the Cabinet had approved on 26.2.2012 the continuation of NRHM for 5 years i.e. from 1.4.2012 to 31.3.2017 which also included efforts to fully integrate preventive actions in respect of NCDs. The NRHM was already supporting a number of initiatives of NCDs in different States. In addition, a number of vertical programmes were also existing.In the remaining years of 12th Plan,however, support for NCD programmes upto the district level and below will be only under the umbrella of NRHM. This will include activities for prevention, life style changes,

screening for early detection, treatment upto District Hospital level and for referral to tertiary care. The tertiary care activities will be dealt with separately and not under NRHM.

Thereafter, views were expressed and interventions were made by DGHS (Dr. Jagdish Prasad), Additional Secretary, DOE (Smt. Anjuly Chib Duggal), Director, Planning Commission (Dr A K Panda), JS ICDS (ShriShreeranjan),Dr. A.K. Shiva Kumar and Dr. K. Srinath Reddy & Chief Director, Statistics Division (Dr. Rattan Chand).

Shri Shreeranjan, Joint Secretary, ICDS conveyed that the Ministry of Women & Child Development supports the proposal. There was a need to identify the disease burden and determine the non-negotiable components. There was need to invest more in prevention and early screening at the Panchayat level which should be linked with IEC and awareness generation activities.

Shri R. P. Singh, Joint Secretary, AYUSH said that the department of AYUSH welcomed the proposal and the proposed activities should integrate with AYUSH so as to derive synergies.

Smt. Sujaya Krishnan, Joint Secretary, MoHFW said that the National Programme for the Control of Blindness has been a part of NRHM and integration at PHC and CHC level is important for all NCDs. She also informed the EPC that data on prevalence of various NCDs was already available so there was no need to conduct further research to identify the disease burden of NCDs. She stated that non-negotiable component needs to be built into the guidelines but States can choose what they want to include in their PIP as is the case with NPCB. She said that guidelines were important to ensure that a minimum standard of care is available at the districts with flexibility for States. She also briefly explained the NCD programmes being dealt by her and included in the proposal.

Similarly, Smt. Shakuntala Gamlin, Joint Secretary, briefly explained the NCD programmes being dealt by her and included in the proposal.

Dr Rattan Chand,Chief Director(Statistics), recommended that all the NCD programmes should have an integrated monitoring system.

Dr Jagdish Prasad, DGHS emphasised the importance of striving to achieve IPHS standards. He said that all programmes should be integrated together at the secondary level at the District Hospitals and PIPs should be based on the requirements of the States.

Addl. Secretary, Deptt. of Expenditure, Ministry of Finance, while supporting the proposal emphasized that with resources being limited and the States having sufficient cash balances, it is expected that the States should contribute more towards these interventions. Further, States should identify programme priorities and the programme guidelines can be more specific and detailed.

Dr. A.K. Shiva Kumar, supported the proposal and the integration of NCDs at the PHC level with other services. He suggested that some incentives for ASHAs for NCDs should also be included. He stated that while it was desirable to have a common pool for NCDs and build in flexibility, guidelines should be given to the States clearly identifying the non-negotiable and compulsory elements.

Dr. Srinath Reddy, supported the proposal. He emphasised that NCDs are a major cause of morbidity and mortality andsince they have a major impact on populationin the 35-65 year age group, this directly affects productivity. Risk factors for NCDs are prevalent across the country and action is needed across the spectrum of disease for prevention rather than focusing solely on tertiary treatment. He also stated that since NCDS also affect communicable disease and maternal health (e.g. gestational diabetes) it is wise to weave them with NRHM. He recommended that tobacco cessation centers should be community based rather than focusing on regional cancer centers and medical colleges.

Dr.A. K. Panda, Director, Planning Commission apprised the EPC of the comments of the Planning Commission. He stated that NCD control was not part of the NRHM and fresh approval of Cabinet for its inclusion would be necessary. He said that there was a mis-match in totals in-as-much as the forwarding note of the EPC agenda gave a total of Rs. 12761 crore while the detailed expenditure tables for the programmes added upto a total of Rs. 17789.25 crore which required reconciliation. Further,an analysis of the proposed programme showed 7.68% of the total proposed amount (Rs. 1365.56 crore) is projected for activities beyond the district level that relate to medical colleges and national level institutes. Since the proposed schemes include components of manpower, training, research, outreach, drugs and supplies which are also funded under other heads of NRHM, he opined that the possibility of synergizing and pooling resources for activities common to different schemes within NRHM may be explored for optimizing resources. That instead of disease specific programmes, the possibility of strengthening primary and secondary care facilities to IPHS standards in a phased manner may be considered.That the selection of nine NCDs is not evidence based as

regional/districtspecific data on incidence or prevalence of these NCDs is not available. Detailing of schematic guidelines would curtail the flexibility of States and the possibility of innovation in devising local, disease specific interventions would be obviated.He recommended an alternative approach for consideration by providing an envelope of flexipool to States within broad nationally set guidelines and to make the States accountable for clear measurable outcomes, measurement of which should form the core component of the scheme. He also stated that the NCD prevention and control requires a package of policy interventions to reduce risk to the population and effective monitoring. These elements need to be suitably included in the proposal.

In response to the observations of the Planning Commission, it was clarified by MoHFW that the amount stated for tertiary care component are not proposed for approval before EPC. Perhaps while adding up, thistertiary component amount has been included by the Planning Commission resulting in the apparent mis-match. Nevertheless, the totals will be re-checked and in any case the ceiling would be the funds provided under the envelopeapproved by the Planning Commission, which is at present Rs. 12325.71 crore. It was further clarified that tertiary care activities, even if mentioned in the proposals would not be undertaken under NRHM. However, certain activities such as IEC, advertisement, setting up of National, State Coordination Cell, and procurement of equipments/medicines may require centralised expenditure at the National/State level and would remain part of NRHM. It was further clarified that the components for the proposed schemes such as training, drugs and research would be specific for the particular NCDs and will not be duplicated under other heads of NRHM. Nevertheless, if there was any overlap/duplication of funding the same would be corrected.In-so-far as the observation of not having guidelines /specific programmes and instead providing money for strengthening primary and secondary care facilities to IPHS standards (as suggested by the Planning Commission) was concerned, it was pointed out that focused attention on the identified NCDs is necessary. It is essential to have a structured programmewith guidelines to facilitate action by the State Governments Moreover, State priorities for the NCDsshould be in synchronization with the National priorities. It was also pointed out,for example,while the type of incidence of cancer in different region may vary, interventions for cancer would be necessary in all States. Similarly, interventions for CVDs, diabetes, mental health, blindness control etc. are essential pan-India.Nevertheless, the proposal provides for sufficient flexibility to the States/UTs to address their specific felt needs. It was clarified that most of the proposals pertain to ongoing programmes. Moreover, sufficient evidence and data is available to justify the NCDs which have been included and we cannot wait for detailed studies and data collection before commencement/ continuation of programmes.

In-so-far as NCD control not being part of NRHM was concerned, the objectives of NRHM, as defined in the framework, include all diseases. Hence, both communicable and non-communicable diseaseswould be included.Further, the Cabinet approval regarding extension

of NRHM in the 12th Plan period specifically mentions that the preventive aspects of Non-Communicable Diseases will also be brought under a common umbrella to build synergy and avoid duplications. In fact, NCDs are very much supported under NRHM even at present when funds are given, for example, for strengthening District Hospital as per the IPHS and National Programme for Control of Blindness and Control of Iodine Deficiency Disorder Programme. The change now proposed is that the NCDs which were operating as separate vertical programmes in the 11th Plan are to be funded under a common NCD flexipool so that synergies can be derived, which is in alignment with the cabinet decision and approved NRHM framework. States will thus have greater flexibility in seeking assistance, and activities for these NCDs upto the district level will be taken up under NRHM instead of vertical programmes.

Secretary (H&FW) summed up the discussions. He also advised that MoHFW should seek Cabinet approval of the pending NUHM proposal so that the overarching National Health Mission, already approved by the NDC, is formalised.

The proposed agenda was approved.

## AGENDA 2

### Proposal to streamline ASHA incentives

Shri Manoj Jhalani, JS (Policy) started with a brief summary of the agenda on Streamlining ASHA incentives as the draft Note for the EPC and the agenda note on the proposal to streamline ASHA incentives had already been circulated to all the EPC members. He informed that in the last meeting of the EPC it was decided that the Ministry should bring a comprehensive proposal on ASHA incentives. He then highlighted that the proposal included three components which were;

i) revision of the rate of existing incentives provided at the national level for specified activities,

ii) introduction of fresh incentives to ASHA for identified new activities, and

iii) structure an assured but performance based payment plan on monthly basis for ASHAs while maintaining the integrity of their voluntary health activist role.

He said that ASHAs are the most visible face of NRHM and they are provided monetary and non-monetary incentives across the country. Further, their capacity needs to be strengthened to address growing health challenges wherein they could play critical role. However, there are concerns that the current incentives provided to ASHA are meager and the incentives need to be enhanced and expanded to ensure that ASHAs remain motivated. In its last meeting, the EPC had directed that While acknowledging the receipt of comments from Internal Finance Division, Department of Expenditure (DoE) and the Planning Commission, he informed that the response of the Ministry to the comments of DoE has been prepared and circulated to all members at the time of meeting, whilethe response to the comments of the Planning Commission could not be prepared and circulated as the comments were received only by late evening yesterday. However, the comments of PC are being taken on record.

As per DoE, the following proposals were not supported - the proposed new incentive of Rs. 500 for 'D – others – line listing of households', since the responsibility for maintenance of records is with ANM; the proposed new incentive of Rs. 500 for 'D – others – notified difficult areas' since ASHAs are resident in community and deployed in own village / locality. DoE also stated thatthe principle of a cost based payment needs to be continued for remuneration of ASHAs and converting it into a stipend/payment for general activities/difficult area allowance is not supported. Finally DoE wanted the availability of funds for the extra incentives may be confirmed.Ministry's response to DoE has been that, the payment toASHAs is linked to specified activities and the payment under the proposed Assured Monthly Package continues to be activity based. It was also conveyed that the proposal for stipend for difficult area for ASHA is dropped and the funds will be provided within the overall resource envelope for the states.

AS (Expenditure) in the meeting agreed that ASHAs should be adequately remunerated so there remains an incentive to work in the community. However, she said that incentive for DOTS failure cases appears to be perverse and should be re-examined.

Planning Commission representative Dr. Panda stated that the principle of centrally deciding what activities an ASHA will do and what remuneration she will be given is against the spirit of 12th Plan document of providing flexibility to states in managing their health programmes. Further he mentioned that the centrally fixed remuneration for each activity all over the country is disregard of the per capita income, employment scenario, and cost of living and is thus avoidable. Planning Commission has also stated that the states should be provided sufficient flexibility to incentivise ASHAs for activities that may be assigned to them at State level based on local disease profile, within a normatively set ceiling on administrative expenses as a proportion of program expenses. Director, Planning Commission also stated during the meeting that the ASHAs should be incentivized and the per capita income and the cost of living in the State should be taken into account to guide the rates of ASHAs incentives. He also expressed concern with the perverse incentives being introduced such as the incentive for ensuring retention of IUCD which may be contradictory to medical opinion in certain conditions.

Mr. A.K. Shivakumar endorsed in principle the proposal for giving an assured package every month with variable incentives added over it. He also said that the incentives should be adjusted against inflation and also the time and effort put in to perform the activity should be taken into account for determining the rates of these incentives. He added that instead of calling it an increase or revision, it should be stated that the incentives are only being indexed to current inflation. Further he suggested that the ministry should also take into account the time spent by an ASHA for performing the tasks assigned to her and then deliberate whether the compensation being given is adequate or not.

JS (ICDS) said that provision for a dedicated health worker with strong links with the community and the health system was necessary. He opined that increasing the incentive amount would be beneficial for motivating ASHAS to work but expressed concern that assuring a fixed amount per month may result in politicization of ASHAs.

The Department of AYUSH and Department of Drinking Water and Sanitation has concurred with the proposal.

AS (Expenditure) cautioned that having an assured monthly sum may be interpreted as an employer –employee relationship which could result in the loss of the voluntary, activist nature of the ASHA programme. Therefore, she stated that the Dept. of Expenditure was not in favour of assuring a monthly minimum amount.

JS (Policy) stated that while a list of incentives has been defined, States have the flexibility to decide which incentive to include and further, these could be prescribed for a rate lower than that specified in the list. He also pointed out that grievances received from ASHAs have reported delay in payments. Hence, provision of an assured package would keep them motivated. He also stated that the proposed incentive amount is based on time, effort and skill

required to perform the activities. These principles have been elaborated in Annexure 5 of the proposal.

AS&MD (NRHM) emphasized that ASHAs have been doing a commendable job in spreading awareness and mobilizing the community. However, it becomes difficult to appraise PIPs for ASHA incentives as States propose incentives at varying rates for a range of activities. Hence it was requested from the EPC to provide an illustrative list of incentives so that a ceiling amount can be arrived for activities routinely performed by an ASHA with flexibility retained for states to provide contextualized incentives. In response to concerns raised that line listing of households was primarily a task performed by ANMs,she said that since there is a shortage of ANMs and the average population covered by an ANM is quite large, she is unable to fulfill this responsibility and therefore, ASHAs are proposed to be entrusted with this essential activity.

Secretary (Health & Family Welfare) was of the opinion that instead of an assured monthly package being given to ASHAs, a list of the essential activities that an ASHA can easily perform may be listed.

After detailed discussion, it was decided to recommend for consideration of the MSG as follows:

1. The revised rates of incentives proposed for existing activities should be approved except for revised incentive to DOTS provider for MDT resistant cases. This should be re-examined to rule out the possibility of perverse incentive for allowing a patient to become multi drug resistant.
2. The incentives for new activities should be approved except for two incentives viz. incentive for IUCD Retention and difficult area incentive to ASHA.
3. The proposed assured but performance based payment plan on monthly basis for ASHAs should not be approved.

Letter no. 3(10)/2012-HFW, Part-II, Planning Commission, Health Division, Dated 2nd April 2013

**Subject: Agenda items for inclusion in the 16th meeting of Empowered Programme Committee (EPC) of the National Rural Health Mission**

Agenda: Proposal to streamline ASHA incentives.

**Proposal:**

The proposal is to revise upwards the existing incentive to ASHA (Annexure-3, Page-32, F/A) provides fresh incentive for newly identified activities (Annexure-I, page 28, F/B) and to structure an assured performance based payment of Rs. 1000/- per month to every ASHA (Annexure-6, Page-33, Flag-C)

**View of Planning Commission**

The principle of centrally deciding what activities an ASHA will do and of what remuneration she wil be given is against the spirit of 12th Plan document of providing sufficient flexibility to States uin managing their health programmes. Central determination of activities limits the flexibility of the States, makes ASHAs activities unrelated to local health burden and priorities. Centrally fixed remuneration for each activity all over the country in disregard of per capita income, employment scenario, cost of living is also avodiable.

For example, the proposal for incentivizing ASHAs to motivate the clients to retain IUCD and paying them on the basis of retained IUCDS at the end of first, third and sixth months is not based on any evidence to the effect that expulsion of IUCDs is a behavioural issue; the proposal may to do more harm than good, since ASHAs are not qualified to judge side effects of such devices, and it could act as a perverse intensive to ASHAs to encourage women to retain IUCDs even in the face of distressing side effects such as excessive bleeding.

In view of the above, the Planning Commission is of the view that States should be provided sufficient flexibility to incentivise ASHAs for activities that may be assigned at State level based on local disease profile, within nationally set ceiling on administrative expenses as a promotion of programme expenses. Needless to add that compliance of the States should be subject to scrutiny at the stage of Program Implementation Plan, and subject to achieving mutually set program objectives.

-Sd/-

(A K Panda)
Director, HFW Division, PC

Letter no. 3(10)/2012-H&FW, Part-III, Planning Commission, Health and Family Welfare Division, Dated 1st April 2013

**Subject: Agenda on NCDs for the 16th meeting of Empowered Programme Committee (EPC) of National Rural Health Mission (NRHM)**

Reference: M/o H&FW letter No. V.11011/1/2013-NRHM-II, dated 6th February 2013.

1. Proposal: The Agenda note is regarding the strategies/schemes for dealing with Non Communicable Diseases during the 12th Five Year Plan.

   1.1 Forwarding: The forwarding of the agenda note outlines the overview for interventions on NCDs up to the district level under the umbrella "National Health Mission". It states that tertiary health care activities are outside its scope. The total allocation proposed is for Rs. 12761 crore.

   1.2 Detailed Programs: Nine Non Communicable Disease control programmes have been detailed under the agenda note, namely on cancer, cardiovascular diseases, Diabetes and Stroke, Blindness, Mental Health, Health Care for Elderly, Deafness, Tobacco Control, Oral health and Palliative Care, and Burns. The total allocation adds upto Rs. 17789.25 crore.

2. Comments of the Planning Commission:

   1. Forum for Decision: Nine programs for prevention and control of NCDs which have been functioning outside the ambit of NRHM in the 11th Plan are now proposed to be included in NRHM. The 12th Plan chapter on health includes prevention and control of NCDs as a priority area under the National Health Mission, NHM(para 20.129). Had the National Health Mission as envisaged in the Plan document been piloted and approved, the instant proposal could have been considered by its Empowered Program Committee. However, as of now, the mandate of EPC of NRHM is limited to deciding on components which have been a part of NRHM at the time of extension as proposed in Cabinet Note dated 27th March, 2012. Since, NCD control was not a part of the NRHM then, fresh approval of Cabinet to its inclusion would be necessary.

   2. Other observations on the Agenda note are as follows:

      2.1 Mismatch in totals: The forwarding of the EPC Agenda note has indicated a total of Rs. 12761 crore while the detailed expenditure tables for the 9 programme add upto a total of Rs. 17789.25 crore. This needs reconciliation.

      2.2 Even though the strategy proposed at page 3 of the Agenda note states that tertiary care activities will not be funded, yet an analysis of detailed schemes shows a total of 7.68% of the total proposed amount (i.e. Rs. 1365.56 crore) is projected for activities beyond the district level that relate to Medical Colleges & National level institutes.

2.3 The proposed schemes include components for manpower and training, research, outreach, drugs & supply and health promotion (IEC), which are also funded under other heads of NRHM. A total of 26.96% of the total (i.e. Rs. 4531.15 crore) is proposed to be spent on these activities. The possibility of synergizing and pooling resources for activities common to different schemes within NRHM may be explored for optimizing resources.

2.4 Under the 9 proposed schemes, standalone infrastructure addressing individual diseases is proposed to be created at primary and secondary levels even as IPHS standards issued by the MOHFW, which are the reference points for public health care infrastructure planning and upgradation, do include standards for management of NCDs. The advantage of investing in upgrading facilities to IPHS standards over individual disease control programs is that it avoids duplication, builds flexibility to meet diverse needs based on local disease profile and also aids in effective monitoring. This is in line with letter and spirit of 12th Plan. Hence, instead, of disease specific programs, the possibility of strengthening primary and secondary care facilities to IPHS standards in a phased manner may be considered.

2.5 Flexible Components:Schematic guidelines appended to the Agenda note specify even minor details, proposals under which would once again be subject to scrutiny of MOHFW at the PIP stage. The selection of these nice NCDs is also not evidence based, as regional / district specific data on incidence or prevalence of these NCDs is not available. Such detailing would curtail the flexibility of States and the possibility of innovation in devising local, disease specific interventions based on locally available infrastructure. An alternative approach for consideration is to provide an envelope of flexipool to States within broad, nationally set guidelines and to make the States accountable for clear, measurement of which should form the core component of the scheme. The guidelines could specify that a minimum proportion of pool funds would be spent on national priorities set in the Plan.

2.6 NCD prevention and control requires a package of policy interventions to reduce risk to the population, and effective monitoring. These elements need to be suitably included in the proposal.

-Sd/-

(A K Panda)
Director, HFW Division, PC

Annexure-1

List of Officers who attended the 16th Meeting of Empowered Programme Committee (EPC) of National Rural Health Mission (NRHM) held on 03.04.2013

| Sl. No. | Name & Designation |
|---|---|
| 1. | Sh. Keshav Desiraju, Secretary (H&FW), MoHFW |
| 2. | Dr. Jagdish Prasad, DGHS, MoHFW |
| 3. | Smt. Anjuly Chib Duggal, Addl Secretary(Exp.), M/o Finance |
| 4. | Sh. S. K. Srivastava, AS & FA, MoHFW |
| 5. | Ms. Anuradha Gupta, AS & MD(NRHM), MoHFW |
| 6. | Sh. A. K. Shiva Kumar, Member, National Advisory Council |
| 7. | Sh. K. Srinath Reddy, Member, President, PHFI |
| 8. | Sh. Manoj Jhalani, Joint Secretary, MoHFW |
| 9. | Sh. N. B. Dhal, Joint Secretary, MoHFW |
| 10. | Sh. Anshu Prakash, Joint Secretary, MoHFW |
| 11. | Ms. Sujaya Krishnan, Joint Secretary, MoHFW |
| 12. | Sh. R. P. Singh, Joint Secretary, AYUSH |
| 13. | Sh. Shreeranjan, Joint Secretary, ICDS Shastri Bhawan |
| 14. | Dr. Rattan Chand, CD (Stats), MoHFW |
| 15. | Dr. N. K. Dhamija, Deputy Commissioner, Training, MoHFW |
| 16. | Dr. S. K. Sikdar, Deputy Commissioner, Family Planning, MoHFW |
| 17. | Dr. Sila Deb, Deputy Commissioner, Child Health, MoHFW |
| 18. | Dr. P. K. Prabhakar, Deputy Commissioner, Child Health, MoHFW |
| 19. | Dr. Suresh K. Mohammed, Director, RCH, MoHFW |
| 20. | Dr. A. C. Verma, Director, NRHM, MoHFW |
| 21. | Sh. Ashok Parmar, Director (Admin, IEC, NMHP), MoHFW |
| 22. | Sh. Amal Pusp, Director, MoHFW |
| 23. | Sh. Sanjeev Chadha, Director, MoHFW |
| 24. | Sh. Deep Shekhar, Director, MoHFW |
| 25. | Ms. Kavita Singh, Director, Finance, MoHFW |
| 26. | Ms. Preeti Pant, Director, NRHM-III, MoHFW |
| 27. | Ms. Limatula Yaden, Director, NRHM-IV, MoHFW |
| 28. | Sh. A. K. Panda, Director, Planning Commission, Yojana Bhawan |
| 29. | Dr. A. C. Dhariwal, Director, NVBDCP, MoHFW |
| 30. | Er. S. C. Sharma, Dy. Advisor, M/o Drinking Water & Sanitation |
| 31. | Dr. G. S. Sonal, Addl. Director, NVBDCP, MoHFW |
| 32. | Dr. N. S. Dharmshakti, DDG (NSD), MoHFW |
| 33. | Dr. W. D. Bhutia, Addl. DDG, NCD, MoHFW |
| 34. | Dr. S. Kulshrestha, Addl. DDG, DGHS., MoHFW |
| 35. | Dr. K. S. Sachdeva, Addl. DDG, DGHS, MoHFW |
| 36. | Dr. Sudhir Gupta, Addl. DDG, DGHS, MoHFW |
| 37. | Dr. D. C. Jain, DDG (NCD), DGHS, MoHFW |
| 38. | Dr. D. M. Thorat, ADG, DGHS, MoHFW |
| 39. | Dr. L. Swastricharan, CMO (NTCP), DGHS, MoHFW |
| 40. | Dr. T. S. Sidhu, PGIMER, Dr. R.M.L. Hospital |
| 41. | Dr. Anoop Kumar Puri, ADG, Leprosy, MoHFW |
| 42. | Mrs. Valsamma Daniel, Deputy Secretary, MoHFW |
| 43. | Dr Sonali Rawal, Consultant (NRHM), MoHFW |
| 44. | Dr Arpana Kullu, Consultant (NRHM), MoHFW |
| 45. | Dr Faisal Sheikh, Consultant (NRHM), MoHFW |
| 46. | Dr Nikhil Utture, Consultant (NRHM), MoHFW |