ANNUAL REPORT
OF
CEHAT

2013-2014

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Period: 2013-14

I. RESEARCH

Research on implementation of targeted health insurance the Rashtriya Swasthya Bima Yojana (RSBY) in achieving universal health care for women and the marginalized

CEHAT proposes an indepth evaluative study on insurance schemes targeting the poor and economical weaker sections with the aim to understand the operations and bring in beneficiaries' perspectives which will be critical for policy making. The RSBY is a national health insurance scheme being implemented across India for BPL families. Under this scheme, households can avail of free treatment upto INR 30000. This project will involve evaluation of RSBY in Maharashtra (covering all 31 districts where the scheme is in operation) where private sector participation is the highest. In order to achieve univeral access, the government has been leaning towards insurance based solutions. As part of these developments, a new crop of state funded insurance schemes for the poor have emerged which have been started by the central as well as state governments. The new schemes tie up with insurance companies in order to tap into the existing private sector health care delivery system. There are states where more than one such scheme run parallel and Maharashtra is one of them where two more similar schemes for the BPL are being implemented along with RSBY. In all such schemes the government becomes a purchaser of care, largely from the private health sector without regulating it for its quality of care. A study of 261 private hospitals in Maharashtra found poor compliance to even basic standards like qualified personnel, maintenance of records, information to patients and so on. Inclusion of such facilities under a public health insurance scheme is cause of concern.

The study proposes to conduct field visits and interviews with implementers and policymakers to understand the operationalisation of these guidelines at the state and district levels. Complementing this exercise, data regarding enrolment, utilization, empanelment of hospitals, de-empanelment, nature and distribution of reimbursement across procedures and location etc. will be acquired from RSBY authorities and analysed. The trends emerging from different districts will be compared for insights into the working of the scheme, and possible suggestions for its improvement. A survey of randomly selected beneficiaries will be conducted; at least 30 per district from one district each per region. This will give us the demand side perspective and knowledge into utilization and OOPs (out of pocket expenses) dynamics. The understanding emerging from this will provide insights for redesigning such PPPs keeping the beneficiary at the centre.

A study which aims to study the implementation of two publicly financed health insurance schemes in Maharashtra is planned. The two schemes being studied are the RSBY and the RJGAY (Rajiv Gandhi Jeevandayee Arogya Yojana). The study will enquire into healthcare availability in the district and its geographical distribution, type of procedures performed at public and private hospitals, utilization pattern and experiences of the beneficiaries.

Health Status of Youth in Urban India

Every fifth person in India is a youth, and one-third of this population live in urban areas making it key demographic cohort. This study tries to provide an overview of the health of the urban youth in India and looking at key health issues related to the rapidly changing profile of the urban youth. It attempts to

overview health by focusing on certain key emerging areas. The study was part of the larger study State of the Urban Youth India by the IRIS Knowledge Foundation and UN-HABITAT which is a first attempt to pull together data and knowledge base on and of youth in urban India.

Key Findings:

- While today's urban youth are healthier and better educated than earlier generations, but young people still face significant risks related to health and many lack the knowledge and power to make informed positive health choices.
- Policies and programmes for the youth misjudge them as a monolith without and hence understanding the diversity within youth through research can enable policy-makers meet their health requirements.
- There is a need to engage young people in the process both directly and through social media making the health programmes more relevant and allowing them to identify the health concerns and also working towards finding solutions to them.
- The major thrust on sexual health with the prism of population control and prevention of infections has to change with a more pragmatic approach of promoting safe choices with informed decision-making and creating an environment of open non discussion.
- Reproductive health should involve the entire process from conception to post-natal care keeping in mind social contexts, gender-bias, power-imbalances, limited knowledge of risks, lack of access to health-care facilities, shortage of trained persons and poor nutrition intake to come up with context-specific programmes.
- Mental health is still to receive adequate attention even with high numbers of youth reporting symptoms of mental health disorders and the extremely high-levels of stress and depression.
- Substance-abuse is another area that is a concern within youth health which requires early education and sensitization with measures for rehabilitation in order to reduce the incidence of addiction.
- Enforcing laws to prevent accidental and occupational deaths and the health consequences of violence both in and outside the home also needs to be looked into while addressing the over-all good health of the youth.

Building Evidence From Intervention Research On Violence Against Women

The service records of the crisis intervention centres were analysed and the following papers were written.

a. The paper on violence during pregnancy was completed and has been accepted for the national conference on Maternal and neonatal health to be held on 24-25 April 2014 at Hyderabad. A strong case for routine screening in ANC settings has been made based on the evidence. 10% women registered at Dilaasa when they were pregnancy and a large number reported that they had faced violence during pregnancy. The paper is attached. As part of the entire analysis that was undertaken, an additional paper focusing on methodological issues in carrying out prevalence studies has emerged and we hope to take it forward. Based on the feedback received at the conference, the paper will be revised for submission to IJPH or NMJI.

b. Paper on risk factors for attempt to suicide among survivors of DV: The Literature review, draft of the review, data analysis using Odds ratio has been completed. A draft paper is ready. The analysis shows interesting results and provides insight into vulnerability to suicidal ideation/attempt amongst survivors of domestic violence. Lack of natal family support,

emotional abuse, years of abuse, age, marital status are some of the factors that may predispose women to suicidal attempts.

c. Paper on evidence on interventions in sexual violence: a paper based on the evidence emerging from the interventions on sexual violence was sent for peer review, finalised for the EPW.

d. Paper on Mandatory reporting: One of the issues that the work with the Ministry of Health threw up was related to the issue of mandatory reporting in all cases of sexual violence. An extensive review of literature on the subject was carried out. A paper raising issues related to consequences of mandatory reporting, how it impinges on right to health care and the changes made in other countries has been written up.

e. Legal outcomes in cases of sexual violence: The scope for this analysis was to study the legal outcomes in 100 cases where we have intervened. A framework for analysis was developed in consultation with Indira Jaising, she also wrote a letter to the Chief Justice of Maharashtra but all cases are still not available. Based on the 16 judgements that we could procure, an analysis has been completed that provides insights into factors leading to convictions or acquittal. The response of the courts to medical evidence will also be analysed in each case.

Policy research on maternal health:

While the national level policy review completed in the year 2012-13 pointed out significant gaps, what is evidence is that several policies and programs related to maternal health are implemented at the state level. In this year we looked at the specific intervention states and districts with the objective of identifying these policies, gaps therein and their implementation on the ground. The two states selected were Bihar and Odisha. Specific state policies and programs related to maternal health were identified and analysed. PIPs of the selected intervention districts were analysed with a focus on identifying gaps specifically related to referral services, emergency obstetric care, availability of medicines etc. Data from interventions being conducted by partners in the respective states was also looked at. Policy papers and policy briefs for the two states were be prepared.

The team visited Oxfam partners in Bihar (in the month of September) and Odisha (in the month of July), and held meetings with them to present the findings emerging from the secondary data and seek their inputs on the same. For the state of Odisha, the key findings emerging were that the rate of institutional deliveries is very high, but the quality is questionable given the poor condition of health facilities in the State. It was observed that the percentage of institutional deliveries is quite high as per the AHS data and according to the partners, this may be an issue of validity of the data. It was suggested that the data being collected through the GPAF project be compared to the AHS data for the intervention districts in order to assess this. Secondly, while the numbers for institutional delivery in the state are extremely high, the quality of said deliveries is questionable given the poor quality of facilities that is apparent from the secondary data review. It was suggested that in addition to the secondary data, data on delivery related and post-natal complications be looked at in the MIS in order to substantiate this point. The other key issue emerging was that of dearth of abortion facilities. The secondary data showed that a very small proportion of abortions are actually being performed by skilled health personnel which is a cause of concern. This would be an important issue to include in the policy brief. Other issues that were discussed for inclusion in the policy brief include the relaxation of the two child norm in maternal health policies in Odisha, and increase in budget allocation to maternal health care in the state. The perceptions of community regarding maternal health services would need to be

brought into the policy brief – the data for this is being collected through the community based monitoring process.

For the state of Bihar, the key issue emerging was that of the high number of home deliveries in the state. The partners reported that while the numbers of institutional delivery in the AHS were low, in reality the numbers were actually much lower based on their experience. The fact that there is no effort being made to address home deliveries was highlighted by the partners and it was suggested that introduction of skilled traditional birth attendants must be included as a recommendation in the policy brief. Further, the poor quality of public health facilities and the great out of pocket expenditure borne by patients due to the privatization of diagnostics facilities was also pointed out as a problem that needs to be addressed. The focus on sterilization and poor quality of care therein was another issue that was discussed at length and recommended for inclusion in the policy brief. The partners in Bihar have been greatly involved with state level advocacy including preparation of a blue print for roll out of the Manav Vikas Mission in Bihar and it was suggested that the recommendations also make reference to this new mission.

Integrating Gender In Medical Education Project

A tool for conducting situational analysis of participating colleges is being prepared. The purpose of this exercise is to get an idea of functioning of the college and hospital and concerns being raised by participants in order to better address them before the next phase of training. This tool is in the form of a questionnaire for conducting semi-structured interviews with faculty-members who have participated in the first ToT as well as other faculty members in each of the departments.

II. ADVOCACY

Charitable Trust Hospitals Study

The findings of the report have been submitted to the Maharashtra State Health Minister Suresh Shetty and the Charity Commissioner so that there can be policy-level changes so that Charitable Hospitals comply with their mandated obligations. The findings have been presented to SATHI and the Jan Arogya Abhiyan in Maharashtra is planning to file a PIL in Bombay High Court to legally ensure the conformity of hospitals in fulfilling their duties and monitoring them regularly. CEHAT has also highlighted the findings of the study in the NUHM (National Urban Health Mission) consultations held in December 2012 by the Union Health Ministry, as well as the Mumbai Development Planning 2014-2034 Consultations with the Municipal Corporation of Greater Mumbai.

Right To Health Care For Survivors Of Sexual Violence-PIL

Inspite of voicing repeated concerns about gender insensitivity and unscientific proformas and manual pertaining to sexual assault examinations and lack of mention related to health care of survivors the GOM , health department refused to make the required changes. Depsite changes in the rape law, the manual and protocol of the GoM were not in consonance with the changed laws. Besides, the Petitioners were constantly pushing for its implementation and argued that it could be revise on the basis of feedback from health professionals related to its usage . The health department also told the High court in April 2013 that they had issued a directive that a training would be undertaken on this issue across Maharashtra. At this juncture the court allowed them to conduct the training but also asked them to look into issue raised by CEHAT.

In the month of May 2012, CEHAT was invited to be a faculty member alongside others for a 5 day workshop on medico legal aspects and role of health professionals. CEHAT seized this opportunity and shared the training modules and contents related to the training and also conducted trainings at JJ hospital, Mumbai and Sasoon hospital Pune. In the training itself, CEHAT busted several myths related to sexual assault. While we conducted the training, GOM issued a GR stating that the proformas and manual by them has been approved by the courts and it will be shortly issued across the state. This was completely erroneous as the court had only allowed them to conduct a workshop, but the protocols were still under court consideration. CEHAT wrote to several experts from the discipline of medicine, forensic science, ethicist, GOM itself and list serves raising questions about such an implementation and providing wrong information to media .These issues were also covered by Indian express,Pune raising questions about whether the protocols were truly gender sensitive. In order to stop such an implementation, CEHAT filed another affidavit in the court in July 2013 drawing the attention of the court to this conduct of the GoM. Letters to this effect have also been sent to the health secretary, chief secretary, to stop implementation of the protocols.

Around the same time CEHAT has been involved in advocacy related to comprehenisve health care response and this work was picked by BLAST (Bangladesh legal aid and service centre) They were also instrumental in opposing the 2 finger test which is prevalent in their country and also wanted additional evidence and advice from CEHAT vis a vis comprehensive and gender sensitive protocols. The evidence from the 6 year practice, review of their protocols as well as their affidavits was undertaken. They have been able to get a positive court order banning unscientific parameters for medical examination in their

country. Though CEHAT has pursued the PIL and engaged with the state health department of Maharashtra for a period of 3.5 years, the GOM has not been able to necessitate the required changed. CEHAT filed another affidavit in Oct 2013 citing that such guidelines are being formulated at the central ministry and that once these are issued, state of Maharashtra should also follow the same. However in Jan 2014, the court ruled in favour of the GoM and the matter is now referred to Supreme Court.

National Committee for Developing Guidelines for responding to sexual violence:

The Ministry of health and family (MOHFW) set up a committee under the Union Health Secretary for the formulation of Guidelines and protocol for responding to sexual violence. The Coordinator, Padma Deosthali was one of the members of the committee. This provided an opportunity for CEHAT to push for central ministry guidelines to be implemented by the rest of the states.

Upscaling of the Dilaasa model:

Several senior policy makers such as Dr Syeda Hameed, Chairperson Planning Commission, Smt Ratna Prabha, Secretary, WCD, Dr Shomita Biswas, member Maharashtra State Womens Commission Smt Rashmi Singh, Executive Director National Mission for Empowerment of Women visted Dilaasa and strongly recommended its upscaling in India. The Union Health Secretary, Shri Keshav Desiraju visited Dilaasa on 15 Jan 2014. He met the counsellors and trained health providers. He strongly recommended that this model be upscaled in other hospitals of the BMC and made other strong recommendations for integrating Gender based violence as a health issue within education and health programmes. Shri Keshav Desiraju appreciated the efforts of Dr Seema Malik and other hospital staff in setting up and sustaining the Dilaasa model and made the following recommendations:

1. Dilaasa offers a model that has worked over the years and should be upscaled under the NUHM in all mega cities and other urban hospitals.
2. Such centres must be set up in other hospitals of the BMC. Social workers in these hospitals should be trained to provide services.
3. The community health workers under the NUHM should be trained to educate communities about gender based violence and refer women to the crisis centres.
4. Recognising the key role that nurses can play in responding to GBV, he said that training on GBV must be included in the ANM and GNM teaching courses as nurses are key in identifying violence and providing basic care and support.
5. The national protocols and guidelines for responding to sexual violence that have been formulated by the MoHFW should be implemented in all hospitals in Maharashtra and other such centres set up under NUHM.

CEHAT's work on gender sensitive protocols featured in the popular show Satyamevjayate(SMJ) on Star Plus:

The first episode on 2 March 2014 was on Fighting rape and was aimed at presenting the status of systemic changes in sectors such as police, health and judiciary since the mass agitation following assault of Nirbhaya and her subsequent death. CEHAT's initiative on ensuring comprehensive health care to sexual assault survivors was telecast in one of the segments. The segment focused on presenting:

- Reasons for gender biased response of health professionals to sexual assault
- Efforts made to change the practice at the level of health system
- Effects of having a comprehensive response from health sector to sexual assault .

The Justice Verma Commission(JVC) report makes strong recommendations for changing the forensic protocol as well as provision of health care and draws from the submission made by CEHAT. This is also reflected in the CLA 2013 which recognizes right to health care for all survivors of sexual violence by making it mandatory for all public and private hospitals to provide free treatment.

Several efforts were being made to ensure that the health sector protocols change. MoFHW has responded positively and under the leadership of the Health Secretary, Shri Keshav Desiraju finalized such guidelines. This protocol will now guide on how health professionals must respond to survivors from different marginalized communities such as persons with disabilities, LGBTQ, person discriminated based on caste, class and religion, sexual orientation amongst others. We are hopeful that these guidelines would be issued soon. SMJ made a call for "gender sensitive protocols to be implemented across the country".

Policy Advocacy Including Interministerial Work On Violence Against Women (VAW) And Health

CEHAT's focus has been on improving the health sector response to VAW, though the intervention require interface with other systems such as social welfare, police and judiciary. The MoHFW set up a committee for developing national protocol and guidelines for health sector to respond to sexual violence in April 2013. This is the first time in India, that national guidelines for health sector have been issued. The purpose of the project is to prepare policy guidelines for the police, public prosecutors and judiciary for interfacing with the health sector on sexual violence and to prepare guidelines for health sector to reposed to VAW.

III. TRANINGS & EDUCATION

State level training of doctors in charge of Bhoomika centres and counsellors:

A two day training was conducted for 25 counselors and 30 health care providers of the Bhoomika, Gender Based Violence Management Centre, Kerala which focused on understanding concepts of gender, understanding psycho social support and counseling, health consequences of the violence, the role of the health care providers in providing the services and being an expert witness in court. These were conducted by Dr Jagdeesh Reddy, U Vindhya, Padma Deosthali, Sangeeta Rege and Prachi Awalaskar.

Developing a Health Sector Response to Violence Against Women - Train the trainer

CEHAT organised a 3-day follow up workshop for developing a health sector response to violence against women. Training was based out of Mumbai. The first phase of 3 day training held in October helped participants understand the legal and ethical obligations of healthcare professionals while responding to Violence Against Women, components of psychological first aid and actual practice sessions to operationalize such a holistic response. The second phase of this 3 day workshop is aimed at enabling health professionals to understand the concept of a one stop crisis centre and its relevance in a hospital setting. We aim to also present specific protocols for responding to domestic violence and sexual assault and develop ways in which these protocols can be implemented at the level of the health system. Further one day would be dedicated to a visit to Bombay based Dilaasa, a hospital based crisis centre to interact with health professionals and to learn from their experience of setting up such services in the given infrastructure of the health setting. The Dilaasa model has been externally evaluated and has shown promising results for upscaling. Efforts have been underway in different states such as Karantaka, Kerala, Gujarat and the like and this training would build on the existing efforts being carried out in different states.

Training on Sexual Violence

In January 2014, training was held for the team members along with other partner organisations by Direct Action for Women Worldwide, a Boston based organisation that works on the issue of gender violence. Training was conducted by Sujata Warrier, the Director of the New York City Program of the New York State Office for the Prevention of Domestic Violence and Meg Bossong, the Community Mobilization Project Manager at the Boston Area Rape Crisis Center (BARCC). The first three days of the training focused on training the skills of the counsellors and the next 2 days were spent honing the skills of the participants to become trainers.

15 doctors and 5 nurses were trained in 2 trainings in the 3 hospitals. An additional 50 doctors were trained from Bharat Ratna Dr. Babasaheb Ambedkar Municipal General Hospital, Kandivali that asked for the training. Following this, training in how to procure materials and assemble a SAFE kit was held for the nurses at the above hospital. This training was also attended by nurses V N Desai Hospital, Santacruz East.

Conferences and education

Along with regular interventions with the survivor, the team also participated and contributed to the collaborative consultation between the police and organizations working on the issue of Violence Against Women organized by SNEHA, Mumbai. This consultation helped bridge the gap between the police and the organizations. The police were informed that in many of the cases, survivors had difficulty in filing a case. Not filing of the FIR can be punished with a year imprisonment and hence, FIRs should be filed immediately. Police were also told that medical examination can happen in any hospital and hence taking the survivor to the police hospital is unnecessary and should not be done. We also spoke about the time lapse between the hospital informing the police to collect the sample and them sending it to the FSL. Such time lapse can affect the results of the test. Issues of sensitivity, privacy were also discussed with the police. The consultation provided a unique platform for discussion with the police and creating more awareness about their duties towards survivors of violence.

Similarly, the team was also present during the staging of the Nirbhaya play at National Center for the Performing Arts (NCPA), Mumbai. The importance of screening for abuse in case of health complaints was discussion with the patrons along with the need for counselling and emotional support for survivors of violence. The Stree Mukti Sangathana organized a talk for their community workers and women from the community about the health consequences of violence and their health rights. The talk cleared a lot of doubts women had about the role of the health care providers and services they can provide.

Integrating Gender In Medical Education: First Training Of Trainers Workshop

The first training of trainers workshop of the Integrating Gender in Medical Education project was conducted from 8th to 12th February, 2014 at YMCA, Mumbai Central. This project is in collaboration with CEHAT, United Nations Population Fund, Directorate of Medical Education and Research (Govt. of Maharashtra) and Maharashtra University of Health Sciences. This first workshop, which is part of a 10-days training course for medical educators, included a total of 27 participants from six government medical colleges from Maharashtra (Nagpur, Aurangabad, Miraj, Dhule, Ambejogai and Kolhapur) and one private medical college (Mahatma Gandhi Memorial Medical College, Navi Mumbai). The participants were deputed by their respective colleges from different departments, namely, Obstetrics and Gynaecology, Medicine, Psychiatry, Forensic Medicine, Preventive and Social Medicine, Surgery and Pathology.

The workshop was inaugurated by Dr. Pravin Shingare, Director, Directorate of Medical Education and Research, Govt. of Maharashtra. He emphasized on the importance of such training so as to incorporate a gender perspective in medical teaching. The output of this three-year project would be put forth to the MUHS for integration in the medical curriculum of Maharashtra.

The project website www.gme-cehat.org developed in coordination with eSocialSciences was launched during the inaugural session. This website is envisaged as a resource repository for the project as well as an interactive space for its participants. This training was conducted by Dr. Sundari Ravindran (Achutha Menon Centre for Health Science Studies, Trivandrum), Renu Khanna (SAHAJ, Baroda), Dr. Suchitra Dalvie (Asia Safe Abortion Partnership), Padma Deosthali (CEHAT), Dr. Ramesh Awasthi (Mahila Sarvangin Utkarsha Mandal, Pune), Dr. Jagadeesh Reddy (Vaidehi Institute of Medical Sciences,

Bangalore) and Dr. Amar Jesani (Editor, Indian Journal of Medical Ethics). This project builds upon the experience of the Gender Mainstreaming in Medical Education project of the Achutha Menon Centre for Health Science Studies, held in 2003, of which Dr. Sundari Ravindran was the course coordinator.

The five-day training included an introduction to concepts of sex and gender, the social construction of gender, patriarchy and intersectionality, gender as a social determinant of health, gender analysis in health, sexuality and sexual and reproductive health and rights including abortion as a gender and rights issue, ethics and rights in medicine, and masculinities. There was also a session on responding to gender reviews of medical textbooks and a session on participants' presentation of key learnings for mainstreaming gender in undergraduate medical teaching.

This training is to be followed by the second phase of five days which is to focus on the participants' role as medical educators to develop strategies for incorporating the conceptual learnings into medical teaching. The trained participants are then expected to carry out college-level activities as well as regional workshops for medical teachers so as to build a human resource base of trained, gender sensitive medical educators and professionals in the state.

IV. INTERVENTION AND SERVICE PROVISION

Crisis Intervention Services For Survivors Of Sexual Violence

During the period April 2013 to March 2014, crisis intervention was carried out in 172 cases of sexual violence reported to the three hospitals. These cases have been followed up for various reasons including emotional support, legal counselling and for any health complaint that needed further assistance. Legal counsel included giving information about court procedures, preparation of the client to face court proceedings. Legal intervention was carried out with doctors to prepare them to provide evidence to the court. Interventions of such kind helped doctors revisit the case a year or more after the survivor had been examined, understand the documentation and give a comprehensive, rational opinion to the court. Three cases are being regularly followed up with visits to the court with the survivor. The mere presence of the interventionist at the court inspires confidence in the survivor even though the evidence is taken in camera. Apart from this, there was a follow up done at the level of police stations to check the status of cases in court where the woman hadn't followed up. This follow up was done to provide legal support to women if any was required.

In order to provide information of procedures and laws pertaining to sexual assault, a note was created to assist support groups of survivors in quest for justice. This note contained information of the responsibilities of the hospital, the police and the judicial system. The points covered were that the hospital is liable to provide treatment including psychosocial first aid to the survivor of sexual assault free of cost, no doing so is punishable under the law. Also the note informed that medical examination can be carried out by any registered medical practitioner and that the woman can approach any hospital for examination and treatment without the police. In terms of the responsibility of the police, concepts such as FIR, panchnama, chargesheet, police and judicial remand and bail were explained along with the rights of the survivor during police investigation. The document also explained the judicial processes and the time taken for the same. It looked at how examination in chief and cross examination takes place, it spoke of the things that aren't allowed in court and the special courts for children under POCSO. Finally, the note also discussed the right of compensation under the Umbrella Scheme.

DILAASA

There were 229 new cases registered at KB Bhabha, Bandra from April 2013 to March 2013 while at KB Bhabha, Kurla, the number of new cases registered was around 50. There were 368 follow-up interventions carried out at KB Bhabha Bandra and 27 at KB Bhabha, Kurla.

On 8th of March, International Women's Day was celebrated by organizing skits and a poster competition. This was done with a view to increase awareness and sensitivity of the women employees of the hospitals, to help them recognize and appreciate themselves as women and to emphasize the importance of reaching out to the patients during the OPD hours. The counselors have presented the work at Dilaasa at a number of trainings for community social workers and other health professionals.

The center was visited by UNAIDS International Goodwill Ambassador and actress Aishwarya Rai Bachchan, UNAIDS Deputy Executive Director Dr Luiz Loures and the Indian Secretary of the Department

of AIDS Control Dr VK Subburaj on 8th March, International Women's Day. They met with the counselors and some of the women who had sought services from Dilaasa.

V DOCUMENTATION AND PUBLICATION (CEHAT)

E-bulletin: CEHAT E-Bulletin January to March and April to June 2014

Publications

Reports

David, Siddarth; Contractor, Sana and Jain, Anita (2014). Hospital Preparedness and Response: 2008 Mumbai Terror Attacks. Mumbai: CEHAT (in process)

Articles

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STAFF DETAILS AS ON 31sT MARCH 2014

Name of the Staff	Designation	
Shobha Kamble	Office Assistant	15,985.00
RadhaPande	Secretary	19,960.00
Anjali Kadam	Secretary	20,660.00
Suchitra Wagle	Research Officer	23,704.00
Sonal Vasanthan	Administrative Assistant	24,845.00
Rashi Vidyasagar	Research Associate	25,295.00
Jasmin Chembuparambil	Research Associate	25,295.00
Ritisha Dukhande	Research Associate	25,520.00
Asilata Karandikar	Research Associate	25,520.00
lpsita Gauri	Senior Research Associate	27,856.00
Pramila Naik	Junior Administrative Officer	31,221.00
Sangeeta Rege	Senior Research Officer	49,062.00
Padma Deosthali	Coordinator- CEHAT	84,333.00
Sudhakar Manjrekar	Office Assistant	15,985.00
Dilip Jadhav	Office Assistant	15,985.00
Vijay Sawant	Secretary	21,010.00
Dhruv Kulshreshta	Research Associate	25,295.00
Siddharth David	Senior Research Associate	29,846.00
Sumeet Pokharnikar	Senior Research Associate	30,396.00